Re-Inventing Your Practice into a Patient Centered Medical Home

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The Patient Protection and Affordable Care Act (ACA) is signed into law
“Amidst the debate about health care reform, there appears to be near unanimity around the fact that a reformed U.S. health care system requires at it’s foundation a robust system of primary care.”

Landon BE, Gill JM, Antonelli RC, Rich EL, J. Gen Int Med 25(6) 581-3
What Is Driving The Renewed Emphasis on Primary Care?

• Urgent need to slow the rate of medical inflation and improve value of health care dollar
  —Primary Care is critical to increasing value
More Specialists Mean Higher Spending

EXHIBIT 7
Relationship Between Provider Workforce And Medicare Spending: Specialists Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)

8,000

7,000

6,000

5,000

4,000

18 19 20 21 22

Specialists per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.
While GPs are Associated with Less Spending

EXHIBIT 9
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)

EXHIBIT 9
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.
As It Turns Out, Cost is *Inversely* Related to Quality

EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001

<table>
<thead>
<tr>
<th>Overall quality ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>11</td>
</tr>
<tr>
<td>21</td>
</tr>
<tr>
<td>31</td>
</tr>
<tr>
<td>41</td>
</tr>
<tr>
<td>51</td>
</tr>
</tbody>
</table>

Annual Medicare spending per beneficiary (dollars)


*NOTE:* For quality ranking, smaller values equal higher quality.
And More Specialists Predict Lower Quality Ranking

EXHIBIT 6
Relationship Between Provider Workforce And Quality: Specialists Per 10,000 And Quality Rank In 2000

<table>
<thead>
<tr>
<th>Quality rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
</tr>
<tr>
<td>26</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.
While More GPs Predict Higher Quality Ranking

EXHIBIT 8
Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000

<table>
<thead>
<tr>
<th>Quality rank</th>
<th>General practitioners per 10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td></td>
</tr>
<tr>
<td>51</td>
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SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.
A major impetus behind the PCMH is coming from commercial payers and states.
Overview of Activity

- 27 Multi-stakeholder and other Pilots in 18 States
- 44 States and the District of Columbia Have Passed over 330 Laws and/or Have PCMH Activity
- Medicaid and Medicare Activity

The Patient-Centered Primary Care Collaborative (PCPCC)

- Started in 2006 by large employers, led by IBM, who were deeply dissatisfied with health care quality they were buying.
The Patient-Centered Primary Care Collaborative

Examples of Broad Stakeholder Support & Participation

Providers
- 333,000 primary care providers
  - ACP
  - AAFP
  - AOA
  - ABIM
  - ACC
  - ACOI
  - AHI
  - AMA

The Patient-Centered Medical Home

Purchasers – Most of the Fortune 500
- IBM
- Ohio
- FedEx
- Iowa
- Dow
- General Electric
- Business Coalitions
- Pfizer
- Microsoft

80 Million lives

Payers
- BCBSA
- Aetna
- United
- Humana
- CIGNA
- Kaiser Permanente
- WellPoint
- Geisinger

Patients
- AARP
- AFL-CIO
- National Consumers League
- SEIU
- Foundation for Informed Decision Making

Source: PCPCC (www.pcpcc.net)
The PCPCC has ready entree to congress and the White House
So What is a Patient-Centered Medical Home?
Joint Principles of the PCMH (February 2007)

The following principles were written and agreed upon by the four Primary Care Physician Organizations – the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association.
Joint Principles of the PCMH (February 2007)

**Principles:**
- Ongoing relationship with personal physician
- Physician directed medical practice
- Whole person orientation
- Coordinated care across the health system
- Quality and safety
- Enhanced access to care
- Payment recognizes the value added

Source: PCPCC (www.pcpcc.net)
Endorsements

• The American Academy of Chest Physicians
• The American Academy of Hospice and Palliative Medicine
• The American Academy of Neurology
• The American College of Cardiology
• The American College of Osteopathic Family Physicians
• The American College of Osteopathic Internists
• The American Geriatrics Society
• The American Medical Directors Association
• The American Society of Addiction Medicine
• The American Society of Clinical Oncology
• The Society for Adolescent Medicine
• The Society of Critical Care Medicine
• The Society of General Internal Medicine
• American Medical Association
• Association of Professors of Medicine
• Association of Program Directors in Internal Medicine
• Clerkship Directors in Internal Medicine
• Infectious Diseases Society of Medicine

Source: PCPCC (www.pcpcc.net)
## Defining the Medical Home

<table>
<thead>
<tr>
<th>Superb Access to Care</th>
<th>Care Coordination</th>
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<td>• Patients can easily make appointments and select the day and time</td>
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<td>• Specialists care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved.</td>
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<th>Team Care</th>
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<td>• Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals (including BH specialists)</td>
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<th>Patient Feedback</th>
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<td>• These systems support high-quality care, practice-based learning, and quality improvement.</td>
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<td>• Practices maintain patient registries; monitor adherence to treatment, have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.</td>
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<td>• Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans.</td>
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# Defining the Medical Home

## Superb Access to Care

- Patients can easily make appointments and select the day and time
- Waiting times are short
- eMail and telephone consultations are offered
- Off-hour service is available
Defining the Medical Home

Patient Engagement in Care

- Patients have the option of being informed and engaged partners in their care
- Practices provide information on treatment plans, preventive and follow-up care reminders, access to medical records, assistance with self-care, and counseling.
## Defining the Medical Home

### Clinical Information Systems

- These systems support high-quality care, practice-based learning, and quality improvement.
- Practices maintain patient registries; monitor adherence to treatment, have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.
Defining the Medical Home

Care Coordination

- Specialists care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved.
- Follow-up and support is provided.
Defining the Medical Home

Team Care

- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals (including BH specialists.)
- Duplication of tests and procedures is avoided
# Defining the Medical Home

**Patient Feedback**

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Defining the Medical Home

Publicly Available Information

- Patients have accurate, standardized information on physicians to help them choose a practice that will meet their needs
# The Medical Home Is Something Fundamentally Different

<table>
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<tr>
<th>Usual Care</th>
<th>Medical Home</th>
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</thead>
<tbody>
<tr>
<td>Relies on the clinician</td>
<td>Relies on the team</td>
</tr>
<tr>
<td>Care provided to those who come in</td>
<td>Care provided for all</td>
</tr>
<tr>
<td>Performance is assumed</td>
<td>Performance is measured</td>
</tr>
<tr>
<td>Innovation is infrequent</td>
<td>Innovation occurs regularly</td>
</tr>
<tr>
<td>Includes only primary care</td>
<td>Includes mental health, Pharm D’s and others</td>
</tr>
<tr>
<td>Navigation and care management not available</td>
<td>Navigation and care management are required</td>
</tr>
<tr>
<td>H.I.T. may or may not support care</td>
<td>H.I.T. must support care</td>
</tr>
</tbody>
</table>

*Image Source: Jefferson Medical College*
A PCMH cannot be created and sustained without a meaningful change in payment to primary care
The Ecology of Medical Care

- Half of all physician visits are to generalist clinicians
- Most visits for common, serious conditions are to primary care practices
- Primary care infrastructure consists of small, relatively independent practices

Typical practice consists of
- 2-5 clinicians
- Fewer than 3 non-clinician nursing and clerical staff for each clinician

Most practices have a hierarchical management structure
- Physician owners and office manager provide oversight

“Climates permeated with stress and overwork”

- Most work on margins of financial viability
  - Little time for self-reflection
  - Little or no training in quality improvement and organizational management

Grumbach K and Bodenheimer J. JAMA (2002):889-93
TransforMed – National Demonstration Project

The largest demonstration of primary care transformation performed to date

NDP - Conclusions

“. . . primary care practices in the U.S. need external resources to successfully undertake the magnitude of redesign envisioned in the PCMH.”

“The NDP model can, thus, probably be disseminated, but only if sufficient time and resources are made available.”
Potential Payment Model

1. Fee for service
2. Payment for case management
3. Pay for performance
4. Support for preventive care outreach
The Geisinger Model

- Incentives to primary care practices to achieve diabetes outcomes
- Case manager in every practice paid for by the Health System
- Preventive care services managed centrally
  - Identify whether patients are up to date with cancer screening and immunizations
  - Write and call patients to obtain these services or invite them in for a visit
    - Scheduled in same patient contact
Applying the PCMH Model to Diabetes Care

1. Facility access
2. Develop a patient registry – identify the practice’s patients with diabetes
3. Standardize care
   - Practice-wide guidelines and protocols
4. Mobilize the entire team
Applying the PCMH Model to Diabetes Care

5. Institute patient and clinician reminders
6. Find ways to engage patient in self-management
7. Case manage high utilizers and/or the hard to reach
8. Measure and report outcomes every month
1. Ensure Access For All

Cost savings chiefly result from keeping patients out of the emergency department.
Every opportunity to prevent an emergency department visit is an emergency
How To Ensure Access

• Supply of appointments must be sufficient
  ─ Extend capacity of phone or e-visits

• Consider “advanced access” or “open access” scheduling
  ─ Keep appointments “frozen” till 24 hours before
  ─ JFMA lowered no-show rate from 23% to 14% overnight
  ─ We schedule 150 patients per day who called within 24 hours
2. Developing A Patient Registry

1. Ideally, EMR should function as a registry
2. Stand-alone electronic registries exist
3. A paper-based registry may be feasible in a small practice
Data Elements in a Diabetes Registry

**Patient identifiers**
- Name
- Birthdate

**Intermediate outcomes**
- A1c
- LDL
- HDL
- Triglycerides
- Microalbumin
- Creatinine
- Blood pressure

**Process measures**
- Eye exam
- Foot exam

**Immunizations**
- Influenza
- Pneumonia

**Therapies**
- ACE or ARB
- Aspirin
3. Standardize Care

1. Establish frequency of testing
2. Set goals of therapy
3. Develop and promote therapeutic flowsheets/guidelines
Examples

1. Testing
   - A1c every 3-6 months
   - LDL annually
   - Eye exam annually
   - Microalbumin annually
Examples

2. Therapy
   - Hyperglycemia:
     ➢ For individuals with A1c <8.9 Metformin 1000 bid; Add sulfonylurea or GLP-I mimetic; Add TZD
     ➢ For individuals with A1c ≥9.0% begin basal insulin and Metformin

3. Goals
   - A1c: <8.0% for all; <7.0% for some
   - LDL: <100mg/dl for all; <70 mg/dl for some
4. Mobilize the Team

- **Everyone** should have a role in achieving team goals
  - Registrars print reminders
  - Medical assistants complete diabetes flow sheet; perform fact-exams; counsel patients
  - Navigators schedule tests and consultations
  - Phone operators ensure access
  - Nurses case manage and serve as health coaches
  - Clinicians counsel and recommend therapy
Add New Team Members

- Mental Health
- Pharm D’s
- Dental
- Recreation
5. Institute Reminders

1. Last A1c, lipid panel, microalbumin, eye exam
   - Manual
   - Electronic

2. Aspirin?

3. Phone calls and letters to patients who are late for testing
   - Best managed centrally
• Meaningful use accredited EMR’s will have reminder capacity
• Stand-alone primary care EMR products issue automatic reminders
Insurance companies use software that can issue reminders:

**NaviNet™** is one example

- Stop creating “non-compliant” patients
- People have trouble adhering for lots of good reasons
  - Lack of social support
  - Financial barriers
  - Competing demands
  - Inadequate knowledge
  - Lack of sense of risk
- Our 15 minute visits are often inadequate to address these barriers
7. Case Manage High Utilizers or Hard to Reach

- Case management or Health Coaching is a care feature of the PCMH
- Lots of ways to identify patients in need
  - A1c >9%
  - Recently hospitalized
  - Misses appointments
  - Evidence from payer of high utilization
How Can You Afford a Case Manager in Your Practice?

• **You probably can’t**
• Look for a partner
  – Hospital (Accountable Care Organization)
  – Insurer (show that you have patients costing them a lot of money)
  – Employer (when one or two large employers dominate)
  – State or National Government
    • Medicaid or Medicare Pilot Programs
8. Measure and Report Outcomes Every Month

I hate measurement!
PCMH Transformation in Practice – Jefferson Family Medicine Associates
Diabetes Information to Support Your Health (DISH)

- A multi-disciplinary group visit model
DISH is held every Friday. Each patient gets individual attention (a “visit”) and a group experience

- Neva White, CRNP-CDE
- Amy Egras, PharmD
- Residents
- Medical Assistants
- Case Manager
Baseline Characteristics

Most Patients in DISH & Matched Controls (52 vs. 236) are:

- Female
- African American
- At least 45 years old
- Obese
- Below 200% of federal poverty level
- Taking oral antidiabetic medications
A1c Values in DISH and Comparison Groups

- **A1c < 7%**
  - DISH: 56%
  - Comparison: 46%
  - *p = 0.0849*

- **A1c < 8%**
  - DISH: 69%
  - Comparison: 70%

- **A1c > 9%**
  - DISH: 28%
  - Comparison: 19%

Bar chart showing baseline and follow-up A1c values for DISH and Comparison groups.
Decline in A1c Values

- DISH group: 76.9%
- Comparison group: 54.3%

CMH statistic 8.9911; \( p = 0.0027 \)
Blood Pressure in DISH and Comparison Groups

<table>
<thead>
<tr>
<th></th>
<th>DISH Baseline</th>
<th>DISH Follow up</th>
<th>Comparison Baseline</th>
<th>Comparison Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP &lt; 140/90 mm Hg</td>
<td>75.0%</td>
<td>60.2%</td>
<td>60.2%</td>
<td>33.5%</td>
</tr>
<tr>
<td>BP &lt; 130/80 mm Hg</td>
<td>32.7%</td>
<td>32.7%</td>
<td>33.5%</td>
<td>33.5%</td>
</tr>
</tbody>
</table>

p = 0.0455
Low Density Lipoprotein Values in DISH and Comparison Groups

- **LDL < 130 mg/dL**
  - DISH: 86.1%
  - Comparison: 75.9%

- **LDL < 100 mg/dL**
  - DISH: 55.6%
  - Comparison: 51.7%
IBC Keystone Health Plan East Practice Quality Assessment Score (PQAS)
I wonder if hiring a Quality Coordinator was a good idea...
JFMA Practice Quality Assessment Scores

percent

Breast Cancer Screening  Cervical Cancer Screening  Colorectal Cancer Screening  HbA1c Testing DM2  LDL Screening DM2  Retinal Exam DM2  Total Score

↑↑ ↑↑ 7.5%  ↑↑ ↑↑ 8.4%  ↑↑ ↑↑ 10.7%  ↑↑ ↑↑ 8.2%  ↑↑ ↑↑ 5.4%  ↑↑ ↑↑ 9.4%  ↑↑ ↑↑ 10.8%

2009 JFMA  2010 JFMA  2010 Peer Average
Improving Outcomes

Wender’s Words of Wisdom
First Words of Wisdom: Make Up Your Mind To Improve

- Create a value-driven practice
- Put outcomes first
- Be willing to invest
Second Words of Wisdom: Be Relentless!

• Improving quality is HARD

• Nothing is perfect
  ─ Particularly first time out

• Keep your eye on the prize
Third Words of Wisdom: Measure The Right Things

• A1c achieved…not just how many were done

• Percent of eligible individuals successfully screened

• Percent of smokers who quit
Fourth Words of Wisdom: Measure and Report Results

• Cystic fibrosis center had the nerve to report their results to the families they care for

• At LEAST, report to each other
The Corollary To The Fourth Word Of Wisdom

- No EMR? Just measure a few outcomes
- Audit 5 diabetics; 5 women over 50; 5 men over 50
- Some results are better than no results
Fifth Words Of Wisdom: Try Anything

• We used resident moonlighters to reach diabetic patients to get eyes and labs checked
• **Diabetes Information and Support for your Health.** The DISH group visit project
• Medical assistants to track results and perform foot exams
• Quality care coordinator
• Pharm D’s in practice
• Open Access scheduling
• Whatever works!
The Corollary To The Fifth Word Of Wisdom

• Do lots of things! No one idea will address all obstacles to care. We’ve tried:
  – Care Now
  – Embedded mental health services
  – EMMI modules
  – Outreach to people who don’t come in
    • Case management for higher utilizers
Sixth Words Of Wisdom: Don’t Do It Alone

• Value your whole team
• Solo practice? – compare results to someone else’s practice
• Find ways to partner with hospital or group practice
Characteristics of the Quality Practice

• Leadership that demands performance
• A culture of quality and pride in the service provided
• Willingness to try new things
• A commitment to measuring what you do
• Appropriate use of technology
• Investment in necessary change
It’s People That Make A Home

- Create a joyful practice
- Have fun trying new things
- Measure what you’re doing and see if it works
The country is watching
It’s our time...