CitiusTech

PCMH: Patient Centered Medical Home

March 2016

Agenda

- **Introduction**
- PCMH Vs. ACO
- Functions and Attributes
- Quality Standards and Measures
- Reimbursement models
- Benefits of PCMH

Introduction

- Patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be."
- Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care
- Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply a place but as a model of the organization of primary care that delivers the core functions of primary health care.
- NCQA Patient-Centered Medical Home (PCMH) Recognition is the most widely-used way to transform primary care practices into medical homes.

Agenda

- Introduction
- **PCMH Vs. ACO**
- Functions and Attributes
- Quality Standards and Measures
- Reimbursement models
- Benefits of PCMH

PCMH Vs. ACO

Difference between PCMH and ACO

PCMH	ACO
Focuses on care improvement for primary care services	Focuses on care improvement for an entire patient population, across the continuum
PCMH is centered around a single practice	ACO consists of many coordinated practices
PCMH is patient-centered care based around a core set of principles to improve quality and safety, financial and clinical outcomes, physician and staff satisfaction and patient engagement, while also lowering the total cost of care	ACOs lies in the concept of shared savings along with defined shared responsibility. Accountable Care absolutely must be about improving and maintaining the health of a population of patients (Not just focused on cost)
PCMH take the approach of having the primary physician lead the care delivery “team”.	ACOs comprise of many medical homes, many primary care providers and/or practices work together
Being a single primary care unit, it is responsible for cost associated with its own unit.	ACOs would be accountable for the cost and quality of care both within and outside of the primary care relationship

Agenda

- Introduction
- PCMH Vs. ACO
- **Functions and Attributes**
- Quality Standards and Measures
- Reimbursement models
- Benefits of PCMH

Functions and Attributes (1/2)

The medical home encompasses five key domains

- **Comprehensive Care**
  - Primary care providers are accountable for meeting the large majority of each patient's physical and mental health needs.
- **Patient Centered**
  - Relationship-based primary care that meets the individual patient and family's needs, preferences, and priorities.
- **Co-ordinated Care**
  - Care that is coordinated across all elements of the broader healthcare system.
- **Accessible Services**
  - Enhanced access to primary care through a variety of means including expanded hours, email and telephone communication
- **Quality & Safety**
  - PCMH model is committed to providing safe, high-quality care through clinical decision-support tools, evidence-based care, shared decision-making, performance measurement, and population health management.
  - Sharing quality data and improvement activities also contribute to a systems-level commitment to quality.

Functions and Attributes (2/2)

PCMH model is built upon three foundational supports:

Foundational Support	Description
Health IT	Health IT can support the PCMH model by collecting, storing, and managing personal health information, as well as aggregate data that can be used to improve processes and outcomes. Health IT can also support communication, clinical decision making, and patient self-management.
Workforce	A strong primary care workforce including physicians, physician assistants, nurses, medical assistants, nutritionists, social workers, and care managers is a critical element of the PCMH model. Amid a primary care workforce shortage, it is imperative to develop a workforce trained to provide care based on the elements of the PCMH.
Finance	Current fee for service payment policies are inadequate to fully achieve PCMH goals. Providers are not routinely compensated for care coordination or enhanced access, contributions of the full team are often not reimbursed, and there is no incentive to reduce duplication of services across the care continuum.

Agenda

- Introduction
- PCMH Vs. ACO
- Functions and Attributes
- **Quality Standards and Measures**
- Reimbursement models
- Benefits of PCMH

Quality Standards (1/2)

- National Committee for Quality Assurance (NCQA) has developed a tool PPC-PCMH which is used to judge the "medical homeness“
- It assesses nine standards:
  - Access and communication
  - Patient tracking and registries
  - Care management
  - Patient self-management support
  - Electronic prescribing
  - Test tracking
  - Referral tracking
  - Performance reporting and improvement
  - Advanced electronic communications
- Other measure for PCMH

Quality Standards (2/2)

10 “must-pass” elements included in the standard are :

- PPC-1A: Written standards for patient access and patient communication
- PPC-1B: Use of data to show standards for patient access and communication are met
- PPC-2D: Use of paper or electronic charting tools to organize clinical information
- PPC-2E: Use of data to identify important diagnoses and conditions in practice
- PPC-3A: Adoption and implementation of evidence-based guidelines for three chronic or important conditions

- PPC-4B: Active support of patient self-management
- PPC-6A: Systematic tracking of tests and follow up on test results
- PPC-7A: Systematic tracking of critical referrals
- PPC-8A: Measurement of clinical and/or service performance
- PPC-8C: Performance reporting by physician or across the practice

- To achieve Level 1 Recognition, practices must successfully comply with at least 5 of these elements.
- Achieving Level 2 or Level 3 depends on overall scoring and compliance with all 10 elements

Quality Measures (1/2)

Checklist

- **Points to be considered for PCMH quality measure**
  - Below clinical information systems should be used for
    - Registries
    - Referral tracking
    - Lab result tracking
    - Medication interaction alerts
    - Allergy alerts
  - Practice should
    - Establish core performance measures
    - Collect data for better clinical management
    - Analyze data for quality improvement
    - Map processes to identify efficiencies
    - Discuss best practices

Quality Measures (2/2)

- Practice should use below checklists and reminders
  - Evidence-based reminders
  - Preventive medicine reminders
  - Decision support

- Care plans should reflect
  - An updated problem list
  - A current medication list
  - Patient-oriented goals and expectations

Agenda

- Introduction
- PCMH Vs. ACO
- Functions and Attributes
- Quality Standards and Measures
- **Reimbursement models**
- Benefits of PCMH

Reimbursement models

Patient-Centered Primary Care Collaborative (PCPCC) believes that the most effective way to re-align payment incentives to support PCMH would be to combine traditional fee-for-service for office visits with a three-part model that includes :

- M**onthly care coordination payment**
  - For the physician and non-physician work that falls outside of a face-to-face visit and for the system infrastructure (e.g. heath information technologies) needed to achieve better outcomes.
- **Visit-based fee-for-service component**
  - Recognizes visit-based services that are currently paid under the present fee-for-service payment system and maintains an incentive for the physician to see the patient in the office when appropriate
- **Performance-based component**
  - Recognizes achievement of quality and efficiency goals

Agenda

- Introduction
- PCMH Vs. ACO
- Functions and Attributes
- Quality Standards
- Reimbursement models
- **Benefits of PCMH**

Benefits of PCMH (1/2)

- **Benefit to Patients**
  - Engaged, happier, and more satisfied patients
  - Better coordinated, more comprehensive and personalized care
  - Improved access to medical care and services
  - Improved health outcomes, especially for patients who have chronic conditions
- **Benefits to Providers**
  - Increased physician and staff member satisfaction
  - Physicians and staff members who practice at the top of their licenses
  - Improved safety and quality of care
- **Benefits for Your Bottom Line**
  - A more efficient use of practice resources, resulting in cost savings
  - Opportunities to participate in payment incentives for adopting the functions of a PCMH
  - A practice that is better prepared to succeed once primary care payment reform has become widespread (e.g., value-based payment or global payment)
  - A practice that is better prepared to participate in accountable care organizations

Benefits of PCMH (2/2)

Benefits to Payers

- A solid return on investment (ROI) can be realized by creating a total cost picture that is a function of an employee's inpatient and outpatient treatments, pharmacy, disability, absenteeism, and workers' compensation.
- Allows physicians to share in savings from reduced hospitalizations
- Allows for additional payments for achieving measurable and continuous quality improvements
- Countries with a greater proportion of physicians practicing primary care medicine tend to have lower per-capita health expenditures than those with a greater proportion of specialists

References

- http://www.ncqa.org/
- http://www.aafp.org/practice-management/transformation/pcmh.html
- http://www.aafp.org/practice-management/transformation/pcmh/benefits.html
- http://pcmh.ahrq.gov/

PCMH implementation example :

- http://www.drmignoli.com/pcmh_overview.pdf

Measures of the PCMH and Primary Care:

- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2869425/table/Tab3/

THANK YOU