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Medical Home NEWS

Using Medical Homes To Combat Infant And Maternal Mortality

A North Carolina Program Grows Rapidly

By Michael Ollove

When Hannah White first showed up at the Mountain Area Health Education Center in Asheville, N.C., three years ago, she was in trouble. She was 20 years old, a couple months into her first pregnancy and on the run from an abusive husband in Texas who already had broken her ribs in an attempt, she said, to kill her unborn child. She also has a form of hemophilia which prevents her body from producing platelet granules that stem bleeding. That disease had robbed her of her Malawian mother when Hannah was three months old, which ultimately led to her adoption by American missionaries.

"I was a mess," White recalled when she first showed up at MAHEC, which serves a 16-county area of western North Carolina. "I was worried about the abuse and was having this bleeding and afraid I was going to die or lose my baby.

MAHEC's ob-gyn program is part of a statewide initiative in North Carolina that identifies low-income women whose pregnancies present a high risk to either the baby or mother. All the women receive care through medical homes.

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Do Pharmacists Run Better Medical Homes Than Nurses?

A New Study Looks Into The Differences

By Lillian Min, M.D., Christine T. Cigolle, M.D., Steven J. Bernstein, M.D., et al.

The American Recovery and Reinvestment Act (ARRA) invested more than $1 billion in redesigning healthcare delivery systems. In response to interest in using electronic health records (EHRs) to perform comparative effectiveness research (CER) on chronic disease management, we were funded by ARRA to develop a unique database that linked a longitudinal chronic disease registry database to multi-payer claims from Medicare, Medicaid, commercial, and county insurance plans. The chronic disease registry, originally designed to support the quality metrics required by the various payers, contained care process measures and some intermediate outcomes. It also had the advantage of using a physician-adjudicated process to confirm patient inclusion. Our goal was to create a large relational database with the flexibility to allow construction of longitudinal datasets to answer specific questions about quality and utilization. The power of such a database would facilitate research that compares care among clinical sites and payer types and examines differing approaches to care.

As a proof of concept, we aimed to test for measurable improvement over time in diabetes care quality and utilization during the implementation of patient-centered medical homes (PCMHs) in the University of Michigan Health System (UMHS) in 2009, including 1 year pre- and 1 year post implementation (resulting in the study window 2008-2010). Of the conditions captured by our registry (including diabetes, heart failure, coronary artery disease [CAD], and asthma), we chose to study diabetes, the largest and most well-established disease registry. Prior research on PCMHs has shown inconsistent benefits from PCMH efforts, such as improved quality or utilization of healthcare, so we used this unique opportunity to measure the longitudinal improvement in individual patients' quality of diabetes care before, during, and after PCMH implementation.

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