



INDIAN HEALTH SERVICE



IPC IMPROVING
PATIENT CARE

Patient Centered Medical Home - PCMH

CAPT Jeff Salvon-Harman, MD
Director, Improving Patient Care Program
Office of Clinical and Preventive Services
IHS Headquarters
Rockville, MD



Objectives

1. Describe the elements of PCMH Principles
2. Describe the NCQA standards of behavioral health integration
3. Support Triple Aim



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)

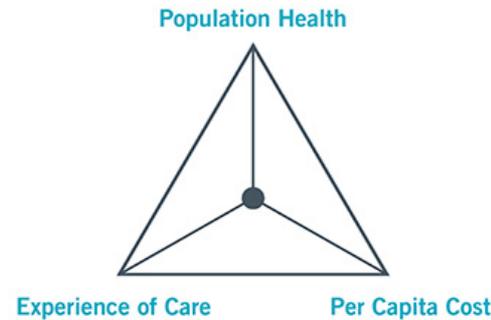
- AAFP incorporated elements into models of primary care service delivery

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



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
- Shared Risk models



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



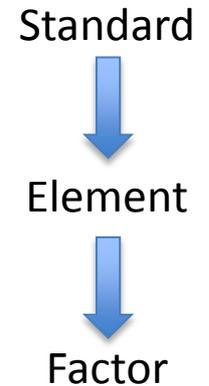
PCMH 2014 Content and Scoring

(6 standards/27 elements)

| Standard | Element | Pts | Standard | Element | Pts |
|---|--|-----|---|---|-----|
| 1: Enhance Access and Continuity | A. *Patient-Centered Appointment Access | 4.5 | 4: Plan and Manage Care | A. Identify Patients for Care Management | 4 |
| | B. 24/7 Access to Clinical Advice | 3.5 | | B. *Care Planning and Self-Care Support | 4 |
| | C. Electronic Access | 2 | | C. Medication Management | 4 |
| | | 10 | | D. Use Electronic Prescribing | 3 |
| | | | | E. Support Self-Care and Shared Decision-Making | 5 |
| 2: Team-Based Care | A. Continuity | 3 | | | 20 |
| | B. Medical Home Responsibilities | 2.5 | 5: Track and Coordinate Care | A. Test Tracking and Follow-Up | 6 |
| | C. Culturally and Linguistically Appropriate Services (CLAS) | 2.5 | | B. *Referral Tracking and Follow-Up | 6 |
| | D. *The Practice Team | 4 | | C. Coordinate Care Transitions | 6 |
| | | 12 | | | 18 |
| 3: Population Health Management | A. Patient Information | 3 | 6: Measure and Improve Performance | A. Measure Clinical Quality Performance | 3 |
| | B. Clinical Data | 4 | | B. Measure Resource Use and Care Coordination | 3 |
| | C. Comprehensive Health Assessment | 4 | | C. Measure Patient/Family Experience | 4 |
| | D. *Use Data for Population Management | 5 | | D. *Implement Continuous Quality Improvement | 4 |
| | E. Implement Evidence-Based Decision-Support | 4 | | E. Demonstrate Continuous Quality Improvement | 3 |
| | | 20 | | F. Report Performance | 3 |
| | | | | G. Use Certified EHR Technology | 0 |
| | | | | | 20 |

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

***Must Pass Elements**





NCQA and BHI

- PCMH Standard 2: Team Based Care
 - Element B: Medical Home Responsibilities
 - Factor 5: The scope of services available within the practice including how behavioral health needs are addressed
- PCMH Standard 3: Population Health Management
 - Element C: Comprehensive Health Assessment
 - Factor 6: Behaviors affecting health
- PCMH Standard 3: Population Health Management
 - Element E: Implement Evidence-Based Decision Support
 - Factor 1: A mental health or substance use disorder (CRITICAL)



NCQA and BHI

- PCMH Standard 4: Care Management and Support
 - Element A: Identify Patients for Care Management
 - Factor 1: Behavioral health conditions
 - Factor 2: Social determinants of health
- PCMH Standard 5: Care Coordination and Care Transitions
 - Element B: Referral Tracking and Follow Up (MUST PASS)
 - Factor 3: Maintains agreements with behavioral healthcare providers
 - Factor 4: Integrates behavioral healthcare providers within the practice site



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



Models of PCMH Behavioral Health Integration

- Off-site referral service
 - Similar to all other specialty referral practices
 - Highest risk of loss to follow up during transition in care
 - Most difficult to coordinate care for
 - Unlikely to share IT/EHR



Models of PCMH BH Integration

- Campus collocation
 - Similar to adjacency
 - More distance between clinics reduces likelihood of same day transfers
 - More distance between clinics increases likelihood of loss to follow up
 - Solely dependent on referrals
 - Less personal relationship between Behavioral Health and Primary Care staffs
 - Stays within single health system but less likely to share IT/EHR



Models of PCMH BH Integration

- Physical Adjacency
 - Behavioral Health Clinic located in close proximity to Primary Care Clinic
 - Referral based
 - Facilitates same day transfer of patients between Clinics
 - Encourage two-way transfer
 - Behavioral Health referral to Primary Care for medical services
 - Allows for occasional intentional meetings and shared-patient review
 - Can still result in missed hand-offs



Models of PCMH BH Integration

- Fully Integrated
 - Physician led/directed team includes a Behavioral Health clinician full time
 - Includes Pharmacist to counsel patients on all types of medications
 - Nursing should include competency in Behavioral Health
 - Nursing Assistants/Medical Assistants/Front Desk staff should receive training in Behavioral Health Integration
 - Pod design reduces patient movement between ancillary services
 - Care Coordinator/Social Services/Patient Advocate services included (may be shared with multiple teams)
 - Increased likelihood of shared IT/EHR



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



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