The Patient-Centered Medical Home: A STARNet Research Agenda

South Texas Ambulatory Research Network

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History of the PCMH Model

• 1960’s-American Academy of Pediatrics
• 1970’s-IOM and WHO definitions of Primary Care
  – Health care that is
    • Accessible
    • Accountable
    • Coordinated
    • Continuous
    • Comprehensive
Optimal health care in the US should be:
- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable
Chronic Care Model

Community
- Resources and Policies
  - Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Improved Outcomes
- Informed, Activated Patient
  - Productive Interactions
- Prepared, Proactive Practice Team

Developed by The MacColl Institute
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Joint Principles of the PCMH

- Personal Physician
- Health care team
- Whole person orientation
- Care that is coordinated/integrated
- Quality and Safety
- Enhanced access
- Payment supporting the model

Endorsed by ACP, AAFP, AAP, AOA March 2007
PCMH Joint Principles

• **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** –
  – 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.
  – includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
PCMH Joint Principles

- **Care is coordinated and/or integrated**
  - across all elements of the complex health care system

- **Quality and Safety**
  - Care maximizes quality and insures patient safety

- **Enhanced Access**
  - Email, interactive websites, open access scheduling

- **Supportive Reimbursement**
  - Multiple models: enhanced FFS, FFS + monthly coordination fee, capitation, accountable health care organizations
How Do We Get There?

PCMH Principles

Building the PCMH
NCQA: What constitutes a PCMH?

• NCQA PPC-PCMH
  – Access and communication
  – Patient tracking and registry
  – Care management
  – Patient self-management support
  – Electronic prescribing
  – Test tracking
  – Referral tracking
  – Performance reporting and improvement
  – Advanced electronic communication
Content Overlap--Primary Care, CCM, PCMH

- Comprehensive
- First Contact
- Self-Management Support
- Decision Support
- Clinical Information Systems
- Community Linkages

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Primary Care

Patient-Centered Medical Home

Wagner CCM
NCQA PCMH Certification

- Standard 1: Access & Communication
- Standard 2: Patient Tracking & Registry
- Standard 3: Care Management
- Standard 4: Self-Management Support
- Standard 5: Electronic Prescribing
- Standard 6 & 7: Test & Referral Tracking
- Standard 8: Performance & Feedback
- Standard 9: Advanced electronic communication
### PPC-PCMH Content and Scoring

#### Standard 1: Access and Communication
- **A.** Has written standards for patient access and patient communication**
- **B.** Uses data to show it meets its standards for patient access and communication**

#### Standard 2: Patient Tracking and Registry Functions
- **A.** Uses data system for basic patient information (mostly non-clinical data)
- **B.** Has clinical data system with clinical data in searchable data fields
- **C.** Uses the clinical data system
- **D.** Uses paper or electronic-based charting tools to organize clinical information**
- **E.** Uses data to identify important diagnoses and conditions in practice**
- **F.** Generates lists of patients and reminds patients and clinicians of services needed (population management)

#### Standard 3: Care Management
- **A.** Adopts and implements evidence-based guidelines for three conditions **
- **B.** Generates reminders about preventive services for clinicians
- **C.** Uses non-physician staff to manage patient care
- **D.** Conducts care management, including care plans, assessing progress, addressing barriers
- **E.** Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities

#### Standard 4: Patient Self-Management Support
- **A.** Assesses language preference and other communication barriers
- **B.** Actively supports patient self-management**

#### Standard 5: Electronic Prescribing
- **A.** Uses electronic system to write prescriptions
- **B.** Has electronic prescription writer with safety checks
- **C.** Has electronic prescription writer with cost checks

#### Standard 6: Test Tracking
- **A.** Tracks tests and identifies abnormal results systematically**
- **B.** Uses electronic systems to order and retrieve tests and flag duplicate tests

#### 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**
- **B.** Survey of patients’ care experience
- **C.** Reports performance across the practice or by physician **
- **D.** Sets goals and takes action to improve performance
- **E.** Produces reports using standardized measures
- **F.** Transmits reports with standardized measures electronically to external entities

#### Standard 9: Advanced Electronic Communications
- **A.** Availability of Interactive Website
- **B.** Electronic Patient Identification
- **C.** Electronic Care Management Support

**Must Pass Elements**
How PPC-PCMH Recognition Works

Physician/practice
• Self-assess, collect data using Web-based software
• Submit documentation to NCQA when ready
• May be asked to submit more data if needed

NCQA
• Evaluates and scores all applications
• Checks licensure of physician
• Audits a sample of applications
• Posts Recognized physicians on web
• Distributes list of Recognized physicians monthly to health plans and others
• Physicians sent media kit, press releases, letter & certificate
Myths about NCQA PCMH

- **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)
Successful PCMH Demonstrations

- North Carolina Medicaid Office
- Geisinger Medical, Pennsylvania
- Group Health of Puget Sound
Benefits of the PCMH

• Geisinger Health System Primary Care Sites
  – Nurse care coordinator
  – Personal care navigator
  – Interoperable EMR
  – Point-of-care Decision Support

• Early outcomes (2 sites)
  – Hospitalization reduced 20%
  – Overall medical costs decreased 7%
Benefits of the PCMH

• North Carolina Medicaid
  – Small Independent private offices
  – Practice “Coaches” to assist with implementation,
  – Nurse care coordinators
  – Overall costs decreased by $118-130 Million
    • Mainly due to reduced ED and Hospitalization
Benefit of PCMH

• Group Health Puget Sound examples:
  – Smaller panel sizes
  – Longer visits
  – Secure email
  – Desktop medicine time
  – Increased team size and diversity
  – Pre-visit chart reviews
  – Pro-active outreach: pharmacy, ED f/u, promotion of group visits
Benefits of the PCMH

• Group Health
  – Decreased staff burnout
  – Improved patient satisfaction
  – Improved quality measures
  – 29% fewer ED visits
  – 11% fewer hospitalizations for ambulatory-care-sensitive conditions
Challenges to the PCMH

- Small practices
- Targeting patients
- Physician skills
- Name
- “Unfettered expectations”
- If you build it, will they come?
  - Patients
  - Physicians
Unanswered Questions

• PCMH shown to improve some outcomes, primarily utilization, costs.
  – Financial benefit to small offices?
  – Does it improve “patient-centeredness”
  – Does it improve clinical outcomes?
• How much does it cost for a practice to become a PCMH?
• What elements of a PCMH are essential to improving outcomes?
• Others?
Your Turn!