



The Medical Home Model of Primary Care

Presentation to the Oregon Health Fund Board and
Delivery System Committee

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SB 329: The Healthy Oregon Act

- Calls for greater emphasis on primary and preventative care, chronic disease management, health promotion and wellness
- Calls for payment reform that rewards more efficient and effective care
- Specifically states that all participants in the Oregon Health Fund Program should have a “primary care medical home”



Challenges Facing Primary Care System in Oregon

- Workforce shortage
- Decreasing access to providers
- Overwhelming workload for primary care providers
- Patients not receiving recommended primary care
- Inadequate and inequitable reimbursement

So what is a “Medical Home”?

- “Right care at the right place at the right time”
(Institute for Medicine)
- “The cornerstone of our entire system is the support of long-term, trusting, continual ***relationships*** with our customers”
(D. Eby- Southcentral Foundation – Alaska)

And also includes: Integration of medical care with the community’s behavioral, dental and public health resources as well as social services to maximize health

Patient-Centered Medical Home

– One definition

- Whole Person Orientation
- Coordinated and/or Integrated Care
- Quality and Safety
- Enhanced Access
- Personal Physician
- Physician Directed Medical Practice
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home


Joint Principles released by American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association in February 2007

Evidence to Support Primary Care and Medical Home Model

- Countries with stronger primary care systems have better health outcomes and lower per-capita costs
- Having a regular source of preventive and primary care is associated with:
 - Lower per person costs
 - Fewer emergency room visits and hospitalizations
 - Better health outcomes
 - Higher patient satisfaction
- Medical homes have the potential to eliminate disparities in terms of access to quality care among racial and ethnic minorities

Medical Home Initiatives and Demonstration Projects

- PEBB requires vendors providing benefits to state employees to work towards providing medical home services to enrollees
 - Kaiser, Regence, Samaritan, Providence
- North Carolina Community Care created networks of providers to link Medicaid population with primary care homes
 - Resulted in better health outcomes and lower costs
- Many others listed in background paper – presenters will describe other efforts in OR



What are the necessary supports to make and sustain a change?

- “Fully integrated care means that every part of the system is intentionally planned to avoid duplication and maximize unique capabilities...this takes planning, learning and supporting the workforce through continual change”

(M. Tierney – Southcentral Foundation – Alaska)

Key Considerations

- The relationship at the center of this paradigm change is that of the patient and his/her primary care team
- Transforming Oregon's primary care practices into medical homes must be seen as one part of wider effort to revitalize primary care and overall delivery of healthcare
- Providers (including physicians, nurses, etc.) must be part of any successful transformation process
- The workforce will need ongoing support through the redesign process, including learning collaborations and quality improvement trainings



Key Considerations - continued

- No one “right” way – communities and practices must have flexibility to innovate and develop models that work in particular settings
- Special consideration must be given to how medical home concept can be implemented in rural communities and for vulnerable populations
- Payment reform needed to reward provision of patient-centered, high-quality, efficient care



Today's Presentations

■ Health Plan Initiatives

- Dr. David Labby - CareOregon
- Dr. Ralph Prows - Regence Blue Cross Blue Shield
- Dr. Thomas Hickey - Kaiser Permanente

■ Clinic/Provider Initiatives

- Dr. Chuck Kilo— GreenField Health, Better Health Initiative
- Dr. David Dorr – OHSU Care Management Plus