# Origins and Differing Definitions of the Patient-Centered Medical Home

The National Medical Home Summit

Robert A. Berenson, M.D.

2 March 2009

# Broad Interest – To the Point of Silver Bullet Status?

- Four primary care societies have endorsed (even some surgical groups supportive)
- Various purchasers and purchasing groups – IBM, GE, ERISA Industry Committee
- Large Insurers – various Blues, United, Aetna, etc.
- The largest insurer – Medicare demo(s)
- Democratic and Republican Presidential campaigns
- Patient Centered Primary Care Collaborative www.pcpcc.net

# Problems For Which Medical Home is Offered as a Solution

- Recognized deficiencies in "patient-centered" aspects of care, e.g. respect for patient values and preferences, access, availability, coordination, emotional support, etc. – most related to competing claims on physician time
- The growing challenge of chronic care
- Relatively poor primary care compensation and the difficulties in relying on FFS to support primary care activities

# "The Tyranny of the Urgent"

"Amidst the press of acutely ill patients, it is difficult for even the most motivated and elegantly trained providers to assure that patients receive the systematic assessments, preventive interventions, education, psychosocial support, and follow-up that they need." (Wagner et al. Milbank Quarterly 1996:74:511.)

# The Pressure of the 15 Minute Visit

"Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stand still…The result of the wheel going faster is not only a reduction in the quality of care but also a reduction in professional satisfaction and an increase in burnout among physicians." (Morrison and Smith, BMJ 2000; 321:1541)

# How Patients are Affected

- Asking patients to repeat back what the physician told them, half get it wrong. (Schillinger et al. Arch Intern Med 2003;163:83)
- Patients making an initial statement of their problem were interrupted by the PCP after an average of 23 seconds. In 23% of visits the physician did not ask the patient for her/his concerns at all. (Marvel et al. JAMA 1999; 281:283)

# Recent Data on High Cost Patients

- 75% of high cost beneficiaries had one or more of 7 chronic conditions: asthma, COPD, CRF, CHF, CAD, diabetes or senility; 70% of inpatient spending was for beneficiaries with one of these – CBO, 2005
- 5% of beneficiaries accounted for 43% of total Medicare spending; the costliest 25% for 85% of spending – CBO, 2005

# Readmissions

- In Medicare, about 11% of patients are readmitted within 15 days and almost 20% within 30 days
- 50% of patients hospitalized with CHF are readmitted within 90 days
- The majority of readmissions are avoidable – declining with time from index admission
- Half of patients discharged to community and readmitted within 30 days after medical DRG had no bill for physician services in the interval

# Annual Prescriptions by Number of Chronic Conditions

| Number of Chronic Conditions | Average Annual Prescriptions* |
|---|---|
| 0 | 3.7 |
| 1 | 10.4 |
| 2 | 17.9 |
| 3 | 24.1 |
| 4 | 33.3 |
| 5 | 49.2 |

*Includes Refills

Sources: Partnership for Solutions, "Multiple Chronic Conditions: Complications in Care and Treatment," May 2002; MEPS, 1996.

# Utilization of Physician Services by Number of Chronic Conditions

| Number of Chronic Conditions | Unique Physicians | Physician Visits |
|---|---|---|
| 0 | 1.3 | 2.0 |
| 1 | 4.0 | 7.8 |
| 2 | 5.2 | 11.3 |
| 3 | 6.5 | 14.9 |
| 4 | 8.1 | 19.5 |
| 5+ | 13.8 | 37.1 |

Sources: R. Berenson and J. Horvath, "The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform," prepared for the Partnership for Solutions, March, 2002; Medicare SAF 1999.

# Incidents in the Past 12 Months

***Among persons with serious chronic conditions, how often has the following happened in the past 12 months?***

| | | Sometimes or often |
|---|---|---|
| 1. | Been told about a possibly harmful drug interaction | 54% |
| 2. | Sent for duplicate tests or procedures | 54% |
| 3. | Received different diagnoses from different clinicians | 52% |
| 4. | Received contradictory medical information | 45% |

# Medicare Spending Related to Chronic Conditions

| | Percent of Medicare Population | Percent of Medicare Spending |
|---|---|---|
| 5+ Conditions | 20.3% | 65.8% |
| 4 Conditions | 11.3% | 12.7% |
| 3 Conditions | 14.8% | 10.3% |
| 2 Conditions | 16.3% | 6.8% |
| 1 Condition | 15.1% | 3.5% |
| 0 Conditions | 22.1% | 0.9% |

Source: Partnership for Solutions, "Medicare: Cost and Prevalence of Chronic Conditions," July 2002; Medicare Standard Analytic File, 1999.

# The Primary Care Shortage Problem and Relative Incomes

- In 1998, 54% of internal medicine residents chose general medicine; 2005 – 20% (Bodenheimer, NEJM; 355:861)
- U.S. medical school graduates entering family medicine residencies:
  - 1997 – 2340
  - 2005 – 1132 (Pugno, Fam Med; 37:555)

# Median Compensation, 1995-2004
## (analysis by Bodenheimer, MGMA data

| | 1995 | 2004 | 10 year increase |
|---|---|---|---|
| All primary care | 133K | 162K | 21% |
| All specialties | 216 | 297 | 38% |
| Dermatology | 177 | 309 | 75% |
| Radiology | 248 | 407 | 64% |

# Fee-For-Service Is Necessarily Rooted in Face-to-Face Encounters

- There are plenty of reasons, e.g.,
  - high transaction costs, associated with non-face-to-face, frequent, low dollar transactions;
  - major program integrity concerns
  - "moral hazard" driving expenditures
- Yet, increasingly, face-to-face visits do not encompass the work of primary/principal care for patients with chronic conditions (most beneficiaries). Thus, we need to think about payment mechanisms other than FFS

# Gaps in FFS Payments

- Current payment policies do not support the activities (not services) that comprise the Wagner Chronic Care Model, incl. non-physician care, team conferences, coordinating care with other physicians, harnessing community resources, using patient registries to facilitate preventive services, etc.
- N.B. This model is more than an electronic health record, which some of view as necessary but not sufficient for what a medical home needs to do

# The Evolution of the PCMH Concept – The Confluence of Four Streams

- "Medical homes" in pediatrics – 40 year Hx, oriented to mainstream care for special needs children especially needing care coordination
- The evolution of primary care deriving from WHO meeting in Alma Alta in 1978 – as summarized by Starfield, core attributes are: first contact care, longitudinal responsibility for patients over time, comprehensive care, coordination of care across conditions, providers and settings

# Evolution (cont.)

- "Primary care case management" in commercial HMOs and a few Medicaid programs – with some success in latter and (probably in former despite disrepute); formal gatekeeper requirements in about half of OECD countries
- Practice redesign focused around EMRs and, somewhat separately, around the Wagner Chronic Care Model (which includes use of EMRs)

# "A 2020 Vision of Patient-Centered Primary Care"

Karen Davis, Stephen C. Schoenbaum, and Anne-Marie Audet, *Journal of General Internal Medicine*, 2005; 20:953-957

- An excellent synthesis of these four streams into a comprehensive and plausible set of attributes and expectations – although as discussed below not necessarily achievable in all practice situations

# Core Principles Agreed to by the Four Primary Care Societies in 2007

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Supportive payment

# Current PCMH Standards Emphasize Organization of the Home

- NCQA Physician Practice Connection (PPC) PCMH Standards emphasize EMRs and CCM – less on attributes of patient-centeredness
- Bridges to Excellence Office Assessment Survey similarly derive from EMR work

# Challenges to Adoption of the Patient-Centered Medical Home

- Lack of agreement on operational definition and emphases; alternative foci – traditional primary care or EMRs or Wagner Chronic Care Model or all of the above
- Practice size and scope – still dominance of solo and small groups – arguably without ability, even with new resources, to adopt many elements of PCMH -- rural vs. urban; small vs. large practice. Do we have same expectations and same models for differently situated practices?

# Challenges (cont.)

- Shortage of primary care physician workforce combined with more demand for services -- if insurance coverage is expanded
- Medical practice culture and structure – the "tyranny of the urgent" has not disappeared
- To whom should the PCMH apply? All patients or those with special needs, e.g. in Medicare, those with multiple chronic conditions

# Challenges (cont.)

- Should principal care physician practices, e.g. endocrinologists for diabetics, qualify?
- Is there any kind of patient "lock-in" – hard or soft?
- Management challenges – even in large groups with an interest, many elements not adopted so far – but there have been no payment incentives to do so

# Challenges (cont.)

- Unfettered expectations – every one has a favorite attribute to hang on the PCMH – care coordination, population health, shared decision-making, cultural competence, reducing disparities, detection of depression – or alcoholism – or cognitive deficits. The list goes on.

# A Final Cautionary Note

"Primary care could also expand beyond its more restrictive role as provider of medical care… The danger, of course, is that primary care's new role will be even more expansive and varied than today's already diverse activities. A redefinition of primary care must be cognizant of this risk, focus on optimizing primary care's strengths, and avoid assuming too many peripheral responsibilities in its formulation." (Moore and Showstack, Ann Inter Med, 138:244)