Opportunities to Promote CV Risk Reduction within the PCMH
Cardiovascular Health Summit
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Billings, Montana

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Medical Director, Education & System Initiatives

Objectives

• Describe the basic concepts of the PCMH
• Apply the PCMH model to CV Risk Reduction
• Detail the evidence that the PCMH model promotes improvement in CV Risk or outcomes

Disclosure

• Dr. Carr has nothing to disclose
It is an interesting time for Primary Care in America.

- Federal healthcare reform is counting on a robust primary care sector to improve quality, reduce costs, and improve patient experience (the triple aim).

  "The Patient Protection and Affordable Care Act (PPACA) of 2010 brings both promise and peril for primary care. This Act has the potential to reestablish primary care as the foundation of US health care delivery."*  

  *Goodson J. Ann Int Med. 2010; 152:742

Reform Implications for Montana and Primary Care

- 35-40% of uninsured will become eligible for Medicaid = doubling by 2019.
- Aging population with increased need for complex medical services + large number of newly insured who will need PCP
- THIS SHOULD BE THE TIME FOR PRIMARY CARE TO RISE!

BUT,

- Shortage of Primary Care Physicians and cohort rapidly diminishing in size
- Evolving physician and patient culture
- The current model of care does not enable us to practice optimal care
- Our systems and processes do not enable us to practice at national standards of care or production.
- We are changing and so are our patients ~ we are operating with old systems in a new “society.”
- Above all Primary Care morale appears to be very low!
Primary Care Morale

• 36% of US PCPs are not satisfied with practicing medicine compared to 11-12% in Norway, New Zealand, or Netherlands, and 19% in the UK.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Primary Care Decline

It is a Real Crisis particularly in MT!

• Data has confirmed what we know: patients want a doctor who knows them and can help coordinate their care.
• Countries with better primary care have better health outcomes and lower costs.
• States with higher primary care/population ratios have lower costs and better quality.*

*Wagner, MacColl Institute for Healthcare Innovation, Group Health Research Institute

Why is it so hard to be a PCP in 2012?

• Changing demography and practice content increasing demand
• Greater care complexity
• Declining real income
• Working harder and harder just to keep up
How are we doing today?

“...adults receive 54.9 percent of recommended care....The deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public. Strategies to reduce these deficits in care are warranted.”


What would it take to deliver 100% of recommended care?

Without a team and a system, the burden of delivering safe care is virtually impossible

“Practice improvements often fail because they rely on the willingness of physicians, who are already too busy, to take on additional work.”

-Tom Bodenheimer

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What is a Medical Home?

- http://www.emmisolutions.com/medicalhome/pcpcc

PCMH Joint principles

- February, 2007: Four primary care societies (American Academy of Family Physicians; American Academy of Pediatrics; American College of Physicians; and the American Osteopathic Association) developed the Joint Principles for PCMH to describe the characteristics of the PCMH practice-based care model

- Summary of the Joint Principles for PCMH:
  - Ongoing relationship with a personal physician
  - Physician-directed medical practice
  - Whole person orientation
  - Care is coordinated and/or integrated
  - Quality and safety
  - Enhanced access to care
  - Payment appropriately recognizes the added value

- Since its introduction in 2007, 18 specialty healthcare organizations have joined the original four physician groups and endorsed the Joint Principles
PCMH is ONE approach stakeholders are testing to transform the way primary care is delivered and reimbursed

**PATIENT ENGAGEMENT**

- Patient-Physician Relationship
- Care Coordination and Management
- Access and Communications

Health information technology facilitates care delivery

Additional components are linked to reimbursement

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In a PCMH, a care team headed by a personal physician is responsible for coordinating all of a patient’s medical care...

**PATIENT ENGAGEMENT**

- Patient-Physician Relationship
- Care Coordination
- Access
  - Health information technology facilitates care delivery
  - Additional components are linked to reimbursement

Comprehensive primary care team

- A team of patients, their families, a personal physician, and other providers working together for all of the patient’s health care
- Team coordination care with specialists and other providers

Coordinated care

- Integrates acute, preventive, and chronic care through all stages of life
- Supports patient engagement across all elements of health care system

Access that is convenient to patients

- Expands hours for access to care and provides new options for communication (e.g., email)

Patient engagement

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...while the practice infrastructure and reimbursement structure are more adequately aligned to support the enhanced requirements

**PATIENT ENGAGEMENT**

- Patient-Physician Relationship
- Care Coordination
- Access
  - Health information technology facilitates care delivery
  - Additional components are linked to reimbursement

Practice infrastructure and health information technology ($$$)

- Contribute to optimal patient care by helping to ensure that patients get indicated care when they need it
- Identify and coordinate evidence-based medicine and support clinical decision making
- Facilitate performance-based measurement, patient education, and enhanced communication

Reimbursement attempts to align the added value to the patient with the additional costs for providing coordinated care
PCMH has the potential for improved outcomes and decreased costs

Potential opportunities include:
- More effective preventive care and greater patient engagement in care
- Improved adherence to physician’s instructions
- Improved management of chronic conditions
- Fewer variations in quality of care and access, with better patient outcomes
- Reduced costs from elimination of duplicate services, avoidable emergency room visits and hospitalizations
- Improved patient and physician satisfaction
- Adequate compensation for time/resources required

While the comprehensive approach is optimal, implementation of individual components may have benefits for your patients and your medical practice.

What’s different?

PCMH is supportive of your desire to improve access and care

<table>
<thead>
<tr>
<th>Example of today’s primary care</th>
<th>Patient-centered medical home approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those who make appointments to see me</td>
<td>Our patients are those who are enrolled in our medical home</td>
</tr>
<tr>
<td>Patients’ chief complaints or reasons for visit determine care</td>
<td>We systematically assess all our patients’ health needs to plan care</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today</td>
<td>Care is determined by a proactive plan to meet patient needs with or without visits</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory or skill of the doctor</td>
<td>Care follows evidence-based guidelines supported by HIT</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A team coordinates patients’ care and encourages patient responsibility</td>
</tr>
<tr>
<td>Acute care is delivered in the next available appointment and on time</td>
<td>Acute care is delivered by open access/same-day availability and e-mail communication</td>
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</table>

Example of today’s primary care

- I know I deliver high-quality care because I’m well trained
- For all of network care, it’s up to the patient to see an what happened to them
- Clinics operations center on meeting the doctor’s needs
- Extra time for patient education and care coordination is not paid
- Additional care coordination is appropriately reimbursed

Many reimbursement frameworks exist — the most common contain three components:

- Increased reimbursement incentivizes the value of comprehensive care management, practice transformation, clinical outcomes, cost of care, and satisfaction.

**Fee-for-service payment per visit**

- Care coordination fee*

**Performance-based payments**

*An care coordination fee could include: physician and nonphysician clinical staff work to manage patients outside of face-to-face visits and HIT and system redesign costs incurred by the practice.

Example: EmblemHealth Medical Home High Value Network Project (NY) provides a care management payment equal to $2.50 per member per month for a fully functioning PCMH practice with an eligible patient population of average care.

A risk-adjusted care coordination fee could include: physician and nonphysician clinical staff work to manage patients outside of face-to-face visits and HIT and system redesign costs incurred by the practice.


**The Ideal Care Model**

**The Patient-Centered Medical Home (PCMH)**

- Personal Physician
- Physician-directed medical practice
- Whole-person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access


**Aren’t we all Patient Centered Medical Homes?**

- Only 46% of US PCPs have an EMR compared to 95+% in the Netherlands, UK, and New Zealand.
- Only 30-40% of US PCPs have the capacity to generate a list of patients with a disease or generate a drug list compared with the majority of MDs in most other developed countries.
- Only 29% of US PCPs have arrangements for patients to see a provider after hours compared to 89% or more in Neth, NZ, and UK.
- Less than 50% of US PCPs have data on the quality of their care.
- 59% of US PCPs use nonphysician staff for patient care compared to 98% in the UK and Sweden.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
Common Elements of PCMH

• Patient Registry to establish a population served.
• Identifying and correcting gaps in care.
• Chronic disease monitoring.
• Reporting quality metrics using common data elements (HEDIS, AHRQ, CMS).
• Reporting to providers on performance.

Variable Elements in PCMH

• Monitoring preventive care.
• Determining patient satisfaction (CAPHS, HCAPHS).
• Payment methodology (pay per member, pay based upon quality, pay based upon achieving TCOC target, combinations).
• Requirement for EMR.
• Care coordination functions

Primary Care Home*

Health Care Team
- Patient
- Physician
- Nurse Navigator
- Non-Physician Provider
- Office Staff
- Nurse
- I.T.

*Billings Clinic PCMH model
The ACO Model

A group of providers willing and capable of accepting accountability for the total cost and quality of care for a defined population.

Core Components:
- People Centered Foundation
- Health Home
- High-Value Network
- Population Health Data Mgmt
- ACO Leadership
- Payor Partnerships

Why PCMH within ACO?

- Emphasizes prevention
- Encourages cognition/relationship over technology
- Less variation in utilization
- Allows for most efficient delivery methods: allied professionals, phone, e-mail, web-enabled
- Proven concept in other modern nations, staff-model HMOs
- Access closest to patients
- Promotes shared decision making
- Leverage point for post-hospital care
CV Disease

Primary Prevention
- Hypertension
- Hyperlipidemia
- Diabetes Mellitus
- Lifestyle
- Rx Adherence
- Metabolic Syndrome

Secondary Prevention
- Hypertension
- Hyperlipidemia
- Diabetes Mellitus
- Lifestyle
- Rx Adherence
- Depression

Only difference: Goal Measurement and NNTT to reduce morbidity/mortality.

Early evidence supports the value of a primary care-centered approach to improve outcomes and lower costs

- Research to date has shown that sufficient access to high-quality primary care results in
  - Lower overall health care costs and reduced use of higher-cost services (e.g., ER, hospitalization)
  - Better preventive care, decreased mortality, and increased patient satisfaction
- PCMH patients with chronic diseases like diabetes, congestive heart failure, and adult asthma have fewer complications, leading to fewer avoidable hospitalizations
- Health care costs are higher in regions with higher ratios of specialists to generalists

Benefits of Implementing the Primary Care Patient-Centered Medical Home:
A REVIEW OF COST & QUALITY RESULTS, 2012

Prepared by:
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Carla Zews, PhD
Tara Hackett, MPH
Paul Grubbs, MD, MPH
http://www.pcpcc.net
Selected Results of Patient-Centered Medical Home Initiatives

**Minnesota: Health Partners**
- 129% increase in optimal diabetes care
- 48% increase in optimal heart disease care
- 39% fewer ER visits
- 24% fewer hospital admissions
- Overall costs decreased to 92% of state average

**BCBS of North Dakota**
- Diabetes: 64.3% improvement in optimal care
- CAD: 8.6% improvement in BP; 9.4% in LDL
- HTN: 8% improvement in blood pressure control
- 24% fewer ED visits
- 18% lower inpatient hospital admissions

**Geisinger Health**
- Improved quality of care:
  - 74% for preventive care
  - 22% for CAD
  - 35% for diabetes care
  - 18% reduced inpatient admissions
  - 7% lower cumulative total spending (from 2005 to 2008)

Montana Patient Centered Medical Home Initiative

- MT Medicaid received planning grant from NASHP to develop PCMH model; stakeholder discussion developed into planning for a multi-payer model
- Commissioner of Securities and Insurance assumed role of facilitating discussions among MT payers and providers
- Working group adopts NCQA Recognition as a definition standard of PCMH for Montana
- Creation of PCMH Advisory Council sponsored by office of Insurance Commissioner
- Adopted Framework for Payment as guidelines for contract development
- Created Uniform Quality Measure Set
- Recommended the attributes of a state technology reporting platform; verified that designated HIE (Health Share Montana) meets them
- Developed proposed legislation to create commission with statutory authority to develop the market rules that encourages multi-payer PCMH
- SB84 Passes Legislature

Patient Centered Medical Home: What are the NCQA Standards?

<table>
<thead>
<tr>
<th>NCQA PCMH Standards (Basic)</th>
<th>What the Standard Includes</th>
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<tbody>
<tr>
<td>Access and Communication</td>
<td>Personal MD, same day visits (25-30% open slots as target), EU phone and e-mail.</td>
</tr>
<tr>
<td>Patient Registry</td>
<td>EMR, patient demographics, organized clinical data system, system identified gaps in care, visit planning (prevent, visit, use of ancillaries, referrals, testing).</td>
</tr>
<tr>
<td>Care Management Guidelines</td>
<td>Identifies screening tests, immunizations, clinical care packages, defined roles for physician and non-physician staff.</td>
</tr>
<tr>
<td>Patient Self-management Support</td>
<td>Educational materials, connects member to educational support programs.</td>
</tr>
<tr>
<td>E-Prescribing</td>
<td>Formulary, generics and tiers, PAs, identifies drug issues.</td>
</tr>
<tr>
<td>Test Tracking</td>
<td>Ensures 100% follow on all test results.</td>
</tr>
<tr>
<td>Referral Tracking and Coordination</td>
<td>Sets up, provides data, obtains reports.</td>
</tr>
<tr>
<td>Performance Reporting</td>
<td>By practice and by provider: HEDIS quality metrics, access tracking, patient experience reporting.</td>
</tr>
</tbody>
</table>
BCBSMT PCMH Program

- Begun in 2009 with Western Montana Clinic (St. Patrick Hospital) and Billings Clinic.
- Planning to add St. Peters, Benefis, Holy Rosary.
- Limited to PCP providers with access to EMR.
- 2009/2010: Chronic disease only.
- 2011 and beyond: Chronic disease and preventative care.

PCMH-Physician Groups (*=active)

<table>
<thead>
<tr>
<th>Physician Group</th>
<th>Number of Physicians</th>
</tr>
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<tbody>
<tr>
<td>Billings Clinic*</td>
<td>77 MD (16 IM, 25 FP, 18 Peds, 18 OB), 23 Midlevel</td>
</tr>
<tr>
<td>Western Montana Clinic*</td>
<td>31 MD (8 IM, 14 FP, 5 Peds, 4 OB), 7 Midlevel</td>
</tr>
<tr>
<td>St. Patrick’s Hospital*</td>
<td>15 MD (6 IM, 9 FP), 5 Midlevel</td>
</tr>
<tr>
<td>Benefis</td>
<td>14 MD (7 IM, 3 FP, 4 OB), 5 Midlevel</td>
</tr>
<tr>
<td>St. Peters Hospital</td>
<td>14 MD (2 IM, 12 FP)</td>
</tr>
<tr>
<td>Kalispell Regional MC*</td>
<td>20 MD (3 IM, 6 IM-Peds, 11 FP), 11 Midlevel</td>
</tr>
<tr>
<td>Comm. Medical Center*</td>
<td>20 MD (5 IM, 11 FP, 4 Peds), 7 Midlevel</td>
</tr>
<tr>
<td>Bozeman Deaconess*</td>
<td>26 MD (9 IM, 6 FP, 6 Peds, 5 OB), 7 Midlevel</td>
</tr>
<tr>
<td>Northern Montana Hosp*</td>
<td>10 MD (3 IM, 5 FP, 2 OB)</td>
</tr>
<tr>
<td>St. Vincent’s*</td>
<td>9 MD (7 IM, 2 FP)</td>
</tr>
<tr>
<td>Holy Rosary Healthcare</td>
<td>4 MD (1 IM, 1 FP, 2 OB)</td>
</tr>
<tr>
<td>South Hills Med. Group*</td>
<td>2 MD (1 NP)</td>
</tr>
<tr>
<td>Total Physicians/Midlevels</td>
<td>242 MD (67 IM, 99 FP, 6 IM-Peds, 33 Peds, 35 OB), 66 Midlevel</td>
</tr>
</tbody>
</table>

2012 BCBSMT PCMH Program

Chronic Diseases
- Asthma
- Ischemic Vascular Disease
- Depression
- Diabetes

Preventive Care
- Preventive exam
- Smoking status
- BMI
- BP
- Breast cancer screening
- Cervical cancer screening
- STI screening
- Immunizations
<table>
<thead>
<tr>
<th>BCBSMT-PCMH Early Trends</th>
<th>All other PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCMH</strong></td>
<td><strong>All other PCPs</strong></td>
</tr>
<tr>
<td>~ 16,000 Lives</td>
<td>~36,000 Lives</td>
</tr>
<tr>
<td>Total Trend: 3.1%</td>
<td>Total Trend: 7.1%</td>
</tr>
<tr>
<td>Stop-loss, excess risk adjusted Trend: 2.6%</td>
<td>Stop-loss, excess risk adjusted Trend: 7.2%</td>
</tr>
</tbody>
</table>

**Improved documentation and reporting on quality measures**

- Evidence-Based Care
- Prevention

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**Blues CMO says there's 'no question' medical-home model works**

(11:30 am; Oct 21)

Tips: Coordinating Care Medical/Home Information Technology-Patient Care

Without hesitation, Dr. Allen Vorn, the Blue Cross and Blue Shield Associations chief medical officer and senior vice president for corporate affairs, declared that the patient-centered medical home has the potential to transform the U.S. healthcare system.

"The things you want going on are going on, and the things you want going down are going down," said Vorn in an interview following his appearance Tuesday on a panel presenting the state of the healthcare industry presented in San Antonio at the National Academy of Medicine. "There is no question that the medical home is working, and that's what's gratifying to me."

While speaking on the panel, Vorn said the steps could be taken to improve the patient-centeredness of the medical-home practice model. Still, he said, the model behind—which use information technology to coordinate care and track the treatment of patients who have chronic diseases—have led to double-digit declines in patients' exposure to radiation from diagnostic tests, a 70% reduction in hospital admissions, and a 20% reduction in office visits for patients with chronic conditions.

They have also boosted physician satisfaction.

"When you permit a physician to perform at his or her highest level, to do what they want to do, these and things like that happen," Vorn said. "And the most important thing the Blue cross medical-home programs have done is remove the 'mother may I' from the practice of medicine. We're raising doctors' salaries. We're not cutting your pay."

He added that, with some 3.3 million members covered by Blue cross medical-home, "we're not kidding anyone."

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**PCMH Perspectives**

- **Provider**
  - Team Model best able to improve access, reduce fragmentation of care
  - "Rules of the Road" setting
  - EHR standards
  - Financial risk/reimbursement with pay-for-success

- **Payer**
  - Assurance that a practice is transforming
  - "Rules of the Road" setting
  - EHR standards
  - Financial risk/reimbursement with pay-for-success

- **Patients**
  - Increased Access
  - Better outcomes
  - Increased satisfaction
For additional PCMH information and resources

Contact your local chapter of AAFP, AAP, ACP, AOA

AAFP:

AAP:
www.medicalhomeinfo.org

ACP:
www.acponline.org/running_practice/pcmh/

Contact your local quality organizations/consortiums/collaboratives

Refer to the PCPCC Proof in Practice report for examples of quality organizations involved in PCMH

Examples of available resources

For all stakeholders
PCPCC: www.pcpcc.net

CMS PCMH Demo:
http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20keyword&filterValue=home&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1199247&intNumPerPage=10

For providers
URAC: http://www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx

For patients
National Partnership for Women & Families:
http://www.nationalpartnership.org/site/PageServer?pagename=ourwork_medicalhome_landing