Patient-Centered Medical Home

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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

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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**

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Starfield B. et al. Health Aff (Millwood). 2001.
Starfield B. et al: Millbank Quarterly, 2005.
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

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* 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 heath care costs**
- **Net increase of dollars into the health care system**

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Medicare Medical Home Demonstration

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.

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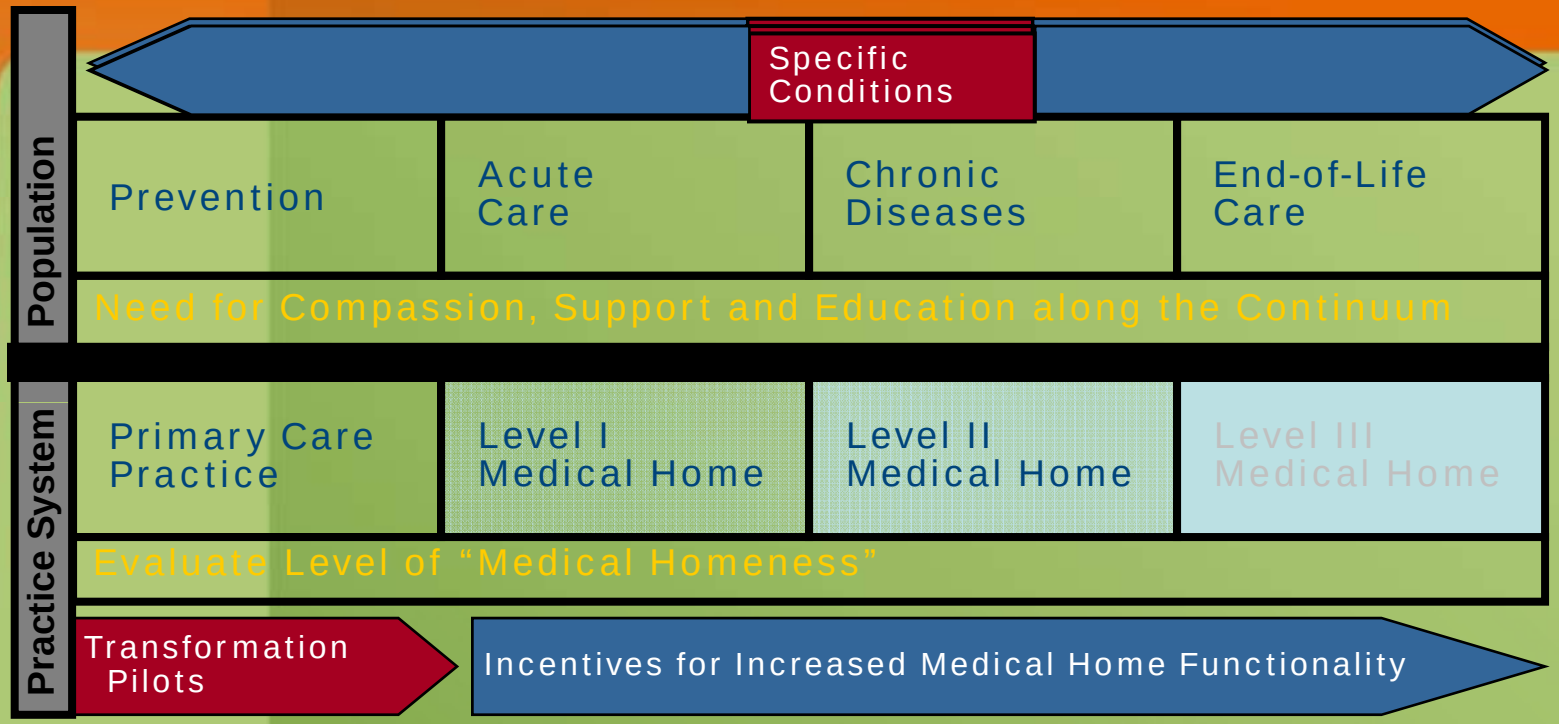
Broad National Spectrum of PC-MH Pilots



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

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Pilot Decisions

Selection Criteria

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

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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

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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.dtl#M
- American College of Physicians http://www.acponline.org/advocacy/?hp
- American Osteopathic Association http://www.osteopathic.org

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