Healthcare Reform and Patient-Centered Medical Home: Principles and Possibilities

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Session Overview

• Understand key environmental drivers for the Patient-Centered Medical Home (PCMH)
• Review the core principles and components of PCMH
• Understand how core PCMH concepts can inform the conversation about care for patients living with HIV/AIDS in Denver
The American Health Care Crisis

• **Costs:**
  – U.S. health care costs per person are 250% higher than the median for 29 other developed nations*
  – Annual cost of measurable medical errors that harm patients was $17.1 billion in 2008****

• **Access and Safety:**
  – 50.7 million Americans (16.7%) are uninsured***
  – 56 million Americans have NO regular source of care
  – Safety: Adverse events in one-third of hospital admissions**
  – Adults receive about half of recommended care; children less than half^

* Health Spending In OECD Countries In 2004: An Update, Health Affairs 26/5, Sept.-Oct. 2007
** New England Journal of Medicine, 354(11), March 2006 (report on RAND Corp study, funded by Robert Wood Johnson Foundation)
***Census Bureau, 2009
****Health Affairs, April 2011, Vol.30 No.4
^McGlynn, EA. www.rand.org/pubs/research_briefs
Our Current Reality
Poor Access → Poor Outcomes

“New York, NY, September 23, 2011 — The United States placed last among 16 high-income, industrialized nations when it comes to deaths that could potentially have been prevented by timely access to effective health care, according to a Commonwealth Fund–supported study that appeared online in the journal Health Policy this week ...”
Our Current Reality

Poor Access to Primary Care ➔ Expensive Care

- Fragmented care
- No PCP connection
- Lack of care coordination
- No preventive services
- Most costly place for primary care services
- Reduction in ER costs could result in an increase in primary care investment to improve patient access and treatment in primary care settings.

- 51% of ER Visits, or just over 60,000 ER visits were either non-emergent or PCP treatable
- 8% of ER Visits, or just over 9,600 ER visits could have been prevented with earlier ambulatory care

NYU Algorithm Analysis
120,897 emergency room visits
June 1, 2008 through May 31, 2009

William G. Runyon, MD, FAAFP
Greater Care Complexity

Preventive Care
7.4 hours

+ Evidence-based Care
10.6 hours

Institute of Medicine Quality Report:
Description of the Problem and Health Reform Blueprint

“Between the health care we have and the care we could have lies not just a gap, but a chasm.”

National Academies Press, 2001
What’s Responsible for the Quality Chasm?

• A system oriented to acute disease that isn’t working for patients or professionals

Courtesy of Ed Wagner, MD
Institute of Medicine Quality Report: *Crossing the Quality Chasm*

• “Current care systems *cannot* do the job.”

• “Trying harder will not work.”

• “Changing care systems will.”

“Systems are perfectly designed to get the results they achieve”  
-Paul Bataldan
The Case for Health Care Reform

• Rising costs and gaps/variation in quality of services
• No link between cost and quality
• Increase in chronic conditions
• Need for better care coordination
• Dysfunctional payment system; rewards volume
• Purchasers’ demand for accountability/transparency
• United States is lagging internationally
Insanity: doing the same thing over and over again and expecting different results.

Albert Einstein 1879-1955
PPACA – AKA “Affordable Care Act”

- On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (P.L. 111-148)
- New legislation, which was amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)
Sweeping Changes....

- Expands health insurance coverage to 32 million more Americans by 2019
- Provides Medicare **bonus payments for primary care physicians and general surgeons**, as well as increased Medicaid primary care payments
- Increases geographic adjustments to Medicare physician payments in portions of 42 states and territories
- Provides small business tax credits to assist in the purchase of health insurance for employees
- Strong consumer protections and administrative simplification provisions
- Prevents denials of care and coverage, including those for pre-existing conditions
- Makes health insurance more affordable for families
- Expands and improves coverage of preventive services in the public and private sectors
- Expands state demonstration grants to develop, implement and evaluate alternative medical liability reform initiatives
- Requires employers with more than 50 employees to offer coverage or pay a penalty
- Requires individuals to have minimum coverage or pay a penalty, effective 2014
- Improves Medicare prescription drug benefits by reducing the coverage gap (e.g., “doughnut hole”)
Patient-Centered Medical Home: PCMH

- The Medical Home... accessible, continuous, Comprehensive, family-centered, coordinated, compassionate, and culturally effective care

- ACP, AAFP, AAP, and AOA—representing 330,000 physicians—establish PCMH “joint principles” in March 2007 to provide standard definition of delivery model and describe the environment necessary to support it
Joint Principles

• Personal physician in MD-directed practice
• Whole person orientation
• Coordinated care, integrated across settings
• Quality and safety emphasis
• Enhanced patient access to care
• Supported by payment structure that recognizes services and value
How do you Know a PCMH When you See One?

• National Committee on Quality Assurance (NCQA) announced a voluntary recognition process based on its Physicians’ Practice Connection (PPC) module, the PPC-PCMH in January 2008
  – ACP, AAFP, AOA, and AAP helped NCQA develop the module
• Recognized PCMHs would also be accountable for quality of care by reporting on evidence-based clinical and patient experience measures

Other recognition programs now!
<table>
<thead>
<tr>
<th>Standard</th>
<th>Content Summary</th>
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<tbody>
<tr>
<td>Enhance Access/Continuity</td>
<td>• Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours</td>
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<tr>
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<td>• The practice provides electronic access</td>
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<td>• Patients may select a clinician</td>
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<td>• The focus is on team-based care with trained staff</td>
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<tr>
<td>Identify/Manage Patient</td>
<td>• The practice collects demographic and clinical data for population management</td>
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<tr>
<td>Populations</td>
<td>• The practice assesses and documents patient risk factors</td>
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<td>• The practice identifies patients for proactive and point-of-care reminders</td>
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<tr>
<td>Plan/Manage Care</td>
<td>• The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems</td>
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<td>• Care management emphasizes:</td>
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<td>– Pre-visit planning</td>
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<td>– Assessing patient progress toward treatment goals</td>
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<td></td>
<td>– Addressing patient barriers to treatment goals</td>
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<tr>
<td></td>
<td>• The practice reconciles patient medications at visits and post-hospitalization</td>
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<td>• The practice uses e-prescribing</td>
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<tr>
<td>Provide Self-Care Support/</td>
<td>• The practice assesses patient/family self-management abilities</td>
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<tr>
<td>Community Resources</td>
<td>• The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources</td>
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<td>• Practice clinicians counsel patients on healthy behaviors</td>
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<td></td>
<td>• The practice assesses and provides or arranges for mental health/substance abuse treatment</td>
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<tr>
<td>Track/Coordinate Care</td>
<td>• The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals)</td>
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<td>• The practice follows up with discharged patients</td>
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<tr>
<td>Measure/Improve Performance</td>
<td>• The practice uses performance and patient experience data to continuously improve</td>
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<td>• The practice tracks utilization measures such as rates of hospitalizations and ER visits</td>
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<td></td>
<td>• The practice identifies vulnerable patient populations</td>
</tr>
<tr>
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<td>• The practice demonstrates improved performance</td>
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<tr>
<td>TODAY’S CARE</td>
<td>MEDICAL HOME CARE</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>My patients are those who make appointments to see me</td>
<td>Our patients are those who are registered in our medical home</td>
</tr>
<tr>
<td>Patients’ chief complaints or reasons for visit determines care</td>
<td>We systematically assess all our patients’ health needs to plan care</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today</td>
<td>Care is determined by a proactive plan to meet patient needs without visits</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory or skill of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
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<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates all patients’ care</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained</td>
<td>We measure our quality and make rapid changes to improve it</td>
</tr>
<tr>
<td>Acute care is delivered in the next available appointment and walk-ins</td>
<td>Acute care is delivered by open access and non-visit contacts</td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them</td>
<td>We track tests &amp; consultations, and follow-up after ED &amp; hospital</td>
</tr>
<tr>
<td>Clinic operations center on meeting the doctor’s needs</td>
<td>A multidisciplinary team works at the top of our licenses to serve patients</td>
</tr>
</tbody>
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Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma
PCMH Gaining Traction

House Tri-Committee Bill: $350 million for PCMH pilot programs, which include Independent PCMHs and Community-based Medical Homes

What about the $$$?

“We are trying to solve some important technical problems in designing the regulatory regime under which accountable care can thrive. I think we will do best at that if, first, we touch base with our goals in health care – what we in CMS are now calling the Triple Aim – better care for individuals, better health for populations, and lower per capita costs of care without any harm whatsoever to patients."

Don Berwick, MD
Section 3022 PPACA

- Directs Secretary to establish Medicare Shared Savings Program by 1-1-2012
- Estimates 20% FFS beneficiaries will grow to 40% 2019
- Beneficiaries will be assigned based on claims data
- Must have developed mechanism to distribute savings
- Assume responsibility for all care of enrollees
- CBO estimated $4.9 billion savings FY2013-FY2019
- [https://www.cms.gov/sharesavingsprogram/](https://www.cms.gov/sharesavingsprogram/)

One option is an Accountable Care Organization (ACO)
Many Pilots Underway

• Multi-payer Advanced Primary Care Practices Demonstrations led by eight states to help physicians become medical homes
• Bundled Payment for Care Improvement Initiative for episodes of care around hospitalization for care redesign
• Pioneer Accountable Care Organization Model Initiative with 32 provider groups taking on financial risk for improving quality and lowering cost for Medicare patients
• State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees with 15 states redesigning care for dual eligible
PCMH Pilot Methodology is Diverse

- Private, public and mixed payor demonstrations underway
  - QI indicators vary
  - Payment models vary
  - Staffing models vary
  - Details of “success” vary
State Medicaid Innovation

• Thirty-four states trying to improve medical home availability in Medicaid/SCHIP programs - via legislative authority or mandates, Medicaid Transformation Grants, dedicated state resources*

• Private Sector Multi-Stakeholder PCMH Pilots Involving Medicaid:
  – Colorado
  – Louisiana
  – Maine
  – New Hampshire
  – Rhode Island
  – Vermont

* Source: National Academy of State Health Policy (NASHP)
Medicaid Results to Date

- More children have appropriate preventive care
- Less ER utilization
- Less hospitalization
- Acceptance of MCD/SCHIP 20% in 2006, 95% now

- Costs per child significantly lower across all age groups
- Patient Satisfaction – 97% would refer a friend
- Practice Manager Satisfaction: 96%
- Provider Satisfaction: 94%
Results to Date

• Medicaid Medical Homes in North Carolina Save $894 Million
  – Analysis of Community Care of North Carolina Cost Savings over 4 years by Milliman*

• **Commonwealth Fund**: A medical home can reduce or even eliminate racial and ethnic disparities in access and quality for insured persons.

• **BCBS of ND Reported** - Chronic Care for Diabetes
  • 6% decrease in hospital admissions
  • 24 % decrease emergency room
  • $500, per member per year savings

Transformational change:
In the Health Care Delivery System

<table>
<thead>
<tr>
<th>Indicator</th>
<th>CareSouth</th>
<th>All Family Practice Physicians (Median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. total annual payment per patient</td>
<td>$1,340</td>
<td>$1,778</td>
</tr>
<tr>
<td>Avg. annual drug payment per patient*</td>
<td>$502</td>
<td>$576</td>
</tr>
<tr>
<td>Avg. office visit payment per patient*</td>
<td>$441</td>
<td>$168</td>
</tr>
<tr>
<td>Avg. inpatient hospitalization payment*</td>
<td>$172</td>
<td>$634</td>
</tr>
<tr>
<td>Average emergency room payment*</td>
<td>$15</td>
<td>$22</td>
</tr>
</tbody>
</table>

For Medicaid patients with Diabetes receiving these services 2000-2002

*Source: South Carolina Office of Budget and Control 2004*
What’s the impact of a MH on blood pressure monitoring and control?

Figure ES-7. Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control

<table>
<thead>
<tr>
<th>Percent of adults 18–64 with high blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not check BP</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Total</td>
</tr>
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Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time. Source: Commonwealth Fund 2006 Health Care Quality Survey.
## Group Health’s Medical Home Pilot

<table>
<thead>
<tr>
<th>Patient Experience</th>
<th>Improved patient experience in access, care coordination, chronic illness care.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff Burnout</strong></td>
<td>Significant reductions in emotional exhaustion and depersonalization.</td>
</tr>
<tr>
<td><strong>Clinical Quality</strong></td>
<td>Significant improvement across 22 quality indicators.</td>
</tr>
<tr>
<td><strong>Utilization</strong></td>
<td>PCP visits declined 6% but pt. contact increased by e-mail and phone. Specialty use increased initially. ER and hospital use 29% and 6% less, respectively.</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td>Total costs $10.30 pmpm less than control clinics.</td>
</tr>
</tbody>
</table>
What Does this Mean for HIV Care in Denver?

- Complicated care system, funded in silos
- Flat or shrinking Federal Funding

Growing Funding Gap for Primary Care
2001 to 2008 – RW Part C
Clients Increased 57%; - Funding Increased 7 %
Aligning Resources for Common & Rare Conditions: HIV/AIDS Patients are High Cost, High Needs

More rare conditions often demand more resources, whereas more common conditions can be managed with fewer resources.
HIV is a Chronic Disease

Population vs. Patient

Never See These In the Office

"WELL"

AT RISK

REALLY SICK
Current Reality

Patient Goes to MD When They are Sick

Delay in Treatment

Emergency Room
40-60% Unnecessary

Payer

Strategies to Manage Medical Loss Ratio:
- Disease Management
- Case Management
- Complex Care Management
- Nurse Advice Line
- Wellness
- Patient Incentives

Specialists

30% unnecessary Referrals

Self-Treatment $2B+

Can’t Get Access

40% Ambulatory Sensitive Conditions

Hospital

Delay in Treatment

Patient

Goes to MD When They are Sick

Emergency Room

40-60% Unnecessary

Payer
Traditional Methods of Managing Work Flow

Adapted from South Central Foundation
PLANNED CARE IN THE NEW ENVIRONMENT

Community Resources and Policies

Health System
Organization of Health Care

Productive Interactions:

Evidence-based clinical management
Collaborative treatment plan
Effective therapies
Self-management support
Sustained follow-up

Informed, Activated Patient

Prepared, Proactive Practice Team

Functional and Clinical Outcomes

Open access
No shows decrease to 2-5%

Guidelines
In exam room with PDAs

Group visits used 25%

EMR eliminates all paper

Continuous flow
Minimizes on-site time

Registry used for master scheduling

Reimbursement aligned to support medical home

17% visits by Email

Community health workers

Care Team Work Spread 7-8:1 Ratio

• Community Health Workers
• Oral Health
• Specialty Care
• Other ancillary providers

N.P. P.A. R.N./LPN M.A. M.D. Pharm.D. DIETITIAN Case Manager Behavioral Health
Parallel Work Flow Redesign

Healthcare Support Team

Medication Refill

Chronic Disease Monitoring

Test Results

New Acute Complaint

Preventive Med Intervention

Point of Care Testing

Acute Mental Health Complaint

Chronic Disease Compliance Barriers

Case Manager

Provider

Certified Medical Assistant

Behavioral Health Consultant

Adapted from South Central Foundation
Take Home Points

• There are fundamental challenges with our current healthcare system
• Redesigning systems of care using PCMH frameworks are beginning to make a difference: better patient care, better population health and lower per capita cost
• Many of those redesign principles can be applied to our overall system of HIV/AIDS care in Denver
RESOURCES

• Patient Centered Primary Care Collaborative
  http://www.pcpcc.net

• AAP Building your Medical Home
  http://www.pediatricmedhome.org/qib/

• Group Health Medical Home Pilot

• General Resources Bibliography
  http://www.medicalhomeinfo.org/publications/bibliography.html

• Kathy Reims kreims@spreadinnovation.com