Building & Strengthening Patient-Centered Medical Homes in the Safety Net

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Objectives

- Review the history, structure, and promise of the PCMH model
- Review the SNMHI model change package for Practice Transformation
- Review payment and financing considerations
- Understand lessons from the field on PCMH implementation
The PCMH: Overview
What is a Patient-Centered Medical Home?

A model of comprehensive, coordinated care that assures:

• Patient-centered approach to care delivery
• Enhanced access to services
• A holistic view of the patient
• Continuity of care
• A focus on continuous performance measurement and improvement
<table>
<thead>
<tr>
<th>Typical Practice Setting</th>
<th>PCMH Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers are responsible for the universe of patients who seek care in the practice.</td>
<td>Patients are paired with a continuity provider who is responsible for a defined panel of patients.</td>
</tr>
<tr>
<td>Care is delivered in reaction to today’s problem.</td>
<td>Care is determined by a proactive plan to meet health needs, with or without clinic visits.</td>
</tr>
<tr>
<td>Providers believe that their extensive training translates to high quality care. Care varies by scheduled time and memory or skill of the provider.</td>
<td>Quality is assured through the measurement of adherence to evidence-based guidelines, and we develop action plans to continuously improve the quality of care we provide.</td>
</tr>
<tr>
<td>The productivity treadmill requires providers to work harder and assume longer work days.</td>
<td>The practice aligns appointment capacity with appointment demand, adjusting staffing and other variables to balance the workload.</td>
</tr>
<tr>
<td>The provider functions as a solo act, even when support staff are available.</td>
<td>An interdisciplinary team works together to serve patients efficiently and effectively, coordinating care, tracking tests and consultations, and providing outreach and follow-up after ED visits and hospitalizations.</td>
</tr>
</tbody>
</table>
Why Create a Medical Home?

- Enhanced access to care
- Improved clinical outcomes
- Reduced health disparities
- Improved patient experience
- Improved staff satisfaction
- Greater efficiency in care delivery
- Reduced cost of healthcare overall
Who Else is Doing This?

• Pilots/demonstration or projects in 39 states (NASHP, Feb 15 2011)
  ➢ Health plans
  ➢ State Medicaid agencies
  ➢ State primary care associations
  ➢ Private foundations
  ➢ Public-private partnerships

• NC QA PCMH recognition stats (NCQA, April 2011)
  ➢ 10,100 + clinicians
  ➢ 2189 sites
  ➢ 45 states
Published Outcomes

15%-20% reduced healthcare spending

• Patients at PCMH sites have 15%-20% reduced total healthcare spending per year compared to patients treated by regional peers.1

Group Health Cooperative, Seattle, WA

• 4% increase in patients meeting target levels on HEDIS measures
• 29% reduction in emergency department utilization
• 16% reduction in avoidable hospitalizations
  • Utilization changes resulted in a net cost reduction of $10.30 PMPM.
• ROI: Saved $1.50 for every $1.00 invested in its PCMH program.

Gennesee Health Plan, Flint, MI

• 74% improvement in preventive care measures
• 35% improvement in diabetes care measures
• 50% decrease in ER visits
• 15% fewer inpatient hospitalizations

Change Concepts for Practice Transformation
Change Concepts

1. Empanelment
2. Continuous and Team-based Healing Relationships
3. Patient-centered Interactions
4. Engaged Leadership
5. Quality Improvement Strategy (*includes HIT*)
6. Enhanced Access
7. Care Coordination
8. Organized, Evidence-based Care
Development

- Safety Net Medical Home Initiative
- Sponsored by The Commonwealth Fund and conducted in partnership with the MacColl Institute for Healthcare Innovation
- Developed by Technical Expert Panel in 2008
- Vetted by the WA State PCMH Collaborative and now used by many others
Sequencing and Emphasis

1. Empanelment
2. Continuous and Team-based Healing Relationships
3. Patient-centered Interactions
4. Engaged Leadership
5. Quality Improvement Strategy (*includes HIT*)
6. Enhanced Access
7. Care Coordination
8. Organized, Evidence-based Care
Engaged Leadership
Quality Improvement Strategy (includes HIT)

Empanelment
Continuous and Team-based Healing Relationships
Patient-centered Interactions

Enhanced Access
Care Coordination
Organized, Evidence-based Care
PCMH-A Background & Context

• Developed to measure a site’s progress towards achieving the 8 Change Concepts
• Self-administered assessment
• Aids in the identification of improvement opportunities
• Stimulates conversations with other sites to learn, share, & transform
• Serves as a standardized measure of progress
### PCMH-A Self-Assessment

#### Sample “Empanelment” Questions

<table>
<thead>
<tr>
<th>Components</th>
<th>Level D</th>
<th>Level C</th>
<th>Level B</th>
<th>Level A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>…are not assigned to specific patient panels</td>
<td>…are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.</td>
<td>…are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.</td>
<td>…are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.</td>
</tr>
<tr>
<td>Score</td>
<td>1  2  3</td>
<td>4  5  6</td>
<td>7  8  9</td>
<td>10  11  12</td>
</tr>
<tr>
<td>Registry or panel data</td>
<td>…are not available to assess or manage care for practice populations</td>
<td>…are available to assess and manage care for practice populations, but only on an ad hoc basis.</td>
<td>…are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.</td>
<td>…are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.</td>
</tr>
<tr>
<td>Score</td>
<td>1  2  3</td>
<td>4  5  6</td>
<td>7  8  9</td>
<td>10  11  12</td>
</tr>
</tbody>
</table>
SNMHI PCMH Resources

- PCMH-A
- Implementation guides
- Policy briefs
- Medical Home Digest
- Webinars
- Videos
Thoughts on Payment Reform
PCMH Landscape: Transformation and Financing

39 states “Medical Home States”:
(1) program implementation (or major expansion or improvement) in 2006 or later;
(2) Medicaid or CHIP agency participation (not necessarily leadership);
(3) explicitly intended to advance medical homes for Medicaid or CHIP participants; and (4) evidence of commitment, such as workgroups, legislation, executive orders, or dedicated staff.

74 medical home projects nationally
46 include enhanced payment
The Case for PCMH Financing

Why Payment Reform?

- Value over volume
  - Move away from visit “churn”
- Reward outcomes
  - Clinical quality
  - Patient experience
  - Cost reductions
- Incentivize primary care
  - Workforce
  - Coordinated care

Why Enhanced Payment?

- Infrastructure support
  - Telephone and system upgrades, HIT
  - New staff
- Lost revenue during QI work
  - Staff training
  - Proactive outreach
- Traditionally unreimbursed services
  - Telephonic and email visits
  - Group visits
  - Education/support visits
  - Multiple visits in single day
### 10 PCMH Payment Models

#### 5 categories:
- FFS w/ adjustments
- FFS plus
- Shared savings
- Comprehensive
- Grant-based

<table>
<thead>
<tr>
<th>Number</th>
<th>Payment Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>FFS with new codes</td>
</tr>
<tr>
<td>2</td>
<td>FFS with higher payment levels</td>
</tr>
<tr>
<td>3</td>
<td>FFS with lump sum payments</td>
</tr>
<tr>
<td>4</td>
<td>FFS with PMPM payment</td>
</tr>
<tr>
<td>5</td>
<td>FFS with PMPM payment and P4P</td>
</tr>
<tr>
<td>6</td>
<td>FFS with PMPY payment</td>
</tr>
<tr>
<td>7</td>
<td>FFS with lump sum payments, P4P, and shared savings</td>
</tr>
<tr>
<td>8</td>
<td>FFS with PMPY payment and shared savings</td>
</tr>
<tr>
<td>9</td>
<td>Comprehensive payment with P4P</td>
</tr>
<tr>
<td>10</td>
<td>Grants</td>
</tr>
</tbody>
</table>

FFS: Fee for service  
PMPM: Per member per month  
PMPY: Per member per year
## Tiering Payments

<table>
<thead>
<tr>
<th>Participation</th>
<th>Complexity</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Level of recognition / certification</td>
<td>• Patient characteristics</td>
<td>• Clinical quality</td>
</tr>
<tr>
<td>• Learning collaborative</td>
<td>• Population characteristics</td>
<td>• Patient experience</td>
</tr>
<tr>
<td>• Data submission</td>
<td>• Medical</td>
<td>• Access</td>
</tr>
<tr>
<td></td>
<td>• Social</td>
<td>• Efficiency</td>
</tr>
<tr>
<td></td>
<td>• Behavioral</td>
<td>• Costs saved</td>
</tr>
</tbody>
</table>

- Outcomes:
  - Clinical quality
  - Patient experience
  - Access
  - Efficiency
  - Costs saved
Tiering Examples

**Colorado Multi-payer Medical Home Pilot**
Includes supplemental PMPM payment (range) and P4P bonus. PMPM Considerations:
Costs incurred including EMR, care coordinator
QI time and participation time
Actuarial analysis of reasonable PMPM to recoup costs

<table>
<thead>
<tr>
<th>NCQA Level</th>
<th>PMPM Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>$4.00 to $5.50 PMPM</td>
</tr>
<tr>
<td>Level 2</td>
<td>$6.00 to $7.00 PMPM</td>
</tr>
<tr>
<td>Level 3</td>
<td>$7.25 to $8.50 PMPM</td>
</tr>
</tbody>
</table>

**CareOregon**
Tiers on self-defined medical home achievement
Balances participation and outcomes

<table>
<thead>
<tr>
<th>Tier</th>
<th>Medical Home Engagement and Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Participation in collaborative, workgroups, learning sessions, and reporting data.</td>
</tr>
<tr>
<td>2</td>
<td>Hitting targets on key metrics including access to care, HEDIS and full participation in the collaborative.</td>
</tr>
<tr>
<td>3</td>
<td>Payment for decreasing ambulatory care-sensitive hospital admissions, emergency department visits, and achieving HEDIS &gt;90th percentile.</td>
</tr>
</tbody>
</table>

# Maryland PCMH Pilot (July 2011)

## PMPM Commercial Population

<table>
<thead>
<tr>
<th>Size (# of patients)</th>
<th>NCQA Level</th>
<th>1+</th>
<th>2+</th>
<th>3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10,000</td>
<td></td>
<td>$4.68</td>
<td>$5.34</td>
<td>$6.01</td>
</tr>
<tr>
<td>10,000-20,000</td>
<td></td>
<td>$3.90</td>
<td>$4.45</td>
<td>$5.01</td>
</tr>
<tr>
<td>&gt; 20,000</td>
<td></td>
<td>$3.51</td>
<td>$4.01</td>
<td>$4.51</td>
</tr>
</tbody>
</table>

## PMPM Medicaid Population

<table>
<thead>
<tr>
<th>Size (# of patients)</th>
<th>NCQA Level</th>
<th>1+</th>
<th>2+</th>
<th>3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10,000</td>
<td></td>
<td>$5.45</td>
<td>$6.22</td>
<td>$7.00</td>
</tr>
<tr>
<td>10,000-20,000</td>
<td></td>
<td>$4.54</td>
<td>$5.19</td>
<td>$5.84</td>
</tr>
<tr>
<td>&gt; 20,000</td>
<td></td>
<td>$4.08</td>
<td>$4.67</td>
<td>$5.25</td>
</tr>
</tbody>
</table>

## PMPM Medicare Population

<table>
<thead>
<tr>
<th>Size (# of patients)</th>
<th>NCQA Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10,000</td>
<td>$11.54</td>
</tr>
<tr>
<td>10,000-20,000</td>
<td>$9.62</td>
</tr>
</tbody>
</table>

PPACA: New Opportunities

New Funding & New Coverage:
- Increased FFS for primary care
- Enhanced preventive care
- Coverage and service expansion
- Health center payment protections

Payment & Delivery Demonstrations:
- CMS Innovation Center (Section 3201)
- Global and bundled payments
- Accountable Care Organizations
- Medical home demonstrations
Section 2703: Medicaid Medical Home State Option

- Permits Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one SPMI to designate a provider as a “health home.”
- Went into effect Jan 1, 2011.
- Offers states a 90% FMAP match for two years for home health-related services, including care management, care coordination, and health promotion.
- State planning grants also available.
Getting Started:
Lessons from the Field
Help set the Stage for Success
Leadership Engagement is Critical

- The multidisciplinary leadership team
  - Executive
  - Physician
  - Nursing
  - IT
  - Quality Improvement
- Beware “The County Syndrome”
- Understand and work with “terminal uniqueness”
Prepare for the Paradigm Shift

PCMH is an epic-level of transformation

• From acute, responsive care to pro-active, planned care
• From solo provider mindset to team-based care
• From volume to value
• From chaos to control
Staffing Considerations

- PCMH is a driver for provider recruitment and retention
- Anticipate HR and union issues
- The Magic Formula
  1 provider: 1.5 MA : 0.5 RN : 3 exam rooms
Select an Appropriate Assessment Tool

Multiple uses:

- Stimulates team discussion about current operations and sets the expectations for the future state
- Provides a gap analysis
- Identifies opportunities for improvement and TA needs
- Quantifies progress for monitoring purposes
- Allows a means of comparing sites to each other
Health Plans Must be in the Game

• PCP assignment process
• Rules for appropriate referrals
• Requirements for specialists’ communication with PCP
• Data mining and data sharing
• Consider piloting payments for innovative visit models
• Provide support to network providers
General Operations

- Safety Net Clinics can become continuity clinics
- Open Access can be a barrier to care
- Empanelment requires continuous attention
- Information Systems can impede transformation
- PCMH readiness can guide EMR design and implementation
- PCMH effort can guide space planning efforts for new facilities or renovations
Large-scale Project Planning

- Articulate goals
- Adopt a project framework and assessment tool
- Define measurement approach early on and stick with it
- Establish reasonable timelines
- Establish relationships with community partners
- Provide different modalities of support
- Encourage and actively facilitate peer-to-peer learning
- Address payment and financing
At the Practice Site Level…
Get Ready…

• Review your organization’s goals
• Adopt a project framework
• Develop a multi-disciplinary Project Team
• Assign a Project Leader
• Develop a plan for regular communication with staff
• Define a measurement structure; ensure that IT systems provide the right data
• Select a PCMH self-assessment tool
Get Set …

• Conduct a scored self-assessment to establish a baseline
• Review scoring; understand gaps
• Develop an Action Plan
• Use a Tracking Sheet / Monitoring Tool to chart progress over time
…. GO !!

- Keep the Vision
- Walk the Talk
- Stay the Course
Resources

• SNMHI website: www.qhmedicalhome.org/safety-net
• PCPCC: www.pcpcc.net
• National Academy for State Health Policy: www.nashp.org
• The Commonwealth Fund: www.commonwealthfund.org
Questions

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