Medical Homes Conference at NJHA May 19, 2010
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Intro
First of all, I want to thank Betsy and the entire NJHA administration for inviting me to join this critical conference…I know that NJHA provides strong representation for every aspect of what comprises the backbone of New Jersey's health-care system: its hospitals.

And today is a perfect example of how NJHA reaches beyond the boundaries of the traditional "hospital" paradigm to think about the system as a whole...about how it can perform better, more efficiently, more effectively, in a timely, patient-centered, and equitable way—to paraphrase the Institute of Medicine.

Spending a day focusing on the medical home is a great way of getting us all out of our silos in the health-care industry, and thinking broadly about all the sectors working together toward a common goal that benefits us all. (I guess that's my new job!)

The "medical home" is one of those terms that has been a buzzword for a long, long time in health care. And, like most of these concepts, it has proved to be easier said than done…

Given the stubbornness of actually implementing medical homes—and getting organizations to pick up the tab—some observers have questioned whether it is even worthwhile to embark upon what is a daunting task.

The Value Case
It turns out that study after study has demonstrated that care delivered by primary care physicians in a medical home model—IF it's consistent and reliably delivered, and that's a big 'if'—is associated with better outcomes, reduced mortality, fewer preventable hospital admissions for patients with chronic diseases, lower utilization and improved patient compliance.

According to the Center for Evaluative Clinical Sciences at Dartmouth, states that relied more on primary care have:

- Lower Medicare spending (inpatient reimbursements and Part B payments);
- Lower resource inputs (hospital beds, ICU beds, total physician labor, primary care labor and medical specialist labor);
- Lower utilization rates (physician visits, days in ICUs, days in the hospital and fewer patients seeing 10 or more physicians); and
- Better quality of care (fewer ICU deaths and a higher composite quality score).

A recent analysis (by Mercer Government Human Services Consulting) of the North Carolina Medicaid program, which enrolls recipients in a network of physician-directed medical homes, showed that an upfront investment of just $10.2 million for North Carolina Community Care operations saved $244 million in overall healthcare costs.

Horizon Medical Home Pilot

When I served as Executive Medical Director for Horizon Blue Cross Blue Shield, New Jersey I had the opportunity to be part of Horizon's Medical Home Pilot with NJ Academy of Family Physicians and NCQA, which you will hear more about today.

Some of the items that we focused on included:

- Access and Communication among patients & healthcare providers
- Test Tracking
- Referral Tracking
- Advanced Electronic Communications

We believe these are linchpins for the foundation of a successful medical home.

Supporting the Key Components

As I said before, it is a tough nut to crack…So how can we actually make medical homes come to fruition?

If we just think about the term—medical home—it suggests the creation of an entire health *ecosystem* for the individual.

Not to carry the analogy too far, but if we think of creating the environment of a home—a kitchen, bathrooms, bedrooms, electricity, plumbing—there are actually a LOT of components to it.

Likewise, there are several components to establishing and maintaining a 'medical home' for an individual…in fact, for individuals who, as Dr. Brenner will surely tell us, aren't always amenable to suggestions about their daily welfare.

I'm sure you will all hear about successful medical home projects like Dr. Brenner's and the one I was involved in at Horizon, but it's also worth unpacking the concept of medical home and considering the necessary components, and how we can implement them.

One of the largest components of that project involves managing chronic diseases. We all know that those who don't manage their chronic diseases become the biggest drain on the system—both financially and in terms of human resources.

In the Department of Health and Senior Services, we've tried to chip away at this issue by funding the holistic management of chronic disease: The state provided funding support to the network of FQHCs to establish collaboratives to address diabetes, asthma, and obesity. This statewide collaborative of 19 FQHCs provides a systematic approach to healthcare quality improvement in which New Jersey's community health centers benefit from lessons learned about improving access to care, managing patient flow more efficiently and providing better preventive care.

The initiative used the Health Resources and Services Administration's Health Disparities Collaborative (HDC) Care and Improvement Models as part of the framework—these manuals are good resources for all of you! HRSA Health Disparities Collaboratives (HDC) is a national effort to achieve strategic system change in the delivery of primary health care.

Another big component in creating a successful medical home or medical-home project involves employing data…real-time, convenient, patient-level data at the fingertips of providers instantaneously.

This concept—the advances made in health information technology—is burgeoning right now, and given the incentives in the Recovery Act for Electronic Health Records, and the grants for health information exchange, we are poised to deploy health IT for important initiatives like medical home.

In fact, the medical home concept is perfectly representative of the *right* case to make for health IT…it's not about the incentives, frankly, though that can help…it's about managing patients better, holistically.

It's about treating the whole patient…so that when a patient enters the ER complaining of vague chest pain but he's not a good historian, we can easily look up data from other facilities to see if there's any history there.

That's what I'm able to do when I treat patients at the VA Hospital, because the VA has spent more than 25 years developing a system that can provide data across facilities.

Conclusion

Before I go, I want to note something else that the IOM emphasized in its landmark "Crossing the Quality Chasm" report in 2001. They talked about the *patient's experience* as being essential to the whole nationwide initiative of quality improvement.

So that really is the cornerstone of successful medical homes…Does the patient believe the caregiver actually cares? Does the patient have the totality of their conditions addressed? Does the patient feel like someone is actually looking after their health? Does the patient feel 'at home'?

I think all of these questions relate to all those component parts that create a successful health ecosystem—chronic disease management, tracking over time, effective and open communication, the concept of the data following the patient.

I aim to bring this approach to the Department of Health and Senior Services as we all try to more comprehensively and holistically manage New Jersey patients.