# Re-Inventing Your Practice into a Patient Centered Medical Home

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Department of Family and Community Medicine

September 29, 2010

# March 23, 2010

The Patient Protection and Affordable Care Act (ACA) is signed into law

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"Amidst the debate about health care reform, there appears to be near unanimity around the fact that a reformed U.S. health care system requires at it's foundation a robust system of primary care."

Landon BE, Gill JM, Antonelli RC, Rich EL, J. Gen Int Med 25(6) 581-3

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# What Is Driving The Renewed Emphasis on Primary Care?

- Urgent need to slow the rate of medical inflation and improve value of health care dollar
  - Primary Care is critical to increasing value

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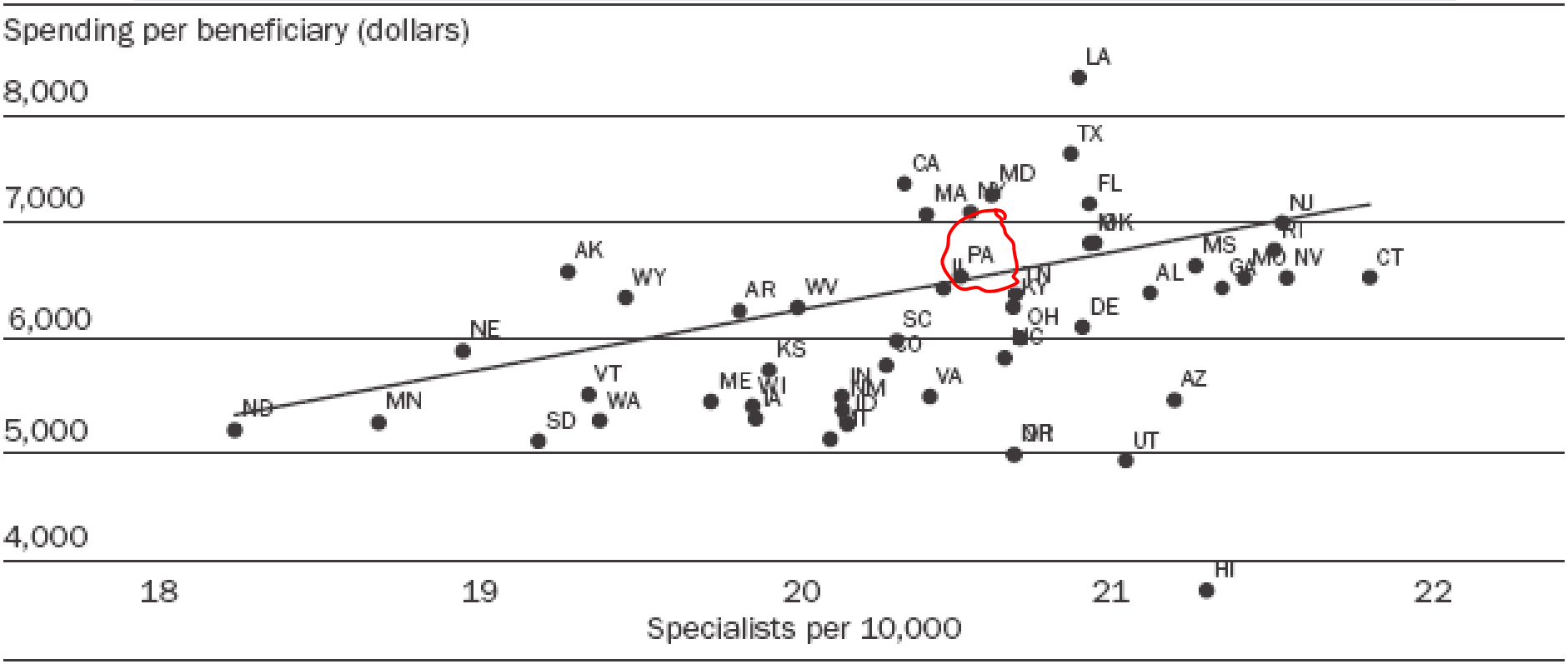
# More Specialists Mean Higher Spending

**EXHIBIT 7**

**Relationship Between Provider Workforce And Medicare Spending: Specialists Per 10,000 And Spending Per Beneficiary In 2000**

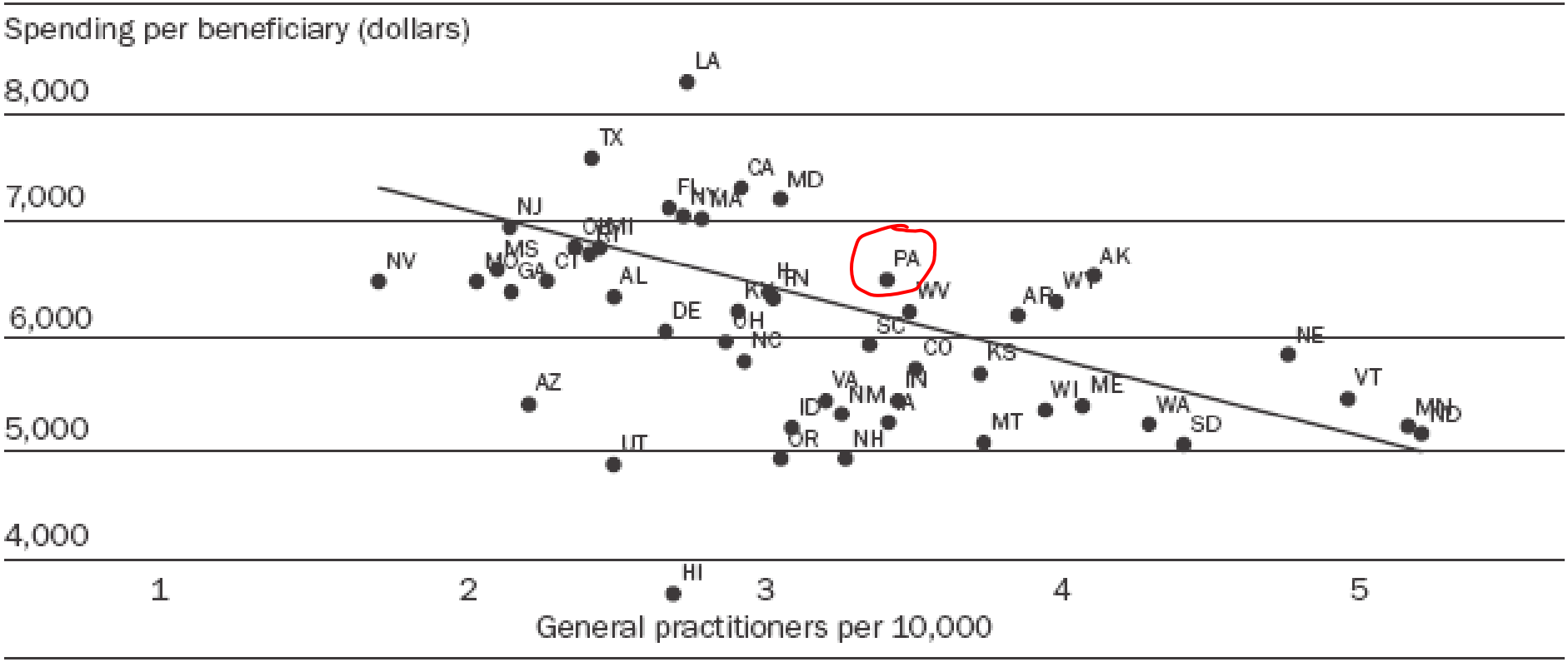



**SOURCES:** Medicare claims data; and Area Resource File, 2003.
**NOTE:** Total physicians held constant.

# While GPs are Associated with Less Spending

**EXHIBIT 9**

**Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000**

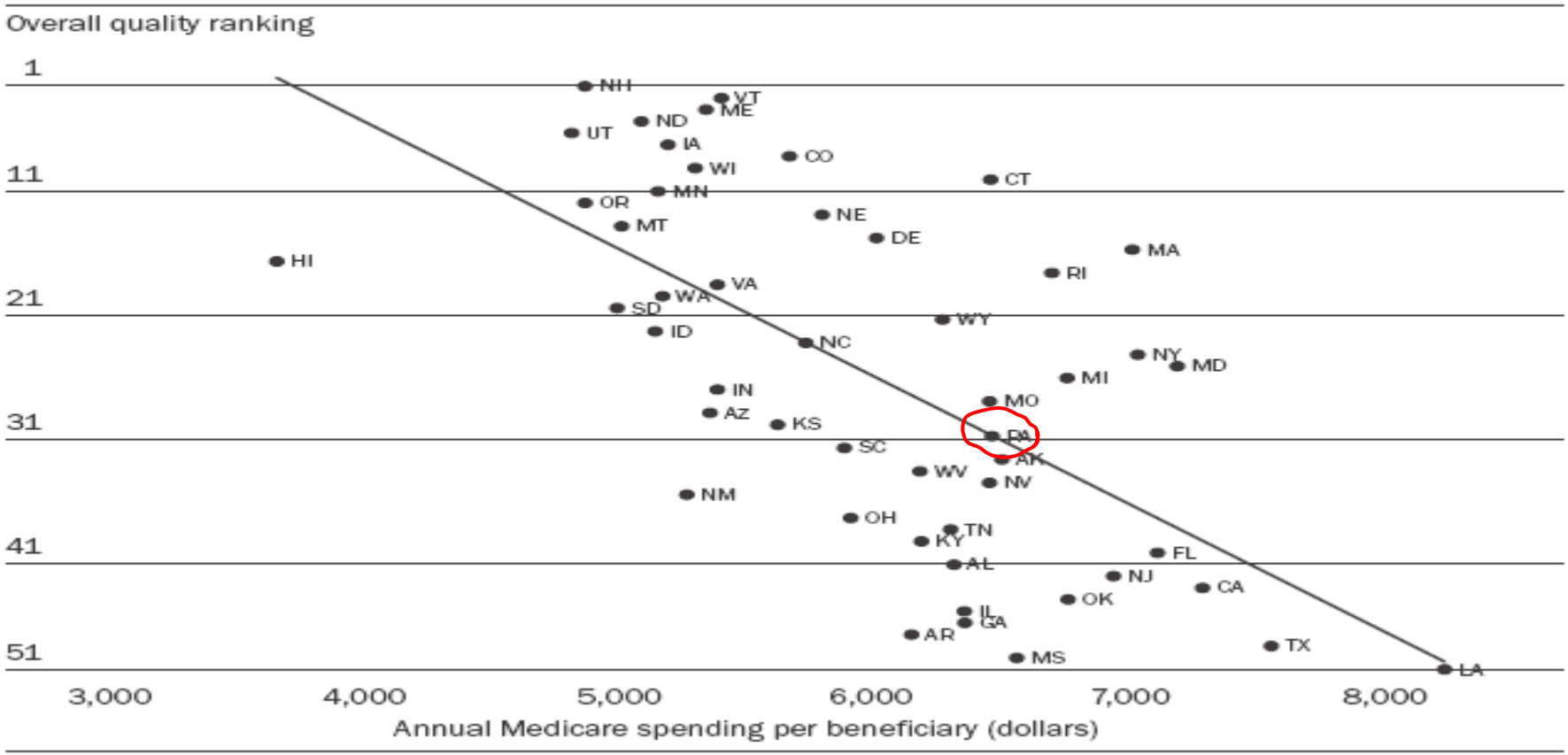



**SOURCES:** Medicare claims data; and Area Resource File, 2003.
**NOTE:** Total physicians held constant.

# As It Turns Out, Cost is *Inversely* Related to Quality

**EXHIBIT 1**

**Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001**

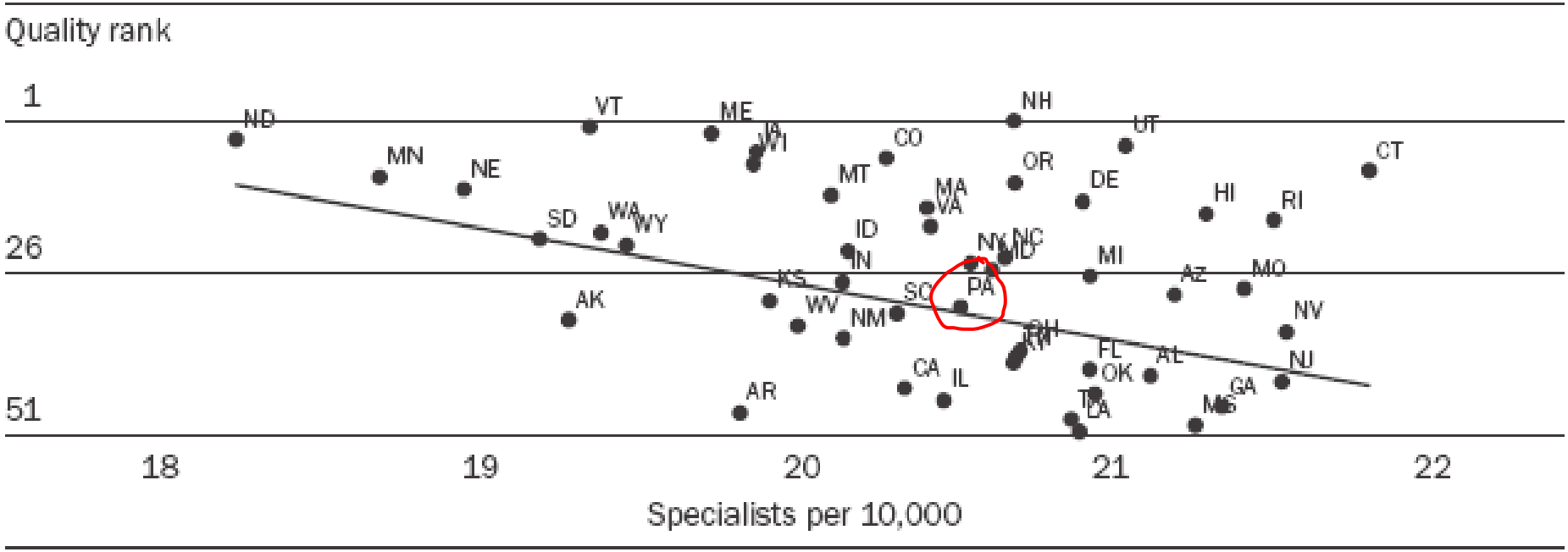



**SOURCES:** Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
**NOTE:** For quality ranking, smaller values equal higher quality.

# And More Specialists Predict Lower Quality Ranking

**EXHIBIT 6**

**Relationship Between Provider Workforce And Quality: Specialists Per 10,000 And Quality Rank In 2000**



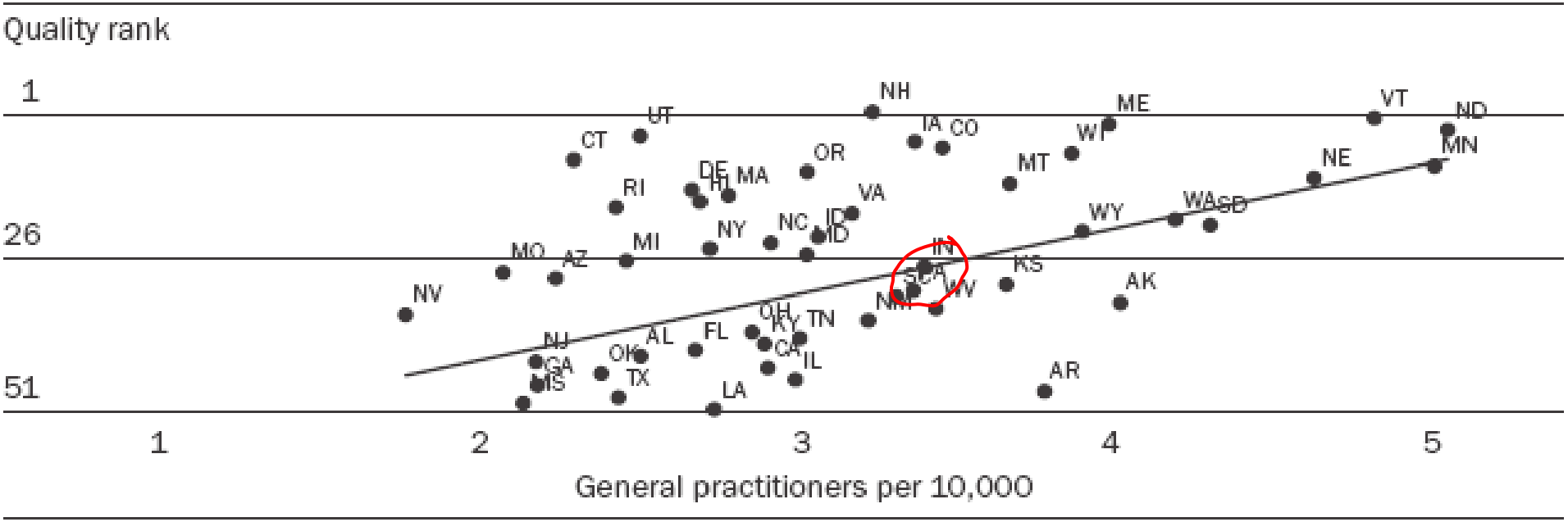

**SOURCES:** Medicare claims data; and Area Resource File, 2003.

**NOTES:** For quality ranking, smaller values equal higher quality. Total physicians held constant.

# While More GPs Predict Higher Quality Ranking

**EXHIBIT 8**

**Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000**




**SOURCES:** Medicare claims data; and Area Resource File, 2003.

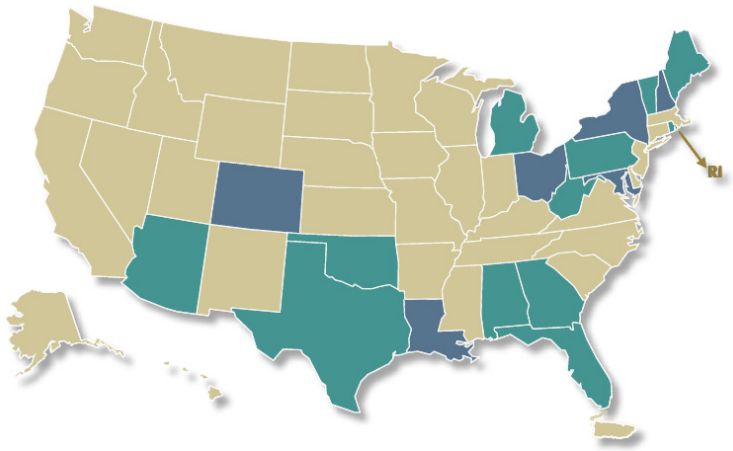
**NOTES:** For quality ranking, smaller values equal higher quality. Total physicians held constant.

- A major impetus behind the PCMH is coming from commercial payers and states

Patient-Centered Primary Care COLLABORATIVE

# Overview of Activity

- 27 Multi-stakeholder and other Pilots in 18 States
- 44 States and the District of Columbia Have Passed over 330 Laws and/or Have PCMH Activity
- Medicaid and Medicare Activity




- Alabama Health Improvement Initiative—Medical Home Pilot (AL)
- UnitedHealth Group PCMH Demonstration Program (AZ)
- The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Pilot (CO)
- Colorado Family Medicine Residency PCMH Project (CO)
- MetCare of Florida/Humana Patient-Centered Medical Home (FL)
- WellStar Health System/Humana Patient-Centered Medical Home (GA)
- Greater New Orleans Primary Care Access and Stabilization Grant (PCASG) (LA)
- Louisiana Health Care Quality Forum Medical Home Initiative (LA)
- Maine Patient-Centered Medical Home Pilot (ME)
- CareFirst BlueCross BlueShield Patient-Centered Medical Home Demonstration Program (MD)
- National Naval Medical Center Medical Home Program (MD)
- Blue Cross Blue Shield of Michigan—Physician Group Incentive Program (PGIP) (MI)
- Priority Health PCMH Grant Program (MI)
- CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot (NH)
- NH Multi-Stakeholder Medical Home Pilot (NH)
- CDPHP Patient-Centered Medical Home Pilot (NY)
- EmblemHealth Medical Home High Value Network Project (NY)
- Hudson Valley P4P-Medical Home Project (NY)
- Greater Cincinnati Aligning Forces for Quality Medical Home Pilot (OH)
- Queen City Physicians/Humana Patient-Centered Medical Home (OH)
- TriHealth Physician Practices/Humana Patient-Centered Medical Home (OH)
- OU School of Community Medicine—Patient-Centered Medical Home Project (OK)
- Pennsylvania Chronic Care Initiative (PA)
- Rhode Island Chronic Care Sustainability Initiative (RI)
- Texas Medical Home Initiative (TX)
- Vermont Blueprint Integrated Pilot Program (VT)
- West Virginia Medical Home Pilot (WV)



Source: PCPCC Pilot Report (http://pcpcc.net/pilot-guide), October 2009

# The Patient-Centered Primary Care Collaborative (PCPCC)

- Started in 2006 by large employers, led by IBM, who were deeply dissatisfied with health care quality they were buying

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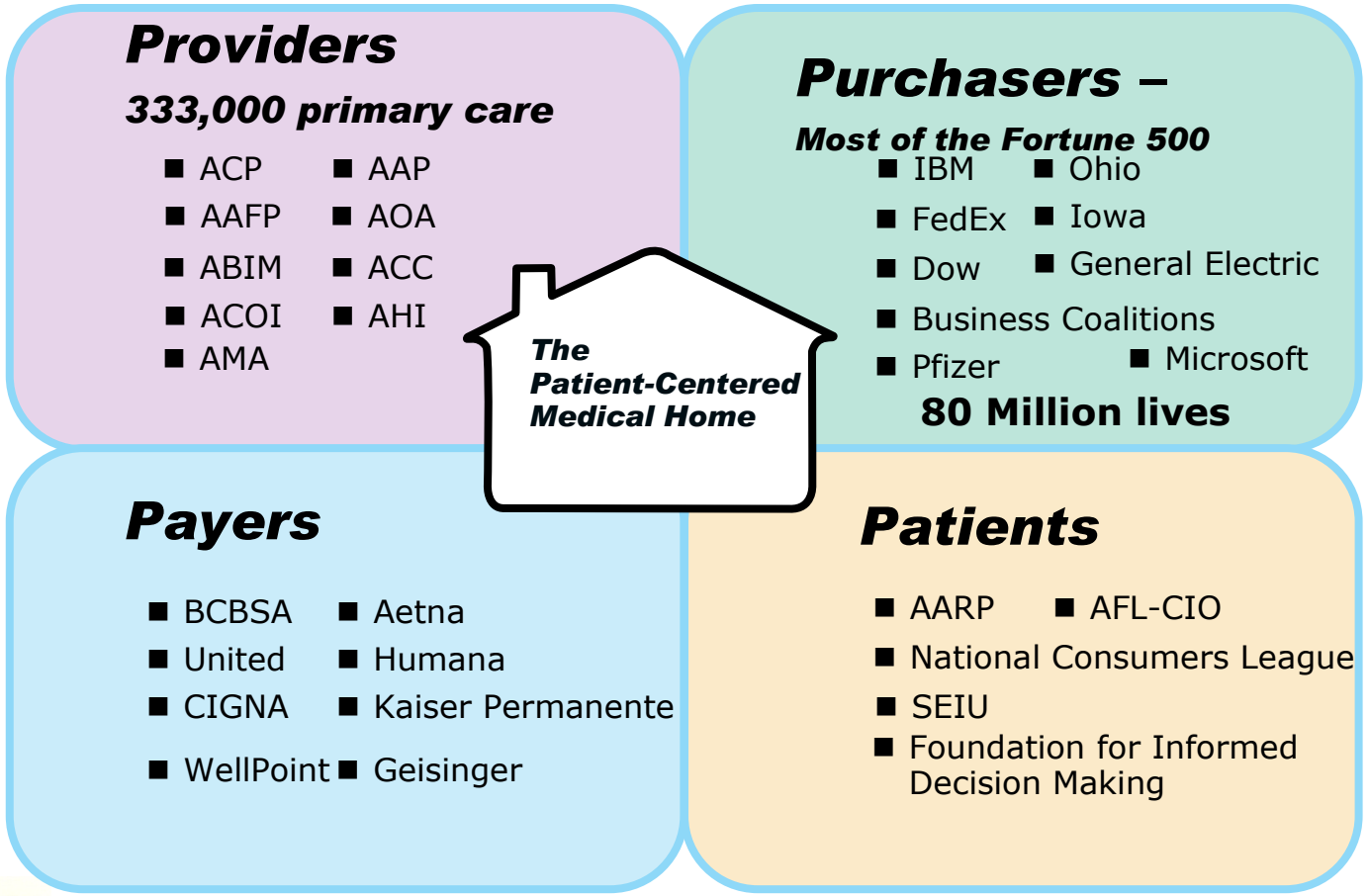
# The Patient-Centered Primary Care Collaborative

Examples of Broad Stakeholder Support & Participation

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Source: PCPCC (www.pcpcc.net)

# The PCPCC has ready entree to congress and the White House

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# So What is a Patient-Centered Medical Home?


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# Joint Principles of the PCMH (February 2007)

The following principles were written and agreed upon by the four Primary Care Physician Organizations – the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association

Source: JCPCSC (www.pcpcc.net)

# Joint Principles of the PCMH (February 2007)

Principles:

- Ongoing relationship with personal physician
- Physician directed medical practice
- Whole person orientation
- Coordinated care across the health system
- Quality and safety
- Enhanced access to care
- Payment recognizes the value added

Source: JCPCSC (www.pcpcc.net)

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# Endorsements

- The American Academy of Chest Physicians
- The American Academy of Hospice and Palliative Medicine
- The American Academy of Neurology
- The American College of Cardiology
- The American College of Osteopathic Family Physicians
- The American College of Osteopathic Internists
- The American Geriatrics Society
- The American Medical Directors Association
- The American Society of Addiction Medicine
- The American Society of Clinical Oncology
- The Society for Adolescent Medicine
- The Society of Critical Care Medicine
- The Society of General Internal Medicine
- American Medical Association
- Association of Professors of Medicine
- Association of Program Directors in Internal Medicine
- Clerkship Directors in Internal Medicine
- Infectious Diseases Society of Medicine

Source: PCPCC (www.pcpcc.net)

# Defining the Medical Home

| | |
|---|---|
| Superb Access to Care | •Patients can easily make appointments and select the day and time<br>•Waiting times are short<br>•eMail and telephone consultations are offered<br>•Off-hour service is available |
| Patient Engagement in Care | •Patients have the option of being informed and engaged partners in their care<br>•Practices provide information on treatment plans, preventive and follow-up care reminders, access to medical records, assistance with self-care, and counseling. |
| Clinical Information Systems | •These systems support high-quality care, practice-based learning, and quality improvement.<br>•Practices maintain patient registries; monitor adherence to treatment, have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments. |
| Care Coordination | •Specialists care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved.<br>•Follow-up and support is provided. |
| Team Care | •Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals (including BH specialists)<br>•Duplication of tests and procedures is avoided |
| Patient Feedback | •Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans. |
| Publicly Available Information | •Patients have accurate, standardized information on physicians to help them choose a practice that will meet their needs |

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# Defining the Medical Home

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# Defining the Medical Home

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# The Medical Home Is Something Fundamentally Different

| Usual Care | | Medical Home |
|---|---|---|
| Relies on the clinician | → | Relies on the team |
| Care provided to those who come in | → | Care provided for all |
| Performance is assumed | → | Performance is measured |
| Innovation is infrequent | → | Innovation occurs regularly |
| Includes only primary care | → | Includes mental health, Pharm D's and others |
| Navigation and care management not available | → | Navigation and care management are required |
| H.I.T. may or may not support care | → | H.I.T. must support care |

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A PCMH cannot be created and sustained without a meaningful change in payment to primary care

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# The Ecology of Medical Care

- Half of all physician visits are to generalist clinicians
- Most visits for common, serious conditions are to primary care practices
- Primary care infrastructure consists of small, relatively independent practices

**Green LA, Freyer GE Jr, et al NEJM 344(2001):2021-25**

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# The Ecology of Primary Care Practices

- Typical practice consists of
  - 2-5 clinicians
  - Fewer than 3 non-clinician nursing and clerical staff for each clinician
- Most practices have a hierarchical management structure
  - Physician owners and office manager provide oversight

**Stange KC et al, J of Fam Pract 46(1998):377-89**

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# Primary Care Practices:
## Culture and Financial Reality

"Climates permeated with stress and overwork"

- Most work on margins of financial viability
  - Little time for self-reflection
  - Little or no training in quality improvement and organizational management

**Crabtree BF. Healthcare Manage Rev, Vol 281(2003):279-83**

**Grumbach K and Bodenheimer J. JAMA (2002):889-93**

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# TransforMed – National Demonstration Project

TransforMED℠
TRANSFORMING MEDICAL PRACTICES

The largest demonstration of primary care transformation performed to date

Annals of Family Med 2010(May/June) suppl.

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# NDP - Conclusions

" . . . primary care practices in the U.S. need external resources to successfully undertake the magnitude of redesign envisioned in the PCMH."

Crabtree BF et.al. Ann. Fam. Med. Vol. 8 (suppl) 2010

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“The NDP model can, thus, probably be disseminated, but only if sufficient time and resources are made available.”

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# Potential Payment Model

1. Fee for service
2. Payment for case management
3. Pay for performance
4. Support for preventive care outreach

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# The Geisinger Model

- Incentives to primary care practices to achieve diabetes outcomes
- Case manager in every practice paid for by the Health System
- Preventive care services managed centrally
  - Identify whether patients are up to date with cancer screening and immunizations
  - Write and call patients to obtain these services or invite them in for a visit
    - Scheduled in same patient contact

# Applying the PCMH Model to Diabetes Care

1. Facility access
2. Develop a patient registry – identify the practice's patients with diabetes
3. Standardize care
   - Practice-wide guidelines and protocols
4. Mobilize the entire team

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# Applying the PCMH Model to Diabetes Care

5. Institute patient and clinician reminders
6. Find ways to engage patient in self-management
7. Case manage high utilizers and/or the hard to reach
8. Measure and report outcomes every month

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# 1. Ensure Access For All

Cost savings chiefly result from keeping patients out of the emergency department

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# *Every opportunity to prevent an emergency department visit is an emergency*


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# How To Ensure Access

- Supply of appointments must be sufficient
  - Extend capacity of phone or e-visits
- Consider “advanced access” or “open access” scheduling
  - Keep appointments “frozen” till 24 hours before
  - JFMA lowered no-show rate from 23% to 14% overnight
  - We schedule 150 patients per day who called within 24 hours

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# 2. Developing A Patient Registry

1. Ideally, EMR should function as a registry
2. Stand-alone electronic registries exist
3. A paper-based registry may be feasible in a small practice

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# Data Elements in a Diabetes Registry

**Patient identifiers**

- Name
- Birthdate

**Intermediate outcomes**

- A1c
- LDL
- HDL
- Triglycerides
- Microalbumin
- Creatinine
- Blood pressure

**Process measures**

- Eye exam
- Foot exam

**Immunizations**

- Influenza
- Pneumonia

**Therapies**

- ACE or ARB
- Aspirin

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# 3. Standardize Care

1. Establish frequency of testing
2. Set goals of therapy
3. Develop and promote therapeutic flowsheets/guidelines

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# Examples

1. Testing
   - A1c every 3-6 months
   - LDL annually
   - Eye exam annually
   - Microalbumin annually

# Examples

2. Therapy
   - Hyperglycemia:
     - For individuals with A1c ≤8.9 Metformin 1000 bid; Add sulfonylurea or GLP-I mimetic; Add TZD
     - For individuals with A1c ≥9.0% begin basal insulin and Metformin
3. Goals
   - A1c: <8.0% for all; <7.0% for some
   - LDL: <100mg/dl for all; <70 mg/dl for some

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# 4. Mobilize the Team

- Everyone should have a role in achieving team goals
  - Registrars print reminders
  - Medical assistants complete diabetes flow sheet; perform fact-exams; counsel patients
  - Navigators schedule tests and consultations
  - Phone operators ensure access
  - Nurses case manage and serve as health coaches
  - Clinicians counsel and recommend therapy

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# Add New Team Members

- Mental Health
- Pharm D's
- Dental
- Recreation

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# 5. Institute Reminders


1. Last A1c, lipid panel, microalbumin,

   eye exam

   - Manual
   - Electronic
2. Aspirin?
3. Phone calls and letters to patients who are late for testing

   - Best managed centrally

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- Meaningful use accredited EMR's will have reminder capacity
- Stand-alone primary care EMR products issue automatic reminders

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Insurance companies use software that can issue reminders:

**NaviNet**™ is one example

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# 6. Engage Patients in Self-Management

- Stop creating “non-compliant” patients
- People have trouble adhering for lots of good reasons
  - Lack of social support
  - Financial barriers
  - Competing demands
  - Inadequate knowledge
  - Lack of sense of risk
- Our 15 minute visits are often inadequate to address these barriers

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# 7. Case Manage High Utilizers or Hard to Reach

- Case management or Health Coaching is a care feature of the PCMH
- Lots of ways to identify patients in need
  - A1c >9%
  - Recently hospitalized
  - Misses appointments
  - Evidence from payer of high utilization

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# How Can You Afford a Case Manager in Your Practice?

- You probably can't
- Look for a partner
  - Hospital (Accountable Care Organization)
  - Insurer (show that you have patients costing them a lot of money)
  - Employer (when one or two large employers dominate)
  - State or National Government
    - Medicaid or Medicare Pilot Programs

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# 8. Measure and Report Outcomes Every Month


I **hate** measurement!

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# PCMH Transformation in Practice – Jefferson Family Medicine Associates


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# Diabetes Information to Support Your Health (DISH)

- A multi-disciplinary group visit model

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DISH is held every Friday.  Each patient gets individual attention (a “visit”) and a group experience

- Neva White, CRNP-CDE
- Amy Egras, PharmD
- Residents
- Medical Assistants
- Case Manager

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# Baseline Characteristics

Most Patients in DISH & Matched Controls (52 vs. 236) are:

- Female
- African American
- At least 45 years old
- Obese
- Below 200% of federal poverty level
- Taking oral antidiabetic medications

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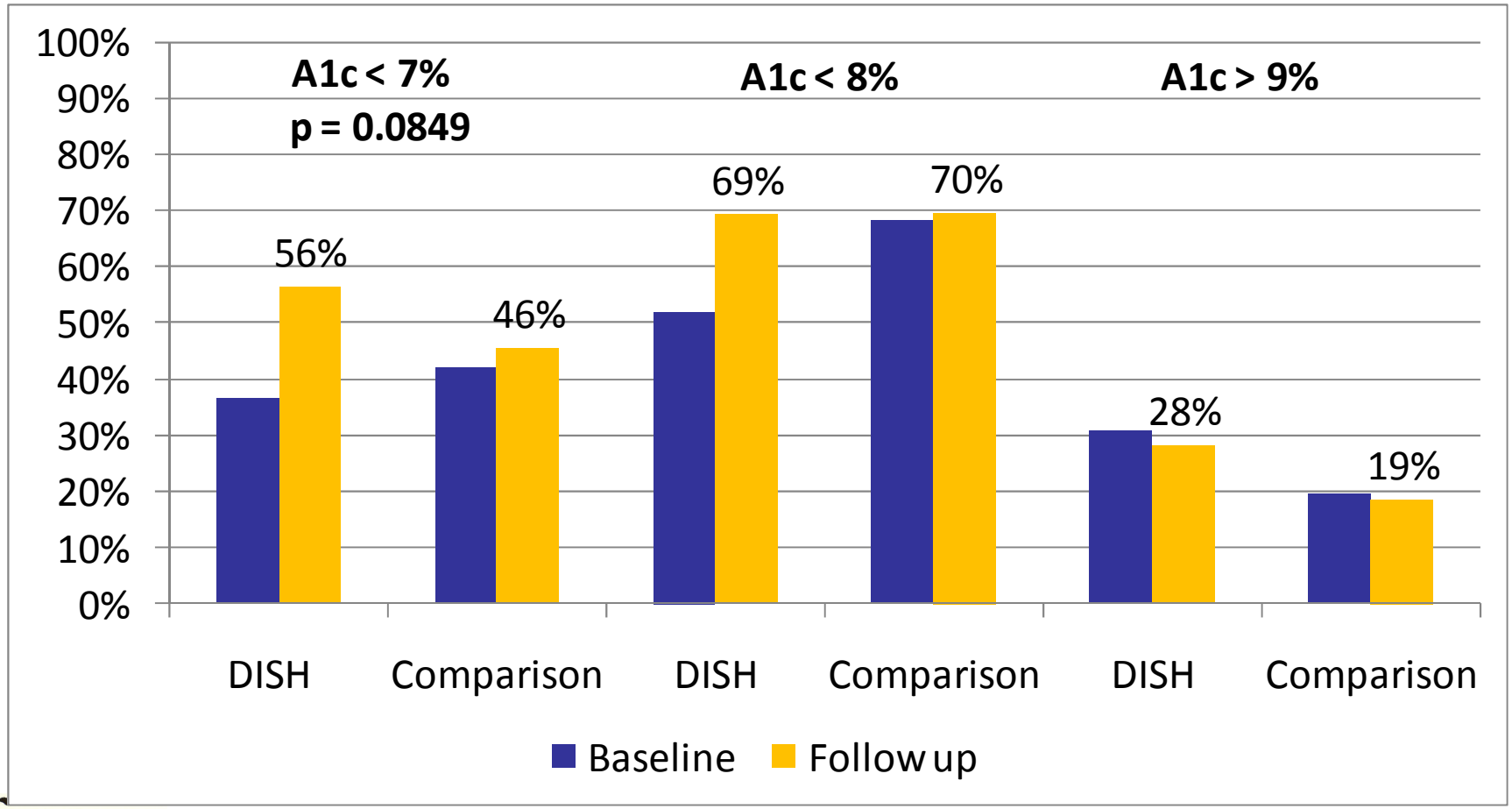
# A1c Values in DISH and Comparison Groups

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# Decline in A1c Values

- DISH group: 76.9%
- Comparison group: 54.3%

CMH statistic 8.9911; p = 0.0027

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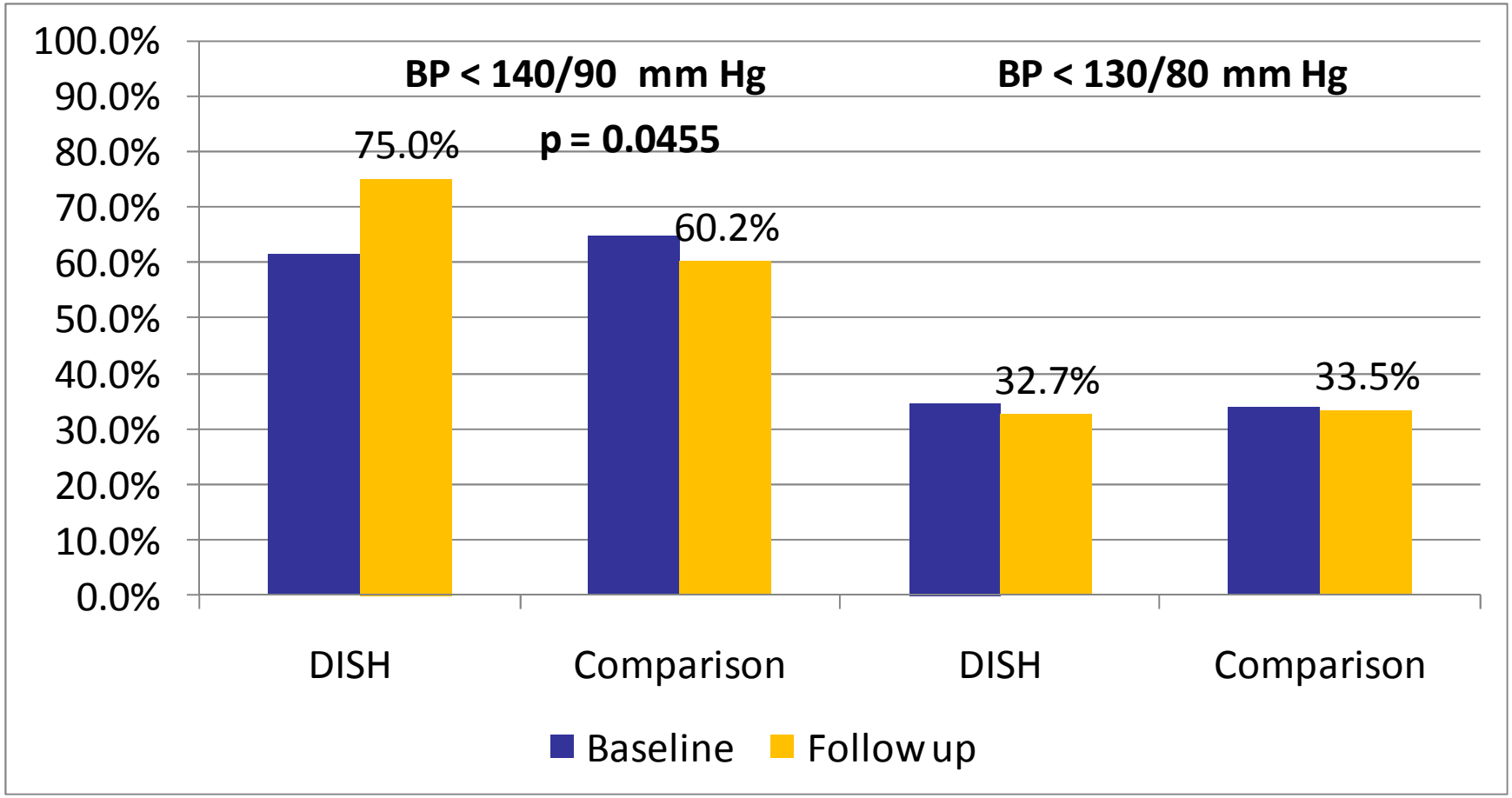
# Blood Pressure in DISH and Comparison Groups

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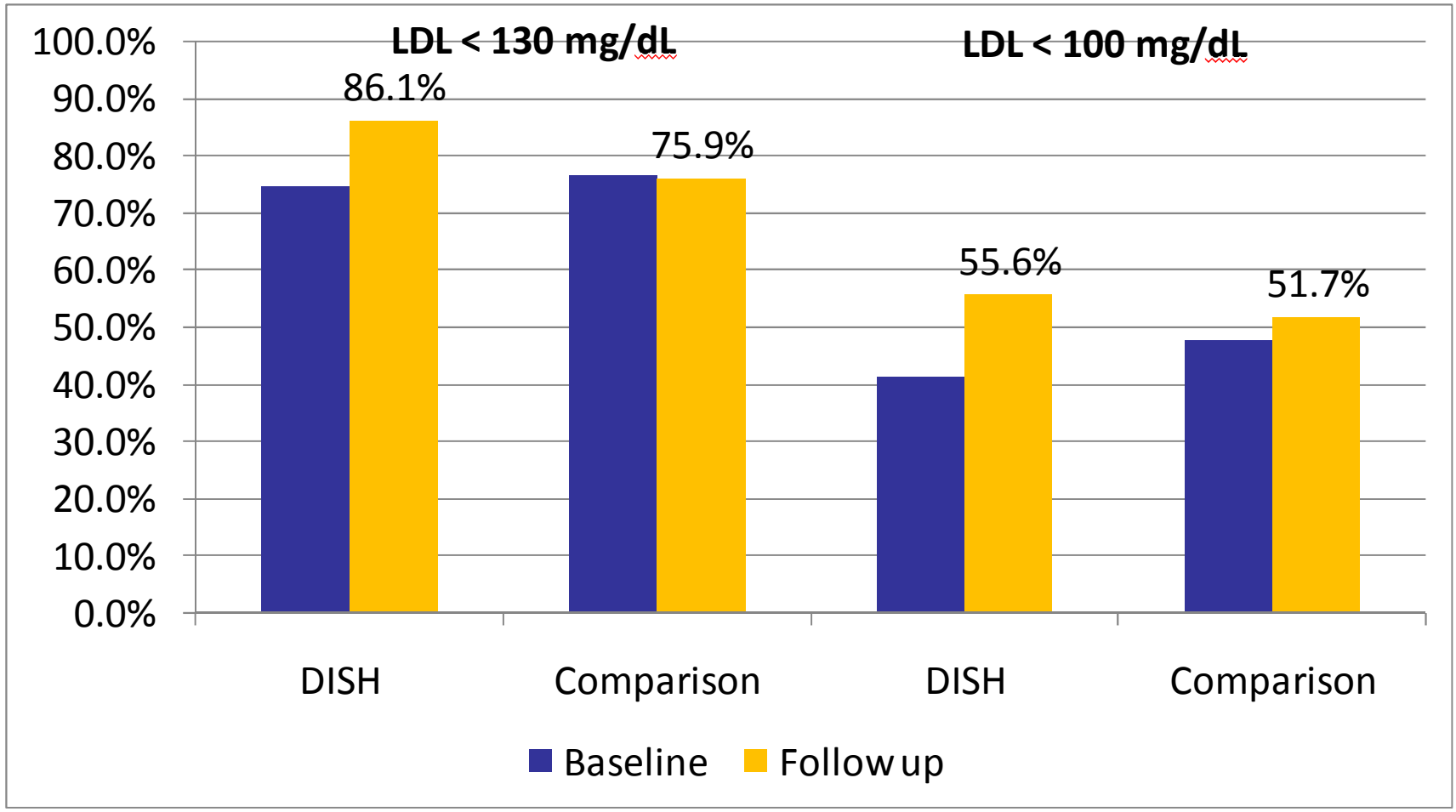
# Low Density Lipoprotein Values in DISH and Comparison Groups

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# IBC Keystone Health Plan East Practice Quality Assessment Score (PQAS)

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I wonder if hiring a Quality Coordinator was a good idea…

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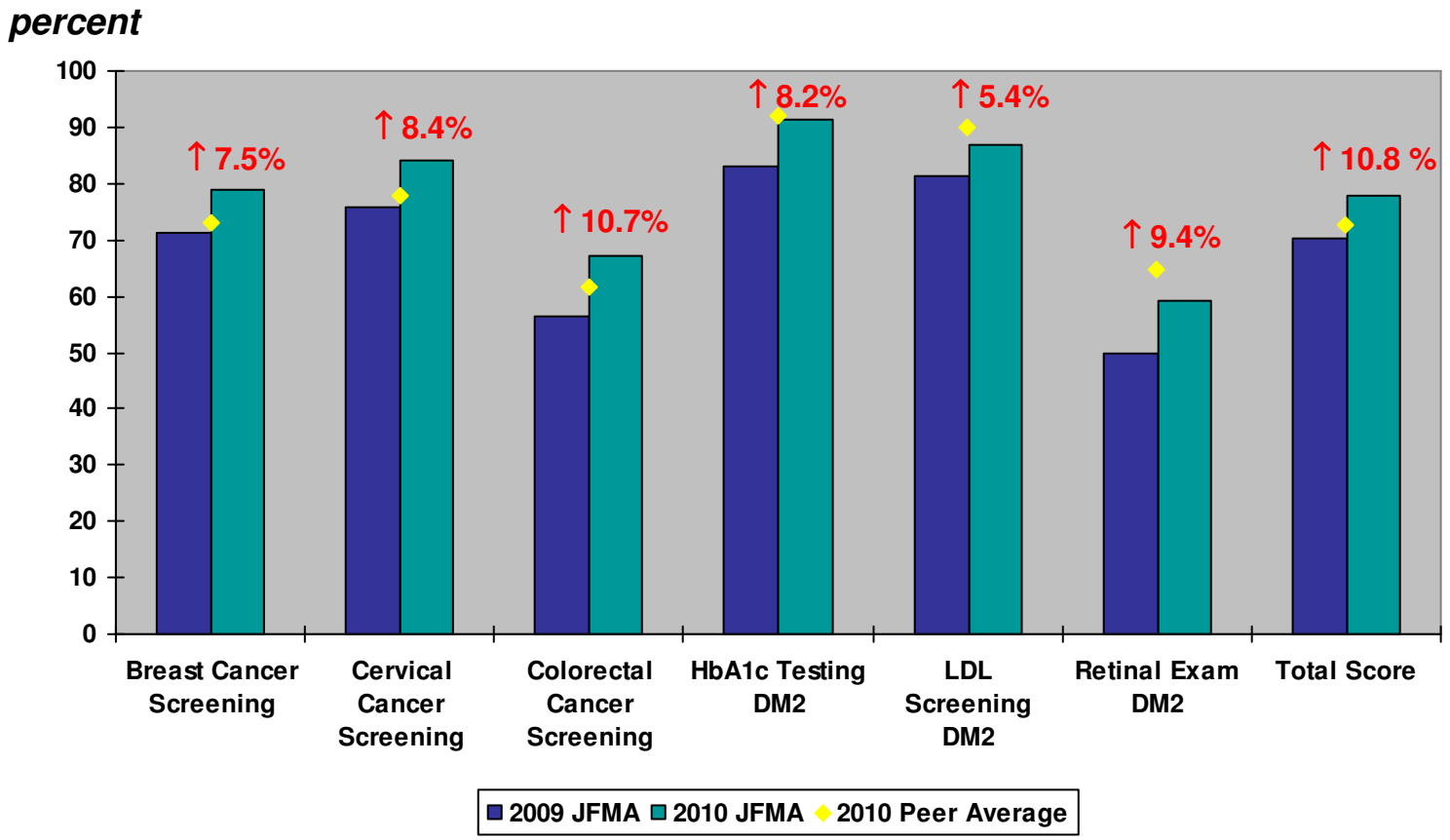
# JFMA Practice Quality Assessment Scores

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# Improving Outcomes

## Wender's Words of Wisdom

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# First Words of Wisdom:
## Make Up Your Mind To Improve

- Create a value-driven practice
- Put outcomes first
- Be willing to invest

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# Second Words of Wisdom: Be Relentless!

- Improving quality is HARD
- Nothing is perfect
  - Particularly first time out
- Keep your eye on the prize

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# Third Words of Wisdom:
## Measure The Right Things

- A1c achieved…not just how many were done
- Percent of eligible individuals successfully screened
- Percent of smokers who quit

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# Fourth Words of Wisdom:
## Measure and Report Results

- Cystic fibrosis center had the nerve to report their results to the families they care for
- At LEAST, report to each other

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# The Corollary To The Fourth Word Of Wisdom

- No EMR? Just measure a few outcomes
- Audit 5 diabetics; 5 women over 50; 5 men over 50
- Some results are better than no results

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# Fifth Words Of Wisdom: Try Anything

- We used resident moonlighters to reach diabetic patients to get eyes and labs checked
- **D**iabetes **I**nformation and **S**upport for your **H**ealth. The **DISH** group visit project
- Medical assistants to track results and perform foot exams
- Quality care coordinator
- Pharm D's in practice
- Open Access scheduling
- Whatever works!

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# The Corollary To The Fifth Word Of Wisdom

- Do lots of things!  No one idea will address all obstacles to care.  We've tried:
  - Care Now
  - Embedded mental health services
  - EMMI modules
  - Outreach to people who don't come in
    - Case management for higher utilizers

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# Sixth Words Of Wisdom: Don't Do It Alone

- Value your whole team
- Solo practice? – compare results to someone else's practice
- Find ways to partner with hospital or group practice

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# Characteristics of the Quality Practice

- Leadership that demands performance
- A culture of quality and pride in the service provided
- Willingness to try new things
- A commitment to measuring what you do
- Appropriate use of technology
- Investment in necessary change

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# It's People That Make A Home

- Create a joyful practice
- Have fun trying new things
- Measure what you're doing and see if it works

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The country is watching
It's our time…