

Utilizing Medical Homes to Create a Patient Centered Approach to Managing Chronic Conditions

PATRICIA DONOVAN: This is Patricia Donovan with the Healthcare Intelligence Network. Today I am speaking with Liz Reardon, a consultant with Commonwealth Medicine. Commonwealth is a public non-profit organization that helps state agencies and health care organizations optimize the effectiveness of health care initiatives for the underserved. Liz is presenting at HIN's audio conference on, "Utilizing Medical Homes to Create a Patient Centered Approach to Managing Chronic Conditions." Thanks for joining me today Liz.

LIZ REARDON, CONSULTANT WITH COMMONWEALTH MEDICINE: Thanks for having me.

PATRICIA DONOVAN: First of all the health care industry is placing a great deal of faith in the establishment of medical homes to improve care access and quality. However when we conducted a non-scientific on-line survey on this topic we found that a great many health care organizations aren't familiar with this term. What do you think needs to be done to further this concept of patient centered care?

LIZ REARDON: Well I think it's always easier when you're trying to think of a new concept to sort of put it in context of something you're already familiar with. And I know that probably a lot of organizations and practices have been really following Ed Wagner and his colleagues chronic care model that really talks about how you put your system of care together to help people and families who have chronic illnesses. And if you think of the medical home concept that sort of parallels Ed Wagner and his folks have done. Ed's program really focuses on the health care system and what kind of things you need to have in place in your system. And the medical home project or the medical home program is really kind of focused on the other end of the stick. They're more complimentary in that they really look to see what's the

best way you can support patients and their families, especially when people have chronic conditions that are going to pretty well last over the lifespan. So I think if you think of a chronic care model and really kind of kicking it up a notch to really, really effectively address the needs of patients and families I think that's a good way to start thinking about it.

PATRICIA DONOVAN: Thanks Liz. Pediatricians have been early champions of this idea of the medical home, particularly for children with special health care needs who account for 80% of pediatric health care costs. And this strategy of the medical home for this population appears to be working in Massachusetts where 48% of parents of these special needs children report that they receive effective care coordination. What can a health care industry learn from these early adopters?

LIZ REARDON: I think they can learn a lot. I think the first thing that you mentioned which is pretty critical is that the medical home concept really comes out of pediatrics. I first heard about it back in the late 90s when again the chronic care model was starting to be looked at. The Hood Center at Dartmouth College Medical School was really doing the program but they were trying to figure out how you helped rural practices and people who live in rural areas who had kids with special health care needs really do a better job. And from listening to them and listening to the families, I think there's three things that they really, really bring to this. And I think again you see this in the Massachusetts program.

I think the first thing is a real awareness that a chronic condition really exists over a lifespan. You really have to take a developmental look at it. And especially pediatricians if you've got a kid with asthma or a child with cerebral palsy or anything like that, what's going to face that child as a preschooler, or moves to middle school, becomes an adolescent, or starts transitioning into adulthood? Those needs are going to

change. And I think that's something that has made them very, very successful in that they really not only plan for or think about the course of the disease and the risk, they also kind of look over the life span to figure out how people can stay as healthy and as connected with the community as they can. So that's a real take away. The second thing is an awareness of a really good division of labor between the family and the parents and the people who support the child and the practice. A lot of times, in chronic care models, which are very valuable, but the focus a lot of times is on teaching, patient education, patient self-management support, which are all very important. But the medical role model really takes this to another level and they identify that there are things that the parents, the families and the patients need to do to support the practice as well. So it's much more of a mutual type thing. Especially when you're working with a child or working with a person who is going to really need to be observed. You're going to have to really pay attention to symptoms and you're really going to have to be providing that practice with information and recommendations on how to do things. So that's another thing, a real clear division of labor between the practice, what they're responsible for and also clear responsibility for the patient and its family.

And I think the other thing that has also been really; really good that the medical home model brings to chronic care is even better a more sensitive awareness of how you really connect with community. Also what are the types of social things that are going on? What are the needs emotionally, spiritually whatever, that the patient and family have, what are their values that they bring to this managing of the illness of the chronic condition, and who are the other connectors? Again you're talking kids, you're talking schools. And I think the other thing that medical homes for children have been able to do is integrate pretty well with school programs. And I think that that's something if you take that idea if you're going to be doing medical homes for people who are older or not necessarily in school figuring out

some of the places where they're more likely to be, employment or community organizations, faith based organizations, bringing them in is going to be pretty important as well.

PATRICIA DONOVAN: Well thanks Liz. And your detailing those three benefits leads me into my next question. I see that the University of Massachusetts Medical School has a grant to demonstrate how existing medical home practices can enhance the care delivered to these children by integrating the families and including community based organizations, which you just mentioned. What are some ways, you mentioned about this division of labor and the need for community resources, but what are some ways that health care organizations can draw the patient's community and family into this effort?

LIZ REARDON: I think there are a couple of things in terms of families that they've been able to do. Taking the chronic care model patient, education patient, teaching patient self-management. I think having the knowledge is absolutely critical. One of the things medical homes have also been able to really do a good job with is building tools. One of the things, if you look at some of the medical home projects that are out there, and before I forget, the American Academy of Pediatrics website which I believe is www.aap.org has actually a whole section on medical homes. So practices or organizations that are interested in hearing more or learning more getting more ideas about tools should go there. But I've found for example a notebook that has little pockets for keeping slips or appointments or other things, plus a structured way for the parent to know what to report to the practice when coming into the office visit. What are some of the things they need to know?

Having the patient really understand what they need to look for, how to write it down and how to communicate with the practice when they come in for that visit and making the most out of that visit is really critical. Especially, when you're talking about

family medicine or other practices, where the providers don't really have a whole lot of time to spend with the patient just because it's the way we pay for health care. The more prepared and the more organized a family or the patient can be with presenting that information to the docs the better it's going to be. And they really are good at that. They also can come up with some very interesting little things like refrigerator magnets to remind you to do different things. But again it's that tool kit as well as the knowledge that's really, really important. And I think that medical home programs have been able to do a good job at this.

I think the other thing that they've really, really done and that practices should think about are the extended families of people who have chronic conditions and it could be a spouse, it could be a child, it could be a grandparent. It's not just the person who has the chronic condition who has to do the management, it's the family, and it's the support system. And a lot of times people who have a diabetic or an asthmatic or somebody else in the family don't necessarily have the training or support that they as a family member need to really have, and that's something they could do really well. As far as the community is concerned I think there are a number of things you can do. In Vermont where I'm based our health department has actually taken a lead in a lot of this type of work. If you go to the Vermont.gov website follow the links to our health department for the past three years the governor's office and the health department have collaborated with communities on what we call the blue print for health. And what it has done is it's taken chronic conditions, looked at what the community needs to do to support it and everything from having communities to an inventories of walking trails or how people can get out and exercise, so exercise support. Or coming up with food vouchers for lower income people to go to farmer's markets to support our local farms and also I'm sure that they can get really good high quality foods. Those kinds of things aren't things that the health care system can do,

but certainly community organizations can get a look at what are some of the key things you need to have in place to be healthy, exercise, diet and supports, and kind of figure out how you can do that. So that's a little more complicated, and it's a little more connected to the community, but if you do have those kinds of things in place certainly they support the medical home, but also they definitely support the health of everybody else.

PATRICIA DONOVAN: Well thanks Liz, those are great ideas. The idea of the parent tool kit and certainly those resources for drawing in the community. Those are all the questions that I have today. Thank you for being with us. We're looking forward to hearing more from you during the audio conference.

LIZ REARDON: Great, looking forward to it myself.

PATRICIA DONOVAN: If you would like to register or receive more information about this audio conference please call 1-888-446-3530. This is Patricia Donovan for the Healthcare Intelligence Network.