Parameters & Implications of the Patient-Centered Medical Home

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Medical Home

- The goals of this presentation are to:
  - Provide you with background on medical home – history, current status, major activities
  - Learn the concerns, challenges or barriers to becoming a medical home
  - Understand the relevancy of medical home to various specialties

Medical Home: Background

- 1967: Concept introduced by American Academy of Pediatrics (AAP)
- 2004: Future of Family Medicine (FFP) expanded the concept
- 2006: ACP introduced its version, the "advanced medical home"
- 2007: AAFP, ACP, AAP & AOA drafted joint principles on the Patient-Centered Medical Home (PCMH)
- Nov. 2008: AMA adopts the joint principles

Medical Home: Background *cont.*

- 7 PCMH Principles include:
  1. Personal physician
  2. Physician directed medical practice
  3. Whole-person orientation
  4. Care is coordinated and/or integrated
  5. Quality and safety
  6. Enhanced access
  7. Payment

Medical Home: Background *cont.*

- PCMH elements compared with the Chronic Care Model:
  - Access: advanced access, wait times, office hours
  - Continuity: each patient has a primary care physician, patient registry
  - Care Coordination: with hospitals sub/specialists, med review

Medical Home: Background *cont.*

- PCMH elements:
  - Comprehensiveness: planned visits, patient registries
  - Physician-directed: team approach
  - Quality & safety: QI, patient participation
  - HIT: patient registries

Medical Home: Background *cont.*

- Attributes include:
  - Support and coordination by the PCP in forming the care team;
  - Promotion of continuous healing relationships;
  - Robust use of technology; and
  - Service-oriented culture

Medical Home & Subspecialty Care

- PCMH should have systems to effectively communicate w/specialists and have efficient referral processes.
- PCMH may complete more preliminary patient evaluations for whom they previously would have referred
  - This may mean a decrease in low complexity referrals; more complex referrals would have more robust documentation to improve the process.

Medical Home & Subspecialty Care *cont.*

- According to ACP, the following are examples of subspecialists serving as a PCMH:
  - Endocrinology practice treating patients with diabetes on complex insulin regimes or with significant complications.
  - Infectious disease practice caring for an HIV+ patient.
  - Rheumatology practice caring for patients with rheumatoid arthritis.
  - Cardiology practice managing someone with advanced heart failure.
  - Oncology practice coordinating care for a person with a malignancy.

Medical Home & Subspecialty Care *cont.*

When a sub/specialist provides ongoing **principal care** for a patient in the PCMH model:

- This physician would be responsible for routine first contact care (e.g., bronchitis, skin infections, urinary tract infections, routine preventive health measures).

- or -

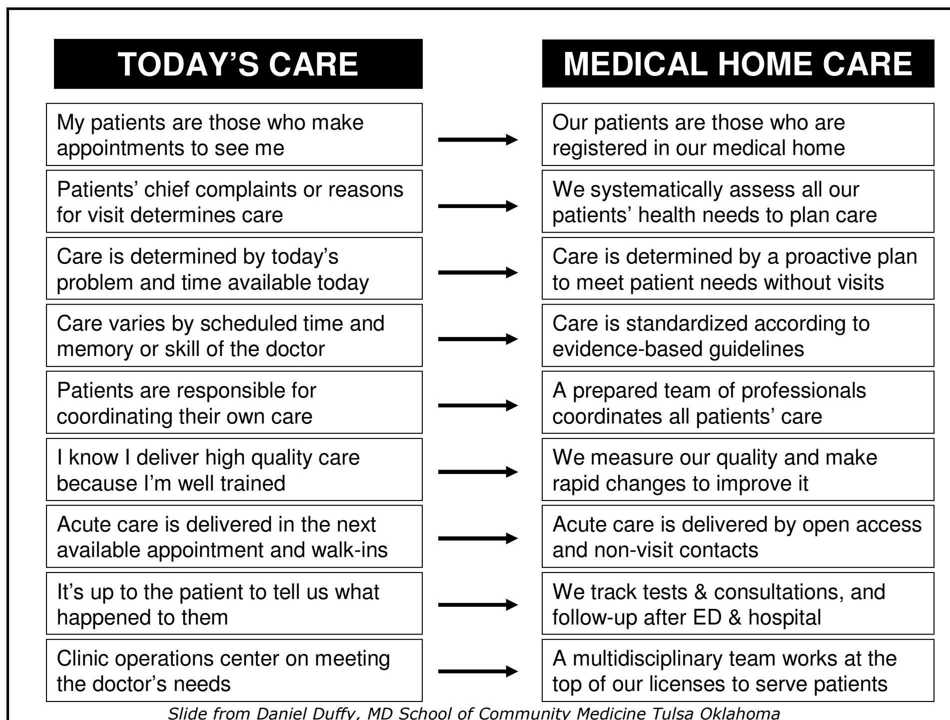
- A **principal care** physician hires an NP for primary care.

- or -

- A **principal care** physician working in a multi-specialist practice can team-up with a primary care colleague.

Medical Home: Communication & Coordination

- The PCMH is responsible for overall patient care coordination
  - Should be recognized by all providers, including sub/specialty physicians, and the patient.
- The PCMH should have systems to:
  - Track patient referrals and sub/specialist treatment; medications; and diagnostic tests and laboratory results.
  - Communicate tracked information, including raw data
- The PCMH should have in/formal agreements with sub/specialty providers which specify communication (e.g., faxed reports)
- The patient should be kept informed of PCMH and sub/specialist communications



Medical Home: Projects & Programs

- Patient-Centered Primary Care Collaborative: a national coalition to develop and advance the PCMH.
  - Recently issued draft guidelines for demo projects testing the PCMH model
  - Goal is to support general consistency w/principles
  - PCMH compensation would reflect enhanced patient experience (improved access, communication, coordination, etc.)
  - Standardization could improve interpretation and understanding of the lessons learned from different PCMH demonstration projects

Medical Home: Projects & Programs *cont.*

- Typically partnerships that focus on chronic disease management and enhanced payment systems
  - Boeing & IBM projects underway in family medicine
- Medicare demo in the works
- AAP launched a National Center for Medical Home Implementation in July 2008

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Medical Home: Projects & Programs
cont.

- Community Care of North Carolina
  - State Medicaid program established 1998
  - Administered under Medicaid Managed Care
    - Consists of regional "networks" to focus on care management
    - Per-member per-month fees
    - Enhanced Medicaid payment (95% of Medicare)
    - Resources to assist physicians with care coordination

Medical Home: Projects & Programs
cont.

- Community Care of North Carolina *cont.*
  - External evaluation found program savings of $60 million (2003); $124 million (2004)
  - Programmatically, savings included:
    - $3.5 million from asthma management program
    - $2.1 million from diabetes management program

Medical Home: National Committee on Quality Assurance

- National Committee on Quality Assurance has developed a certification program
  - Physician Practice Connections Patient-centered medical home (PPC-PCMH)
    - Practice recognition program
    - Objective assessment of practice capability to provide quality care
    - Provides a checklist of office systems and processes to address in your office

Medical Home: NCQA *cont.*

- NCQA definition of a medical home:
  - Each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.
  - The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians

Medical Home: NCQA *cont.*

- PPC-PCMH has 3 levels of recognition and measures:
  - Access/communication
  - Patient tracking/registry functions
  - Care management
  - Patient self-management support
  - E-prescribing
  - Test/referral tracking
  - Performance reporting
  - "Advanced" electronic communication

Medical Home: NCQA *cont.*

- Scoring is done by 3 levels and consists of 10 elements:
  - **Level one**: must pass 5 elements at a 50% scoring level
  - **Level two**: must pass 10 of 10 at a 50% scoring level (50 – 74 points)
  - **Level three**: must pass 10 of 10 at a 50% scoring level (75+ points)

Medical Home: NCQA *cont.*

- Status:
  - In 2008, tested models around the country to determine
    - Associated quality/cost outcomes?
    - Payment associated with recognition?
  - Still waiting for details, but . . .

Medical Home: Challenges

- 2008 Deloitte report highlights costs to become a medical home for individual primary care physician.
  - *$80 – 100k* in one-time costs
    - (EMR w/registry, PHRs, etc.)
  - *$100 - $115k* in incremental costs for primary care clinician;
  - *$78k* per year for health coach; *$22k* for part-time data manager (both incremental costs).
  - Model assumes that each clinician gets paid an **additional 100k** for care coordination

Medical Home: Challenges *cont.*

- Deloitte report acknowledges high risk to physicians and recommends the following steps:
  - Long-term bonus structure and up-front capital from a strategic partner
  - Revamping practice operations to focus on care coordination & patient adherence

What Does this Mean for Me?

- It depends on your practice
- And in the short-term, possibly not that much.
  - California does not have any statewide pilots

What Does this Mean for Me?

- But, stay tuned:
  - Terminology has traction in the media and in the policy arena
  - Performance may be measured by certain medical home elements
    - Medicare, P4P, etc.
  - Collaborative opportunities
  - Medicare demo

Medical Home: Tools

- AAFP's TransforMed PCMH assessment tool (free)
- AAP – special needs resources
- Patient-Centered Primary Care Collaborative
- Your team!

Medical Home: Next Steps

- Consider the role of you and your team
- Provide your leadership with feedback
  - Education & resource needs
  - Interest in participation in events / activities
- Understand what incentives you may be eligible for (e.g., P4P)
- Provide input into legislation, guidelines, or project development

Medical Home Resources

- The Medical Home, Access to Care, and Insurance: A Review of the Evidence (*Pediatrics* 2004; 113; 1493 – 1498)
- The Medical Home: An Idea Whose Time Has Come . . Again (*Family Practice Management*, Sept. 2007)
- The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change (Robert Graham Center, November 2007)
- Making Medical Homes Work: Moving from Concept to Practice (Center for Studying Health Systems Change, December 2008)