# The Patient-Centered Medical Home: A STARNet Research Agenda

South Texas Ambulatory Research Network

April 8, 2010

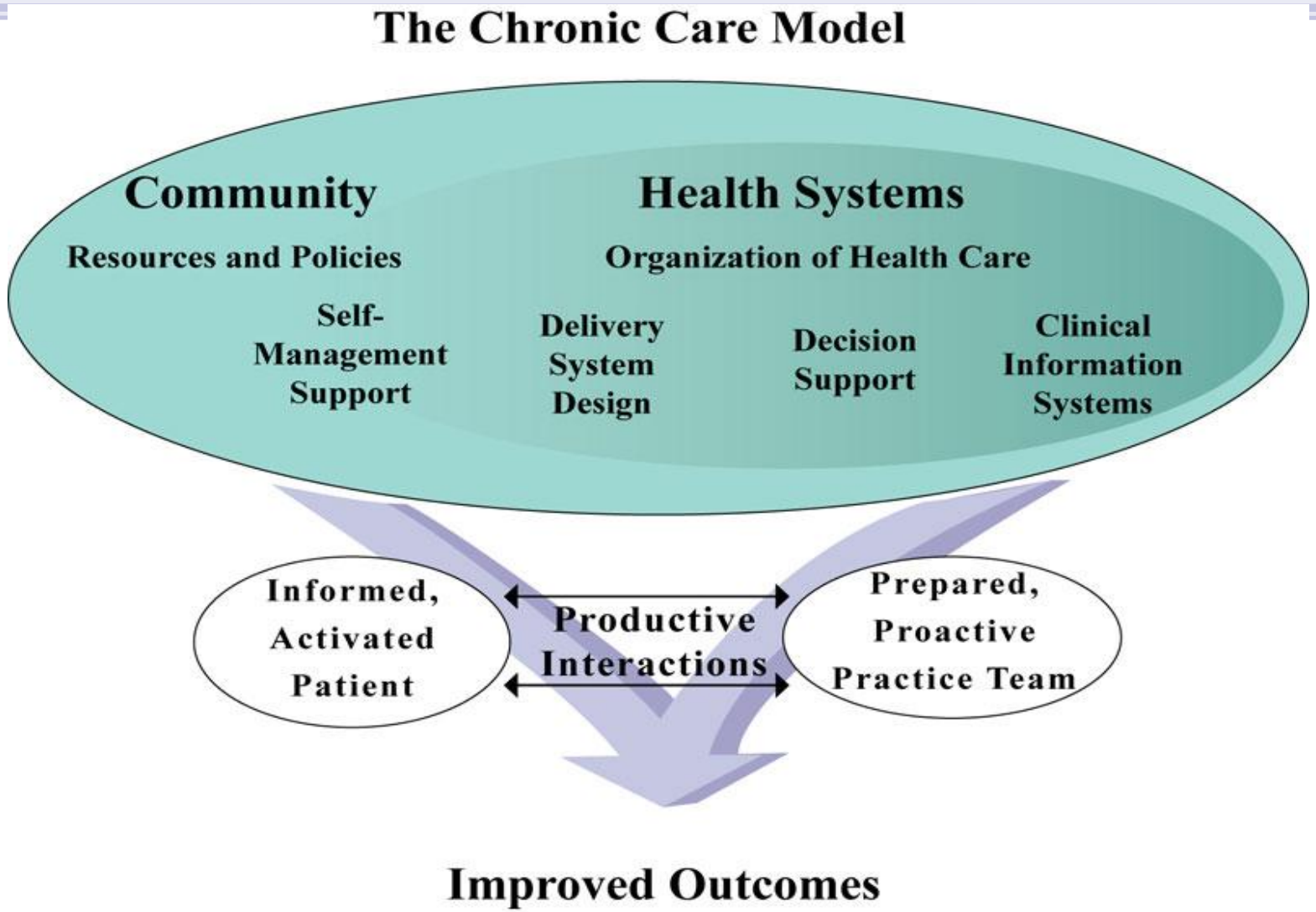
# History of the PCMH Model

- 1960's-American Academy of Pediatrics
- 1970's-IOM and WHO definitions of Primary Care
  - Health care that is
    - Accessible
    - Accountable
    - Coordinated
    - Continuous
    - Comprehensive

# Institute of Medicine
# *Crossing the Quality Chasm* (2001)

- Optimal health care in the US should be:
  - Safe
  - Effective
  - Patient-centered
  - Timely
  - Efficient
  - Equitable

# Chronic Care Model




Developed by The MacColl Institute
® ACP-ASIM Journals and Books

# 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?

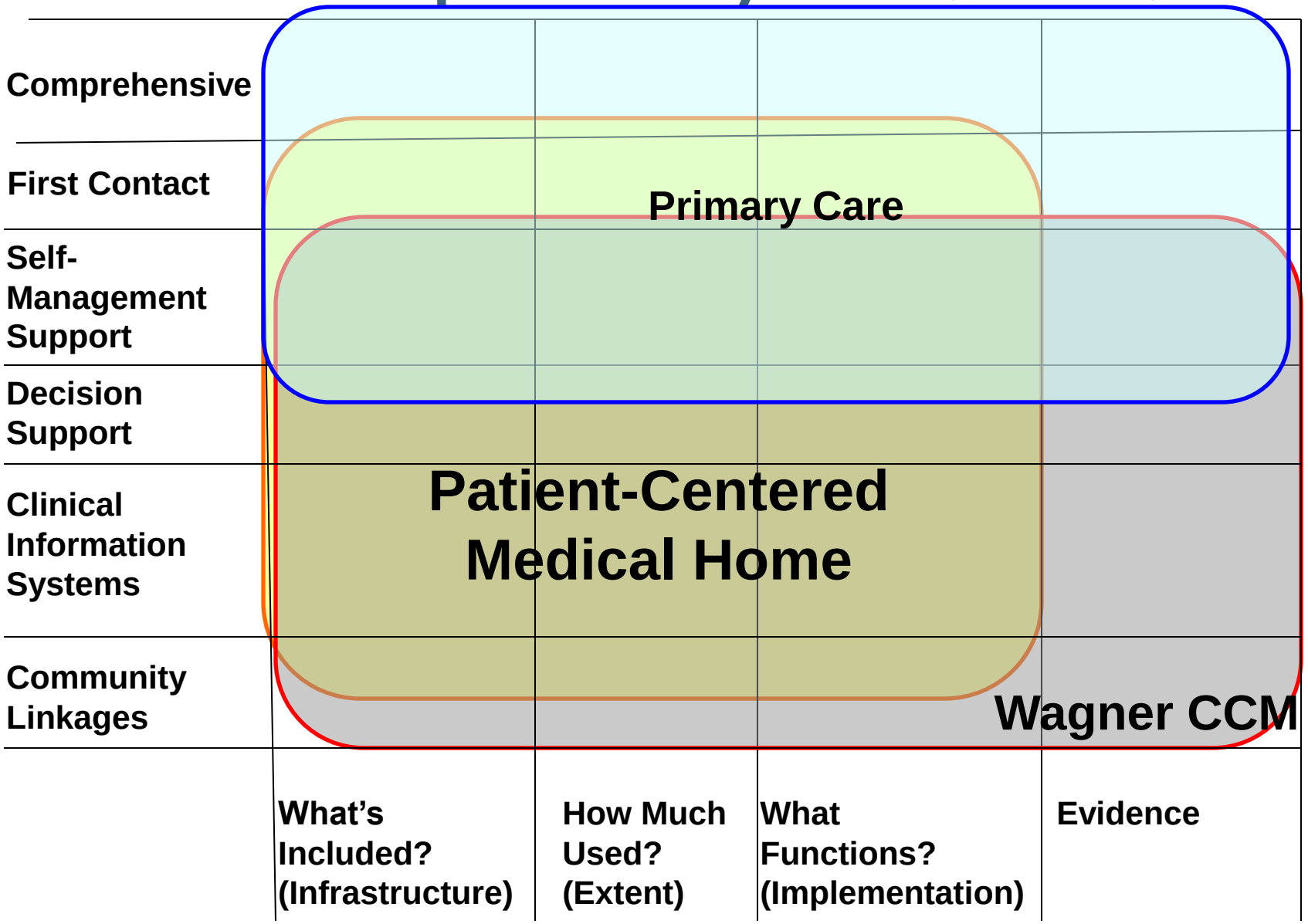
PCMH Principles

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



# 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 | Pts |
|---|---|
| A. Has written standards for patient access and patient communication** | 4 |
| B. Uses data to show it meets its standards for patient access and communication** | 5 |
| | 9 |

| Standard 2: Patient Tracking and Registry Functions | Pts |
|---|---|
| **A. Uses data system for basic patient information (mostly non-clinical data)** | 2 |
| **B. Has clinical data system with clinical data in searchable data fields** | 3 |
| **C. Uses the clinical data system** | 3 |
| D. Uses paper or electronic-based charting tools to organize clinical information** | 6 |
| E. Uses data to identify important diagnoses and conditions in practice** | 4 |
| **F. Generates lists of patients and reminds patients and clinicians of services needed (population management)** | 3 |
| | 21 |

| Standard 3: Care Management | Pts |
|---|---|
| A. Adopts and implements evidence-based guidelines for three conditions ** | 3 |
| **B. Generates reminders about preventive services for clinicians** | 4 |
| **C. Uses non-physician staff to manage patient care** | 3 |
| **D. Conducts care management, including care plans, assessing progress, addressing barriers** | 5 |
| **E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities** | 5 |
| | 20 |

| Standard 4: Patient Self-Management Support | Pts |
|---|---|
| **A. Assesses language preference and other communication barriers** | 2 |
| B. Actively supports patient self-management** | 4 |
| | 6 |

| Standard 5: Electronic Prescribing | Pts |
|---|---|
| **A. Uses electronic system to write prescriptions** | 3 |
| **B. Has electronic prescription writer with safety checks** | 3 |
| **C. Has electronic prescription writer with cost checks** | 2 |
| | 8 |

| Standard 6: Test Tracking | Pts |
|---|---|
| A. Tracks tests and identifies abnormal results systematically** | 7 |
| **B. Uses electronic systems to order and retrieve tests and flag duplicate tests** | 6 |
| | 13 |

| Standard 7: Referral Tracking | PT |
|---|---|
| A. Tracks referrals using paper-based or electronic system** | 4 |
| | 4 |

| Standard 8: Performance Reporting and Improvement | Pts |
|---|---|
| A. Measures clinical and/or service performance by physician or across the practice** | 3 |
| **B. Survey of patients' care experience** | 3 |
| C. Reports performance across the practice or by physician ** | 3 |
| **D. Sets goals and takes action to improve performance** | 3 |
| **E. Produces reports using standardized measures** | 2 |
| **F. Transmits reports with standardized measures electronically to external entities** | 1 |
| | 15 |

| Standard 9: Advanced Electronic Communications | Pts |
|---|---|
| **A. Availability of Interactive Website** | 1 |
| **B. Electronic Patient Identification** | 2 |
| **C. Electronic Care Management Support** | 1 |
| | 4 |

****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.
  - Finanical 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!