The Patient-Centred Medical Home

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The Patient-Centred Medical Home

What is our shared vision for the health system?

What is my role in it?

The PCMH in the health system

The Medical Neighbourhood

Implementation examples

Primary Health Care

Shi L, Macinko J, Starfield B, Wulu J, Regan J, Politzer R. The relationship between primary care, income inequality, and mortality in US States, 1980-1995. The Journal of the American Board of Family Practice /American Board of Family Practice. 2003;16(5):412-22.

Shi L, Macinko J, Starfield B, Xu J, Politzer R. Primary care, income inequality, and stroke mortality in the United States: a longitudinal analysis, 1985-1995. Stroke. 2003;34(8):1958-64.

USA

Starfield B, Shi L. Policy relevant determinants of health: an international perspective. Health Policy. 2002;60(3):201-18.

13 industrialised countries

Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. Health services research. 2003;38(3):831-65.

18 OECD countries

Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502.

Primary Health Care

Strong primary health care in a health system is associated with

- reduced system costs
- better outcomes
- reduced health impacts of social inequalities

An increase of 1 primary care physician per 10000 US population associated with a 5.3% reduction in average annual mortality.

STILL TRUE?

Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015.

Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. JAMA Intern Med. 2019 Feb 18. doi: 10.1001/jamainternmed.2018.7624.

- 3142 US counties, 7144 primary care service areas, 306 hospital referral regions
- 10 additional primary care physicians per 100 000 population associated with a 51.5-day increase in life expectancy
- 10 additional specialist physicians per 100 000 population associated with a 19.2-day increase in life expectancy
- 10 additional primary care physicians per 100 000 population associated with reduced cardiovascular, cancer, and respiratory mortality by 0.9% to 1.4%.

The Patient Centred Medical Home?

Standards for Child Health

American Association of Pediatrics 1967

“For children with chronic diseases or disabling conditions, the lack of a complete record and a ‘medical home’ is a major deterrent to adequate health supervision. Wherever the child is cared for, the question should be asked, ‘Where is the child’s medical home?’ and any pertinent information should be transmitted to that place” (pp 77-79).

The Patient Centred Medical Home

The 2007 "Joint Principles of the Patient Centred Medical Home"

http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf

Seven principles agreed by all primary care colleges in the US and ratified by 22 professional organisations.

Agency for Health Care Quality and Research & PCPCC

http://www.pcpcc.org/about/medical-home http://pcmh.ahrq.gov/page/defining-pcmh

Five principles describing a medical home in the US context, built on the principles agreed by all primary care colleges in 2007 and appear on US govt website.

Safety Net Medical Home Initiative

http://www.safetynetmedicalhome.org/change-concepts

Eight change ideas are less descriptive and more "how" to transform an organization to a medical home

Australian Centre for the Medical Home

Eleven principles resulting from a consultation process which was deliberately inclusive to capture all ideas relevant to the Australian expression of the medical home.

http://medicalhome.org.au/what-is-a-medical-home/

RACGP "what is general practice"

http://www.racgp.org.au/becomingagp/what-is-a-gp/what-is-general-practice/

This definition contains many elements of the others and additionally places general practice in the context of the health system

The PCMH

The 2007 "Joint Principles of the Patient Centred Medical Home"	**Agency for Health Care Quality and Research**	**Safety Net Medical Home Initiative**	**Australian Centre for the Medical Home**	**RACGP "what is general practice"**
http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf	*http://www.pcpcc.org/about/medical-home* *http://pcmh.ahrq.gov/page/defining-pcmh*	*http://www.safetynetmedicalhome.org/change-concepts*	*http://medicalhome.org.au/what-is-a-medical-home/*	*http://www.racgp.org.au/becomingagp/what-is-a-gp/what-is-general-practice/*
Agreed by all primary care colleges in the US and ratified by 22 professional organisations. Has an "industrial" tone in the funding principle.	*These five principles describe a medical home in the US context, are built on the principles agreed by all primary care colleges in 2007 and appear on US govt website.*	*These eight change ideas are less descriptive and more "how" to transform an organization to a medical home*	*These eleven principles are the result of a consultation process which has been deliberately inclusive to try to capture all ideas relevant to the Australian expression of the medical home.*	*This definition contains many elements of the others and additionally places general practice in the context of the health system*
PATIENT CENTRED				
NO EQUIVALENT	Patient-centered: A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.	Patient-Centered Interactions: Respect patient and family values and expressed needs. Encourage patients to expand their role in decision-making, health-related behaviors and self-management. Communicate with their patients in a culturally appropriate manner, in a	NO "PATIENT–CENTRED" PRINCIPLE AS SUCH Self Management A medical home will have systems to foster self management of each person's health Patient Participation	person centredness: general practitioners understand that health, illness and disease are ultimately personal experiences, and that their principal role is to relieve personal dis-ease in all its forms, in the manner best suited to each individual. The patient's needs, values and desired health

		that the patient understands. Provide self-management support at every visit through goal setting and action planning. Obtain feedback from patients/families about their healthcare experience and use this information for quality improvement.	Patients will be able to participate in the design of the services that a medical home offers.	remain central to the general practitioner's evaluation and management processes.
COMPREHENSIVE				
Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.	Comprehensive: A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.	Continuous and Team-Based Healing Relationships: Establish and provide organizational support for care delivery teams accountable for the patient population/panel. Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.	Comprehensive, whole person care A medical home will be the custodian of a person's whole health story. It will either provide care itself, or make sure that people can access the most appropriate provider for all their health needs.	comprehensiveness: general practitioners are not limited by age, gender, body system, disease process or service site. The scope of clinical practice is challenging, spanning prevention, health promotion, early intervention for those at risk, and the management of acute,
		Ensure that patients are able to see their provider or care team whenever possible. Define roles and distribute tasks among care team members to reflect the skills, abilities and credentials of team members.	Team Based Care A medical home adopts a team based approach that includes practice nurses in the role of care managers, and other allied health providers.	chronic and complex conditions within the practice population whether in the home, practice, health service, outreach clinic, hospital or community.

COORDINATED				
Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.	Coordinated: Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.	Care Coordination: Link patients with community resources to facilitate referrals and respond to social service needs. Integrate behavioral health and specialty care into care delivery through co-location or referral agreements. Track and support patients when they obtain services outside the practice. Follow-up with patients within a few days of an emergency room visit or hospital discharge. Communicate test results and care plans to patients/families	Connections to the 'medical neighbourhood' A medical home will have good relationships with other providers in their community. It will act as a gateway to the health system. and will have developed systems to make sure that all providers in a patients care are part of an integrated care team – with clear roles, goals and communication pathways.	coordination and clinical teamwork: general practitioners work in close and respectful relationships to deliver accessible, integrated patient care: leading, supporting and coordinating their flexibly configured clinical teams; contributing appropriately to external clinical teams, and engaging with diverse specialists and other sector services according to individual patient or family needs. The general practitioner is increasingly the custodian of, and conduit for, key patient clinical information.
ACCESSIBLE				
Enhanced access to care is available through	Accessible: Patients are able to	Enhanced Access: Promote and expand	Accessibility A medical home will	NO EQUIVALENT
systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice	access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT	access by ensuring that established patients have 24/7 continuous access to their care teams via phone, email or in-person visits. Provide scheduling options	actively manage its appointment systems to improve the provision of timely routine appointments. It will have systems to	

the medical home model. Patients and families participate in quality improvement activities at the practice level.				and managing their health according to individual capacities.
NO EQUIVALENT	NO EQUIVALENT	Engaged Leadership Provide visible and sustained leadership to lead overall culture change, as well as specific strategies to improve quality and spread and sustain change. Ensure that the PCMH transformation effort has the time and resources needed to be successful. Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model. Build the practice's values on creating a medical home for patients into staff hiring and training processes.	NO EQUIVALENT	NO EQUIVALENT
Payment appropriately recognizes the added	NO EQUIVALENT	NO EQUIVALENT	NO EQUIVALENT	NO EQUIVALENT
value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-				

Patient Centred
Comprehensive
Coordinated
Accessible
Quality and Safety

Accountable
Continuity

Patient Centred Care

A Medical Home partners with patients, carers, and family to ensure cultural preferences and values are respected. Patients receive the education and support they need for shared decision making and to manage their own conditions to the extent they are able. Patients have the opportunity to participate in the care design of the medical home.

Comprehensive

The medical home team is responsible for the range of each patient's physical and mental healthcare needs - including prevention and wellness, acute care and chronic care.

Care in the medical home is continuous - each patient has an ongoing relationship with a particular GP and the medical home team.

Coordinated

The medical home ensures each patient can access the full team they need to manage their health, which includes arranging and coordinating care with other providers. This may sometimes include hospital inpatient care.

The medical home ensures that each person experiences integrated (joined-up) health care, in which there is informational consistency between all team members with clear roles, goals and communication pathways.

The medical home retains accountability for a patient's care, even when that person is not standing in front of them. It tries to ensure that each patient receives best possible care from all members of their care team.

Accessible

In a medical home, patients can access care for their acute or routine medical needs when required. The medical home is also proactive in managing chronic conditions

A medical home uses a range of communication tools with patients, (face to face/telephone/virtual)

Focus on Quality and Safety

A medical home has a system based approach to make sure that each patient receives best practice care. It has systems to improve patient safety.

A medical home is the curator of each person's medical history, and maintains accurate clinical records.

It uses registers to monitor patient population needs, and it measures performance for quality improvement.

Evaluations

Agency for Healthcare Research and Quality 2014 Zutshi et al

Reviewed 498 articles 2000-10. 14 evaluations of 12 interventions. “mostly inconclusive results” “found some favorable effects on quality of care, hospital and emergency department use, and patient or caregiver experience, and a few unfavorable effects on costs.”

https://pcmh.ahrq.gov

Patient Centred Primary Care Collaborative 2016 The Patient-Centered Medical Home’s Impact on Cost and Quality Annual review of evidence 2014/15

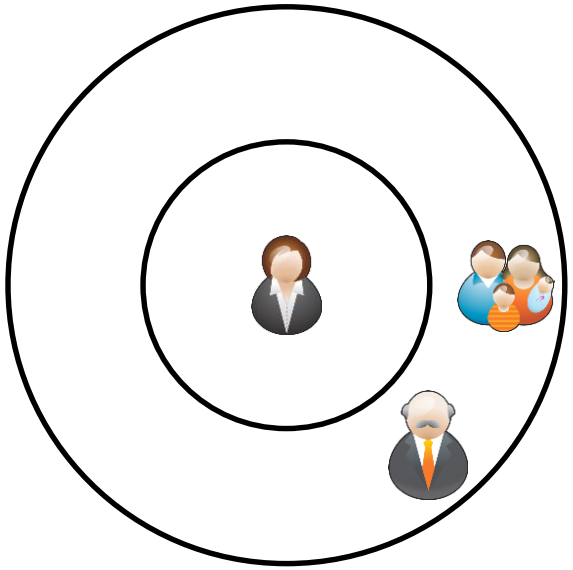
30 initiatives. 21/23 reported cost reductions

https://www.pcpcc.org

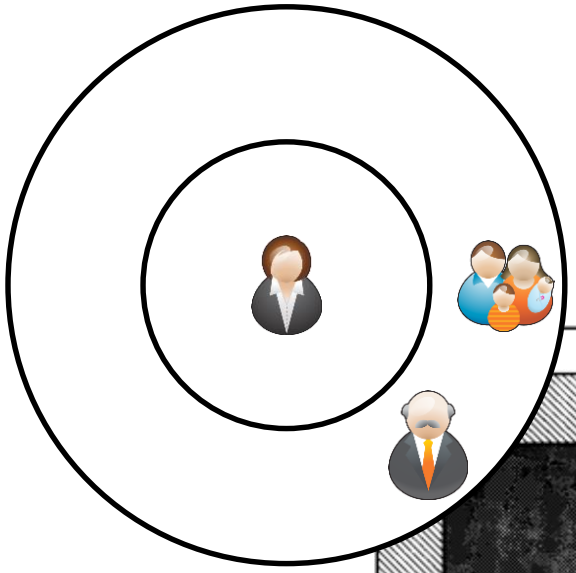
Sinaiko et al Health Affairs 36, no.3 (2017)

Metaanalysis of 11 major initiatives. Heterogeneity in outcomes. 1.5 percent reduction in the use of specialty visits and a 1.2 percent increase in cervical cancer screening among all patients, and a 4.2 percent reduction in total spending (excluding pharmacy spending)and a 1.4 percent increase in breast cancer screening among highermorbidity patients.

Home



Home



White KL 1961

THE ECOLOGY OF MEDICAL CARE

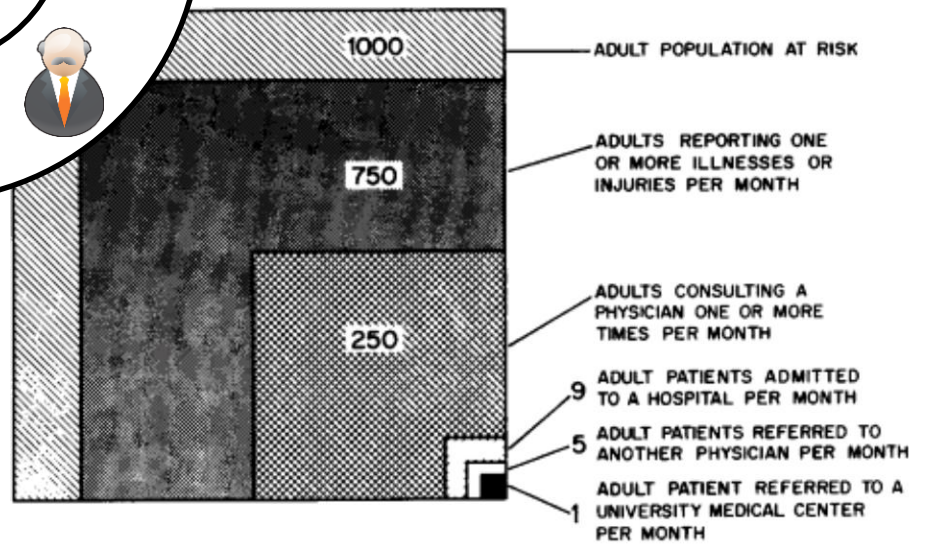
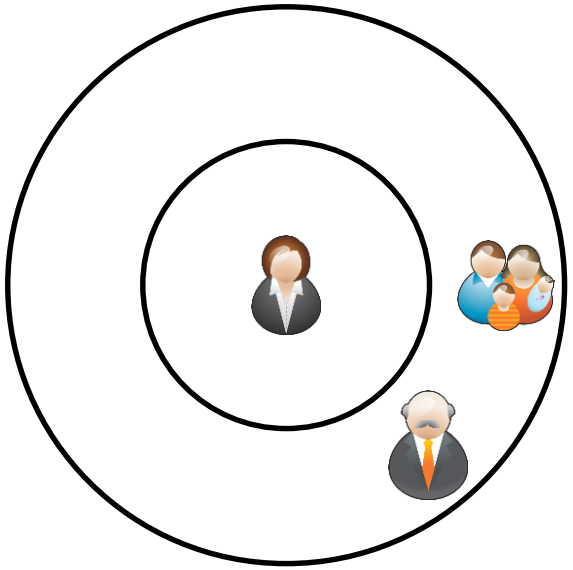
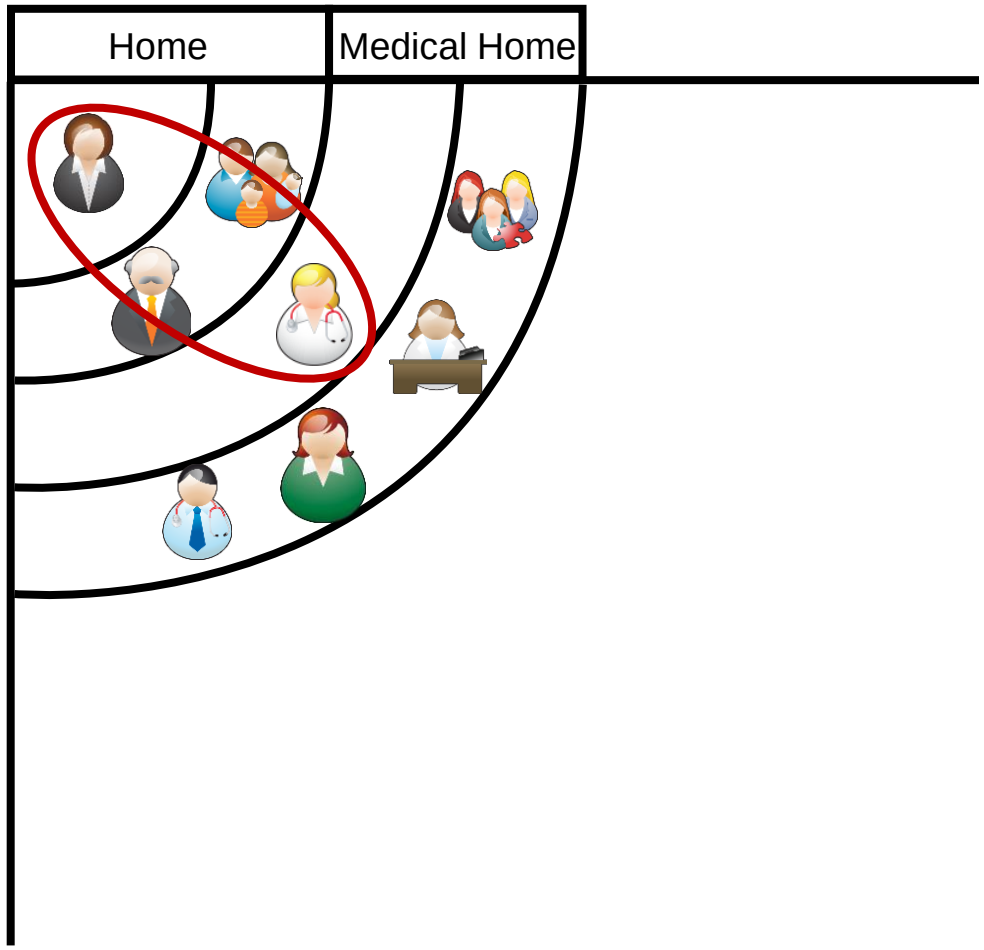
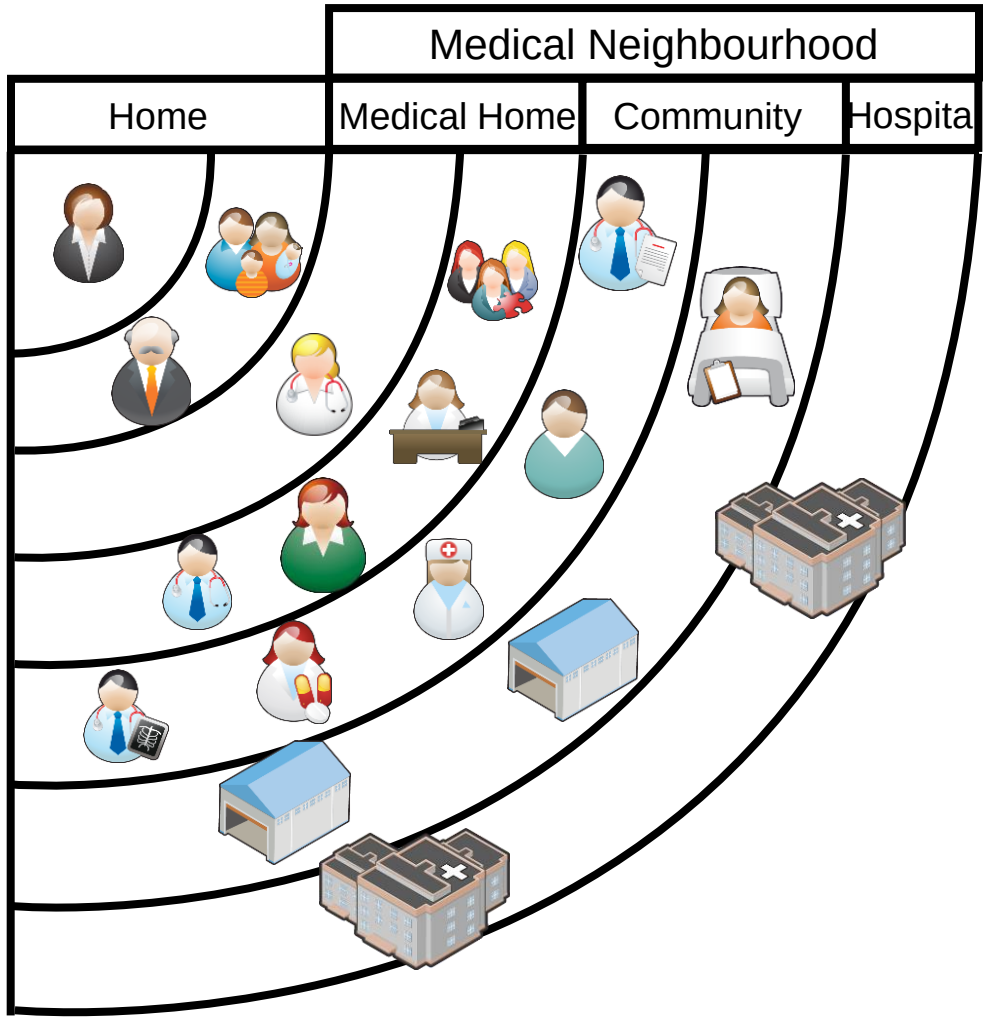
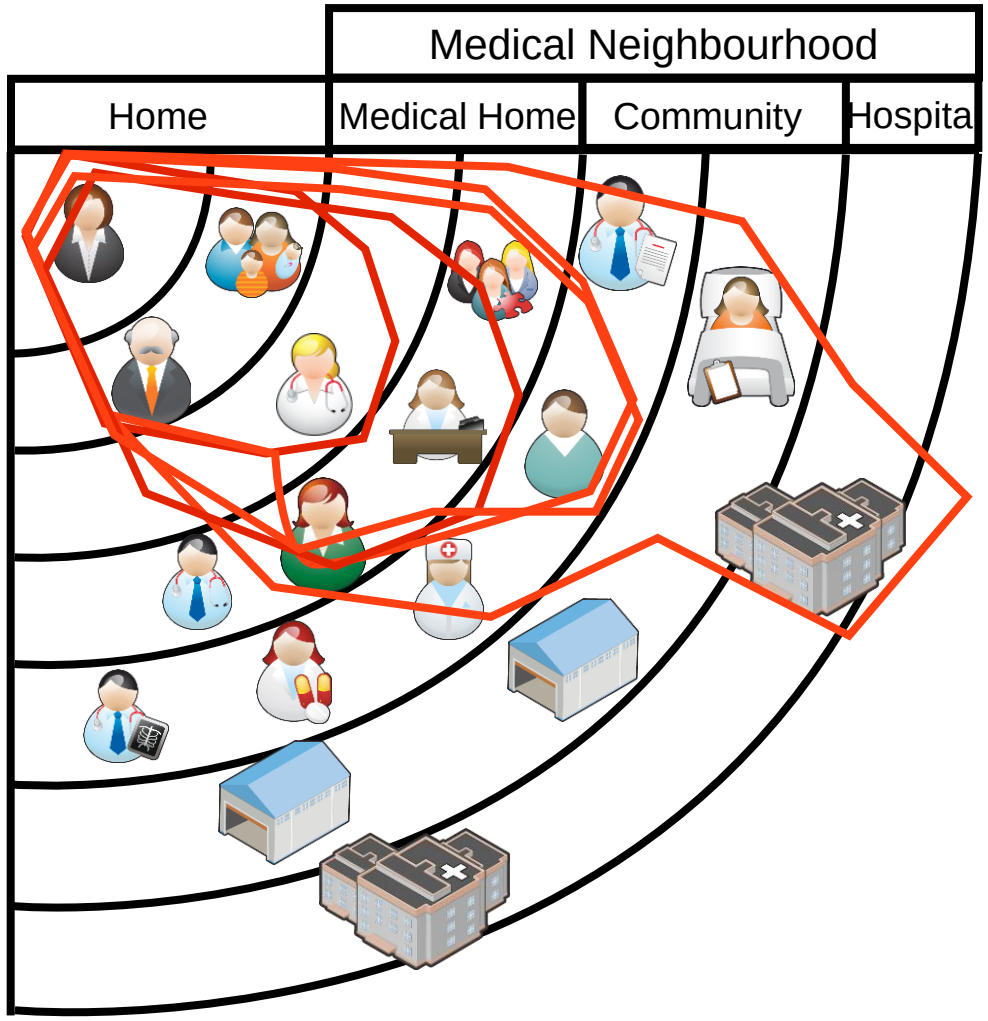


FIGURE 1. Monthly prevalence estimates of illness in the community and the roles of physicians, hospitals, and university medical centers in the provision of medical care (adults sixteen years of age and over).

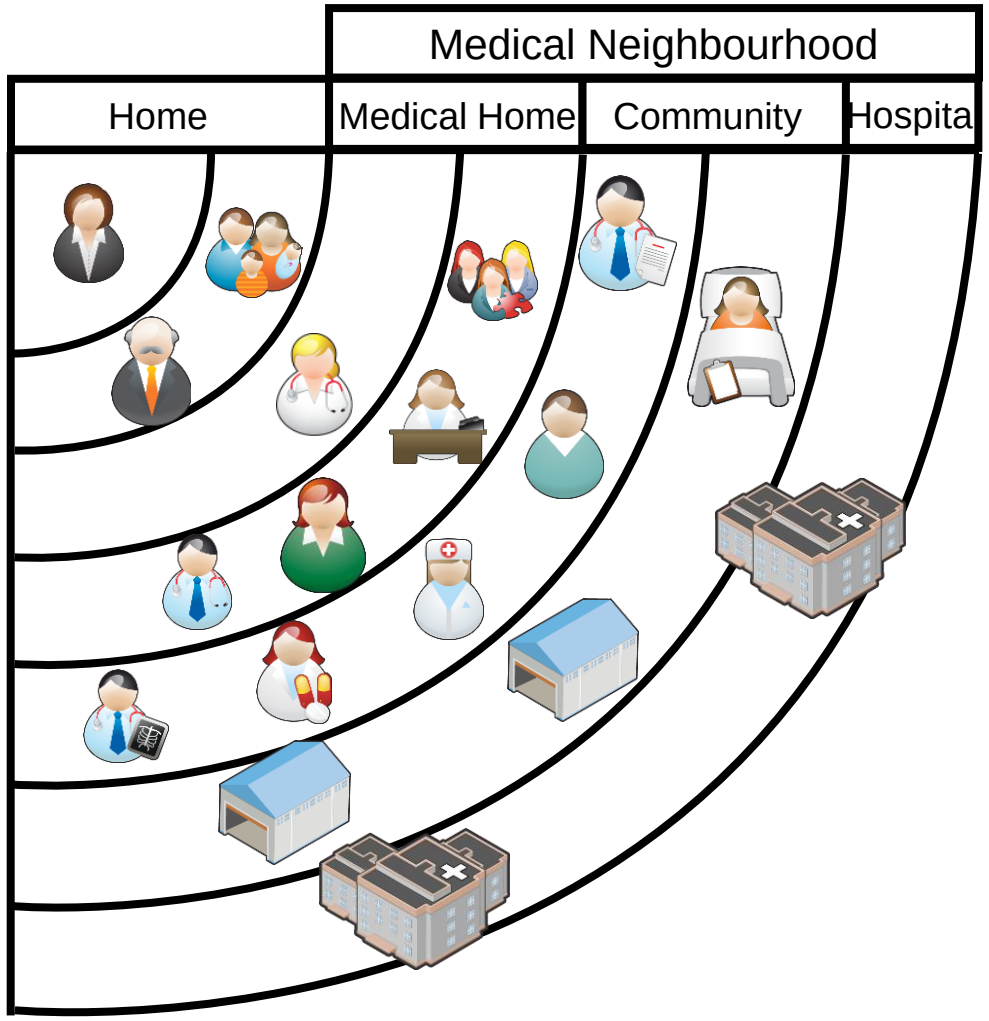



Home
Medical Home


Medical Neighbourhood
Home
Medical Home
Community
Hospita



The Person-Centred Health System



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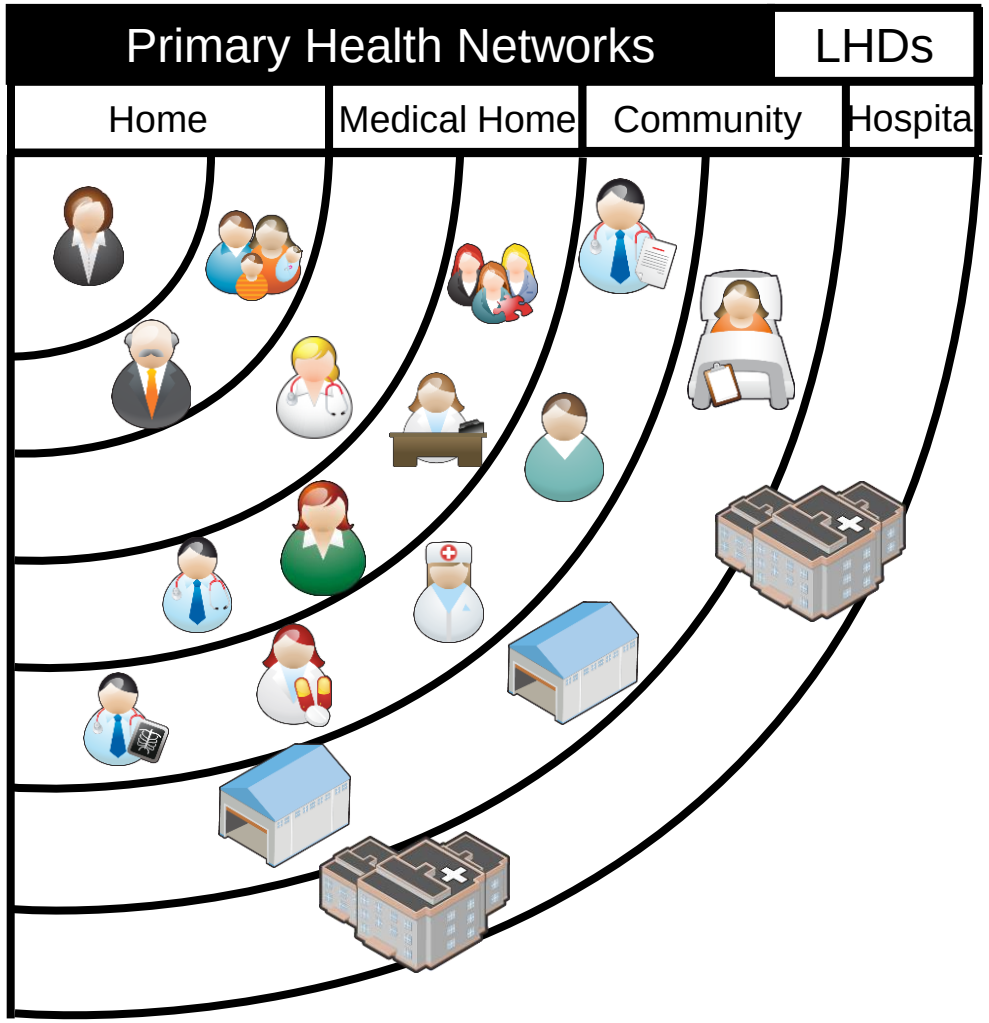


General Practice: A vision for what we can be

Patients: A standard to look for and demand

Funders/Policy: A model to design for

Specialists: A definition of role

Policy Impact

Navigating the Healthcare Neighbourhood NSW Agency for Clinical Innovation..
https://www.aci.health.nsw.gov.au/nhn

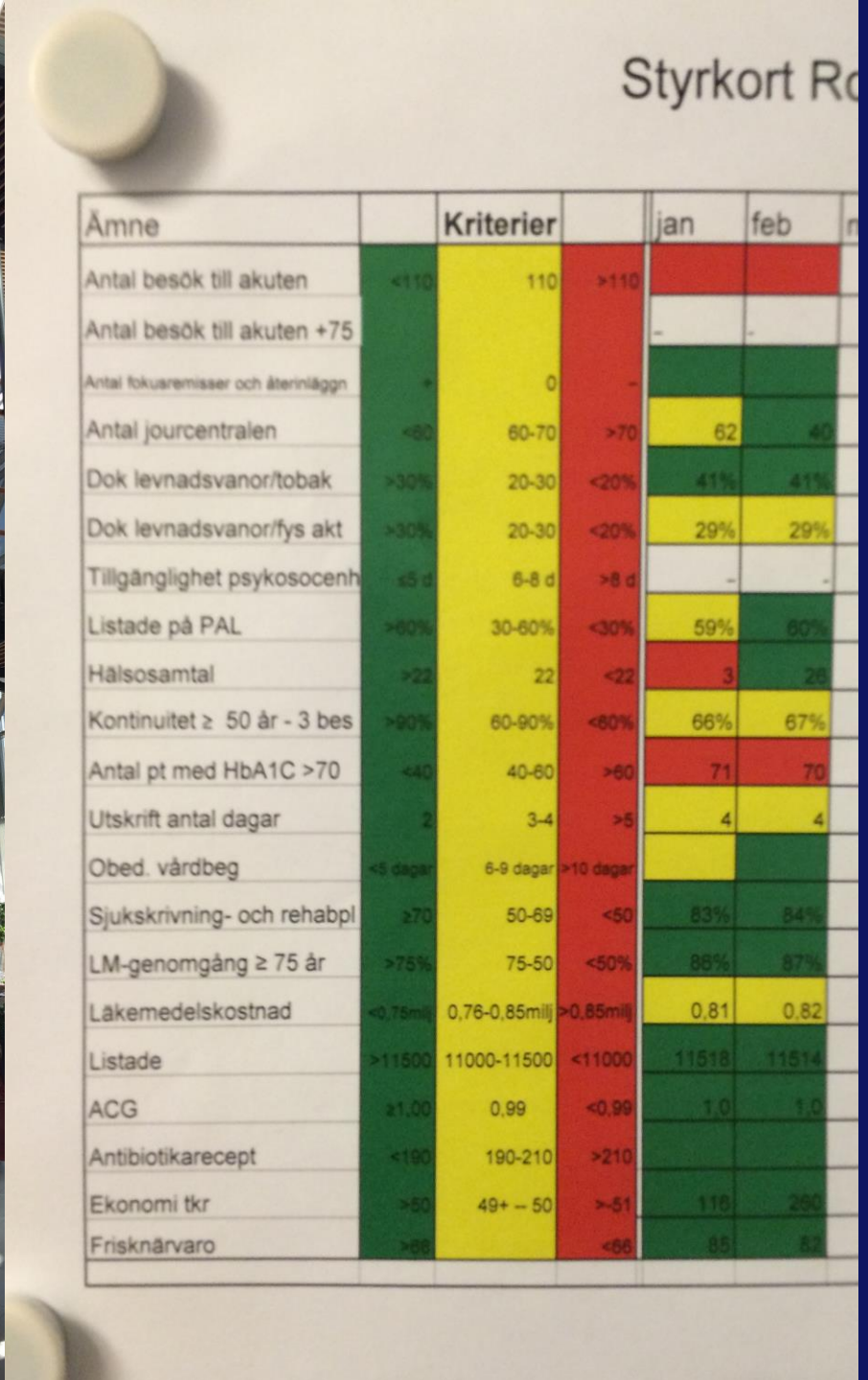
Healthcare Homes Trial – chronic disease bundled payment, quality improvement, joint care planning

My Health Record. 90% Australians. Information across the system.

Quality Improvement Practice Incentive Payment – August 2019, GP data submission, participation in QI. 90% of GPs

Voluntary registration with GP. $448 million over 3 years for chronic disease patients over 70

Bra Liv Clinic
Husqvarna
Jönköping
Sweden



Styrkort R

Ämne		Kriterier		jan	feb
Antal besök till akuten	<110	110	>110		
Antal besök till akuten +75				-	-
Antal fokuaremisser och återinläggn	*	0	-		
Antal jourcentralen	<60	60-70	>70	62	40
Dok levnadsvanor/tobak	>30%	20-30	<20%	41%	41%
Dok levnadsvanor/fys akt	>30%	20-30	<20%	29%	29%
Tillgänglighet psykosocenh	≤5 d	6-8 d	>8 d	-	-
Listade på PAL	>60%	30-60%	<30%	59%	60%
Hälsosamtal	>22	22	<22	3	26
Kontinuitet ≥ 50 år - 3 bes	>90%	60-90%	<60%	66%	67%
Antal pt med HbA1C >70	<40	40-60	>60	71	70
Utskrift antal dagar	2	3-4	>5	4	4
Obed. vårdbeg	<5 dagar	6-9 dagar	>10 dagar		
Sjukskrivning- och rehabpl	≥70	50-69	<50	83%	84%
LM-genomgång ≥ 75 år	>75%	75-50	<50%	88%	87%
Läkemedelskostnad	<0,75milj	0,76-0,85milj	>0,85milj	0,81	0,82
Listade	>11500	11000-11500	<11000	11518	11514
ACG	≥1,00	0,99	<0,99	1,0	1,0
Antibiotikarecept	<190	190-210	>210		
Ekonomi tkr	>50	49+ -- 50	>-51	116	280
Frisknärvaro	>86		<66	85	83

Number of patients attending ED

Number of patients 75+attending ED

Number of urgent readmissions

Number of ED presentations

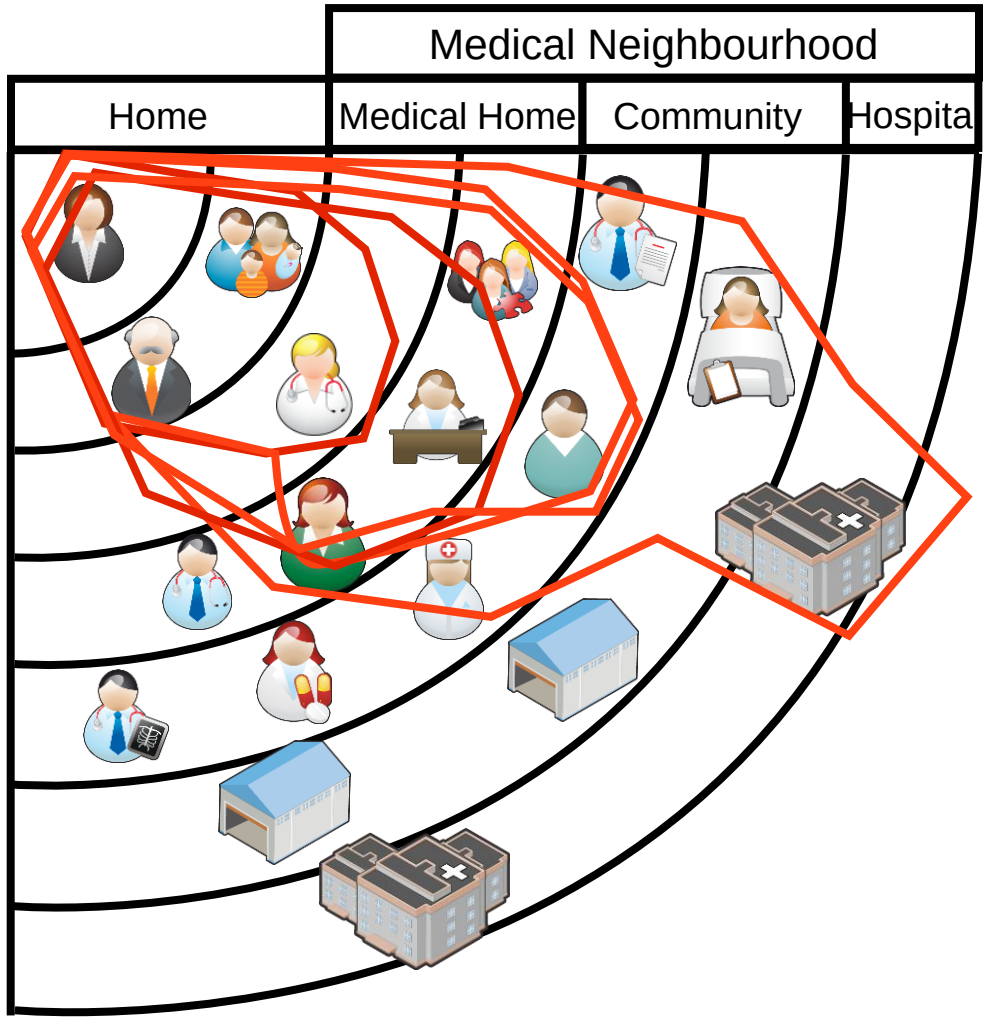
Scheduled by name to your own GP

Continuity:age 50+ 3 last visits to same GP

Patients with HbA1C over 7

Unassessed demand at hospital

Economy ”hold your budget”



PCMH
Medical Neighbourhood

What is our shared vision for the health system?

What is my role in it?