Healthcare Delivery Redesign: The Patient-Centered Medical Home & Payment Models to Support Innovation

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The Case for Health Care Reform

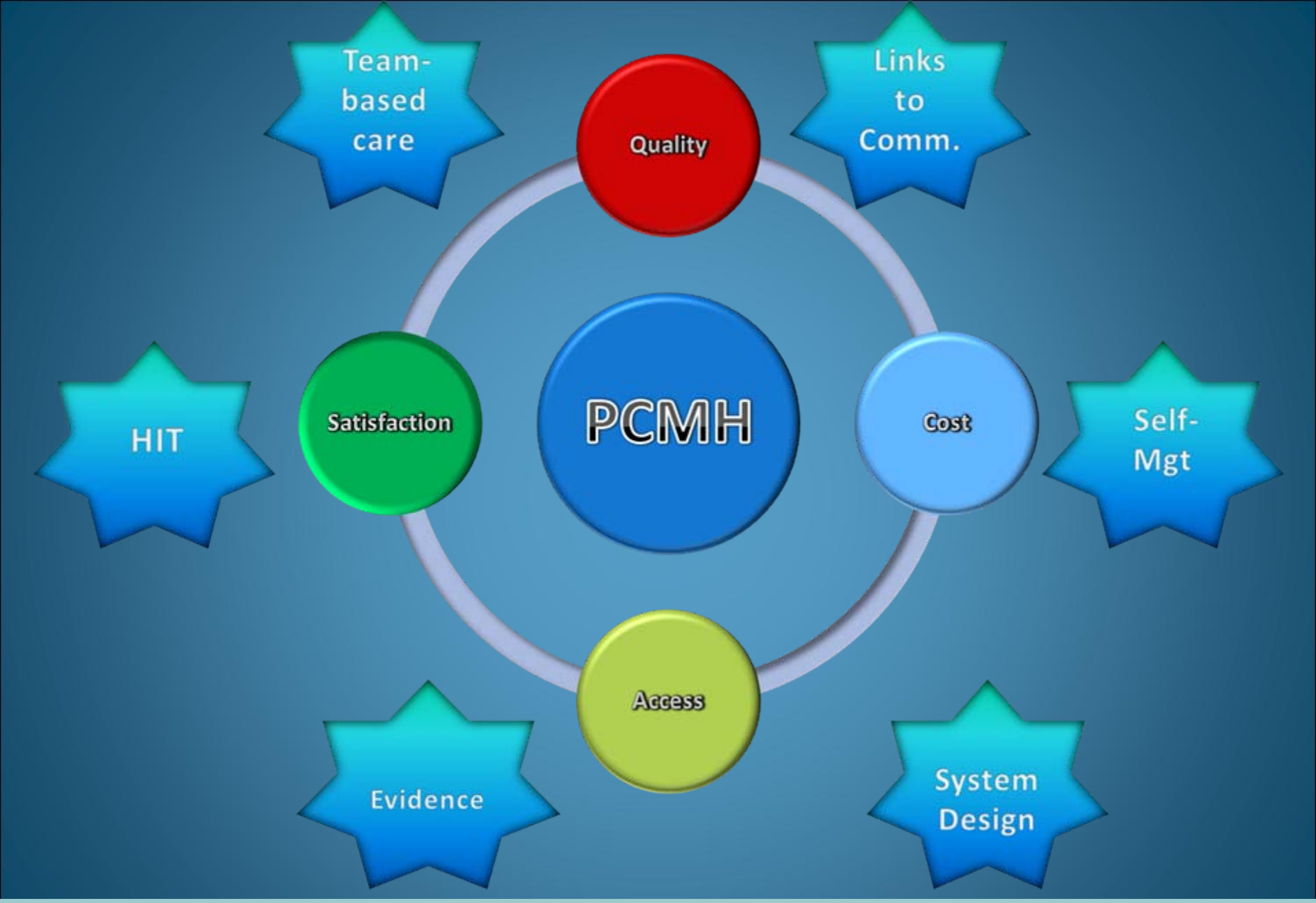
- Poor access to care, especially for the uninsured
- Escalating costs & volume of services
- No link between cost and quality
- Excessive administrative costs
- Dysfunctional payment system
- United States is lagging internationally
- Impending "collapse" of primary care

What is the Patient-Centered Medical Home?

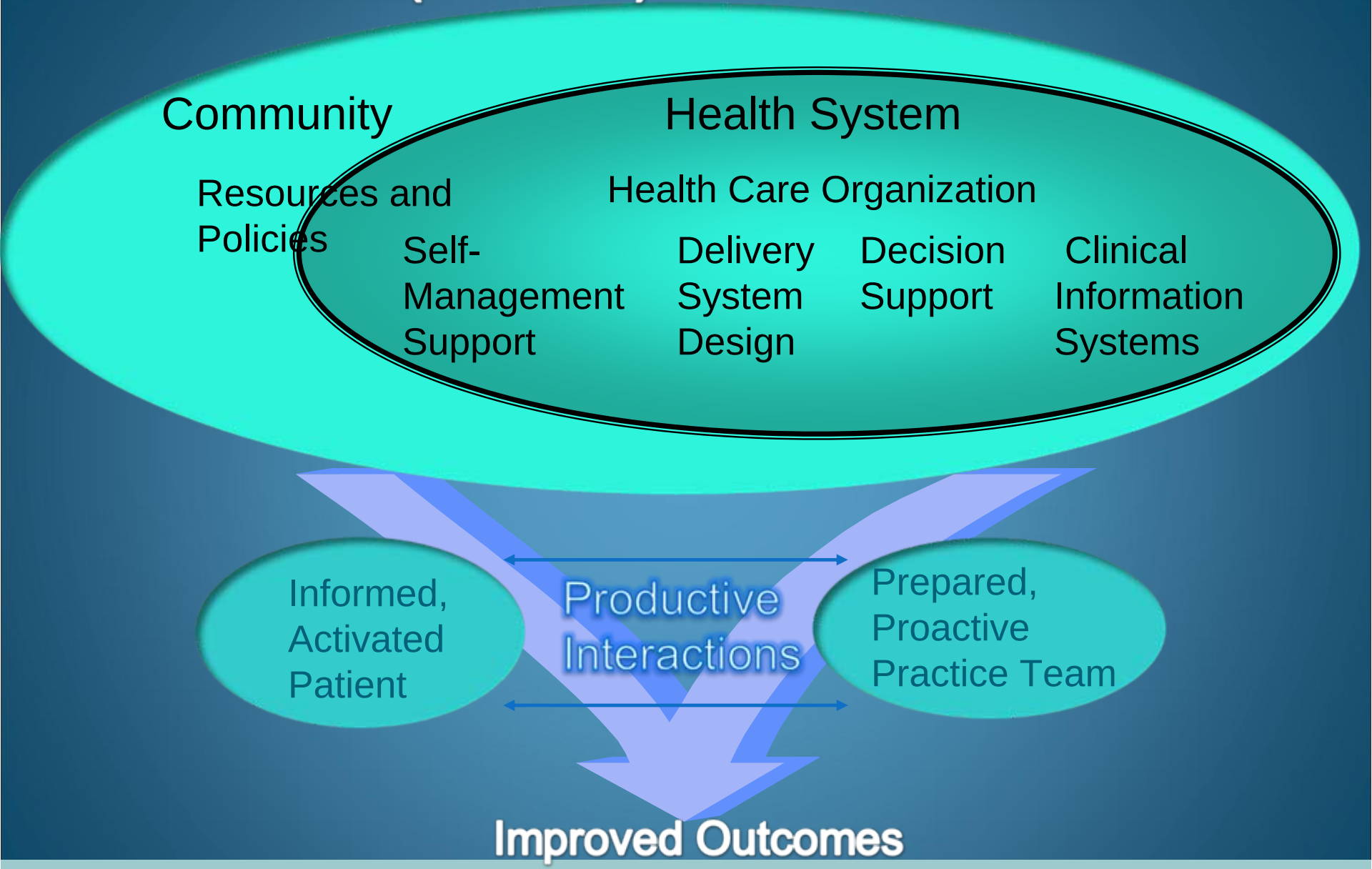
- …a vision of health care as it should be
- …a framework for organizing systems of care at both the micro (practice) and macro (society) level
- …a model to test, improve, and validate
- …part of the health care reform agenda

"PCMH" is a Term…

- …to describe a pathway to excellent health care
- …to re-claim a role as advocates for our patients (with our patients & their families)
- …to encourage team-based care
- …to create educational opportunities
- …to attract medical students and residents to primary care


Team-based care
Quality
Links to Comm.
HIT
Satisfaction
PCMH
Cost
Self-Mgt
Access
Evidence
System Design

(Chronic) Care Model



http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998: 1:2-4.

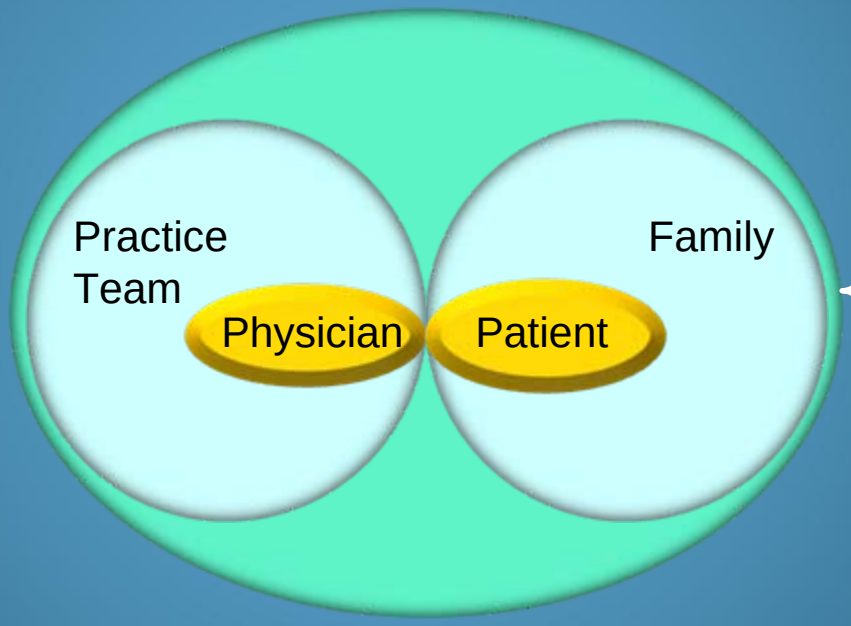
The Joint Principles of the PCMH

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access to care
- Payment to support the PCMH

Team-based care:
NP/PA
RN/LPN
Medical Assistant
Office Staff
Care Coordinator
Nutritionist/Educator
Pharmacist
Behavioral Health
Case Manager
Social Worker
Community resources
DM companies
Others…

Core of Team-Based Care

- NP/PA
- RN/LPN
- Medical Assistant
- Office Staff
- Care Coordinator
- Nutritionist/Educator
- Pharmacist
- Behavioral Health
- Case Manager
- Social Worker
- Community resources
- DM companies
- Others…



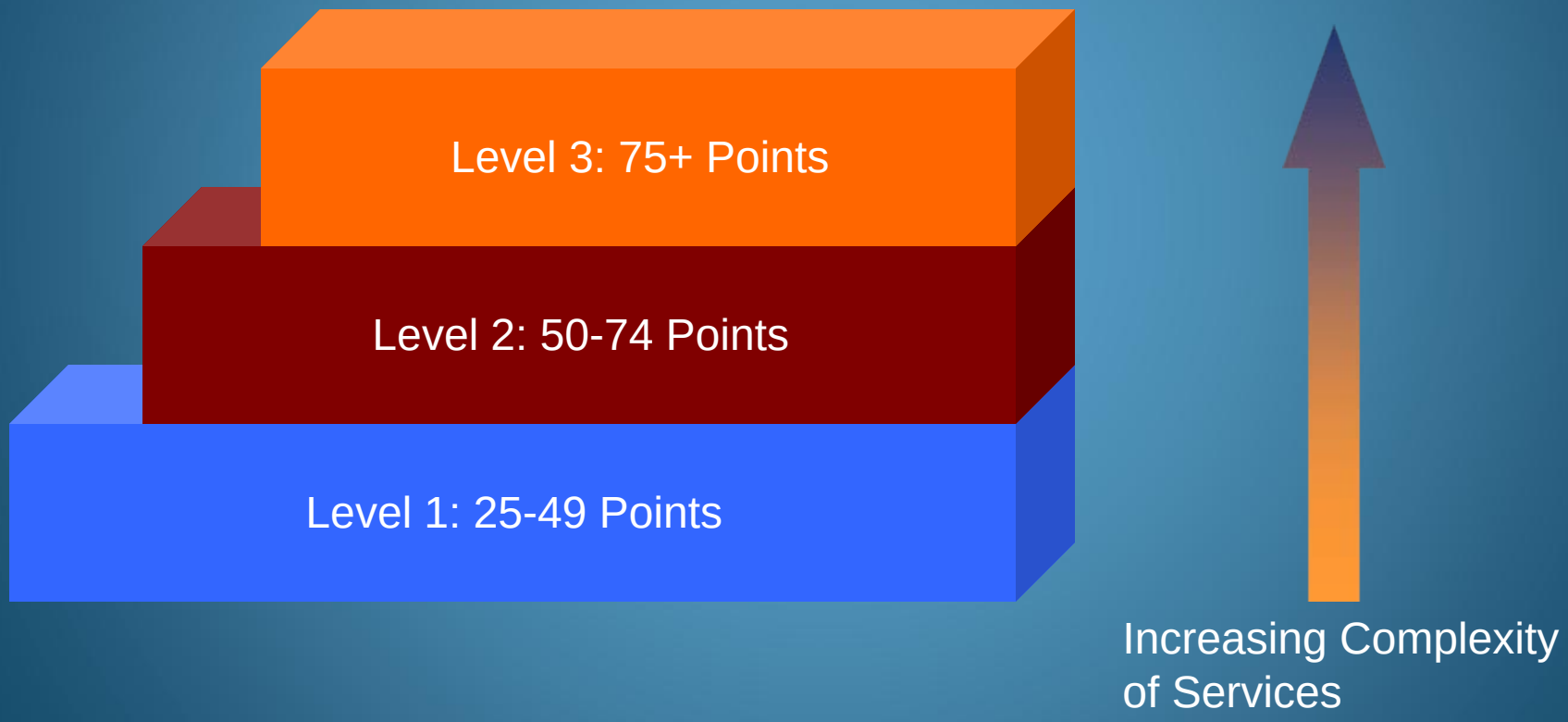
- Caregivers
- Immediate family
- Extended family
- Friends
- Neighbors

Adapted from:
Defining Primary Care: An Interim Report, Institute of Medicine 1994

NCQA: Physician Practice Connections/PCMH

1. Access & Communication
2. Patient Tracking & Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting & Improvement
9. Advanced Electronic Communication

Stepping Up to Excellence



Level 1: 25-49 Points

- Demonstrates timely access and communication processes
- Organizes charts (paper or electronic) to facilitate team-based care and tracking age-appropriate and condition-specific interventions
- Identifies key clinical conditions among population served & follows evidence-based guidelines
- Encourages and provides support for patient/family self-management
- Addresses health literacy issues
- Tracks tests & referrals to assure completion
- Collects and reports on quality & satisfaction data to practice

Key Points for Level 1 PCMH

- Does not require electronic health record
- Will require registry & tracking functions
- Emphasis is on providing better care through:
  - Access to care
  - Organization of office structure & processes
  - Enhancing patient self-management; addressing health literacy issues
  - Introduction of evidence-based guidelines, measurement & quality improvement

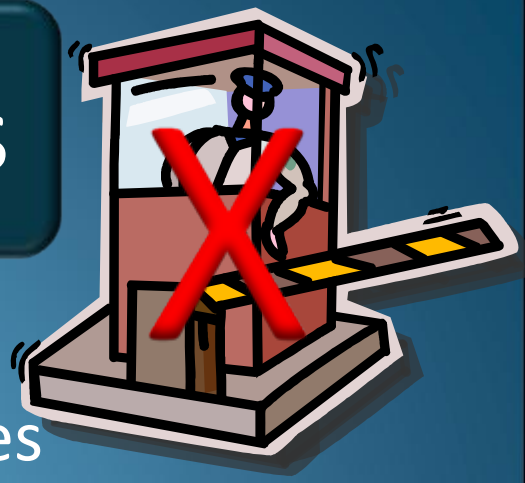
Level 2 → Level 3

- Advanced access options for patients
- Electronic health record
- More, and more complex care coordination and patient support
- Robust population management
- Advanced reporting and quality improvement initiatives
- Additional technology solutions

More Features of a PCMH Practice

- Uses each team member to highest capability
- Supports cultural competency training
- Understands health literacy
- Establishes connections to the community and available resources
- Provides extensive self-management support
- Engages a Patient/Family Advisory Group

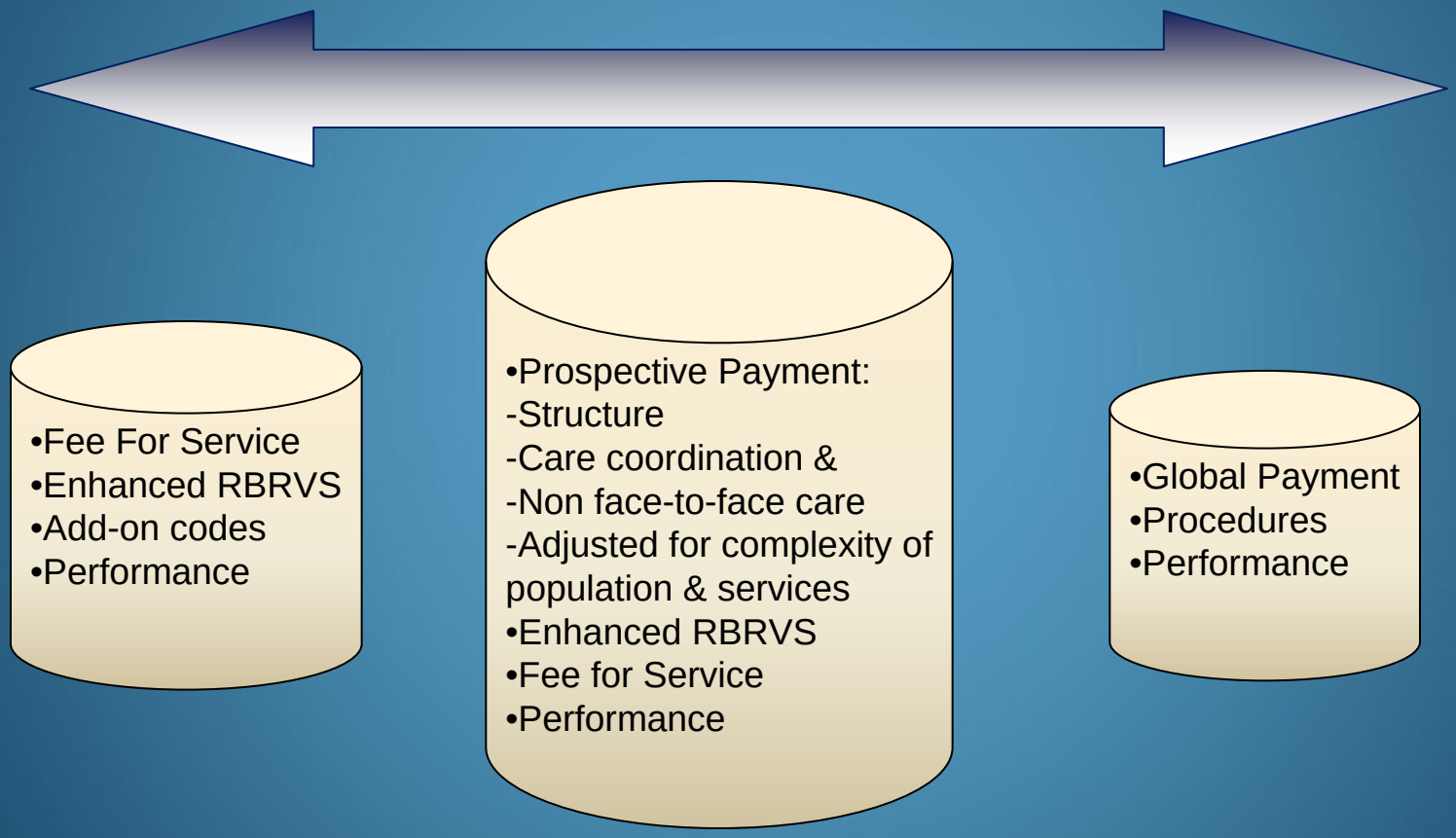
Specialty Care Connections



- PCMH is NOT a gatekeeper system
- Jointly develop/identify referral guidelines
- Emphasis on transitions in care & continuity
  - Referral agreements
  - Care transitions programs
- Some subspecialists may want to qualify as PCMH
- ACP in discussions with several groups regarding the PCMH model and primary care/specialty care interface (sharing care)

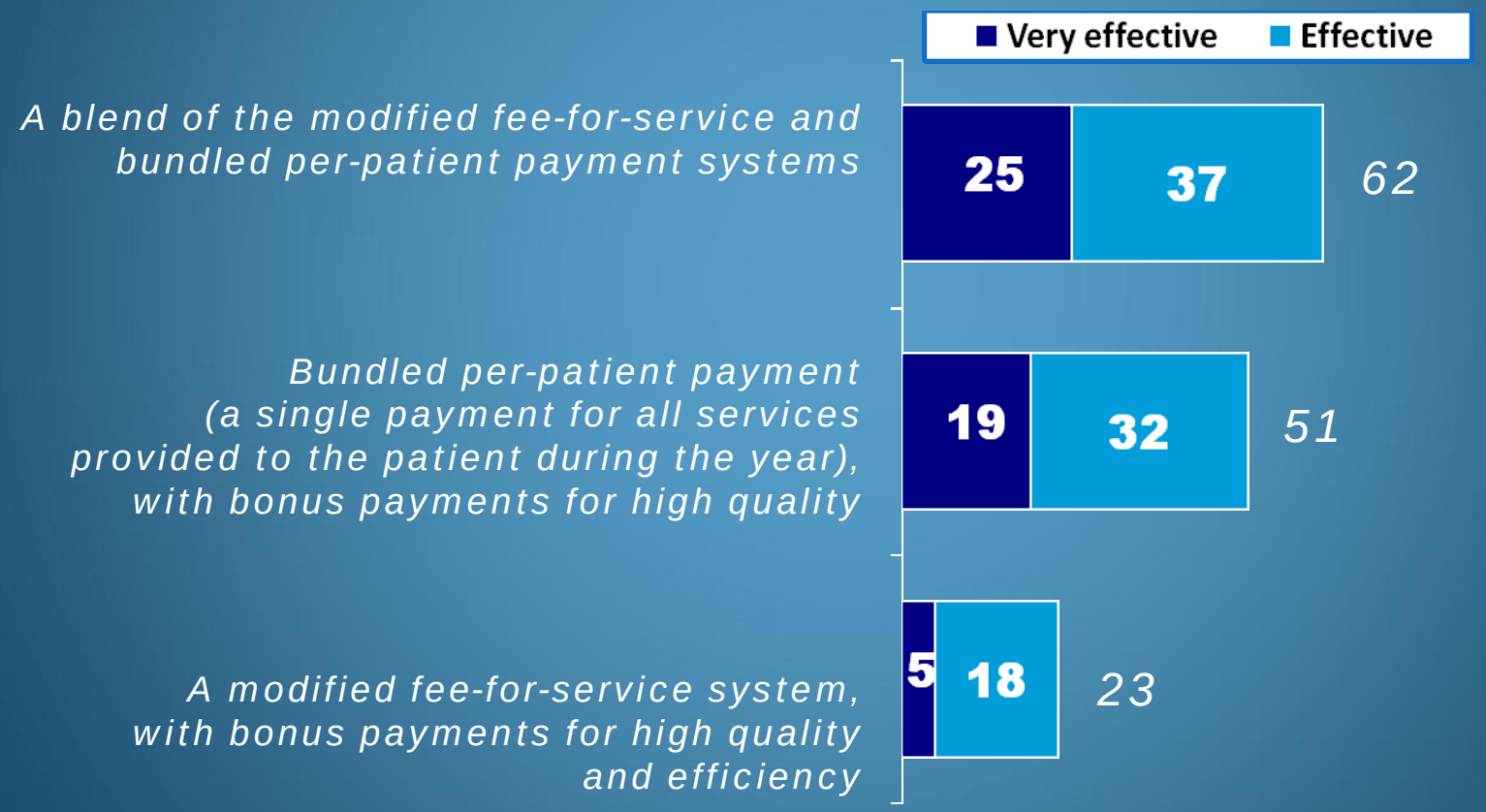
Strengths	Weaknesses
• Patient-centered model • Encourages evidence-based medicine • Could improve quality • Could bend the curve on costs • Payment models decrease incentive for volume and encourage investment in practice changes to promote quality	• Requires considerable change in practice • Data pending on practicality • Unknown return on investment • May disenfranchise small practices • Workforce projections for primary care • Uncertain impact on access – will panel sizes decrease?
Opportunities	**Threats**
• Demonstration projects including public & private payers • Inter-professional collaboration • Health information technology • Modeling of different payment models and organizational structures	• Perception that this is a zero-$um game • Primary care workforce • Physicians overwhelmed • Fear of change • Consumers may not understand/accept the model (or name) • Unintended consequences

Payment Models for the PCMH



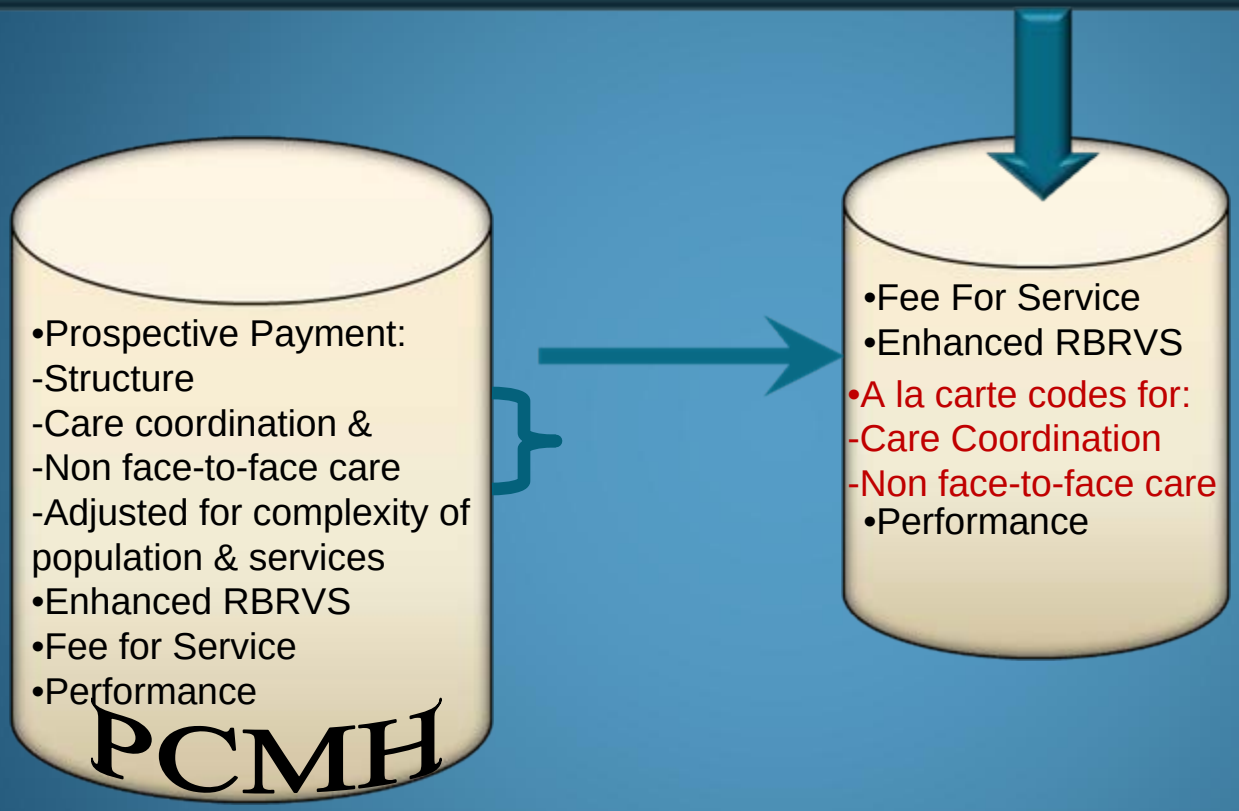
Blend of Modified Fee-for-Service and Bundled Per-Patient Payment Perceived as Most Effective for Efficient Health Care System

"How effective do you think each of the following payment approaches would be in facilitating a more efficient health care system?"



K. Stremikis, S. Guterman, and K. Davis, Health Care Opinion Leaders' Views on Payment System Reform, The Commonwealth Fund, November 2008

Payment Model for a Non-PCMH



Payment Model Supports Better Care

- Movement away from volume-driven, episodic, fee-for-service system
- Supports valuable yet currently non-reimbursed activities such as care coordination and non face-to-face care
- Aligns incentives through performance-based compensation and shared savings approaches

New Payment Models Should…

1. Support specific policy objectives to ensure accuracy, predictability, and the appropriate valuation of physician services
2. Increase value to the health care system
3. Support patient-centered care and patient engagement in shared decision-making
4. Encourage appropriate expenditures on physician services
5. Align incentives across the health care system
6. Encourage the optimal number and distribution of physicians in the workforce

New Payment Models Should…

7. Encourage the use of health information technology
8. Recognize differences in practice characteristics, including the prevalence of small practices
9. Minimize the imposition of new administrative tasks and costs on physician practices and seek to reduce the cumulative burden of existing requirements that detract from patient care
10. Recognize the costs to physicians associated with the transition to the new payment structure
11. Allow for on-going evaluation and assessment for change

Performance Measurement

- Measures should be reliable, valid and based on sound scientific evidence
- Measures should be selected based on where there has been strong consensus among stakeholders and predictive of overall quality performance
- Outcome measures should be appropriately risk-adjusted and stratified
- The set of measures should reflect a spectrum rather than a single dimension of care (e.g., prevention and health promotion, chronic illness, acute care and procedures)

A Commitment to Excellence

- Patient-centered communication
- Shared decision making
- Timely access to care
- Electronic health records
- Use of comparative effectiveness research & evidence-based guidelines
- Measure, improve, measure
- Transparency & accountability
- Safety