

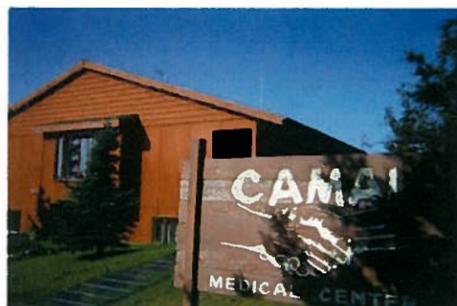
Tri-state Child Health Improvement Consortium

(Oregon, Alaska & West Virginia)



Medical Home Model Demonstration

What is a Medical Home?



Alaska's T-CHIC Goals

1. Test Federal Quality Measures of Children's Care
2. Promote the Use of Health Information Technology (HIT)
3. Develop Medical Home Approaches for Children's Care

Pilot Projects

will address all three of the following areas:

- ▶ Developing, adopting and/or implementing quality measurement tools.
- ▶ Developing, adopting and/or improving Health Information Technology, Electronic Health Records (EHR) and participation in Health Information Exchanges (HIE).
- ▶ Developing, adopting and/or improving medical home approaches to child care.

Seven Core Competencies of an Alaskan Medical Home

DHSS has identified a set of seven core competencies that a primary care practice must attain in order to be a medical home.

1. Patient Access.

Patient access encompasses:

- ▶ Improving the means by which patients can access primary care providers and their services by using non-traditional means such as email, text messaging, and telephone consultations; and enhancing depth of telemedicine capabilities.
- ▶ Establishing a medical home relationship with a personal provider or care team such that each patient and his or her family has a specific primary care provider and care team that is taking responsibility for providing and managing his or her care, and building capabilities to complement primary care/medical home with care/case management for children.
- ▶ Providing 24-hour access seven days a week to a member of the care team or a triage service trained to support a medical home by providing appropriate care or referrals rather than using the emergency department.



2. Accountability and Quality Improvement utilizing population approaches to care.

Quality improvement encompasses:

- ▶ Improving the degree to which health services for individuals and populations attain desired health outcomes and are consistent with current professional knowledge.

Population approaches encompass:

- ▶ Using data to track the health status, and changes in health status, and to track/delivery of evidence-based care to the practice's full population, and to subgroups of the practice population.
- ▶ Managing members of a population with a defined condition in a manner that proactively identifies and meets educational and service needs that address the targeted condition as well as all health care needs;
- ▶ Emphasizing and documenting patient self-management



3. Patient/Family Centeredness.

Patient/family-centered care is a negotiated agreement between patient/family and provider and encompasses:

- ▶ patient/family education about the management of the patient's medical condition, and
- ▶ patient/family participation in selecting goals and strategies of patient and family-centered care, and in assessing if they are working.
- ▶ Patient/family participation in evaluating medical home performance.
- ▶ increasing transparency and communication around pediatric and pediatric subspecialty services.



4. Continuous Culturally Effective Care.

Continuous Culturally Effective Care encompasses:

- ▶ Provider continuity,
- ▶ Information continuity,
- ▶ encouragement of continuity of patient eligibility,
- ▶ geographic continuity,
- ▶ provisions for overcoming language barriers,
- ▶ recognition and respect for cultural background, beliefs, rituals and customs

5. Coordinated and Clinically Managed Care.

Coordinated and clinically managed care encompasses:

- ▶ care coordination for patients (and their families) who have current medical conditions and/or risk factors or who are healthy, but in need of services to prevent diminution of health status.
- ▶ clinical care management services for children with chronic conditions and/or special needs.



6. Team-based, Comprehensive Care.

Team-based, comprehensive care:

- ▶ means a care team, composed of at least the primary care clinician, another licensed care provider, and a care coordinator that assumes responsibility individually and collectively for providing and coordinating the provision of health and support services needed by the patient across the continuum of care. Team members may be located in different communities and coordinate care delivery through HIT, EHRs, HIE, Tele-Health or other effective communications.
- ▶ refers to the availability of a wide range of services in primary care, dental and behavioral health and their appropriate provision across the entire spectrum of types of needs for all but the most uncommon problems in the population by a primary care provider and/or care team. This includes services that promote and preserve health; prevent disease, injury and dysfunction; and care of illness, disability and discomfort as long as these needs are not too uncommon for the primary care practitioner to maintain competence.
- ▶ developing and improving communication and coordination of comprehensive care delivery



7. Cost Control and Alternative Payment Options

Cost control and alternative payment options encompass:

- ▶ strategies that alter the financial incentives of traditional fee for service (FFS) compensation, and encourage effectiveness and efficiency rather than quantity.
- ▶ providing financial incentives to achieve efficiencies in health care delivery.
- ▶ maintaining or reducing per-patient costs while improving overall population outcomes.



Quality Measurement Tools

- ▶ The Program and successful applicants will use tools provided by CMS and AHRQ as the basis of discussion for selecting the "quality measures" they will test.

- ▶ It is anticipated that several of the 24 proposed quality measures may not be amenable to practice-based reporting, but will require state Medicaid claims and enrollment data for accurate reporting.

- ▶ Reference materials to be used include the 24 quality measures proposed by CMS for Medicaid and Denali Kid Care eligible pediatric patients

Health Information Technology

- ▶ Applicants are expected to adopt the use of Electronic Health Records (EHRs) and to participate in the state Health Information Exchange (HIE) to improve coordination and quality of care.

- ▶ The use of EHRs and their private, secure exchange between practices and the authorized entity (HIE) will facilitate data collection and provide timely feedback to providers.

- ▶ It will also support state Medicaid and Denali Kid Care reporting on quality measures for required reporting and for undertaking program improvement.

