

# The Evidence Base for SNMHI Change Concepts

February, 2013

**Safety Net  
Medical Home Initiative**

# Background

*“Primary care is an essential component of a rational health care system, because it delivers health care to populations with both equity and efficiency.”<sup>1</sup>*

- US Health Care is one of the most costly in the world and expected to increase to 20% of GDP by 2020.<sup>2</sup>
  - Chronically ill patients account for “virtually all” of recent growth in Medicare spending.<sup>3</sup>
- Widespread agreement that traditionally organized primary care practices must redesign infrastructure, organization and care delivery to achieve more effective, less costly care.<sup>4</sup>
- Building a strong primary care sector now a major goal of American health care policy.<sup>4</sup>

(1. The Commonwealth Fund, 2011; 2. Centers for Medicare and Medicaid Services; 3. Berenson et al., 2008; 4. Goodson, 2010)

# Roots of Patient Centered Medical Home (PCMH)

- Combination of two well-established models:
  - **Pediatric Medical Home Model:**<sup>1,2</sup>
    - First known use of term “medical home” introduced in 1967 by the AAP Council on Pediatric Practice.
    - Accountability for comprehensive, continuous, accessible, coordinated, and patient- and family-centered placed on generalist clinician team.
    - What patients should expect and how practice can meet expectations.
  - **The Chronic Care Model:**<sup>3</sup>
    - Structural and functional modifications to practice that support patient activation and planned proactive care.
    - How care should be structured.
- Both models **emphasize relationship between primary care provider/team and patient/family.**

# PCMH and Primary Care

- **Primary care** is associated with better health outcomes and is a tenant of PCMH:<sup>1</sup>
  - One additional primary care physician per 10,000 persons is associated with a **decrease in mortality** rate of 3-10% in England and the United States.
  - An increase of one primary care physician is associated with 1.44 **fewer deaths**/10,000 persons in the United States.
  - Adults using a primary care physician rather than a specialist had 19% **lower mortality** rates after adjusting for demographic and health characteristics.

(1. Starfield et al., 2006)

# Definition of PCMH

*The **joint principles**<sup>1</sup> developed by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association:*

- **Personal Clinician**— every patient has an on-going relationship with their personal provider who serves as the first contact with the medical system.
- **Clinician directed medical practice** – provider leads team of individuals who collectively take responsibility for patients.
- **Whole person orientation** – personal physician responsible for providing all health care needs and coordinating care with specialists.
- **Coordinated or integrated care** – across all elements of the health care system and patient's community

# Definition of PCMH Cont.

- **Quality and Safety** – hallmarks of PCMH including:
  - Support of patient-centered outcomes.
  - Evidence-based medicine.
  - Accountability for continuous quality improvement that includes patients and their families.
  - Use of health information technology.
- **Enhanced Access** – including open-scheduling, expanded hours and new communication strategies such as email.
- **New Payment Structure** – that recognizes the value of a PCMH including typically non-reimbursable services such as care coordination and email communication and:
  - Supports adoption of health information technology.
  - Recognizes case mix differences in a patient population.
  - Allows physicians and practices to share in cost-savings from reduced hospitalizations.

# PCMH Outcomes

*“PCMH improves quality, affordability and patient satisfaction with care through collaboration and aligned incentives.”<sup>1</sup>*

- Patient Centered Medical Home satisfies the **Institute for Healthcare Improvement’s Triple Aim:**<sup>2,3,4</sup>
  - 1. Improved Health**
    - Better patient health outcomes.
    - Decreased health disparities.
  - 2. Improved Patient Experience**
  - 3. Decreased Per Capita Cost**
- As well as **increased provider satisfaction and increased quality of care.**

# PCMH Outcomes: Improved Health

- **Chronic Illness Outcomes**<sup>1,2</sup>

- WellMed Inc, TX:

- Among diabetic patients an increased control of HbA1C levels from 81% to 93%, increased of 51% to 95% in controlled LCL levels, and increased control of blood pressure levels from 67% to 90%.

- CareOregon, OR:

- Among diabetic patients an increased control of HbA1C levels from 45% to 65%.

- Pennsylvania UPMC, PA:

- 20% long-term improvement in control of blood sugar and 37% improvement in long-term cholesterol control among diabetics.



# PCMH Outcomes: Improved Health Cont.

- Humana Queen City Physicians, OH.<sup>1</sup>
  - 22% decrease in uncontrolled blood pressure patients.
- Regence Blue Shield, WA.<sup>1</sup>
  - 14.8% improved self-reported physical and mental function.
  - 65% reduction in missed workdays for patients.
- Genesee Health Plan, MI.<sup>2</sup>
  - Of patients reporting chronic pain, 37% reported improved pain management.
  - Of patients reporting depression, 42% reported reduction in depressive symptoms.

(1. Nielsen et al., 2012; 2. Patient Centered Primary Care Collaborative, 2012)

# PCMH Outcomes: Improved Health Cont.

- **Increased healthy behaviors** after implementation of a Health Navigator Self-Management Support System in Genesee Health Plan that covers more than 25,000 uninsured adults.<sup>1</sup>
  - 53% of people who did not eat adequate amounts of fruits and vegetables, now eat adequate amounts;
  - 53% of people who reported no regular physical activity, now are physically active;
  - 17% of smokers quit smoking; and
  - 85% of patients who were not taking their medications regularly, now do take medications at prescribed intervals.

# PCMH Outcomes: Decreased Health Disparities

- Health disparities decrease with access to primary care:
  - Urban and rural counties with adequate rates of primary care providers have **higher than average health outcomes** despite social disparities such as differences in income.<sup>1</sup>
  - Minorities are more likely to receive care in low-quality settings rather than poor care from individual providers.<sup>2</sup>
  - Racial and ethnic disparities are reduced for families who can identify their primary care provider.<sup>3</sup>
- Disparities are further reduced given access to a PCMH:
  - Disparities in access to and quality of care are eliminated or reduced between Latinos and White patients given access to a PCMH.<sup>2</sup>
  - A national survey found that racial and ethnic differences in access and receiving preventative care disappear with equal access to a medical home.<sup>3</sup>

# PCMH Outcomes: Patient Experience

- Group Health Cooperative, WA:<sup>1</sup> **Higher patient satisfaction** ratings than controls at 12 and 24 months after adjusting for age, education, self-reported health status, and baseline satisfaction.
- Genesee Health Plan, MI:<sup>2</sup> 80% of patients agreed or strongly agreed their provider helped them to be healthy and cared about their health.
- HealthPartners Medical Group, MI:<sup>3</sup> **Improvements on all measured patient satisfaction ratings** and significant increases on:
  - *Ability for patients to get an appointment when they wanted;*
  - *Patients were treated with dignity and respect; and*
  - *Patients received timely test results.*

# PCMH Outcomes: Patient Experience Cont.

- *Lesson Learned:*<sup>1</sup>
  - However, the TransforMED National Demonstration Project found **decreased patient satisfaction** after 26 months. This is thought to be due to:
    - Less interpersonal communication in the care setting.
    - Lack of patient-centered communication through the process.
    - Difficulty of EMR implementation.
  - *“It's very difficult to work on the practice while being so busy working in the practice.”* - Edward Schwager, MD, of Tucson, Arizona, TransforMED participant.<sup>2</sup>

# PCMH Outcomes: Decreased Cost

- Primary care is associated with lower overall population-level healthcare spending.<sup>1</sup>
- States with higher ratios of primary to specialty care providers have **lower**:<sup>2</sup>
  - **Medicare spending** (inpatient reimbursements and Part B payments).
  - **Resource inputs** (hospital beds, ICU beds, total physicians labor and medical specialist labor).
  - **Utilization rates** (physician visits. Days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians).

# PCMH Outcomes: Decreased Cost

- Cost savings occur in two primary areas:<sup>1,2</sup>
  - Reduced hospitalization/re-hospitalization
  - Reduced ED use
- Some health care costs increase (e.g., primary care costs, pharmacy costs) but these costs are outweighed by the savings achieved.<sup>1,2</sup>
  - Most demonstrations have achieved cost savings or cost neutrality even after making additional investments in primary care (e.g., enhanced payment)

# Per Capita Cost: Business Case

- Expenses associated with PCMH practice transformation depend on a number of factors including needing the following:
  - New staff (e.g., RN care manager)
  - Staff training (e.g., Medical assistant skills training)
  - PCMH recognition (unreimbursed time and application fee)
  - Infrastructure/capacity upgrade (e.g., phone)
  - HIT (e.g., EMR, registry)
- Participating in a PCMH payment demonstration/pilot can help defray costs and/or increase revenue.
- Many practices have successfully transformed without enhanced payment.
- Transformation is an investment in your practice's future.



# PCMH Outcomes: Operating Costs

- Some PCMH transformation costs are ongoing (e.g., staff training).
- In addition, the PCMH Model requires functions and delivery mechanisms that are often not reimbursed in a traditional FFS environment:
  - Non-face-to-face visits/new access points: Phone and email visits
  - Alternative visit models: Group visits, multiple visits in single day, Nurse-only visits, Health educator-only visits.
  - Care team time for QI (meetings, data review) and patient engagement, coordination & referral management, proactive outreach for preventive & chronic care.

# Expense of Operating as a Medical Home

- Evidence is limited and mixed
- Some research indicates small incremental costs. For practices operating on small margins, even small costs can be problematic.
- PCMH transformation in an investment
- PCMH transformation should result in better practice efficiency and for some, this results in some financial benefits/gains
- Payment reform/enhanced payment is important for the long-term

# Cost Data on PCMH Operating Costs

## Predicted Spending by PCMH Score Category

Estimates from a combination of: NCQA Physician Practice Connections–Patient-Centered Medical Homes (PPC-PCMH) recognition tool (2008), Medical Group Management Association (MGMA) Cost Survey, and the American College of Physicians (ACP) Practice Management Checkup Tool for 2006

		PCMH Score Category		
		Low	Mid	High
<b>Type of Spending per Physician (\$1,000s)</b>	Support Staff	152	157	154
	General Operating	120	122	134
	IT	5	8	11
	Physician	205	193	195
	<b>TOTAL</b>	<b>513</b>	<b>514</b>	<b>525</b>
<b>Per Patient-Month (2,640 patients per physician)</b>	Support Staff	\$4.80	\$4.96	\$4.86
	General Operating	\$3.79	\$3.85	\$4.23
	IT	\$0.16	\$0.25	\$0.35
	Physician	\$6.50	\$6.09	\$6.16
	<b>TOTAL</b>	<b>\$16.19</b>	<b>\$16.22</b>	<b>\$16.57</b>

# PCMH Outcomes: Cost Savings through Clinical Efficiency

- **Empanelment:** Allows practices to predict patient demand and staff accordingly—fewer unused appointment slots.
- **Enhanced Access:** Same-day scheduling decreases the number of no-show patients, as fewer appointments are deflected to a future date. Telephone/email/group visits allow physician time to be protected for acute and complex care services, which typically have higher reimbursement rates.
- **Team-based Care:** Proper reallocation of nonclinical work to non-provider staff increases overall staff productivity. Optimizing care/preventing care gaps (max packing) results in higher visit revenue.<sup>1</sup>

(1. Span et al., 2004; 2. Lewis et al. 2012)

# PCMH Outcomes: Decreased Cost Cont.

## Group Health Cooperative, WA<sup>1,2</sup>

- 29% reduction in ER visits
- 16% reduction in hospital admissions
- \$10 per patient per month total cost reduction
- Return on Investment = 1.5:1

## Health Partners Medical Group, MN<sup>3</sup>

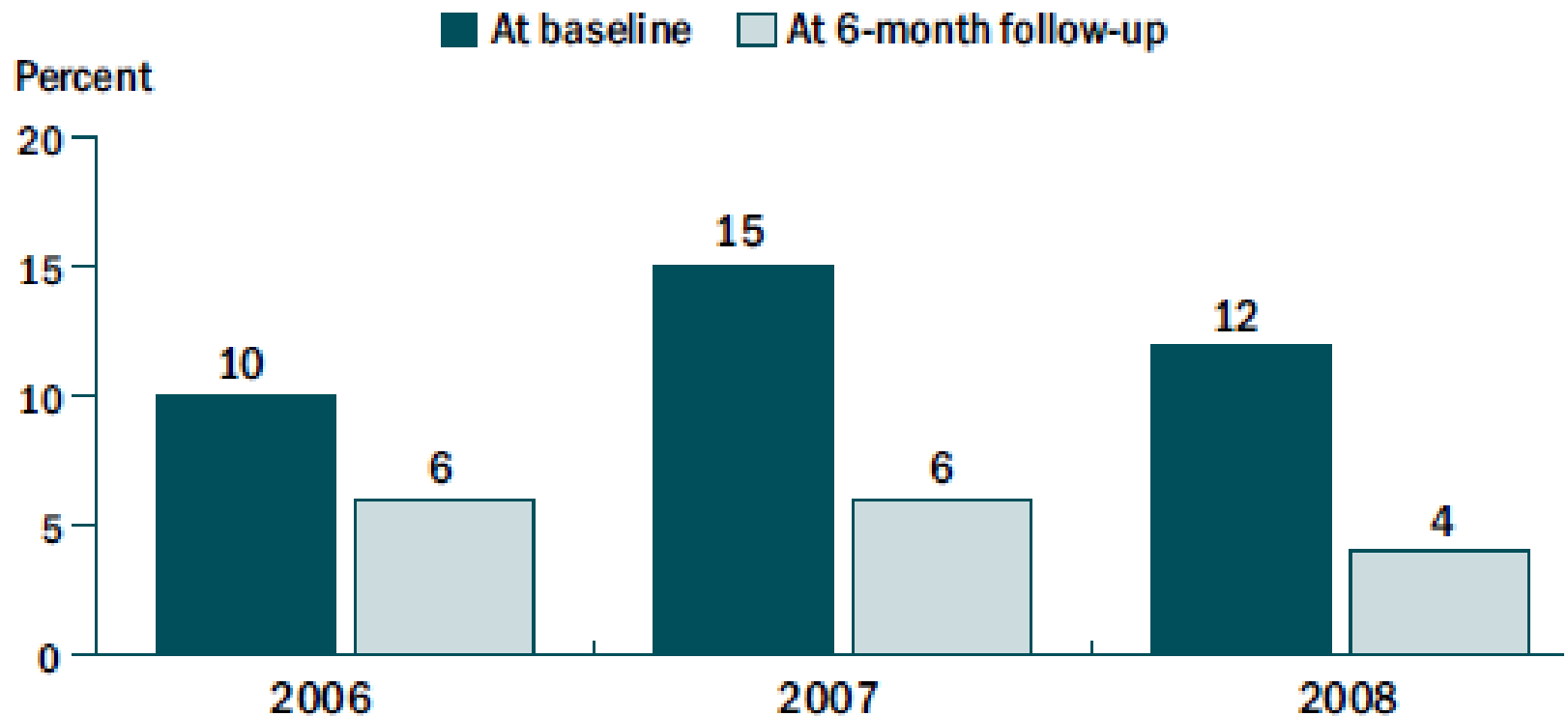
- 39% decrease in ER visits
- 24% reduction in hospitalizations

## ProvenHealth, Geisinger Health System, PA<sup>4,5</sup>

- 9% reduction in total medical costs
- 40% reduction in hospital 30-day readmissions
- 20% reduction in overall hospital readmissions.
- Return on Investment = >2:1

# EX: Savings for Payers & Communities: Genesee Health Plan, Michigan

Percent of Patients Engaged in Self-Management Support Who Report One or More Hospital Admissions in the Past Three Months<sup>1</sup>

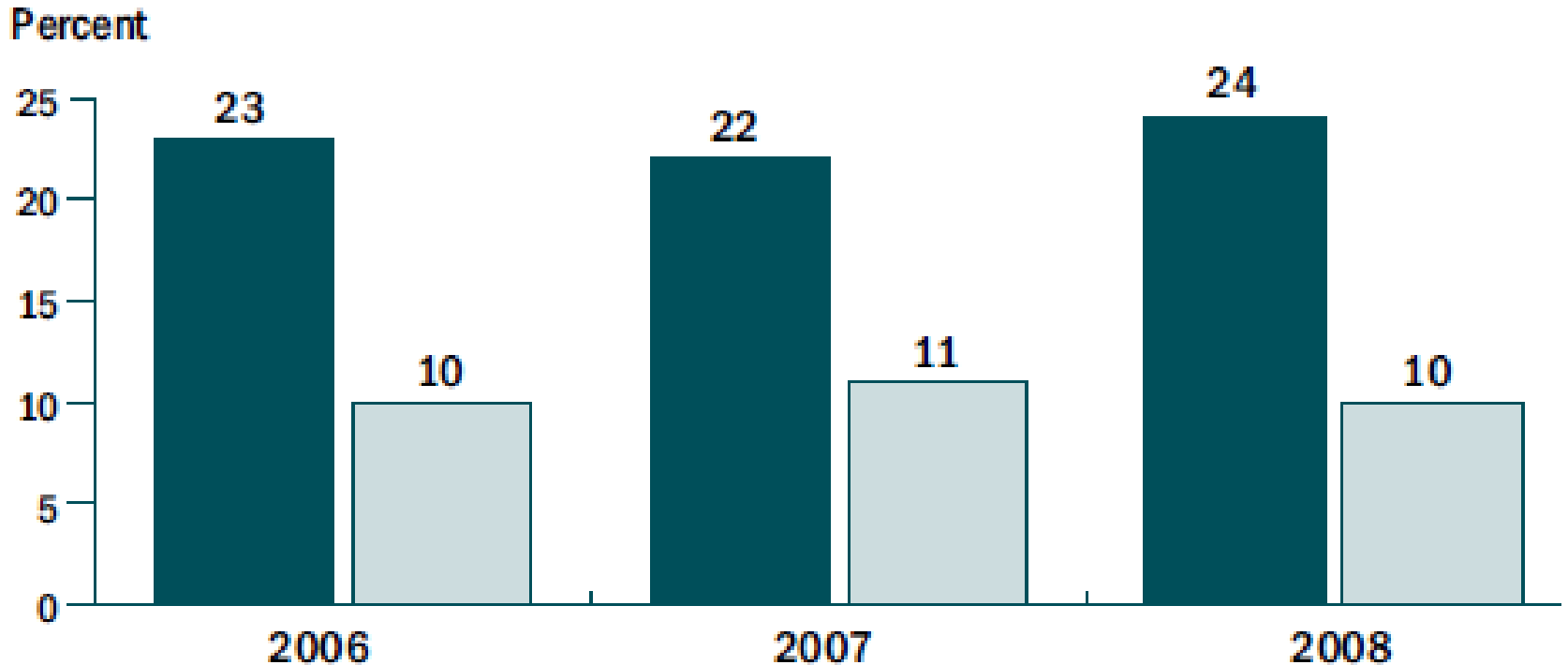


Source: Genesys HealthWorks and Genesee Health Plan.

# EX: Savings for Payers & Communities: Genesee Health Plan, Michigan

**Percent of Patients Engaged in Self-Management Support Who Report One or More E.D. Visits in the Past Three Months<sup>1</sup>**

■ At baseline    □ At 6-month follow-up



Source: Genesys HealthWorks and Genesee Health Plan.

(1. Patient Centered Primary Care Collaborative, 2012)

# How Exactly are These Savings Achieved?

Typical Practice Setting	PCMH Care	Efficiency/Cost Savings
Providers are responsible for the universe of patients who seek care in the practice	Patients are paired with a continuity provider who is responsible for a defined panel of patients	Care teams proactively assist their patients in staying healthy and managing existing illnesses or conditions – patients stay healthier and avoid complications.
Care is delivered in reaction to today's problem	Care is determined by a proactive plan to meet health needs, with or without clinic visits.	
Providers believe that their extensive training translates to high quality care. Care varies by scheduled time and memory or skill of the provider.	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.	Practices coordinate patient care among an organized team of health care professionals – this reduces the likelihood of duplicative tests and procedures and other types of waste.
The productivity treadmill requires providers to work harder and assume longer work days.	The practice aligns appointment capacity with appointment demand, adjusting staffing and other variables to balance the workload.	
The provider functions as a solo act, even when support staff are available.	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.	Enhanced access to a primary care team reduces avoidable ED use. Improved care coordination and proactive outreach reduces care gaps, particularly risk for re-hospitalization.

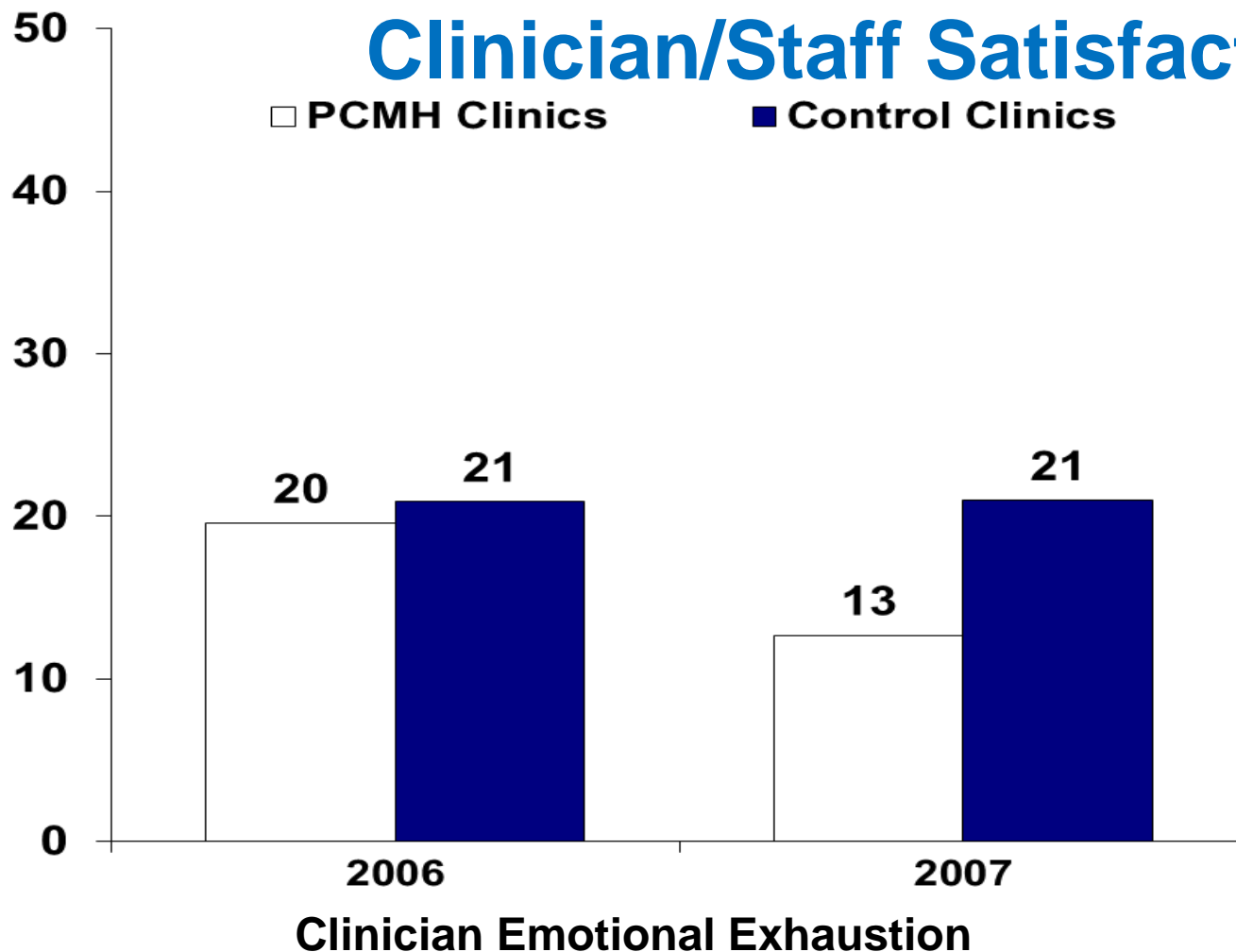


# PCMH Outcomes: Provider Satisfaction

- Safety Net Medical Home Initiative, CO, MA, ID, PA, OR:<sup>1</sup>
  - Providers and staff who reported a greater number of PCMH characteristics self-reported higher morale but with lower provider freedom from burnout.
    - Makes recruitment easier and reduces turnover.
- Group Health Cooperative, WA:<sup>2</sup>
  - Lower staff burnout and depersonalization
  - Only 10% of staff in clinics who had undergone PCMH transformation reported high emotional exhaustion compared to 30% of staff in control clinics.



# PCMH Outcomes: Clinician/Staff Satisfaction



Notes: Mean difference in composite clinical quality changes from 2006 to 2007 between clinics significant at  $p < 0.01$ ; difference in mean emotional exhaustion in 2007 between clinics significant at  $p < 0.01$ .

(Reid, et al., 2009)

# PCMH Outcomes: Clinical Quality

- **Healthcare Effectiveness Data and Information Set (HEDIS).**<sup>1</sup>
- Year 1: Quality improved 2x that of control clinics
- Year 2: Quality improved 20 –30% more than comparison sites in 3 of 4 composites
- **Increased optimal chronic illness care:**<sup>1,2</sup>
  - Community Care, NC: 93% asthmatics received appropriate medication.
  - Health Partners Medical Group, MN: 129% increase in patients receiving optimal diabetes care, 48% increase in patients receiving optimal heart disease care.
- **Higher rates of preventative care:**<sup>2,3,</sup>
  - Genesee Health Plan, MI: 137% Increase in mammography screening rates, 36% reduction in smoking.
  - Colorado Medicaid and SCHIP: 72% children had well-child visits compared to 27% of controls.

# PCMH Transformation Overview



Practice  
Point

- Medical home transformation involves:<sup>1</sup>
  - **Practice redesign:** structure and process changes.
  - **Identity shift:** enhanced teams, engaged patients, proactive care.
  - **Paradigm shift:** comprehensive, coordinated, patient centered care.
  - **Patience:** a long-term commitment.
    - Can take 3-5 years of external assistance.

# Evidence for Change Concepts for Practice Transformation

# SNMHI Transformation Framework

## 1. Laying the Foundation

Engaged Leadership

Quality  
Improvement Strategy

## 2. Building Relationships

Empanelment

Continuous,  
Team-Based Relationships

## 3. Changing Care Delivery

Patient-Centered Interactions

Organized,  
Evidence-Based Care

## 4. Reducing Barriers to Care

Enhanced Access

Care Coordination

# Transformation Framework Cont.

- While “**Laying the Foundation**” is not directly associated with the outcomes discussed previously, this step is necessary for successful PCHM transformation.
  - **Engaged leadership** and **Quality Improvement** are the drivers for subsequent steps.

# 1. Engaged Leadership

- **Key Changes:**
  - Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality and spread and sustain change.
  - Ensure that the PCMH transformation effort has the time and resources needed to be successful.
  - Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.
  - Build the practice's values on creating a medical home for patients into staff hiring and training processes.



# 1. Engaged Leadership

## What



### Practice Point

*Provide visible and sustained leadership to lead overall cultural change and specific strategies to improve quality and spread and sustain change.*

- “Direct involvement of top- and middle-level leaders” is most critical to successful system redesign.<sup>1</sup>
- Successful leaders must create a quality-oriented culture and define the clinic reality, often with data.<sup>1,2,3</sup>
- **Sustain enthusiasm.**<sup>2</sup>

# 1. Engaged Leadership

## What

*Ensure that the PCMH transformation effort has resources needed to be successful.*



**Practice  
Point**

- Develop **champions** and **teams**.<sup>1</sup>
- Increase involvement of patients and staff in the process.<sup>2</sup>
- Assure support from the Board of Directors.<sup>2</sup>
- Ensure protected time for staff members to conduct activities beyond direct patient care consistent with the medical home model.<sup>3</sup>

# 1. Engaged Leadership

## Why

- Effective leaders have knowledge and skills in:<sup>1</sup>
  - **Systems thinking:** capacity to understand the practice as a series of interrelated processes that determine performance.
  - **Envisioning change:** recognizing the gap between current and optimal practice and promising changes to close the gap.
  - **Change management:** implementing proven strategies for quality improvement and engaging staff in the process.

(1. Taylor et al., 2010)

## 2. Quality Improvement Strategy

- **Key Changes:**
  - Choose and use a formal model for quality improvement (QI).
  - Establish and monitor metrics to evaluate improvement efforts and outcome; ensure all staff members understand the metrics for success.
  - Ensure that patients, families, providers, and care team members are involved in quality improvement activities.
  - Optimize use of health information technology to meet Meaningful Use criteria.

## 2. Quality Improvement Strategy

### What

- **Lean** has been used in numerous clinical settings for QI including to meet Centers for Medicare and Medicaid Services (CMS) quality indicators.<sup>1</sup>
- *Case study*: Use of **Six Sigma** to identify causes of inefficiency and to restructure a large public safety net health system was successful in addressing:<sup>2</sup>
  - Timeliness.
  - Referral process time.
  - Overall clinic follow-through.

## 2. Quality Improvement Strategy

### What

- **Health information technology (HIT)** such as electronic medical records is another tool to incorporate a successful QI strategy.<sup>1</sup>
- HIT was a **main component of Group Health's PCMH transition** to assist with:<sup>2</sup>
  - Engaging patients in their treatment plan.
  - Maintaining continuity of care and treatment across providers.
  - Improving access to medical information for providers and patients.
  - Increasing provider adherence to evidence-based care.

## 2. Quality Improvement Strategy

### Why

- Using a **standardized, validated, and scientifically-based** survey instrument or QI strategy allows:<sup>1</sup>
  - Accurate measurement.
  - Comparison between different clinics.
  - Comparison to national research.
  - Comparison between groups of patients.
  - More credibility of results to payers and others.
  - Analysis of changes over time.

(1. Browne et al., 2010)

## 2. Quality Improvement Strategy

### Why

- However, **research supporting one specific QI strategy or tool is lacking.**<sup>1,2</sup>
  - Selecting and integrating a QI strategy into organizational culture is more important than choosing a specific strategy.
- Using one QI strategy to compare health outcomes across multiple chronic conditions is difficult with a small number of patients or when comparing between patients with and without a chronic disease.<sup>3</sup>
- The effect of quality improvement efforts on conditions that were not targeted by QI measures has not been noticeable.<sup>4</sup>



## 2. Quality Improvement Strategy

### Evidence

- **Using a formal QI strategy is associated with better clinical and process outcomes:**
  - Cochrane review found 47 articles supporting a positive association between increased practice performance and a standardized process of providing healthcare professionals with data about their performance (audit and feedback).<sup>1</sup>
  - *Case study:* Uptake of chronic illness management programs was greater in medical groups participating in quality improvement activities.<sup>2</sup>

# 3. Empanelment

- **Key Changes:**
  - Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.
  - Assess practice supply and demand, and balance patient load accordingly.
  - Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

# 3. Empanelment

## What



Practice  
Point

*If panels are too large, high-quality care cannot occur.*

- The process of empanelment occurs through examination of past patient use:<sup>1,2,3</sup>
  - Patients consistently visiting one provider are assigned to that provider.
  - Patients with inconsistent visits are discussed and assigned a relevant provider.
- Patient reassignment does not result in lowered satisfaction if thoughtfully managed.<sup>4</sup>

# 3. Empanelment

## Why

*Sustained partnership between patient and physician is most important to improving health.<sup>1</sup>*

- *Case study: San Francisco Department of Public Health<sup>2</sup>*
  - Established physician panels that automatically assign active patients and drop non-active patients.
  - This allows administrators, medical directors, and providers to easily view utilization rates and manage resources.
  - Allows patient data to be collected to analyze trends over time.

# 3. Empanelment

## Why

- **Patient Satisfaction:**

- Almost all patients value having a primary care physician as a source of first contact and coordinator of referrals.<sup>1,2</sup>
- Longer continuity of care (time with same physician) is associated with higher patient satisfaction.<sup>3</sup>
- A majority of patients would rather see a primary care physician than a specialist.<sup>1</sup>
- However, patients who felt they had difficulty obtaining referrals to a specialist had lower rates of trust of their primary care physician and medical group and lower satisfaction.<sup>1</sup>

# 3. Empanelment

## Evidence

*PCMH depends on the establishment of the patient-provider relationship.*

- Visits with the **same provider** lead to:



### Higher:

- Quality patient-provider communication.<sup>1</sup>
- Identification of medical problems.<sup>1</sup>
- Patient satisfaction.<sup>1,2,3</sup>
- Provider satisfaction.<sup>2</sup>
- Use of preventative care.<sup>1</sup>



### Lower

- Overall costs.<sup>2,4</sup>
- Hospital and ER admissions.<sup>1</sup>

# 4. Continuous and Team-Based Healing Relationships

- **Key Changes:**
  - Establish and provide organizational support for care delivery teams accountable for the patient population/panel.
  - Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
  - Assure that patients are able to see their provider or care team whenever possible.
  - Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

# 4. Continuous and Team-Based Healing Relationships

What



Practice  
Point

- Team-based care is **most successful when**:<sup>1</sup>
  - Tasks are matched to skills, credentials and interests.
  - Appropriate training occurs.
  - Roles are clearly defined.
  - Team roles are transparent to patients.
  - Team members work at the top of their licensure.
  - Cross-training occurs.



# 4. Continuous and Team-Based Healing Relationships

## Why

- Primary care providers do **not have enough hours in a day** to provide chronic disease and preventative care to a full patient panel.
  - This would take 18 hours!<sup>1</sup>
- Many services **don't require a primary care provider** and are better performed by a team member including:<sup>2</sup>
  - Self-management education.
  - Care coordination.
  - Population management
  - Protocol-based regulation of medication.
  - Intensive follow-up.

(1. Ostbye et al., 2005; 2. Wagner et al., 2000)

# 4. Continuous and Team-Based Healing Relationships

## Why

- Clinical care improves and costs decrease when practice team members other than the primary care provider help to meet patient need.<sup>1</sup>
- Process of care improves when the collective clinical expertise of the team improves.<sup>1</sup>
- *Lesson learned:* Care from other team members shows no decrease in patient satisfaction as long as the patient perceives the provider to be part of a well-functioning team with good communication.<sup>2</sup>

# 4. Continuous and Team-Based Healing Relationships

## Why

- Experts now recommend that self-management support be an ongoing process best performed in the context of multiple clinical interactions.<sup>1,2</sup>
- The **health coach** is emerging to meet the need for self-management support in primary care.
  - Medical assistants and even lay people have, with appropriate training, proven to be effective health coaches.<sup>3</sup>
  - Health coaches have been shown to increase healthy behaviors and chronic care management in a safety net population including diabetes management, chronic pain, and depression.<sup>4</sup>

# 4. Continuous and Team-Based Healing Relationships

## Evidence

- Team-care been shown to be effective in populations of patients with:
  - **Diabetes:** Case management where nurse or pharmacist has made independent medication changes is associated with better glycemic control.<sup>1</sup>
  - **Hypertension:** Team member support was associated with significantly greater blood pressure reduction than contact with a physician alone.<sup>2</sup>
  - **Depression:** Collaborative care had a stronger effect on reducing depressive symptoms compared with physician-only care at 6 months.<sup>3</sup>

# 5. Patient-Centered Interactions

- **Key Changes:**

- Respect patient and family values and expressed needs.
- Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.
- Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.
- Provide self-management support at every visit through goal setting and action planning.
- Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.

# 5. Patient-Centered Interactions

## What

Care that is “*respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions.*” - Institute of Medicine.<sup>1</sup>

- Quality of care from patient’s and family’s perspective depends on the extent to which care is consistent with patient needs, preference, values, and expectation.<sup>2</sup>
- Most patients **want the opportunity to discuss:**<sup>2,3</sup>
  - Treatment options,
  - Preferences, and
  - Concerns about treatment.

# 5. Patient-Centered Interactions

## Why

- About half of patients leaving medical encounters do not understand what was recommended due to low health literacy.<sup>1,2</sup>
- Patient-centered interactions that engage the patient and use **teach-back** or “closing the loop” (asking patients to recount what they have been asked to do) leads to:<sup>3</sup>
  - Better medication adherence.
  - Better self-management.
  - Better health outcomes.

# 5. Patient-Centered Interactions

## Evidence

- Lead to improved well-being through:<sup>1,2</sup>
  - Reduced anxiety.
  - Reduced depression.
  - Improved overall-mental health.
  - Increased trust.
  - Increased self-efficacy in navigating the health care system.



# 6. Organized Evidence-Based Care

- Key Changes:
  - Use planned care according to patient need.
  - Identify high risk patients and ensure they are receiving appropriate care and case management services.
  - Use point-of-care reminders based on clinical guidelines.
  - Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.

# 6. Organized Evidence-Based Care

## What

- Addresses the underuse of proven preventative interventions, clinical assessments, and treatments.
- Should be **tied to a QI Strategy**.
- **Planned visits** identify needed services before the visit and allow services to be delivered during the visit.<sup>1</sup>
  - Most research into planned visits care has been focused on group visits and chronic disease management.<sup>1,2</sup>

# 6. Organized Evidence-Based Care

## Why

- Proven preventive interventions, clinical assessments, and treatments are currently underused.<sup>1</sup>
  - Barriers to use of scientific guidelines are deficiencies in systems of care, not in providers working within those systems.
  - Providers are often unaware when their patient needs a given service or test and may not have time to address this need in one visit.
  - Many services to patients, especially chronically ill patients, are predictable.
- Provider reminder systems reflecting evidence-based guidelines and embedded in an **EMR** have been shown to increase the likelihood that recommended services are delivered.<sup>2</sup>

# 6. Organized Evidence-Based Care

## Evidence

- Most research into planned visits care has been focused on group visits and chronic disease management.<sup>1,2</sup>
  - Uses available resources more efficiently.<sup>1</sup>
  - *Case study*: A1C levels in patients with diabetes receiving nurse-led planned-care visits were significantly lower than controls.<sup>3</sup>
  - *Case study*: Cochrane review found that planned visits reduced glycemic control when led by a trained nurse.<sup>4</sup>

# 6. Organized Evidence-Based care

## Evidence

- Cochrane review of **computer reminder implementation** found **improved care** in the following areas:<sup>1</sup>
  - Medication orders.
  - Appropriate vaccination.
  - Test ordering.
- *Case study*: Guided care, evidence-based care that incorporates patient preference, resulted in higher satisfaction ratings and higher self-rated health.<sup>2</sup>
- *Case study*: An intervention using nurse care managers who provided evidence-based, patient centered management improved depression significantly more than usual care.<sup>3</sup>

# 7. Enhanced Access

- **Key Changes:**

- Promote and expand access by ensuring that established patients have 24/7 continuous access to their care team via phone, email or in-person visits.
- Provide scheduling options that are patient- and family-centered and accessible to all patients.
- Help patients attain and understand health insurance coverage.

# 7. Enhanced Access

## What



Practice  
Point

- **Telephone access during office hours** can be improved through more efficient management of incoming calls:
  - Bypass administrative options.
  - Connect patients directly with care teams.
- Increased telephone access during office hours has been associated with:<sup>1,2</sup>
  - Reduced costs.
  - Increased patient satisfaction.
  - Lower clinician burnout.

# 7. Enhanced Access

## What

*Only 25% of American adults with chronic illness can regularly get a same-day appointment.<sup>1</sup>*

- *Case Study:* A consumer-governed health organization in Minnesota saw a 350% reduction in appointment waiting time with PCMH implementation.<sup>4</sup>
- **Open- or advanced-access appointment scheduling** has been proposed as a way to better meet patients needs<sup>2</sup> and has been shown to:
  - Improve appointment wait time.<sup>3</sup>
  - Reduce no-show rates.<sup>3</sup>
  - However, effects on patient satisfaction are mixed.<sup>3</sup>
- *Case Study:* Implementing an open access system in a large multispecialty medical group for patients with diabetes, coronary heart disease (CHD), or depression led to higher rates of primary care visits.<sup>5</sup>



# 7. Enhanced Access

## Why

*Less than 30% of American primary care doctors provide after-hours care.<sup>1</sup>*

- **Telephone access after hours** through triage or consultation services has been shown to:
  - Increase clinician satisfaction.<sup>2</sup>
  - Reduce clinical workload.<sup>2</sup>
  - Reduce emergency department use.<sup>3</sup>
  - However, patients express dissatisfaction if service is viewed as a barrier to being seen.<sup>2</sup>
- *Case Study:* After implementing a nurse advice/triage line, a Kansas City clinic reported positive patient experience, reduced ED use, and a return of \$1.70 for every dollar spent.<sup>4</sup>

# 7. Enhanced Access

## Why

Comprehensive  
Appointment  
System

Reduced No-  
Shows

Better Clinic  
Flow

Reduced  
overall Cost

- **Missed appointments** result in:<sup>1,2,3</sup>
  - Lost revenue.
  - Longer appointment lead times.
  - Lower quality of care.
  - Lower patient satisfaction.
- Emotions, perceived disrespect, and not understanding the scheduling system are associated with missing appointments without notifying clinic staff.<sup>1</sup>
  - Patients felt less obligated to keep an appointment if they felt disrespected by the healthcare system.<sup>1</sup>

# 7. Enhanced Access

## Why

*Medical homes, especially those serving lower-income populations, should help patients understand or obtain health insurance.*

- ~20% of Medicaid-eligible children<sup>1</sup> (~12% of with major chronic conditions)<sup>2</sup> are **uninsured** because their parents lacked the necessary information or were intimidated by the enrollment process leading to:
  - Lack of preventative care.
  - Unnecessary hospitalizations and increased ER use.
  - Increased health disparities.

# 7. Enhanced Access

## Why

- Leads to decreased system costs:
  - Barriers to accessing primary care, such as limited urgent care appointments, or after-hours care, are associated with costly hospitalizations and emergency room use.<sup>1</sup>
- Those with low income are also more likely to delay primary or preventative care, leading to:<sup>2</sup>
  - Increased hospitalization.
  - Longer hospital stays.
  - Worse health outcomes.
- Longer wait-time for primary care services is associated with higher mortality.<sup>3</sup>

(1. Bindman et al., 1995; 2. Weissman et al., 1991; 3. Prentice & Pizer, 2007)

# 7. Enhanced Access

## Evidence

- Decreased health disparities on a population-level:
  - Urban and rural counties with adequate rates of primary care providers have **higher than average health outcomes** despite social disparities such as differences in income.<sup>1</sup>
- Decreased health disparities on an **individual-level**:<sup>2</sup>
  - A national survey found that racial and ethnic differences in access and receiving preventative care disappear with equal access to a medical home.
  - Racial and ethnic disparities are reduced for families who can identify their primary care provider.

(1. Shi et al., 2005; 2. Beal et al., 2007)

# 8. Care Coordination

- **Key Changes:**

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.
- Track and support patients when they obtain services outside the practice.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Communicate test results and care plans to patients/families.

# 8. Care Coordination

## What

*Care transition management, interventions when a patient is moving from a hospital to a home setting, is necessary to reduce avoidable readmissions.*

- *Case Study:*<sup>1</sup> Starting in 2011, Centers for Medicare and Medicaid Services (CMS) contracted with sites across the country to identify root causes of readmission and employed coaches who visit patients in the hospital, follow-up with patients 28 days post discharge and provide self-management support using the Care Transitions Intervention.<sup>2</sup>
  - Hospital readmission and ER visits post-discharge have already significantly decreased.

# 8. Care Coordination

## Why

- **Consumers value care coordination** including between:<sup>1,2</sup>
  - Primary care provider and patient.
  - Primary care provider and other health care providers such as specialists.
  - Care team members.
- Communication breakdowns between multiple sources of care limit the effectiveness of medical services.<sup>3</sup>
  - When a care team organizes multiple sources of care, the PCP is more likely to discuss specialist visits with the patient and be aware of possible complications or unmet needs.<sup>2</sup>



# 8. Care Coordination

## Why

### *Behavioral health integration*

- Patients with chronic illness and behavioral health comorbidities have significantly higher medical costs than those with one diagnosis.<sup>1</sup>
- Treating behavioral health issues can lower overall costs for these patients by as much as 50%.<sup>1,2</sup>
- *Case Study:* The Washington Medicaid Integration Partnership (WMIP) that integrates managed care services in mental health, drug and chemical dependency treatment, and medical care found:<sup>3</sup>
  - 40% reported care was better coordinated.
  - 24% reported fewer delays in care.

# 8. Care Coordination

## Evidence

- Care coordination leads to better medical care through:
  - Decreased medical errors.<sup>1</sup>
  - Decreased medication errors.<sup>1</sup>
  - Increased accuracy of post-discharge plans.<sup>2</sup>
  - Decreased probability of adverse medication interaction.<sup>1</sup>
  - Lower rates of hospital readmission.<sup>2</sup>
  - Shorter future hospital stays.<sup>2</sup>
  - Decreased duplication of procedures.<sup>2</sup>

# 8. Care Coordination

## Evidence

- Care coordination leads to **greater patient satisfaction** and understanding of healthcare systems.<sup>1</sup>
- Communication from practice to patient is elemental to care coordination, especially communication of test results and care plans.<sup>2</sup>
  - Preference studies indicate that most patients find timely mail or electronic communication of normal results to be acceptable, but strongly prefer a telephone call for abnormal results.

# Thank you

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# Resources

Qualis Health Patient-Centered Medical Home

[www.qhmedicalhome.org](http://www.qhmedicalhome.org)

[coachmedicalhome.org](http://coachmedicalhome.org)

American Academy of Family Physicians PCMH Model:

[www.aafp.org/online/en/home/membership/initiatives/pcmh.html](http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html)

TransformMED: [www.transformed.com/MedicalHome/Solutions1\\_07-12.cfm](http://www.transformed.com/MedicalHome/Solutions1_07-12.cfm)

[Health Resources & Services Administration \(HRSA\) Patient-Centered Medical Home Initiative](#)

[Centers for Medicare & Medicaid Services \(CMS\): Federally Qualified Health Center \(FQHC\) Advanced Primary Care Practice Demonstration](#)

[National Academy for State Health Policy \(NASHP\): Defining & Recognizing a Medical Home](#)

[Patient-Centered Primary Care Collaborative \(PCPCC\)](#)

[The Commonwealth Fund: Patient Centered Care](#)

[Agency for Healthcare Research & Quality \(AHRQ\): PCMH Resource Center](#)

# Accreditation Resources

[NCQA's Patient-Centered Medical Home \(PCMH\) 2011](#)

The Joint Commission Recognition Program

<http://www.jointcommission.org/about/jointcommissionfaqs.aspx>

URAC

[www.urac.org](http://www.urac.org)

Accreditation Association for Ambulatory Health Care Inc.

[www.aaahc.org](http://www.aaahc.org)

# Resources

# Appendix





# PCMH Payment 101

# Case for PCMH Payment

## Why Payment Reform?

### Pay for Value, Not Volume

- Population health
- Move away from visit 'churn'

### Expect and Reward Outcomes

- Clinical quality
- Patient experience
- Cost reductions

### Address Coverage Issues

- Telephonic and email visits
- Group visits, patient education
- Community care
- Integration: behavioral, oral

## Why Enhanced Payment?

### PCMH Start-up Costs

#### Infrastructure

- Infrastructure: telephone and system upgrades, EMR or HIT
- Lost revenue during QI work
- New staff
- Staff training

### Incentivize Primary Care

- Reward accountability for new work and new risk: care coordination
- Increase and support workforce

# Payment Pilots and Demonstrations

- There are scores of payment demonstrations occurring across the country.
- These demonstrations are testing new and innovative ways of paying primary practices for delivering PCMH care. They are also testing ways of effectively rewarding practices for improvement.
- Multi-payer and single payer; some include Medicare or Medicaid/Medicaid Managed Care.

# Payment 101

- There are many different payment models available to support PCMH.
- All have pros and cons or benefits and risks depending on how they are applied.
- “Traditional” models build-on or add to FFS (higher FFS, additional codes, additional payment streams).
- More “radical” (or “reform minded”) models replace FFS (typically with “comprehensive payment”, also know as capitated or global payment, and the opportunity for shared savings and/or performance-based payments).

# Payment 101

- The most common way to re-align payment incentives to support the PCMH is to combine traditional FFS for office visits with a three-part model that includes<sup>1</sup>:
  - **FFS**: recognizes visit-based services paid under the current FFS payment system & maintains an incentive for the physician to see the patient in an office-visit when appropriate.
    - *New Hampshire's statewide Multi-Stakeholder Medical Home Pilot includes a FFS component providing payment for care plan oversight and traditional services.*<sup>3</sup>
  - **PMPM**: monthly care coordination payment (can be risk-adjusted) for physician and non-physician work that falls outside of a face-to-face visit and for system infrastructure (e.g. HIT).
    - *CMS' FQHC Advanced Primary Care Practice Demonstration, pays health centers \$6 per Medicare beneficiary per month (PMPM) to implement the PCMH model.*<sup>2</sup>

# Payment 101 Continued

- **Pay-for-Performance:** A performance-based payment that rewards providers/practices for meeting specific goals, typically quality and/or cost.
  - *The EmblemHealth Medical Home High Value Network Project in New York offers performance-based payment, equal at maximum to \$2.50 PMPM, for each member that is identified on the practice's member list. The specific amount earned by the practice depends on practice results on performance measures relating to quality, efficiency, and patient experience.*<sup>3</sup>
- **Shared Savings:** Typically additive to another model, this payment mechanism allows providers/practices to share in savings that are generated by the program.
- **Comprehensive payment:** Also known as global payment. A practice receives a lump sum per patient (can be risk-adjusted) for total primary care costs.

# Enhanced Payment Models

Payment Model	Specific Payment Type	Feasible for Small Practice Size	Includes Upfront Payment	Financial Support for Traditionally Non-Billable Services
Grants-Based	Grants	X	X	X
FFS with Adjustments	FFS with new codes	X		
	FFS with higher payment levels	X		
FFS Plus	FFS with lump sum payments	X	X	X
	FFS with PMPM payment	X	X	X

**FFS** = Fee-For-Service

**PMPM** = Per-Member-Per-Month

# Enhanced Payment Models (cont.)

Payment Model	Specific Payment Type	Feasible for Small Practice Size	Includes Upfront Payment	Financial Support for Traditionally Non-Billable Services
Shared Savings	FFS with PMPM and P4P	X	X	X
	FFS with PMPY payment	X		X
	FFS with lump sum payments, P4P, and shared savings		X	X
	FFS with PMPY payment and shared savings			X
Comprehensive	Comprehensive payment with P4P		X	X

**FFS** = Fee-For-Service

**PMPM** = Per-Member-Per-Month

**PMPY** = Per-Member-Per-Year

**P4P** = Pay-for-Performance



## FFS Plus: FFS & P4P

# Blue Cross Blue Shield Michigan (BCBSM)

- Collaborative partnership between BCBSM and physician organizations across Michigan, with the goal of optimizing patient care and transforming the state's health care delivery system.<sup>2</sup>
- Operates on a **FFS plus model**: incentive dollars reward physicians/practices that quality and outcome goals.<sup>2</sup>
- BCBSM's PCMH practices have:<sup>1</sup>
  - 22% *lower* rate of hospital admissions for people with chronic conditions
  - 9.9% *lower* rate of emergency department visits
  - 7.5% *lower* rate of high-tech radiology usage

### Participating Practices<sup>2</sup>

Practices: 2,477

Physicians: 8,147

Physicians/Practice: 1-90

**Practice Types:** Internal & Family Medicine, Pediatrics, Other: Geriatrics, specialists (oncologists, cardiologists, ob-gyns, etc.), mixed PCP/specialist practices

**Covered Lives:** 1,800,000

# FFS, PMPM & Shared Savings: Chronic Care Initiative, Pennsylvania

- Incremental rollout across the state based on regions and payer representation.<sup>4</sup>
- Includes Medicaid enrollees (approx. 35.2 % enrollees).<sup>1</sup>
- Operates on a **FFS plus model**: practices received initial infrastructure payments as well as supplemental payments based on NCQA PCMH™ recognition and practice size.<sup>1</sup>

Start	PA Region	Unique Situation <sup>4</sup>	PCMH Payment Amount <sup>2</sup>
2008	Southeast	<ul style="list-style-type: none"> <li>• First Rollout</li> <li>• Payers very engaged</li> <li>• CRNP Practices included</li> <li>• 8 Pediatric Practices</li> </ul>	Up to \$4.00 PMPM
2009	South Central & Southwest	<ul style="list-style-type: none"> <li>• Large geographic region with multiple systems</li> <li>• Some compensated and uncompensated practices</li> <li>• 2 Pediatric Practices</li> </ul>	
2009	Northeast	<ul style="list-style-type: none"> <li>• Health Systems involved (Geisinger, Intermountain, Horizon, etc.)</li> <li>• Smaller practice sizes</li> <li>• Care Management initiated very early on in the creation of a system of care</li> </ul>	Up to \$3.00 PMPM plus shared savings

**Participating Practices<sup>3</sup>**

**Practices:** 170 (including FQHCs)

**Physicians:** 780

**Physicians/Practice:** 1-10

**Practice Types:** Internal & Family Medicine, Pediatrics

**Payers:** Commercial, Medicare Advantage, Medicaid Managed Care

**Covered Lives:** 1,093,246

(1. Gabbay et al., 2011; 2. Bailit Health Purchasing. 2009; 3. Patient Centered Primary Care Collaborative, 2012; 4. Governor’s Office of Health Care Reform Commonwealth of Pennsylvania, 2010)



# PMPM, P4P & Shared Savings: Maryland Multi-Payer PCMH Pilot

99

- All participating practices—including FQHCs—are eligible for incentive payments if they meet performance criteria.
  - Practices that meet the performance criteria are entitled to payments of 30% - 50% of any savings generated by the practice.
  - FQHCs will be able to share in 65% of savings for patients with Medicaid coverage.
- A unique payment methodology has been developed that makes special accommodation for small practices.

**Participating Practices**

**Practices:** 53

**Providers (included NP's & PAs):** 329

**Practice Types:** Internal & Family Medicine, Pediatrics, Geriatrics

**Covered Lives:** 200,000

PMPM Payment: Commercial Population			
Physician Practice Size (# of patients)	NCQA PPC-PCMH™ Recognition		
	Level 1+	Level 2+	Level 3+
< 10,000	\$4.68	\$5.34	\$6.01
10,000 – 20,000	\$3.09	\$4.45	\$5.01
> 20,000	\$3.51	\$4.01	\$4.51

PMPM Payment: Medicaid Population			
Physician Practice Size (# of patients)	NCQA PPC-PCMH™ Recognition		
	Level 1+	Level 2+	Level 3+
< 10,000	\$5.45	\$6.22	\$7.00
10,000 – 20,000	\$4.54	\$5.19	\$5.84
> 20,000	\$4.08	\$4.67	\$5.25

PMPM Payment: Medicare Population	
Physician Practice Size (# of patients)	NCQA PPC-PCMH™ Recognition
	Year 1 of Pilot: Level 1+ or higher Year 2 of Pilot: Level 2+ or higher
< 10,000	\$11.54
10,000 – 20,000	\$9.62

(National Academy for State Health Policy, 2012)



# (primarily) Comprehensive Payment: Capital District Physician's Health Plan (CDPHP)

**Pilot Year 1 Results:** Physician practices involved in year one of the CDPHP medical home pilot experienced:

- 9% reduction in the rate of overall medical cost increases — a savings of \$32 PMPM — as compared to other area physician practices.
- Improvements in quality measures
- Significant reductions in advanced imaging utilization and ER visits.
- 24% Reduction in total hospital admissions

## Participating Practices<sup>1</sup>

**Practices:** 3

**Physicians:** 18

**Physicians/Practice:** 3-10

**Practice Types:** Internal & Family Medicine

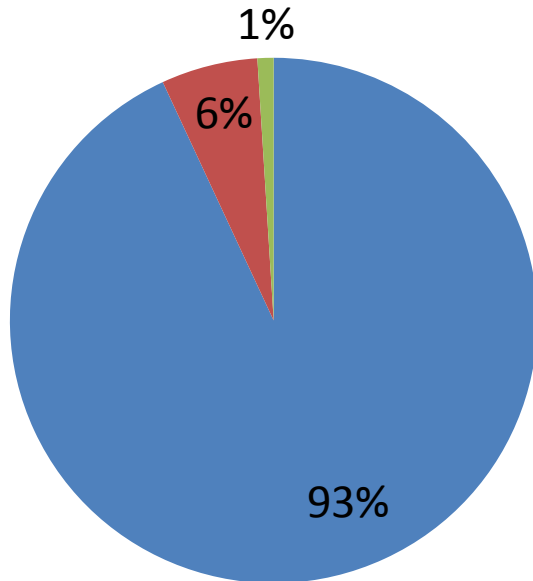
**Payers:** Commercial, Medicare Advantage, Medicaid Managed Care

**Covered Lives:** 13,500

**Early Conclusion:** Practice transformation support, and payment changes made a difference in the way care was provided. Quality measures improved; overall costs decreased.

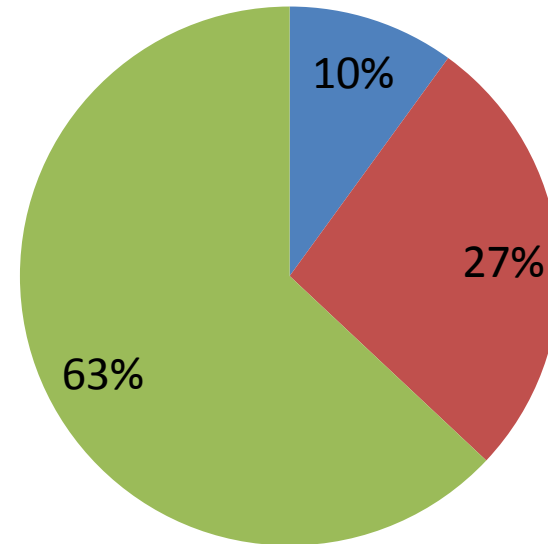
## Traditional Payment

- FFS (90-94%)
- Quality Payment
- PMPM Care Management Fee (\$1)



## PCMH Payment Pilot

- FFS RVRBS
- Bonus Payment\*\*
- Risk-Adjusted Comprehensive Payment\*



\*Targeted at improving base reimbursement by approximately \$35,000.

\*\* Uses IHI Triple Aim for bonus payment.

# CDHP Bonus Payments

## Population Health

(18 HEDIS Quality Metrics; 5 domains)

**1. Population Health:** cervical cancer, breast cancer, colorectal cancer, Chlamydia, glaucoma, adolescent well care visits

**2. Diabetes:** eye exam, HbA1c testing, LDL testing, nephropathy attention

**3. Cardiovascular:** complete lipid profile, persistent medication management-ACE/ARB, persistent medication monitoring diuretics

**4. Respiratory:** antibiotic use for acute bronchitis, asthma medications, Tx for children with pharyngitis, Tx for children with UTI

**5. Imaging Studies** for Low back pain

## Satisfaction

(CG-CAHPS) : threshold for bonus eligibility

## Per Capita Cost

### Population & Episode-Based:

- Specialty care and other outpatient hospital
- Pharmacy
- Radiology

### Utilization:

- Inpatient hospital admissions (selected)
- Emergency room encounters (selected)

# Other Opportunities: Medicaid Health Home

- **Meaningful Use Payments**
- **Medicaid Health Home Option (PPACA Section 2703):**
  - PPACA provided states with a new Medicaid option of providing “health home” services for enrollees with chronic conditions.<sup>1</sup>
  - Health home services can be reimbursed as an increase to the existing PMPM rate. States eligible for 90% Federal Match Rate (FMAP) for eight calendar quarters.
- **Health Home Requirements<sup>2</sup>:**
  - Designated provider – physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, another entity or provider.
  - Team of health care professionals that links to a designated provider.
  - Interdisciplinary, inter-professional health team – must include: medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers (including mental health providers as well as substance use disorder prevention and treatment providers), chiropractors, licensed complementary and alternative medicine practitioners, and physicians' assistants.

(1. The Commonwealth Fund, 2011; 2. Affordable Care Act, 2010)

# State Health Home SPAs (as of June 2012)

State	Delivery System	Providers	Payment	Geographic Area
<b>Iowa</b> FINAL SPA APPROVED (06/08/12)	FFS Program	Primary care practices, CMHCs, FQHCs, rural health centers meeting State standards and shares policies/procedures and electronic systems if practice includes multiple sites.	Patient management PMPM ; Performance payment based on quality beginning in 2013.	Statewide
<b>Missouri</b> FINAL SPA APPROVED (10/20/11)	Managed care & FFS	Missouri Coalition of Community Mental Health Centers (CMHCs) meeting State qualifications.	Clinical care management PMPM payment. Interested in shared savings strategy and performance incentive payment	Statewide
<b>New York</b> FINAL SPA APPROVED (02/03/12)	Managed care & FFS	Any interested providers or groups of providers that meet State defined health home requirements that assure access to primary, specialty and behavioral health care and that support the integration and coordination of all care.	PMPM adjusted based on region, case mix (from Clinical Risk Group (CRG) method) and eventually by patient functional status.	3-phase regional roll-out; phase one includes 10 counties
<b>North Carolina</b> FINAL SPA APPROVED (05/24/12)	PCCM Program	Medical Homes	Tiered PMPM reimbursement plus add-on payments that support specialized care management for individuals with special health needs.	Statewide
<b>Oregon</b> FINAL SPA APPROVED (03/13/12)	Managed care & FFS	Patient-Centered Primary Care Homes (PCPCH) will be defined by six core attributes, each of which is further detailed by standards and measures. Oregon Health Authority will recognize practices as Tier 1, 2, or 3 PCPCHs Primary care providers or practices that meet the State's qualifying criteria.	PMPM based on PCPCH Tier met by practice or provider group; reflecting foundational, intermediate and advanced functions.	Statewide
<b>Rhode Island</b> FINAL SPA APPROVED (11/23/11)	Managed care & FFS	CEDARR Family Centers certified to meet HH criteria (CEDARR Family Centers provide services to Medicaid-eligible children who are identified as having 1 or more special health care needs).	Alternate payment methodology; rate developed based on level of effort required and market based hourly rate.	Statewide



# Leveraging Community Partnerships

- Community partners can be helpful in supporting PCMH efforts
- Encourage practices to think broadly about their community partners and ways they may be able to leverage expertise or resources in their communities
- Innovative examples include:
  - Eye health/vision care, equipment, or referrals from Lions Club
  - Patient transportation from Rotary Club, AARP, or State-run Senior Social Services
  - Diabetes education/nutrition counseling from local WIC or YMCA programs
  - Patient education or registration support from trained AmericCorps Volunteers

# Standard Categories

## •Enhance Access & Continuity

- Access During Office Hours\*
- Access After Hours
- Electronic Access
- Continuity (with provider)
- Medical Home Responsibilities
- Culturally/Linguistically Appropriate
- Services
- Practice Organization

## •Identify/Manage Patient Populations

- Patient Information
- Clinical Data
- Comprehensive Health Assessment
- Use Data for Population Management\*

## •Plan/Manage Care

- Implement Evidence-Based Guidelines
- Identify High-Risk Patients
- Manage Care\*
- Manage Medications
- Electronic Prescribing

## •Provide Self-Care & Community Resources

- Self-Care Process\*
- Referrals to Community Resources

## •Track/Coordinate Care

- Test Tracking and Follow-Up
- Referral Tracking and Follow-Up\*
- Coordinate with Facilities/Care
- Transitions

## •Measure & Improve Performance

- Measures of Performance
- Patient/Family Feedback
- Implements Continuous Quality\*
- Improvement
- Demonstrates Continuous Quality
- Improvement
- Report Performance
- Report Data Externally

\* Indicates **must-pass element**: Practices must achieve a score of 50% or higher on ALL 6 of must-pass elements

# Change Concepts & NCQA PCMH™ Recognition

- All NCQA PCMH™ elements (28) are reflected in the Change Concept elements (32), and a majority of Change Concept elements (all but 3) are reflected in the NCQA PCMH™ elements.

NCQA PCMH™ Recognition Standard Category		Change Concepts
1	Enhance Access & Continuity	Empanelment, Enhanced Access, CTBHR, PCI, Engaged Leadership, Quality Improvement Strategy, OEBC
2	Identify/Manage Patient Population	Empanelment
3	Plan/Manage Care	OEBC, PCI
4	Provide Self-Care & Community Resources	PCI, Care Coordination
5	Track/Coordinate Care	Care Coordination
6	Measure & Improve Performance	Quality Improvement Strategy, PCI

# Payment Resources

- American College of Physicians. A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care. Philadelphia: American College of Physicians; 2006: Position Paper. Available at [http://www.acponline.org/advocacy/where\\_we\\_stand/policy/change.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/change.pdf). Accessed: June, 2012.
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