PCMH, PCMH-N…… and Beyond

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Patient Centered Medical Home (PCMH)

- In response to a healthcare system characterized by
  - Unsustainable cost growth
  - Mediocre quality
  - Aging population with multiple chronic care needs coupled with payment system unsupportive of needed services
  - Declining PC workforce at time of research reflecting importance of strong PC foundation

- AAFP, AAP, ACP and AOA developed the Joint Principles of the Patient Centered Medical Home (2007)
PCMH

Hybrid Care Delivery Model with Elements of:

- **Primary Care** --- as a foundation --- longitudinal, first contact, whole person orientation.
- **Wagner Chronic care model**
  - Emphasis on care coordination
  - Team based care
  - Population management guided by evidence based clinical guidelines
- **Patient-Centered**
  - Practices meet the needs and preferences of the patient:
    - Decision making
    - Increased access
- **Use of HIT**
- Identified to have at least one private payer medical home pilot under development or underway
- Identified to have a Medicaid and/or CHIP medical home initiative
- Identified to have both a private payer and a Medicaid and/or CHIP medical home

= Identified as a Medicare CPCI or APC State, which includes private payers, Medicaid and/or CHIP, and Medicare FFS

* As tracked by the American College of Physicians (updated 2012)
PCMH

• Improved Quality and Efficiency --- data generally supportive --- mostly industry developed studies.
  • Savings mostly through decreased unnecessary ER and hospital use --- some through improved coordination/integration to reduce unnecessary procedures/ problems due to uncoordinated care (e.g. lack of medication reconciliation).
    (PCPCC 2012 available at http://www.pcpcc.net/guide/benefits-implementing-pcmh)

• Payment --- remains primarily FFS with addition of a monthly care coordination payment if practice engages in processes consistent with model
  • Verified by third party ----NCQA, URAC, TJC, AAAHC
The Role of Specialist/Subspecialists and other Providers within the PCMH?
In 2007 ACP CSS called for the creation of a Workgroup to address the interface between the Patient Centered Medical Home Care Model and subspecialty/specialty practices.

- Representatives volunteered from 15 different medical societies
- The workgroup reviewed the available literature plus the proceedings of relevant transition conferences (e.g. Transitions of Care Consensus Conference (TOCCC) and Stepping Up to the Plate (SUTTP) Alliance initiative.)
- Developed specialty patient vignettes and examined how this situation is handled now and how would could it be handled under PCMH model
- Developed Policy Paper on the role of Specialty/Subspecialty practices within the PCMH model.
THE PATIENT-CENTERED MEDICAL HOME NEIGHBOR: THE INTERFACE OF THE PATIENT-CENTERED MEDICAL HOME WITH SPECIALTY/SUBSPECIALTY PRACTICES

American College of Physicians
A Position Paper
2010

http://www.acponline.org/advocacy/where_we_stand/policy/
The PCMH model cannot achieve its goal of improved care coordination/integration without effective collaboration with the other physicians, healthcare professionals and healthcare entities providing care to their patients -- the medical home neighborhood.

“Effective care coordination ... requires not only full access to all the necessary clinical information obtained at multiple sites, but also a willingness by all the physicians involved in a patient’s care to participate in collaborative decision making ... There are (currently) no incentives for other physicians or hospitals to share information, improve coordination, or support shared decision making for patients who are in the medical home.”

PCMH without a Neighborhood

Photo © Scott Hammond MD
Care Coordination Issues

- The typical PCP has 229 other physicians working in 117 practices with which care must be coordinated. (Pham et. al., Ann Int Med. 2009)

- In the Medicare population, the average beneficiary sees seven different physicians and fills upwards of 20 prescriptions per year. (Partnership for Solutions, Johns Hopkins Univ. 2002)

- For referred patients: 68% of specialists reported receiving no information from the primary care provider prior to referral visits: 25% of primary care providers had not received any information from specialists 4 weeks after referral visits (Gandi et. al. J Gen. Int. Med. 2000)

- 2/3 of physicians treated a hospital discharged patient before receiving the discharge summary. Those received often lacked key information e.g. discharge information, follow-up plans. (Kripalini et al. JAMA, 2007)
Effects of Poor Care Coordination

- Having to repeat unnecessarily medical histories and tests.
- Receiving inappropriate and non-reconciled medication.
- Receiving inconsistent medical instructions or information.
- Experiencing poor transitions between sites of care.
- Using higher intensity settings than necessary—unnecessary emergency department use and hospital readmissions.

MedPAC: Report to the Congress, June 2012
ACP Policy Paper Contains a ……

- Statement supporting the importance of PCMH Neighbors (PCMH-N)
- Definition of PCMH-N Concept
- Framework to categorize interactions between the PCMH and neighbor practices
- Guiding principles for care coordination agreements between PCMH and neighbor practices
- Discussion of the importance of incentives (financial and non-financial) to encourage neighbor collaboration with PCMH practices
- Discussion of a potential PCMH-N recognition process with suggestions for evalulative categories
Who Composes the Medical Home Neighborhood (PCMH-N)

- All healthcare professionals and others that share in the care of the patient. Including:
  - Physicians and other providers - specialists, subspecialists, behavioral health clinicians, hospitals, nursing homes, home health, hospice, pharmacists, labs, etc.
  - Educators - care management educators, nutritionists, etc.
  - Case Managers
  - Community Resources – community centers, churches, support groups, etc.
PCMH-Neighbor (PCMH-N) Definition

- facilitate communication, coordination and integration with PCMH practices in a bidirectional manner to provide high quality and efficient care;
- facilitate appropriate and timely consultations and referrals that complement the aims of the PCMH practice;
- facilitate the efficient, appropriate and effective flow of necessary patient and care information;
- effectively guides determination of responsibility in co-management situations;
- support patient centered care, enhanced care access and high levels of care quality and safety; and
- support the PCMH practice as the provider of whole person primary care to the patient and as having overall responsible for ensuring the coordination and integration of the care provided by all involved providers.
PCMH-N Model

- Significant interest in model ---
  - Currently being implemented in a number of settings.
  - College providing support to a number of groups implementing the model.
  - NCQA Interviews with key stakeholder

- NCQA is in the final stages of developing a Neighbor recognition process --- to be released this Spring.
  - PCMH and ACP’s PCMH-N Models as foundation
  - Emphasis on care coordination and integration processes
  - Aligned with MU
PCMH-N

Issue of how to incentivize Neighbors to participate:

- Non-financial
  - improved referral
  - better prepared patient

- Financial
  - preferred status
  - decreased co-payments
  - provision of “in-kind” services
  - additional payments --- either direct or through shared savings. e.g. Vermont Blueprint for Health, Large western health plan
And Beyond

- **Accountable Care**
  - Reflects sea change in payment model --- aligned with quality and efficiency as opposed to volume. Includes shared saving, capitation, episode of care and bundled payment.
  - Provides framework to more tightly integrated care
  - Approx. 300 initiatives throughout the country. Most recognized is the Medicare Shared Saving Program
  - The same processes/procedures required within the PCMH and PCMH-N service delivery models are required to be successful within this accountable care environment.
    - E.g. ACOs will tend to choose those practices already familiar with and engaging in the defined processes.