The Patient-Centered Medical Home: Reorganizing the Delivery System for High Performance

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Five Key Strategies for High Performance

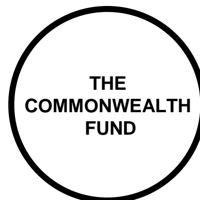
1. Extending affordable health insurance to all
2. Organizing care to ensure accessible, patient-centered, coordinated care
3. Aligning financial incentives to enhance value and achieve savings
4. Meeting and raising benchmarks for high-quality, efficient care
5. Ensuring accountable national leadership and public/private collaboration

Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007

The Patient-Centered Medical Home:
Joint Principles Endorsed by Four Primary Care Specialty Societies

- Personal Physician
- Whole person orientation
- Coordinated and integrated care
- Safe and high-quality care (e.g., evidenced-based medicine, appropriate use of HIT, continuous QI)
- Enhanced access to care
- Payment that recognizes the added value provided to patients who have a patient-centered medical home

ACP, AAFP, AAP and AOA. Joint Principals of the Patient-Centered Medical Home, March 2007.



National Measures to Qualify Medical Homes Exist: Physician Practice Connections (PCMH)

Practice must demonstrate proficiency in at least five areas to qualify as PCMH, such as:

- Written standards for patient access and patient communication; use of data to show meeting this standard
- Use of paper or electronic-based charting tools to organize clinical information
- Use of data to identify important diagnoses and conditions in practice
- Adoption and implementation of evidence-based guidelines for three conditions
- Active support of patient self-management
- Tracking system to test and identify abnormal results
- Tracking referrals with paper-based or electronic system
- Measurement and reporting of clinical and/or service performance by physician or across the practice

Source: National Committee for Quality Assurance, Measures for Patient-Centered Medical Home, 2007.

Adults with an Accessible Primary Care Provider

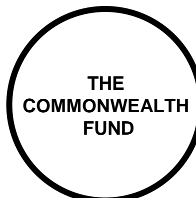
Percent of adults ages 19–64 with an accessible primary care provider*

	Percent
U.S. Average	
2002	66
2005	65
U.S. Variation 2005	
White	69
Black	59
Hispanic	49
400%+ of poverty	73
200–399% of poverty	63
<200% of poverty	53
Insured all year	74
Uninsured part year	51
Uninsured all year	37

Axis: 0, 20, 40, 60, 80, 100

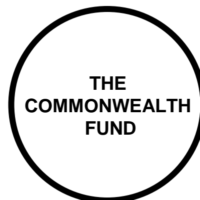
* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, and referrals, and who is easy to get to
Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

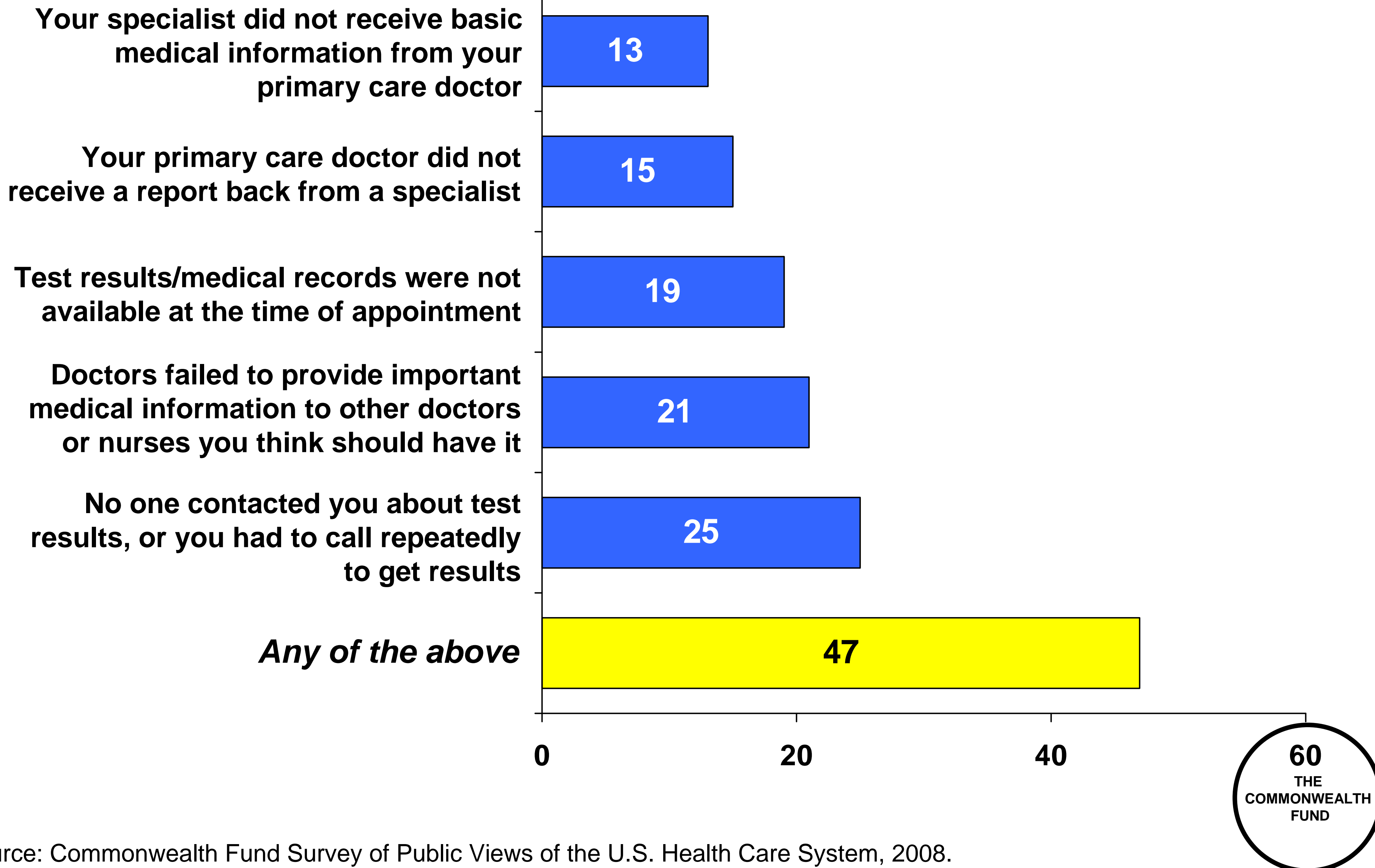


Why the U.S. Needs to Reform the Delivery System to Improve Accessibility and Accountability of Primary Care

1. Patients are frustrated with the lack of coordination in our fragmented health system
2. No one is accountable for ensuring that patients receive recommended preventive care and that patient conditions are controlled
3. Patients report use of emergency rooms that could have been avoided if personal physician had been available
4. Wide variability in cost of caring for patients with chronic conditions across the U.S.



Poor Coordination: Nearly Half Report Failures to Coordinate Care



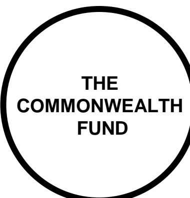
Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Coordination: Medical Records Not Available During Visit or Duplicative Tests, by Medical Home

Percent of adults reporting

	AUS	CAN	GER	NETH	NZ	UK	US
Has medical home	11	10	16	8	8	7	16
No medical home	27	19	23	11	18	19	29

Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
Source: 2007 Commonwealth Fund International Health Policy Survey.
Data collection: Harris Interactive, Inc.



Receipt of Recommended Screening and Preventive Care for Adults

Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex*

U.S. Average

2002 49

2005 50

U.S. Variation 2005

400%+ of poverty 58

200–399% of poverty 47

<200% of poverty 39

Insured all year 53

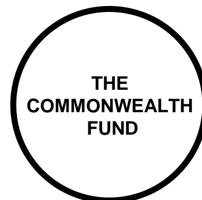
Uninsured part year 46

Uninsured all year 32

0 20 40 60 80 100

* Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot.
Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

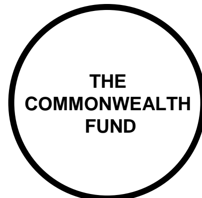


Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

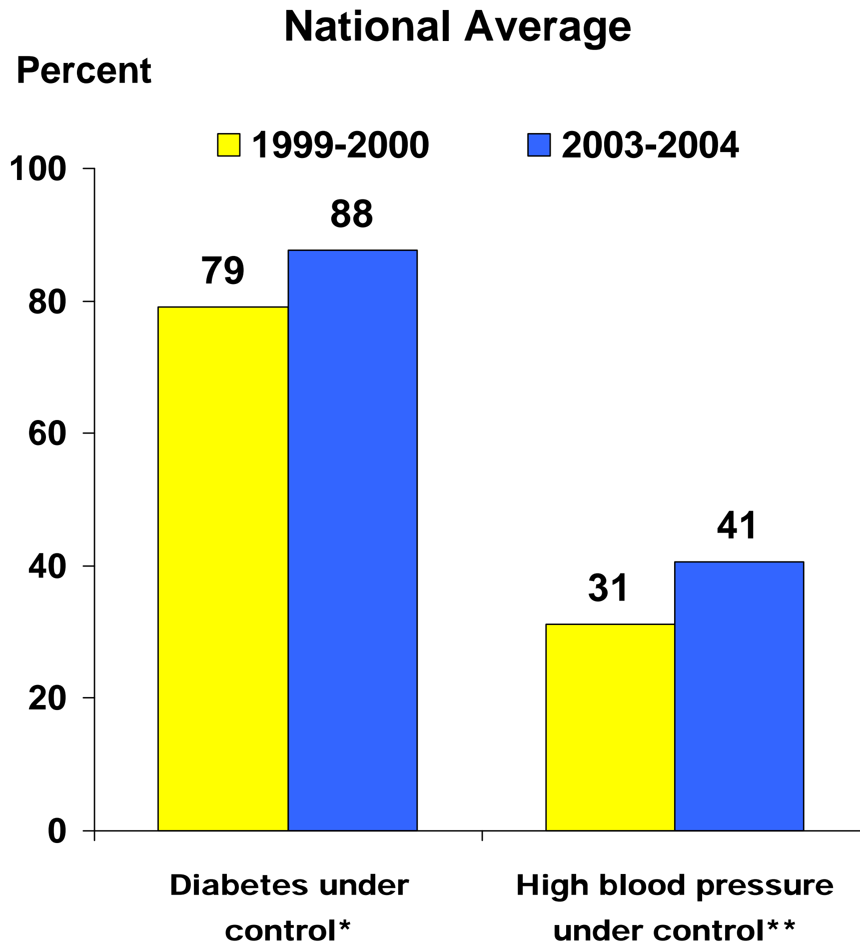
Percent of adults 18–64 reporting always getting care they need when they need it

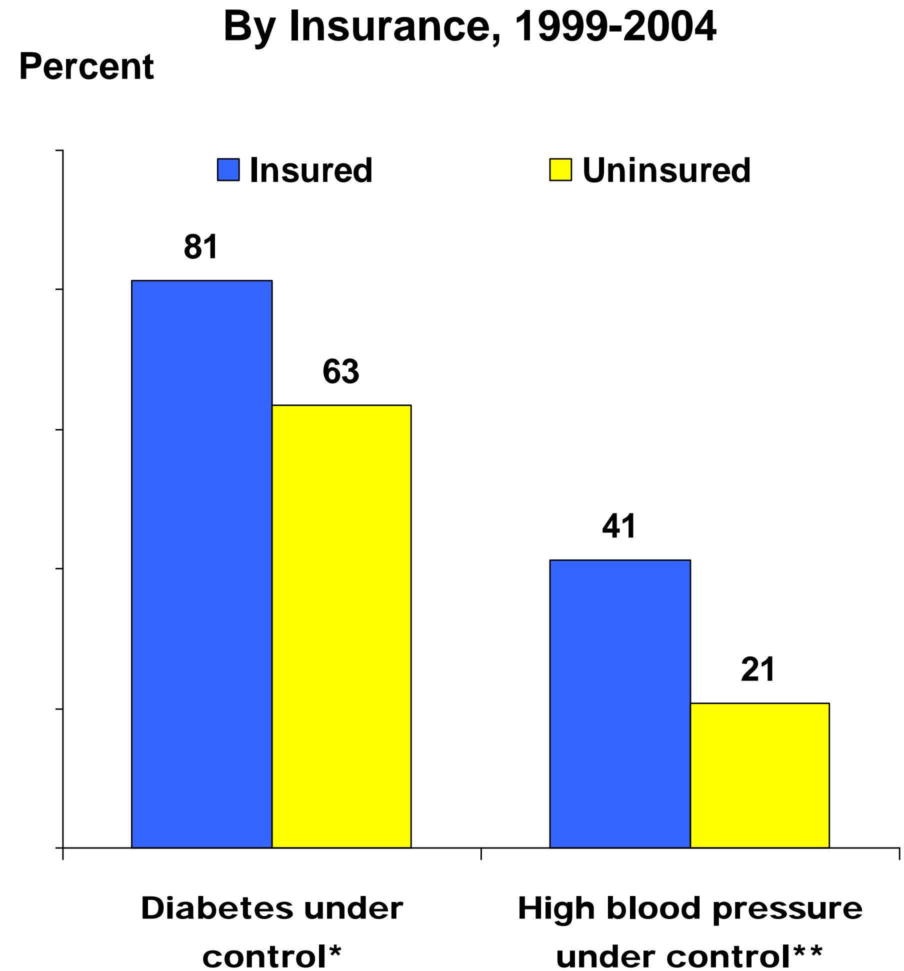
	Medical Home	Regular source of care, not a medical home	No regular source of care/ER
Total	74	52	38
White	74	53	44
African American	76	52	31
Hispanic	74	50	34

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.



Chronic Disease Under Control: Diabetes and Hypertension

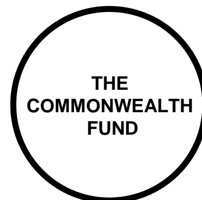




*Refers to diabetic adults whose HbA1c is <9.0 **Refers to hypertensive adults whose blood pressure is <140/90 mmHg.

Data: J. McWilliams, Harvard University analysis of National Health and Nutrition Examination Survey

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

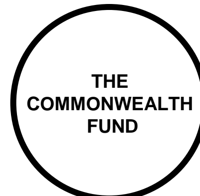


Costs of Care for Medicare Beneficiaries with Multiple Chronic Conditions, by Hospital Referral Regions, 2001 and 2005

		Average annual reimbursement					Ratio of percentile groups	
		Average	10th percentile	25th percentile	75th percentile	90th percentile	90th to 10th	75th to 25th
All 3 conditions (Diabetes + CHF + COPD)								
	2001	**$31,792**	**$20,960**	**$23,973**	**$37,879**	**$43,973**	**2.10**	**1.58**
	2005	**$38,004**	**$25,732**	**$29,936**	**$44,216**	**$53,019**	**2.06**	**1.48**
Diabetes + CHF								
	2001	**$18,461**	**$12,747**	**$14,355**	**$20,592**	**$27,310**	**2.14**	**1.43**
	2005	**$23,056**	**$16,144**	**$18,649**	**$26,035**	**$32,199**	**1.99**	**1.40**
Diabetes + COPD								
	2001	**$13,188**	**$8,872**	**$10,304**	**$15,246**	**$18,024**	**2.03**	**1.48**
	2005	**$15,367**	**$11,317**	**$12,665**	**$17,180**	**$20,062**	**1.77**	**1.36**
CHF + COPD								
	2001	**$22,415**	**$15,355**	**$17,312**	**$25,023**	**$32,732**	**2.13**	**1.45**
	2004	**$27,498**	**$19,787**	**$22,044**	**$31,709**	**$37,450**	**1.89**	**1.44**

CHF = Congestive heart failure; COPD = Chronic obstructive pulmonary disease.
Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

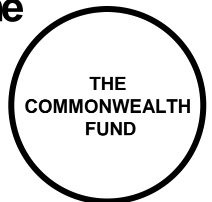


Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control

Percent of adults 18–64 with high blood pressure

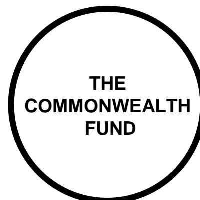
	Total	Medical home	Regular source of care, not a medical home
Does not check BP	56	48	58
Checks BP, not controlled	15	10	17
Checks BP, controlled	29	42	25

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.



Patient-Centered Medical Homes:

Demonstration Projects



Overview of Current Pilot Activity and Planning Discussions of the PCMH (as of July 2008)

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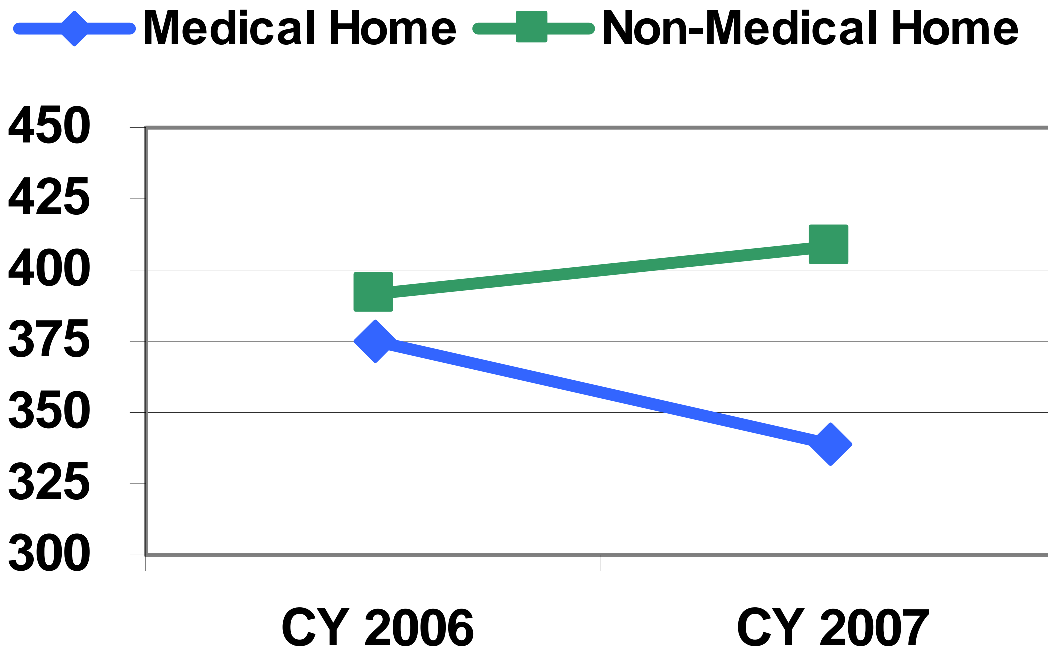
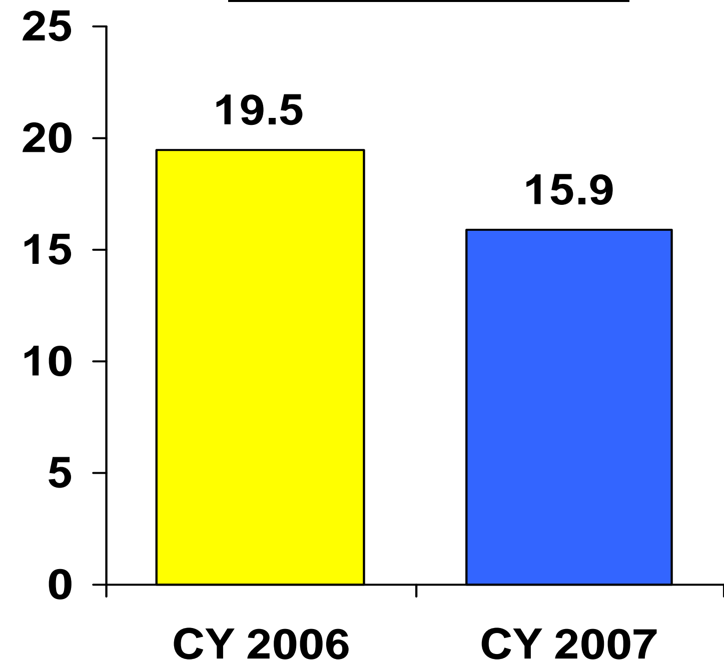
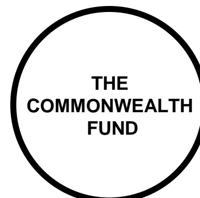
Source: Patient-Centered Primary Care Collaborative, July 16, 2008.

Geisinger Medical Home Sites and Hospital Admissions/ Readmissions



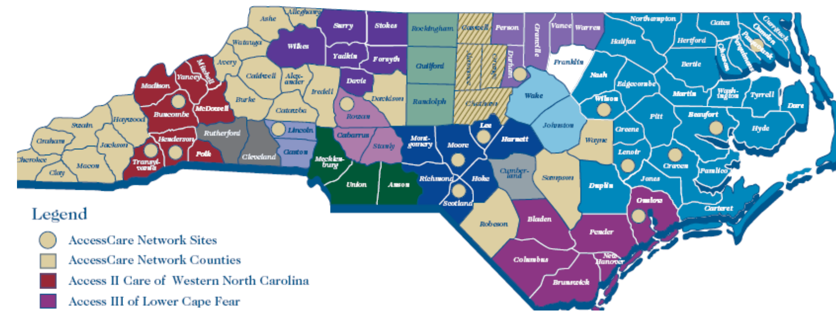


- 20% reduction in hospital admissions
- 18.5% reduction in hospital readmissions
- 7% total medical cost savings



Source: Geisinger Health System, 2008.

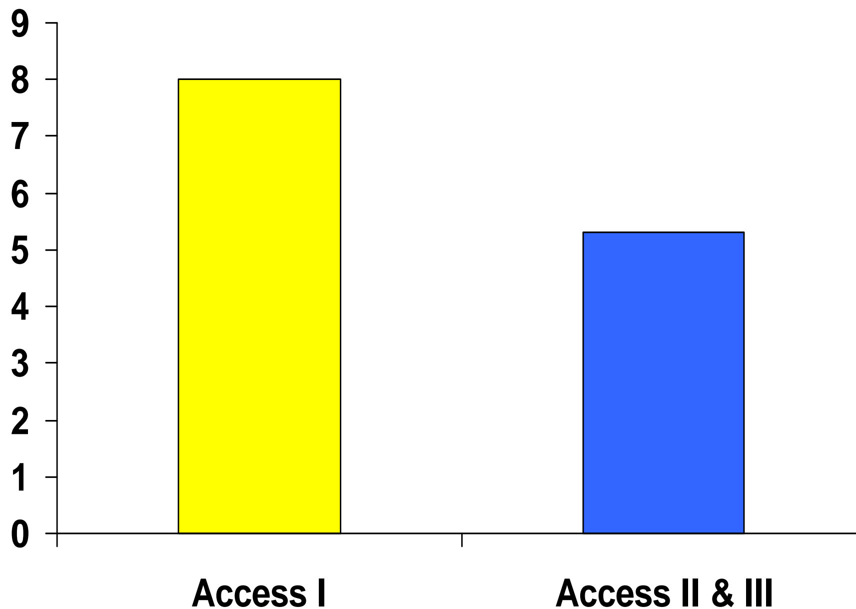
Community Care of North Carolina: Medicaid



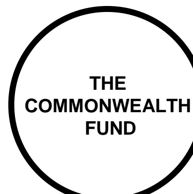
Asthma Initiative: Pediatric Asthma Hospitalization rates

(April 2000 – December 2002)

In patient admission rate per 1000 member months

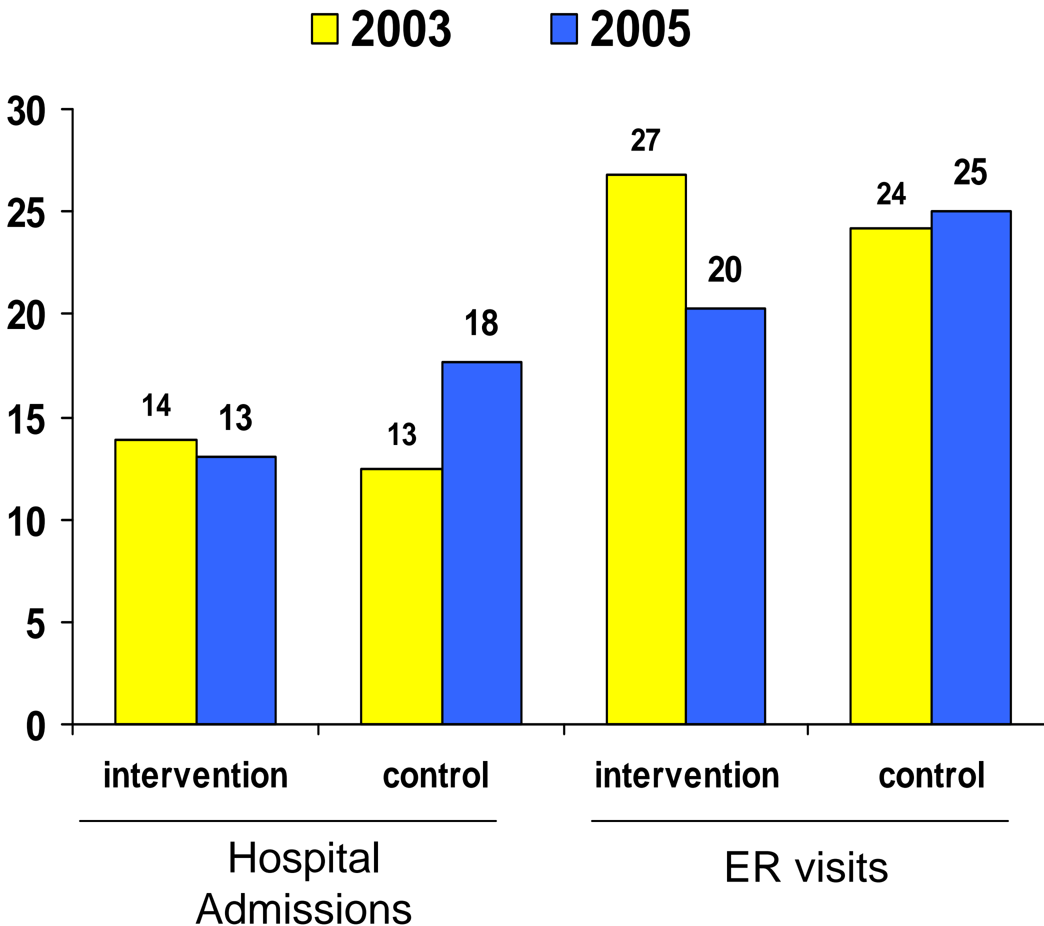


- 14 networks, > 3,200 MDs, >800,000 patients
- $3 PMPM to each network
- Hire case managers/medical management staff
- $2.50 PMPM to each PCP to serve as medical home and participate in disease management
- Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more!
- Case management: identify and facilitate management of costly patients
- Cost savings analysis (per Mercer):
  - FY2003: $60 million
  - FY2004: $124 million
  - FY2005: $77-85 million
  - FY2006: $154-170 million



Source: L. Allen Dobson, MD, presentation to ERISA Industry Committee, Washington, DC, March 12, 2007

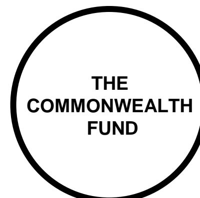
North Dakota's Experience: Results from MeritCare and BCBS-ND



- Pilot program – linked patients with a chronic disease management (CDM) nurse stationed in primary care clinic. Physicians referred patients with diabetes to CDM nurse who set goals for diabetes self-management, followed-up with patient and made other referrals.
- Hospital admissions decreased by 6% and ER visits decreased by 24% within the intervention group from 2003 to 2005 (graph)
- In 2005, total costs / member / year were $530 lower than expected, <u>saving an estimated $102,000 for 192 patients in the pilot.</u>

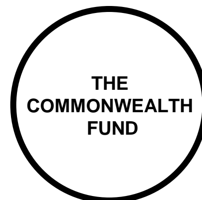
Source: D. McCarthy, R. Nuzum, and S. Mika, et al, The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation, The Commonwealth Fund, May 2008

Policies Required to Spread Patient-Centered Medical Homes



Strategies to Spread Adoption of Patient-centered Medical Homes

1. Certification of primary care practices as patient-centered medical homes
2. Incentives for enrollee designation of medical homes
3. New payment methods for patient-centered medical homes
4. Support patient-centered medical homes within actual or virtual organized care system
   - Assist with adoption of health information technology and health information exchange
   - Provide technical assistance to create high-quality patient-centered medical homes
   - Quality improvement unit for data feedback, reporting, and improvement



Bridges to Excellence Medical Home Payment Initiative

- A multi-state, multiple employer initiative which gives primary care physicians $125/patient covered by participating employer for providing "medical homes"
- Participants include large employers (Ford, GE, Humana, P&G, UPS, and Verizon), health plans, NCQA, MEDSTAT and WebMD, among others
- Medical home metrics include: follow-up on referrals to other MDs, systematically tracking tests, flagging abnormal results in a standardized way, and adhering to medical guidelines to monitor and treat chronic conditions like diabetes and hypertension.
- Improvements in quality is estimated to save $250-$300 per patient in the first year

Source: V. Fuhrmans, "Group offers doctors bonuses for better care," Wall Street Journal, January 31, 2008

Organization and Payment Are Interrelated: Need Incentives for Organized Care

Continuum of Payment Bundling (vertical axis, left, bottom to top):
- FFS and DRGs
- Blended FFS and medical home fees
- Global primary care fees
- Global ambulatory care fees
- Global DRG fee: hospital only
- Global DRG fee: hospital, post-acute, and physician inpatient
- Integrated system capitation

Continuum of P4P Design (vertical axis, right, bottom to top):
- Preventive care; management of chronic conditions measures; small % of total payment
- Care coordination and intermediate outcome measures; moderate % of total payment
- Outcome measures; large % of total payment

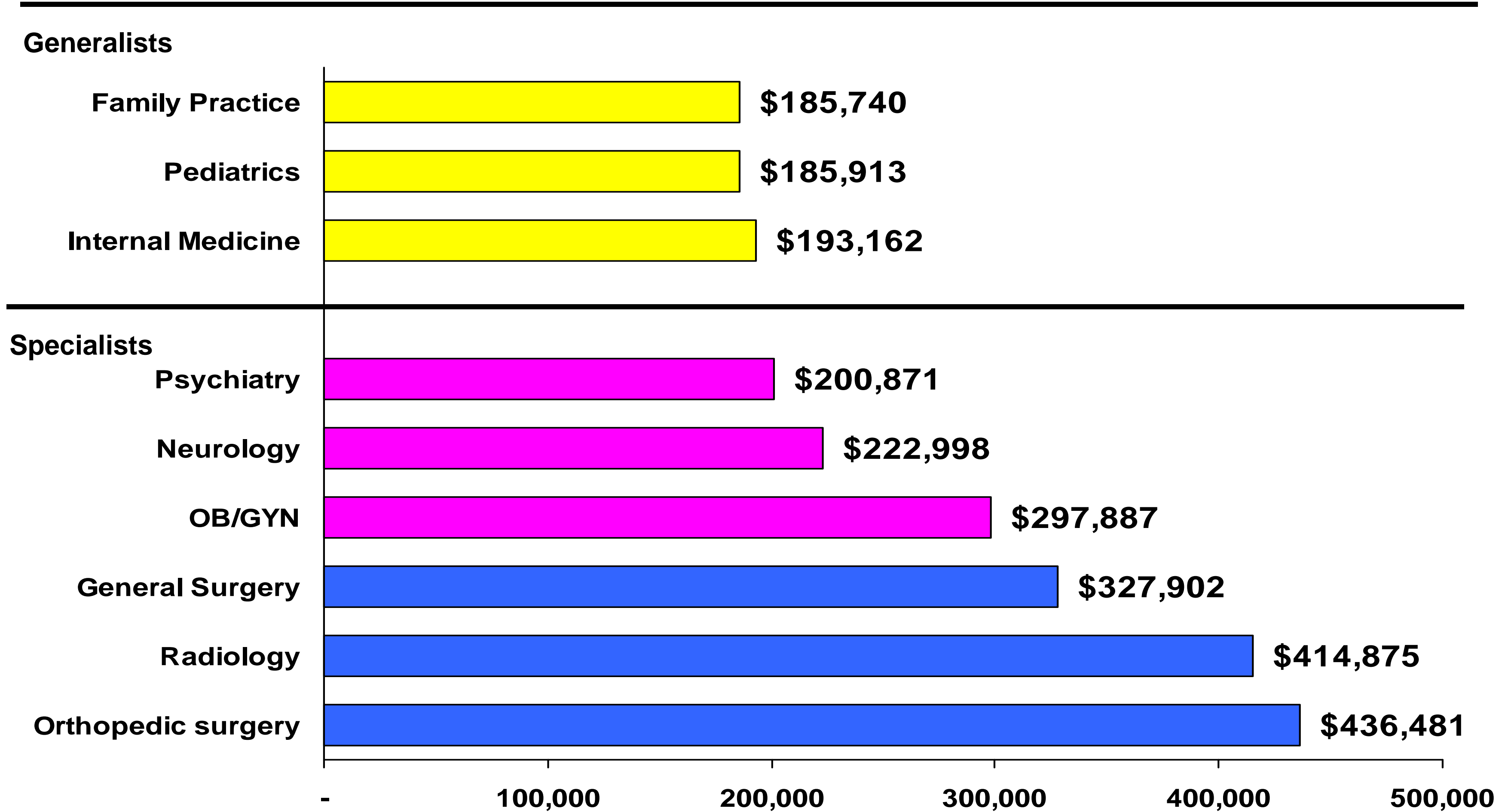
Horizontal axis (left to right):
- Small MD practice; unrelated hospitals
- Primary care MD group practice
- Multi-specialty MD group practice
- Hospital System
- Integrated Delivery System

Less Feasible

More Feasible

Source: A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance*, The Commonwealth Fund, August 2008

Primary Care is Undercompensated Relative to Specialty Care (2007)



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Source: AMGA data, reported in JAMA

Agenda for Change

- The U.S. has an historic opportunity to adopt reforms that will achieve a high performance health system
- The key ingredient is instituting a reform proposal that will ensure quality, affordable health insurance for all
  - The U.S. has a path towards expansion of health insurance to all
- Coverage for all must be pursued *simultaneously* with comprehensive reforms in cost, quality and access
  - Payment reform to encourage integrated health care organizations and other providers to be accountable for results and resources
  - Rewarding primary care and patient-centered medical homes
  - Instituting a global fee covering hospital, physician, and other services including 30-day follow-up for acute episodes of care
  - Incentives for adoption of information technology
  - Information on comparative effectiveness and evidence-based medicine

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Thank You!

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