

MEDICAL HOME

Over the last several years, several problems affecting the efficient delivery of health care services have been identified. Prominent among these are the high and growing prevalence of chronic illness in the population and the expected shortage of primary care physicians. The convergence of these two problems has led to the concept of the patient-centered medical home as a model for efficient and effective primary care.

Maine has a high incidence of chronic illness in the population. These diseases, including obstructive lung disease, diabetes, cardiovascular disease, and cancer, affect a high number of Mainers. Nationwide, 45% of the population has a chronic illness, and half of these people have more than one. The incidence of chronic disease is higher in older people. 83% of Medicare beneficiaries have one or more chronic conditions; 23% have five or more. Complications of chronic disease account for a large portion of hospital admissions and for emergency room use. Many of the episodes causing these services are felt to be avoidable, that is, they could have been prevented with more adequate primary care.

However, primary care practices have been hampered by increasing clinical and administrative demands and by declining reimbursement relative to other specialties. As a result, fewer medical school graduates are entering primary care fields.

The concept of the patient-centered medical home (also called the advanced medical home) has been advanced by primary care associations and specialty societies as one that embodies the principles of coordinated, longitudinal, relationship-based care which should be supported by an alternative payment model that recognizes the investment required by practices to embrace this model. Collaborations of providers, purchasers, and payers have formed to promote the medical home model across the country. Many practices, health systems, purchasers and payers in Maine have expressed interest in a medical home pilot model. The medical home model will embody the principles advanced by the American College of Physicians, the American Academy of Pediatrics, the American Association of Family Practice, and the American Osteopathic Association. These include:

- Every patient has a personal physician
- Care is provided by a physician-directed team that collectively cares for the patient.
- The personal physician is responsible for providing all patient's needs. Or arranging for services to be provided by others.
- Care is coordinated and integrated across all aspects of healthcare.

- Quality and safety are hallmarks; evidence-based guidelines and tools guide care; the practice regularly assesses the quality of its care.
- Patients are offered enhanced access to care (e.g. expanded hours, enhanced communication).
- Payment recognizes added value of medical home.

Studies have shown that practices modeled on these principles are associated with better patient outcomes, reduced costs, and reductions in health disparities. Notably, the Primary Care Study Commission of the current legislature included recommendations to change primary care practice in this way.

Maine Quality Forum, along with Quality Counts, the Maine Health Management Coalition, Martins Point Healthcare, and Anthem Blue Cross Blue Shield of Maine have begun preliminary discussions about implementing a medical home pilot project in Maine.

Tasks:

By the end of 2008, an initial planning period will result in:

- Formation of a wider steering group to guide the pilot
- Identification of key principles for a Maine-based model which is consistent with emerging national models and supports principles that are unique to Maine
- A structured process for obtaining direct input from patient and consumers about their vision for the medical home
- Identification of clear goals for the pilot
- A framework for evaluation of the pilot, including specific performance measures and data sources
- Convening of all major private and public payers in Maine to discuss a common framework of reimbursement policies and methods
- Recommendations for benefit design elements needed to support effective implementation of the medical home.
- Identification of practices to participate in the pilot
- A plan and methods to support the practice transformation needed to become a medical home
- A plan for linking pilot practices with local community resources and the public health infrastructure
- A business case for stakeholders that identifies resources needed to support all components of the pilot project, including project leadership, practice payment, practice transformation, and evaluation of the pilot, as well as potential sources of funding to support these.