The Patient-Centered Medical Home Model of Care — Promise and Challenges

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The Patient-Centered Medical Home: What Is It?

- It's not a place, such as a hospital or house, but a way of delivering primary care services effectively and efficiently.

National Committee for Quality Assurance (NCQA) definition:

- "The patient-centered medical home (PCMH) is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship."

The Patient-Centered Medical Home: Origins

- The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In 2002, AAP expanded the medical home concept to include these operational characteristics: **accessible, continuous**, **comprehensive, family-centered, coordinated, compassionate**, and **culturally effective care**.
- The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) also have models for improving patient care.
- In 2007, AAFP, AAP, ACP and the American Osteopathic Association developed and endorsed the **Joint Principles of the Patient-Centered Medical Home**
- The new health law contains multiple reference to the PCMH including demonstration projects for Medicare, Medicaid, and federally qualified health centers.

The Patient-Centered Medical Home: Joint Principles

- The joint principles include these elements:
  - **Personal physician** — Patients are assigned to a personal physician for "first contact, continuous and comprehensive care."
  - **Physician-directed medical practice** — A physician leads a team of health care providers who work collaboratively to improve the patient's care.
  - "**Whole person" orientation** — A physician is responsible for all of the patient's care including acute, chronic, preventive, and end-of-life care.
  - **Integrated and coordinated care** — Care is coordinated across all facilities through health care technology.
  - **Enhanced access to care** — Patients can take advantage of open scheduling, expanded hours, and new communication options with the physician practice.

The Patient-Centered Medical Home: Joint Principles

- Quality and safety:
  - Practice collaborates with patient and family to define a care plan.
  - Practice uses evidence-based medicine and care pathways.
  - Practice performs continuous quality improvement .
  - Patient feedback is incorporated into performance measurement.
  - Patients and families participate in practice quality improvement.
  - Information technology is a foundation of care, performance measurement, communication, and patient education.
  - Practices are certified as patient-centered by a nongovernmental entity.
  - Physicians share in savings from reduced hospitalizations.
  - Physicians receive bonus payments for attaining predetermined quality metrics.

The Patient-Centered Medical Home: Joint Principles

- **Payments** should reflect both physician and nonphysician value and encompass payment for all services including non-face-to-face visits and care management.

The Patient-Centered Medical Home: What Does It Look Like?

Attribute	Services
Access to care	• Open access • Shorter waiting times • Online appointments and e-visits • Group visits • Telephone consultations • After-hours service • Electronic prescribing
Patient engagement	• Care reminders • Anticipatory guidance • Individualized care plans and health information • After-visit summaries
Team-based care	• Multidisciplinary physician-led team responsible for care

The Patient-Centered Medical Home: What Does It Look Like?

Attribute	Services
Care coordination	• Coordination of specialist care • Follow-up to ensure attendance at referral visits • Systems to prevent errors for patients with multiple doctors • Open communication between providers treating the same patient • Chronic disease management
Clinical information systems with decision support	• Electronic health records • Patient registries • Patient/physician reminders of care opportunities • Clinical practice guidelines software
Feedback to physicians	• Patient surveys • Outcomes analysis
Transparency	• Publicly available cost, quality, and demographic information by physician

The Patient-Centered Medical Home: Theory to Testing

- There are approximately 100 planned or established PCMH pilot programs in the United States.
- In 2006, AAFP launched the National Demonstration Project (NDP) to test a model of the PCMH in 36 family practices.
- Currently, there are 27 multi-stakeholder (involving more than one insurer) pilot projects in 20 states, and multiple projects with individual insurers.
- In addition, 38 states have ongoing Medicaid/Children's Health Insurance Program (CHIP) pilot projects.
- The U.S. Department of Veterans Affairs is transforming its primary care clinics to a medical home model of care.

The Patient-Centered Medical Home: Standards

- In 2008, NCQA published PCMH standards on how a practice can become recognized as a medical home.
- There are three levels of recognition in the NCQA guidelines based on nine standards and 30 corresponding elements:
  - There are 10 "must pass" elements.
  - For Level 1, a practice must meet five of the 10 elements.
  - For Levels 2 and 3, a practice must meet all 10 elements.
- Most pilot projects reward practices based on the NCQA level achieved.
- A practice can achieve Level 1 and possibly Level 2 but not Level 3 without an electronic health record.

The Patient-Centered Medical Home: Standards

Standard 1: Access and Communication

- ❑ A. Has written standards for patient access and patient communication*
- ❑ B. Uses data to show it meets the standards for access and communication*

Standard 2: Patient Tracking and Registry Functions

- ❑ D. Uses paper or electronic-based charting tools to organize clinical information*
- ❑ E. Uses data to identify important diagnoses and conditions in practice*

Standard 3: Care Management

- ❑ A. Adopts and implements evidence-based guidelines for three conditions*

Standard 4:Patient Self-Management Support

- ❑ B. Actively supports patient self-management*

Standard 5: Electronic Prescribing

* Must-pass elements

The Patient-Centered Medical Home: Standards

Standard 6: Test Tracking

- A. Tracks tests and identifies abnormal results systematically*

Standard 7: Referral Tracking

- A. Tracks referrals using paper-based or electronic system*

Standard 8: Performance Reporting and Improvement

- A. Measures clinical and/or service performance by physician or across the practice*
- C. Reports performance across the practice or by physician*

Standard 9: Advanced Electronic Communications

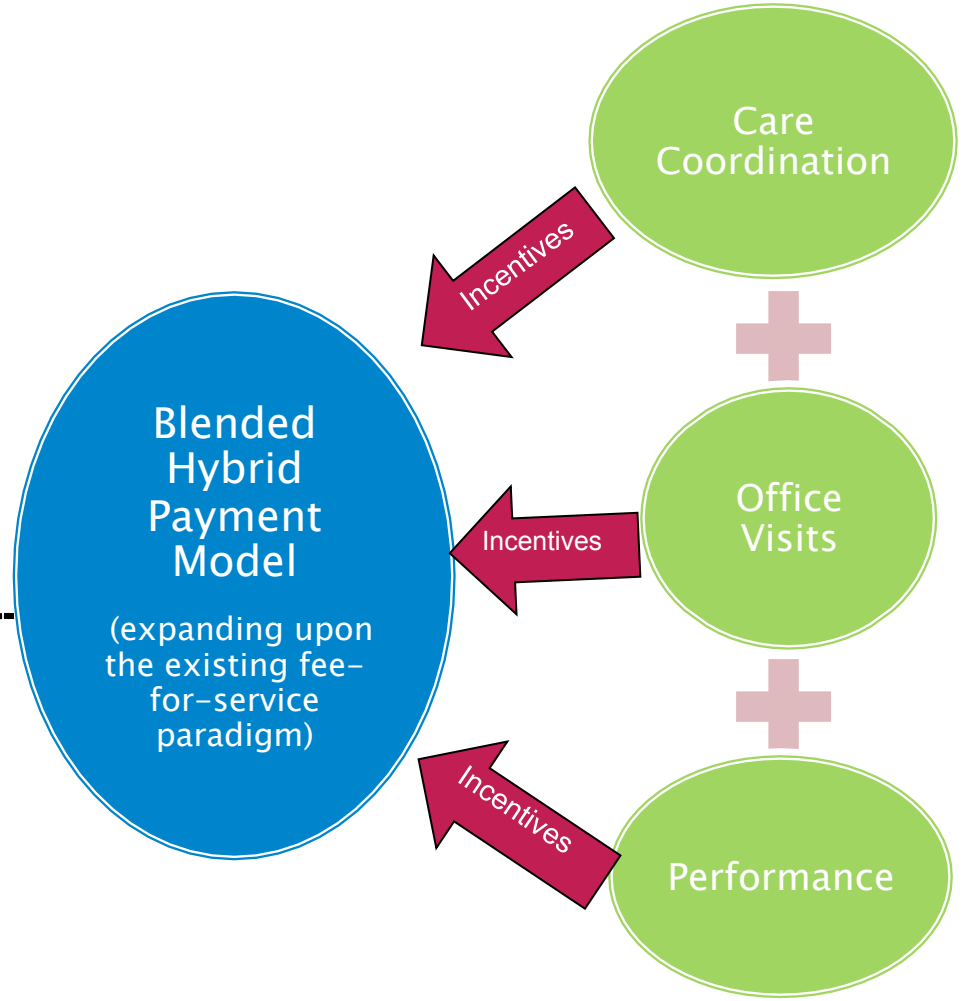
* Must-pass elements

PCPCC Payment Model

Key physician and practice accountabilities/value-added services and tools

- Proactively work to keep patients healthy and manage existing illness or conditions
- Coordinate patient care among an organized team of health care professionals
- Utilize systems at the practice level to achieve higher quality of care and better outcomes
- Focus on whole person care for their patients (including behavioral health)

Performance Standards



The Patient-Centered Medical Home: Public Initiatives

Community Care of North Carolina (CCNC) developed a medical home program for the state's Medicaid beneficiaries in 1998.

- CCNC links beneficiaries to a primary care medical home, provides technical assistance to practices to improve chronic care services, employs nurses to collaborate with practices in the management of high-risk patients, and added a $3-per-enrollee-per-month care coordination fee
- As of 2009, it served more than a million patients and encompassed 1,360 practices.
- CCNC has documented a 40-percent decrease in hospitalizations for asthma and a16-percent lower emergency department (ED) visit rate; 93 percent of asthmatics receive appropriate maintenance medications, and diabetes measure improved by 15 percent.
- Total savings to the Medicaid and CHIP programs are estimated to be $135 million for the community-based populations and $400 million for the aged, blind, and disabled population.

The Patient-Centered Medical Home: Public Initiatives

Colorado has implemented a PCMH program for low-income children enrolled in the state's Medicaid and CHIP programs.

- Primary care practices must have 24/7 access, open access, or similar convenient scheduling of appointments and provide care coordination,
- Performance-based payments are made to providers who participate in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) component of Medicaid,
- 150,000 children are enrolled in these practices, involving 97 different community-based practices and 310 physicians,
- Evaluation shows that 72 percent of children in the medical home practices have had well-child visits compared with 27 percent of controls.
- Median annual costs were $785 for PCMH children compared with $1,000 for controls, due to reductions in hospitalizations and ED visits.

Patient-Centered Medical Home: Texas Medicaid Health Homes for Children

- N April 2010, the Texas Health and Human Services Commission (HHSC) issued a request for proposals (RFP) from practices to establish Medicaid pediatric “health home” pilots .
- HHSC allocated $25 million from the *Frew* strategic initiatives to fund the pilots over two years.
- Up to eight pilot sites will be selected, with implementation expected in October 2010.
- The RFP states: “Pilot projects that include a minimum of 5,000 children enrolled in Medicaid under age 21 years are preferred.”
- The RFP selection process will also favor proposals that lend themselves to continuations after the pilot concludes.

Patient-Centered Medical Home: Texas Medicaid Health Homes for Children

- The objectives of the RFP "are to encourage innovation and assess the impact of varied models of health homes in:
  - "Increasing access to primary care and specialty services for children receiving Medicaid benefits;
  - "Improving the quality of primary care and specialty services for children enrolled in Texas Medicaid by increasing the number of enrolled children receiving recommended primary prevention services, proper management of chronic conditions, and all needed specialty and social support services including dental and behavioral health services;
  - "Meeting the first two objectives in a cost-effective manner such that the innovations are sustainable over time and conducive to replication across the State of Texas;
  - "Providing care in a manner that is "patient/family-centered, population-based, coordinated, clinically managed, team-based, and comprehensive."

The Patient-Centered Medical Home: Private-Sector Pilots

Group Health Cooperative, a large health system in the Pacific Northwest, developed a model that reduced the patient panel for physicians (typically from 2,500 patients to 1,800 patients) and increased the amount of time that primary care doctors spent with each patient (from 15 to 30 minutes).

- Other aspects of the intervention included using secure e-mail threads, increased numbers of telephone encounters, and daily "huddles" for the care team to plan the day's patient encounters.
- The intervention was applied across all primary care patients rather than just those with chronic diseases.
- Group Health began with one of its 20 primary care clinics so it could use another clinic as a control.
- At the end of the first year, there was an 11-percent reduction in hospitalizations, a 29-percent reduction in ED visits, and a total savings of $71 per patient.
- Group Health also reported improved physician and staff morale and less burnout.

The Patient-Centered Medical Home: Public/Private Partnerships

Location	Sponsor	Demographics
Southeast Pennsylvania	Chronic Care Commission — Office of Governor Rendel	170 practices 780 physicians 1,090,000 covered lives
Maine — statewide	Maine Quality Forum	26 practices 221 physicians 75,000 covered lives
Colorado	Health Team Works (nonprofit quality collaborative)	17 practices 51 physicians 100,000 covered lives
Rhode Island	Office of Health Insurance Commissioner	5 practices 28 physicians 28,000 covered lives

PCMH: Legislative/Regulatory Initiatives

- California adopted legislation in September specifying a standard PCMH definition.
- In 2011, the Joint Commission, an accrediting entity for hospitals and ambulatory health care organizations, will add an optional medical home component for ambulatory health care organizations wishing to offer it.

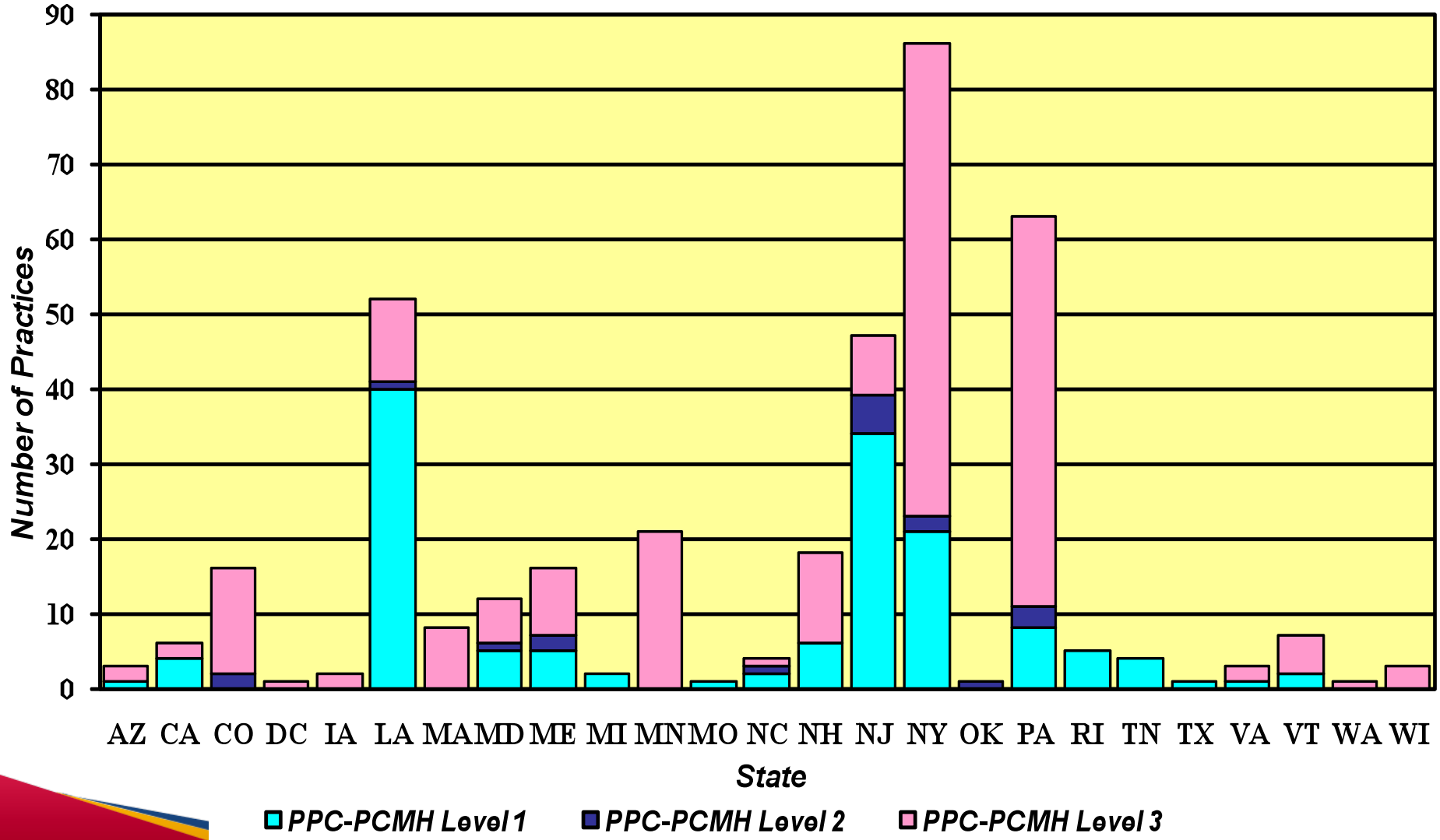
Patient-Centered Medical Home: Texas Medical Home Initiative (TMHI)

- Multi-stakeholder group convened in 2008 by Texas Chapter of the American College of Physicians and the Texas Academy of Family Physicians.
- Stakeholders include TMA, the Texas Pediatric Society, Coalition of Nurses in Advance Practice; Office of the Medical Director for Medicaid/ CHIP; Title V; patient advocates; Pfizer; Merck; Aetna; Blue Cross and Blue Shield of Texas; CIGNA; and United Healthcare.
- Mission: Develop, implement, and evaluate the (PCMH) in Texas to:
  - Focus on ***improved access*** **to** ***high quality in all care dimensions*** (acute, chronic, preventive);
  - Improve the ***patient-centered care experience;***
  - Invest in a ***sustainable infrastructure;***
  - Realize effective and efficient ***cost management;*** *and*
  - Enhance ***practitioner and patient satisfaction.***

Patient-Centered Medical Home: Texas Medical Home Initiative

- TMHI has developed a comprehensive plan to transform seven to 10 adult primary care practices in North Texas to a PCMH model in a two-year pilot.
- Start-up funding was received from professional organizations and some of the payers. None of the payers has yet to commit to enhanced payments to practices for enhanced services.
- The pilot will provide assistance to practices through practice coaches and a series of learning collaboratives that include training on transitioning young adults with special health care needs into adult medical practices.
- The pilot includes a formal evaluation component, which will measure pre- and post-quality measures and patient and practitioner experience.
- TMHI will help the pilot practices build a “medical neighborhood.”

NCQA Recognized PCMH practices 12/31/09



Source: NCQA

Patient-Centered Medical Home: PPACA Provisions

PCMH Initiative	Description
Innovation Center	The Centers for Medicare & Medicaid Services will test and evaluate models that include the PCMH
Health Plan Performance	Medical homes identified as one performance indicator for health plans
Chronic Medicaid Enrollee Care	Starting in 2011, the federal government will match state funds up to 90 percent for two years to states that provide medical home options for Medicaid enrollees.

Patient-Centered Medical Home: PPACA Provisions

PCMH Initiative	Description
Community Care	PPACA provides grants to community care teams that organize themselves under the medical home model.
New Model for Training	Primary Care Extension Program is created, which provides primary care training and implementation of MH quality improvement and processes.

Patient-Centered Medical Home: Medical Home Demonstrations Under PPACA

Demonstration	Medicare Medical Home Demonstration	Multipayer Advanced Primary Care Practice Demonstration	Federally Qualified Health Centers (FQHCs) Advanced Primary Care Demonstration
Geographic Scope	Up to 8 states (urban, rural, underserved areas)	Expect 6 states	Up to 500 clinic sites
Participants	Individual physician practices (attract small practices <3 FTEs)	Practices (MD & NP) participating in state HC reform initiatives promoting APCP	FQHCs (and "look alikes") serving relatively large numbers of Medicare beneficiaries
Practice Qualifications	NCQA PPC-PCMH-CMS	Dependent on state program	To be determined
Targeted Beneficiaries	1 or more chronic conditions	Dependent on state program	Medicare beneficiaries receiving primary care from FQHC
Payment	Medicare FFS plus monthly care management fee plus shared savings	Established by state multipayer reform initiative	Medicare all-inclusive rate plus monthly care management fee

Patient-Centered Medical Home: Medical Home Demonstrations Under PPACA

Medicaid Medical Home State Plan Option

States eligible for 90-percent federal Medicaid match for two years to set up medical home programs for patients with two or more chronic conditions, one chronic condition but at risk of developing others, or severe persistent mental illness.

Patient-Centered Medical Home: Analysis of Seven Pilots

Pilot	Hospitalization reduction	ER visit reduction	Total savings per patient
Colorado Medical Home for Children	18%	NA	$169-$530
CCNC	40%	16%	$516
Geisinger	15%	NA	NA
Group Health	11%	29%	$71
Intermountain Healthcare	4.6 – 19.2%	0-7.3%	$640
MeritCare/BCBS of North Dakota	6%	24%	$530
Vermont Blueprint for Health	11%	12%	$215

The Patient-Centered Medical Home: Challenges

- The NDP published its preliminary results in 2010. It was the first systematic test of PCMH effectiveness.
- The research concluded the PCMH model is potentially effective in reducing costs and improving health status.
- However, it requires significant investment and operating competencies, which may be problematic to some physicians.
- Among the study's major takeaways:
  - Change is hard: Implementation can be disruptive.
  - Some practices are better at changing than others.
  - Practices that received help had an easier time.
  - Information technology implementation is easier than changing care delivery.
  - Patients may not be quick to appreciate the change.

The Patient-Centered Medical Home: Texas Challenges

- Lack of commitment to pilot by the payers, although they participated in the planning process:
  - Only a few pilots have individual insurers vs. multipayer demonstrations, which are more efficient from a practice and community point of view.
  - The reasons given for lack of commitment are concern over the effects of health system reform, antitrust issues, and lack of consistent evidence that PCMH model is effective
  - All successful pilots to date have included new incentives for physicians.
- Health care workforce shortages: Team-based approach to care may help mitigate problem, but Texas is facing a severe shortage of PCPs and will need to recruit and retain more to foster widespread use of PCMH model.
- Texas physicians primarily organized as small groups or solo practices, which typically lack financial or staffing resources to implement all PCMH components.

The Patient-Centered Medical Home: Final Thoughts

- We have the potential to implement a fundamental change in the way health care is delivered in Texas. In the process, improve access and outcomes, decrease ED and hospital utilization, improve safety and patient/physician experience.
- We have physicians willing and able to make these changes and as such, raise the standard of health care in Texas.
- Our ultimate goal is to improve the health of all Texans.
- Transforming practices to medical homes takes significant time and resources. Change will occur over time not overnight.