Patient-Centered Medical Home

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Richard Lafleur, M.D., FACP
Why the Patient-Centered Medical Home?

- Gaps/variations in quality and safety and rising healthcare costs
  - Disparities in health and health care
- Current crisis in primary care recruitment and retention
- Aging population & increased prevalence of chronic diseases
- Current system emphasizes episodic treatment for acute care and more care, not better care; Capitation can lead to less care
- Need for patient-centered care which means:
  - Better coordination of care among providers
  - Continuity of care (whole person orientation)
  - Increased patient engagement
- Disease management as currently exists yielding mixed results; DM activities most successful when integrated with a physician practice
- Decreased patient, provider and employer satisfaction
Access to Primary Care Associated with...

Primary care is associated with higher quality more cost-efficient care

- 33% lower costs
- 19% less likely to die from their conditions compared to those who received care from a specialist
- Improved health outcomes for conditions like cancer, heart disease, stroke, infant mortality, low birth weight, life expectancy, and self-rated care
- Less likely to die prematurely
- Reduced socio-demographic and socio-economic disparities
- 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 3-10%
- In the United States, an increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons
- Recent Annals of Internal Medicine article documented better Quality measures with increased physician connectedness

Starfield, presentation to The Commonwealth Fund, Primary Care Roundtable: 2006
What is the Patient-Centered Medical Home

A primary care practice that provides patients with accessible, continuous & coordinated care through a patient-centered, physician-guided, cost-efficient & longitudinal approach to care

Joint Principals of the Patient Centered Medical Home (PC-MH):

- Each patient has an ongoing relationship with a **personal physician** trained to provide first contact, continuous and comprehensive care
- **Physician-directed medical practice** in which a team of individuals collectively take responsibility for ongoing care of patients
- **Whole-person orientation** of care for all stages of life
- Care is **coordinated and/or integrated** across all elements (practices, hospitals, nursing homes, consultants) of the health care system
- Use **evidence-based guidelines** in the treatment of chronic conditions, acute illness and injury, and the provision for preventive care
- Patients have **enhanced access** to care through systems such as open scheduling, expanded hours and new options for communication
- **Payment** appropriately recognizes the added value to patients who have a medical home
- **Quality and Safety** are hallmarks of the medical home

* Adopted by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and the American Osteopathic Association (AOA)
What the Patient-Centered Medical Home is NOT

- Reemergence of capitation
- Just another way to increase primary care reimbursement
- Panacea for rising healthcare costs
- Net increase of dollars into the health care system
Background

• Section 204 of the Tax Relief and Health Care Act of 2006 requires the Secretary to establish a demonstration “…to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high need populations…”.

• 3-year demonstration providing reimbursement in the form of a care management fee to physician practices for the services of a “personal physician.” The legislation directs CMS to use the relative values scale update committee (RUC) process to establish the care management fee codes for care management fees.

• “High need” patients include those with prolonged or chronic illnesses that require regular medical monitoring, advising, or treatment.
Broad National Spectrum of PC-MH Pilots

- Need for Compassion, Support and Education along the Continuum
- Evaluate Level of “Medical Homeness”
- Transformation Pilots
- Incentives for Increased Medical Home Functionality

NCQA PCMH-PPC
- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management Support
- Test Tracking and Follow-up
- Referral Tracking
- Performance Reporting and Improvement
- Electronic Prescribing
- Advanced Electronic Communication

Anthem
Pilot Decisions

Selection Criteria
- Geographic Diversity
- Demonstrated Medical Home Readiness
  - Able to reach NCQA Level-1
- Patient Panel Composition
- Organizational Commitment
Conclusion

• Pilot Results To Help Guide Local And National Health System Changes

• Value Proposition Based On Above Results To Lead To Future Pilots
  – Targeting Transformation Of Practices To PCMH
  – Implementation Of EHR
Questions

For More Information or a copy of the Joint Principles of the Patient-Centered Medical Home:

• American Academy of Family Physicians
  http://www.futurefamilymed.org

• American Academy of Pediatrics:
  http://aappolicy.aappublications.org/policy_statement/index.ctl#M

• American College of Physicians
  http://www.acponline.org/advocacy/?hp

• American Osteopathic Association
  http://www.osteopathic.org