



The Medical Home

**The Triple Aim
Institute for Healthcare Improvement**

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Medical Home – Background

Evidence shows that having an effective longitudinal function in healthcare that can address simple medical problems, coordinate complex medical care, screen effectively and provide early interventions, and help navigate the complex healthcare system, results in improved outcomes for less total cost and improved satisfaction. This function is often called primary care and the label ‘medical home’ has more recently been used.

In most medical systems this function has been centered around a primary care physician and their medical office practice. The Medical Home effort in the U.S. has been largely driven by the professional associations of primary care physicians. While this has helped bring coordination and visibility to the discussion, this physician led approach threatens to limit both the support for the discussion and the range of possible medical home structures.

The NCQA has proposed Medical Home measures. In other countries it has been a variable mix of professional organizations and government policy structures. The limitation of the efforts to date has been an over-simplification of the requirements and continued emphasis on physician based delivery structures. In the U.S. similar over-simplification of deliverables and structures has resulted in the perceived ‘failure’ of the managed care/gatekeeping efforts in the 1990’s and the CMS sponsored Nurse Case Management efforts of this decade. The ‘Medical Home’ effort is at risk of the same end point in the way it is currently developing.

The Medical Home effort within the IHI Triple Aim framework has resulted in a more flexible and robust result. The emphasis has been on functions, not structures, and taking a whole system perspective of healthcare design while nesting within that overall structure an optimally functioning basic platform of longitudinal care, care coordination, and effective partnering between those giving and receiving health services. By not defining the specific structures, it allows for innovation and creativity to develop around structures and methods for accomplishing the needed functions.

Characteristics of a ‘Medical Home’

1. **Population Health** - Ability to relate effectively to a population over time around personal health issues – the ‘what’ of a medical home
2. **Effective internal design** – the ‘how’ of a medical home – team design, information management, relationship optimization, whole person – whole family capabilities.
3. **Ability to coordinate care** across entire range of health system services – care coordination, navigation, macro and micro system capability.
4. **Ability to optimize role in larger community** – optimizing interactions with other community resources (social services, housing, transportation, etc.) and becoming truly community responsive and community driven in design and use of resources.

Design Assumptions

As these four characteristics/levels of activity of a medical home are discussed and developed, there are some basic assumptions/requirements that are underlying this work:

- 1. The control of most variables related to chronic health conditions lies with the individual and is heavily influenced by their context, beliefs, values, and social network. Therefore for any system to be effective it must be primarily driven by them, their priorities, their needs.
- 2. The work of a Medical Home is similar to other service industries, not manufacturing or product industries. Therefore how we select our workforce, structure them, train them, reward them, and motivate them must reflect this reality. Who we learn from, benchmark against, and aspire to be like are service industry leaders.
- 3. The Medical Home is a classic complex adaptive system. This means that simple rules, protocols, and standards will not be effective as the primary tools to drive excellence. It is necessary to adopt principle driven frameworks and management systems instead and strive to create effective learning organizations where all involved in the system continually ‘own’ the system and its effectiveness.
- 4. The ‘Medical Home’ is the unifying, coordinating function underlying the entire health system and the entire health system therefore must rethink and reorganize to optimize all part of the system as an intentionally designed overall system with the ‘Medical Home’ as the main coordinating hub for the population.

· The term ‘Medical Home’ is an inadequate term. The work ‘medical’ is too limiting and has too many associated conceptions of its meaning. The word ‘home’ has connotations of a specific physical location, which is in the way of becoming this coordinating, integrating function. The best design will weave appropriate services into the day to day life of those receiving services as much as possible rather than requiring services to adapt to the system’s locations and structures. The best effort will describe and require functions and outcomes and not predetermine any particular structures or specific array of clinical professionals.

Further Development of the four Requirements of a Medical Home:

- I. Level 1 - **Population Health** - Ability to relate effectively to a population over time around personal health issues – the ‘what’ of a medical home
 - a. Narrative Discussion
 - i. Healthcare expenditures are a common good. Even in the U.S. the majority of funding is either through the government or by employers on behalf of a group of people. Therefore, healthcare expenditures are mostly provided for the population and expenditure prioritization and structure ought to be customer/community driven.
 - ii. All providers of basic services and coordinators of services across the system should be obligated to create systems that effectively track population health and provide opportunity for improvement and intervention at the population level and the individual level in the context of overall population health.
 - iii. This requires information systems capable of tracking health status, identifying opportunities for proven appropriate interventions, and the ability to interact well with those receiving services - to improve health measures over time.
 - b. Level One Measures
 - i. Individuals on panel /list per responsible individual/team providing services.
 - ii. Number of contacts per year per person with primary provider (PCP) or team and total visits throughout the rest of the system.
 - iii. Match Rate – number of times seen by PCP or Case Manager as a percentage of total direct entry level encounters into the system.
 - jjj. Number of pt driven PCP changes per month/year
 - ii. Identifying through Registries of the number per panel with key modifiable clinical conditions – DM, CHF, Cancer, HIV, Obesity, Tobacco, Learning disability, etc.
 - c. Level One Questions
 - i. Do you currently have a defined list or population? How could you move toward this?
 - ii. Can you generate disease registries for your population, and track your effectiveness in delivering good care to groups of patients? What would move you closer?
 - iii. How do you prepare your workforce to deliver care for a defined population? How do you propose to do case management and care coordination?

- iv. What other challenges need to be addressed? What measures should be in place?
 - v. What skills does your system need that it does not have?
- d. What could you test by next Tuesday?
- i. Defined population for each care provider
 - ii. Disease Registries launched
 - iii. Multi-faceted access expanded – add email, phone, extenders
 - iv. Define performance standards – create data mall
 - v. Begin process of run charts with performance on key population health measures.
 - vi. Make it easy to always interact with the same provider and/or case manager
 - vii. Make it so the care team only interacts with their assigned patients
- II. Level 2 - **Effective internal design** – the ‘how’ of a medical home – team design, information management, relationship optimization, whole person – whole family.
- A. Narrative Description
- i. In order to effectively interact with a defined population over time, barriers to access must be removed or minimized (time, place, language, style, attitude, gender, culture, etc.). Evidence shows that personal, first name basis relationships greatly enhance the ability to modify behavior, improve outcomes, and reduce cost. Strong evidence also exists to support integrated care teams, bringing the mind and body back together, and using non-physicians extensively. The more the system can weave services into the lives of those receiving the services on their terms, the more likelihood of sustainable improvements in outcomes and costs.
 - ii. At a minimum there is wide consensus that a Medical Home must be able to:
 1. Provide definitive care for basic medical conditions
 2. Facilitate self care and care across the continuum
 3. Be integrated teams capable of managing physical, mental, spiritual aspects.
 4. Optimize roles of each team member
 5. Provide optimal, multifaceted Access
 6. Listen to customer and act on what is said
 7. Measure and act on findings

B. Activities required to do this appropriately:

- i. Defining the purpose – optimal personal, human, trusting, accountable relationships
- ii. Moving from product to service as the fundamental base of entire system
- iii. Customer driven design – reallocation by design of power and control at every level
- iv. Ability to connect deeply in story – understanding context, values, personal motivators, social network/family – and ability to inspire and motivate to action
- v. Understanding principle driven management processes and structures, that the ‘medical home’ work is by definition messy human relationship stuff both in relating to those receiving service and managing those providing the service.
- vi. Become a learning organization

C. Level 2 Measures

- i. Access – same day? 3rd next available?
- ii. % virtual visits (vs. exam room visits)
- iii. PMPM visits to ER? Urgi-care?
- iv. Satisfaction ratings – those receiving and giving services
- v. Staff turnover rates
- vi. % on target for prevention and screening – immunizations, cancer screening, other
- vii. % within defined targets for chronic conditions – DM measures, HTN, Chol, CHF, HIV – benchmarked with HEDIS or other
- viii. BH measures – depression, anxiety, referrals – screening, improvement in scores, evaluation of referral quality, etc.
- ix. Total cost PMPM across entire system.
- x. Ambulatory Sensitive Conditions admission rate

D. Level Two Questions

- i. Who is on this team? What are their roles? How do they know?
- ii. How is the individual and the family seen as members of the team?
- iii. How important is the idea of mind and body back together – behaviorists on team
- iv. Provide same-day access? Alternatives to in-person visits?
- v. What other challenges/opportunities need to be addressed? What measures in place?
- vi. What skills does your system need that it does not have now?

E. By Next Tuesday...

- i. Flow diagram of current processes.
- ii. Evaluation of flow diagram for current roles and responsibilities – and evaluation of possibility of changing these – everyone doing only those things that only they can do – work at the top of your license.
- iii. Open discussion as to the co-location and integration of:
 1. Behaviorists, Dieticians, Social Workers, Pharmacists
 2. Case Managers – and – Case Management Support
- iv. Consider all phone calls directly to care team rather than any other centralized, triage, advice line, or other work-around.

III. Level 3 - **Ability to coordinate care** across entire range of health system services – care coordination, navigation, macro and micro system capability.

A. Narrative Description

- i. Evidence shows that effective ‘navigation’ or care coordination will reduce total costs and improve outcomes - if done well. Evidence also shows that this must be personal, human, and longitudinal in a supportive way or it will fail (as proven by CMS attempt at impersonal phone based case management).
- ii. Redefinition of most specialty care to be only that which only specialists can do – consultative advisory (not ‘owning’ the patient) and procedure (specialized complex surgical or other procedure only done by a specialist) are the roles for specialists.
- iii. Healthcare is too complex and expensive to rely on self-navigation and coordination for all but the few highly informed and motivated in society.

B. Level 3 Measures

- i. Hospital Re-Admission rates w/in 30 days
- ii. PMPM visits to specialists
- iii. Number of service agreements with specialists – and performance measures put in place and used by those signing the service agreements.
- v. Quality of care measures for specified chronic conditions requiring specialty coordination – CHF, MI, HIV, COPD, Liver disease, complex children, etc.
- vi. PMPM use of high end tests or procedures??

C. Level 3 Questions

- i. How does a primary care practice determine what services it will provide (make) and what it will refer elsewhere (buy)?
- ii. Does primary care ‘do’ transitions or is it specialized?
- iii. How can a primary care practice engage specialty care in addressing the needs of a population? Providing services closer to the community? Co-located?
- iv. What is the role of the family in integrating care?
- v. What needs redesigning in primary care to do this well?
- vi. Can primary care manage hospital discharges?
- vii. What other opportunities need to be addressed? What measures should be in place?

D. What Could be done by next Tuesday

- i. Open discussion with key specialists about relative roles and responsibilities
- ii. Begin writing at least one service agreement with one specialist you work with well.
- iii. Invite one key specialist to explore them doing at least part of their work at your primary care site.
- iv. Identify primary care role in hospital discharges

IV. Level 4 **Ability to optimize role in larger community – becoming community responsive and community driven** – optimizing interactions with other community resources (social services, housing, transportation, etc.) and becoming community responsive and community driven in design and use of resources.

A. Narrative Discussion

- i. The majority of health expenditures come from the government or employers for the good of groups of people. Therefore healthcare is a community asset and the community ought to drive prioritization of expenditures and system design, particularly as related to other community assets and programs.
- ii. Community variables drive population health outcomes more than medical services and there is good evidence to show that close connectivity between employment, workplace health services, education, housing, social services and transportation results in improved outcomes and reduced costs at a population level.

B. Level 4 Measures

- i. Quality of Life measures at an individual, family, and community level.
- ii. Number of written service agreements in place between healthcare structures and other community structures – and measures of effectiveness of these agreements.
- iii. Patient reported obstacles due to money, transportation, child care, etc. to proven health services.
- iv. PMPM referral rate ‘in’ or ‘out’ of community services by the local healthcare structures/programs.
- v. % individuals reporting active exercising over time
- vi. % individuals reporting regular helmet use
- vii. Tobacco use
- Viii. PMPM rate of change in ‘home’ location (amount of moving around is a fairly sensitive indicator of high social complexity and risk).

C. Level 4 Questions

- i. How can connecting to community resources be improved?
- ii. What activities belong in a practice versus other structures/locations?
- iii. How should the effectiveness of primary care be measured/rewarded in a community context?
- iv. What is the ‘responsibility’ of a private practice to the community? How should the community ‘shape’ it?
- V. Is all health money a community good? How is prioritization of healthcare money expenditure discussed and done with an eye towards overall community good?
- Vi. What other challenges/opportunities need to be addressed? What measures should be in place?

D. Level 4 By Next Tuesday

- i. Open discussion with key community leaders and/or organizations about relative roles and responsibilities
- ii. Begin writing at least one service agreement with one community or organization.
- iii. Invite one key community member or organization to open conversation about them doing at least part of their work at your primary care site.

- iv. Identify primary care role in community conversations on funding and planning priorities
- v. Invite several community members to be part of your Board or create a very active community advisory council (or several of them).

V. Summary—Required elements to successfully create effective Medical Homes

A. Workforce – new realities

- i. Complex Adaptive Systems – all staff must be engaged, skilled, and ‘owning’ system
- ii. Principle driven management and design
- iii. Human interaction, teaching, motivating, supporting – partnering – main skill to hire for, train for, and reward!
- iv. Different managers/leaders needed than what has usually been done in healthcare
- v. Training, rewarding, advancement all need redefinition to align expenditures, rewards, and incentives
- vi. Meeting to design, improve, review and learn – all done in integrated teams
- vii. Job Progressions, Career Ladders
- viii. Formal Mentorship with curricula, goals, measures, forms, advancement defined
- ix. Network of Directors, Improvement Advisors, Improvement Specialists, others
- x. Work at top of your license,
- y. De-officing managers, group offices for leadership
- z. Effective use of dashboards, scorecards, data
- aa. Create a learning organization
- xi. Three Areas of Competency for All Staff:
 - 1. Connecting Deeply in Story – Relationship - (Senge - Society for Organizational Learning, SCF Core Concepts)
 - 2. Technical Improvement Skills – Improvement - basic analysis, problem solving, data – PDSA, run charts, control charts, ADLI, dashboard (Brent James ATS training, IHI Improvement Advisor training)
 - 3. Alignment, Big Picture, Context – Application of Baldrige framework. Operational Principles, Scorecard, Annual plan, performance action plans, project charters, etc.

B. Patient and Family Roles

- i. Self-Care – meet them where they are and walk in respectful partnership
- ii. High end self-care and family-care – encourage and support those highly capable
- iii. Identify primary family ‘coordinator’
- iv. Honor, respect, dignity – deep listening – will result in expanded self-care
- v. More Self-confidence = more self care

C. Information Management

- i. Ability to know all data related to the individual and their ‘family’ when needed.
- ii. Ability for each individual receiving services to have access to their information and to interact effectively with their care team around that information.
- iii. Ability to track at a population level and to generate action lists where appropriate.
- iv. Ability to provide optimal decision support to those giving services and those receiving services to assure best possible information is being used optimally all the time.

D. Structures - Ultimately ‘primary care’...

- i. *Will not be a ‘Medical Home’ – but a set of functions and relationships built optimally into everyday life.*
- ii. Will allow for there to be various ways of providing these functions and relationships and they will continually improve and evolve
- iii. Will be learning entities continually adapting and improving in their ability to support the health journey of the individual, family, and community

VI. Remember...

- A. THEY ARE in control (those receiving services).
- B. We are a service industry in primary care
- C. Team based approaches – or very small pt. panels
- D. Longitudinal relationship only works with unimpeded access – time, place, language, attitude, culture, gender, etc.
- E. They must define and ‘own’ the goals, success, what is of value
- F. ‘We’ want...
 - i. Optimized overall costs and optimized uses of all that modern medicine offers
 - ii. Good population and individual health outcomes over time
 - iii. Excellent Experience of Care
 - 1. Quality, Safety
 - 2. Satisfaction, Delight
 - 3. Expanded self confidence and pride
- G. In their words...
 - i. They give me what I and my team have defined I need when, where, and how I want and need it...in a safe, effective, and optimized way...*
 - ii. They really know me and care about me*
 - iii. They listen to me, advise me, and support me on my entire health journey*
 - iv. My questions and concerns are answered, my care is coordinated, my values and goals are what drive my health plans*

Project Coordinator’s Concluding Note --- Reviewers of this document have suggested that this framework should not be limited to the Medical Home/Primary Care conversation, but ought to be broadened to the entire Triple Aim Conversation – that these four characteristics/ levels/functions are what the overall system needs to be talking about and structuring around. It is my opinion that these are one and the same discussion – that what primary care must do as the coordinating, longitudinal hub of the entire system, is, by definition, therefore the core function/requirement of the entire health system.





