The Patient-Centered Medical Home: The Best Hope for Engaged Collaborative / Coordinated Care

The Washington Circle
May 2009

Ray Fabius, MD, FACPE
Principal - AB3Health
Strategic Adviser to President
Health & Wellness Walgreens

Thanks to Michael Barr MD of ACP for the use of several of his slides

- State of Health Care in America
- The Importance of the Trusted Clinician
- The Value of Primary Care
- The Medical Home
- How it may Relate to Behavioral Health & Substance Abuse

Our Agenda Today

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

50 million – **Uninsured**
70+% **are employed**
16 million – **Underinsured**
125 million – **Chronically Ill**
16.2% ($2.2 trillion) – **of GDP**
$7,421 **per capita in 2007**

State of Health Care in America

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

15th to 19th - Amenable Mortality

<50% - access to rapid appointment

75% - difficulty with after hours care

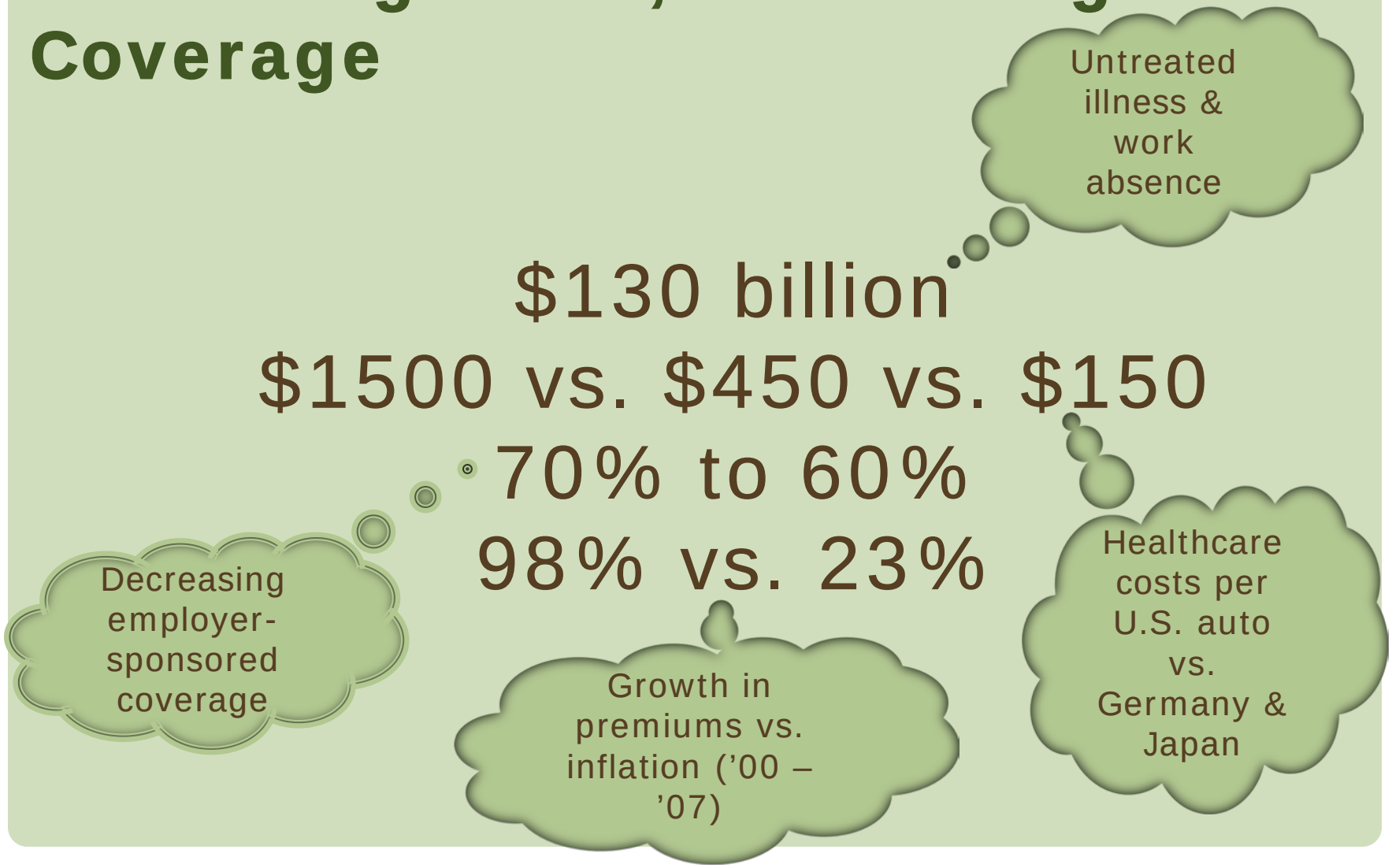
18% readmission rate within 30 days

$100 billion – wasteful spending

State of Health Care in America

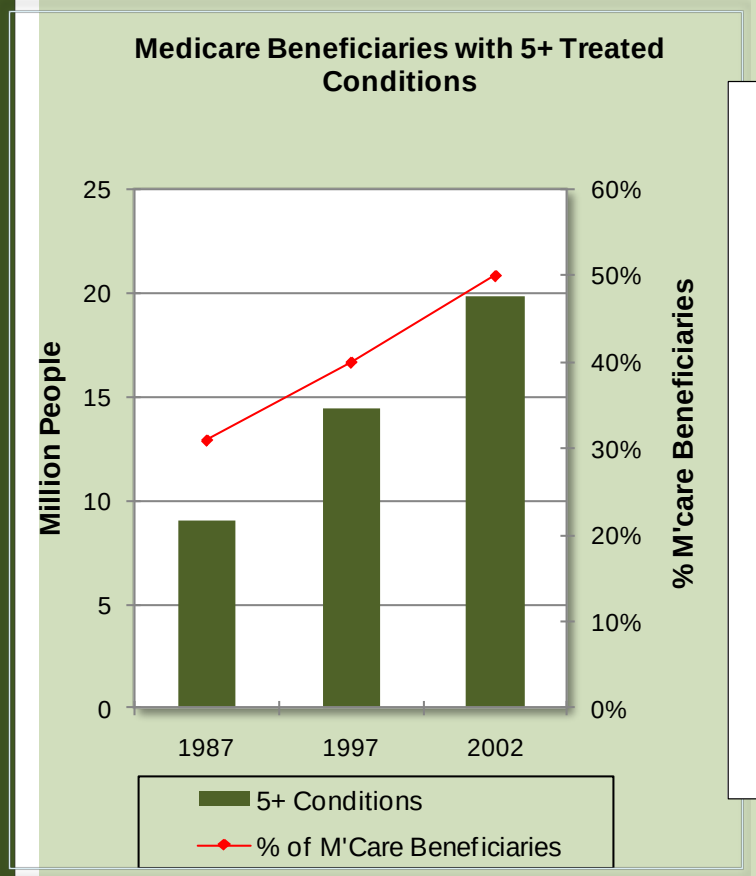
Copyright © 2009 AB3Health, LLC. All Rights Reserved.

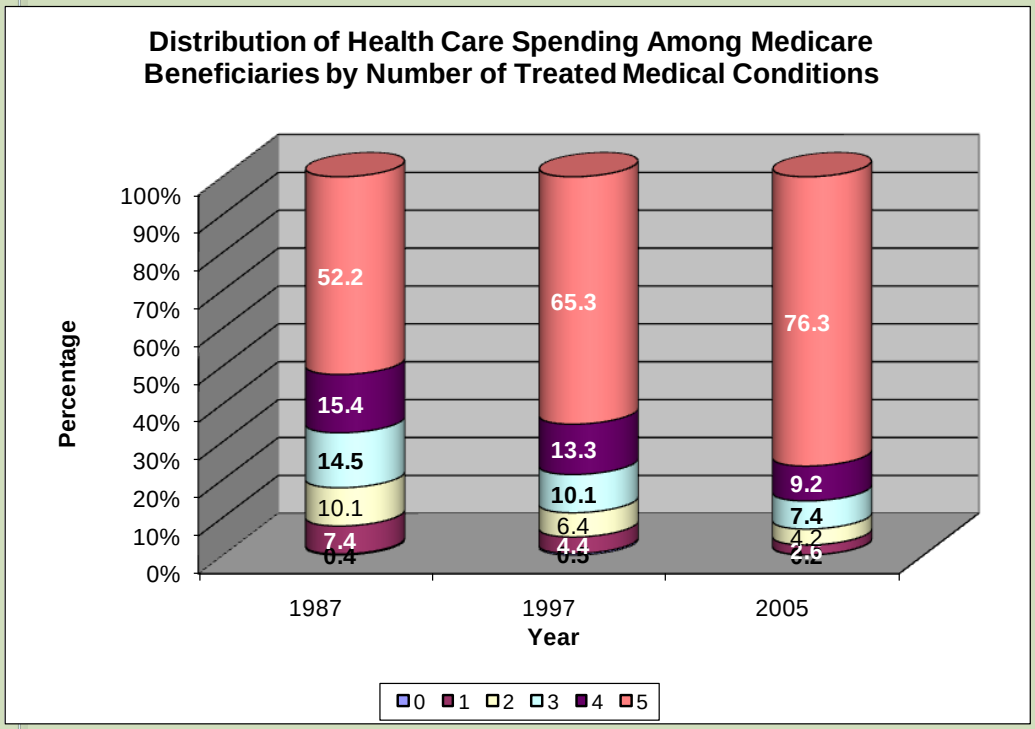
Escalating Costs, Decreasing Coverage



Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Increasing Prevalence & Cost of Treated Chronic Conditions in Medicare Beneficiaries

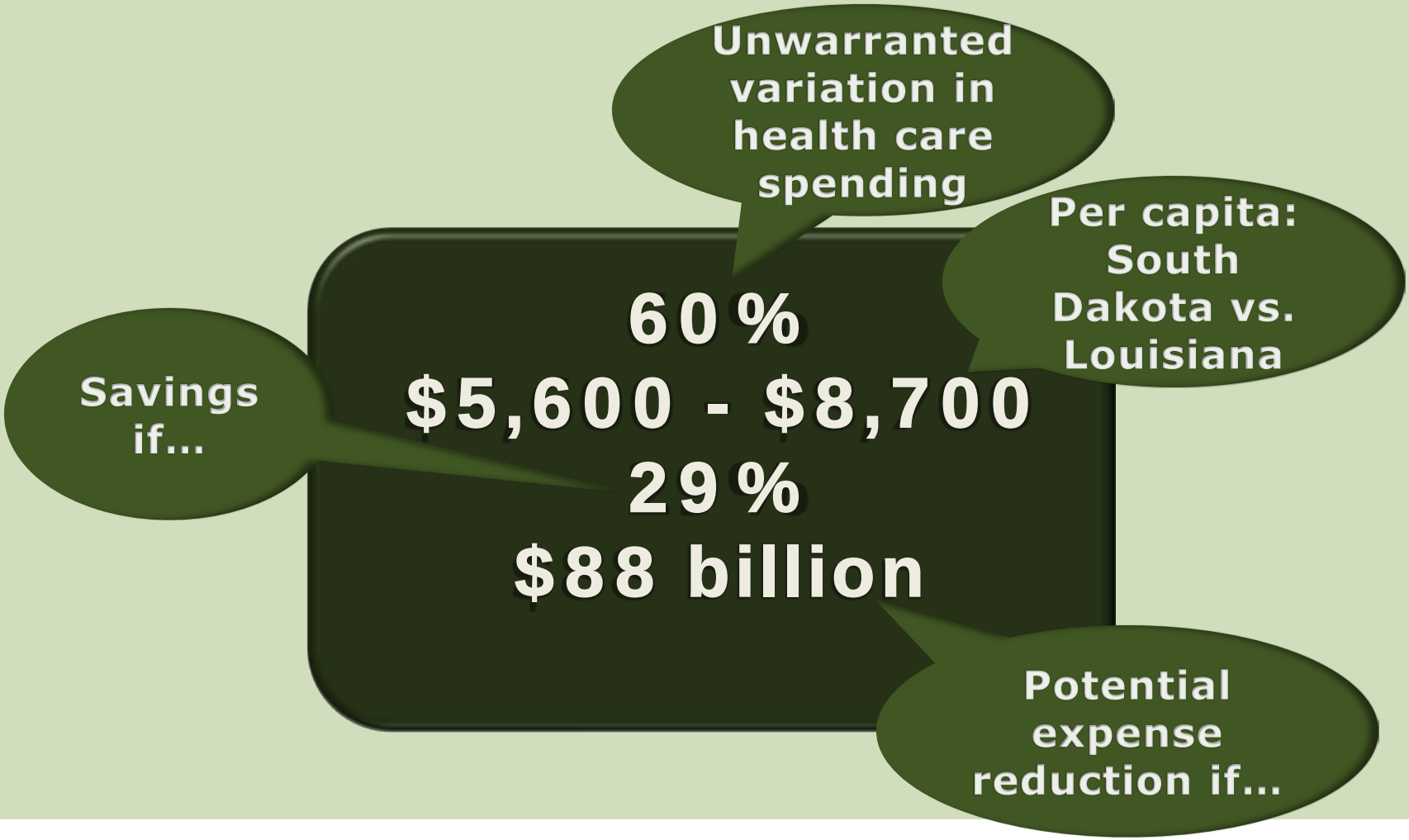




Data from Thorpe, K., Howard, D.
Health Affairs 25 (2006): w378–w388; 10.1377/hlthaff.25.w378

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Six Sigma : Variation is our Enemy

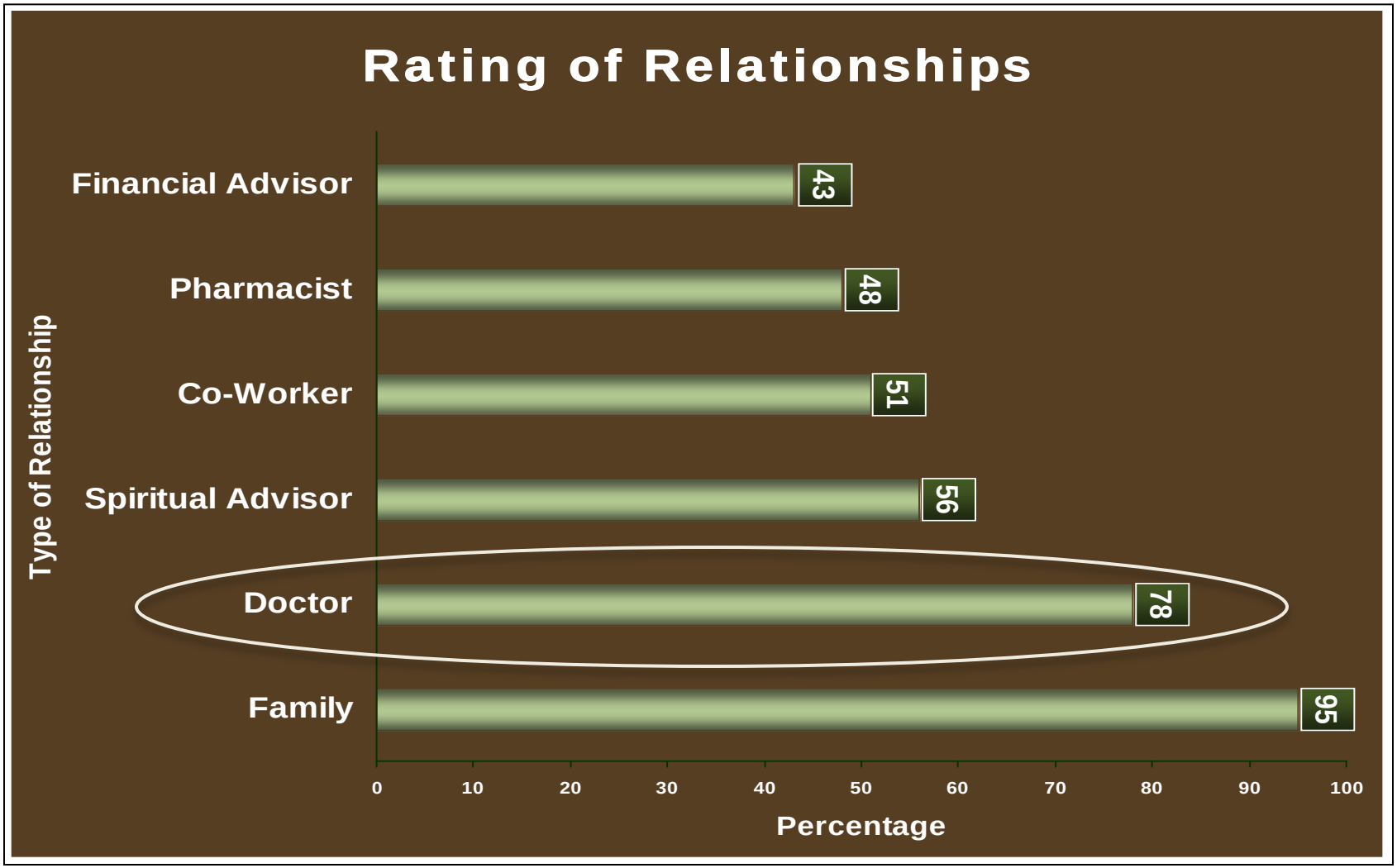


Copyright © 2009 AB3Health, LLC. All Rights Reserved.

"How can we fail to provide health insurance for 16% of our population, deliver uneven quality to the 84% of Americans who are insured, and yet pay 50% more per person than countries like France, Israel, and Britain, which cover all of their citizens?"

Ezekiel J. Emanuel, MD, PhD
Healthcare, Guaranteed: A Simple, Secure Solution for America, 2008

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

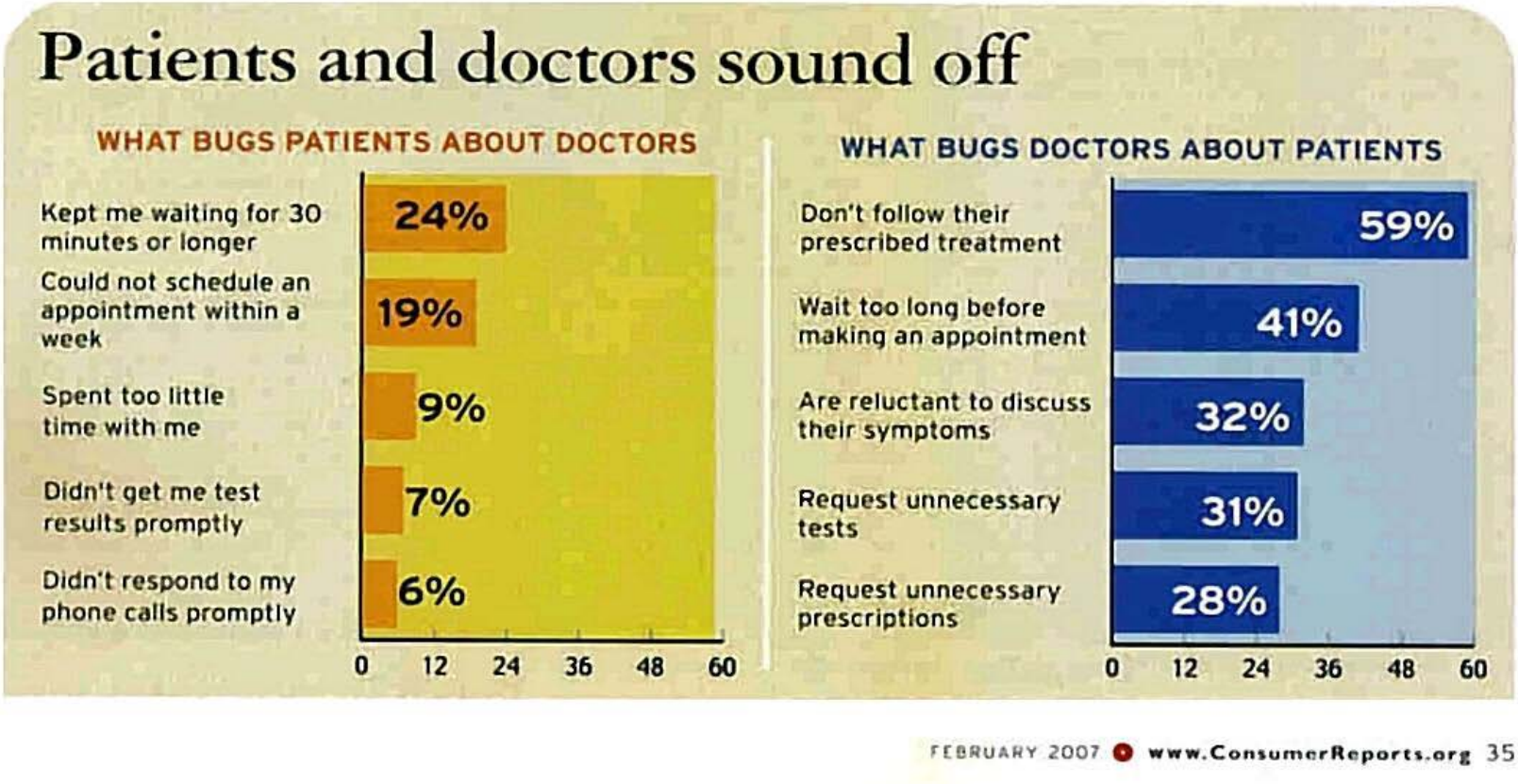


Source: Magee, J., *Relationship Based health Care in the United States, United Kingdom, Canada, Germany, South Africa and Japan. 2003*

The Trusted Clinician Can be a Powerful Resource

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Patients Complain About Access
Doctors Complain About Compliance



Copyright © 2009 AB3Health, LLC. All Rights Reserved.

What do consumers want from the healthcare system ?

- Ease of Access
- Availability
- Caring Provider

Where better to provide this than the workplace through the trusted clinician?

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

How do Trusted Clinicians generate value?

Behavior Change

Improve lifestyle

Increase compliance

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Primary

- Lifestyle Change
- Immunizations
- Seat Belts

Secondary

- Compliance with guidelines
- Screenings
  - Cancer
  - Blood pressure
  - Cholesterol

Tertiary

- Compliance with Care
- Disease Management

The Trusted Clinician's Focus: 3 Levels of Wellness

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

The Trusted Clinician: Literature Validation

Replete with examples where the trusted clinicians' involvement improved the outcomes of:

- Smoking cessation
- Weight loss programs
- Dietary Management
- Seat Belt Usage
- Screening Program Compliance
- Disease Management Engagement & Outcomes

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Trusted Clinicians Improve Outcomes –

Smoking Cessation

"An early meta-analysis showed an overall cessation rate of 8.4% at 6 months with brief(<5 min) **physician advice**."

"Since then, there have been several large studies of physician advice that have shown quit rates of up to **10%**".

New Developments in Smoking Cessation

Allan V. Prochazka, MD, MSc
Chest. 2000;117:169S-175S.

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Trusted Clinicians Improve Outcomes -

Mammography Screening

Analyses showed that the **most important variable** that predicted whether women of all racial groups had mammogram, at any time or within the last year, was whether their **doctors had discussed mammography** with them.

The effect of physician-patient communication on mammography utilization by different ethnic groups.

Fox SA, Stein JA
Division of Family Medicine, School of Medicine,
University of California, Los Angeles.
Med Care. 1991 Nov; 29(11):1065-82

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Trusted Clinicians Improve Outcomes –

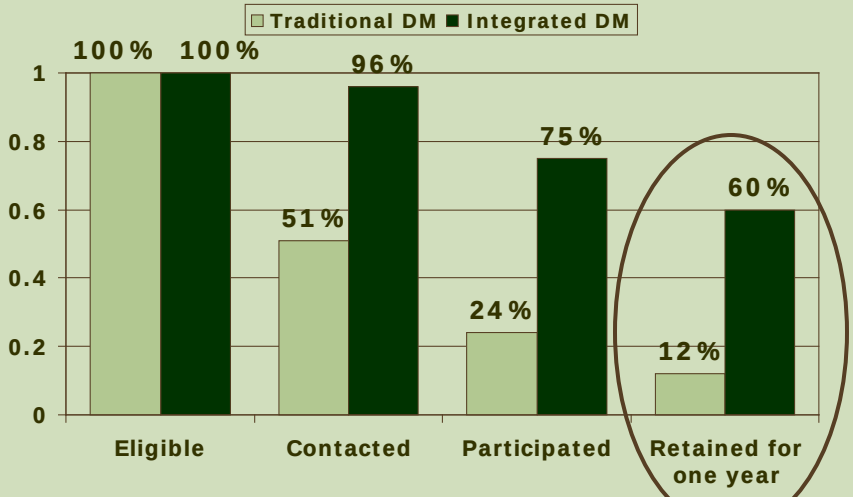
Diabetic Care

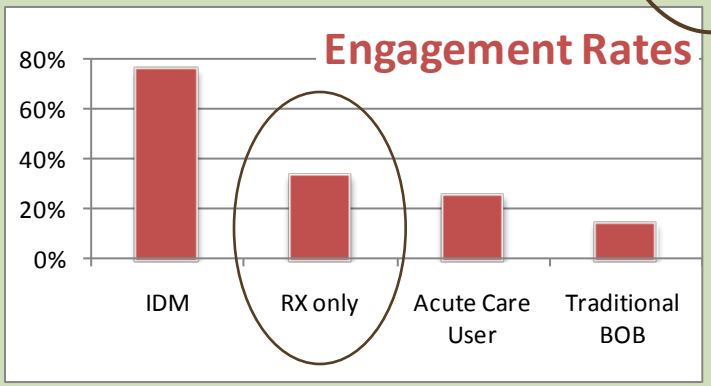
"Periodic **primary care sessions** organized to meet the complex needs of diabetic patients improved the process of diabetes care and were associated with **better outcomes**".

Chronic care clinics for diabetes in primary care: a system-wide randomized trial.

Wagner EH, Grothaus LC, Sandhu N, Galvin MS, McGregor M, Artz K, Coleman EA
W.A. MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle, Washington 98101
Diabetes Care. 2001 Apr; 24(4):695-700

Copyright © 2009 AB3Health, LLC. All Rights Reserved.





- Peer – reviewed publication
- DMAA best article of 2007
- Improved engagement & retention rates with integrated program

- Engagement rate related to depth of relationship
- Proven research influencing the marketplace
- Retention rate article will be in October issue of JPHM

The Power of The Trusted Clinician

Higher rates of engagement & retention

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Dartmouth Medicare Study
The Value of Primary Care

- Lower Medicare spending
  - Inpatient reimbursement
  - Part B payments
- Lower resource inputs
  - Hospital admissions
  - ICU admissions
- Lower utilization rates
  - Hospital days
- Better quality of care
  - Fewer ICU deaths

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

The Value of Primary Care

Barbara Starfield MD - Johns Hopkins Meta-Analysis

- Primary care oriented vs Specialty Care Oriented
  - 33% lower cost
  - 19% lower mortality rate
    - One added primary care doctor per 10K patients reduces mortality rate 3-10%
  - Better outcomes
    - Cancer, Heart disease, Stroke
    - Infant mortality, Low birth rates
    - Life expectancy, Self-rated care
  - Reduced disparities of care

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

The Principles of a Patient Centered Medical Home

- March 2007 consensus
  - AAP, ACP, AOA, AAFP
  - At the request of several large employers
- Shared decision making
- Enhanced Access
- Personal physician – trusted clinician
- Physician led medical team
- Whole person orientation
- Care is coordinated / integrated
- Quality Assessment / Improvement
  - Application of evidence based medicine
  - Accountable for results
  - Committed to tracking care and outcomes over time
- Patient Safety

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

What Does Good Primary Care Do?

- Screening – *for substance abuse*
- Brief Intervention – *promote engagement*
- Referral – *direct to appropriate specialist*
- Treatment Collaboration –
  - promote compliance to evidence based guidelines
  - Adherence to medication & action plan

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

"PCMH" Means…

- …to describe a pathway to excellent health care
- …to designate an advocate for patients
- …to encourage team-based care
- …to create educational opportunities
- …to increase engagement & compliance
- …to attract medical students and residents to primary care

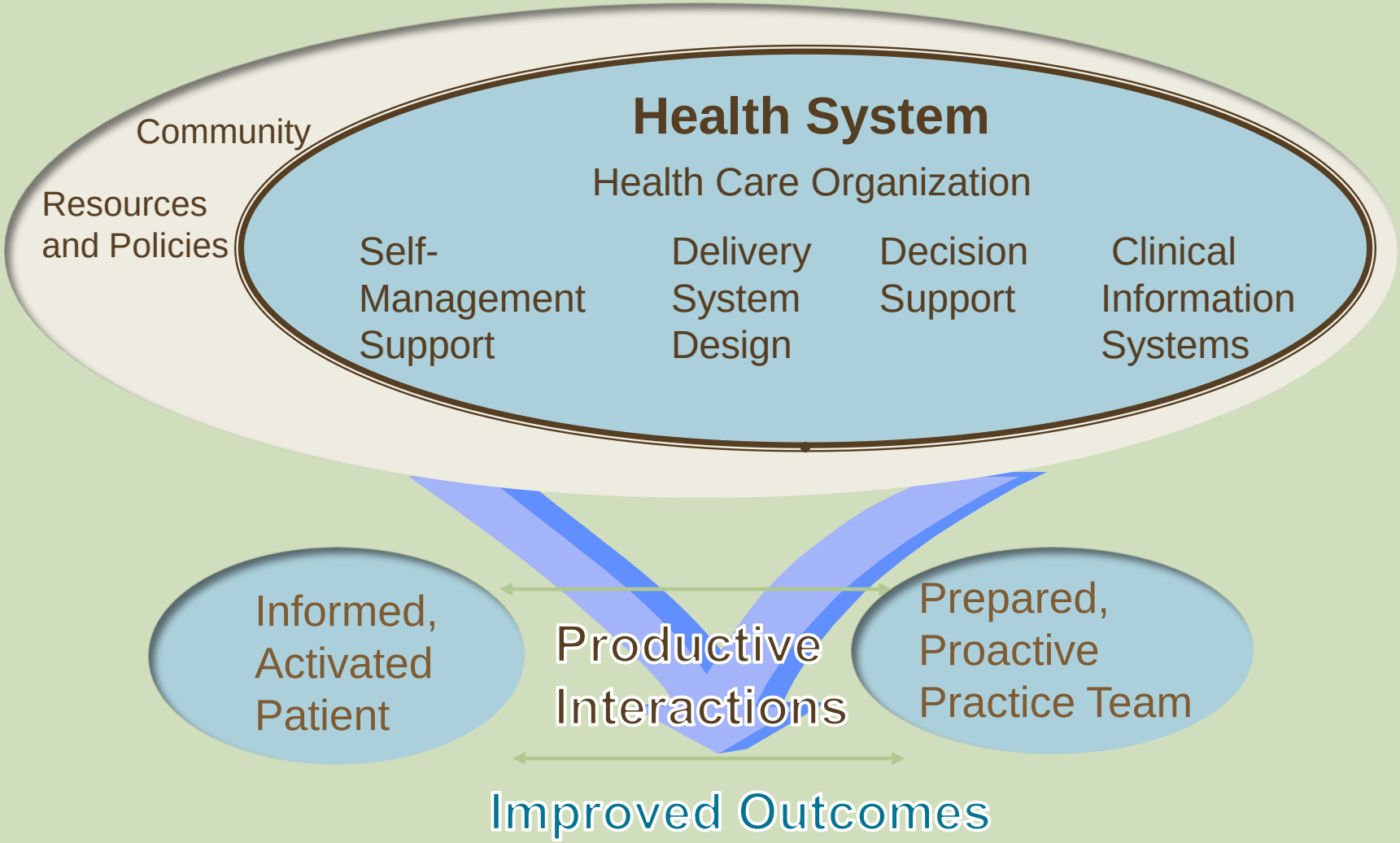
Copyright © 2009 AB3Health, LLC. All Rights Reserved.

What is the Patient-Centered Medical Home?

- …a vision of health care as it should be
- …a framework for organizing systems of care at both the micro (practice) and macro (society) level
- …a model to test, improve, and validate
- …part of the health care reform agenda

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Chronic Care Model



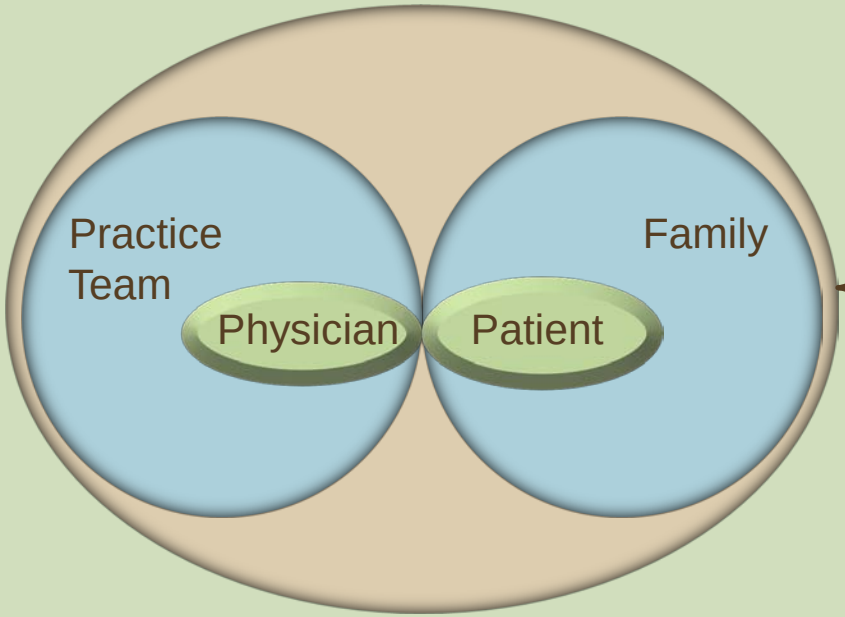
http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998: 1:2-4.

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Core of Team-Based Care

NP/PA
RN/LPN
Medical Assistant
Office Staff
Care Coordinator
Nutritionist/Educator
Pharmacist
Behavioral Health
Case Manager
Social Worker
Community resources
DM companies
Others…



Caregivers
Immediate family
Extended family
Friends
Neighbors

Adapted from:
Defining Primary Care: An Interim Report, Institute of Medicine 1994

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Teams

- Wikipedia definition: A team comprises a group of people linked in a common purpose. Teams are especially appropriate for conducting tasks that are high in complexity and have many interdependent subtasks.
- Interdependent team:
  - no significant task can be accomplished without the help of any of the members;
  - within that team members typically specialize in different tasks, and
  - the success of every individual is inextricably bound to the success of the whole team. No football player, no matter how talented, has ever won a game by playing alone.

Adapted from: http://en.wikipedia.org/wiki/Team

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

National Priorities Partnership

1. Engage patients & families in managing their health and making decisions about their care.
2. Improve the health of the population
3. Improve the safety & reliability of America's healthcare system.
4. Ensure patients receive well-coordinated care within and across all healthcare organizations, settings and levels of care.
5. Guarantee appropriate & compassionate care for patients with life-limiting illnesses.
6. Eliminate overuse while ensuring the delivery of appropriate care.

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

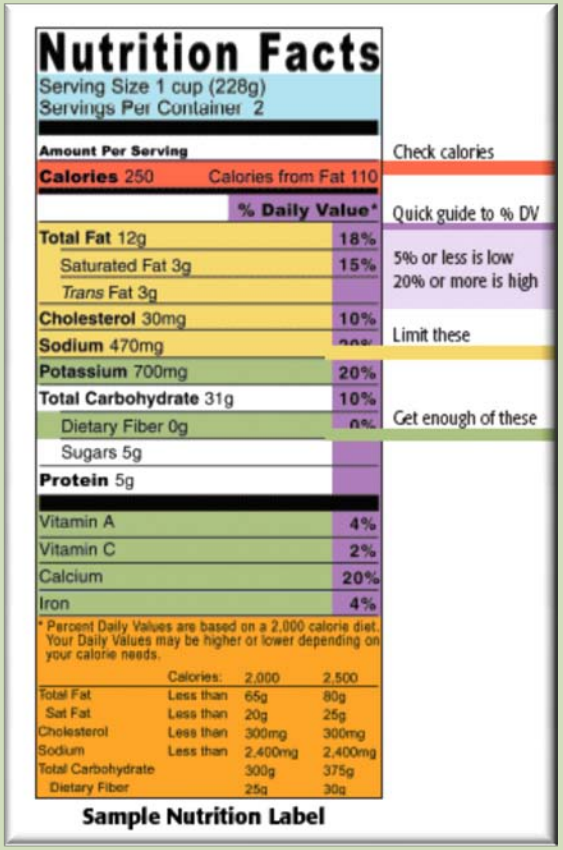
Collaborative Care

- Collaboration includes ongoing interdisciplinary communication regarding the care of individuals and populations of patients in order to promote quality and cost-effective care
  - Critical to ensuring that all patients receive the highest possible quality of care

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Required Ingredients

- Patient capable of sharing in medical decisions
- Prepared, well-organized health care team
- Practice to level of license, skill, ability – no lower
- High technology + high touch
- Organizational support
- Resources



Sample Nutrition Label

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Building the Medical Home

- Collaboration
- Recognition
- Demonstration
- Advocacy
- Education
- Education
- Education

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Important Questions

1. How do you recognize a PCMH?
2. What does it cost and how will I be paid?
3. Will it improve quality and reduce cost?
4. Will patients be satisfied?
5. How do we prepare physicians, students & residents?

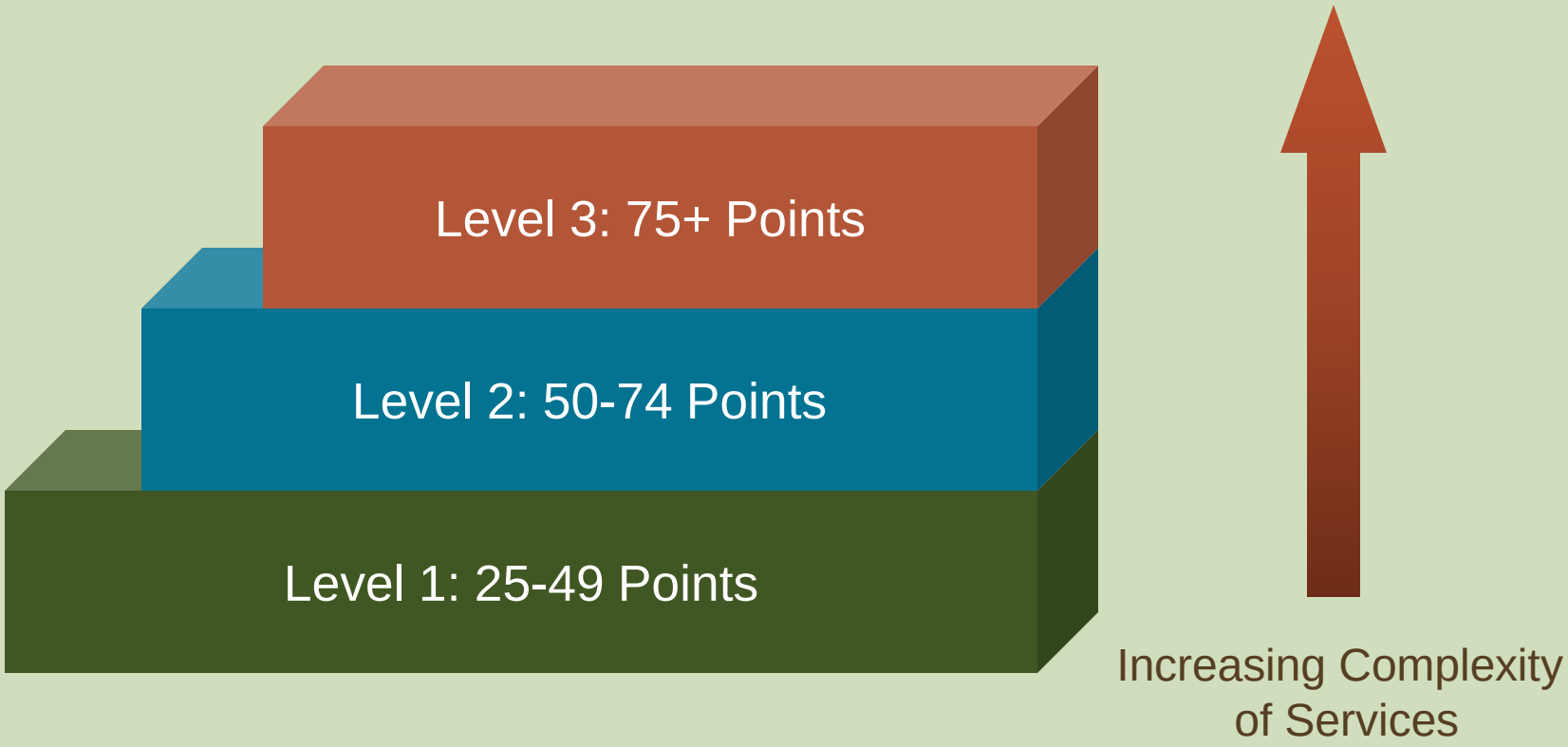
Copyright © 2009 AB3Health, LLC. All Rights Reserved.

NCQA: Certification Elements
Physician Practice Connections/PCMH

- Access & Communication
- Patient Tracking & Registry Functions
- Care Management
- Patient Self-Management Support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting & Improvement
- Advanced Electronic Communication

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Stepping Up to Excellence



Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Practice Implications

- Need to understand challenges of transformation
- Initial capital and restructuring costs
- Ongoing support & maintenance
- Reporting on quality, cost and satisfaction
- Implementation of HIT coincident with PCMH

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

The Need for Education & Support

- Team-based care
  - Everyone practices to the level of his/her license, skill, and ability – and no lower
- Patient-centered care
- Communication skills
- Use of technology
- Quality improvement & measurement skills

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

A Commitment to Excellence

- Patient-centered communication
- Shared decision making
- Timely access to care
- Electronic health records
- Use of comparative effectiveness research & evidence-based guidelines
- Measure, improve, measure
- Transparency & accountability
- Safety

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Growing Interest in the PCMH

- Patient-Centered Primary Care Collaborative
  - 300+ organizations; represent 50+ million people
  - www.pcpcc.net
- Articles in NEJM, JAMA, Health Affairs, Annals of Internal Medicine
- Trade & Lay Press
- Legislation
- New entrepreneurs

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

February 7, 2009 New York Times

UnitedHealth and I.B.M. Test Health Care Plan

By REED ABELSON

……the insurer is teaming up with seven doctors' groups to make another attempt, in Arizona, at the prodding of one of the state's big employers, I.B.M. UnitedHealth will try giving doctors more authority and money than usual in return for closely monitoring their patients' progress, even when patients go to specialists or require hospitalization. The insurer will also move away from paying doctors solely on the basis of how many services they provide, and will start rewarding them more for the overall quality of care patients receive.

The new approach, which is also being tested in various guises by other insurers around the country, is known as the "medical home" model of health care. Many experts hope it will prove one of the best ways to rein in the nation's runaway medical costs, while making people healthier. The theory is that by providing a home base for patients and coordinating their treatment, doctors can improve care, prevent unnecessary visits to the emergency room, reduce hospitalizations and over overall medical spending.

The experiment will initially involve about 7,000 patients who are the patients of 26 doctors at the seven medical groups. I.B.M. employees will be only a small portion of the total, which will also include Medicare and Medicaid beneficiaries that UnitedHealth covers in the state.

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Washington, D.C., March 25, 2008—The AAMC (Association of American Medical Colleges) has adopted a formal position on the "medical home" model of health care delivery, which provides patients with a coordinated, comprehensive approach to primary care.

The position statement was developed and proposed by the AAMC Advisory Panel on Health Care (composed of representatives from within and outside the AAMC) and approved by the association's Executive Council last month.

In the medical home model of health care delivery, the ongoing relationship between care provider and patient is essential. A medical home ensures around-the-clock access to medical consultation, respect for a patient's cultural and religious beliefs, and the comprehensive coordination of a patient's care among providers and community services.

"Many Americans, even among those with comprehensive health insurance, feel 'medically homeless' and lost in a system that is difficult to navigate when they require care," said AAMC President and CEO Darrell G. Kirch, M.D. "We believe the medical home model holds great promise for improving Americans' health by ensuring that they have an ongoing relationship with a trusted medical professional."

The AAMC position statement affirms the following principles:

•Every person should have access to a medical home-a provider or team of providers to help patients navigate the system-with whom there is a continuous relationship.
•Further research and evaluation of the medical home model is needed, and more evidence must be gathered on how the model is best implemented.
•Payment for the medical home model should appropriately recognize and reward providers for prevention, care delivery, and coordination.
•Health care providers should be trained to understand and implement the medical home model within a team environment.
•The AAMC should work with medical schools and teaching hospitals to develop a better understanding of how the medical home model can be adopted in academic and community settings.

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Behavioral Health & The Medical Home

A ROOM IN THE MEDICAL HOME
Consumers deserve “first-floor” access to mental and substance use care in collaborative care systems
by RONALD W. MANDERSCHEID, PHD

A house has different rooms but is still one home. Likewise, a *medical home* has different specialties but is still a single source of care. The primary care disciplines developed the medical home concept as a simple way to communicate the idea and importance of collaborative care, whether or not the care is physically collocated. For several key reasons, the medical home model is important to the mental health and substance use care fields. The medical home model will allow our fields to retain their own identities yet be fully collaborative with primary healthcare services. It will permit any entry point to be the “right” door to care. In addition, it will address the needs of mental health and substance use care clients for a full range of primary healthcare services, and it will encourage our fields to effectively address the care needs of consumers with co-occurring mental and substance use conditions.

As we develop our dialogue with colleagues from the primary care and family practice fields, we are going to encounter the medical home model a lot. Like mental health and substance use care, primary care disciplines are in a period of rapid ferment. Also like us, they are trying to overcome their fragmentation and address staffing problems.

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

National Quality Forum

- Evidence Based Substance Abuse Treatment
- Substance Abuse is a chronic illness
- Substance Abuse is associated with co-morbidities – mental illness
- Identify important components of effective treatment
  - General to all substances
  - Specific to certain substances
  - Determine process metrics
- Apply best practice in clinical setting
  - Opportunity to leverage the medical home

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

National Voluntary Consensus Standards for the Treatment of Substance Use Conditions:

Table 1 – Practice Specifications for Treating Substance Use Conditions

Patients with substance use illness should be offered long-term, coordinated management of their care for substance use illness and any coexisting conditions, and this care management should be adapted based on ongoing monitoring of their progress.

Target Outcome:

1) Receives care for all conditions (substance use,medical, and mental health).

2) Stabilization of coexisting conditions.

3) Retention in treatment.

4) Engagement in long-term monitoring.

5) Prevention of relapse or delayed time to relapse.

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

- More primary health care providers are prescribing psychotic drugs (1996-2006)
  - Seniors – 2x
  - Adults – 73% more
  - Children 50% more
- Reasons
  - Clinician comfort
  - Greater coverage

Primary Care is Prescribing Psycho-tropics
Health Affairs – May 5th 2009

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Medical Home: Looking at Populations & Panels

Senile and presenile organic psychotic conditions	1	1
Alcoholic psychoses	2	6
Drug psychoses	1	1
Other organic psychotic conditions (chronic)	1	5
Affective psychoses	49	256
Other nonorganic psychoses	2	2
Psychoses with origin specific to childhood	2	2
Neurotic disorders	67	216
Personality disorders	1	4
Sexual deviations and disorders	3	19
Alcohol dependence syndrome	8	89
Drug dependence	1	1
Nondependent abuse of drugs	15	29
Special symptoms or syndromes, not elsewhere classified	10	55
Acute reaction to stress	6	48
Adjustment reaction	38	164
Specific nonpsychotic mental disorders due to organic brain damage	2	2
Depressive disorder NEC	38	80
Disturbance of conduct, not elsewhere classified	7	13
Hyperkinetic syndrome of childhood	31	66
Specific delays in development	2	8

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

The IMPACT Model

- Collaborative care
  - individual's primary care physician works with
  - a care manager/ behavioral health consultant
- Develop and implement a treatment plan
- Consult with a psychiatrist to change the treatment plan if the individual does not improve.
- Doubles the effectiveness of care for depression
- Improves physical functioning
- Improves pain status for participants
- Lowers long term healthcare costs.

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Behavioral Health & The Medical Home

- People living with serious mental illnesses are dying 25 year earlier than the rest of the population, in large part due to unmanaged physical health conditions.
- The medical home's emphasis on self-care resonates with the behavioral health system's movement towards a Recovery and Resilience orientation.
- However, there has not been a clear articulation in the medical home model of the role of behavioral health.
- Behavioral health is a central part of healthcare and that healthcare
- Focus on supporting a person's capacity to set goals for improved self management

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer Support
- Respect
- Responsibility
- Hope

Substance Abuse & Mental Health Services Adm Consensus Statement on Recovery

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

- Financing;
- Policy
- Regulation
- Workforce
- Information sharing
- Research - costs, cost offsets & outcomes of patient-centered healthcare home models for the population with serious mental illnesses.

Issues & Barriers

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

Substance Abuse & The Medical Home

- Who provides comprehensive longitudinal care?
  - For worried well family members
  - For those dealing with substance abuse
  - For those dealing with substance abuse & mental illness
- How will reimbursement take place?
  - Fee for service
  - Capitation
  - Coordination Fee
  - Blended rate
  - Pay for performance

Copyright © 2009 AB3Health, LLC. All Rights Reserved.

- The State of Health Care in America is alarming
- The Importance of the Trusted Clinician is crucial to engagement and retention
- The Value of Primary Care has been proven in peer reviewed literature
- The Medical Home is a Solution
- Behavioral Health & Substance Abuse can work more closely with primary care to build medical homes

Our Agenda Today

Copyright © 2009 AB3Health, LLC. All Rights Reserved.