The Patient-Centered Medical Home (PCMH)

Medical Homes and Retail Clinics: Complementary Care or Conceptual Clash?

Evidence-Based Health Policy Project
UW Population Health Institute
April 7, 2009
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WISCONSIN ACADEMY OF FAMILY PHYSICIANS
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Agenda

- What is a PCMH?
- What is PCMH Recognition?
- What is the current status of PCMH in Wisconsin?

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What is a PCMH?

AAFP:

"A patient-centered medical home is an approach to providing comprehensive primary care for people of all ages and medical conditions. It is a way for a physician-led medical practice, chosen by the patient, to integrate health care services for that patient who confronts a complex and confusing health care system."

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What is a PCMH?

In a Patient Centered Medical Home:

- Patients have a **relationship** with a personal physician.
- A practice-based care **team** takes collective responsibility for the patient's **ongoing care.**
- Patients can expect care that is **coordinated** across care settings and disciplines.

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What is a PCMH?

In a Patient Centered Medical Home:

- **Quality** is measured and improved as part of daily work flow.
- Patients experience **enhanced access** and communication.
- The practice uses **electronic health records**, electronic prescribing, preventive and chronic disease **registries**, & other **clinical support systems**.

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Features of a PCMH

- 2007 - The AAFP, AAP, ACP, and AOA publish the Joint Principles of the Patient-Centered Medical Home with 7 Core Features

- Personal Physician
- Physician Directed Medical Practice Team
- Whole Person Care Orientation
- Coordinated/Integrated Care
- Quality and Safety
- Enhanced Access
- Full Value Payment Reform w/ Blended Payment Model
  - FFS
  - Care Mgmnt. Fee
  - P4P

Sources: "Joint Principles of the Patient-Centered Medical Home" available at http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf

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PCMH vs. "PCP Office"

Personal Physician & Whole Person Orientation

- Ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care
- Care in the context of person's living situation, community, etc.
  - Mind and body
  - All stages of life
  - Acute, chronic, prevention, end-of-life
- Many (but not all) current PCP offices meet these elements

Having a usual source of care is associated with a greater likelihood that people receive appropriate care, preventive care, better outcomes, lower cost

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Physician Directed Medical Practice Team

- Team approach
  - Flexes depending on the complexity of needed care
  - Low complexity tasks handled by other members of the team
  - Team members can be internal or external to the practice
- Collaborative relationship between physician and non-physician practitioners

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Coordinated/Integrated Care

- Facilitated by
  - Registries
  - Proactive care
  - Information Technology
  - Health Information Exchange
- Chronic care coordination
  - Internal or external care coordinating staff
  - Frequently part of a patient’s health plan
- Reduced duplication and improved coordination across the spectrum of care

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PCMH vs. "PCP Office"

Quality and Safety

- Evidence Based Medical care
  - Optimal chronic care guidelines embedded in practice
  - Among all teammates in care
- QI projects at the practice level
  - Quality metrics regularly measured and reviewed
  - Focused on conditions that matter in a practice
- EHR systems can greatly enhance quality
  - Use appropriately to enhance care
  - Adoption of e-prescribing an excellent 1st step

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PCMH vs. “PCP Office”

Enhanced Access

- More than Extended Hours
  - Open/advanced scheduling (significant {?>60%} appointment spots available for same day visits)
  - Increased same day access avoids ER and ⇑ continuity
- Group visits, team visits
- New methods of communication
  - Secure Email, Web, Text
  - Appt scheduling, question answering, compliance, lab results
  - Based upon a person’s preference

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Independent PCMH Recognition

- How can patients and payors know that a practice is truly functioning like a PCMH?
  - Objective practice evaluation
  - Independent 3rd party recognition is preferable to numerous “home grown” standards/audits

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What is PCMH recognition?

- NCQA's PPC®-PCMH™ recognition program
  - Recognizes physician practices functioning as medical homes by using systematic, patient-centered and coordinated care management processes
- NCQA is rapidly becoming the accepted standard of PCMH verification by AAFP, AAP, ACP, AOA, large employers, and third party payors
- NCQA allows a practice to approach recognition at its own pace using an online process

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NCQA Recognition Current Status

- Standards released in early 2008
- Currently 0 practices in WI are PCMH recognized
- Currently 0 payors in WI are paying additional for PCMH recognition
  - Over 50 national pilots are underway
  - Details can be found at
    - http://wafp.org/pcmh/payment-reform.html
    - click on “Current PCMH Pilot Projects”
  - Large WI payors are interested in a WI program

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Recent Survey of WAFP Members

182 Respondents out of ~1800 FPs

Component	Planned in '09	Part. Impl'd	Fully Impl'd	Total
Electronic Health Records	16%	15%	60%	91%
E-Prescribing	18%	9%	58%	85%
Quality Outcome Measurement	7%	42%	32%	81%
Use of EBM Guidelines and Protocols	5%	55%	20%	80%
Disease Registries	7%	35%	25%	67%
Chronic Care Model	8%	36%	17%	61%
Team Approach	4%	35%	19%	58%
Advanced Access Scheduling	4%	33%	20%	57%
Office Redesign to Inc. Efficiency	12%	29%	12%	53%
Email with Patients	7%	23%	16%	46%

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- Barriers to PCMH Implementation
  - 34% Resistance from partners/admin.
  - 31% Time
  - 22% Cost
  - 20% Inadequate payment
  - 13% Large “system” prohibitive to change
  - 11% Resistance from payors
  - 10% Staffing
- 20% of respondents have begun or plan to apply for NCQA recognition in 2009

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PCMH Summary

- A PCMH is characterized by
  - Greater access to care
  - Better quality of care
  - Greater focus on coordination of care
  - Greater focus on prevention
  - Early identification and management of health problems.
  - Efficient use of teams and systems technology

Current Model	PCMH Model
• Inefficient, • Fragmented • Rewards high volume, over-specialized care	• Strong primary care foundation • Integrated • Clear incentives for quality and efficiency

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Additional References

- www.WAFP.org/pcmh
- www.AAFP.org/pcmh
- www.NCQA.org
- www.TransforMED.com

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