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)
The IHI 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
## PCMH 2014 Content and Scoring
(6 standards/27 elements)

### 1: Enhance Access and Continuity
- **A.** Patient-Centered Appointment Access
  - Points: 4.5
- **B.** 24/7 Access to Clinical Advice
  - Points: 3.5
- **C.** Electronic Access
  - Points: 2

**Total Points:** 10

### 2: Team-Based Care
- **A.** Continuity
  - Points: 3
- **B.** Medical Home Responsibilities
  - Points: 2.5
- **C.** Culturally and Linguistically Appropriate Services (CLAS)
  - Points: 2.5
- **D.** *The Practice Team*
  - Points: 4

**Total Points:** 12

### 3: Population Health Management
- **A.** Patient Information
  - Points: 3
- **B.** Clinical Data
  - Points: 4
- **C.** Comprehensive Health Assessment
  - Points: 4
- **D.** *Use Data for Population Management*
  - Points: 5
- **E.** Implement Evidence-Based Decision-Support
  - Points: 4

**Total Points:** 20

### 4: Plan and Manage Care
- **A.** Identify Patients for Care Management
  - Points: 4
- **B.** *Care Planning and Self-Care Support*
  - Points: 4
- **C.** Medication Management
  - Points: 3
- **D.** Use Electronic Prescribing
  - Points: 5
- **E.** Support Self-Care and Shared Decision-Making

**Total Points:** 20

### 5: Track and Coordinate Care
- **A.** Test Tracking and Follow-Up
  - Points: 6
- **B.** *Referral Tracking and Follow-Up*
  - Points: 6
- **C.** Coordinate Care Transitions

**Total Points:** 18

### 6: Measure and Improve Performance
- **A.** Measure Clinical Quality Performance
  - Points: 3
- **B.** Measure Resource Use and Care Coordination
  - Points: 4
- **C.** Measure Patient/Family Experience
  - Points: 4
- **D.** *Implement Continuous Quality Improvement*
  - Points: 3
- **E.** Demonstrate Continuous Quality Improvement
  - Points: 3
- **F.** Report Performance
  - Points: 0
- **G.** Use Certified EHR Technology

**Total Points:** 20

### Scoring Levels
- **Level 1:** 35-59 points.
- **Level 2:** 60-84 points.
- **Level 3:** 85-100 points.

*Must Pass Elements*
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

1. Laying the Foundation
   - Engaged Leadership

2. Building Relationships
   - Empanelment
   - Continuous and Team-Based Healing Relationships

3. Changing Care Delivery
   - Organized, Evidence-Based Care
   - Patient-Centered Interactions

4. Reducing Barriers to Care
   - Enhanced Access
   - Care Coordination

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The diagram outlines a sequential approach to transforming PCMH (Patient-Centered Medical Home) care, emphasizing foundational leadership, relationship building, care delivery improvements, and barrier reduction strategies.
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


• Comprehensive Primary Care Initiative. Centers for Medicare and Medicaid Services (CMS), http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html