ADIRONDACK REGION MEDICAL HOME PILOT

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Medical Homes: Two Approaches to Consider

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What is a Medical Home?

The Adirondack Region Medical Home Pilot provides a model for the delivery of health care that emphasizes the role of primary care.

It is not a place, building or structure!

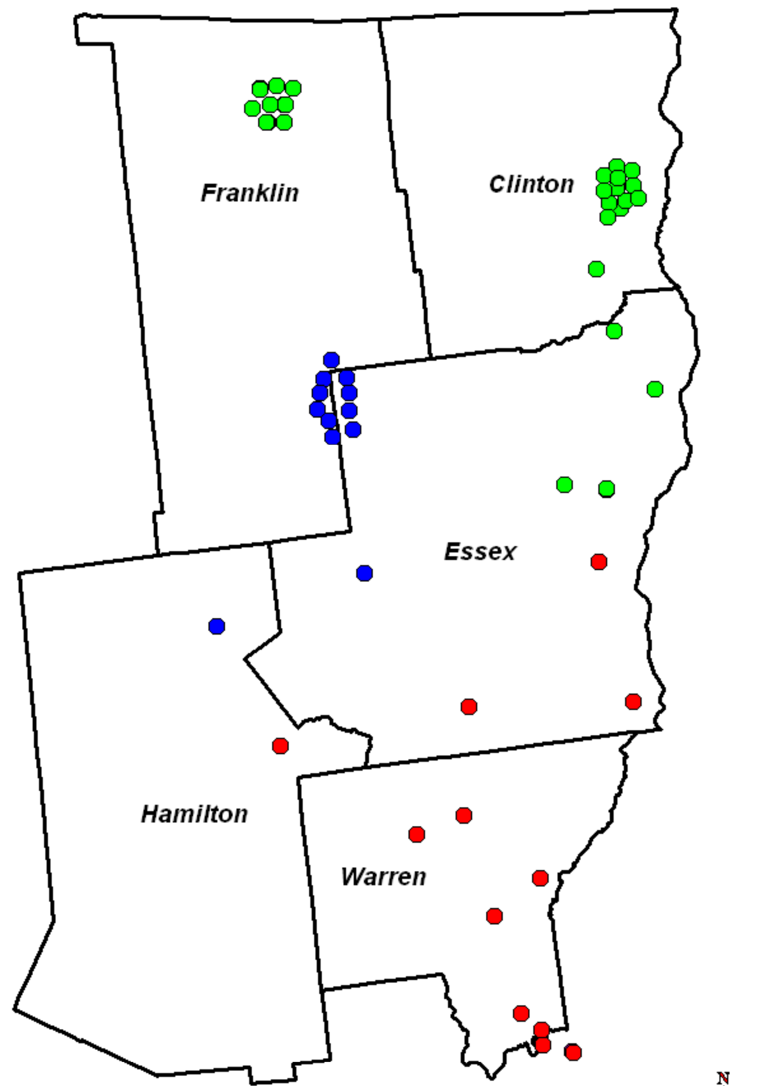
The pilot includes Clinton, Essex, Franklin, Hamilton, Warren and northern Saratoga counties, with areas being coordinated within geographic "PODS".

Specifically:

Lake George POD – Hudson Headwaters Health Network, Long Lake Health Center, Newcomb Health Center, and the Glens Falls Hospital
Tri-Lakes POD – Adirondack Medical Center, the communities of Saranac Lake and Lake Placid
Northern Adirondack POD – Champlain Valley Physicians Hospital, Elizabethtown Community Hospital, Alice Hyde Medical Center, the communities of Plattsburgh, Willsboro, Elizabethtown, and Malone

The pilot is expected to improve access to services, improve the quality of care, and lower costs over the long term.

Adirondack Medical Home Pilot


ADIRONDACK REGION MEDICAL HOME
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Data Source: Providers: Hudson Headwaters Health Network; HPSAs, MUA/Ps, HRSA
Map prepared by Community Data Services LLC, Voorheesville, NY
www.thecommunitydataservcies.com
November 2009

Adirondack Region Medical Home Project Demographics

- 110,000 Covered Lives—Across the Counties of Warren, Hamilton, Essex, Clinton, and Franklin
- 32 Primary Care, Internal Medicine, and Pediatric Practices—Across 49 sites
- 194 Primary Care Providers
  - 101 Physicians
  - 93 Mid-Level Extenders
- 9 Participating Health Plan Payers

NCQA
National Committee for Quality Assurance

The fundamental standards that shape the model of care for the Person-Centered Medical Home are:

- **Access to Care**
  - » Same-day appointments
  - » 24/7 coverage
  - » Each patient assigned to a personal clinician/team
- **Care Management—Health Coach**
  - » Transitional Care
  - » Referral and lab follow-up
  - » Provide patient education and access to community resources; i.e., CVPH Diabetes Center
- **Enhance Overall Quality of Health Care**
  - » Continuity of care
  - » Recruit for and retain primary care physicians in our community
- **Physician Payment Enhancements**
  - » Seven commercial payers, NYS Medicaid and Medicare

Adult Chronic Disease States
Evidence-Based Guidelines—EBGs

- Diabetes
- Coronary Artery Disease
- Hypertension

For each disease state, physicians will follow the same EBGs.

Each patient who is diagnosed with the selected disease will be monitored following the same criteria and measurement. This information will be collected through the practice EMR system as reportable data. These data will be collected across the pilot as the project moves forward.

Adult Patients with Diabetes

- All practices provide 24/7 access with a personal clinician or team of clinicians.
- Transitional Care Program—supports will be in place to ensure that post-discharge plans are communicated to the PCP by an RN who also provides support to the patient.
- Care coordination will be provided to ensure treatment plan compliance and reduce hospital admissions and subsequent readmissions.
- Diabetic supports will be offered, with follow-up to ensure compliance as needed.
- Better diabetic management will lead to overall better health, reduced hospital admissions, and lower prescription drug costs.

Pediatric Disease States
Evidence-Based Guidelines—EBGs

- Prevention
- Asthma
- Childhood Obesity

For each disease state, physicians will follow the same EBGs.

Each patient who is diagnosed with the selected disease will be monitored following the same criteria and measurement. This information will be collected through the practice EMR system as reportable data. These data will be collected across the pilot as the project moves forward.

Childhood Obesity

- Provide education and supports to ensure that women breastfeed for a minimum of six months—ideally the first 12 months.
- Increase physical activity for children in the community.
- Improve nutrition for children in the community.
- ADK 2015 developed to provide support and a prescription for better health
  - Active lifestyle; good dietary choices; and keeping a balance
- Partnership created between physicians, families, school districts, public health department, and the community.

HEAL 10 Grant

- Pilot participants have also been awarded a HEAL 10 grant from the New York State Office of Health Information Technology Transition.

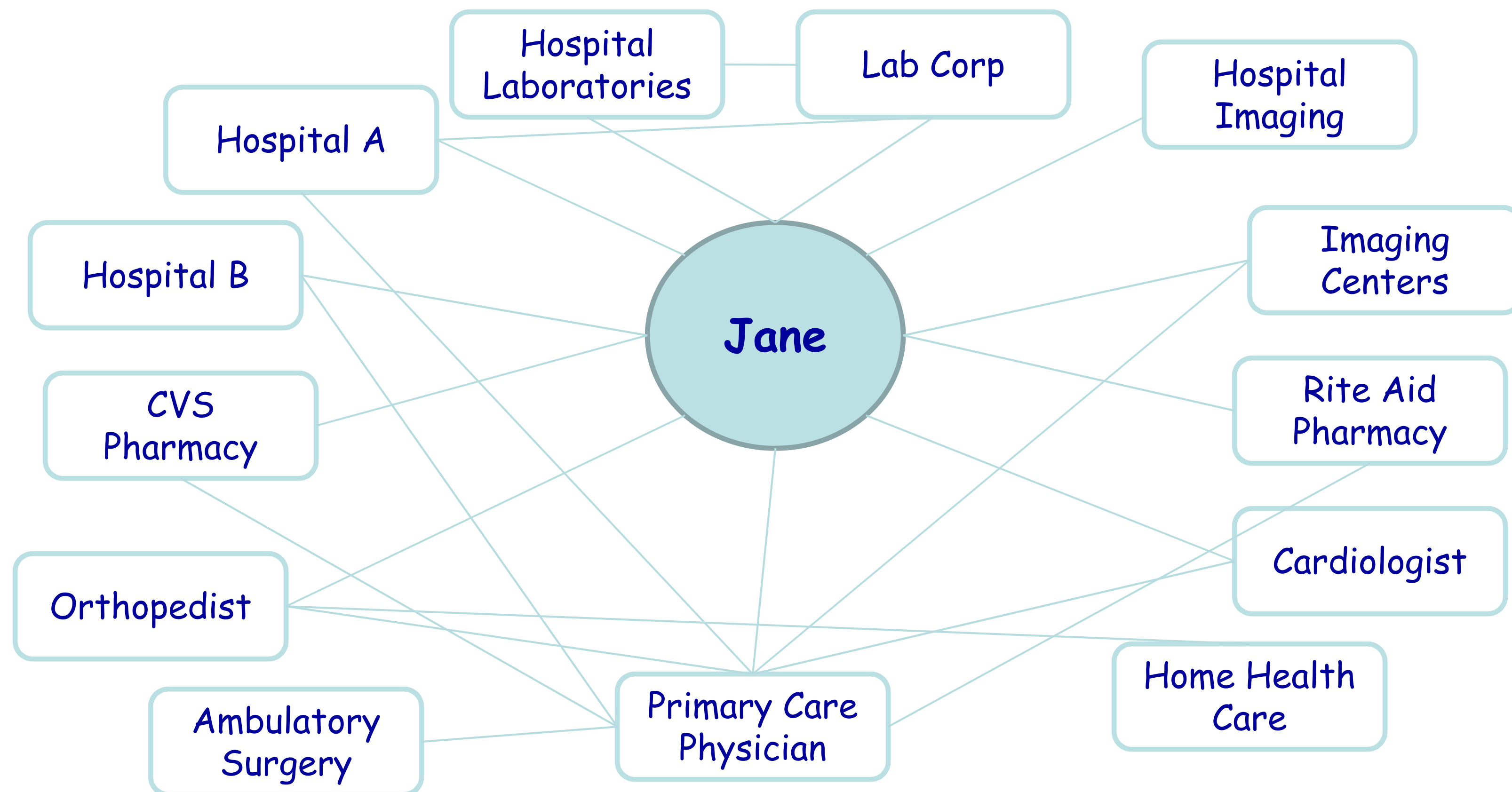
  Grant dollars and stakeholder match total $14 million to implement interoperable electronic health records and a clinical support system.

  This grant includes support to:

  - incorporate 9 distinct EMR systems; utilizing the local RHIO – HIXNY (Health Information Exchange in Northern NY)—offering providers a "collaborative community health record" for each patient—ultimately leading to better patient outcomes;
  - HIXNY will also transfer data to the pilot quality data warehouse; and
  - provide consultants from Massachusetts eHealth Collaborative to work with individual practices to improve and enhance the use of their EMRs, as well as capturing data relative to the pilot objectives and outcomes.

Standard Approach to Health Information Exchange

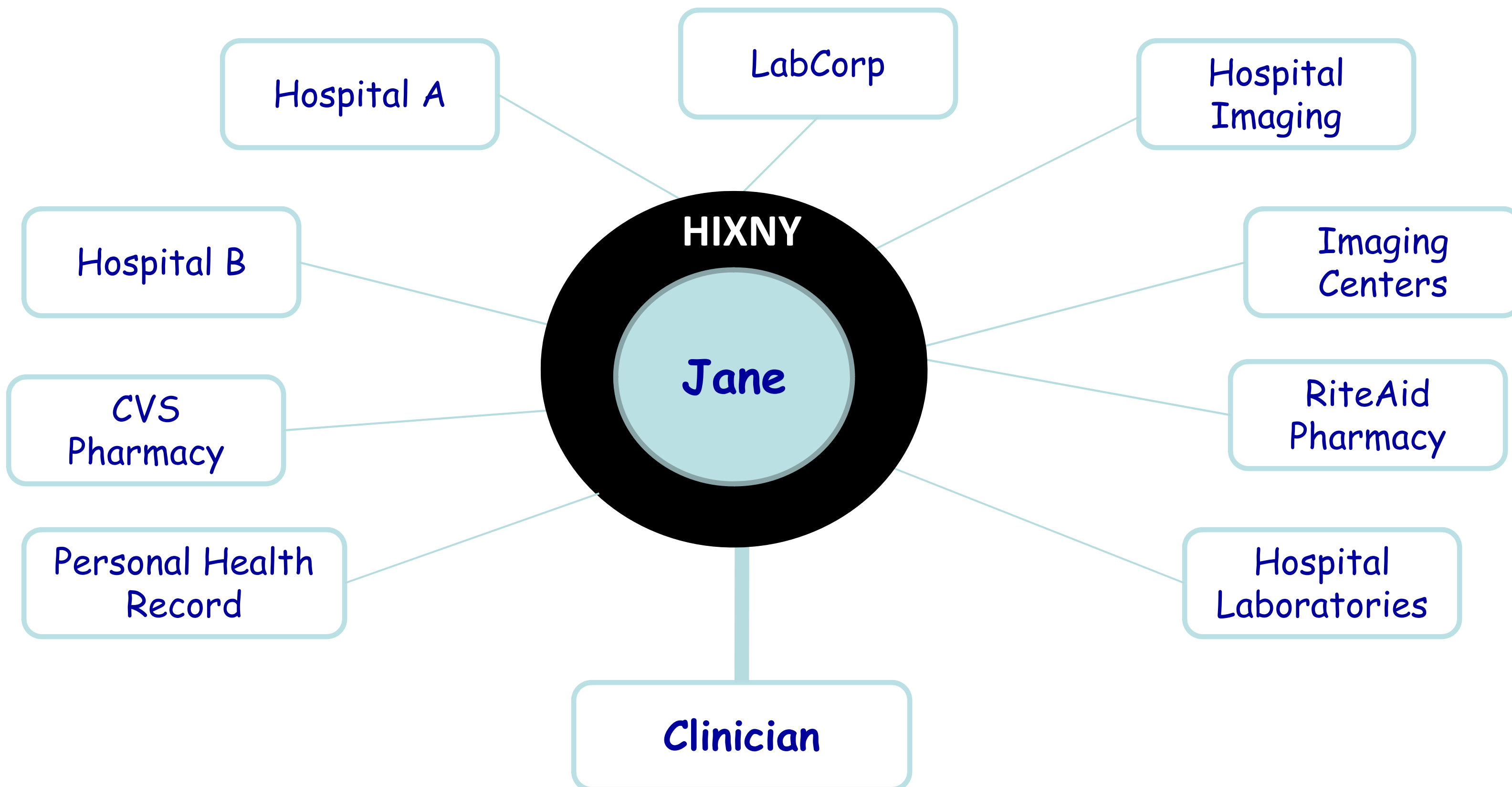
Those exchanging information for Jane use processes for sharing her information that are familiar, but are uncoordinated, largely inefficient, and ripe for error and for change.



Using fax, mail, phone calls, multiple portals, is a fractured, labor -intensive approach with patients as couriers.

Now: More Complete, Timely Information

With the RHIO as an enabler, there is a means to reduce time wasted on tracking down results, exposure to repeated tests, and delays in determining appropriate treatment plans.



Collaborative Efforts

- This project combines the efforts of physicians in their communities—working toward a common goal of improved health care and lower health care costs over the long-term.

- Rural health care has long been burdened with barriers related to patient demographics and a lack of primary care doctors. This project is designed to reduce these barriers in the best interest of the patient, the physician, and the community

What Are the Desired Outcomes?

Payer enhancement to be offset by: decreased costs from fewer hospital preventable admissions; decreased use of enhanced specialty care; lower prescriptions costs; and an increase in overall better health!

- **For our communities?**
  - Maintain primary care physicians in our area
  - Enhance the quality of health care
  - Enhance the region's economic future
- **For Health Care Costs?**
  - Reduce preventable admissions
  - Reduce preventable readmissions
  - Create interface for transmission of electronic discharge summaries, lab results and radiology results

For patients, providers and the community?
This project has helped to create collaborative efforts and partnerships that will have a lasting affect on the health of residents in the Adirondacks!

Questions

Thank you!

For more information –
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