Patient Centered Medical Home Foundation for Accountable Care
Outline of Presentation

- History and tenants of the patient-centered care and PCMH model
- Defining, measuring, recognizing, and evaluating the PCMH
- Lessons learned in transforming practices to being patient-centered care medical homes—the new PCMH recognition requirements
- Linkage of PCMH and reimbursement strategies
- Towards the future—ARRA, ACA and beyond
Patient Centered Medical Home

“A blending of aspirations and evidence based building blocks”

“Whatever works in improving patient centered primary care”

A JOURNEY TO TRANFORMING PRIMARY CARE— NOT TO A KNOWN DESTINATION
The Medical Home—Initial definition
ACP, AAFP, AAP, AOA

• **Personal physician** — each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

• **Physician directed medical practice** — the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

• **Whole person orientation** — the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

• **Care is coordinated and integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
Empirical Frameworks Informing Development of PCMH

Based on best available *evidence* in each area and on *testing of the reliability and validity of assessment tools on ongoing basis*

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<thead>
<tr>
<th>Chronic Care Model</th>
<th>Patient Centered Care</th>
<th>Cultural Competence</th>
<th>Medical Home</th>
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<tr>
<td>Clinical information Systems</td>
<td>Respect Patient Values</td>
<td>Culturally competent interactions</td>
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<td>Accessible</td>
<td>Language services</td>
<td>Physician directed team</td>
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<td>Patient Self-Management</td>
<td>Family-Centered</td>
<td>Reducing disparities</td>
<td>Whole person orientation</td>
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<td>Delivery System Redesign</td>
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**NCQA**
First contact-comprehensive-continuous-coordinated
What is Patient-Centered Care?

*Davis et al, 2006*

- Access to care, including alternatives for in-person visits
- Patient engagement in care—provider as advisor, information for patients, clear delineation of patient responsibility, help with self-care, behavior change, education
- Integrated, comprehensive care and smooth information transfer across provider teams
- Coordination and communication among care providers across location & time
- Publicly available information on practices
Addressing Patient Needs

• Customizing care
  - “Patient-centered care is focusing on the individual needs of that patient and looking at things for that patient in a very broad scope, looking at how certain conditions, problems really tie into each other and how one thing may be affecting another.”

• Promoting evidence-based care
  - “Treating all patients the same, using consistent protocols (including follow-up frequency) so all staff and clinicians can provide consistent message.”
Need for a Standardized Tool for Qualification

• If payers are going to provide extra reimbursement to PCMHs, they need a valid and reliable, actionable assessment

• When reimbursement is at stake, major problems with:
  - Use of practice (clinician) surveys without documentation or on site verification
  - Use of clinical performance measures or patient experience of care (sample size, cost, risk adjust)
  - Critical for practices to have access to standardized assessment since practices may participate in projects for multiple payers

• Link to Board certification (MOC) and meaningful use
What the NCQA PPC PCMH is NOT

• It does NOT define a PCMH
  – The joint principles (and others as well) “define” the PCMH

• It does NOT “certify” practices as medical homes
  – It, along with attestation, only qualifies a practice as having met the basic standards that “predict” being a PCMH

• It is NOT Permanent in content or scoring
  – Was designed to evolve over time
PPC–PCMH: What it is

• Provides valid, reliable and “auditable” means for incentivizing investment in quality infrastructure and processes
• Encourages practices to adopt proven systems for improving care
• Complements evaluation of clinical effectiveness, patient experiences, and efficiency
NUMBER OF PPC-PCMH SITES BY STATE

As of 9/24/10

1018 PPC-PCMH SITES

0 Sites
1-20 Sites
21-60 Sites
61-200 Sites
201+ Sites
### PPC–PCMH Practices*

**NUMBER OF PHYSICIANS IN RECOGNIZED PRACTICES**

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* As of 8/31/10
Studies of PCMH Show Better Quality can Cost Less

- Bridges to Excellence”
  - Compared to non-recognized physicians, physicians with PPC Recognition
    - significantly fewer episodes per patient (0.13; 95% CI = 0.13, 0.15)
    - lower resource use per episode ($130; 95% CI = $119, $140)

- Group Health Puget Sound, Geisinger, North Carolina Medicaid
  - All showed enhanced quality, lower overall costs (mostly lower ER and hospital use)
Myths

• Small practices can’t qualify (>20% of qualified practices are solo physician sites/practices)
• Passing (25 points) is too hard (practices do not have to submit tool until they score above passing)
• Passing (25 points) is too easy (estimate fewer than 15% of practices could pass without making changes)
• You have to have an EMR to pass (can get nearly 50 points without ANY electronic process—and over 80 without full EMR)
Criticisms

• Insufficient emphasis on access, coordination
  – *Looking at increasing in future versions*
• Isn’t patient-centered
  – *Looking at ways to further incorporate patient experience data*
• Too much emphasis on HIT
  – *Strong support from public and private payors*
• Doesn’t get at issues beyond primary care
  – *Looking at medical home “neighbor”; multi-specialty environments*
• Doesn’t measure quality
  – *Studies have found relationship; can be combined with P4P*
Guiding Principles for PCMH 2011

- **Practical** – blueprint for practice transformation
- **Evidence-based** – built on solid foundation
- **Collaborative** – improve team-based interactions
- **Flexible** – applicable to spectrum of practices (basic-complex, small-large, low-high tech)
- **Solution to problem** – nationally used to evaluate primary care practices
PCMH 2011 Key Components

- **Access**
  - Evening/weekend hours, agreement with facility for after-hours care

- **Coordination of care**
  - Information to/from specialists/facilities/patient, update care plan

- **Team-based care**
  - Defined roles and responsibilities, training, communication

- **Role of medical home**
  - Discuss roles/expectations for medical home and for patients

- **Care management**
  - Pre-, post-visit planning, care planning during visit, patient self-care
  - Medication management
  - Include mental health/substance abuse/behaviors affecting health

- **Community resources/referrals**

- **Identify/address population needs/risks**

- **Quality improvement**
  - Performance measurement
  - Patient experience
Comparison of PPC-PCMH and PCMH 2011

PPC-PCMH (9 standards/30 elements)
1. Access and Communication
   - Processes
   - Results
2. Patient Tracking and Registry Function
3. Care Management
   - Continuity Between Settings
4. Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting and Improvement
   - Measures of Performance
   - Patient Experience
9. Advance Electronic Communication

PCMH 2011 (6 standards/25 elements)
1. Access/Continuity
   - Access
   - Medical Home Responsibilities
   - CLAS
   - Practice Team
2. Identify/Manage Patient Populations
3. Plan/Manage Care
   - Care Management
   - Medication Management/E-Prescribing
4. Self-Care Support
5. Track/Coordinate Care
   - Test/Referral Tracking
   - Facilities
6. Performance Measurement/Quality Improvement
   - Measures of Performance
   - Patient Experience
   - Quality Improvement
   - Reporting
PCMH 2011 Alignment with HIT Meaningful Use Requirements

- **E-prescribing** – medication list, allergies
- **Patient tracking/registry** – demographics, diagnoses, vital signs, smoking, population management, insurance
- **Care management** – reminders for follow-up care, decision support, RX reconciliation
- **Electronic capability** – e-health info. to patient, visit summary, e-access to health information, provider information exchange
- **Performance reporting/improvement**
Implementing and Evaluating PCMH

**Inputs**
- Individual Clinician-Staff Attitudes, behaviors and proficiencies
- Office Practice Systems and Process

**Qualification**
- Patient Experience of Care Measures (PCMH related)

**Evaluation**
- Clinical Process And Outcome Measures (Recognition programs & Group/plan data)
- Resource Use Cost of Care Measures

**Output**
- Patient Centered Primary Care
- Assessment of Practice Systems And Process (PPC-PCMH)
- Research Measures (Clinician-staff Satisfaction, retention etc)
Linkage of PCMH to Reimbursement: ABSOLUTE NECESSITY

Pay for Performance
Triple aims: Clinical Quality, Resource Use and Patient Experience

Fee Schedule for Visits/Procedures

Payment per Patient for services not included in FFS Visits AND for being qualified patient centered medical home
The Patient Centered Medical Home as Foundation for Health System Transformation
The Current Model of Care: Connection by Billing
Key Steps to a Different Model

• Patient-Centered Primary Care as key building block
• Implementation and use of health information technology and care systems at all levels of health care
• Integration and coordination of care (real or virtual)
• Reimbursement linked to desired process and outcomes of care (pay for what you want)
• Measurement and feedback to determine if you are getting where you want to be
Problems in health care NOT limited to Primary Care

• Coordination of care shown to be critical element in overall care of patients with chronic illness (Wagner–others)

• All physicians providing evaluation and management services affected by reimbursement system (pay for volume)

• Safety, quality and cost issues at hospital level as well (IOM)

• Early, positive results from PCMH and PCMH “like” demonstrations are in organized systems of care (Geissinger, GHPS etc)
Future Model of Care: Patient Centered “Medical Neighborhood”

- Sub-specialty “Medical Home Neighbor”
- Sub-Specialty Procedural Practice
- Patient-Centered Medical Home
- Hospital
- Insurer
- Data Center
The Future Model of Care: Patient Centered Accountable Care System

Sub-specialty “Medical Home Neighbors” Referrals and Procedures

Patient Centered Hospital

Patient Centered Medical Home

Insurer

Data Center
Summary

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• Lessons learned in transforming practices to being patient-centered care medical homes
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