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What Makes a Medical Home a Medical Home?

MEDICAL HOME – A WHOLE NEW INITIATIVE IN PRIMARY HEALTH CARE IN PEDIATRICS

The basic premise of the medical home concept is care that is managed and coordinated by a personal physician with the right tools and that should lead to better outcomes, this doctor has done it.

HOST:

Dr. Larry Kaskel

GUEST:

Dr. Javier Sevilla.

Welcome to the Clinician's Roundtable. I am your host Dr. Larry Kaskel.

My guest today is Dr. Javier Sevilla Chief of Pediatrics, Whole Child Pediatrics in Lakewood Ranch, Florida. Dr. Sevilla is the American Academy of Pediatrics representative to the Committee for Quality Assurance.

Dr. KASKEL:

Dr. Sevilla, welcome to the show.

Dr. SEVILLA:

Glad to be here, Larry.

Dr. KASKEL:

I would like to start with really kind of some definitions and if you could help us define really what exactly is a medical home?

Dr. SEVILLA:

A medical home, and I am going to give you the definition of the American Academy of Pediatrics, which I think is probably the best one; it is not a building, it is really a relationship between the patient and their doctor that provides accessible, continuous, coordinated family centered, comprehensive and compassionate care. It is a place like the _____0105 everybody knows your name and everybody is prepared when you come in.

Dr. KASKEL:

This has been kind of evolving over about 40 years through the American Academy of Pediatrics, how have you seen it evolve from its initial idea to what it is today?

Dr. SEVILLA:

Well initially Larry, this has actually coined the term, medical home was actually coined in 1967. It was the first time that this was out there in the pediatric literature and since then it has been polished around the edges a little bit, and it originally started as a definition for children with special needs, but then it really was expanded to really see something that we wanted to have every child in America to have, and right now that is pretty much the vision of the American Academy of Pediatrics for every child to have a medical home. Now, this concept has been taken up by the American Academy of Family Practitioners back in 2004 and by the American College of Physicians which represents internal medicine doctors in 2006 and it has kind of snowballed into kind of a rallying cry for fixing what's wrong with the health system, fixing primary care by using the medical home model.

Dr. KASKEL:

Well, since it has evolved over the years, have there been any outcome studies done looking to see if the home actually does lead to better outcomes.

Dr. SEVILLA:

There is certainly a lot of literature out in the pediatric arena and we know that especially with the children with special needs we know that children that are located in the medical home or that have a medical home tend to have a lot less unnecessary ER visits, unnecessary hospitalizations. There is less days missed from school, there is less parental days missed from work from just having a medical home. Now, there is indirect evidence also. There is some very good evidence from Elliot Fisher that shows that this is basically in terms of children and adult that people who have good primary care and regions of the country that have good primary care, actually have the best outcomes, and there are actually international studies also done by the Commonwealth Fund which shows that industrialized countries that have the elements of medical home and basically I would equate this with a very strong primary care tend to have much better health outcomes, and amazingly enough it tends to be a lot less costly than the US system.

Dr. KASKEL:

Is the US system prepared to convert over to a medical home and what exactly is the difference between what I am used to just going to the pediatrician with my child versus going to a medical home, what would I expect to see?

Dr. SEVILLA:

First of all, I think the US is ready. This is our last chance in primary care to get this right. As I was telling you Larry, the professional society for the first time in history, I think has agreed that this is the best evidenced based model to practice primary care, and I left out the American Osteopathic Association, which was also part of the joint one voice coming from primary care, and amazingly enough the employers are also behind this movement, they really don't like what they are buying right now. They are buying fragmented care and they want us to go into the medical home. Now the insurance companies obviously are serving the employers and so they are having to accommodate this and there is even elements in the political establishments that are really clamoring for a better primary care in this country, so I think the stars are finally aligned and I think this is our best chance to improve primary care in the US. The second part of your question which was how can I tell a medical home from my regular old "plain vanilla primary care doc" and from the definition some of the thinks that you may find different in a medical home, first of all is access and one of the hallmarks of the medical home is superb access, so same day access if you need to come into the doctor, you can get into the doctor that day that you call, you don't have to wait for days or weeks to get in to see the doctor.

Dr. KASKEL:

Will you be seeing the doctor or might you be seeing an extender?

Dr. SEVILLA:

This is something that obviously is going to depend on the office, but really who you are going to be seeing is your personal physician or your personal clinician, so if your clinician seems to be a nurse practitioner, well, that's who you should see, if it's your doctor that's who you should see, and this actually also translates to a theme. So if your medical home is this theme where the doctor and the nurse practitioner are part of the theme, then sure, you may see one or the other. The difference here is the coordination, okay, and if you are seeing a theme then you would expect in a medical home prior to that day the theme which includes the clinicians, the nurses, the receptionists would have met and would have gone through your child's chart to be proactive and to be prepared for when you come in so that you are not fishing out for missing labs and missing x-rays and that everything is there and that everybody is on the same page about what you are doing with that child. So that part of coordination is something that you may not see in current primary care because it's not paid for. The only think that's paid for is your face-to-face time with the patient, but none of that other stuff that happens behind the scenes, behind the curtains is recognized by insurance companies and so in a lot of practices it doesn't have them. In one of the other areas that you would see a difference is this issue of being family centered or patient centered for adults and this is again a shift, a big shift from being a kind of physician centered health care to being a patient centered health care so that the patient is really at the center and there are really the force of control of what happens with their help.

Dr. KASKEL:

If you have just tuned in, you are listening to the Clinician's Roundtable on ReachMD XM 157. I am your host Dr. Larry Kaskel and my guest today is Dr. Javier Sevilla, Chief of Pediatrics at Whole Child Pediatrics and American Academy of Pediatrics representative to the National Committee for Quality Assurance, and we are discussing about what makes a medical home, home.

Dr. Sevilla, as you described all of the different things that make up a home, as I am listening I am thinking, well this is what we are supposed to be doing in primary care, but we are just not doing a good job at it. We are supposed to provide access, coordination,

patient-centric care, so what else is missing besides those things that really defines a medical home?

Dr. SEVILLA:

Well, one of the other definitions that I mentioned is continuous. Continuous means that you are creating a relationship between the doctor and the patient or the doctor and the family. It is a continuous relationship. This is not a relationship that only lasts for 15 minutes once a year or 15 minutes every 2 months or whatever the periodicity of face-to-face visits are. This is a continuous relationship that can take many forms, for example, e-mail communication or phone communication or face-to-face communication also, but this would be another element that is missing now because we have a payment system that only rewards and only recognizes that face-to-face contact.

Dr. KASKEL:

We only get paid if that patient comes into the office, so we are incentivized to seeing them. So what is the financial difference with a medical home. Are you actually paid differently by the insurance companies, and if so, how?

Dr. SEVILLA:

Well, this is the million dollar question right now. What has been proposed looking at different models from different countries is to a look at this in three ways. So we would continue to get the fee for service because the fee for service it rewards all human intensity and that's about it, it doesn't reward any of those attributes that I mentioned that belong to a medical home and this would be supplemented by a prospect of payment per member per month that would cover all that work that happens in the practice behind the scenes when the patient is actually not in the practice. So all the care coordination, all the preparation to the visits and everything else would be actually covered by the this fee and this would be, as I said, a per member per month fee.

Dr. KASKEL:

That sounds to me like we are going backwards to the HMO Capitation System and we were paid per person and then we don't want to see them again because if they come in, they take up too much time.

Dr. SEVILLA:

Right, it's actually different, and let me just tell you the third part of the payment, at least the payment structure that people are proposing, and that is a pay for performance so looking at the outcomes of some clinical outcomes, you would also get a different payment, so there would be kind of a _____10:32, if you like payments you would get, fee for service prospective and then you would get a paid for performance. Now to address the very valid point that you just made which was, you know we are just going back to capitation, to good old kind of HMO Health and really capitation was designed with basically one purpose and that was to decrease utilization and the reason you were paid a capitation fee was to decrease utilization. Now in this model because you do have the fee for service still there and hopefully at the same level that you have right now, the prospective payment would just cover for all that other stuff that you are doing anyway right now because all of us are having to do at least some care coordination and a lot of telephone care that does not get reimbursed by any insurance company.

Dr. KASKEL:

So Dr. Sevilla is anybody in fact getting paid now for a medical home from an insurance company.

Dr. SEVILLA:

Not right now because this medical home just started probably about January 2008 is when the MCQA, the National Community of Quality Assurance, actually released some indicators that would qualify you as a medical home, and right now what's going on is demonstration projects so what is going on right now is there are demonstration projects going on all around the United States trying to look at this model and trying to look at the payment model to see if it actually works and if it actually makes sense, you know, to the doctors and to the insurance company. So outside of those demonstration projects, right now I don't think there is anybody getting paid for these things at the moment.

Dr. KASKEL:

Well, on that note, Dr. Javier Sevilla of Whole Child Pediatrics in Lakewood Ranch, Florida, thank you so much for talking with me.

Dr. SEVILLA:

Thank you so much. It was great talking to you, Larry.

Dr. KASKEL:

I am Dr. Larry Kaskel. You have been listening to the Clinician's Roundtable on ReachMD XM 157. To comment or listen to our full library of on-demand podcasts, please visit us at www.reachmd.com. You can also now reach us by phone with your comments and suggestions at 888-MD-XM157 and thank you for listening.

Hi, I am Dr. Michelle McMurry, Director of the Health, Biomedical Science and Society Initiative at the Aspen Institute and you are listening to ReachMD XM 157, the channel for medical professionals.