

AMCHP 2007 ANNUAL CONFERENCE

HEALTHY COMMUNITIES

March 3rd to 7th, 2007

Medical Home: The Bridge Across the Quality Chasm

CHARLIE HOMER: Good morning everyone. It is a pleasure to see you. So many friends in the audience, people that I've had the pleasure of working with. It's good to see you and I look forward to meeting those of you that I haven't had the pleasure of working with. So as Bonnie said what I'd like to do in the next little bit is tell you about the work we've been privileged to do with you and with the Bureau in spreading the Medical Home concept and a little bit of the underlying theoretical frameworks. This will be a very once over lightly approach and again I know several of you in the audience are familiar with it and I hope we'll have time for questions as we look through.

One just a brief comment as to so how does this work relate to the efforts of the organization I'm privileged to run the National Initiative for Children's Healthcare Quality. Well it falls smack dab in the middle of our mission. Our mission is to eliminate the gap between what is and what can be in healthcare for all children. We've coined our mission before the term chasm was so widely adopted but it's the same concept. Our strategy for driving change in the healthcare system has three levels. One is to build will for change. To convince the community, the community of providers, the public health community, the community of the public to know that in fact there is a need to change care. That's a lot easier now

then when we started in 1999. But not only there's a need to change care but that's it's actually possible. For example the Medical Home is possible and it's possible to have better outcomes.

The second is to bring new ideas in the Medical Home concept. While not a brand new idea the way that we've implemented I think is somewhat new in the use of quality improvement and reliability theory as a strategy as what we view as an innovation into health care.

And then the third part of our strategy is to work on the ground with Title V programs, with primary care practices, with hospitals and with others so that we can actually demonstrate results to give confidence back to the first of building will. Now we like many national nonprofit organizations like viewing ourselves as having a big national scope and we've run all kinds of national projects. And we think they're fun and we like getting frequent flier miles and seeing exotic places like you know, Arlington, Virginia. But there are limitations in a national strategy particularly if you are trying to achieve results, particularly if you are trying to change things on the ground.

One is the obvious cost in mounting a national initiative. Cost to us, cost to the federal government, cost to the participants. The second is obviously the distance. If you're in a primary care practice or community health center it's awfully hard to set aside extra time and extra money to travel. The third is the issue of credibility. Why should somebody who is practicing in a community listen

to somebody from halfway across the country? What do they know about the local settings and the local conditions? Fourth is your ability to truly provide in real time practical assistance and last when the financial conditions while in general the broad outlines of for example health insurance are pretty similar across the country, the details of which plans and what Medicaid benefit is covered and how you get paid for what really varies. So your ability to run things nationally is limited and that led us at NHCQ in concert with the Bureau and Carl to think about how could we take our national model and customize it and build it into a local area.

Now NCHQ approached this concept of how we could build local efforts, build local support agnostically. We didn't come into this saying we have precisely the solution that will locally. I suspect actually there is no one single solution that will work locally. And we have done a series of experiments over the last five years with different strategies for building local infrastructure to support quality improvements in general and specifically quality improvements around care of child with special health care needs. So one strategy is to build on the capability of local chapters of professional societies such as but not only the American Academy of Pediatrics but also AFP.

A second is clearly the work we're doing with you which is building on the capabilities within the public health and Title V programs. We've also done similar work with immunization. A third strategy is to say well geez, maybe there

are state universities, particularly state medical schools that could be a locust for providing technical support. A fourth could be on rare occasion perhaps maybe if we can get changes in SCHIP regulations, Medicaid agencies. Another might be a managed care organizations and perhaps some combination of all of the above. So we have actually run projects that if I had all day to talk to you about it I could describe for you what we've learned in each of these. And of course the main lesson is there are strengths to each strategy and there are certain weaknesses and the relative advantages and disadvantages. But clearly one of the things we've learned is to the extent that all these different entities can collaborate within a state in order to drive change, the more likely to succeed. And who the lead agency is probably varies depending on context and funding and personality and a whole bunch of other complicated things.

So in that broad context of how can we identify and support local capacity to improve care at the primary care level in order to improve outcomes for children with special health care needs is how we came up with Carl Cooley and his group together with discussions with Merle and Bonnie how we came up with the concept of the Medical Home learning collaborative.

Now the aim of this initiative when it started was to improve care obviously for children with special health care needs by implementing the Medical Home concept. The concept you're very well familiar with. And in the process of doing that to foster better relationships between Title V and primary care. So the Title V

could be that local infrastructure to support improvement in practices and not only improvement in practices who would happen to participate in the national collaborative but really could be the (inaudible), the formation, the leading edge for further spread of Medical Home concept within their state. As Bonnie said, this concept of the Medical Home has been around for some time and yet many of you know this is not exactly been something that spread as quickly as cell phones. So the question is why is it that this brilliant model, this concept which we believe is obviously beneficial for children and youth with special health care needs has been hard to spread.

And I think there's several reasons. One could be the lack of awareness of the model but a second one is in our view was that the model was conceptually outlined but it wasn't outlined at a level of how do I actually go from this concept to making it happen in the real world. There wasn't a level of practicality about the way the model was described that enabled organizations or practices to pick it up. Then clearly there are real logistic barriers such as the amount of time it takes to both be a Medical Home but also to go from not being a Medical Home to being one knowledge about what it is, clarity about the roles involved, clearly be the "R" word as we ended up calling it on our collaboratives. The word reimbursement was an obstacle.

And then this last one which gets to the PDSA concept that Merle already mentioned was it actually takes skill and methods to change. Now that's like

“duh” but you know there are whole consulting companies out there, really, really big ones that in the world of private industry exists on going from concept to reality. In healthcare for some reason and I think perhaps in government there’s more of a concept that if you just lay out the concept somehow or another organizations are presto chango going to go from where they are to the concept of where things will be without any coaching in the technique of change. And we felt that that was a significant obstacle and in fact we could possibly overcome that.

So I am going to briefly mention several of the conceptual frameworks that we use to overcome those obstacles through the Medical Home collaborative. One is operationalizing to a greater extent the Medical Home concept by combining it with Ed Wagner’s chronic care model to come up with what we call The Care Model for Child Health in the Medical Home. The second is the collaborative model so that if you don’t all have it by heart you will at least see it. Third is briefly The Model for Improvement and fourth very high level once over The Model for Spread.

You all know what a Medical—the attributes of a Medical Home. Accessible, family centered, continuous, comprehensive, coordinated, compassionate and culturally effective. This complicated diagram is in fact our operationalization if you’ll excuse that word of the Medical Home into the Care Model concept. Let me spend just a few minutes describing what this is for those of you who aren’t

familiar with it. The concept is to improve outcomes, functional and clinical outcomes for children and families of children with special health care needs you need three things. One is you need to enable the family with the skills, the tools to have both information and competency in decision making to manage their child's wellbeing. In order to do that you need a time in a practice. Notice concept of team that anticipates what needs are and are prepared to make changes. And this is actually one of the differences between the approach we did and what Ed Wagner's initial approach is that it needs to be in the context of a community that has the resources and is connected to both families and practices.

In order to make those changes you need to have things take place within the healthcare system and you need to have changes take place within the community. Within the healthcare system there do need to be organizational and policy changes such as better reimbursement practices such as training in both quality improvement and in the Medical Home concept. But then at the practice level you also need to have information systems such as primarily that means registries. You need to have what we call decision support strategies for getting evidence, what evidence exists and where evidence doesn't exist. Consensus recommendations available at the point of care to the providers and available to families. You need to have a team within the practice with defined roles. That includes of course the role of care coordination. And last is this concept of care partnership support which really again involves primarily changing the framework

of how you think about what medical practice is from the captain telling families what to do to a coach enabling families to better manage their child's wellbeing.

So those are the four components and their details under each. That was Model One. Model Two is our favorite model for improvement. We love the concept of plan, do, study, act cycles. Let me just step up from that for a second and realize that the first thing is you need to be clear in improvement about what you're trying to accomplish. So clarifying your aim is a very important step which is often overlooked. The second is clarifying what metrics you will use, not at the individual test level but how you can see whether your overall initiative is making progress. And third is where can you beg, borrow or steal good ideas that you can apply, including the care model but not only the care model as good ideas.

And then you move into this concept of what's the largest meaningful test of change that we can undertake by next Tuesday. All aspects of the test are negotiable except that it needs to be by next Tuesday and a meeting doesn't count as a test. So those are sort of the guidelines for implementing the Model for Improvement.

The third concept, the third framework and the one that we used at the—in the Medical Home collaboratives was this concept of the breakthrough series, a model which is really a good decade old right now. A model that recent—last week's New England Journal reported the outcomes of the breakthrough series

as applied in the Bureau of Community Health Centers applied to specific chronic conditions including diabetes and asthma. Showing significant improvements in clinical process measures for several specific chronic conditions in those centers over time. So I believe that is at least moderate to significant support for the collaborative model as a significant strategy. Let me give a quick once over about the collaborative model and then an even quicker concept of how it was modified in this particular context. The collaborative model assumes that some group which was our expert team synchronizes the knowledge and comes up with core recommendations and measures at the start. Then teams are recruited to participate in a collaborative who come to a series of face to face meetings, called learning sessions and god, there's way to much jargon in this model. Learning sessions, we bring these teams to face to face conferences a series of times over about an 18 month period.

At those face to face meetings teams are provided the content of what the Medical Home is and this case also provided coaching as to how they make changes. So that's what different about this from standard educational programs. And what's critically important in a collaborative is in between learning sessions are what we call action periods where organizations undertake these plan, do, study, act cycles and report to the evil taskmasters of our improvement advisors who say have you sent in your report this month. Both your text report that describes all the wonderful things you did but your monthly data. And again the concept of this is very different than your every five year report to the Bureau.

This is what data have you tracked this month to see whether you're better this month than you were last month. That's the general process of a collaborative. Now we did make significant modifications in the Medical Home collaborative to the model. We did have the three learning sessions and the action periods and all that good stuff. But the two changes that we made, one is that it was—we recruited the local infrastructure which was you, Title V, was in fact recruited and we recruited a number of state Title V programs who themselves recruited individual practices. So at these learning sessions we were teaching at two different levels. One was the way we always taught to practices but we were also teaching and working with you and your colleagues at the state level as to how you can further support work at those practices. And Debbie Allan was the Chair of our Title V component and we couldn't have asked for a better leader in that area.

In addition we recruited parents to participate on the improvement teams and of course parents could participate on the state Title V team. So we had an additional track directly involving parents in this process and we prefaced each of our learning sessions either on the phone or in person with additional training and support for Title V and for the parent groups. The last—so these are the modifications. I think I went over these already so I'll skip this slide.

And the last model which really is too complicated to give it a two minute version which is the concept of spread. Because I don't believe the goal is for us to run

collaboratives which will include every practice in the country over time. It's too expensive and it's too intensive a strategy. What we need to do is view the practices and to some extent the Title V programs as the demonstrations of success because you need a successful model if you're going to build will and if you're going to have champions who could then spread that concept across.

It's a little bit like if you'll allow me to go on my stupid cell phone analogy. It's why the cell phone companies get their cell phones or their palm pilots or Blackberries to those consultants who wait in line at the airports so that everyone else says oh, that important person wearing a suit has a Blackberry or a cell phone. It must be important. I want to do that too. To some extent what we're trying to do is get these practices and to get these fantastic Title V programs to be those people waiting in line at the airport that the other practices and the other Title V programs are going to look at and say I want one of those too. I want a great Medical Home too. What do I need to get it and then your job is to support them when they call up saying how can I get one of those. How can I get myself a Medical Home? You might even be reaching out. And that's the concept of the Spread Model, of how do you create both the leaders and then create an infrastructure to enable are you getting out, have you identified who your market segments are out there. Have you reached out to them? Have you made it easy for them to buy the Medical Home when they're ready to get it? Now again, many of us are allergic to the for profit models but the concept is fairly similar to what we're trying to accomplish through spread.

Now we did run as Bonnie said, two rounds of the Medical Home collaborative. Many of you are in the room who we participated. The states are listed here. It's really fantastic. We had lots of teams from every state. The practices looked like practices everywhere. Often community based, sometimes hospitals, sometimes community health centers. Sometimes primary care. We did have teams from each practice which always included a parent. Coming up with a measurement strategy was challenging. We got a little better at it but the main outcomes I'll share with you are ED visits and unplanned hospitalizations and the Medical Home index.

The Medical Home index that your probably all deeply familiar with which is again the measure that Carl and Jeannie developed with support from the Bureau has a variety of dimensions, organizational capacity, chronic care management, etc. and more is good. And basically before and after we showed that the practices that participated in the collaborative had significant improvements. In fact they improved in the course of the collaborative as much or more which was about a one year period than they had through about a two year period of coaching through the initial strategy, in office coaching that Carl and Jeannie did. And the second Medical Home collaborative basically replicated the results with fairly comparable improvements.

We also showed some decreases in emergency department visits over time in both collaboratives which we viewed as at least suggestive of improvement. Again we didn't have external comparisons. It's not necessarily seasonally adjusted. I don't have multi-year trend data. But at least we viewed as suggestive of improvement. Same thing for hospitalizations. Qualitatively I'm running out of time so I don't want to spend too much more time other than saying qualitative analysis was that it was viewed extremely positively. Particularly this concept of building that relationship between Title V and the practice was extraordinarily helpful as well as this PVSA concept. The concept of spread we did develop a tool but it was I'd say a harder concept for it to move forward on.

The parent participation was a key component of our strategy and you can see the quotes that the parents themselves found it valuable and both Title V and the families and the practices found this a very important component. Bonnie, do I have time to show the video or do you want to go to Jeff? I think this might be a good opportunity, we created a video from a subsequent collaborative which we've done which is focused specifically on improving care and access for child with epilepsy. It's another collaborative supported by the Bureau in concert with the Epilepsy Foundation. But it focuses very much on implementation of the Medical Home and enhancing coordination between primary care and subspecialty care. And this project we are centrally involving parents. In fact it was parents and parent organizations that recruited the practices to participate. We have—this is the last segment of about a 15 or 16 minute video. I'm going to

show you, it's about a five minute clip where we're interviewing some of the parents and then talk to a few of the providers just to give you a sense of the power that bringing parents into the process brings. Go ahead.