

Patient-Centered Medical Home: The Keystone for Primary Care?

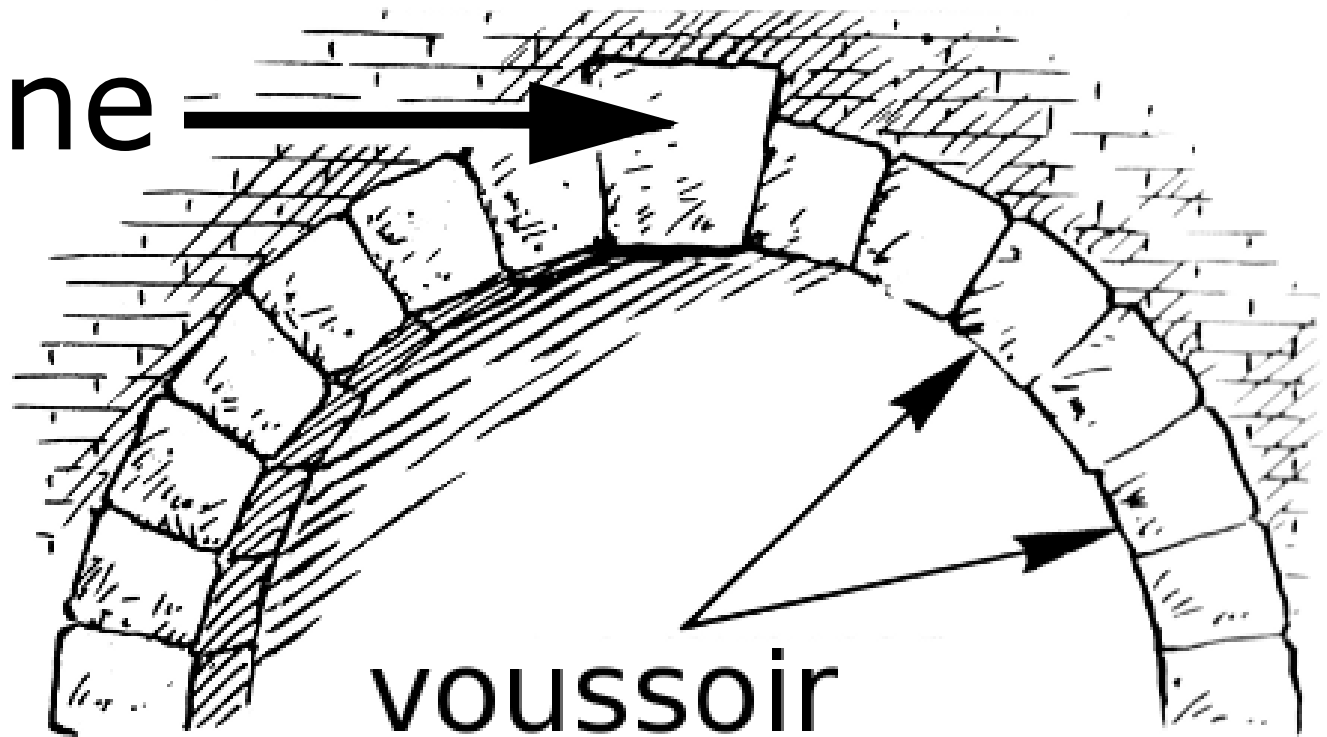
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keystone



How well is Australia's health care doing?

- Treating sinusitis?
- Managing obesity?
- Preventing heart disease?
- Preventing lung cancer?
- Managing individuals with multiple chronic diseases?
- Providing care for long-term cancer survivors?
- Managing depression?
- Treating substance abuse?

Quality issues are because:

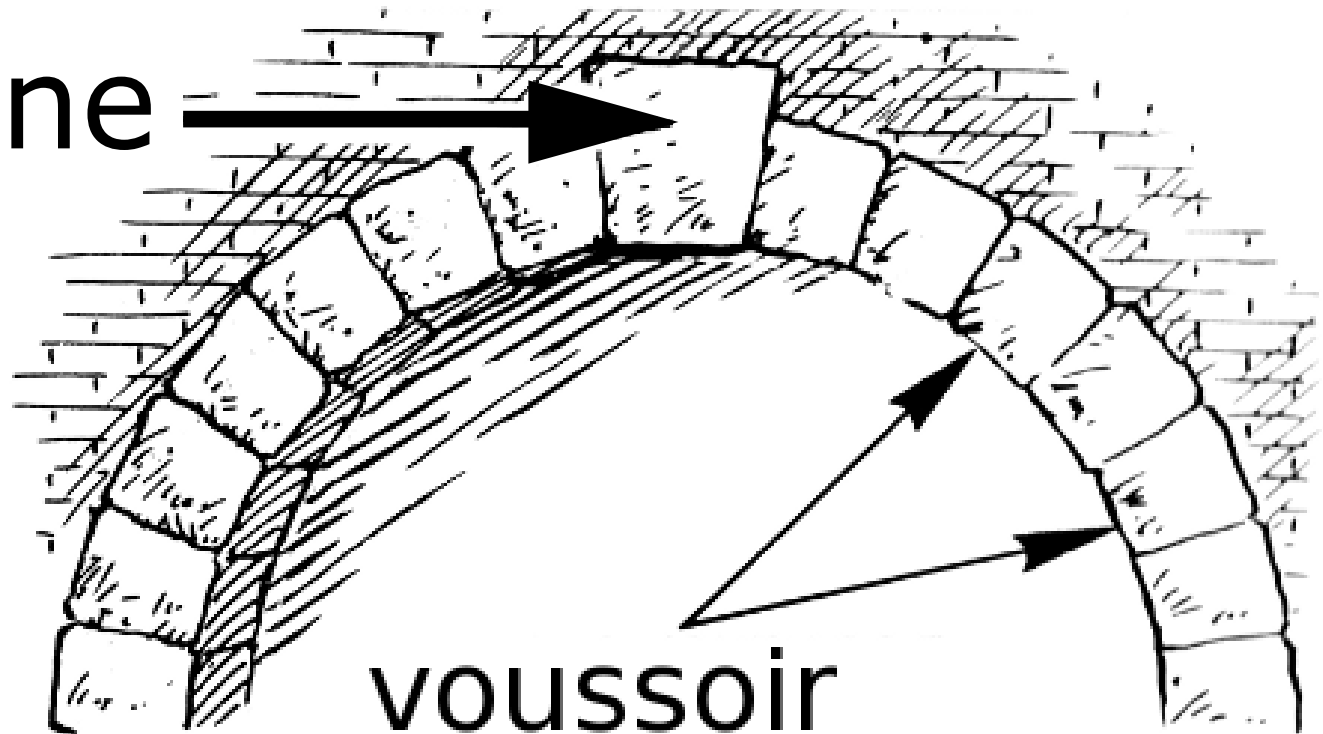
- A. The country doesn't spend enough on health care.
- B. Doctors don't know these are problems that should be addressed.
- C. Competing demands make it impossible to do everything.
- D. Practices are designed for care of acute problems and single chronic diseases.
- E. Australia doesn't address the underlying determinants of health.

A Primary Care Clinical Story

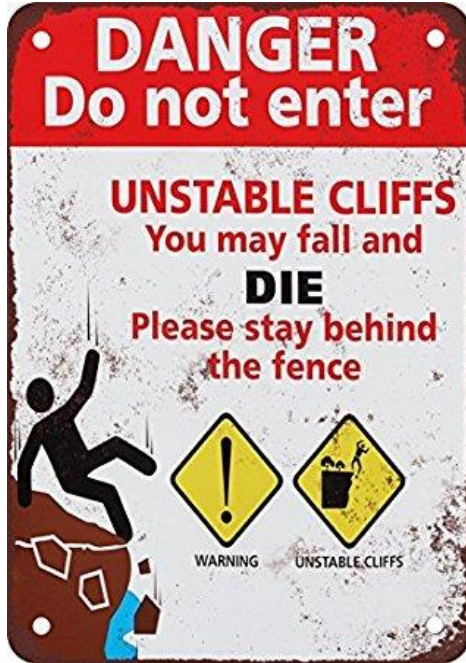
- Helen slumps in the corner of the exam room. Dr. Jones, her family physician, enters for his 10 minute visit.
- Dr. Jones looks at Helen and asks, “How many seizures are you having?”
- This is the 12th visit in 2 years with multiple providers for this 46 year old woman with chronic problems of abdominal complaints, seizures, hypertension, type 2 diabetes, & depression.
- How can Dr. Jones meet the patient-centered needs of Helen?

Is the PCMH the keystone for Helen?

keystone

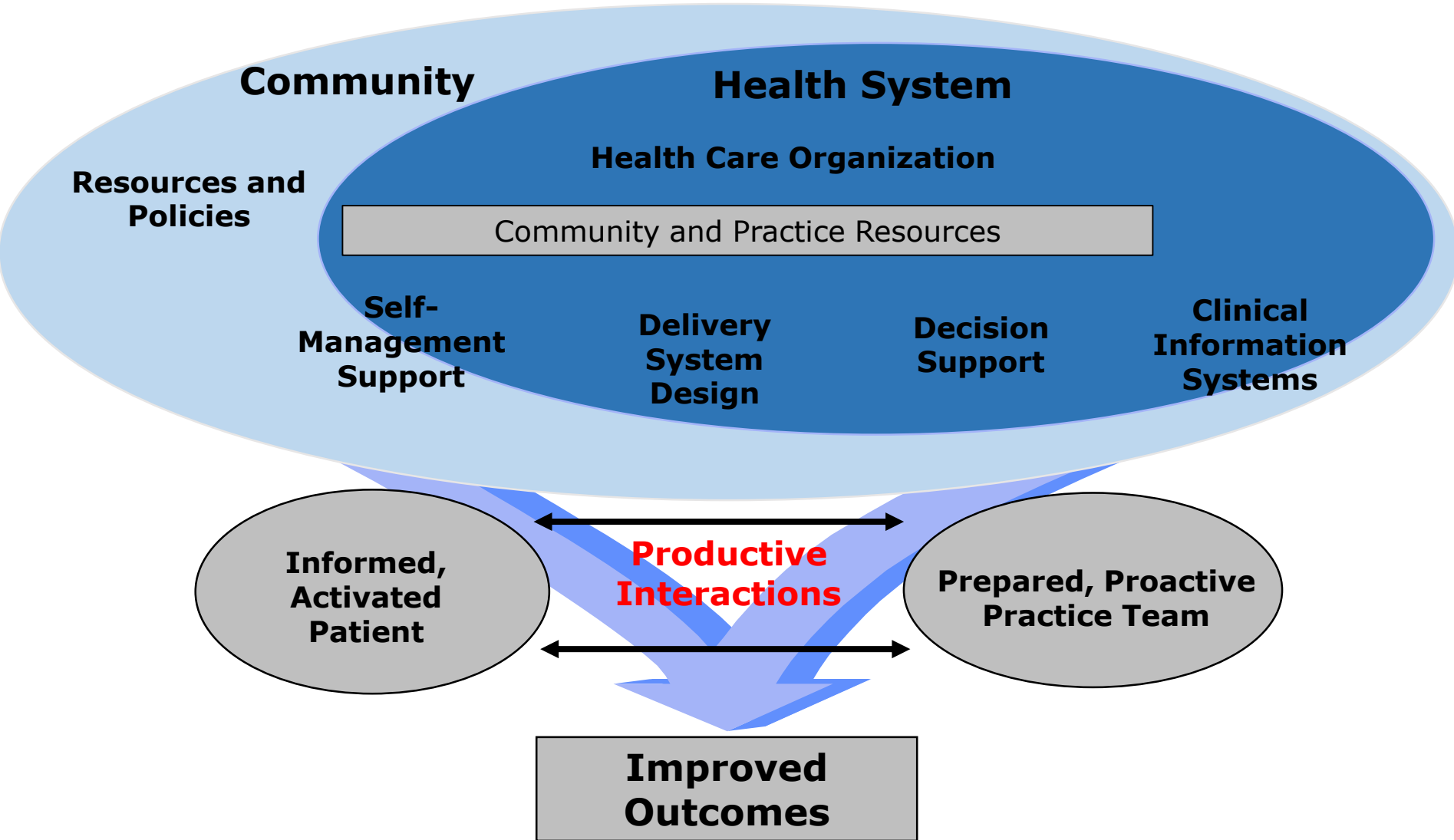


US Primary care is in transition...

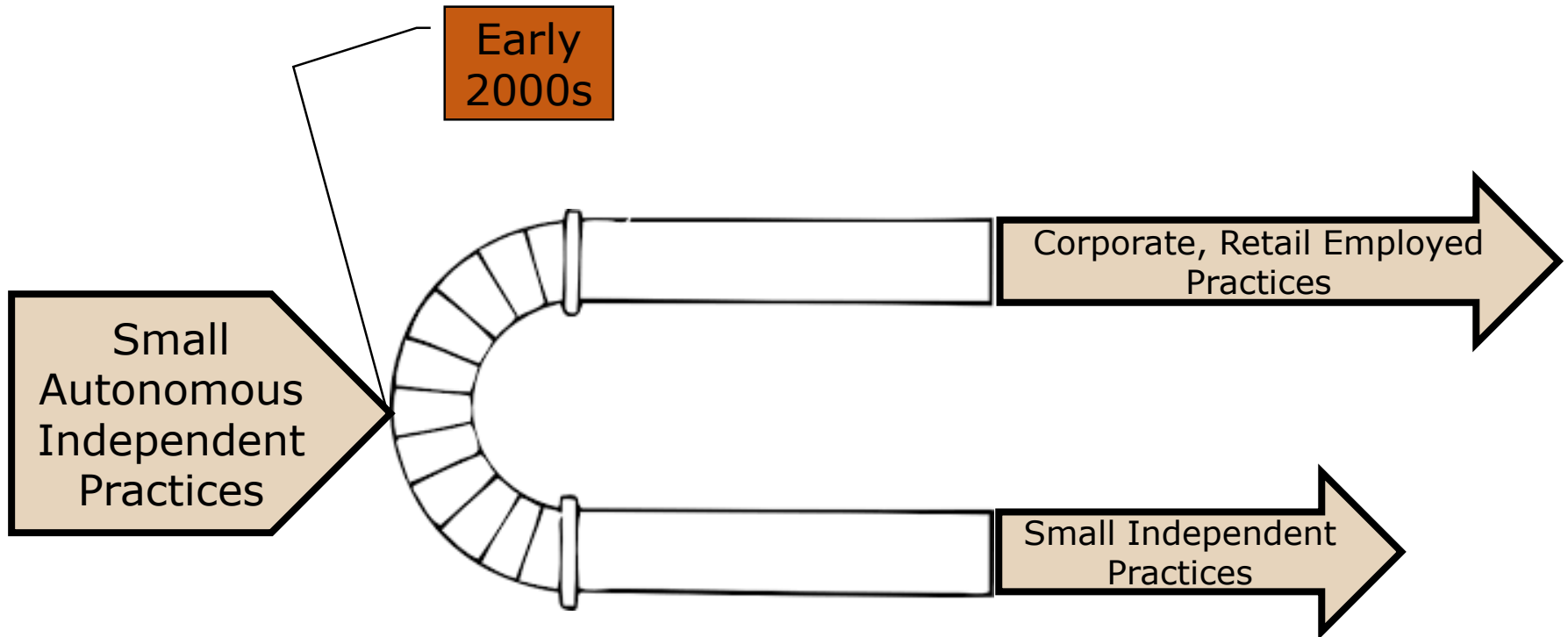


- Barbara Starfield's international comparisons of primary care finds the US lags behind
- IOM Chasm Report of 2001 finds huge quality gaps in US
- Future of Family Medicine Report of 2004 proposes major practice redesign
- NCQA, ACA, Meaningful Use & a whole host of disruptions!

Chronic Care Model



Healthcare Bifurcation Point in the United States



The US Primary Care Bifurcation

2000

- **Keystone III Conference**

Family Medicine recognition that the discipline of family medicine was in serious trouble, commissioned study in 2002

2004

- **Future of Family Medicine Report**

New Model of practice and recommended “proof of concept” demonstration project in typical family practices

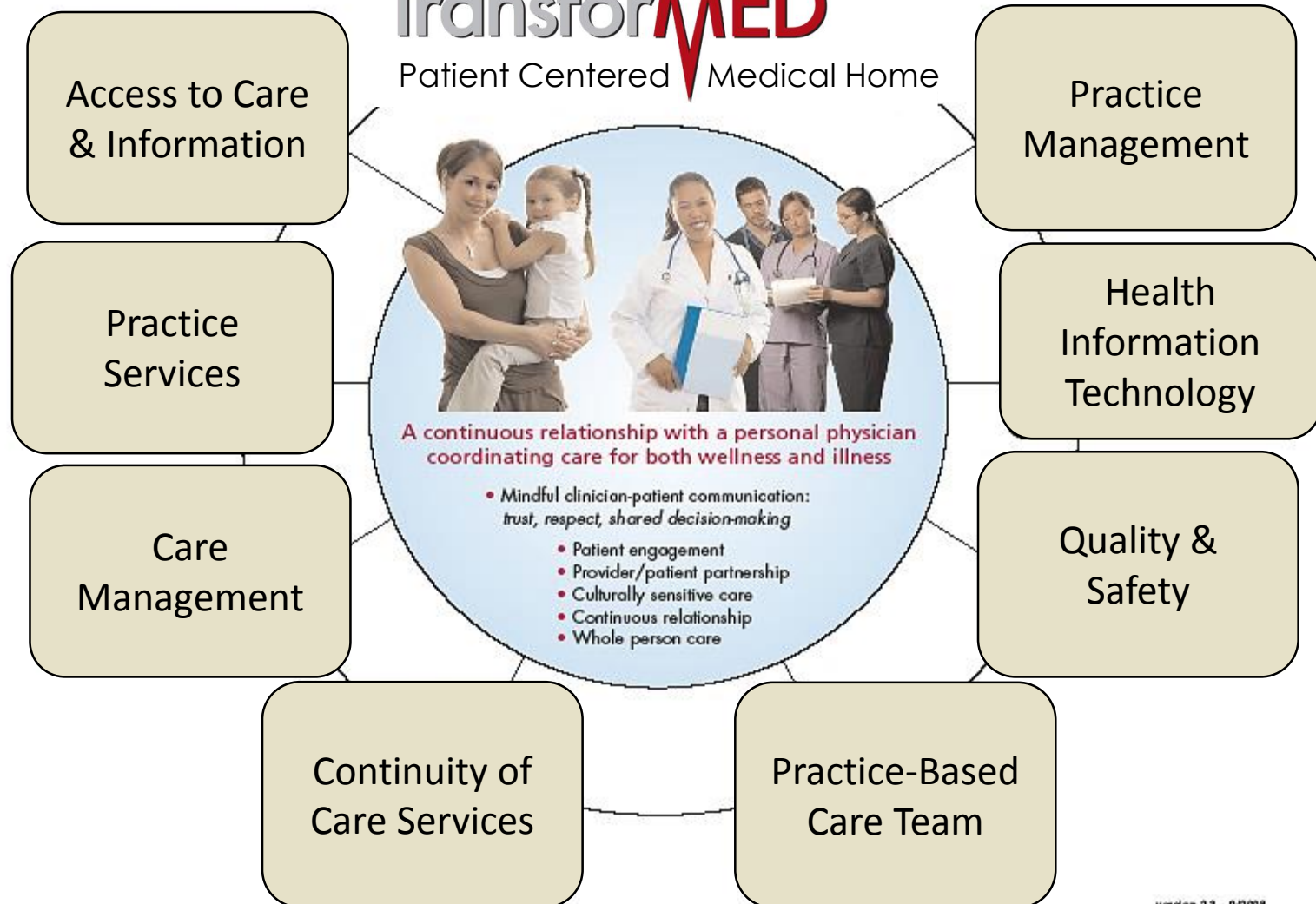
2006

- **AAFP creates TransforMED and begins NDP**

- 36 family medicine practices randomized to two arms to implement NDP Model with independent evaluation

TransformSMMED

Patient Centered Medical Home



Find out more at www.TransformMED.com

version 2.3 - 9/2008
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The US Primary Care Bifurcation

2007

- **Joint Principles of a Patient Centered Medical Home**
- AAFP, ACP, AAP and AOA release consensus statement

2007

- **NCQA announces Physician Practice Connections**
- A program with criteria that medical practices should meet to be recognized as medical homes

2008

- **Primary Care Patient-Centered Collaborative (PCPCC)**
- Announces 16 significant state-level or multi-payer medical home demonstration projects are underway

NCQA Proposed PCMH Recognition Criteria in 2007



- Access and communication
- Patient tracking & registries
- Care management
- Patient self-management support
- Electronic prescribing
- Test tracking
- Referral tracking
- Performance reporting & improvement
- Advanced electronic communications

The US Primary Care Bifurcation

2010

- ACA in March 2010 creates integrated delivery systems platforms with PCMH often a major part
- **Accountable Care Organizations (ACOs) take off**

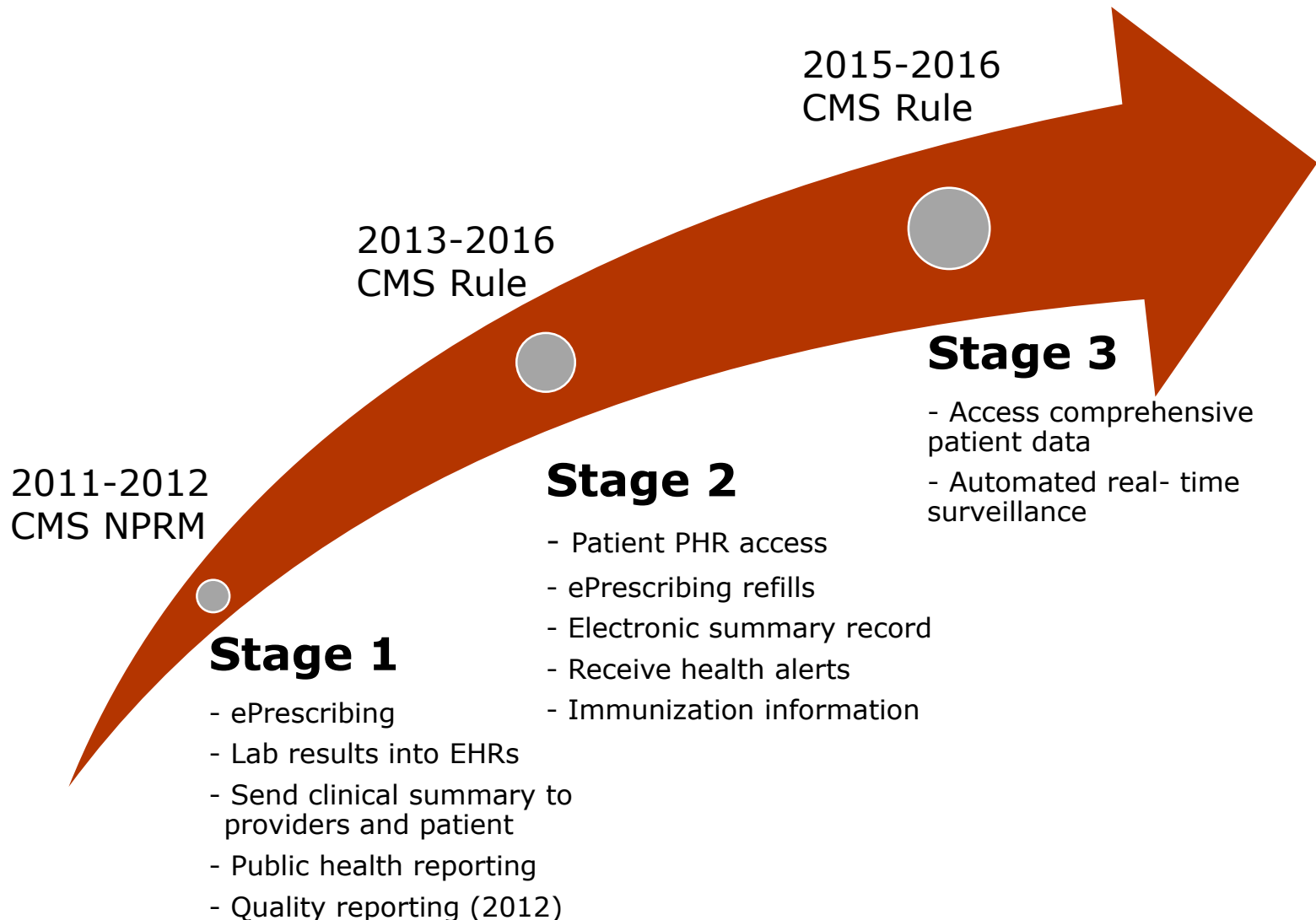
2011

- **NCQA Updates Recognition Criteria**
- New NCQA criteria are announced with the PCMH Survey tool. This was updated again in 2014 & 2017

2012

- **First stage of Meaningful Use initiated by CMS to implement EHRs**
- Stage 2 and Stage 3 instituted over next several years

Meaningful Use- Staged approach



The Primary Care Bifurcation

2014

- Meaningful Use Stage 2 & EHRs
- **SIM grants 2013**

2015

- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**
- Takes affect in 2017

2017

- **Change in US Administration and attempts to repeal and/or replace ACA**



The Patient Centered Medical Home



So, what is the PCMH?

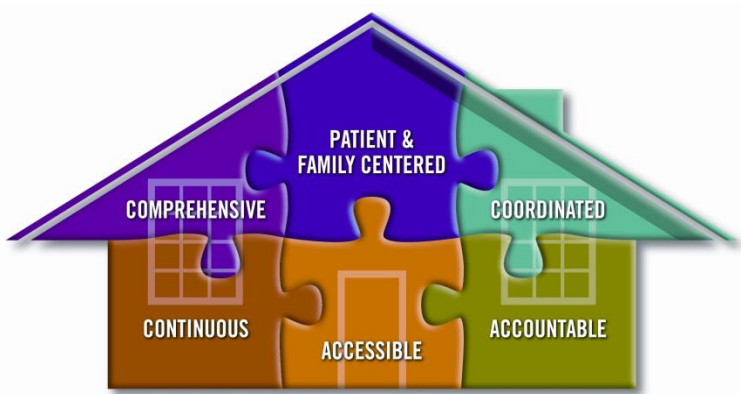
- Team of people embedded in a community seeking to improve health and healing in that community & consisting of:
 - Fundamental tenets of primary care (Starfield)
 - First contact access
 - Comprehensiveness
 - Integration / coordination
 - Relationships involving sustained partnership
 - New ways of organizing practice
 - Development of practice internal capabilities
 - Health care delivery system & payment changes
 - **Evolving political construct**

PCMH's Magic Formula

$$QA = (P + FCA + CS + CI + 0.45CWF) G$$

or

$$(4C + .45WF) G$$



The Quadruple Aim

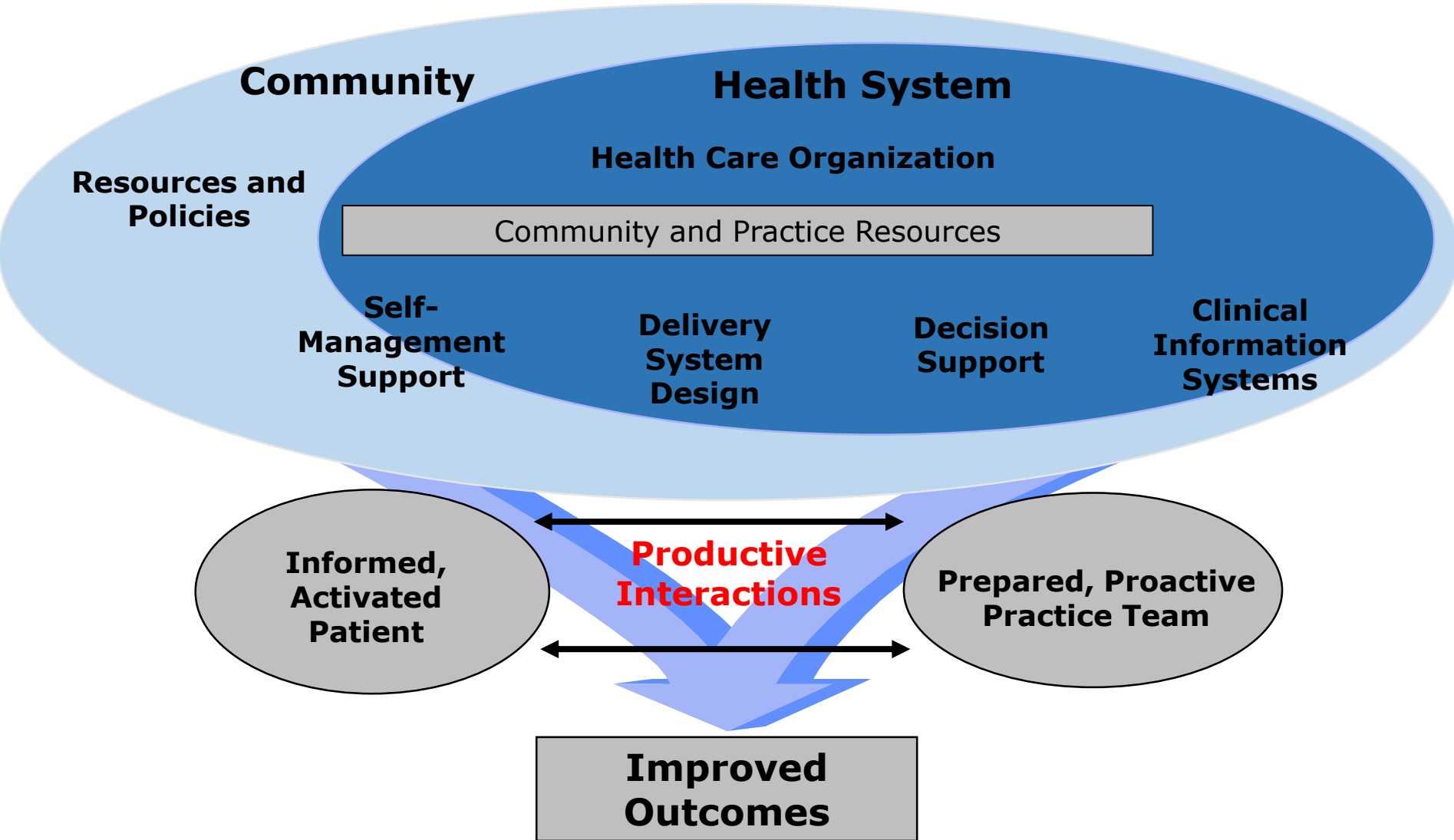
The PCMH is not built in isolation



The PCMH self-organizes according to a basin of attraction often outside the practice

- NCQA Recognition
- Accountable Care Organizations
- Fee for Service Documentation
- Meaningful Use
- Pay for performance on disease outcomes
- Employer mandates
- And many more...

Chronic Care Model Attractor



The NCQA Attractor in 2007: 166 practice-report items

46%	Use of information technology
14%	Care for 3 specific chronic diseases
13%	Systems for coordinating care
9%	Processes for accessibility
5%	Performance reporting
4%	Tools for organizing clinical data
2%	Use of non-physician staff
2%	Collection of data on patient experience
1%	Preventive service delivery
1%	Continuity of care
1%	Patient communication preferences



The ACO Attractor in the US

- Network of doctors & hospitals that share financial & medical responsibility for providing coordinated care.
- By 2016, more than 800 new public & private ACOs have been formed in all 50 states:
 - Medicare Shared Savings Program (MSSP) Accountable Care Organizations
 - Medicaid Accountable Care Organizations
 - Integrated Delivery Systems
 - Multispecialty Group Practice (usually don't own the health plan, but contract with multiple plans)
 - Independent Practice Associations
- Drastic shift away from private independent practices to affiliated & owned practices

The Meaningful Use Attractor

- Implement drug-drug and drug-allergy interaction checks
- Maintain up-to-date problem list of current and active diagnoses
- Generate and transmit permissible prescriptions electronically
- Maintain active medication list
- Record demographics and vital signs
- Implement clinical decision support rule for high clinical priority and track compliance
- Patients can view online, download, and transmit information
- Provide clinical summaries for patients for each office visit

Lots of Other Attractors

- Changing Demographics
- Pay for Performance
- Incentives for targeting high risk patients
- Fee for Service Documentation

What PCMH Models have Emerged?



Addition



Hybrid



Renovation



Integration

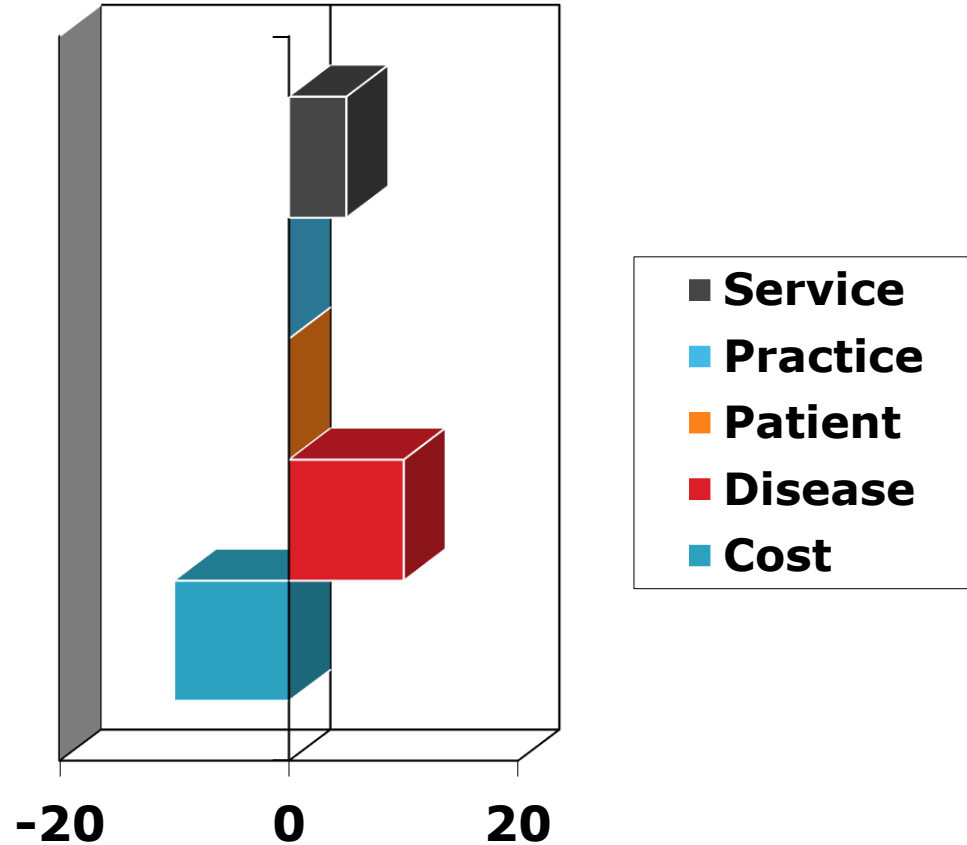
PCMH as Home Addition



Addition example

- Healthy Valley, a rural FQHC, added care management, which began as telephonic, disease-specific care but soon grew to include health center-embedded care managers, transition coaches for recent hospital discharges, and community resource advocates.
- Added 4 behavioral healthcare providers (integrated PsyD and LCSW, plus co-located psychiatric NP and LCSW).
- Behavioral health integrated as full members of care teams and warm hand-offs are typical.
- Level 3 NCQA Recognized PCMH.

Benefits of Addition



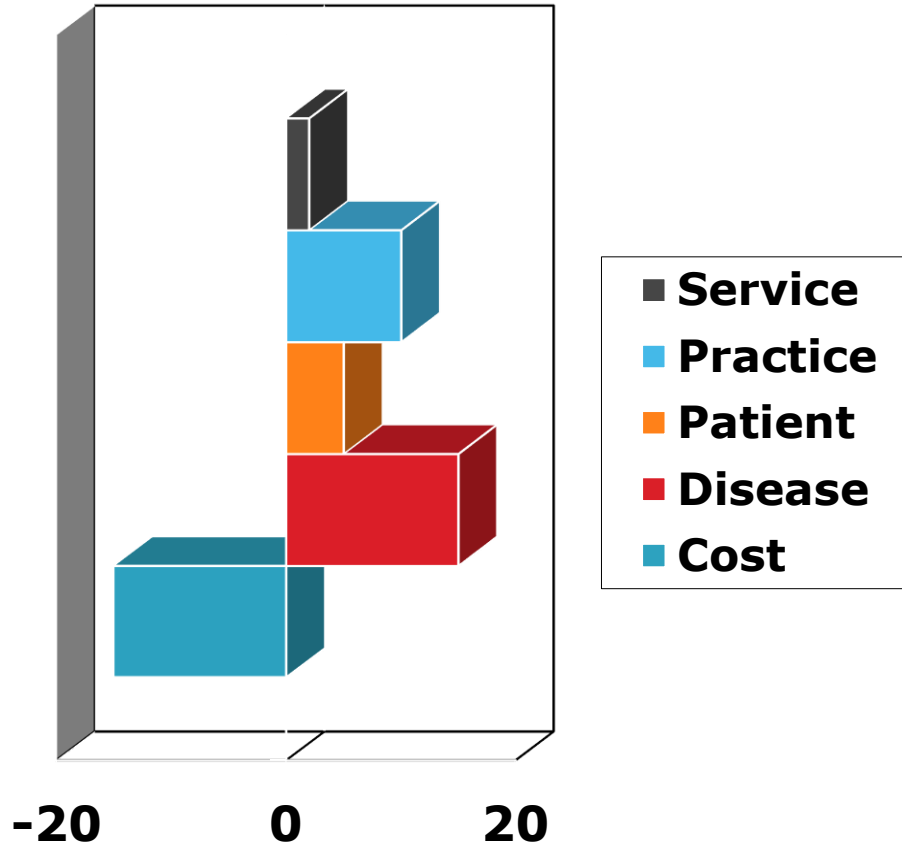
PCMH as Home Renovation



Renovation example

- Big Island Family Practice adopted Toyota Lean & taught this to all leaders & many staff.
- Using existing personnel, created teams of 2 physicians, one mid level, 1 RN, and 2 MA's, with all teams sharing a pharmacist. Joint workspaces created for MA's/clinicians, with nurses located.
- Created "Flow Stations" by up-skilling traditional MA roles and creating partnerships of a clinician and MA's who worked together.
- MA called flow manager & manages the flow of patients & all the paperwork.
- Pharmacy & Care manager are available to keep things flowing.
- All work is finished by end of the day.
- Level 3 NCQA recognized PCMH.

Benefits of Renovation



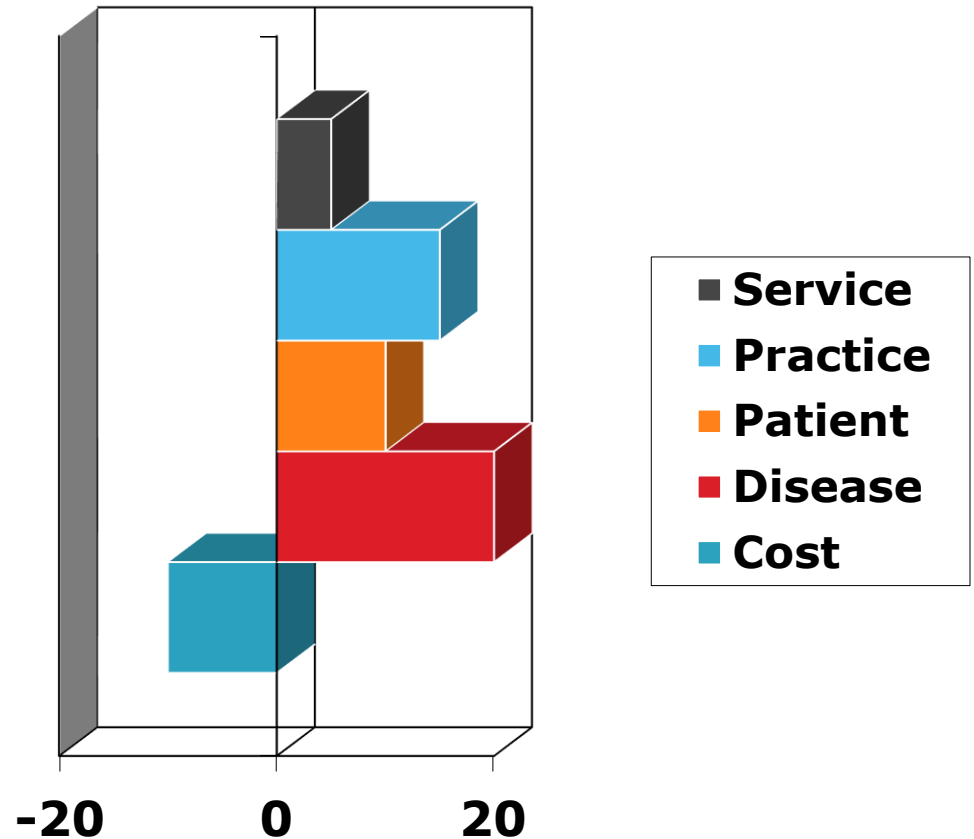
PCMH as Home Hybrid



Hybrid example

- Mayville Physician's Clinic is a semi-urban practice in a small system that combines elements of "Addition" and "Renovation" described above.
- Addition of a Licensed Clinical Professional Counselor who sees patients who are on narcotics, who have addictive behaviors, and who have chronic diseases.
- Renovated staffing roles into teamlets whereby MA starts the visit (chart review and HPI), scribes while the clinician examines patient, and then finishes the visit (including scheduling the next appointment) when the provider leaves to see the next patient.
- Daily practice-wide huddles for ten years that includes the entire team.
- Level 3 NCQA PCMH recognition since 2008.

Benefits of Hybrid Model



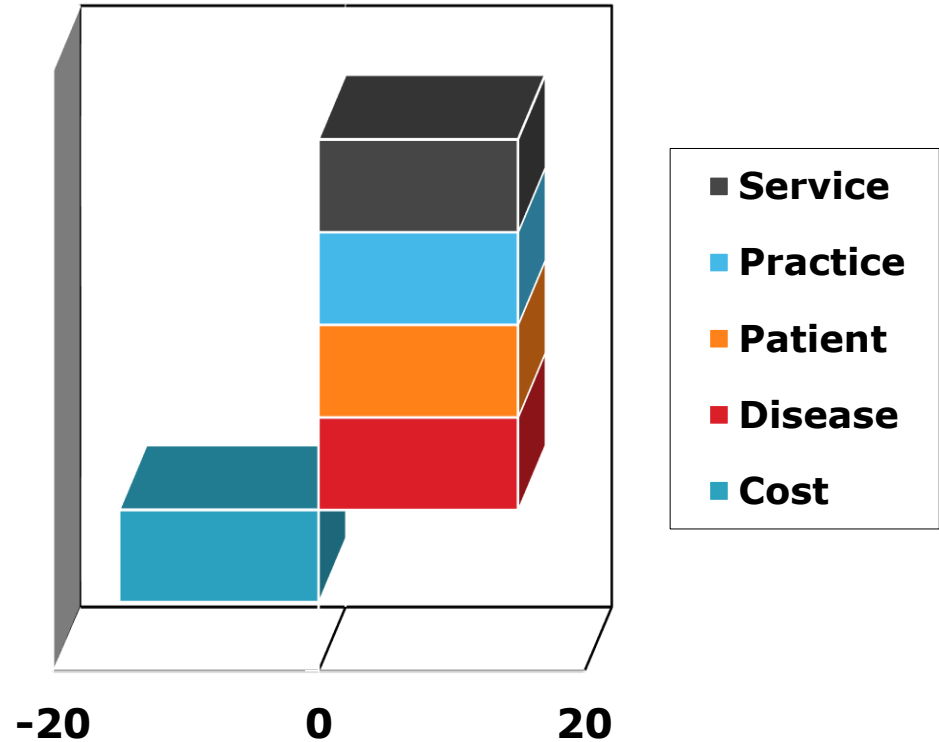
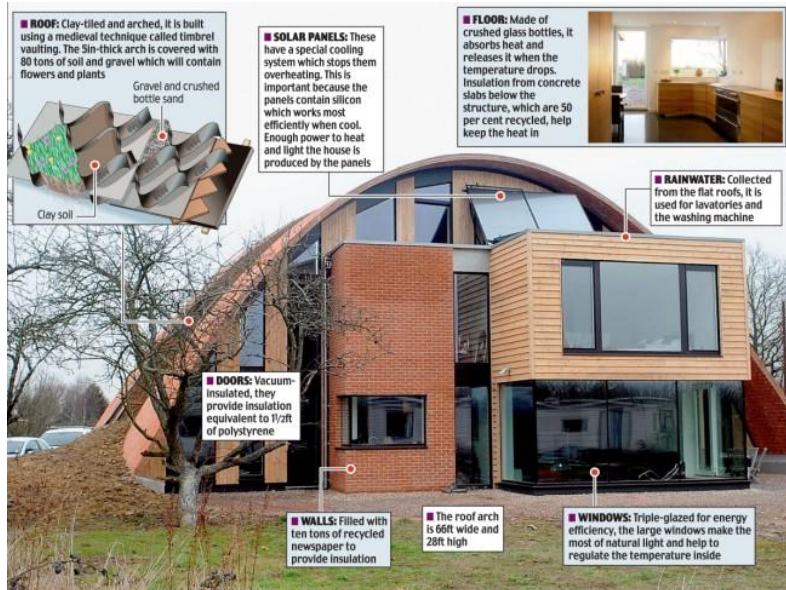
PCMH as Integration



Integration example

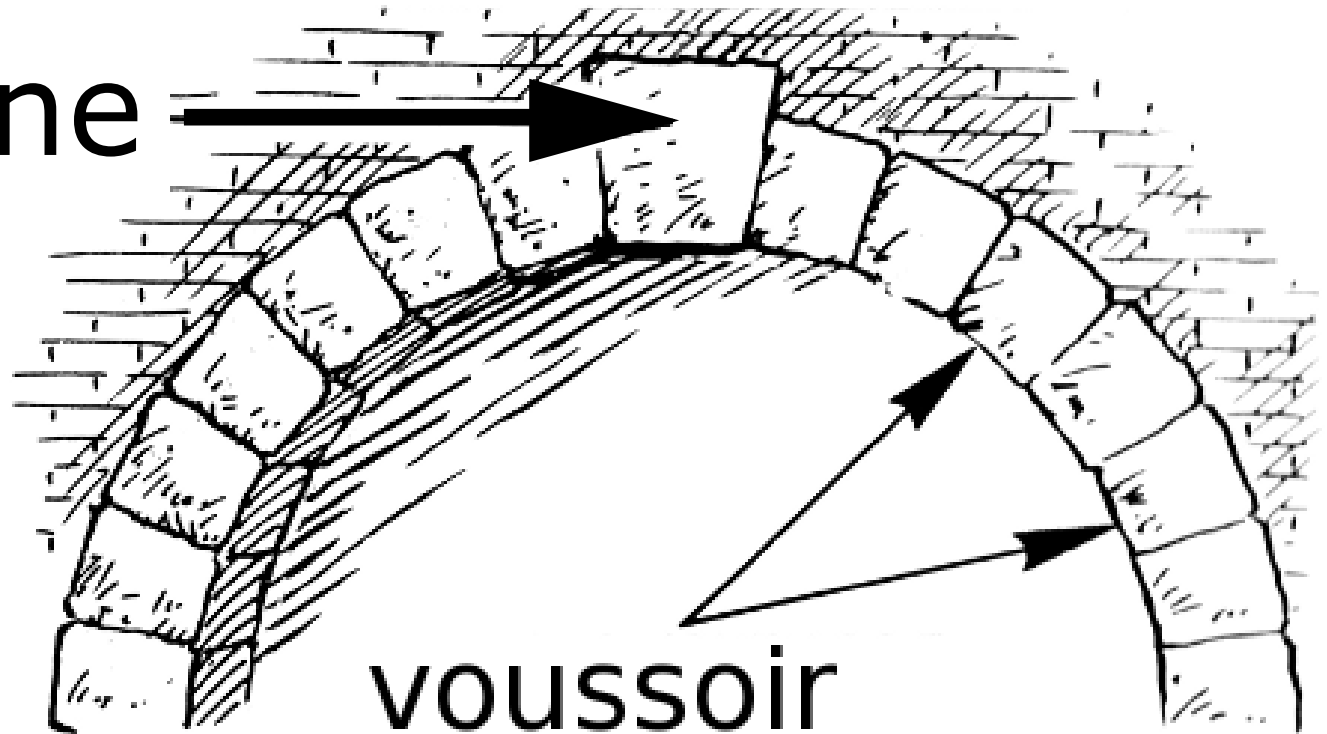
- Western Medical Clinic is a suburban private practice that combined elements of “Addition” and “Renovation” described above, while also integrating behavioral health, community, and medical neighborhood.
- Created team-based care (Red/Blue) and provider-MA dyads using existing personnel to assess patients’ needs, coordinate support services, and provide multidisciplinary care.
- Added and integrated onsite psychologist (Ph.D.), health coach (M.Ed.), and chiropractor (D.C.).
- Created physician compacts with more than 50 local specialists to improve transitions in care and communication among doctors and patients.
- Level 3 NCQA PCMH recognition in 2009.

Benefits of Integration



Are these emerging PCMH's the keystone?

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Which PCMH Model?



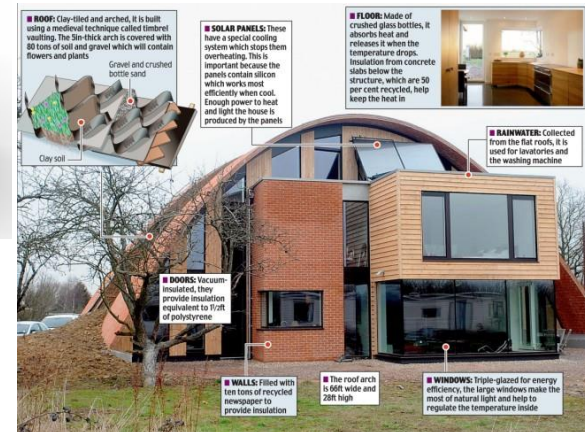
Addition



Renovation



Hybrid



Integration

Emerging Models Require Comprehensive Descriptions & Evaluations



Our Collaborative Team's Program of Research

Crabtree BF, Nutting PA, Miller WL, McDaniel RR, Stange KC, Jaen CR, Stewart EE. **Primary care practice transformation is hard work: Insights from a 15 year developmental program of research.** Medical Care, 49(Dec Suppl): S28-35, 2011.

Observation

DOPC

Direct
Observation of
Primary
Care
(1994-1997), NCI R01



P&CD

Prevention
&
Competing
Demands in Primary Care
(1996-1999), AHRQ R01

IMPACT

Insights from
Multimethod
Practice
Assessment of
Change over
Time
(2001-2004), NCI R01

Intervention

STEP-UP

Study
To
Enhance
Prevention by
Understanding
Practice
(1996-2000), NCI R01

ULTRA

Using
Learning
Teams for
Reflective
Adaptation
(2002-2007), NHLBI R01



SCOPE

Supporting
Colorectal
Outcomes through
Participatory
Enhancements
(2005-2010), NCI R01

NDP
National
Demonstration
Project
(2006-2009)

Some Lessons Learned

- Practices are complex systems
- Change is HARD
- RELATIONSHIPS matter
- LEADERSHIP is key
- PERSONAL transformation is needed
- There is no such thing as “Plug ‘n Play”
- The promise of the patient-centered medical home remains elusive
- AND, the healthcare world is rapidly changing and our thinking needs to extend beyond the individual practice.

We are currently studying different PCMH models plus other primary care models

PCMH Implementation Strategies: Implications for Cancer Survivor Care

- A comparative case study of 16 advanced primary care practices throughout the US recruited from March 2015 to April 2017.
- Purpose is to identify and describe innovative primary care practices that have implemented some of the most challenging attributes.
- Researchers conducted 10-12 days of ethnographic data collection in each practice, including interviews with practice personnel and observations of practice operations and patient office visits.
- Fieldnotes, transcripts, and practice documents were analyzed across cases to identify salient themes.

Union Employee Model

- Urban Family Practice has capitation contracts with unions and services union members in a dense urban area.
- There are 6 clinicians who are each paired with one MA as a teamlet.
- Teamlets are organized into two teams, with an RN, 2 health coaches, and a floor coordinator supporting each team. They also have access to 2 LCSWs and a registered dietitian.
- There is heavy QI focus, with QI targets being selected related to PCMH recognition.
- Level 3 NCQA recognition PCMH.

Unique Medicare Advantage Model

- Aura Primary Care only sees patients 65+ and uses teams of 3 health coaches/physician.
- Patients come in to see their health coaches, not necessarily doctors.
- The workday begins with a 45-minute team huddle, with mini-huddles between doctors and health coaches on Wednesday afternoons to review patient panels.
- Patients' primary relationship is with the health coach.
- Health coaches have a standard 1-hr visit and never schedule more than 7 in a day.



Direct Care Model

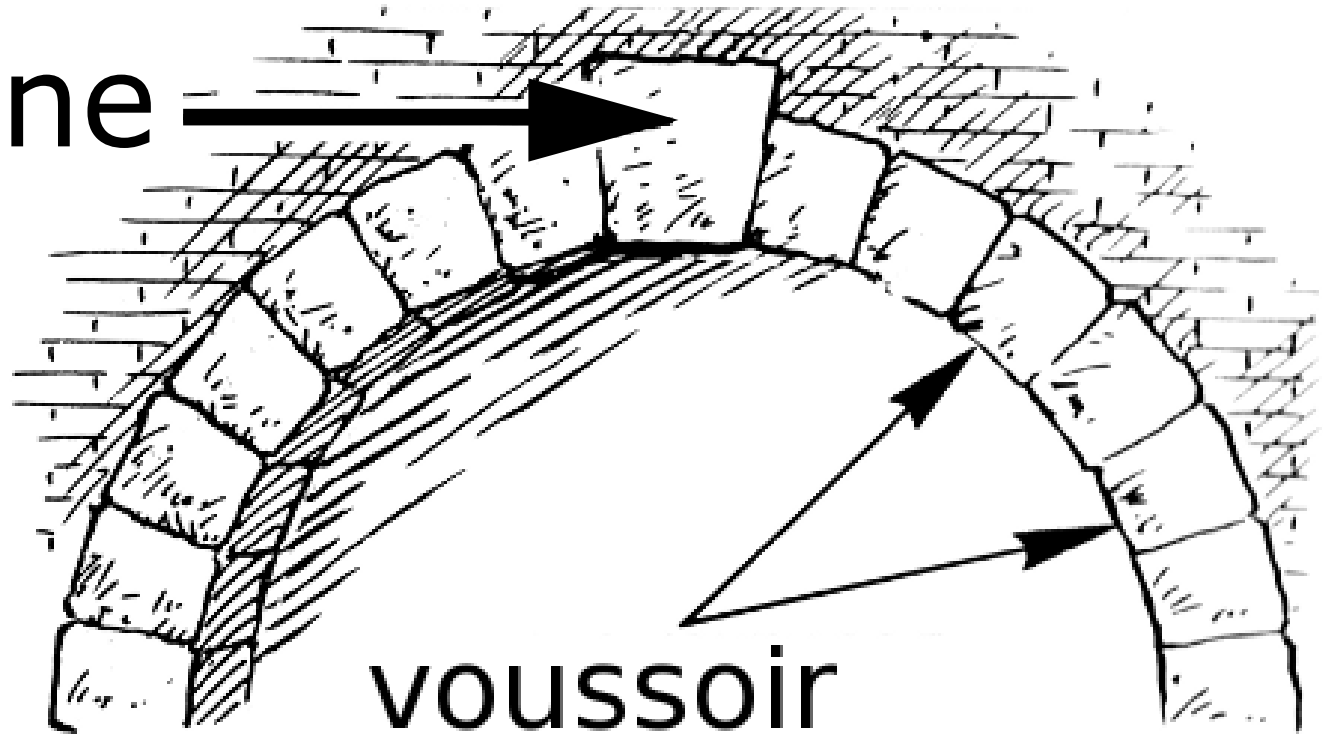
- Quality Care is an urban Direct Care practice in which patients sign up for “membership” and pay a monthly fee that allows them to access primary care services.
- Evolved from a “concierge model” but for the masses (social justice philosophy) including Medicaid.
- The clinic is deemphasized with a lot of work happening via phone, text, or email.
- Clinicians are responsible for doing a lot of the care coordination and follow-up with staff minimally involved in actual care delivery.

Insights into Workforce Challenges

- Current physicians (and others) must transform themselves (Mental models).
- Future professionals need to learn the basics of leadership, teamwork, and organizational behavior.
- New professional roles need to be conceptualized and programs created to train for the future.
- Cultures of teamwork and collaboration need to be established within and across primary care and specialty practices, as well as throughout the neighborhood.

Is primary care the keystone for family and patient-centered care?

keystone





PCMH



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 - Data collection: Ellen Rubenstein, PhD; Heather Lee, PhD; Jennifer Tsui, PhD
- Kieber-Emmons AM, Miller WL. A PCMH Framing Typology: An emerging guide for understanding structure, function, and outcomes of Patient-Centered Medical Homes. J Am Board Fam Med, in press.

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