

# Medical Home Movement

Holly Batal, MD, MBA

Denver Health

August 25, 2009



# Joint principals of the patient-centered medical home

- personal physician;
- whole-person orientation;
- safe and high-quality care (e.g., evidence-based medicine, appropriate use of health information technology);
- enhanced access to care; and
- payment that recognized the added value provided to patients who have a patient-centered medical home.



# A rose by any other name...

- Medical home
- Advanced medical home
- **Patient-centered medical home**
- Personal medical home
- Health home
- Integrated health home
- Primary care medical home



# Importance of primary care

- Countries more oriented to primary care have residents in better health at lower costs
- Health is better in US regions that have more primary care physicians
- There are fewer disparities in health across population subgroups in primary care-oriented health systems



# Comparison of US health care and within US health care

- Within the United States, adults with a primary care physician had 33 percent lower costs of care and were 19 percent less likely to die, after adjusting for demographic and health characteristics
- Primary care physician supply is consistently associated with improved health outcomes for conditions like cancer, heart disease, stroke, infant mortality, low birth weight, and life expectancy.
- In both England and the United States, each additional primary care physician per 10,000 persons is associated with a decrease in mortality rate of 3 to 10 percent.
- In the United States, an increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons .



According to the Center for Evaluative Clinical Sciences at Dartmouth, states in the US that relied more on primary care have:

- **lower Medicare spending** (inpatient reimbursements and Part B payments)
- **lower resource inputs** (hospital beds, ICU beds, total physician labor, primary care labor, and medical specialist labor)
- **lower utilization rates** (physician visits, days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians)
- **better quality of care** (fewer ICU deaths and a higher composite quality score)



# What is primary care?

- First point of contact for all new health needs and problems
- Delivering long-term, person-focused care
- Comprehensively meeting all health needs except for rare conditions
- Coordinating care that must be received elsewhere
- Dealing with problems that are never attributed to a specific diagnosis

**Primary care physician – physician who is trained to provide first-contact, continuous, and comprehensive care**



# Limits of primary care delivery in current model

- Reimbursement
- Coordination
- Time
- Specialist care
- Primary care physician shortages



# Limits of primary care delivery in current model

- Reimbursement
  - reimbursed based on visits
  - At least  $\frac{1}{4}$  of care by means other than visits
- Coordination
  - Typical panel also seeing 200 other providers
  - Average PCP deals with only 40% of health care needs of current patient
- Time
  - Would take 108 hours/week to provide all preventive care to patient panel
  - Patients explaining their problem to a physician were interrupted after an average of 23 seconds
  - 50% of patients leave the office not understanding what the physician told them



# Specialist care instead of primary care

- More than half of specialist visits in US are for routine follow-up
- Large variations in referral rates and use of specialist services not explained by differences in patients' needs
- Focus on disease, not necessarily the person with the disease



# Primary care as compared to specialist care

- Apparently poorer quality for individual diseases
- Similar functional health status at lower cost for people with chronic disease
- Better quality, better health, greater equity, and lower cost for whole people and populations



# Current health care reform

Shift from:

- Fragmentation to coordination
- Highly specialized care to primary care and prevention

Patient-centered medical home is one model of delivery system reform



# History of the medical home

- Introduced by American Academy of Pediatrics in 1967. Policy statement in 1992.
- 2005 ACP developed an “advanced medical home model”
- 2006 Patient-Centered Primary Care Collaborative
- 2007 – Joint Principles of the Patient-Centered Medical Home



- <http://www.emmisolutions.com/medicalhome/pcpcc/index.html>



# 4 cornerstones of the PCMH model

- Primary care
- Patient-centered care
- New-model practice
- Payment reform



# Primary care

- Comprehensive
- First-contact
- Acute, chronic, and preventive
- Across life span
- Delivered by a team led by the patient's personal physician



# Patient-centered care

- Tailoring of care to meet the needs and preferences of patients
- Expanding access and improving options for patient-clinician communication
- Shared decision making
- Patients as active, prepared, and knowledgeable participants in their care



# New-model practice

- Evidence-based processes of care
- Population-based care management



# Payment reform

- Combination of:
  - Fee for service
  - Pay for performance
  - Separate payment for care coordination and integration



# Joint principals of the patient-centered medical home

- personal physician;
- whole-person orientation;
- safe and high-quality care (e.g., evidence-based medicine, appropriate use of health information technology);
- enhanced access to care; and
- payment that recognized the added value provided to patients who have a patient-centered medical home.



# Key features of the Patient-Centered Medical Home

- Personal physician – 1<sup>st</sup> contact, continuous, comprehensive care
- Team care – collectively take responsibility for ongoing care
- Whole person orientation – take responsibility for all patient needs by delivering or arranging care
- Coordinated care – across all elements of the healthcare system
- Quality & safety – by implementation of CCM, continuous QI, and voluntary recognition process
- Enhanced access – via open scheduling, expanded hours, and new options for communication
- Payment – recognizes value of the PCMH, pays for coordination and electronic communication with patients, supports IT use



# National Center for Quality Assurance standards

- 3 levels of achievement
- 9 areas – 30 discrete elements (10 elements are mandatory “must pass”)
- Recognition not accreditation
- Access and communication
- Patient tracking
- Care management
- Patient self management support
- Electronic prescribing
- Test tracking
- Referral tracking
- Performance improvement
- Advanced electronic communication

# Testing the model

- 22 multistakeholder demonstration pilot projects in 14 states
- CMS Medical demonstration pilot projects in 400 practices in 8 regional sites
- 20 bills promoting PCMH concept in 10 states



# Commonwealth Fund Safety Net Medical Home Initiative

- 4 year development of 68 CHCS in 5 states into PMCH
- Support to improve care delivery to patients
  - Better coordinated care
  - Enhancing access to care
  - Improving doctor-patient interactions
  - Implementing quality improvement
- Evaluation



# Importance of a medical home

- Better health (individual and population)
- Lower overall costs of care
- Reductions in disparities (between socially disadvantaged and socially advantaged)
- Insurance does not guarantee a medical home



Medical home – defined as a health care setting that provides timely, well organized care and enhanced access to patients

Survey respondents who have a medical home report:

- They have a regular provider or place of care
- They experience no difficulty contacting their provider by phone
- They experience no difficulty in getting care or advice on weekends or evenings
- They report that their office visits are always well organized and on schedule



## Indicators of a Medical Home (adults 18-64)

Indicator	Total		Percent by Race			
	Estimated millions	Percent	White	African American	Hispanic	Asian American
Regular doctor or source of care	142	80	85	79	57	84
<i>Among those with a regular doctor or source of care . . .</i>						
Not difficult to contact provider over telephone	121	85	88	82	76	84
Not difficult to get care or medical advice after hours	92	65	65	69	60	66
Doctors' office visits are always or often well organized and running on time	93	66	68	65	60	62
All four indicators of medical home	47	27	28	34	15	26

Source: Commonwealth Fund 2006 Health Care Quality Survey.

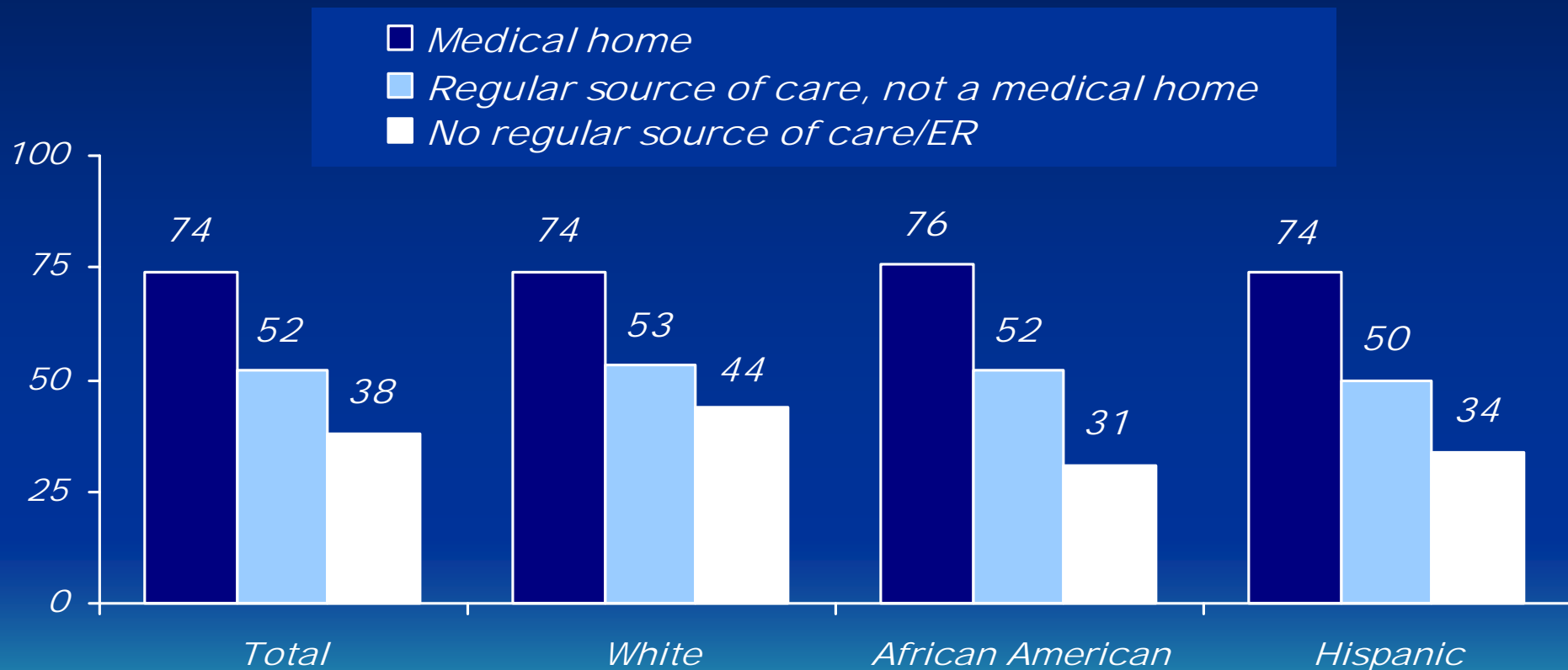
## Indicators of a Medical Home by Usual Health Care Setting (adults 18–64)

		Usual Health Care Setting		
Indicator	Total	Doctors' office	Community health center or public clinic	Other settings*
Regular doctor or source of care	80%	95%	78%	63%
<i>Among those with a regular doctor or source of care . . .</i>				
Not difficult to contact provider over telephone	85	87	77	77
Not difficult to get care or medical advice after hours	65	67	54	69
Always or often find visits to doctors' office well organized and running on time	66	68	56	60
All four indicators of a medical home	27	32	21	22

\* Includes hospital outpatient departments and other settings.  
Source: Commonwealth Fund 2006 Health Care Quality Survey.

# Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

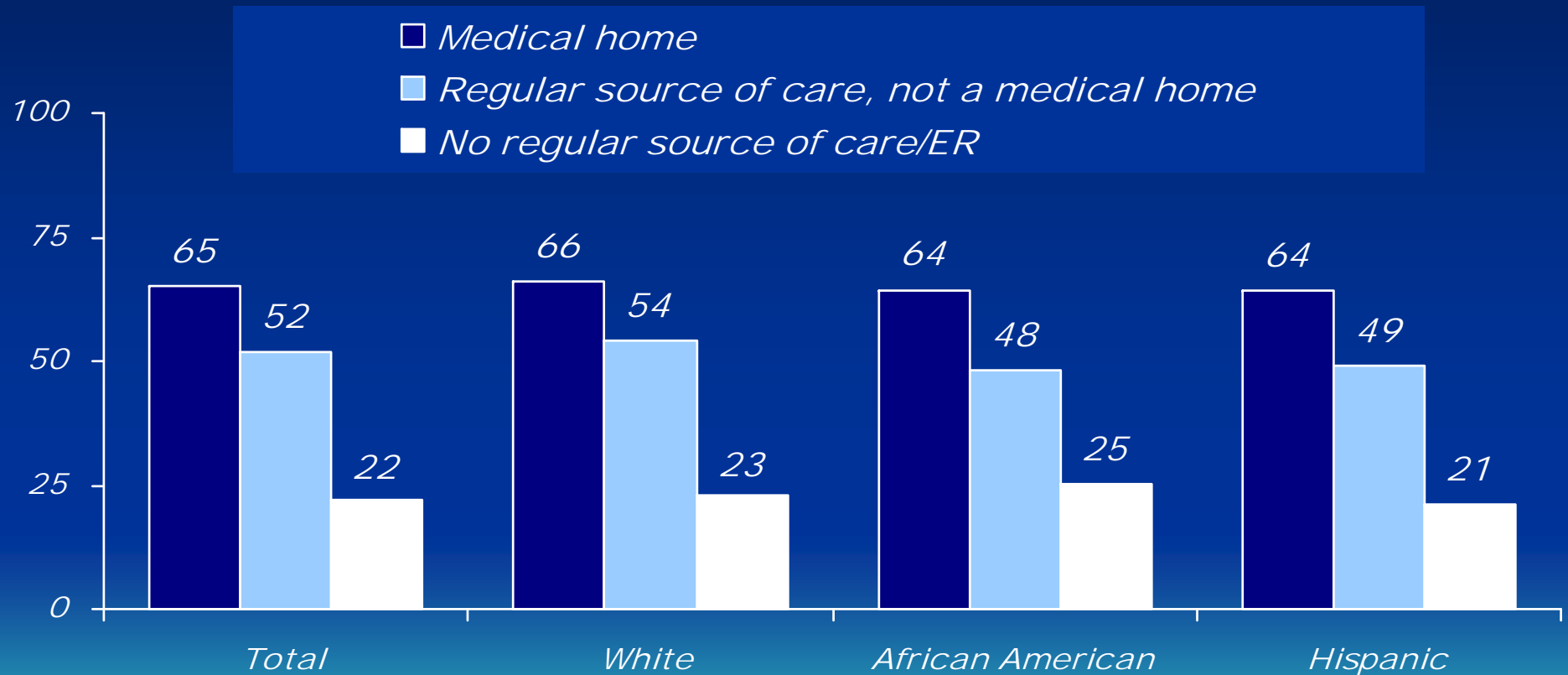
Percent of adults 18–64 reporting always getting care they need when they need it



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.

# When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits

Percent of adults 18-64 receiving a reminder to schedule a preventive visit by doctors' office



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.

A research team from RAND and the University of California at Berkeley undertook a rigorous evaluation of care provided according to PCMH principles. For almost 4,000 patients with diabetes, congestive heart failure (CHF), asthma and depression, they found that

- Patients with diabetes had significant reductions in cardiovascular risk;
- CHF patients had 35% fewer hospital days;
- Asthma and diabetes patients were more likely to receive appropriate therapy.



# Other evidence

- The North Carolina Medicaid program - upfront \$10.2 million investment saved \$244 million in overall healthcare costs for the state (2004). Similar results were found in 2005 and 2006.
- Denmark has organized its entire health care system around patient-centered medical homes, achieving the highest patient satisfaction ratings in the world. Primary care physicians are highly accessible and supported by an outstanding information system that assists them in coordinating care. Among Western nations, Denmark has among the lowest per capita health expenditures and highest primary care rankings.



# Group Health experience

- After one year pilot are expanding to all sites
- Broke even on primary care investment because of 29% decrease in ED/UCC visits and 11% decrease in hospitalizations
- Improved quality indicators
- Enhanced patient experience
- Improved employee satisfaction



How hard is it to become a medical home?



# First National Demonstration Project on Transformation to PCMH

- June 2006
- American Academy of Family Physicians
- Diverse national sample of 36 family practices
- Preliminary lessons published
- Full evaluation to be published in 2010



# First National Demonstration Project on Transformation to PCMH

- Addresses effect of PCMH model on patient and practice outcomes
- Effectiveness of facilitated intervention in bringing about transformation



# First National Demonstration Project on Transformation to PCMH 6 critical lessons

- Becoming a PCMH requires transformation
- Technology needed is not plug and play
- Requires personal transformation of physicians
- Change fatigue
- Strategic developmental approach
- Local process



# First National Demonstration Project on Transformation to PCMH Health Policy Recommendations

- Assure adequate financial resources
- Tailor the approach to the practice
- Assist physicians with their personal transformation
- NCQA should modify its PCMH recognition process



# First National Demonstration Project on Transformation to PCMH Practice Recommendations

- Establish realistic initial expectations for time and effort required
- Develop a practice technology plan, be flexible and reflective
- Monitor change fatigue
- Learn to be a learning organization



# Personal transformation of physicians

- Working in practice teams
- Using chronic care model
- Incorporating population management
- Evidence at the point of care
- Facilitating leadership skills
- Change management
- Training staff as peers
- Patient partnering
- Thinking outside of the examination room



# Will the patient trust the team?

- If team approach clearly explained...
- If offered continuity with the team...
- If team members provide patient-centered, high-quality care...
- ...patients will transfer their trust in the physician to a trust in the team



# How to fund it?

- Management fee for care coordination
- Pay for performance
- Comprehensive payment by episode of illness
- Subsidized primary care salaries by sharing in the revenue generated by specialists in large group practices
- Risk-adjusted “base payment” supplemented by a risk-adjusted “bonus” for achieving desired outcomes in the areas of cost, quality, and patient satisfaction



# Challenges

## Standard measurement criteria

- NCQA – overemphasize IT
- Need measures of care that reflect experiences and relationships

## Public perception

- Medical home = nursing home
- Funeral home follows your visit to the medical home
- Gatekeeper
- Disease management



# Differences from gatekeeper

- Gatekeeper – restricts patient access to services
- Personal physician – leverages key attributes of the advanced medical home to coordinate and facilitate the care of patients and is directly accountable to each patient



# Differences from disease management

- Disease management – case manager provided by health plan or a contracted company. Mostly relationship between care manager and patient.
- Medical home – care and coordination resides with the patient's physician and his/her health care team



# Benefits of medical home

- **Revitalize patient-physician relationship**
- Stimulate practice-level innovation
- Enhance coordination of care
- **Recognize that care provided by a personal physician is a highly valuable service**
- Lead to macro system changes required to support this health care model (financing, coverage, reimbursement, physician education & training, workforce distribution)



# Cost savings in PCMH

- Reduce redundancies
- Decreased medical errors
- Decreased ED visits
- Decreased hospitalizations for ambulatory sensitive conditions
- Decreased rehospitalizations for patients recently discharged
- Prevention of costly complications



# Commonwealth Fund Safety Net Medical Home Initiative

- 4 year development of 68 CHCS in 5 states into PMCH
- Support to improve care delivery to patients
  - Better coordinated care
  - Enhancing access to care
  - Improving doctor-patient interactions
  - Implementing quality improvement
- Evaluation



# Change to PCMH at DH (Commonwealth Project)

- Engaged leadership
- Quality improvement strategy
- Empanelment
- Patient-centered interactions
- Organized, evidence-based care
- Continuous and team-based healing relationships
- Enhanced access
- Care coordination



# Conclusion

Even assuming that the demonstration projects will improve quality, reduce cost, and satisfy the needs of patients and families, unless other major policy changes occur, the PCMH cannot significantly improve the plight of the uninsured, reduce pervasive health disparities, or solve the primary care and geriatric workforce issues. However, the PCMH model may provide a pathway for revitalization of primary care and become an essential part of a new approach to healthcare delivery in the United States.

