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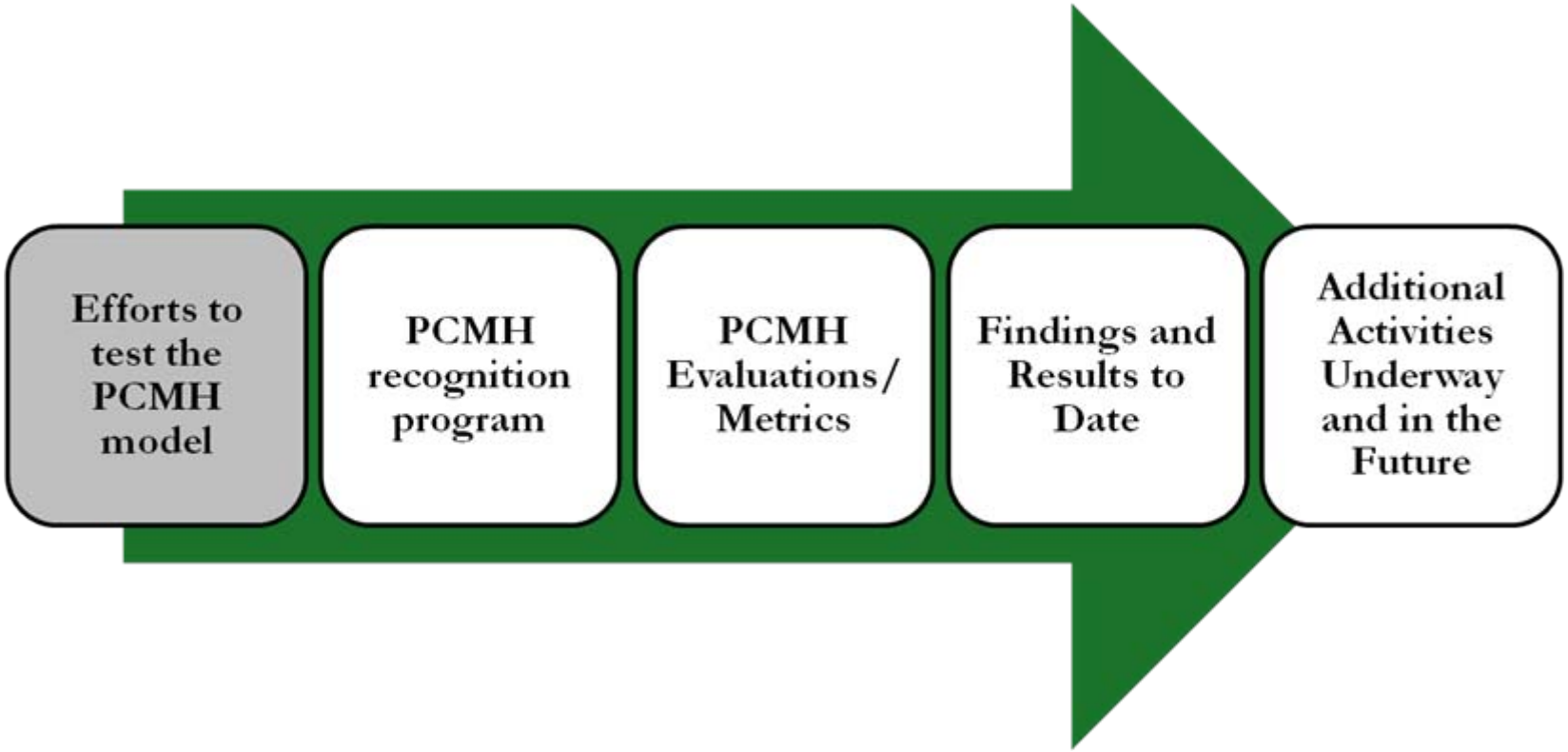
Overview of the Patient Centered Medical Home (PCMH) Movement

The Second National Medical Home Summit

February 28, 2010

Shari M. Erickson, MPH
Senior Associate, Center for Practice Improvement & Innovation
American College of Physicians

Presentation Outline



Efforts to Test PCMH

Term "medical home" is used widely and can mean many things

Guidelines for PCMH Demonstration Projects* Developed by ACP/AAFP/AAP/AOA to provide direction to projects in the planning phase in order to facilitate consistency with the Joint Principles – they include recommendations about:

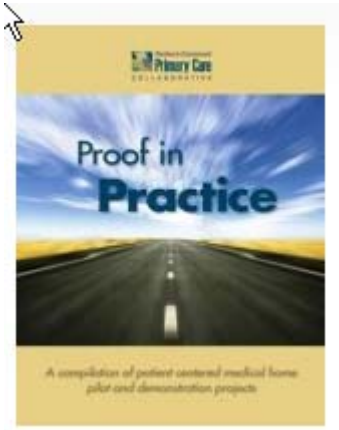
- Who should collaborate on the projects;
- How they should choose practices to participate;
- What kind of support should be provided to participating practices;
- How participating practices should be reimbursed; and
- What each project should to do to analyze and distribute their results.

* Detailed guidelines available at: http://www.acponline.org/running_practice/pcmh/demonstrations/guidedemo.pdf

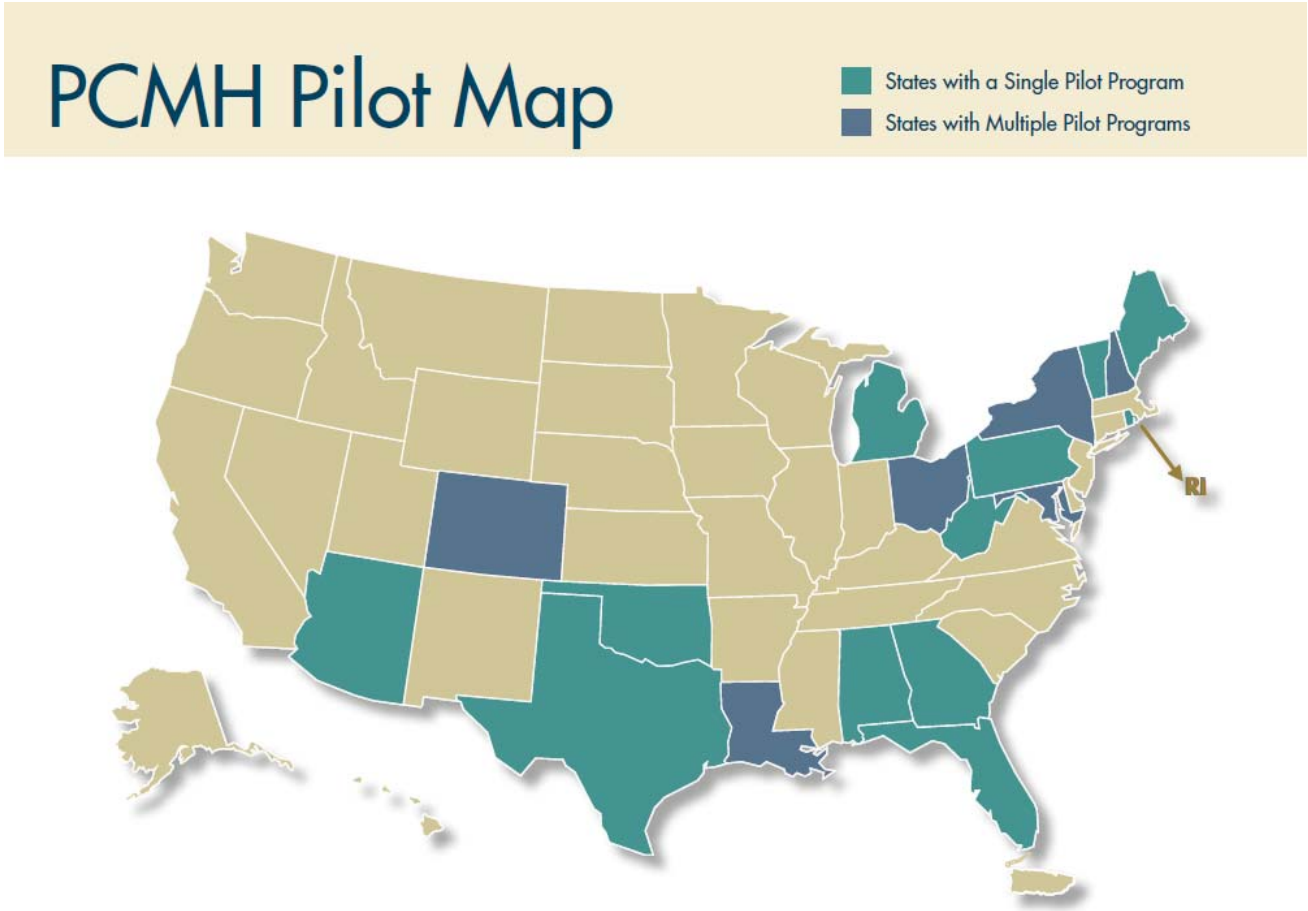
Types of PCMH Test Projects

- Multi-payer/multi-player commercial plans
- Medicare Advantage
- Medicaid/SCHIP
- Safety-Net Medical Home Initiative
- Federal Efforts: Medicare FFS, Veterans Administration, Department of Defense

Overview of PCMH Commercial Pilot Activity



- 27 projects
- 18 states



Source: PCPCC Pilot Report (http://pcpcc.net/pilot-guide), October 2009

Overview of PCMH Commercial Pilot Activity (cont.)

- Alabama Health Improvement Initiative—Medical Home Pilot (AL)
- UnitedHealth Group PCMH Demonstration Program (AZ)
- The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Pilot (CO)
- Colorado Family Medicine Residency PCMH Project (CO)
- MetCare of Florida/Humana Patient-Centered Medical Home (FL)
- WellStar Health System/Humana Patient-Centered Medical Home (GA)
- Greater New Orleans Primary Care Access and Stabilization Grant (PCASG) (LA)
- Louisiana Health Care Quality Forum Medical Home Initiative (LA)
- Maine Patient-Centered Medical Home Pilot (ME)
- CareFirst BlueCross BlueShield Patient-Centered Medical Home Demonstration Program (MD)
- National Naval Medical Center Medical Home Program (MD)
- Blue Cross Blue Shield of Michigan—Physician Group Incentive Program (PGIP) (MI)
- Priority Health PCMH Grant Program (MI)
- CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot (NH)
- NH Multi-Stakeholder Medical Home Pilot (NH)
- CDPHP Patient-Centered Medical Home Pilot (NY)
- EmblemHealth Medical Home High Value Network Project (NY)
- Hudson Valley P4P-Medical Home Project (NY)
- Greater Cincinnati Aligning Forces for Quality Medical Home Pilot (OH)
- Queen City Physicians/Humana Patient-Centered Medical Home (OH)
- TriHealth Physician Practices/Humana Patient-Centered Medical Home (OH)
- OU School of Community Medicine—Patient-Centered Medical Home Project (OK)
- Pennsylvania Chronic Care Initiative (PA)
- Rhode Island Chronic Care Sustainability Initiative (RI)
- Texas Medical Home Initiative (TX)
- Vermont Blueprint Integrated Pilot Program (VT)
- West Virginia Medical Home Pilot (WV)

Source: PCPCC Pilot Report (http://pcpcc.net/pilot-guide), October 2009

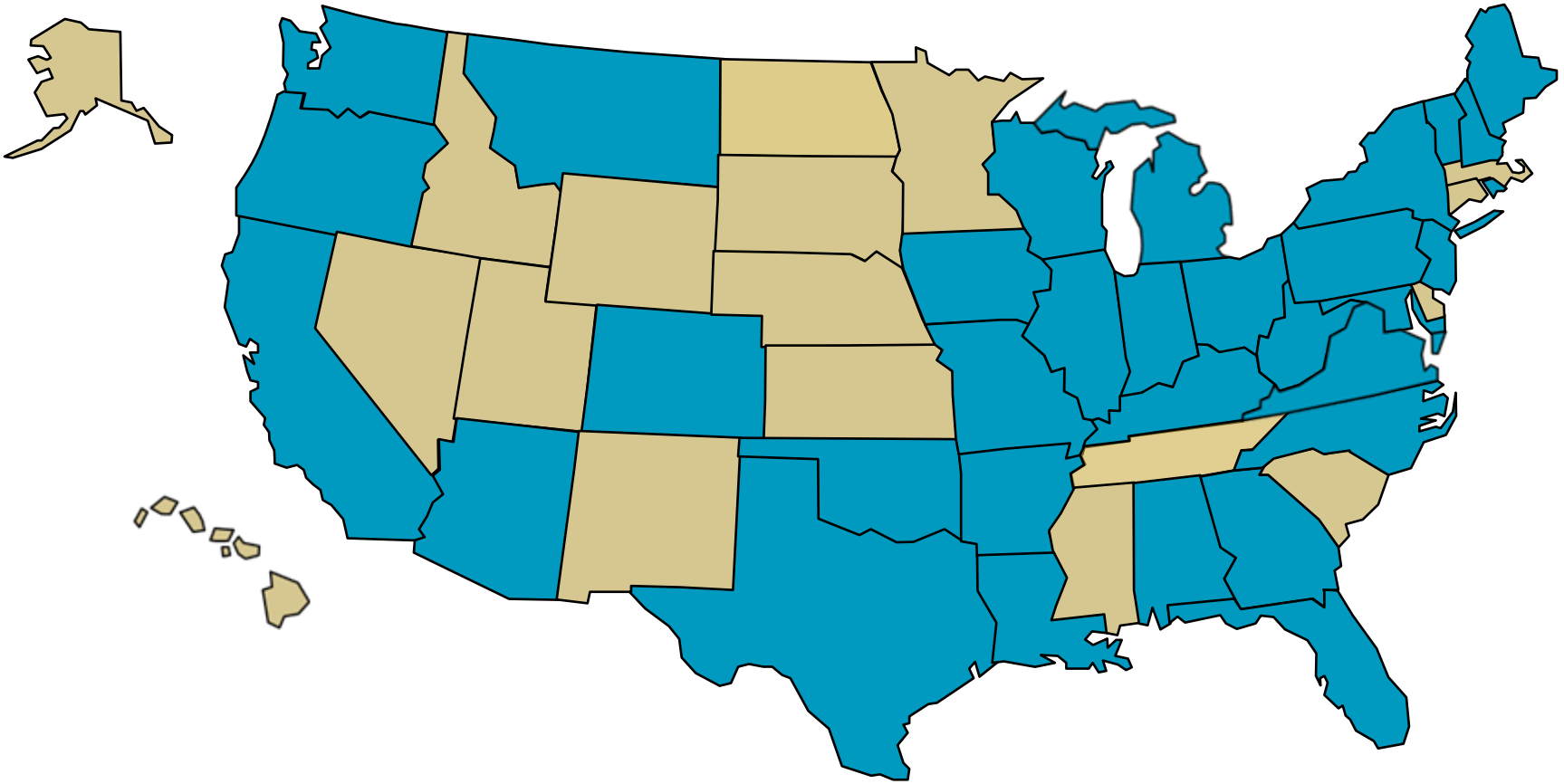
Overview of PCMH Commercial Pilot Activity (cont.)

Additional commercial PCMH projects under development or underway in at least 12 more states:

- Arkansas
- California
- Illinois
- Indiana
- Iowa
- Missouri
- Montana
- New Jersey
- North Carolina
- Oregon
- Virginia
- Washington
- Wisconsin

Additionally, new projects are under development in the previous states, such as New York (Adirondack region), Florida (BCBS)

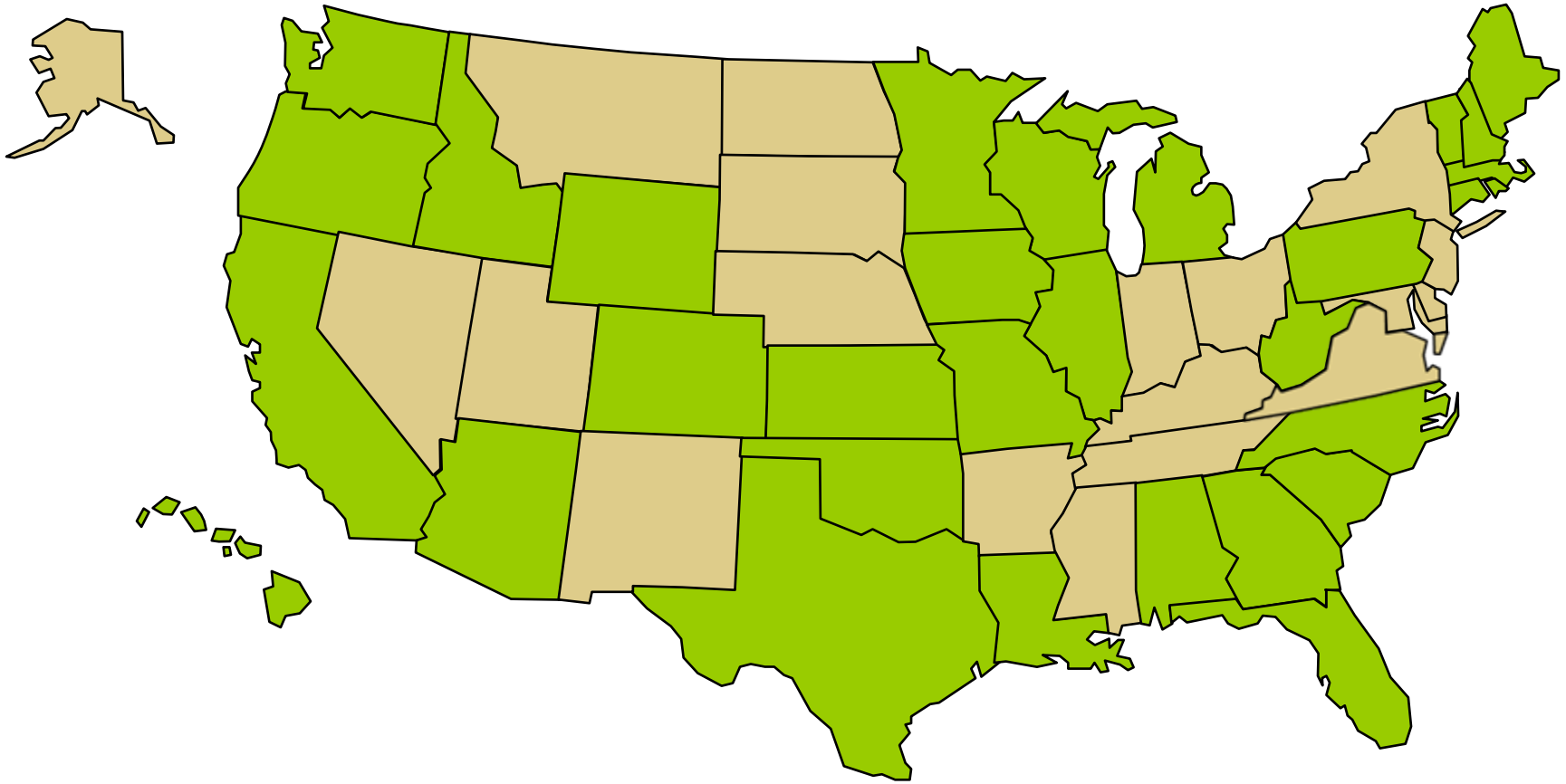
Overview of PCMH Commercial Pilot Activity (cont.)*



= Identified to have at least one private payer medical home pilot under development or underway

* As tracked by the American College of Physicians

Initiatives to Advance Medical Homes in Medicaid/ SCHIP



= Identified to have a Medicaid and/or SCHIP medical home initiative

Source: National Academy for State Health Policy (NASHP) State Map (http://nashp.org/med-home-map), 2009

State Medicaid/SCHIP Innovation (cont.)

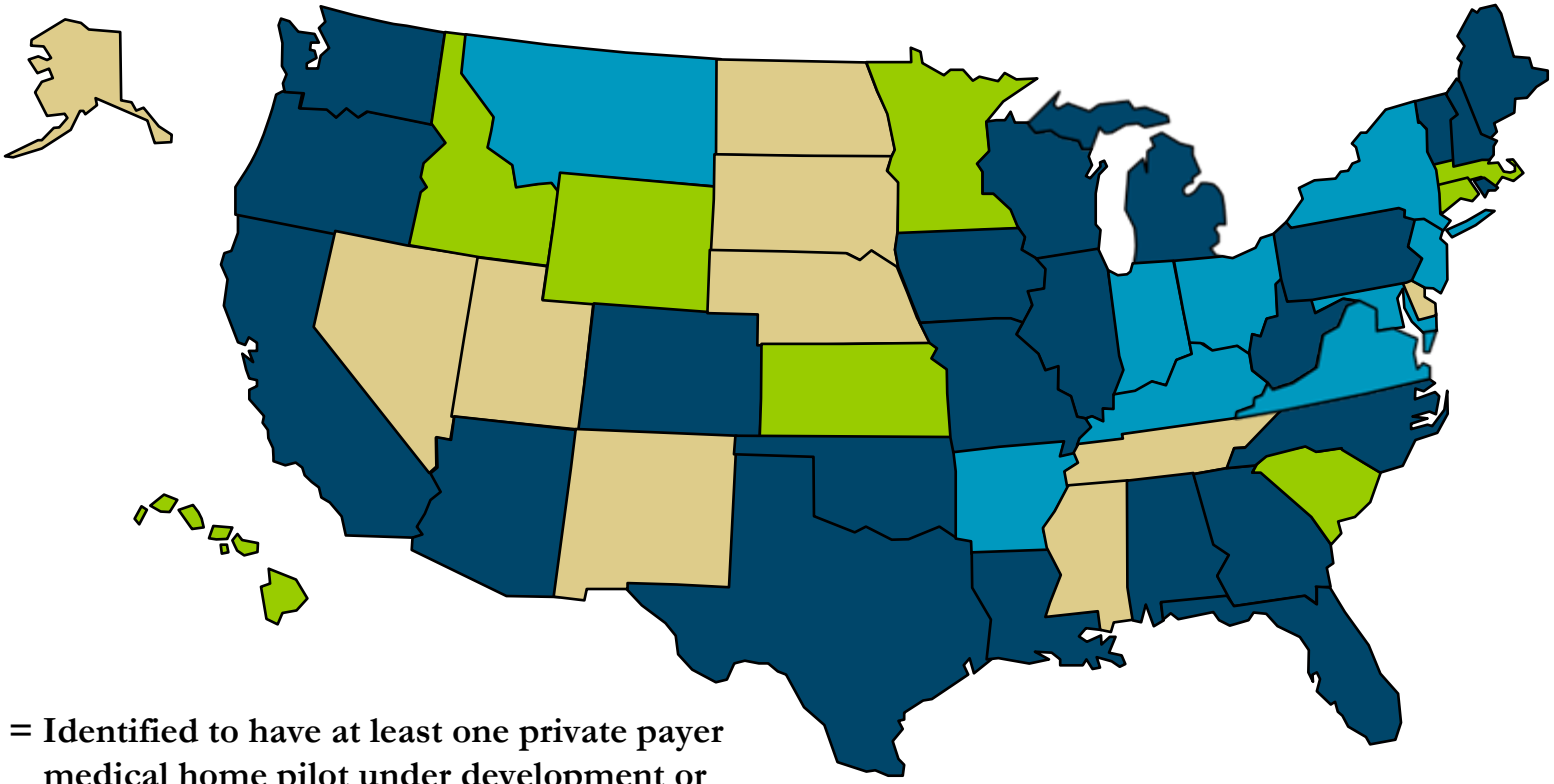
Over 30 states trying to improve medical home availability in Medicaid/SCHIP programs - via legislative authority or mandates, Medicaid Transformation Grants, dedicated state resources*

Private Sector Multi-Stakeholder PCMH Pilots Involving Medicaid:

- Colorado
- Louisiana
- Maine
- New Hampshire
- Rhode Island
- Vermont

* Source: National Academy of State Health Policy (NASHP), 2008 at: http://nashp.org/sites/default/files/medical_home_scan_Nov_2008.xls and http://nashp.org/sites/default/files/combined_slides.pdf

Combined Commercial and Medicaid/SCHIP PCMH Activity



= Identified to have at least one private payer medical home pilot under development or underway

= Identified to have a Medicaid and/or SCHIP medical home initiative

= Identified to have both a private payer and a Medicaid and/or SCHIP medical home initiative

Examples of Multi-Stakeholder Efforts to Test PCMH – Pennsylvania

Pennsylvania Chronic Care Commission Rollouts

- An integration of the Chronic Care Model and the Patient-Centered Medical Home concept
- Six rollouts across the state – southeast, south central, southwest, northeast, northwest, north central; project underway and to run for three years
- Involves multiple health plans in each area, including Medicaid and Medicare Advantage business
- Includes over 100 internal medicine, family medicine, pediatric, and NP-led practices (in urban, suburban, and rural areas)
- Utilizing NCQA recognition program
- 3-component payment structure: (1) prospective infrastructure development payments, (2) enhanced FFS/capitation via lump sum payments associated with level of achievement on NCQA PPC-PCMH, (3) P4P using a consistent set of core measures by 2010
- Practice support provided by Improving Performance In Practice, a Robert Wood Johnson Foundation funded quality improvement program that is located in several states

Examples of Multi-Stakeholder Efforts to Test PCMH – Colorado

Colorado Multi-Payer, Multi-State PCMH Pilot

- Involves 7 health plans, including state Medicaid (no Medicare fee-for-service at this time) in Denver metro, Colorado Springs, and Ft. Collins
- 16 internal medicine and family practices
- Must be recognized by NCQA as Tier 1, 2, or 3
- 3-component payment structure: (1) prospective PMPM within a given range, (2) FFS, (3) P4P using a consistent set of core measures
- Practice support provided by Improving Performance In Practice, a Robert Wood Johnson Foundation funded quality improvement program that is located in several states
- Evaluation funding by The Commonwealth Fund; evaluation to be conducted by Harvard School of Public Health
- Sister site – Cincinnati metro area, Ohio/Northern KY (the two sites together will include 22-30 practices and approximately 60,000 patients)
- Underway and to run for two years

Examples of Multi-Stakeholder Efforts to Test PCMH – Texas

Texas Medical Home Initiative

- Under development
- Texas ACP Chapter is the convening organization; have established a separate 501c3 entity called the Texas Patient-Centered Medical Home Initiative
- Have multiple stakeholders at the table
- Have some start-up funds from Pfizer; pursuing additional opportunities
- Adopted Joint Principles; endorsed NCQA certification process
- Plan to include diverse practices (size, demography, payer mix)
- Will likely include focus on medical home – specialist relationships
- Will likely look at the costs associated with practices becoming PCMHs

Common Themes of PCMH Multi-Stakeholder Demos

- Major success factor = local/regional leadership
- Market share
- Practice penetration
- Tests of reimbursement models
- Measurements of quality, cost, satisfaction
- External evaluator
- Practice support

Safety-Net Medical Home Initiative

Launched by The Commonwealth Fund, Qualis Health and the MacColl Institute for Healthcare Innovation

Project duration: April 2009 – April 2013

Project goal – to develop a replicable and sustainable implementation model for medical home transformation

Five Regional Coordinating Centers (RCCs) have been selected:

- Colorado Community Health Network
- Executive Office of Health and Human Services & Massachusetts League of Community Health Centers
- Idaho Primary Care Association
- Oregon Primary Care Association & CareOregon
- Pittsburgh Regional Health Initiative

Source: http://www.qhmedicalhome.org/safety-net/index.cfm

Safety-Net Medical Home Initiative (cont.)

Each RCC has partnered with 12-15 safety net clinics in their state.

- These collaboratives will receive technical assistance on practice re-design topics such as enhanced access, care coordination and patient experience.
- They will also receive funding to support a Medical Home Facilitator (who will lead clinic-based quality improvement projects) and other activities.

Source: http://www.qhmedicalhome.org/safety-net/index.cfm

Federal PCMH Efforts: Medicare FFS

Medicare Medical Home Demonstration Project

- Authorized under Section 204 of the Tax Relief and Health Care Act of 2006
- October 26, 2009: Project put on hold by CMS pending legislation that would repeal it and replace it with a similar pilot

Medicare "Advanced Primary Care" Demonstration Project

- New 3-year project announced by HHS Secretary Kathleen Sebelius on September 16, 2009
- Will allow the participation of Medicare beneficiaries in state-initiated medical home projects that also include Medicaid and private payers

Federal PCMH Efforts (cont.)

Veterans Administration

- 820 primary care sites
- 4.5 million primary care patients
- Using the ACP Medical Home Builder

Department of Defense

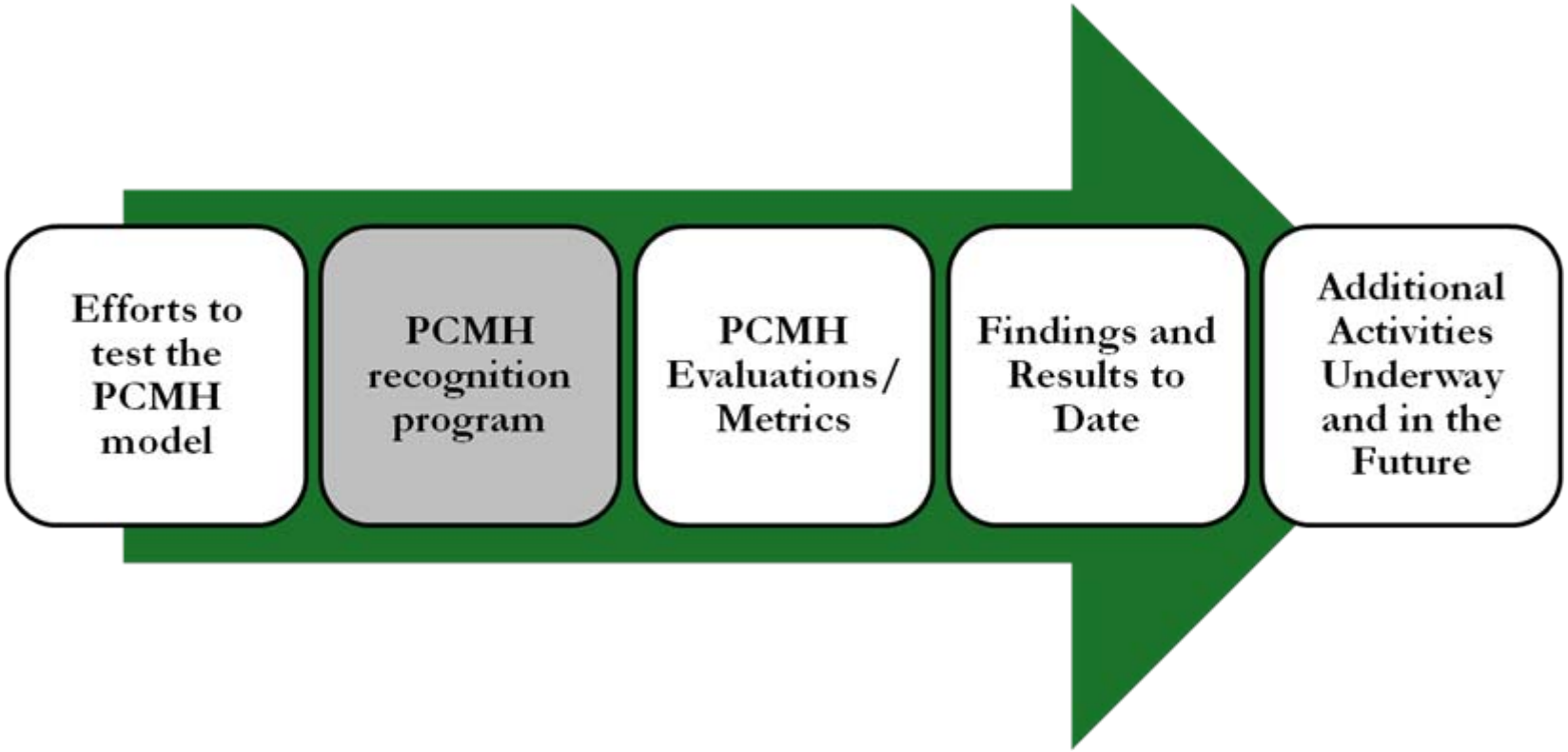
- National Naval Medical Center PCMH Pilot
- Tri-Service Medical Home Summit
- "The PCMH model of care will be implemented across the Services" – MHS Policy Statement on September 18, 2009

Health Services and Resources Administration (HRSA)

- Announced by President Obama on December 9, 2009
- Will evaluate the impact of the advanced primary care practice model on the accessibility, quality, and cost of care provided to Medicare beneficiaries served by Federally Qualified Health Centers (FQHCs).

PCMH Activities also occurring in: AHRQ, SAMHSA, CDC

Presentation Outline



How do you Know a PCMH When you See One?

Process needed to recognize practices that have and use the capability to provide patient-centered care

Practice recognition provides purchasers (employers, government) and patients with prospective assurance that the practice has capabilities

National Committee on Quality Assurance (NCQA) announced a voluntary recognition process based on its Physicians' Practice Connection (PPC) module, the PPC-PCMH in January 2008

- ACP, AAFP, AOA, and AAP helped NCQA develop the module

Other entities can develop PCMH recognition process

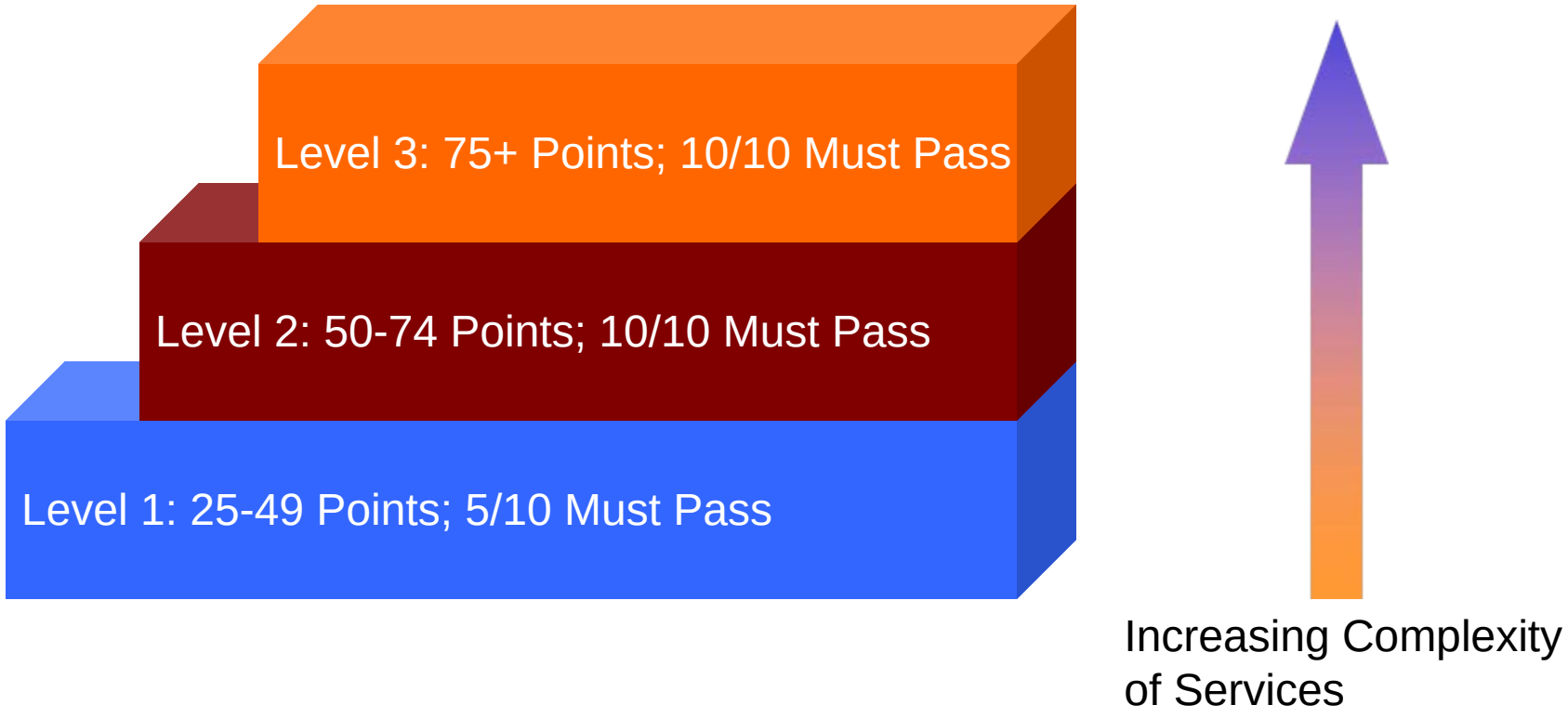
Recognized PCMHs would also be accountable for quality of care by reporting on evidence-based clinical and patient experience measures—provides retrospective assurance

NCQA PPC-PCMH Recognition Module; Major Domains/Standards

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

Each standard contains sub-elements – 10 of which are considered "must pass"

Scoring: Building a Ladder to Excellence



NCQA Recognition Activity

264 practices (with 1449 physicians) have received recognition across 21 states

- 34% Level 1
- 5% Level 2
- 61% Level 3

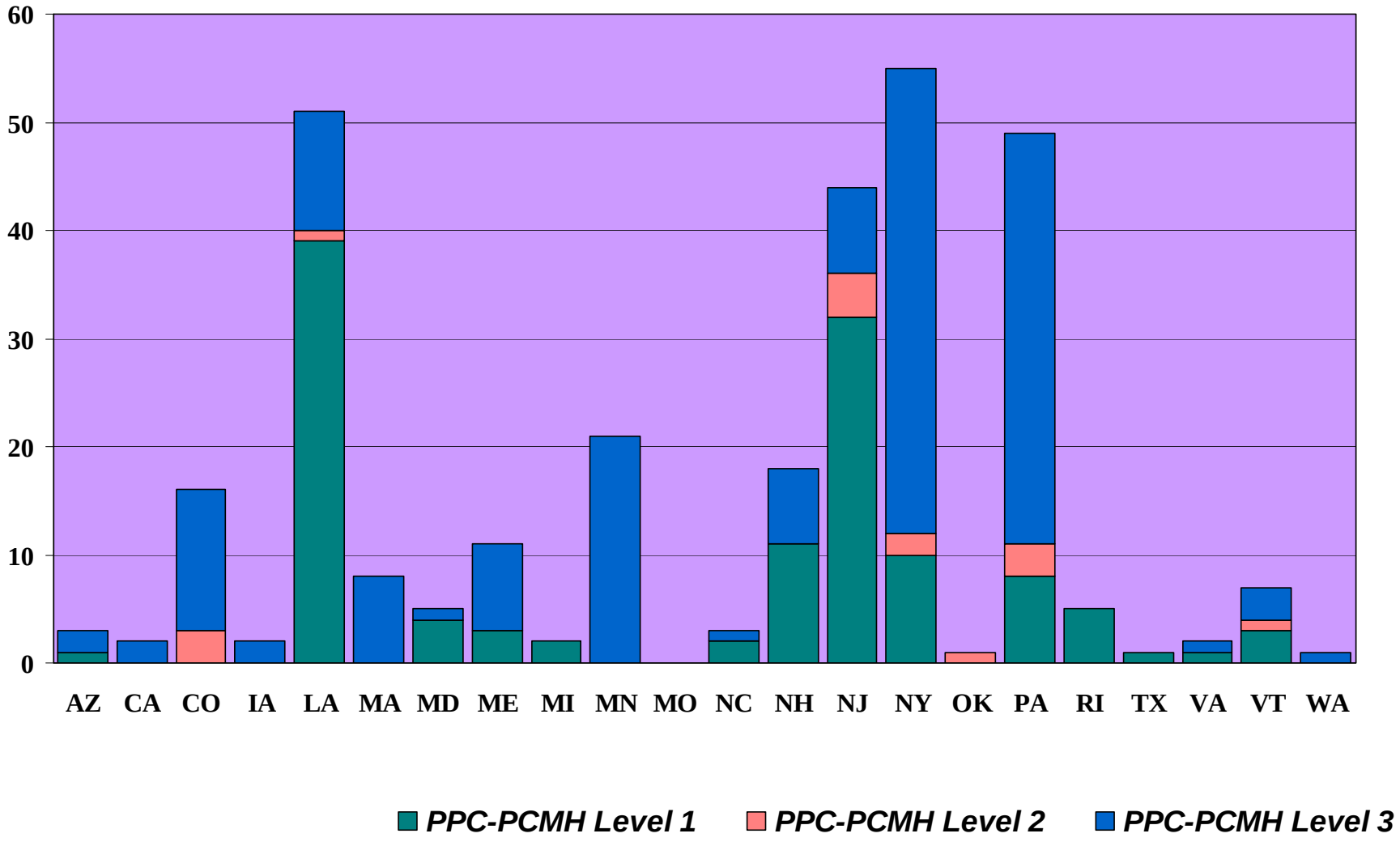
Greater than 20% of qualified practices are solo physician sites/practices

Practices more likely to seek recognition when/where tied to reward

Smaller practices (in number of physicians) somewhat more likely to be Level 1; larger practices somewhat more likely to be Level 3

SOURCE: NCQA, October 2009

NCQA PPC-PCMH RECOGNIZED PRACTICES BY STATE
(As of 10/31/09)



SOURCE: NCQA, October 2009

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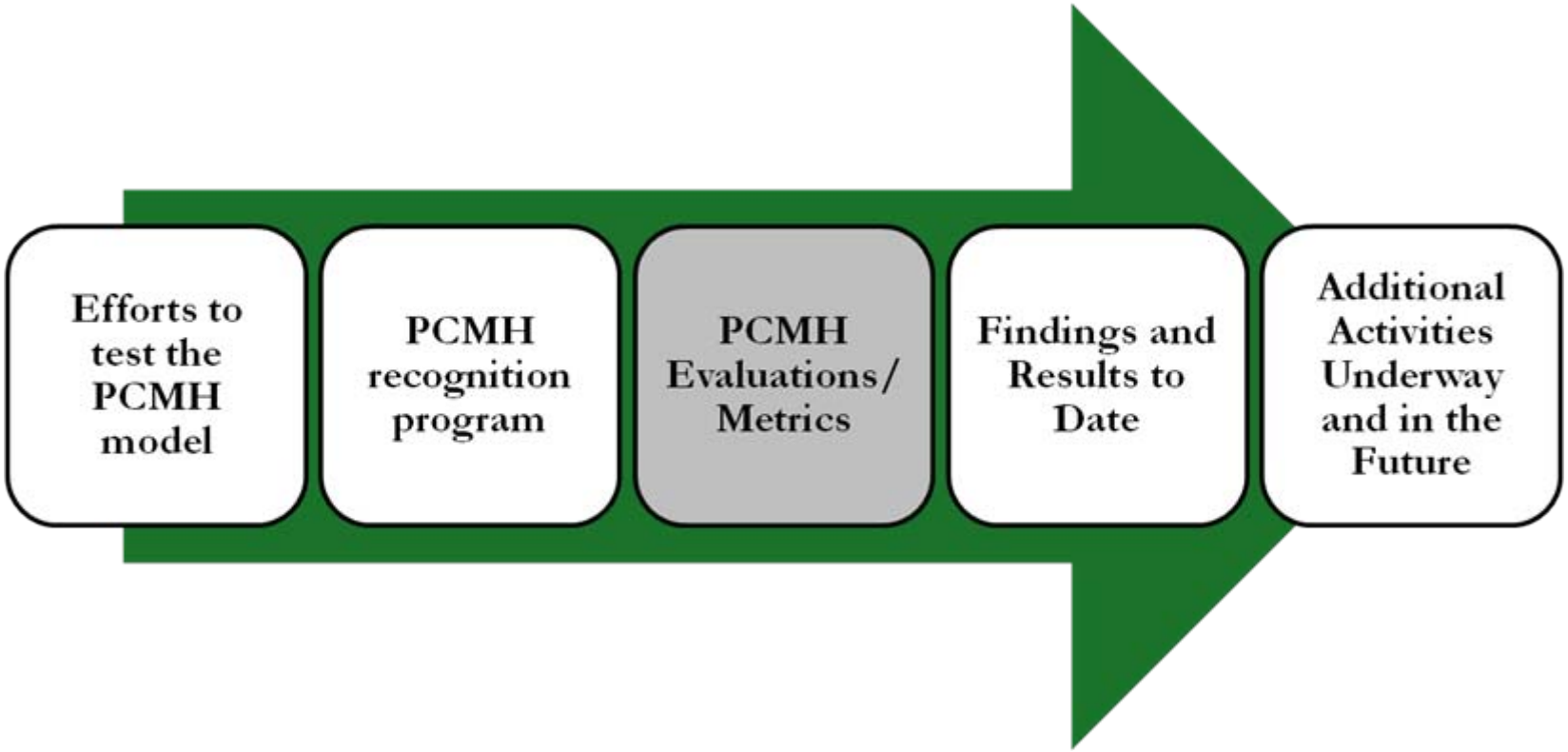


Several PCMH Evaluations Underway…

Approximately 14 independent evaluations represented in the PCMH Evaluators' Collaborative (other evaluators are welcome to participate)

The evaluations are examining a breadth of demonstrations:

- From one payer to multi-payer pilots
- Involve anywhere from 5-70 primary care practices with 28-250 clinicians
- Include 27,000 -- 1,000,000 beneficiaries
- Many include safety net centers, pediatric sites and Medicaid as a payer
- Variety of payment models (hybrid, PMPM, annual comprehensive PC fee)

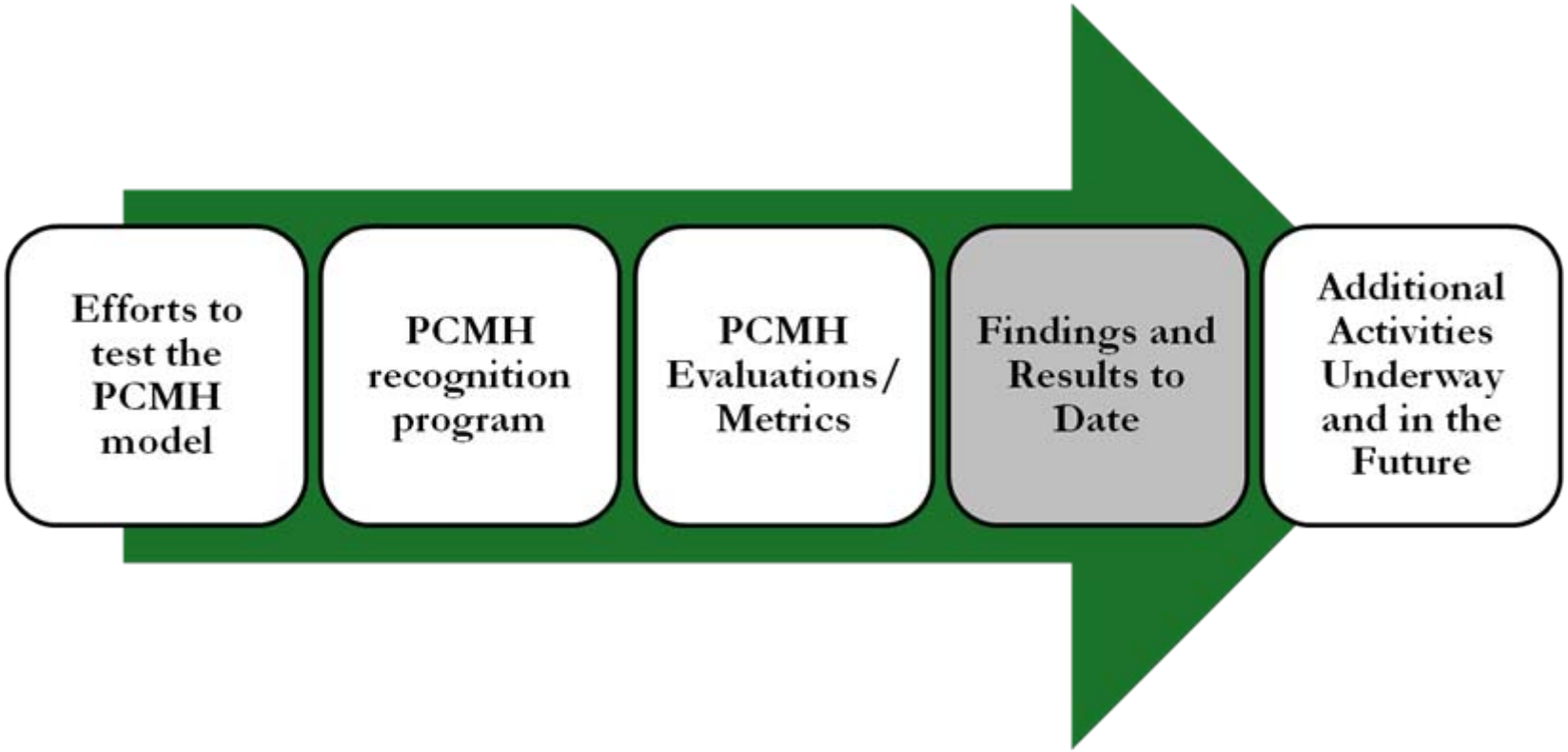
All of these independent evaluations have comparison groups

PCMH Evaluations (cont.)

Key Questions Under Investigation:

- What does it take to become a medical home?
- Do PCMHs improve:
  - Clinical Quality?
  - Patients' Experiences?
  - Physician/Staff Experience?
  - Efficiency?
- Is this sustainable/ are practices financially stable?

Presentation Outline



Community Implications - Published Results of PCMH Projects to Date

Group Health Cooperative of Puget Sound

- 29% reduction in ER visits; 11% reduction in ambulatory care sensitive admissions
- Improvements in diabetes and heart disease care
- Cost neutral after 1 year

Geisinger Health System

- 14% decrease in hospital admissions
- Improvements in diabetes and heart disease care
- 9 % reduction in costs
- ROI greater than 2 to 1

Source: PCPCC Pilot Guide, 2009

Community Implications – Published Results of PCMH Projects (cont.)

Colorado Medicaid & SCHIP

- Median annual costs $785 vs $1000
- Reduction in ER visits & hospitalizations
- More well-child visits (72% vs 27%)
- Lower median costs for children with chronic conditions ($2,275 versus $3,404)

HealthPartners Medical Group (MN)

- 39% decrease in ER visits
- 24% decrease in hospital admissions
- Better diabetes and cardiac care
- Reduced costs

Source: PCPCC Pilot Guide, 2009

Community Implications – Preliminary Findings of Other PCMH Projects

Greater New Orleans Primary Care Access and Stabilization Grant (PCASG)

- Started 9/21/07 – for 3+ years
- Multi-stakeholder; federal grant program
- 91 practices – IM, FP, Peds, others; 160,000 lives/year
- 13 of the 25 organizations achieved recognition by NCQA as PCMHs at 36 clinic locations (ranging from levels 1-3) in 2008.
- All organizations have implemented 24/7 access to clinician by phone and same day appointments for urgent care.
- The total system volume (number of individuals served) has increased by 15% every six-month period starting March 2007 for outpatient primary and behavioral health care.
- The 25 participating organizations have expanded the number of service delivery sites from 7 pre-grant to 91 today.

Source: PCPCC Pilot Guide, 2009

Community Implications – Preliminary Findings of Other PCMH Projects (cont.)

National Naval Medical Center Medical Home Program (Bethesda, MD)

- Started 4/1/08 – ongoing
- 1 IM practice; 35,000 covered lives
- PCM continuity of care increase of 33%
- 20.8% decrease in network ER visits per 100 enrollees
- 39.5% decrease in total annual ER visits per 100 enrollees
- 40.4% decrease in total specialty care visits per 100 enrollees

Source: PCPCC Pilot Guide, 2009

Community Implications – Preliminary Findings of Other PCMH Projects (cont.)

Rhode Island Chronic Care Sustainability Initiative

- Started 10/1/08; 2-3 years
- 5 IM and FP practices; 28,000 covered lives
- Multi-stakeholder
- First nine months of program (all sites combined):
  - Diabetes patients with a documented hemoglobin A1c improved from 64% to 72%
  - Diabetes patients with BP <130/80 improved from 18% to 30%
  - CAD patients on Beta blocker improved from 40% to 65%
  - Smokers with documented advice to quit improved from 14% to 35%

Source: PCPCC Pilot Guide, 2009

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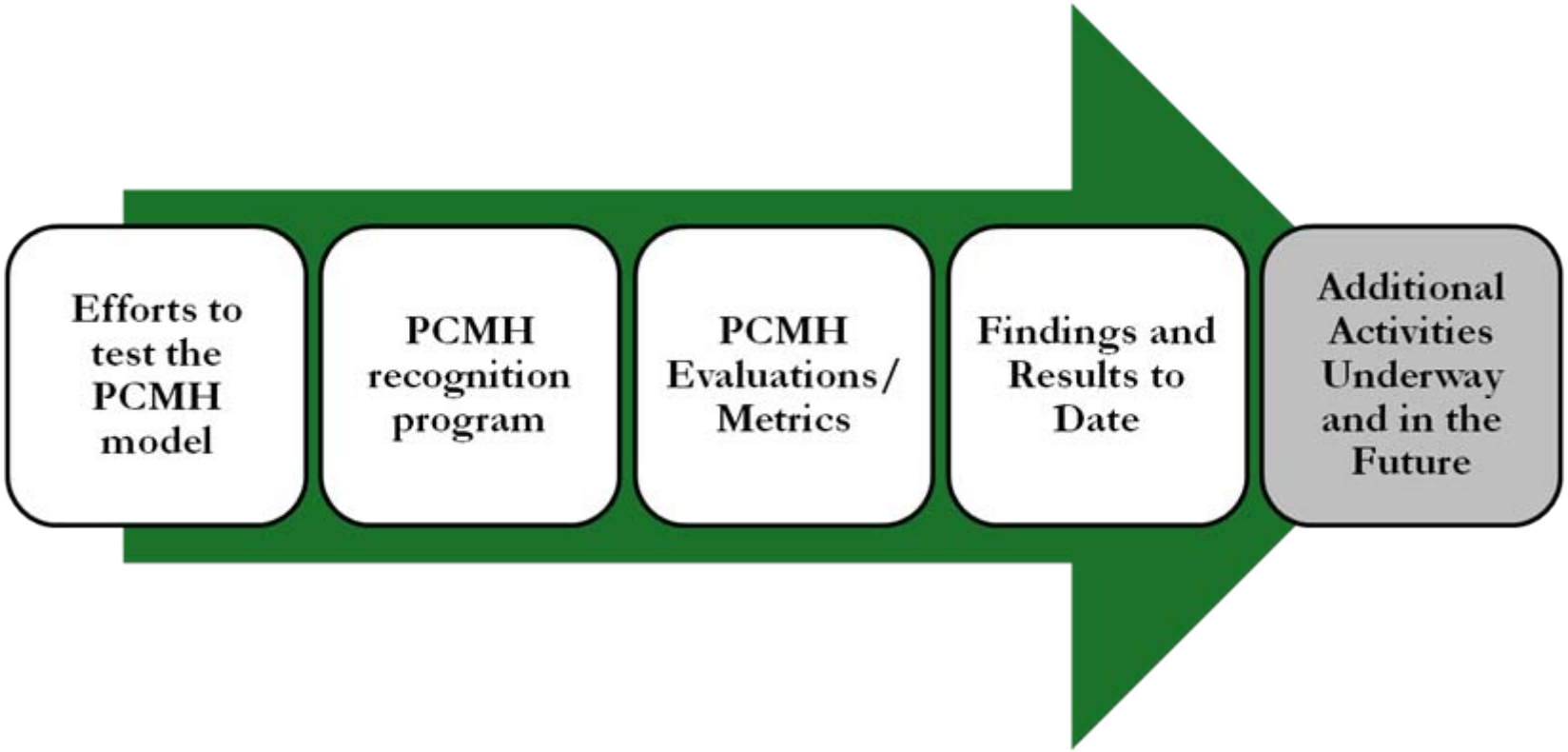

Additional Efforts Underway and In the Future

Role of subspecialists/specialists

- Facilitating coordination with other providers and caregivers to provide optimal care

Practice Support

Understanding/facilitating needed HIT

Specialty Care Connections

PCMH is NOT a gatekeeper system

Emphasis on transitions in care & continuity (e.g., referral agreements, care transitions programs)

ACP in discussions with several groups regarding the PCMH model and primary care/specialty care interface (sharing care)

ACP Council of Specialty Societies PCMH workgroup:

- Developed FAQs on the relationship of the PCMH to specialty physicians*
- Facilitating the development of the "PCMH Neighbor" concept

* FAQs available at: http://www.acponline.org/running_practice/pcmh/understanding/specialty_physicians.htm

Genesis of PCMH Neighbor Concept

Most Specialty/Subspecialty practices don't want to serve as the PCMH and be responsible for:

- Serving as first contact, primary care provider
- Serving as the communication/coordination hub of overall care

Issue of Specialty/Subspecialty practice as a PCMH for a subgroup of their patient panel

Specialty/Subspecialty practices want recognition for any increased work and responsibility required to deliver effective and efficient care in conjunction with the PCMH

Broad Characteristics of the PCMH Neighbor Concept

Reflects a specialty/subspecialty practice's ability to engage in processes to facilitate improved communication and care coordination with PCMH practices.

Reflects a specialty/subspecialty practice's ability to offer many of the other infrastructure, patient-centered and quality improvement elements included in the "Joint Principles".

Incentives for Practice to be a PCMH Neighbor (PCMH-N)

Non-financial

- Improved quality of referrals;
- An increased likelihood of PCMH's referring their patients to PCMH-Ns due to their emphasis on integrating, coordinating processes.

Financial

- An enhanced payment to cover the time and infrastructure costs of providing services consistent with the PCMH-N definition:
  - Perhaps initially a premium added to certain FFS codes, or a small monthly bundled payment.
  - Over time, it is anticipated that this payment would be incorporated into the structure of more integrated payment models e.g. Accountable Care Organizations (ACOs).

Additional Efforts Underway and In the Future

Role of subspecialists/specialists

- Facilitating coordination with other providers and caregivers to provide optimal care

Practice Support

Understanding/facilitating needed HIT

Practice Support Approaches

Payment – e.g., PMPM, performance bonus, shared savings

Learning Collaboratives – face-to-face and and/or virtual

Practice redesign guidance and support – on-site and/or virtual

- ACP Medical Home Builder (see next slide)

Provision of and support for information technology – e.g., registries, EHRs

Data services – e.g., aggregation for patient population management and performance reporting

Engagement of patients as advisors

OVERVIEW

- Patient-Centered Care & Communication
- Access & Scheduling
- Organization of Practice
- Care Coordination & Transitions in Care
- Use of Technology
- Population Management
- Quality Improvement & Performance Improvement

OVERALL BIOPSY STATUS:

You have not yet started your Practice Biopsy.

Click the **Practice Biopsy** tab to assess your practice.

import responses

- relative weakness
- average performance
- relative strength
- not yet analyzed

print page

Let's Begin...

Are You Ready to Improve Your Practice and Patient Care?

Welcome to **Medical Home Builder™** from the American College of Physicians. This online workbook will help you assess your practice's ability to provide different aspects of care and will point you in the direction of practical tools and educational resources to assist you in improving your practice. It's designed to help you self-evaluate your practice, identify areas for improvement, and implement and manage change using the talents and capabilities of your office team.

A practical, self-paced, web-based application, the workbook includes a Practice Biopsy and modules on a variety of topics, which are well suited for all members of the health-care team. The Practice Biopsy enables you to assess office functions and clinical practice and directs you to pertinent modules. The modules, listed in on the left of your screen, cover *Patient-Centered Care and Communication*, *Access and Scheduling*, *Organization of Practice*, *Care Coordination and Transitions in Care*, *Use of Technology*, *Population Management*, and *Quality Improvement and Performance Improvement*. The modules are designed to help you address your self-identified areas for change effectively and efficiently. The Quality Improvement Module allows you to quickly measure your current practice, design and implement change processes, and re-measure to see if your strategies were successful. This module will help

Found in: [clear]

- Organization of Practice

- To get started with the first module, *Patient-Centered Care and Communication*, **proceed to the Introduction** material.
- To begin with the practice assessment, **proceed directly to the Practice Biopsy**.

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Additional Efforts Underway and In the Future

Role of subspecialists/specialists

- Facilitating coordination with other providers and caregivers to provide optimal care

Practice Support

Understanding/facilitating needed HIT

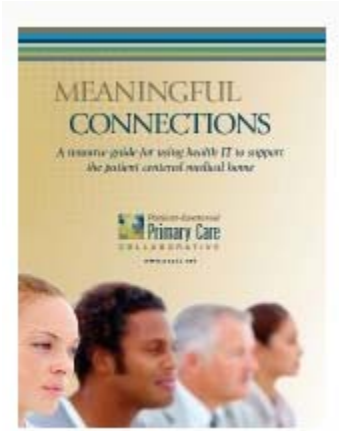
Goals of "Meaningful Use"

2011 Goal: To electronically capture in coded format and to report health information and to use that information to track key clinical conditions

2013: Same as 2011

2015 Goal: To achieve and improve performance and support care processes and on key health system outcomes

http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_888532_0_0_18/FINAL%20MU%20RECOMMENDATIONS%20TABLE.pdf



Understanding/Facilitating Needed Health Information Technology

Meaningful Connections: IT Resource Guide

- White paper by the PCPCC.
- Identifies the capabilities and functionalities of eHealth applications that experts consider crucial to support the PCMH.

Available at: http://www.pcpcc.net/content/meaningful-connections-it-resource-guide

Meaningful Connections: IT Resource Guide

Capabilities to Support the PCMH:

- Ability to collect, store, manage and exchange relevant personal health information
- Ability of providers, patients and other members of a person's health team to communicate among themselves and in the process of care delivery
- Ability to collect, store, measure and report on the processes and outcomes of individual and population performance and quality of care
- Ability of providers and their practices to engage in decision support for evidence-based treatments and tests
- Ability of consumers and patients to be informed and literate about their health and medical conditions and appropriately self-manage with monitoring and coaching from providers

HIT – What are PCMH Projects Using Now?

- Registries
- E-prescribing
- Practice management systems
- EMRs
- Patient portals
- Secure e-mail software
- Home monitoring devices

Thank You!

Shari M. Erickson, MPH
Senior Associate, Center for Practice Improvement & Innovation
American College of Physicians
25 Massachusetts Avenue, NW, Suite 700
Washington, DC
Phone: 202-261-4551
Email: serickson@mail.acponline.org