# The Patient Centered Medical Home (PCMH): Overview of the Model and Movement Part I

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## Presentation Outline

### Part I:

- Why the patient-centered medical home (PCMH)?
- What is the PCMH?
- How do I know a PCMH when I see it?
- Where does specialty care fit in?

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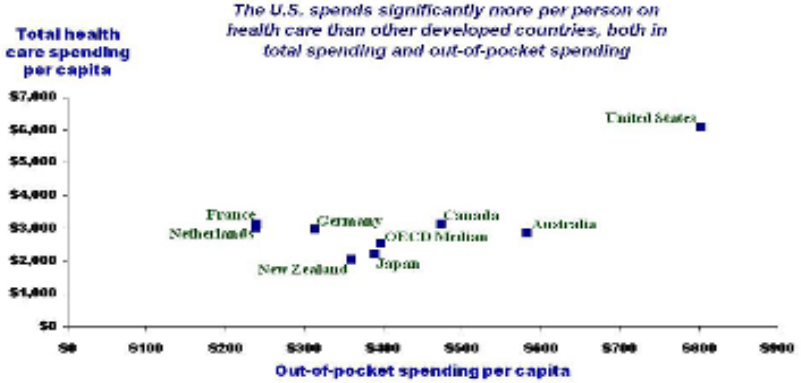
# The Cost of American Healthcare

## Health Care Expenses In an International Context

*The U.S. spends significantly more per person on health care than other developed countries, both in total spending and out-of-pocket spending*




Source: The Commonwealth Fund, calculated from 2004 OECD Health Data released in 2006.

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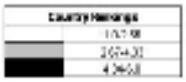
# For all the Money We Spend, How Well Does Our System Perform?

*A Commonwealth Fund study ranked the performance of the health systems of six countries, with 1 being the highest ranking and 6 being the lowest. The U.S. ranked at or near the bottom in 9 of the 10 categories.*

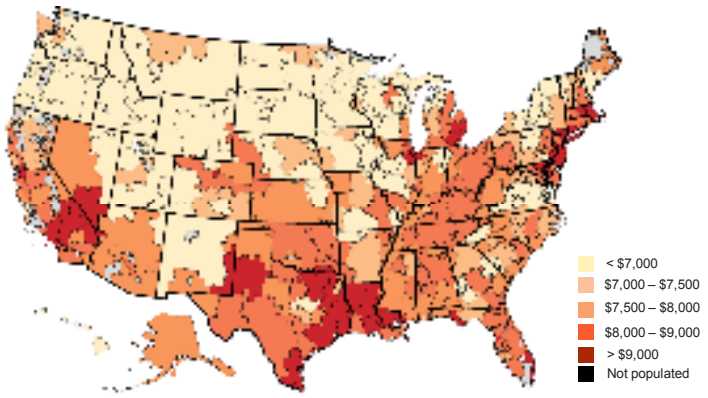


| | AUSTRALIA | CANADA | GERMANY | NEW ZEALAND | UNITED KINGDOM | UNITED STATES |
|---|---|---|---|---|---|---|
| OVERALL RANKING | 3 | 5 | 1 | 4 | 2 | 6 |
| Quality Care | 4 | 6 | 1 | 2 | 3 | 5 |
| Right Care | 5 | 6 | 1.5 | 1.5 | 3.5 | 3.5 |
| Safe Care | 4 | 5 | 1 | 3 | 2 | 6 |
| Coordinated Care | 3 | 5 | 1 | 2 | 4 | 6 |
| Patient-Centered Care | 4 | 6 | 2 | 1 | 3 | 5 |
| Access | 3 | 5 | 1 | 4 | 2 | 6 |
| Efficiency | 4 | 5 | 3 | 2 | 1 | 6 |
| Equity | 2 | 5 | 4 | 3 | 1 | 6 |
| Long Healthy, and Productive Lives | 1 | 3 | 2 | 4.5 | 4.5 | 6 |
| Health Expenditures per Capita, 2004 | $2,076 | $3,165 | $3,005 | $2,083 | $2,546 | $6,102 |

Source: Country Rankings on Overall Health System Performance, Commonwealth Study, 2007 (2003 Data)

# What about within the U.S.? – Significant Geographic Variation

Chart 1: Medicare Spending per Beneficiary, by Hospital Referral Region, 2006




Source: The Dartmouth Atlas of Health Care. (2009). *The Policy Implications of Variations in Medicare Spending Growth*. Link: http://www.dartmouthatlas.org/atlases/Policy_Implications_Brief_022709.pdf.
Note: Data adjusted for age, race, and sex but not price. Category definitions as in source document.

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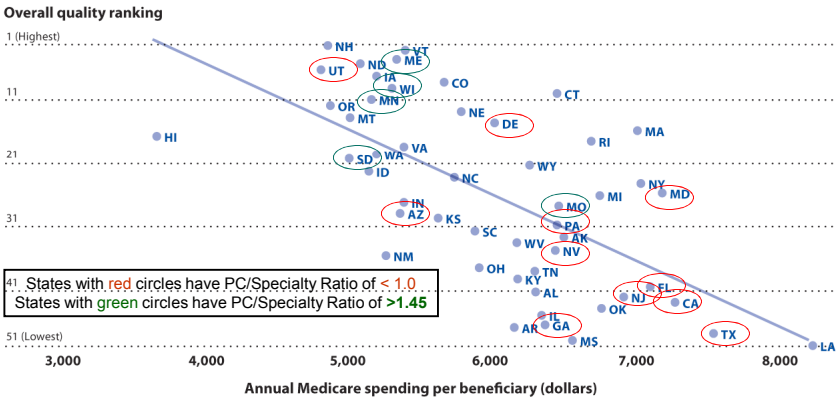
EQUITY AND EFFICIENCY • MULTIPLE CONDITIONS • CHART 5:9

## Relationship Between Quality of Care and Medicare Spending

States with higher spending per Medicare beneficiary tended to rank lower on 22 quality of care indicators. This inverse relationship might reflect medical practice patterns that favor intensive, costly care rather than the effective care measured by these indicators.

**Relationship between quality and Medicare spending, as expressed by overall quality ranking, 2000–2001**




Source: Medicare administrative claims data and Medicare Quality Improvement Organization program data, as analyzed by Baicker and Chandra (2004). The solid line shows that for every $1,000 increase in Medicare spending per beneficiary, a state's quality ranking dropped by 10 positions. Adapted and republished with permission of *Health Affairs* from Baicker and Chandra, "Medicare spending, the physician workforce, and beneficiaries' quality of care" (Web Exclusive), 2004. Permission conveyed through the Copyright Clearance Center, Inc.

Leatherman and McCarthy, *Quality of Health Care for Medicare Beneficiaries: A Chartbook, 2005*. The Commonwealth Fund

## Increasing Demand for Health Care Services

### Population and service demand growing

- U.S. population projected to be 349 Million by 2025
- 902 million visits were made to physician offices in the US in 2006 - 2/3 Primary care - IM, Peds, and FP
- Insurance reform will expand coverage

### Aging and chronically ill population

- 2011 10,000 seniors per day will become eligible for Medicare
- 83% of current Medicare patients have one or more chronic conditions
- 23% of current Medicare patients have 5 or more chronic conditions, account for ~ 3/4 of Medicare spending, see about 14 different physicians in a year and have about 40 office visits

SOURCES: American College of Physicians. How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?. Philadelphia: American College of Physicians;2008: White Paper; Anderson GF. Medicare and Chronic Conditions. Sounding Board. N Engl J Med.2005;353(3):305-9; http://thomas.loc.gov/medicare/factpage4.html

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## In Order to See Real Change…

## We Need to Redesign How We Deliver Care and How We Pay for It!

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"[Better] performance is not simply – it is not even mainly – a matter of effort; it is a matter of design"

*- Don Berwick*
*Administrator of CMS*
*(Former CEO, IHI)*



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## What is the Patient-Centered Medical Home?

- Vision of primary care as it should be
- Strengthening the physician-patient relationship
- Getting patients the care they want and need when they need it
- Framework for organizing systems of care at both the micro (practice) and macro (society) level
- Model to test, improve, and validate
- Important component of more comprehensive reform (including accountable care organizations)



## Evolution of the PCMH "Joint Principles"

ACP, American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), and American Osteopathic Association (AOA) have similar positions in promoting PCMH

↓

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

↓

These joint principles guide the collective actions of the organizations to further develop, promote, and test the PCMH

## Joint Principles

- **Personal physician in physician-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**

Team-based care:

- NP/PA
- RN/LPN
- Medical Assistant
- Office Staff
- Care Coordinator
- Nutritionist/Educator
- Pharmacist
- Behavioral Health
- Case Manager
- Social Worker
- Community resources
- DM companies
- Others…

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## "Neighbors" Endorsing the Joint Principles

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

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## How do you Know a PCMH When you See One?

Process needed to recognize practices that have and use the capability to provide patient-centered care

Practice recognition provides purchasers (employers, government) and patients with prospective assurance that the practice has capabilities

Recognized PCMHs would also be accountable for quality of care by reporting on evidence-based clinical and patient experience measures—provides retrospective assurance

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
- Undergoing revisions now, with new version to be released in January 2011

Other entities are also developing PCMH recognition/accreditation processes – The Joint Commission, URAC, CARF, AAAHC

## NCQA PPC-PCMH Recognition Module; Major Domains/Standards

1. Access & Communication
2. Patient Tracking & Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting & Improvement
9. Advanced Electronic Communication

Each standard contains sub-elements – 10 of which are considered "must pass"

For more information:
http://ncqa.org/tabid/631/Default.aspx

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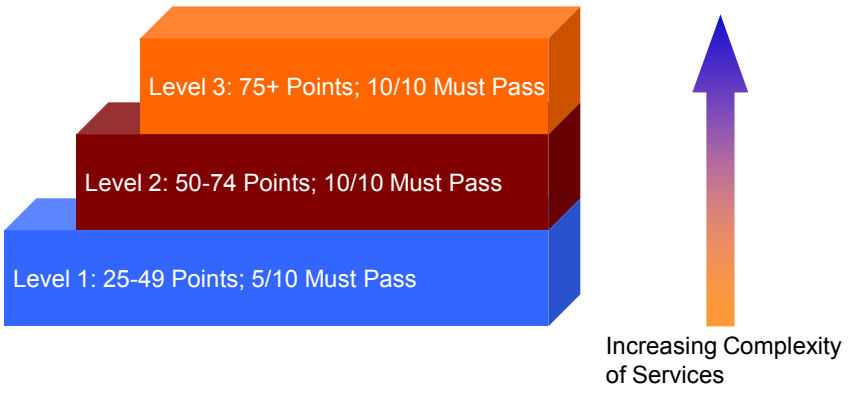
## Scoring: Building a Ladder to Excellence

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## NCQA Recognition Activity

>1500 practices have received recognition

- 33% Level 1
- 5% Level 2
- 62% Level 3

58 % of practices have < 5 physicians at the site

47% of practices are part of multi-sites

Concentration in the Northeast and Mid-South

- Practices more likely to seek recognition when/where tied to reward

About 66% are adult primary care practices; 15% are pediatric practices

31 (17%) are community health centers

SOURCE: NCQA, July 2010

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## Complex Delivery

**Health care delivery is complex – e.g., the typical primary care physician coordinates care with 229 other physicians working in 117 practices**

H H Pham, et al *Ann Intern Med.* 2009;150:236-242



## Specialty Care Connections

**PCMH is NOT a gatekeeper system**

**Emphasis on transitions in care & continuity (e.g., referral agreements, care transitions programs)**

**ACP in discussions with several groups regarding the PCMH model and primary care/specialty care interface (sharing care)**

**ACP Council of Specialty Societies PCMH workgroup:**

- **Developed FAQs on the relationship of the PCMH to specialty physicians***
- **Facilitating the development of the "PCMH Neighbor" concept – white paper to be released in late Summer/early Fall 2010**

* FAQs available at: http://www.acponline.org/running_practice/pcmh/understanding/specialty_physicians.htm

# Thank You!

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Questions?