Healthcare Transformation: The Patient Centered Medical Home

Paul Kleeberg, MD, FAAFP, FHIMSS
CMIO Stratis Health

Iowa Association of Rural Health Clinics
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Conflict of Interest

- Dr. Kleeberg is the Clinical Director for the Minnesota - North Dakota Regional Extension Assistance Center for HIT (REACH) – An ONC REC
- Dr Kleeberg also serves on the Physician Advisory Board for Elsevier
- No other conflict of interest

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Outline

- Background
- The changing landscape
- Primary care as the foundation
- Patient Centered Medical Home
- Healthcare Transformation
- Where to start

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What is our ideal of medical care?

- Marcus Welby, M.D.
- Physician at the bedside
- Lower mobility
  - We knew our patients and they knew us
- Technology expectations were not as high

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What has Happened?

- Specialties
- Reimbursement
  - Volume over Value
- Technologies
- Specialized skills

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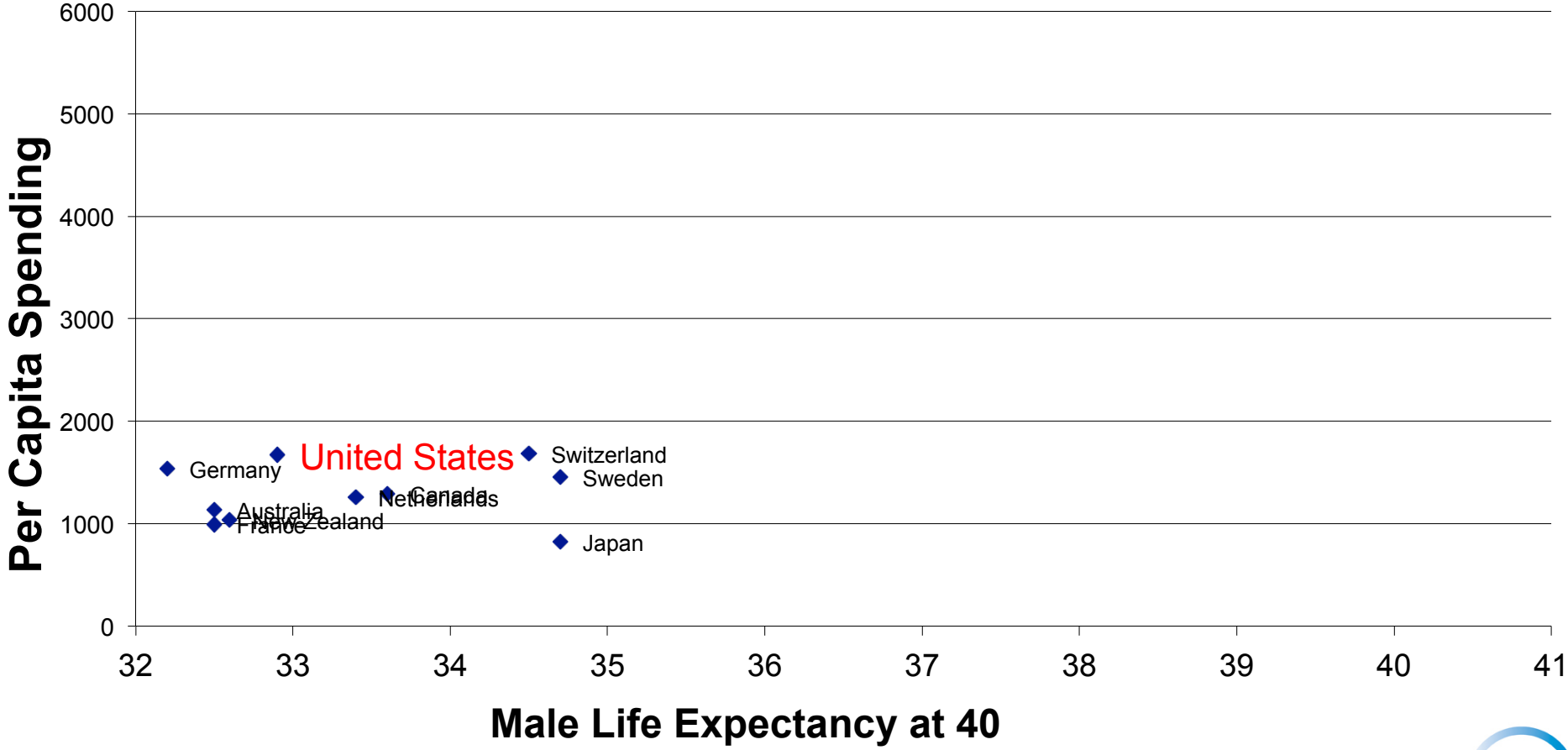
So where has this led?

Spending and Life Expectancy 1976



Adapted from a slide by Sherry Glied, Wagner School, NYU

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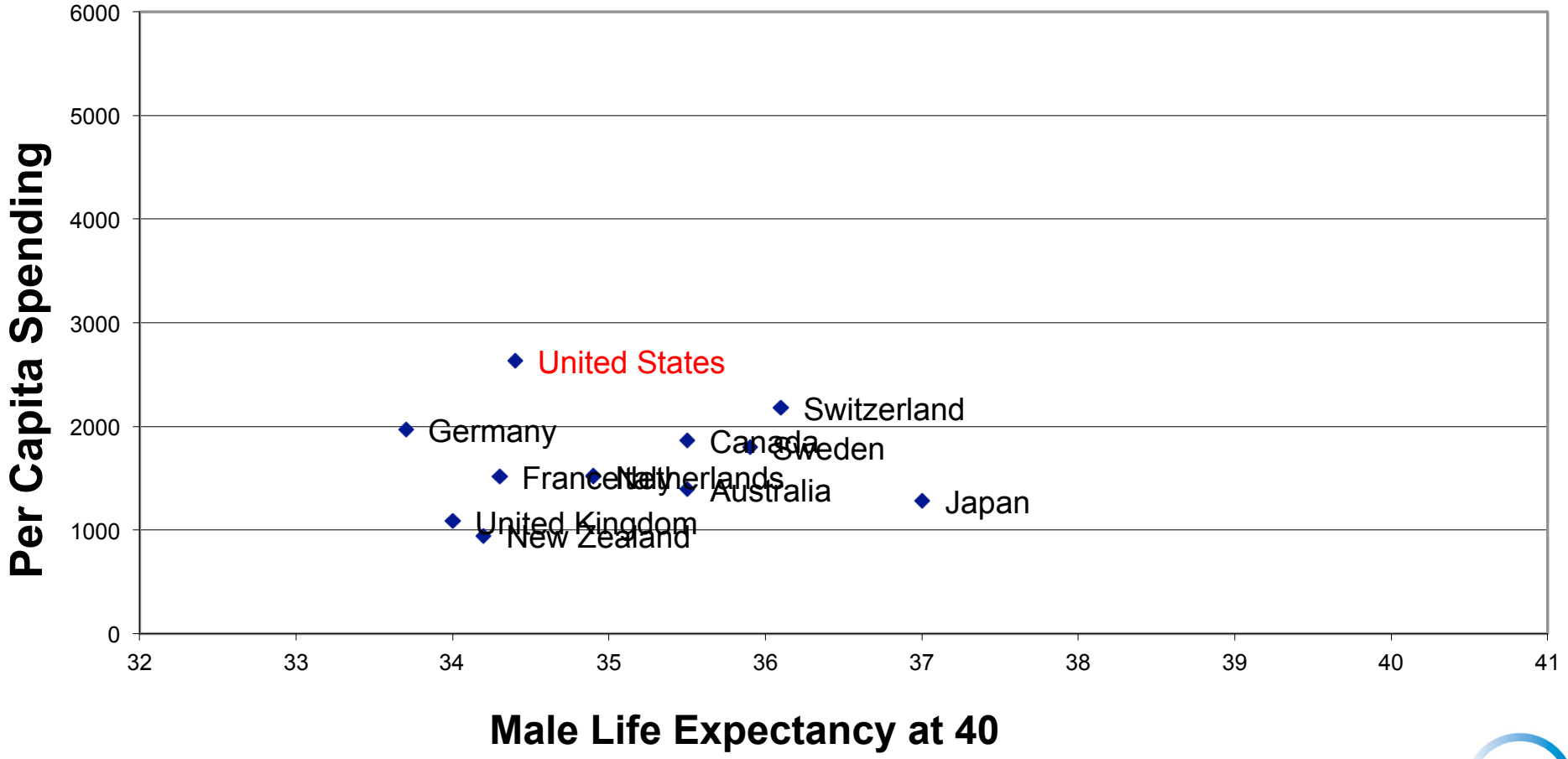
Spending and Life Expectancy 1986



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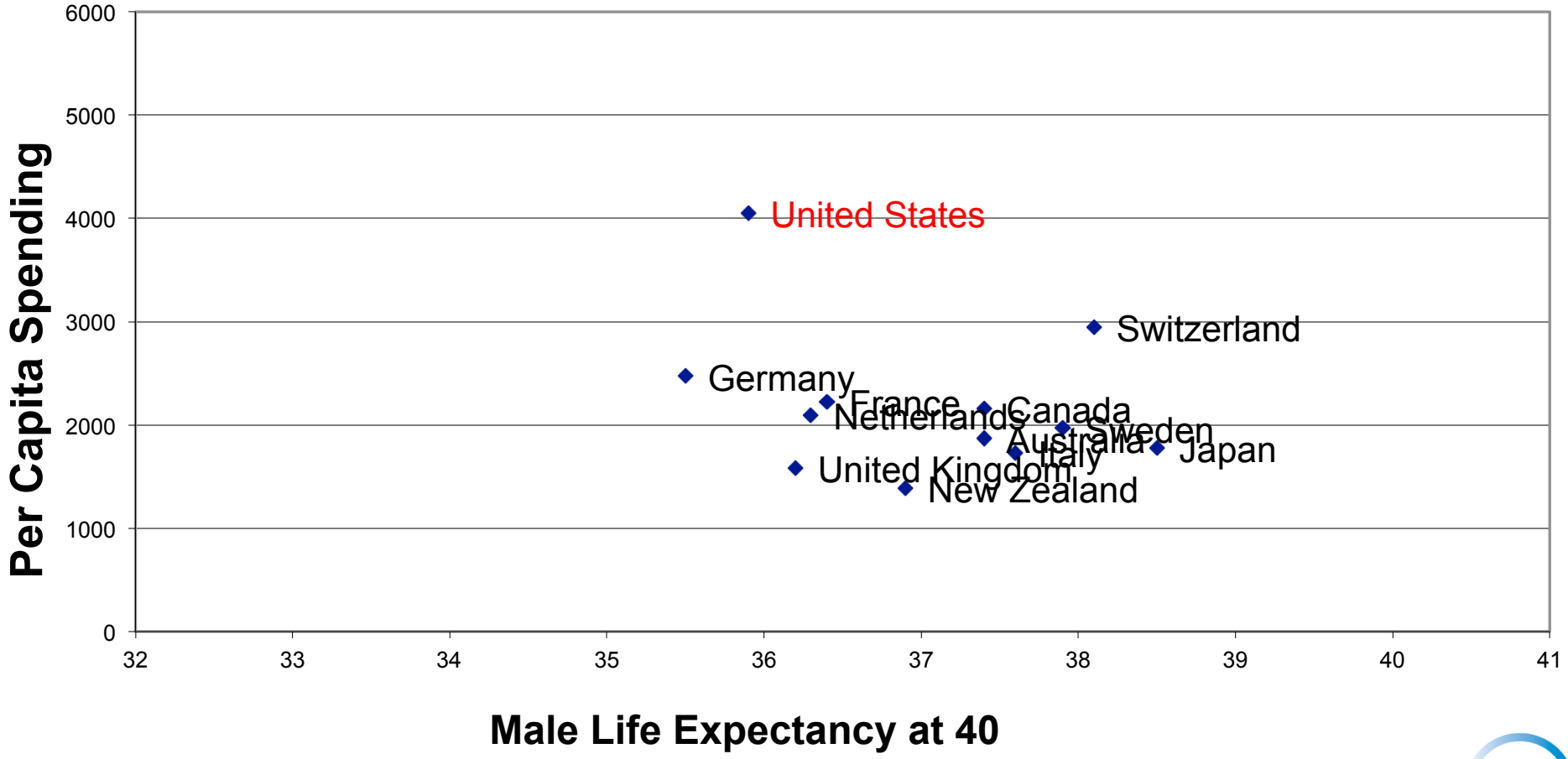
Spending and Life Expectancy 1996



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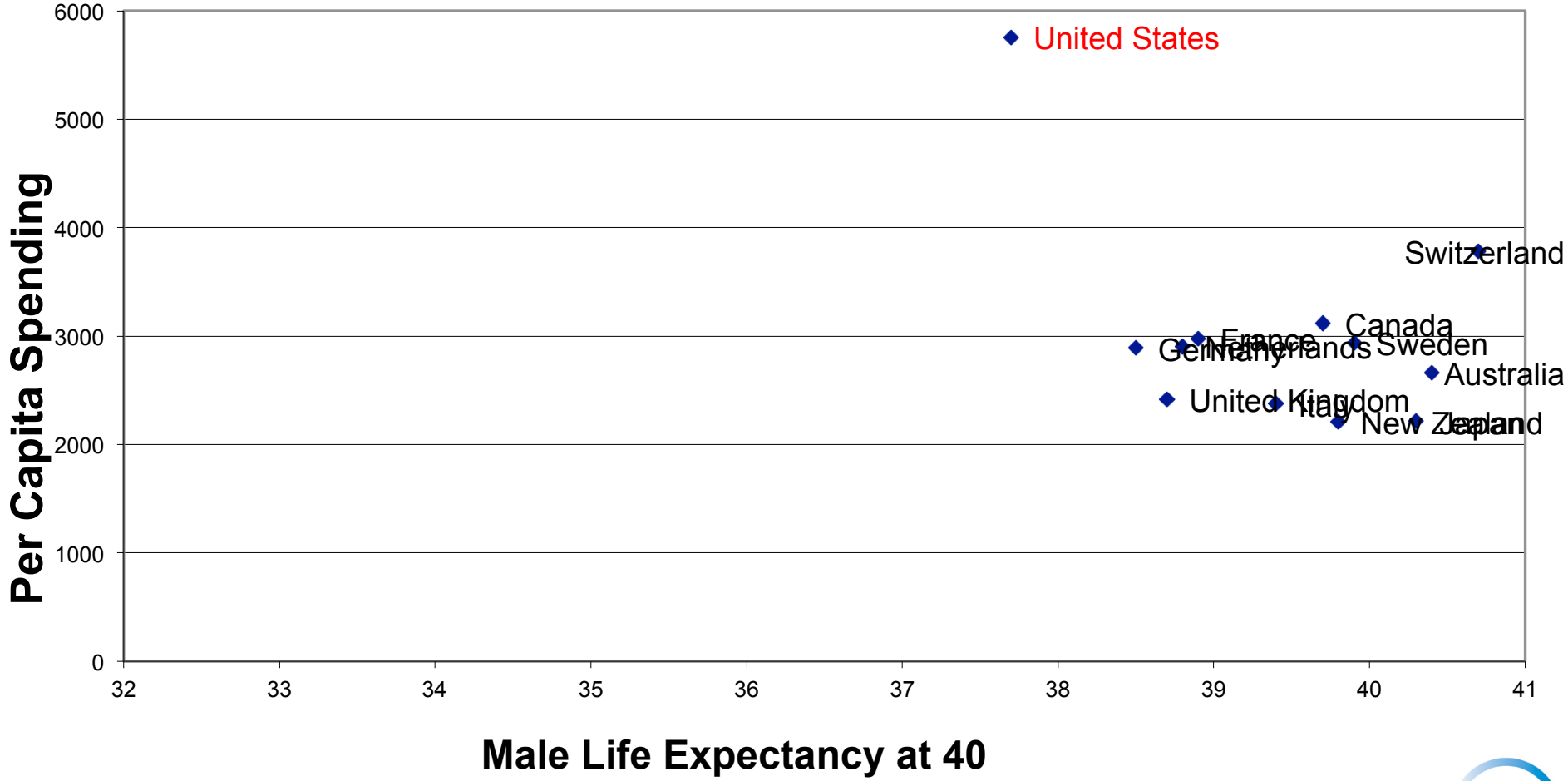

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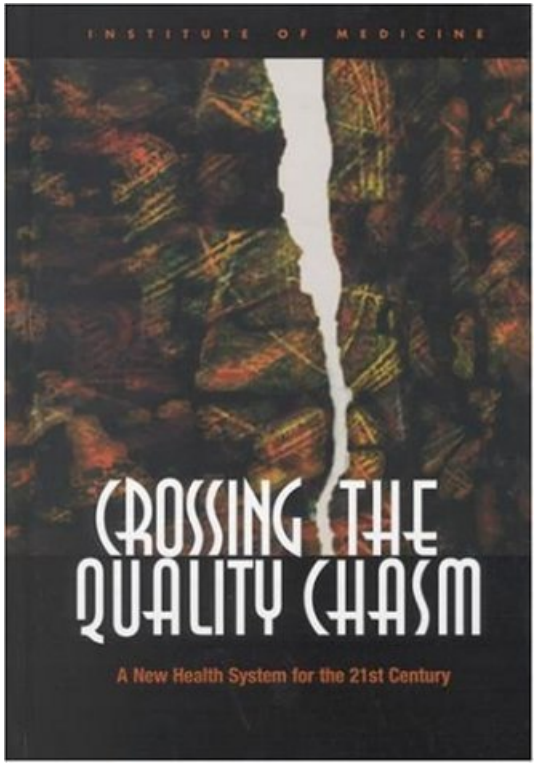
So where has this led?

- Rising health care costs
- Growing specialization
  - Driving a need to refer
- Poor communication among providers
- Fractionated care
  - Repeated tests and poor communication

Institute of Medicine: Crossing the Quality Chasm (2001)

"A new Health System for the 21st Century"

- Our common purpose as a health system is that care should be:
  - Safe
  - Effective
  - Patient-Centered
  - Timely
  - Efficient
  - Equitable



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Crossing the Quality Chasm: Health Care Redesign Rules:

1. Care is based on continuous healing relationships
2. Care is customized based on patient needs and values
3. The patient is the source of control
4. Knowledge is shared and information flows freely
5. Decision making is evidence-based
6. Safety is a system property
7. Transparency is necessary
8. Needs are anticipated
9. Waste is continuously decreased
10. Cooperation among clinicians is a priority

Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System of the 21st Century. Washington: National Academy Press, 2001.

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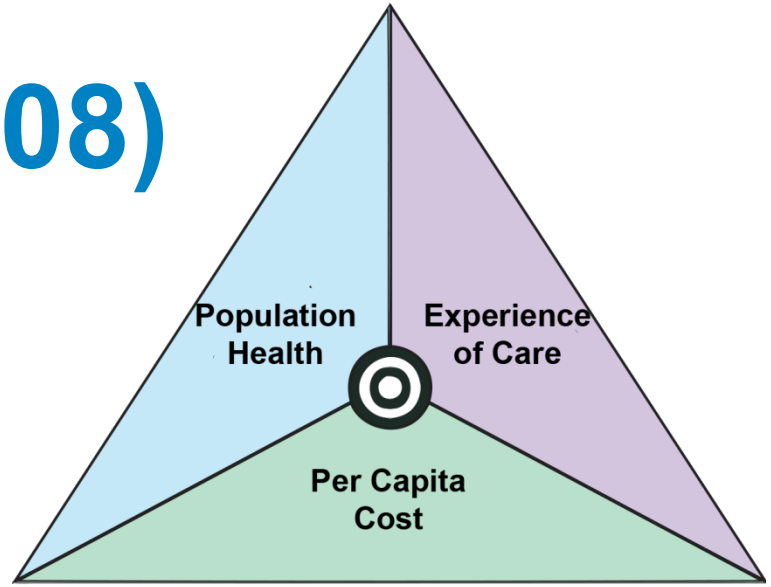
The Triple Aim (2008)

- A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to health system performance



IHI Triple Aim

- The three dimensions are:
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations
  - Reducing the per capita cost of health care

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Health Care Reform

- Moving away from an episodic, fee for service payment approach and towards a coordinated model that is focused on delivering high-quality, low-cost care across the continuum of care.

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Strengthen Primary Care

- After more than 30 years of academic study, research findings demonstrate that countries and health systems that heavily invest in primary care have better health outcomes at lower total cost.

Moving from Volume to Value

40%

predict that in three years, value-based models will support more than half of their businesses

90%

expect value-based payment models to impact their top three business objectives

Health Plan Readiness To Operationalize Value-based Payment Models:
An Availity Research Study April 2013 Availity

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Payment Reform

- Attempted repeal of the Medicare Sustainable Growth Rate (SGR)
  - A move away from a fee-far-service (FFS) model to one that rewards quality, efficiency, and innovation
  - Named the PCMH as a supportive framework for alternative value-based payment models that rewards quality and value
- Commercial health plans increasingly transitioned their PCMH "demonstrations" or pilots into a standard business operation, incentivizing with PMPM payments or care coordination fees

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PQRS Value Based Reimbursement

- The Value Modifier Program (or Value-based payment modifier program) will begin to be applied to the CQM PQRS EP reporting of CQMs
  - In 2015, it will apply to groups of physicians with 100 or more EPs and based on data from 2013
  - In 2016 CMS will apply the Value Modifier to groups of physicians with 10 or more EPs.
  - By 2017, all physicians will be added
- The Value Modifier assesses
  - **quality of care** furnished
  - **cost of that care** under the Medicare Physician Fee Schedule t**o determine EP CMS reimbursement** levels and will be either an up, down or neutral adjustment.

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PCMH is at the foundation of an ACO

- Accountable Care Organization:
  - A health care organization and a related set of providers that are accountable for the cost and quality of care delivered to a defined patient population.
  - The goal is to reduce costs through enhanced preventative care and disease management, improve quality through coordination of care, and develop the necessary skills and resources to meet cost and quality health care goals.
  - ACOs that achieve quality and cost targets receive a financial bonus.

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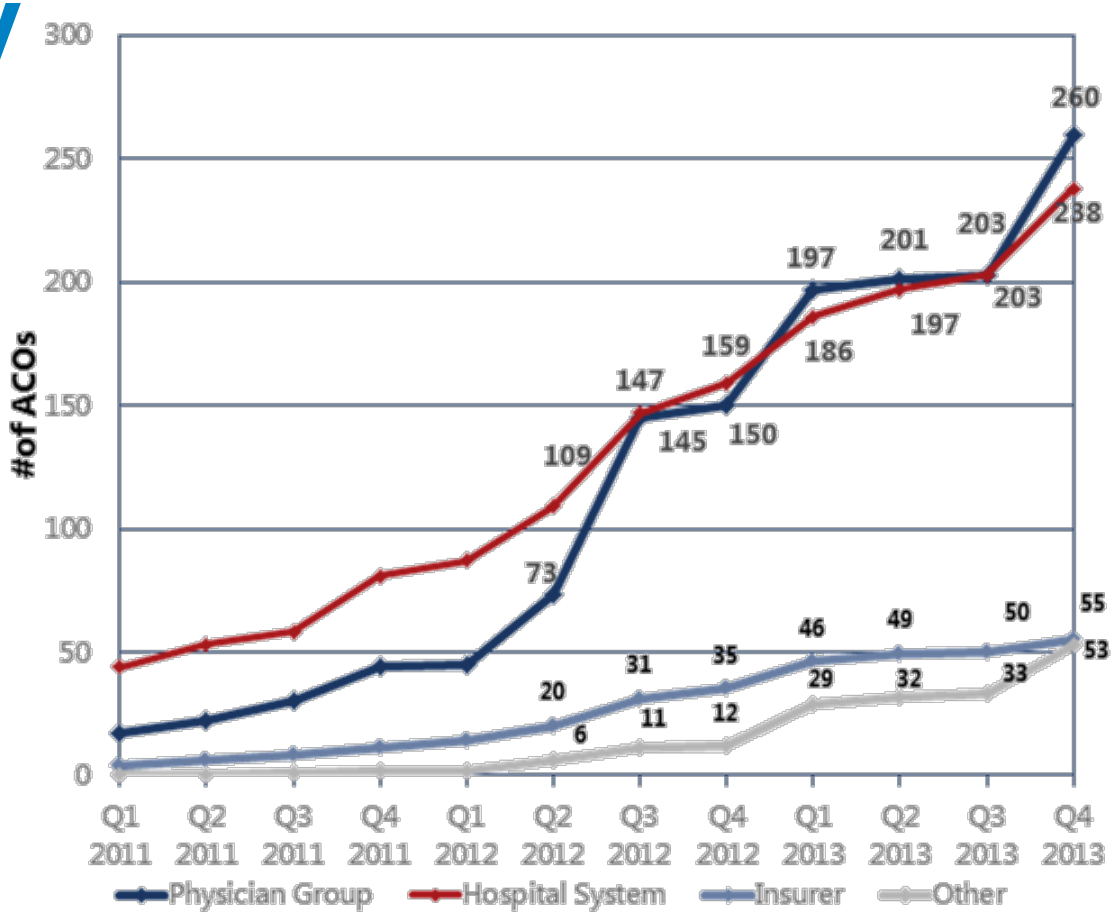
Total Accountable Care Organizations by Sponsoring Entity



Source: Leavitt Partners Center for Accountable Care Intelligence, http://healthaffairs.org/blog/2014/01/29/accountable-care-growth-in-2014-a-look-ahead/ Accessed March 12, 2014

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Total Accountable Care Organizations

Source: Leavitt Partners Center for Accountable Care Intelligence, http://healthaffairs.org/blog/2014/01/29/accountable-care-growth-in-2014-a-look-ahead/ Accessed March 12, 2014

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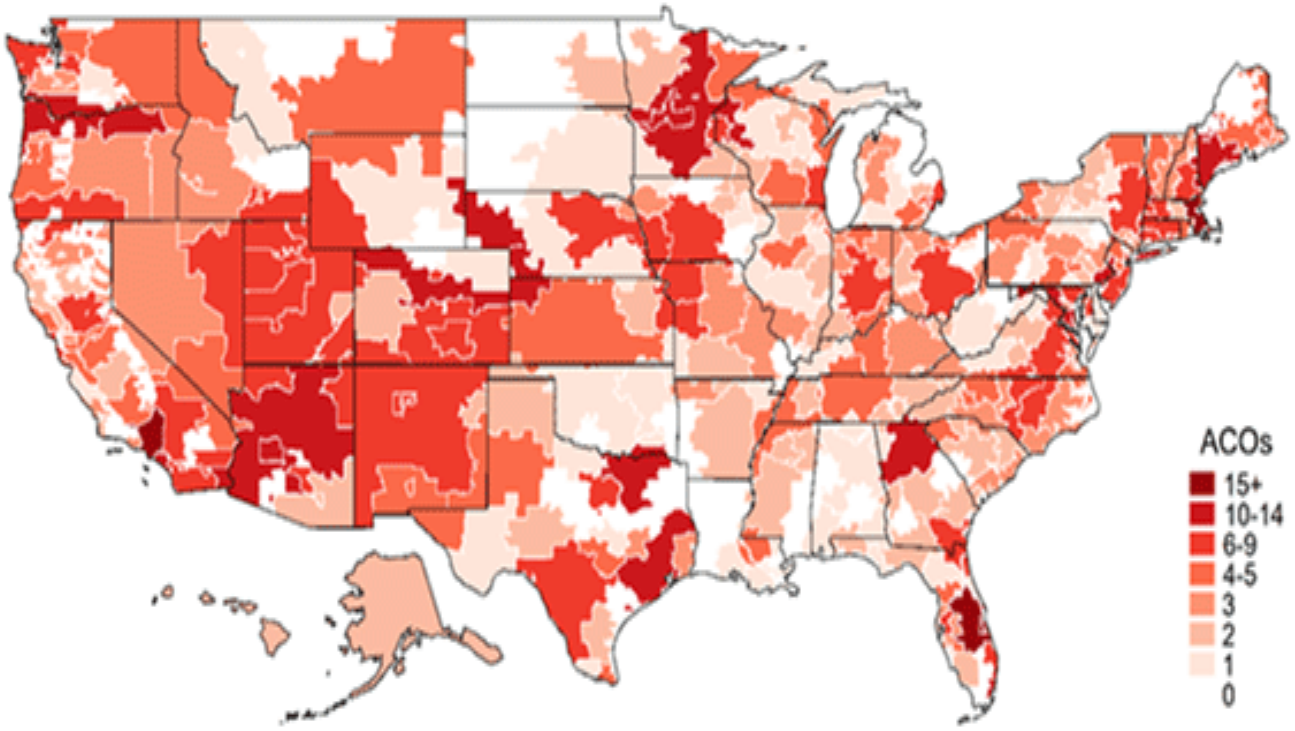
Accountable Care Organizations by Hospital Referral Region



Source: Leavitt Partners Center for Accountable Care Intelligence, http://healthaffairs.org/blog/2014/01/29/accountable-care-growth-in-2014-a-look-ahead/ Accessed March 12, 2014

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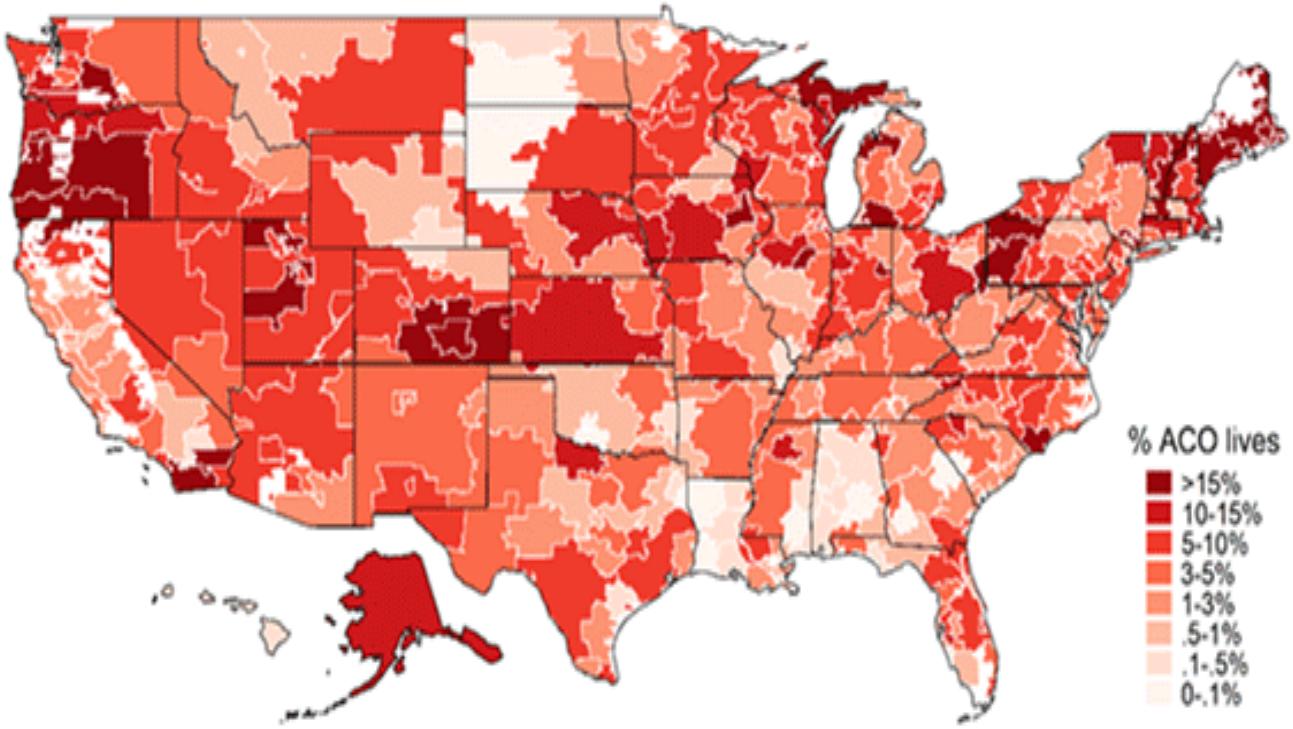
Estimated ACO Covered Lives by Hospital Referral Region



Source: Leavitt Partners Center for Accountable Care Intelligence,
http://healthaffairs.org/blog/2014/01/29/accountable-care-growth-in-2014-a-look-ahead/
Accessed March 12, 2014

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What is a PCMH?

- It is best described as a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality and safety.(3)
- Supported by robust health information technology (health IT), provider payment reform focused on patient outcomes and health system efficiencies, and team-based education and training of the health professions workforce.(4)

ARHQ. (2014). *Defining the PCMH. Retrieved* March 12, 2014, from http://pcmh.ahrq.gov/page/defining-pcmh

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Payers are supporting the PCMH

- A 2012 Publication of the Commonwealth Fund stated:
  - In recognition of its value, it is supported by over 90 commercial insurance plans, multiple employers, 42 state Medicaid programs, numerous federal agencies, the Department of Defense, hundreds of safety net clinics, and thousands of small and large clinical practices nationwide.

http://www.commonwealthfund.org/Publications/Data-Briefs/2012/May/Measures-Medical-Home.aspx

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Studies demonstrated PCMH improvement by:

- Decreases in the cost of care
- Reductions in the use of unnecessary or avoidable services
- Improvements in population health indicators and increase in preventive services
- Improvements in access to care
- Improvements in patient satisfaction

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Varieties of PCMH

- A subset of approximately 7,000 practices have achieved PCMH recognition (also known as certification or accreditation) from an external accrediting body or expert entity including;
  - the Accreditation Association for Ambulatory Health Care (AAAHC)
  - the Joint Commission
  - The National Committee for Quality Assurance (NCQA)
  - URAC (formerly the Utilization Review Accreditation Commission)
- Other developers of PCMH standards:
  - States such as Minnesota, Oklahoma, and Maine
  - Several commercial health plans, such as Blue Cross Blue Shield Michigan

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The Joint Principles of the PCMH
Endorsed by the ACP, AAFP, AAP, AOA

- Key Characteristics of the Medical Home:
  - Personal physician
  - Physician directed medical practice
  - Whole person orientation
  - Care is coordinated and/or integrated across all elements of the complex health care system and the patient's community

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The Joint Principles of the PCMH

- Also included that:
  - Quality and safety are hallmarks of the medical home
    - Care planning, evidence-based medicine, clinical decision support, continuous quality improvement, patient participation and feedback, and appropriate Health Information Technology
  - Enhanced Access
  - Payment Based on Value not Volume

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PCMH: A Strategy for Quality Improvement

- Long-term partnerships, not hurried visits
- Care that is coordinated among providers
- Better access through expanded hours and on-line tools
- Shared decisions so patients make informed choices
- Lower costs from reduced ER/hospital use
- More satisfied patients and providers

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URAC PCMH Principles

1. Patient Centered Care Team Culture
2. Appropriate Access to Care
3. Individualized Care Planning
4. Effective and Timely Care Coordination and Follow-up
5. Eliminating Health Care Disparities
6. Promoting Care Quality and Continuous Improvement
7. Stewarding the Cost-Effective Use of Healthcare Resources
8. Excellence in Customer Service
9. Commitment to Transparency
10. PCMH Infrastructure and Operations

Source: Kylanne Green Presentation @ Medical Home Summit, 3/17/14

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URAC PCMH Program

- 29 Comprehensive Standards
  - Mandatory and Essential
- Aligned with Meaningful Use Requirements
- All practice offices are audited
- Certificate awarded to the practice
- URAC Directory of PCHCH Achievements
  - 7 Clinics Nationwide
- No information on # of practices with certificates

Source: Kylanne Green Presentation @ Medical Home Summit, 3/17/14

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Accreditation Association for Ambulatory Health Care (AAAHC)

- Relationship
  - Patient perceptions, care team, patient education, patient understanding, address health issues, prevention, adequate time and resources
- Accessibility
  - Medical service, health information, written standards
- Comprehensiveness
  - Scope of services, self help resources, community resources

Source: Dennis Schultz Presentation @ Medical Home Summit, 3/17/14

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AAAHC PCMH

- Continuity of Care
  - Care team visits, referrals & consultations, follow up visits, missed and cancelled appointments, transitions of care, after hour care, phone and messages,
- Quality
  - Guidelines, quality monitoring and management, quality improvement

Source: Dennis Schultz Presentation @ Medical Home Summit, 3/17/14

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The AAAHC approach to accreditation/certification

- Consultative, educational survey process:

  Discovery vs. inspection

  Consultative vs. prescriptive

  Collaborative vs. dictatorial

- 5800+ Ambulatory Healthcare Organizations
- 398 Sites achieved Medical Home recognition

Source: Dennis Schultz Presentation @ Medical Home Summit, 3/17/14

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The Joint Commission PCMH

- Founded in 2011
- 118 accredited organizations which includes 1108 sites
- Based on the AHRQ Definition of a medical home:
  - Patient centered care
  - Comprehensive care
  - Coordinated care
  - Superb access to care
  - Systems-based approach to quality and safety
- Differences and similarities to the NCQH PCMH model:
  - http://www.jointcommission.org/assets/1/6/compare_tjc_pcmh_ncqa_pcmh.pdf

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BCBS Michigan PCMH

- Patient-Provider Partnership
- Patient Registry
- Performance Reporting
- Individual Care Management
- Extended Access
- Test Tracking and Follow-up
- Preventive Services
- Linkage to Community Services
- Self-Management Support
- Patient Web Portal
- Coordination of Care
- Specialist Referral Process

Source: Lisa Rajt Presentation @ Medical Home Summit, 3/17/14

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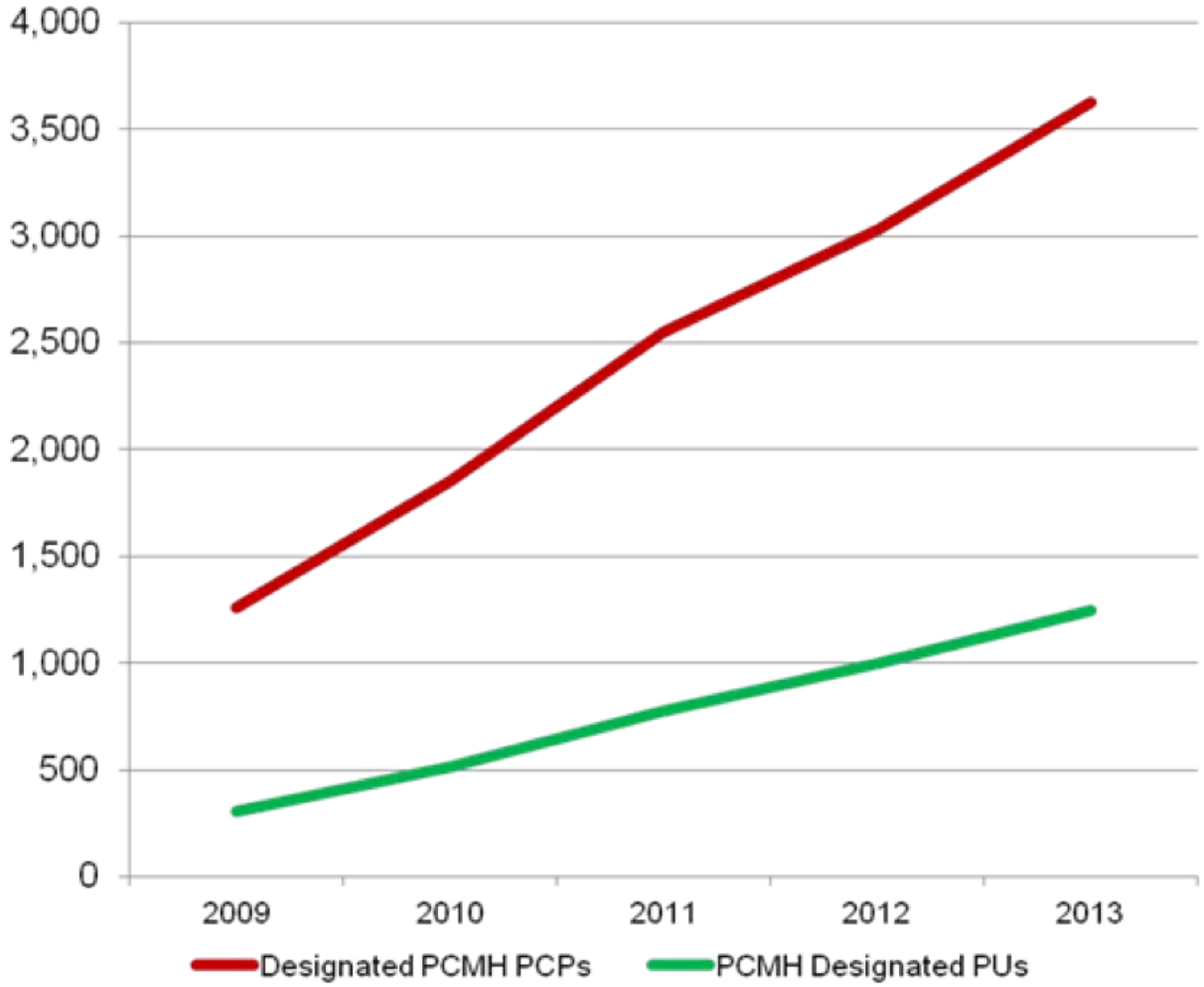
BCBS MI PCMH Growth



Source: Lisa Rajt Presentation @ Medical Home Summit, 3/17/14

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Minnesota Health Care Home

- Access for all enrollees, particularly those with complex or chronic conditions
- Population health management
- Team based care with a primary care provider and care coordinator;
- Registries and tools to support care coordination, monitor patient health, and screen enrollees
- Care plans
- Continuous access to staff
- Coordinated care processes within the clinic and community
- Ability to measure, monitor, and provide feedback on population health
- Patient engagement and care improvement.

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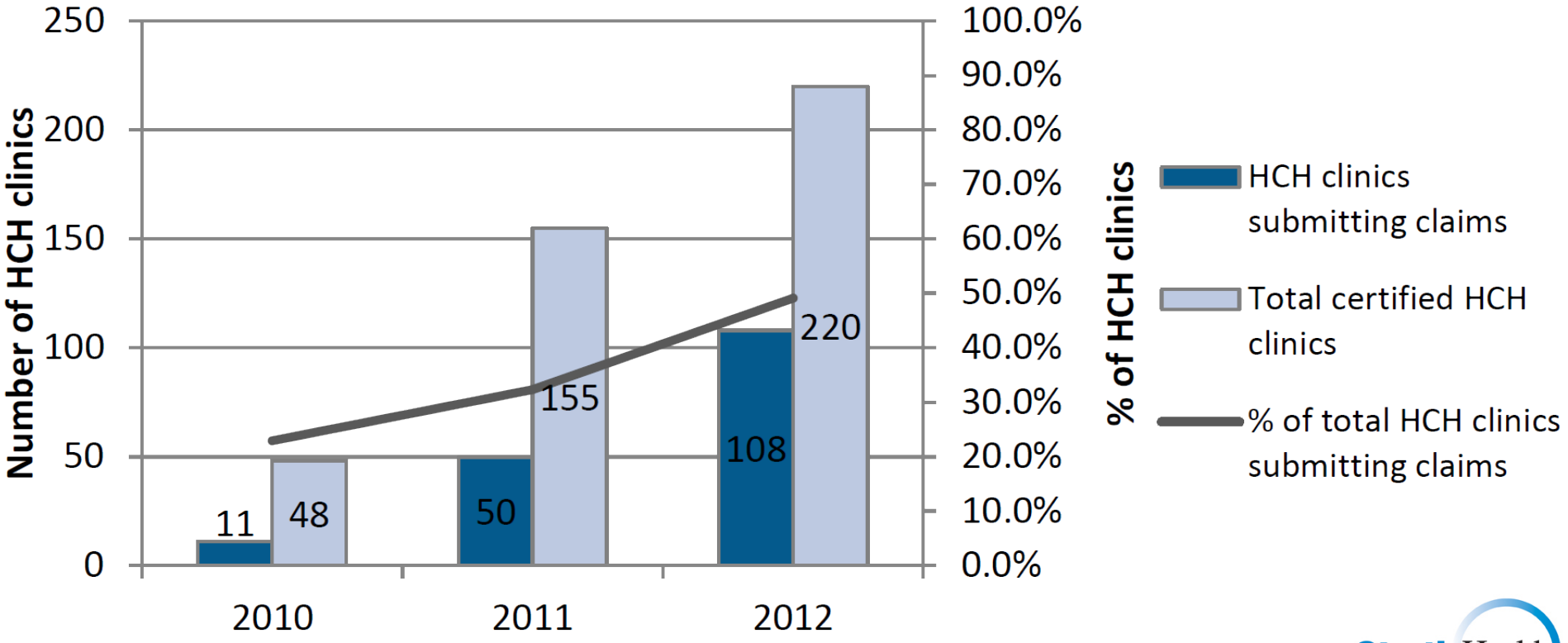
MN HCH Growth

Medicaid HCH Claims 2010 - 2012



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NCQA PCMH

- Private, independent non-profit healthcare quality oversight organization
- >32 States have Public and Private PCMH initiatives that use NCQA recognition
- >6,350 NCQA-Recognized medical homes nationwide as of Nov 2013
- 2011 PCMH Standards are aligned with Meaningful Use Stage 1 objectives and have been revised for 2014 to align with Stage 2.

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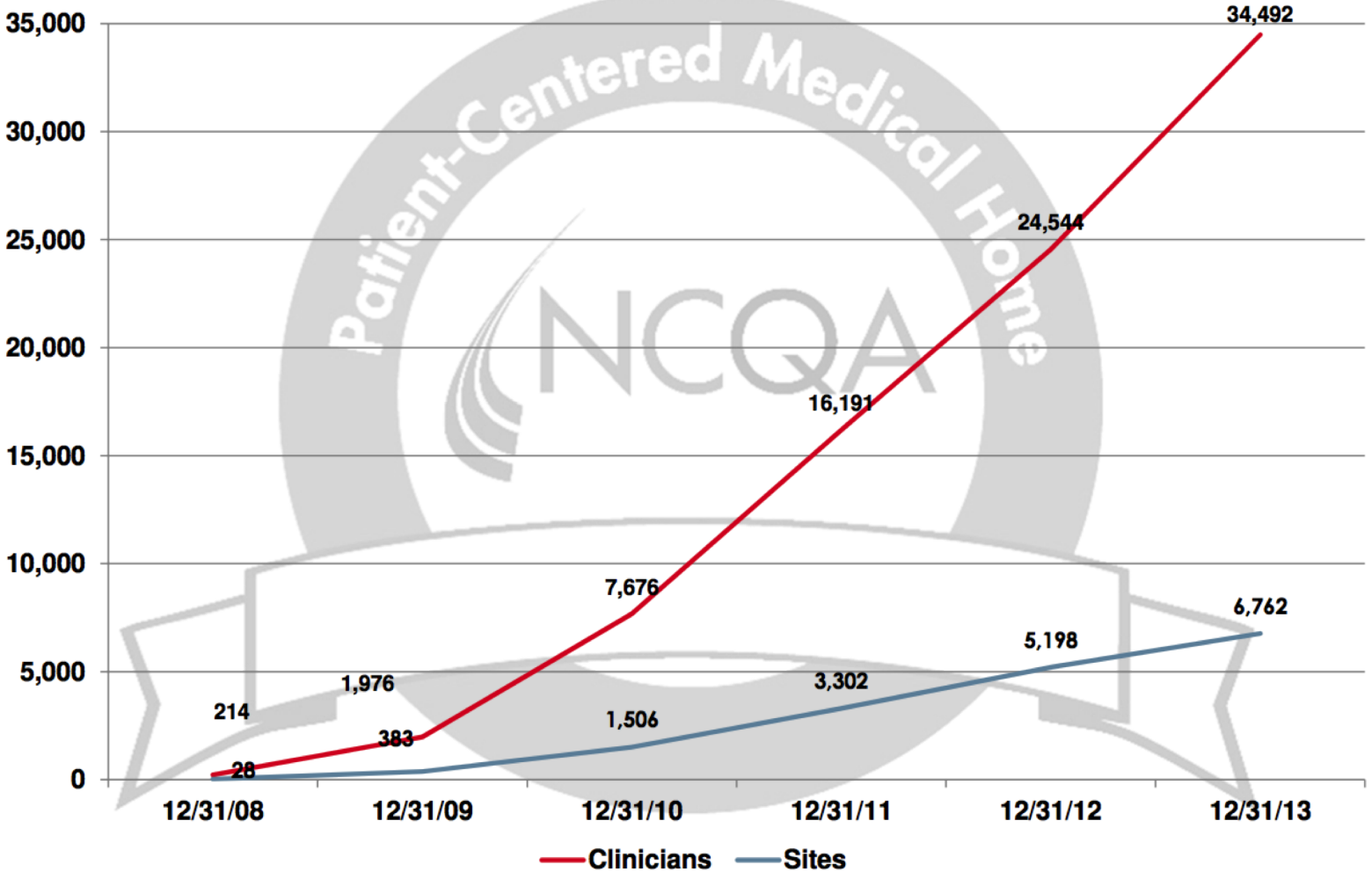
NCQA PCMH Growth



Source: Patricia Barrett Presentation @ Medical Home Summit, 3/17/14

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6 NCQA PCMH Standards

1. Enhance Access and Continuity (20 pts)
2. Identify and Manage Patient Populations (16 pts)
3. Plan and Manage Care (17 pts)
4. Provide Self-Care Support and Community Resources (9 pts)
5. Track and Coordinate Care (18 pts)
6. Measure and Improve Performance (20 pts)

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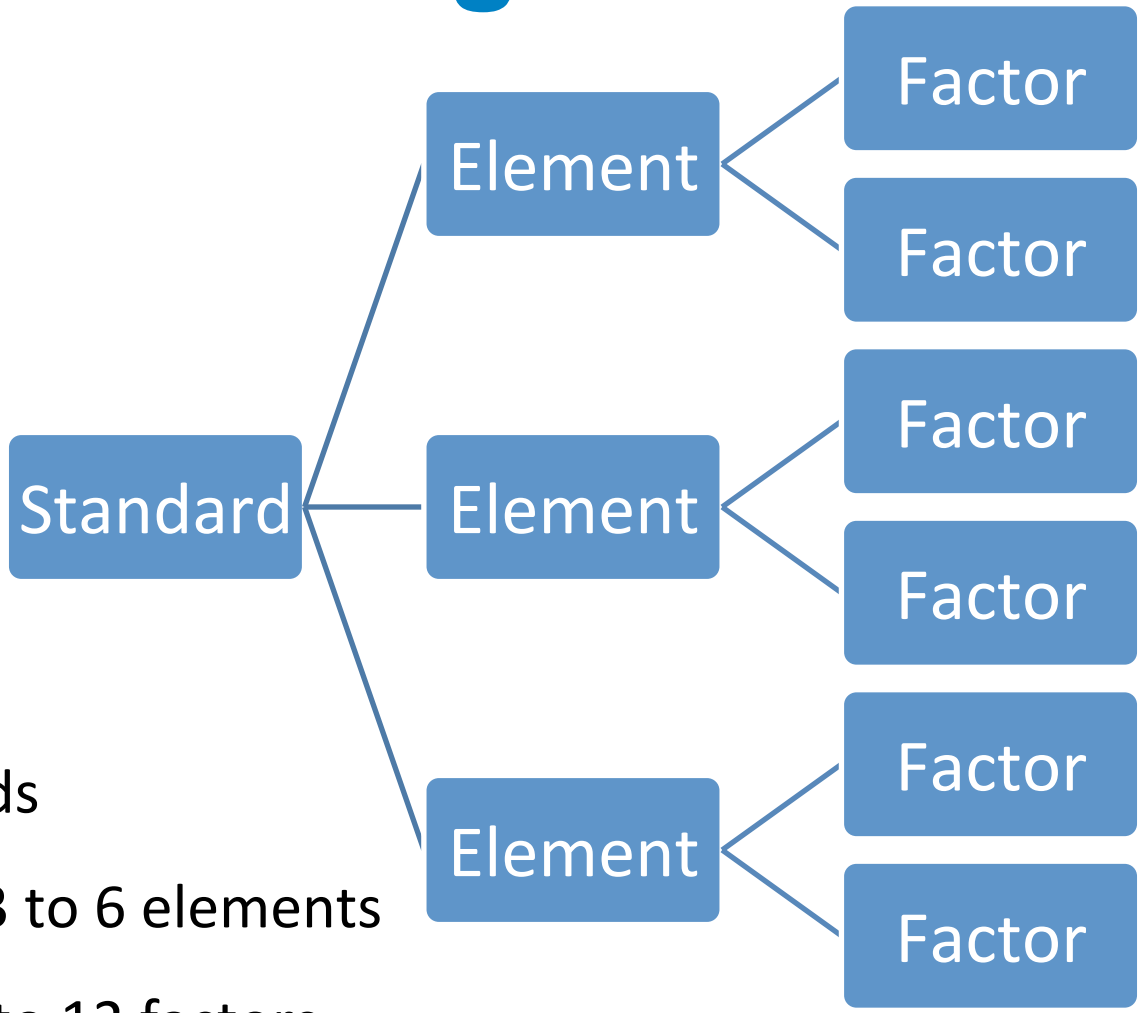
NCQA PCMH Lingo



There are 6 standards

Each Standard has 3 to 6 elements

Each Element has 2 to 12 factors

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PCMH Levels

Recognition Level	Required Points
Level 1	35 – 59 points
Level 2	60 – 84 points
Level 3	85 – 100 points

- Each of the standards has a Must-Pass element
- Passing the Must-Pass element is required for each level
- Score for each Must-Pass element must be ≥ 50%

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1. Enhance Access and Continuity (20 pts)

A. Access during office hours ***Must Pass***
B. After-hours access
C. Electronic access
D. Continuity
E. Medical home responsibilities
F. Culturally and linguistically appropriate services
G. Use a team to provide a range of patient care service

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2. Identify and Manage Patient Populations (16 pts)

A. Patient Information (Demographics)
B. Clinical Data (Meaningful Use Data)
C. Comprehensive Health Assessment
D. Use Data for Population Management *Must Pass*

3. Plan and Manage Care (17 pts)

A. Implement Evidence-Based Guidelines
B. Identify High-Risk Patients
C. Care Management—*Must Pass*
D. Medication Management
E. Use Electronic Prescribing

4. Provide Self-Care Support and Community Resources (9 pts)

A. Support Self-Care Process ***Must Pass***

B. Provide Referrals to Community Resources

5. Track and Coordinate Care (18 pts)

A. Test Tracking and Follow-Up
B. Referral Tracking and Follow-Up ***Must Pass***
C. Coordinate With Facilities and Manage Care Transitions

6. Measure and Improve Performance (20 pts)

A. Measure of Performance
B. Measure Patient/Family Experience
C. Implements Continuous Quality Improvement ***Must Pass***
D. Demonstrates Continuous Quality Improvement
E. Report Performance
F. Report Data Externally

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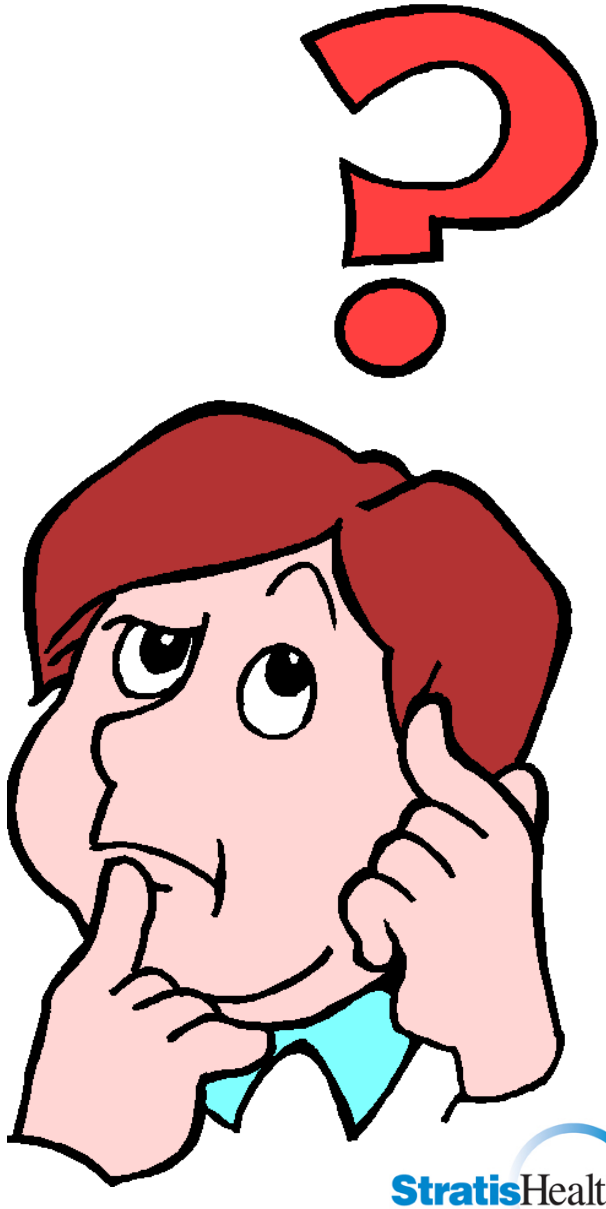
This seems so hard! Remind me why we want to do this?



Why? Because…

- PCMH improves health outcomes
- Enhances the patient and provider experience of care
- Reduces expensive, unnecessary hospital and emergency department utilization

Benefits of Implementing the PCMH: A Review of Cost & Quality Results, 2012
http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

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Benefits

- Alaskan Native Medical Center:
  - 50% reduction in urgent care and ER utilization
  - 53% reduction in hospital admissions
  - 65% reduction in specialist utilization

Reference: Asinof, R. (2012, May 28). A new model of health care. Retrieved June 14, 2012 from Providence Business News: http://www.pbn.com/A-new-model-of-health-care,67796

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Benefits

- Community Care of North Carolina (Medicaid) Improvements in asthma care
  - 21% increase in asthma staging
  - 23% lower ED utilization and costs
  - 25% lower outpatient care costs
  - 11% lower pharmacy costs
  - 112% increase in influenza inoculations

Reference: PRNewswire: http://www.marketwatch.com/story/blue-cross-and-blue-shield-companies-patient-centered-medical-home-programs-are-improving-the-practice-and-delivery-of-primary-care-in-communities-nationwide-2012-06-04

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Benefits

- Oklahoma Medicaid
  - Reduction from 1,670 to 13 patient inquiries related to same-day/next-day appointment availability
  - 8% increase in patients “always getting treatment quickly.”

Reference: Takach, Mary. (2011, July 7). Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results. Health Affairs, 30(7):1325-34.

Benefits

VALUE Partnerships
Improving Health Care in Michigan

- Blue Cross Blue Shield of Michigan

Metric	PCMH Designees Compared to Non-PCMH Practices		
Adults (18-64)	**2010 Data***	**2011 Data***	**2012 Data***
Emergency department visits (per 1,000)	**-9.7%**	**-9.3%**	**-8.8%**
Primary care sensitive emergency department visits (per 1,000)	**-11.2%**	**-11.3%**	**-11.2%**
Ambulatory care sensitive inpatient discharges (per 1,000)	**-22.1%**	**-23.8%**	**-19.1%**
High-tech radiology services (per 1,000)	**-7.5%**	**-8.3%**	**-7.3%**
High-tech radiology standard cost PMPM	**-5.0%**	**-4.3%**	**-3.1%**
Low-tech radiology services (per 1,000)	**-4.9%**	**-7.3%**	**-6.7%**
Low-tech radiology standard cost PMPM	**-5.1%**	**-7.4%**	**-5.6%**
Generic dispensing rate	**3.8%**	**3.0%**	**1.9%**

Source: Lisa Rajt Presentation @ Medical Home Summit, 3/17/14

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Benefits

- Minnesota
  - Improved measures of care related to cancer screening, asthma, diabetes, vascular care and depression
    - 20% Increase in asthma care measure
    - 8% increase in colorectal cancer screening
    - 4-8% higher for optimal vascular care
- Reduced Medicaid costs by 9%

Reference: *Evaluation Health Care Homes: 2010-2012,* Report to the Minnesota Legislature January 2014
http://www.health.state.mn.us/healthreform/homes/outcomes/documents/evaluationreports/evaluationhch20102012.pdf

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Where does one start?

- Start with a small team
- Evaluate the different options and choose the one that is best for you
- Complete a readiness assessment
- Enlist a clinical champion
- Start gradually tackle the items that are easy and have the most value
- Track and measure your results

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Successful PCMH

- Starts with strong leadership with a clear focus
- Frequently requires a culture change:
  - Focus on provider/patient relationship
  - Make the patient the center of care---Informed, engaged, empowered.
  - Provide accessible, comprehensive and continuous, quality (patient defined) care
  - Collect and report data that are meaningful to the patient
  - Continuously strive to improve and innovate
- Avoid a check-box mentality

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HEALTH REFORM

Actions to Build Capacity for the Triple Aim and Succeed in Multiple Payment Models

ACTIONS TO BUILD THE FOUNDATION	ACTIONS TO BUILD RELATIONSHIPS, MANAGE POPULATIONS AND ADD VALUE	OUTCOMES

- Provide Visionary Leadership and Promote a Learning Culture
- Embed Strong Organizational Change Skills Supported by Quality Improvement Methods
- Redesign Care to Consistently Use Evidence-based or Best Practices
- Establish an Enabling IT Platform with Interoperable EHR and Effective HIE

- Better Care
- Better Health
- Lower Cost

 Sources: *The Strategy that Will Fix Health Care,* Michael E. Porter and Thomas H. Lee, *Harvard Business Review,* October 2013. *The Chronic Care Model,* Edward H. Wagner.

Resources

- Iowa Association of Rural Health Clinics PCMH Resources
  - http://iarhc.org/home/patient_centered_medical_home_resources.php
- Benefits of a Patient Centered Medical Home, 2012 review:
  - http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home
- The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013, January 2014
  - http://www.pcpcc.org/resource/medical-homes-impact-cost-quality

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In Conclusion

- Being a PCMH has been demonstrated to:
  - Improve quality
  - Increase patient access
  - Reduce costs
  - Increase patient satisfaction
  - And succeed in keeping people healthier and out of acute settings
- Achieving certification is a challenge, but in today's environment will become a necessity
- Getting a head start, will put you in a better position in the future

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Contact Information:

Paul Kleeberg, MD, FAAFP, FHIMSS

Email: pkleeberg@stratishealth.org

Ph: 952-853-8552

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

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