THE MEDICAL HOME:
A CONSUMER'S PERSPECTIVE

A Model of Care That Could Dramatically Improve Consumers' Health and Wellness

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The Medical Home: A Consumer's Perspective

For Mike Chilcoat, it all came down to denial. Afflicted with Type 2 diabetes, Chilcoat was on the same low-intervention path as millions of other Americans: A medication regimen. Sure, he may have been a bit overweight. But the medicine, he figured, was good enough.

Until the day it wasn't.

A dockworker for the better part of three decades, the native of Wrightsville, PA, knew a piece of hard work when he saw one. But the most difficult task faced was to confront the truth: His case of Type 2 diabetes was killing him. The realization was difficult, and were it not for a new program he became involved in through his health system, it may never have come to be at all.

Chilcoat now considers himself a proud proponent of an emerging model of health care delivery known as the medical home – a collaborative, team-oriented approach to the way in which everyday consumers interact with health care providers (i.e., your primary care physician and other certified professionals) and the health care system as a whole.

"There's no doubt it helped me out," says Chilcoat, 65, who has battled diabetes for the past 10 years. "It's been a journey that has made me aware that I need to improve my diet, exercise routine and other lifestyle choices."

Chilcoat is part of a pilot project near his home in nearby York, PA, that is establishing medical homes within dozens of local primary care practices. With a focus that binds time-honored elements of the past – close relationships between physicians and patients – with communication strategies based on modern efficiencies, such as email communication, electronic prescribing and electronic medical records, the medical home model seeks to reinvigorate primary care and redefine the way in which consumers receive their health services.

"One of the primary goals of the medical home model is to get physicians and patients to work together as partners," says Kathy Hutcheson, a patient partner coordinator with Aligning Forces for Quality – South Central Pennsylvania, one of 16 regional coalitions that are part of the Robert Wood Johnson Foundation's initiative to improve health care.

"It's still rather new," Hutcheson adds, "but for consumers, I think it offers the best options among all the other programs out there."

Surveying the Foundation

Earlier this year, the National Medical Home Summit hosted a well-received conference devoted to the model. The health reform law and other federally-backed initiatives have invested more than $40 million in grants to bolster its expansion (in one program alone). URAC, a health care accreditation organization, released its Patient Centered Health Care Home program in 2011 to meet the needs of this increasingly popular health care delivery option.

A recent study from the University of California, Davis, even found that three cornerstone elements of the medical home model – comprehensive care, patient-centeredness and extended office hours – correlate with a longer lifespan among patients, according to a study that appeared in the *Annals of Family Medicine*.

Where it has become part of people's lives, the medical home model has consistently shown to transform the very nature of our collective health care interactions. But, what exactly is a medical home?

"When they say the medical home, they want patients to take a more active part in their treatment," says Chilcoat, who works with Hutcheson as a "patient partner" with Aligning Forces For Quality – South Central Pennsylvania. In his role, Chilcoat is participating on the ground floor of the medical home transformation, providing invaluable feedback on ways his health care providers could be more medical home-friendly.

"It's not a tangible place," he says. "It's more about taking an active part."

That's one facet of the medical home – proof that the behind-the-scenes machinations are working correctly,

but the real driver of the medical home is the primary care practice.

“This is an approach based on driving quality first, and trying to get costs down that way,” says Paul Mahoney, a spokesperson for Community Care of North Carolina, a public-private partnership that has supported the development of a statewide medical home model for patients with Medicaid insurance coverage. “This is a much more collaborative direction, and it is popular with both physicians and patients.”

In many ways, the medical home model helps primary care physicians in that it pulls them from administrative duties that have bogged down their practices and puts them in front of a team of practitioners equipped to track a patient across their lifespan. The team may include a registered nurse, care manager, health educator and social worker. This network serves as an out-of-office extension that bridges the patient with the primary care physician, and it helps prevent one-off visits to the emergency room or acute care clinic that can leave a patient with gaps in his or her care plan – not to mention a more expensive episode of care. This physician-led team, and the overriding philosophy of continuous, direct patient care, defines the structure of the medical home.

“It’s a change in the way health care is delivered,” says Hutcheson. “This is about establishing a relationship with your physician and building trust so that you can work together to set goals. And a big difference is that the clinical team is there to help.”

Part of the difference between the medical home model and models of the past is marked by a newfound focus on the wants and desires of the consumer.

“In any other industry, when they’re developing products they develop them around their consumers,” says Hutcheson. “And that hasn’t happened in health care. As a whole, health care is only starting to realize that, ‘Wow, that’s important.’ This is new for health care overall to actually look at the consumer.”

Part of the change has to do with changes in consumers themselves and the ways in which they are confronting diseases. The Centers for Disease Control and Prevention (CDC) estimates that approximately 50 percent of all Americans are living with at least one chronic disease, a list that includes heart disease, stroke, cancer, diabetes and arthritis. Also included is obesity, one of the leading causes of negative, co-morbid health outcomes. About one in three American adults is obese, says the CDC.

“As the nature of disease changes, how we approach treating it has to change too,” says Hutcheson.

This different approach is evident in Mike Chilcoat’s story. Since entering the medical home program, Chilcoat has lost 40 pounds and, more importantly, he has taken active control over his condition.

“In the past three months, I’ve gotten really serious about it, and I’m bringing my A1C numbers down,” Chilcoat says, referring to the test that measures his blood glucose levels. “I think I’m finally out of denial. I have to take charge and do this on my own.”

Chilcoat’s story displays the powerful effects of education and close patient involvement – what’s known in medical circles as patient engagement – that the medical home model prides itself on. The medical home has the potential to effect real changes across a variety of settings and populations and to create more satisfied consumers.

Looking Back to Forge Ahead

What now seems an idea of striking foresight, the American Academy of Pediatrics first introduced in 1967, intending it to become a holding place for medical records and a hub from which health care professionals could access a child’s medical history.

Fast forward 45 years, and the progenitors of the concept would likely be shocked that a central repository of a patient’s health information, whether child or adult, doesn’t exist. Although medical records continue to proliferate, accessible, interconnected data systems cross all health care platforms haven’t been created. Along with both private and federal initiatives, the medical home seeks to change that status, with electronic medical records and connected data sharing key parts of the medical home’s blueprint to achieve more coordinated care.

Of course, this is one key area that impacts the average health care consumer; after all, if your physician is able to quickly glance back at your medical history, including your family's incidence of genetic disease, chances are you will receive the screenings and other preventive measures that can keep you healthy by identifying potential disease states early. Its tenets of optimal health care practices and paradigms stretch across eras of health care delivery.

"It's very modern and data-driven and systems-oriented," says Kate Berrien, RN, nurse coordinator of the CCNC pregnancy medical home program. "But the other piece is the exact opposite; It's having closer patient touch, having patients connected to their doctors."

The program that Berrien is involved in speaks to the model's adaptability. The pregnancy medical home program at CCNC is a year-old endeavor and is one of the innovative offshoots of the original primary care-based design. While it maintains the core elements of the original model, encapsulated by a care management outreach program that maintains the connectedness of health care patient and provider, the teams are led by an obstetrician as opposed to a primary care doctor. Yet the main tenets – and the benefits to the patient – carry through.

"When it's working well, the patient has a consistent source of care, a practice that knows her, a practice that she can access easily when she needs it," says Berrien. "The patient is supported by a care management component that can follow up with her outside of the office to address needs that may be affecting her health and her ability to access health care."

While the application of medical home principles to a pregnancy setting is on the cutting edge, the CCNC model appears to have a bright future, according to Dr. Russ Suda, an obstetrician at Cabarrus Health Alliance and "OB champion" of the pregnancy medical home in the three-county Southern Piedmont Region.

"I'm very optimistic about this program," says Suda. "I think it's going to be around for a long time to come."

Though measurable outcomes are still too early to come by, Suda's optimism stems from his experience seeing the benefits of the program firsthand – as well as the program's cost-effectiveness. The CCNC initiative deals exclusively with patients on Medicaid, but it appears the results are strong enough to extrapolate benefits across all strata of demographics and income levels. In the future, there may be pregnancy medical homes, and other specialized models, cropping up in private insurance networks and health systems.

Driving Consumer Appeal

The research to date shows ample evidence to chart the medical home model's consumer appeal. Consider the following snapshots, all involving bolstered care and strong returns on patient engagement and/or satisfaction:

- CareOregon, a managed care plan in the state of Oregon, developed the Primary Care Renewal project. Using team-based care consisting of physicians, medical assistants, care managers and behaviorists, the initiative reduced hospitalizations by 16 percent. It improved diabetes metrics, increasing the number of patients with "good control of the disease" by 20 percent. The program drastically reduced the average wait time from 17 days to three days. Patient satisfaction scores testified to the practice's improvements: Six out of 10 patients ranked their patient care experience as a "9" or "10" on a scale of 1 to 10.
- A program developed at Johns Hopkins Bloomberg School of Public Health known as Guided Care leans on a nurse care coordinator to work directly with patients, often in a one-on-one, home-based setting. The nurses target the over-65 population by conducting community outreach, providing education about disease self-management and alerting patients to early warning signs that signal a worsening disease state. The evidence shows that the Guided Care model works. On average, the initiative has rendered 24 percent fewer hospital inpatient days, 15 percent fewer visits to the emergency room and a 37 percent drop that patients spend in a skilled nursing facility. Guided Care patients also were twice as likely as usual care patients to rate their care highly.
- In early 2010, the Veterans Health Administration launched a three-year plan to transform 900 primary care clinics into fully functional medical homes.

Tips for Achieving Medication Reconciliation

What is medication reconciliation?

URAC defines medication reconciliation as creating the most accurate list of all medications a patient is taking – including drug name, dosage, frequency and how taken – and comparing that list against all the physician's admission, transfer and/or discharge orders, with the goal of providing correct medications to the patient at all times. (Source, IHI.org) Medication reconciliation is important because it helps keep you safe and avoid medication errors, and it reminds you to speak with your health care provider about your medications.

Patients should remember to:

- Always bring all medications to your health care appointments.
- Keep an active list in your wallet of all medications that you take including:
  - The name of the prescribed medication with the dosage and the time of day you take the medication.
  - All "over-the-counter" medications , including vitamins, aspirin, acetaminophen (Tylenol®), ibuprofen (Advil®) and naproxen (Aleve®, Naprosyn®).
  - Any herbal supplements you are taking.
- Keep a list of any known allergies, including allergies to food and medicines, and share this information with your clinician (doctors, pharmacists, nurse practitioners, physician assistants) at each health care visit, in the emergency room or hospital.
- Understand why you are taking a medication and what foods or other medicines you need to avoid, if the medication should be taken on an empty stomach or with food and any restrictions regarding time of day for that medicine.
- Tell your clinicians(s) if you have seen another clinician and received any new medications and remember to update your active list with these new medications.

What you need to know:

Most pharmacies provide patients with education and counseling regarding their medications. Ask your pharmacist when you have a question or need to speak with your health care provider about your medication. You can also call your health plan and ask for a drug therapy management review from your pharmacy benefit management company. If you have a chronic condition, also ask your health plan about available disease management services or case management programs to assist you with health education, community resources and navigating the health care system for your specific needs.

For an easy way to make sure all of your medications are in order, URAC offers Medication Reconciliation Bags *– an insulated tote bag for carrying all of your medications to the doctor, and even comes with a helpful consumer fact sheet, 'Tips to Achieve Medication Reconciliation'. You can also carry your medications to the emergency room, or urgent care so that your medications can be reviewed by a health care practitioner. Visit the Online Store at www.urac.org for more information.*

Questions to Ask When Visiting the Doctor

What to ask when selecting a doctor:

Go online to your health plan's website for information about finding a doctor that's right for you, and programs that can assist you with your personal health care.

- ☐ Which primary care practices does your health plan designate as a medical home?
- ☐ Which practices are taking new patients?
- ☐ Does the office have a contract with or in the network of providers with my particular health care insurance or would you be considered out-of-network?
- ☐ What hours and days of the week is the office open?

What to ask before your first appointment:

- ☐ What should I do if I have an emergency?
- ☐ Would I be able to access my medical record if needed?
- ☐ Am I required to pay my co-pay before I see my doctor?
- ☐ Do you accept personal checks and credit cards?
- ☐ Does your office provide other services, such as lab, pharmacy, or X-ray? If not, are these services in your building?
- ☐ What is the appointment cancellation policy?
- ☐ If I need a referral, would I be able to get it on the same day, or is there a waiting period?
- ☐ What is the average length of time a patient waits to see the physician or clinician after arriving at your office for a scheduled appointment?
- ☐ How can I transfer my medical records to your office?

You should ask as many questions as you need to fully understand your diagnosis and treatment plan and ask to be sent a copy of your treatment plan and lab results.

What to ask your clinician at a visit:

- ☐ How do I get prescription refills? Does the practice use e-prescribing?
- ☐ Is the name of my preferred or local pharmacy on my medical record?
- ☐ Do you have my cell number listed on my medical record?
- ☐ When will I need to schedule a follow-up appointment with my clinician?
- ☐ What are my vital signs? This may include your blood pressure, pulse, height, weight, temperature, etc. depending on the type of appointment.
- ☐ If you are having a physical, you may ask your clinician, "What parts of my body will be examined and will I need to fully or partially undress?" (It also would be helpful for you to have your medical and family history available, since this is usually a question you will be asked.)
- ☐ If you are feeling ill, it is important to accurately describe your symptoms and let your clinician know how long you have had them. This will help your clinician with your diagnosis. If you are taking any medication (prescribed, over-the-counter or herbal) for this illness, it is also important to mention it to your clinician.
- ☐ What is my diagnosis?
- ☐ How severe is my diagnosis and would it affect my life style?
- ☐ What caused my illness?
- ☐ What is my treatment plan?
- ☐ Will this improve my condition or make me feel better?
- ☐ Should I look for certain side-effects from my treatment plan?
- ☐ Will I need additional lab tests or an X-ray? If so, when or how often?
- ☐ Do I have any dietary restrictions? For example, low sodium diet.
- ☐ How long am I required to take a certain medication or have therapy?
- ☐ What should I do if my condition gets worse?
- ☐ If you are traveling internationally, you should ask your clinician or health department about required vaccinations you will need.
- ☐ Are there any foods or over-the-counter medicines I should not take at the same time as the medications already prescribed for me?
- ☐ When should I stop taking the medications?
- ☐ Is there any particular equipment or other arrangements that must be completed after my appointment today? Who will do this?
- ☐ How will you coordinate my care with other physicians that I see throughout the community- even with those that are in different facilities?
- ☐ Do you take follow-up questions by email?

At a budgeted cost of $227 million, the program's achievements include the shortening of wait times from as much as 90 days to same-day access; a significant drop in unnecessary trips to the ER, from 52 percent to 12 percent; and improved outcomes for common chronic diseases like diabetes. Capturing the spirit of the medical home, "its model organizes care around an interdisciplinary team of providers who work together to increase access and clinical effectiveness by identifying and removing barriers to high-quality care."

- When it comes to sheer cost-savings, Community Care of North Carolina offers a compelling case of statistics. From 2007 to 2009, an independent analytic company estimated that CCNC had saved almost $1.5 billion through its innovative programs. CCNC works with patients who use Medicaid as their insurance provider. As such, the substantial decreases in cost are salutary for patients, providers, taxpayers and the wide expanse of the health care system. "What we've found is that better primary care is better for every population," says Mahoney. "The core value of coordinating care across settings and over time – that's true with everyone."
- Addressing the uninsured population (recent totals put the number at 35 million nationwide), Genesee Health Plan in Flint, Michigan, created a medical home model that used a "health navigator" to work as the bridge between in-office physician care and achieving healthy behaviors outside of the primary care setting. After four years, more than seven out of 10 individuals identified a primary care practice as their medical home; the key attribute of preventive health improved, marked by a 137 percent increase in mammography screening rates and a dramatic 50 percent reduction in unnecessary emergency room visits.

Bringing It Home

When Mike Chilcoat first engaged in the medical home initiative, one of the biggest surprises he experienced was the number of people who were, in fact, just like him. In the mid-sized physician practice where he receives care, there are more than 800 individuals with diabetes.

"That number just wowed me," he said.

And that number is expected to skyrocket. According to current statistics from the CDC, more than 25 million Americans, or roughly 8 percent of the population, have diabetes. Like other chronic diseases, the lifetime costs of diabetes are extremely high, particularly in those individuals who don't manage the condition effectively. Direct medical costs total $116 billion per year (in 2007 numbers), while disability, work loss and early death account for another $58 billion.

The scary news is that, if current trends continue, one in three Americans will have diabetes by 2050. The costs – in health and spending – are astronomical. But there is solace in innovative programs like the medical home that are reaping real results.

Chilcoat muses about the possibility. "I think to myself, if I can get together with 10 people and bring their A1Cs down, then how will that affect the average?"

It's a lesson wrought by the careful, person-by-person progress of the medical home. No matter how large the system, it all distills down to simple steps.

"When you're making change, you can't really change the whole world," says Hutcheson. "You have to start with a piece of it."

About URAC

URAC, an independent, nonprofit organization, promotes health care quality through its accreditation, education and measurement programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system and provides a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry. To learn more about URAC's Patient Centered Health Care Home Programs please call (202) 326-3943 or visit www.urac.org\pchch.

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