Patient Centered Medical Home - PCMH

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Objectives

1. Provide an overview of PCMH evolution
2. Describe the PCMH Principles
3. Review change strategies

In the Beginning…

- 1967: American Academy of Pediatrics (AAP)
    - Introduced term “medical home”
    - Single source of information about a patient
    - Grew into partnership with families
    - Accessible, family-centered, coordinated, comprehensive, continuous, compassionate, culturally effective

Early Days

- 1978: World Health Organization (WHO)
  - “Primary care ‘is the key’ to attaining ‘adequate health’”
  - Health = “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity” and “is a fundamental human right”

Early Days

- 1996: Institute of Medicine (IOM)
  - Mentioned term “medical home” in Primary Care: America’s Health in a New Era
  - Influenced the specialty of Family medicine

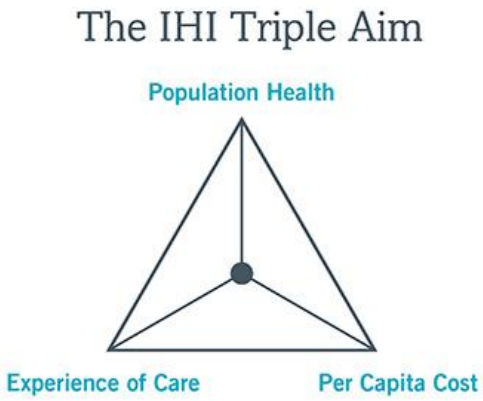
- 2002: American Academy of Family Physicians (AAFP)
  - Future of Family Medicine: A Collaborative Project of the Family Medicine Community
    - Every American should have a Personal Medical Home

Early Days

- 2004: Chronic Care Model (MacColl Institute for Healthcare Innovation
    - AAFP incorporated elements into models of primary care service delivery

- 2007: Joint Principles of the Patient Centered Medical Home (Patient Centered Primary Care Collaborative)
    - Jointly accepted principles adopted by AAP, AAFP, American College of Physicians (ACP), and American Osteopathic Association (AOA)

Triple Aim



- 2008: Institute for Healthcare Improvement (IHI)
    - The Triple Aim: Care, health, and cost. *Health Affairs*
    - Introduced concepts of:
        - Improving the experience of care
        - Improving the health of populations
        - Reducing per capita costs of health care

PCMH Joint Principles

- Personal Physician
- Physician Directed Medical Practice
- Whole Person Orientation
- Coordinated/Integrated Care
- Quality and Safety
- Enhanced Access
- Payment Reform

1. Personal Physician

- Patients know their physician by name
- Physicians know their patients by name
- Continuous healing relationships
- Patient needs are central
- Usual source of care
    - Greater association with actually receiving care
    - More likely to receive preventive care services
    - When combined with continuous care, associated with better health outcomes and lower total costs

2. Physician Directed Medical Practice/Team

- Physician leads a team who collectively care for patients
- Care team flexibility with patient needs/healthcare demands
- Multi-disciplinary team working at height of credentials
- Eliminates confusion about clinical roles
- Facilitates planned/coordinated team-based care
- Feedback to team from patients improves quality of team function

3. Whole Person Orientation

- Physician responsibility: care for all stages of life; acute care; chronic care; preventive services; and end of life care
- Address both body and mind
- Context of patient personal values
- Integrating/organizing care across settings
- Community and public health connectivity

4. Coordinated/Integrated Care

- Registries
- Information Technology (IT)
- Health Information Exchange (HIE)
- Complex and time consuming work
- Knowledge gap of patients to navigate healthcare
- Requires planned communication, standardized processes
- Linkage to the Medical Neighborhood

5. Quality and Safety

- Evidence-Based Medicine (EBM)
- Clinical Decision Support (CDS) tools
- Continuous quality improvement
- Shared decision making with patients
- IT utilization for optimal patient care
- Patient and family involvement in improvement activities
- Formal PCMH Recognition
    - National Council on Quality Assurance (NCQA)
    - The Joint Commission (TJC)
    - Accreditation Association for Ambulatory Health Care (AAAHC)

6. Enhanced Access

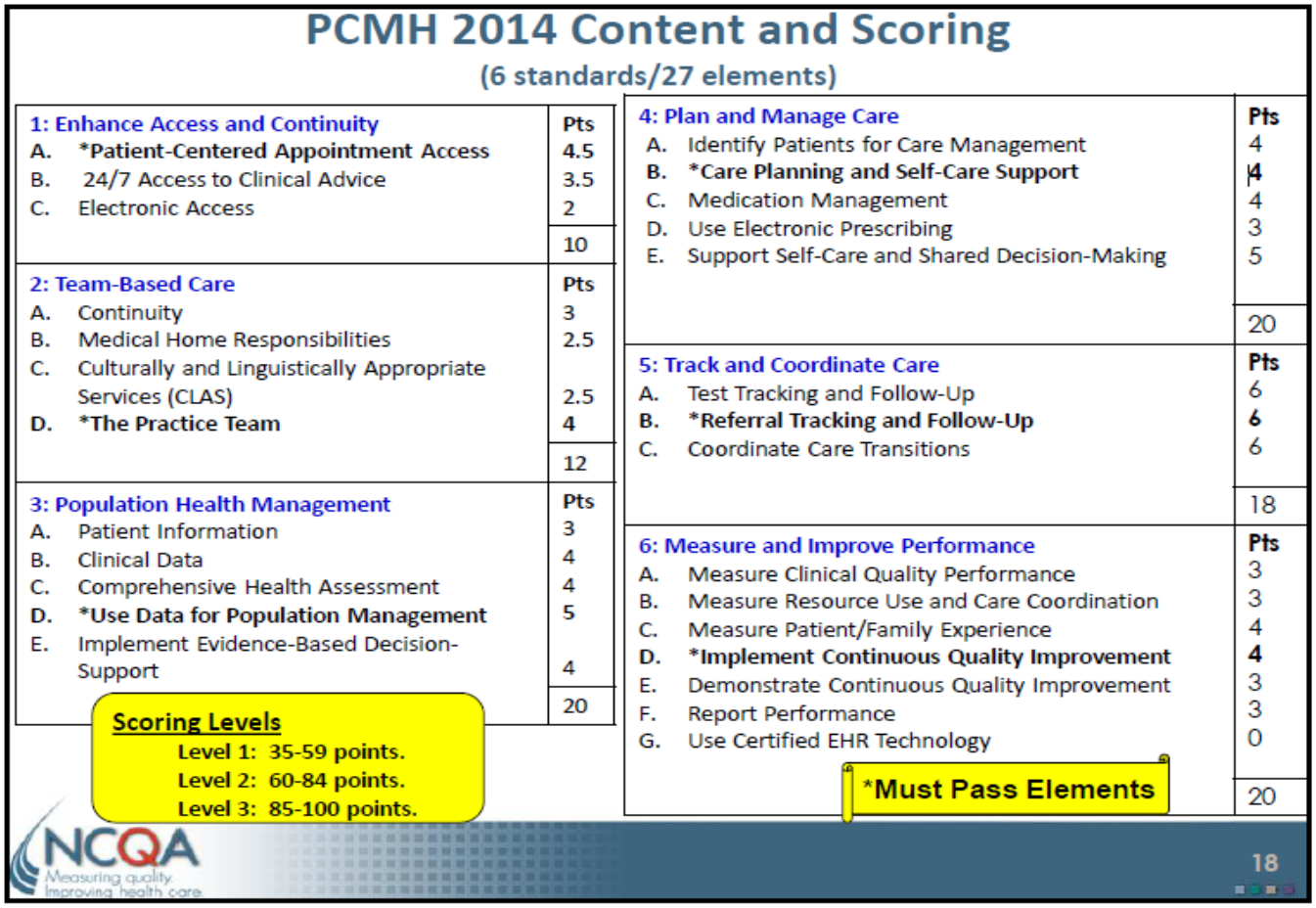
- Care and/or information available 24/7
- Open Access
- Max-packing appointments
- Group appointments
- Telemedicine
- Patient Portal/Secure Messaging

7. Payment Reform

- Driven by legislation, CMS, insurers
- Continuous and patient-centered care should be incentivized
    - Comprehensive Primary Care Initiative (CMS)
    - Chronic Conditions Management reimbursement (CMS)
    - Value-based vs Volume-based reimbursement (MACRA)
    - Shared Risk models (ACOs)

National Committee for Quality Assurance (NCQA)

- Established first set of PCMH recognition standards in 2008
- Reviewed and updated every 3 years (2011, 2014)
- 3 Tiers of recognition
    - Based on achieved points for various components of PCMH
    - Critical Factors – must pass for recognition at any level
    - Level 1 – Lowest recognition level but a significant achievement
    - Level 2 – Enhanced achievement beyond Level 1
    - Level 3 – Highest level of achievement, comprehensive PCMH



Standard

Element

Factor

Joint Principles: Integrating Behavioral Health Care into the PCMH

- 2014: Published in the Annals of Family Medicine
- Endorsed by: AAFP, AAP, AOA
    - Also by:
        - American Psychological Association
        - American Board of Family Medicine
        - Association of Departments of Family Medicine
        - Association of Family Medicine Residency Directors
        - North American Primary Care Research Group
        - Society of Teachers of Family Medicine
        - Collaborative Family Healthcare Association

Joint Principles: Behavioral Health Care

- Physician Directed Medical Practice
  - Team of health care professionals who will act together to integrate the physical, mental, emotional and social aspects of the patient's health care needs
  - On-site by the team or connected to specialists in the medical neighborhood

Joint Principles: Behavioral Health Care

- Whole Person Orientation
  - "…cannot be imagined without including the behavioral together with the physical"
- Coordinated/Integrated Care
  - "…shared registries, medical records (esp. problem and medication lists), decision-making, revenue streams, and responsibility…"
  - "…makes regular sharing of information for purposes of better care the rule rather than the exception"

Joint Principles: Behavioral Health Care

- Quality and Safety
  - Care planning must include Behavioral Health clinicians
  - IT/EHRs must include the Behavioral Health provider's notes with appropriate securities
  - Recognition must demonstrate Behavioral Health integration with the PCMH

Joint Principles: Behavioral Health Care

- Enhanced Access
  - Includes Behavioral Health resources
  - Open Access for Behavioral Health care
  - Culturally effective Behavioral Health professionals accessible 24/7 through multiple media
  - Physical integration of a Behavioral Health professional into the primary care team

Joint Principles: Behavioral Health Care

- Payment Reform
  - Everybody's best interest to pay for BH care in the PCMH
  - Effective collaborations between primary care and behavioral health clinicians
  - Payments should not separate primary care BH payment from primary care medical payments

Joint Principles: Behavioral Health Care

- Payment should be based on:
  - Value (in-person or virtual)
  - After hours service
  - Mental health and substance abuse screening/early intervention
  - Coordinating care among behavioral caregivers
  - Communications between patient, family, caregivers, and PCMH
  - Separate services on the same day
  - Complexity
  - Shared cost savings
  - Quality Improvement
  - Pricing incentives for patients participating in a PCMH with Behavioral Health integration

Triple Aim Linkage

- Behavioral Health Integration with Primary Care is Comprehensive Care
- Integrated Care in the PCMH setting reduces stigma
    - Less externally visible
- Integrated Care in the PCMH and BH settings increases access to both types of care
    - The entire population receives care for physical and behavioral needs
- Integrated Care in the PCMH setting reduces health care costs
    - Shared resources in integrated settings

PCMH Transformation

- Engaged leadership
- Quality improvement strategy
- Empanelment and population management
- Continuous and team-based healing relationships
- Organized, evidence-based care
- Patient-centered interactions
- Enhanced access
- Care coordination across the medical neighborhood

Change Package for PCMH transformation

Improving Patient Care (IPC) 2.0

- IPC - Made Simple (IPC-MS)
  - 9 month fundamentals of improvement (regional)
- IPC Medical Home (IPCMH)
  - 16 month recurring curriculum (national)
  - Aligned with NCQA standards
- IPC Intensives
  - Applies improvement skills to Agency initiatives (national)

Summary

- Physician-centered → Patient-centered practices
- Integration of services for the “whole” patient
- Behavioral Health is a critical component of the Patient Centered Medical Home
- Change should have a structure
- Improving Patient Care 2.0 propels PCMH transformation

Thank You

- Questions?

References

- PCMH – History, Core Features, Evidence, and Transformational Change. Robert Graham Center for Policy Studies in Family Medicine and Primary Care, November 2007
- Joint Principles of the Patient Centered Medical Home. Patient Centered Primary Care Collaborative, February 2007, http://www.pcpcc.net/joint-principles
- Comprehensive Primary Care Initiative. Centers for Medicare and Medicaid Services (CMS), http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html
- Joint Principles: Integrating Behavioral Health Care into the Patient-Centered Medical Home. Annals of Family Medicine, March/April 2014; 12(2): 183-185