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A joint project of the Washington State Department of Health and the Washington Academy of Family Physicians

Patient-Centered Medical Home Results in Primary Care Transformation

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WA State Department of Health

Objectives

Describe the importance of primary care and the current challenges.

Describe the characteristics of a patient-centered medical home (PCMH) and how it is being implemented in Washington.

Review the results that suggest PCMH decreases health disparities.

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Bias

- Primary care is the foundation of health care reform.
- Patient-Centered Medical Home is an amplification of primary care with a 21st century use of technology.

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Features of primary care:

Institute of medicine (IOM) defines:

1. First contact of care
2. Long term person (not disease) focused care
3. Comprehensive Care
4. Coordinated care

Institute of medicine (IOM). 1978. A Manpower Policy for Primary Health Care. IOM publication 78-02. Washington, DC. National Academy of Sciences

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Who is a primary care provider?

- Family physicians, general internists and general pediatricians .
- Primary care nurse practitioners, physician assistants.
- Possibly endocrinologists for people with diabetes; nephrologists for people on dialysis.

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Evidence for primary care

States with a higher ratio of primary care :

1. Lower rates mortality
2. Less heart disease (CAD)
3. Less stroke
4. Decreased infant mortality

Shi, L. 1992. The Relationship between Primary Care and Life Chances. Journal of Healthcare for the Poor and Underserved 3:321-35.

Shi, L. 1994. Primary care, Specialty care, and Life Chances. International journal of Health Services 24:431-58.

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Dartmouth Atlas Data

- States with higher spending per Medicare beneficiary tended to rank lower on 22 quality of care indicators.

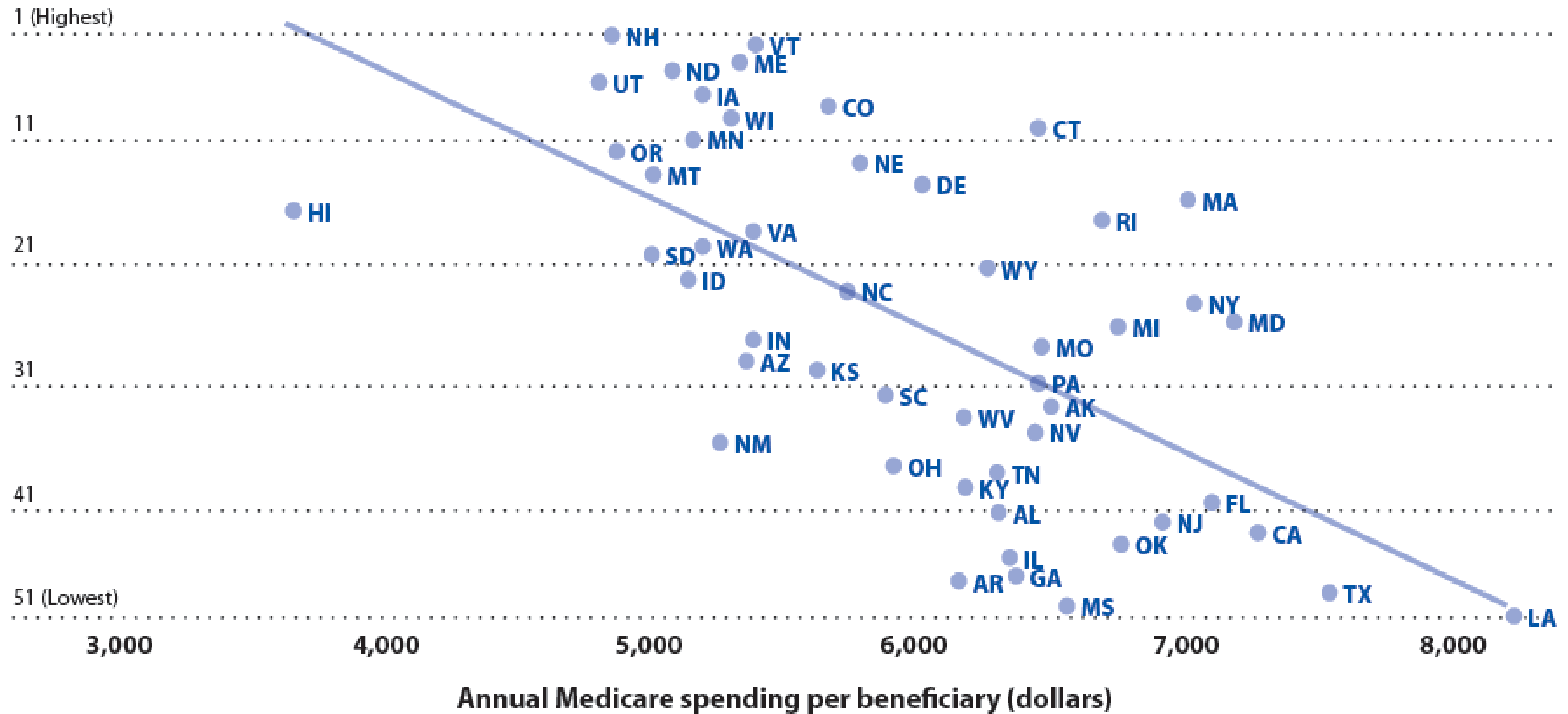
- When it comes to chronic illness, more care is not better…

Wennberg, John, (Lead author) Fisher, Elliot, Goodman, David, Skinner, Jonathan (Co-authors)

Executive Summary, *Tracking the Care of Patients with Severe Chronic Illness,*

The Dartmouth Atlas of Health Care, 2008

For the full version see www.dartmouthatlas.org



Relationship Between Quality of Care and Medicare Spending: As Expressed by Overall Quality Ranking, 2000–2001

Data: Medicare administrative claims data and Medicare Quality Improvement Organization program data. Adapted and republished with permission of *Health Affairs* from Baicker and Chandra, “Medicare Spending, The Physician Workforce, and Beneficiaries’ Quality of Care” (Web Exclusive), 2004.

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Dartmouth Atlas Study chronically ill patients

"Greater risk of dying in regions where the health system delivers more supply-sensitive care."

Care becomes more complex

- more physicians involved
- less and less clear who is responsible
- miscommunication-and medical errors-become more likely."

Fisher, Elliot, Skinner, Jonathan, Weinstein, James "An Agenda for Change Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and Obama Administration", Dartmouth Atlas White Paper, December, 2008

Likely explanation

- "A system that rewards procedure and visit volume and reinforces fragmentation."
- "The payment system fails to reward office based physicians for managing disease and coordinating care."

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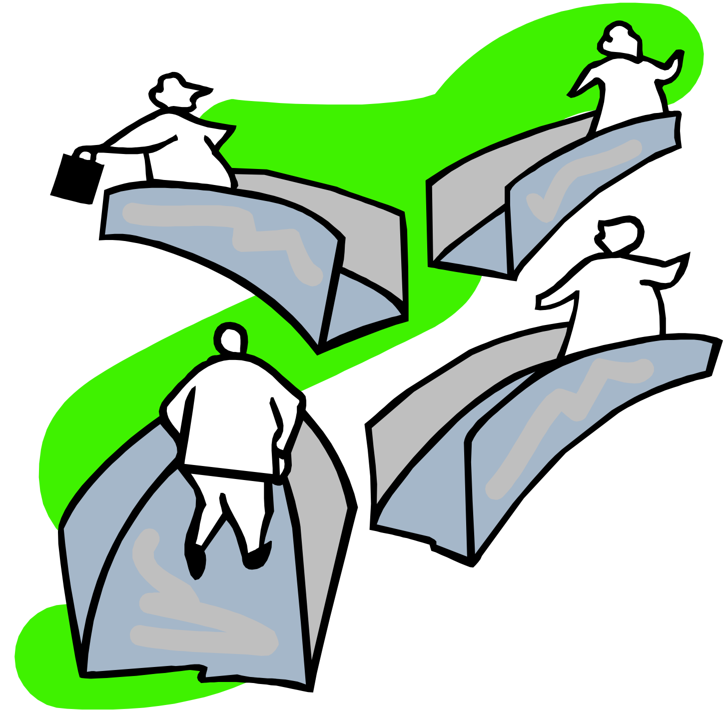
Care for Chronic Illness is…

- Fragmented
- Discontinuous
- Difficult to access
- Inefficient
- Unsafe
- Expensive



Boult, Chad, Karm, Lya, Groves, Carol Improving Chronic Care: The "Guided Care" Model, The Permanente Journal/Winter 2008/Volume 12 No. 1

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Primary care: relationship skills are critically important

…the patient and family's whole story is witnessed.

The wholeness of the story is integral to the art of healing.

The whole story is essential for patient safety.

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Specialty Care

- Important and necessary
- Coupled differently with primary care
- Reciprocal coordination
- Intentional, visible plan related to roles

The system of nonsense

- Nearly 90 percent of the reasons people would seek healthcare falls under primary care. (Institute of Medicine)
- Yet primary care physicians are at the bottom of the earnings ladder and earn half as much as some specialties.
- Primary care is not a procedure-focused care model. Pay is based on procedures.

(Scherger)

Ingredients for a perfect storm

- U.S. medical students entering family practice residencies dropped by 50 percent.
  (1997 to 2005)
  (Bodeneheimer,2006)
- Aging of boomers: demographic bolus

- 49% of physicians plan:

  -to reduce the number of patients they see

  or

  -stop practicing entirely in the next 3 years.

(Physicians Foundation Survey, 2008)

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A Solution

- Medical Home is about culture change within the primary practice "microsystem."

- Medical Home is about culture change in the larger macrosystem of healthcare that surrounds and interacts with primary care.

  (The Medical Neighborhood)

Welcome the Medical Home

Patient-Centered Medical Home first conceptualized for children with special health care needs

The Joint Principles adopted by:

- American Academy of Pediatrics
- American Academy of Family Physicians
- American College of Physicians
- American Osteopathic Association
- American Medical Association

Components of a Medical Home

- Accessible and Continuous
- Coordinated and Comprehensive
- Family Centered or Patient Centered
- Compassionate and Culturally Effective

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Early evidence suggests…

- Patient satisfaction improves.
- Provider satisfaction improves.
- Burn-out decreases.
- Avoidable emergency room visits decrease.
- Clinical outcomes improve.
- Cost savings or neutralizes cost increase.

Washington's approach to primary care transformation

- Washington State Collaborative
- Six Collaboratives 1999-2009
- Over 200 primary care organizations trained in the Chronic Care Model
- Demonstrated improvement in disease management
- Needs payment transformation for sustainability

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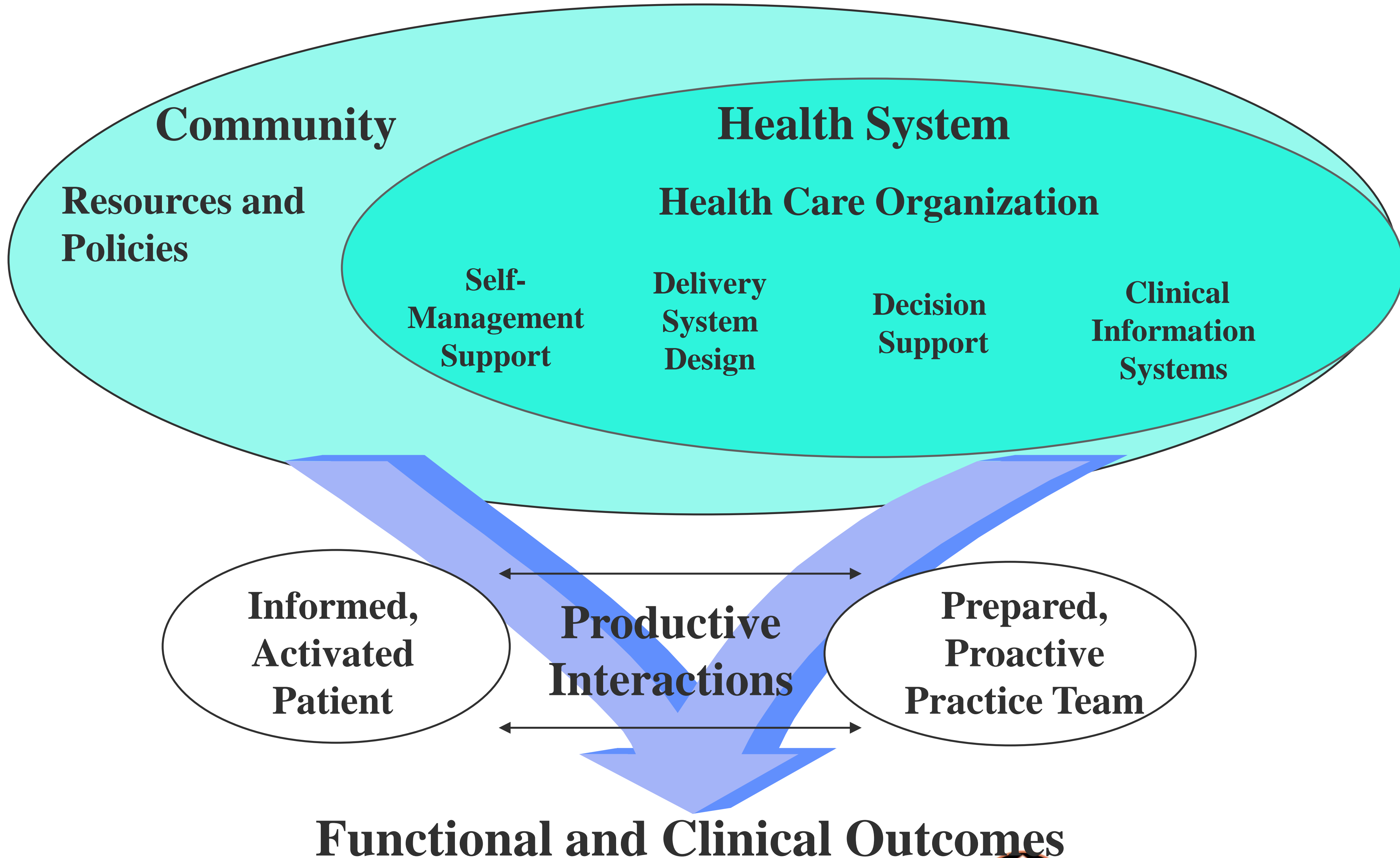
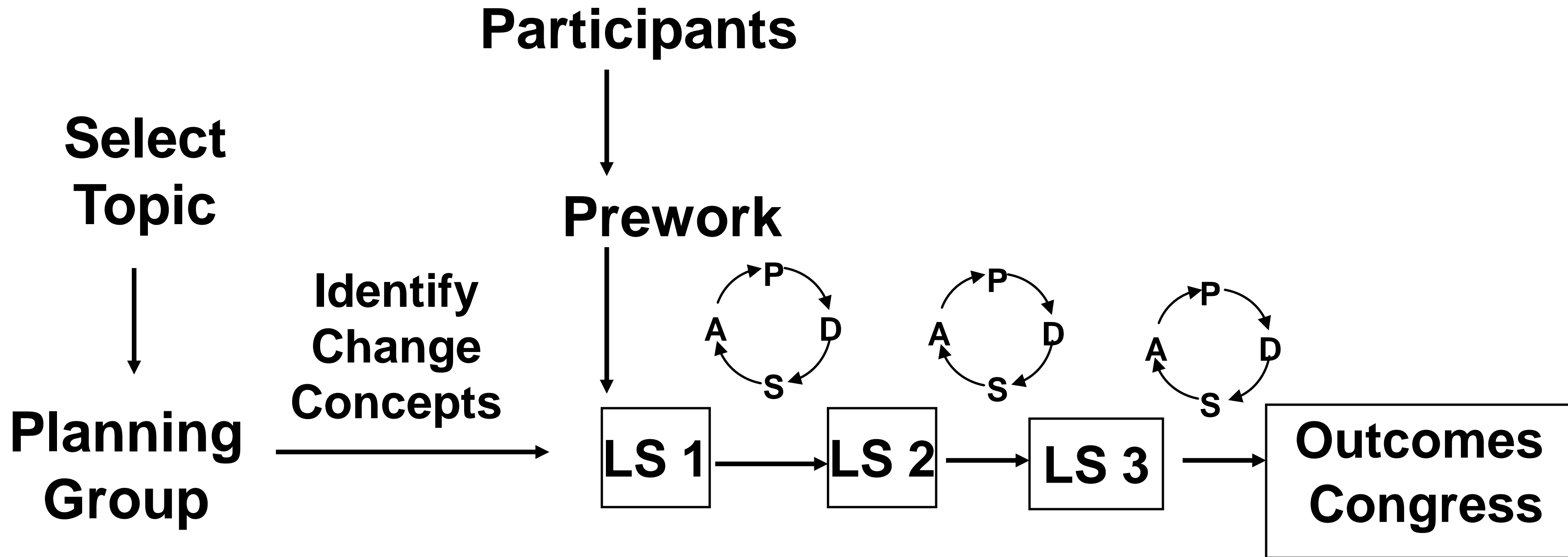
Chronic Care Model



Collaborative Process



Supports

E-mail Visits Web-site

Phone Assessments

Senior Leader Reports

(13 month time frame)

What makes this collaborative different?

Past collaboratives	Washington Patient-Centered Medical Home Collaborative
Close the gap between evidence and practice	Build evidence from current Medical Home pilots
Focus on clinical protocols	Focus on organizational culture, structures and processes of care.

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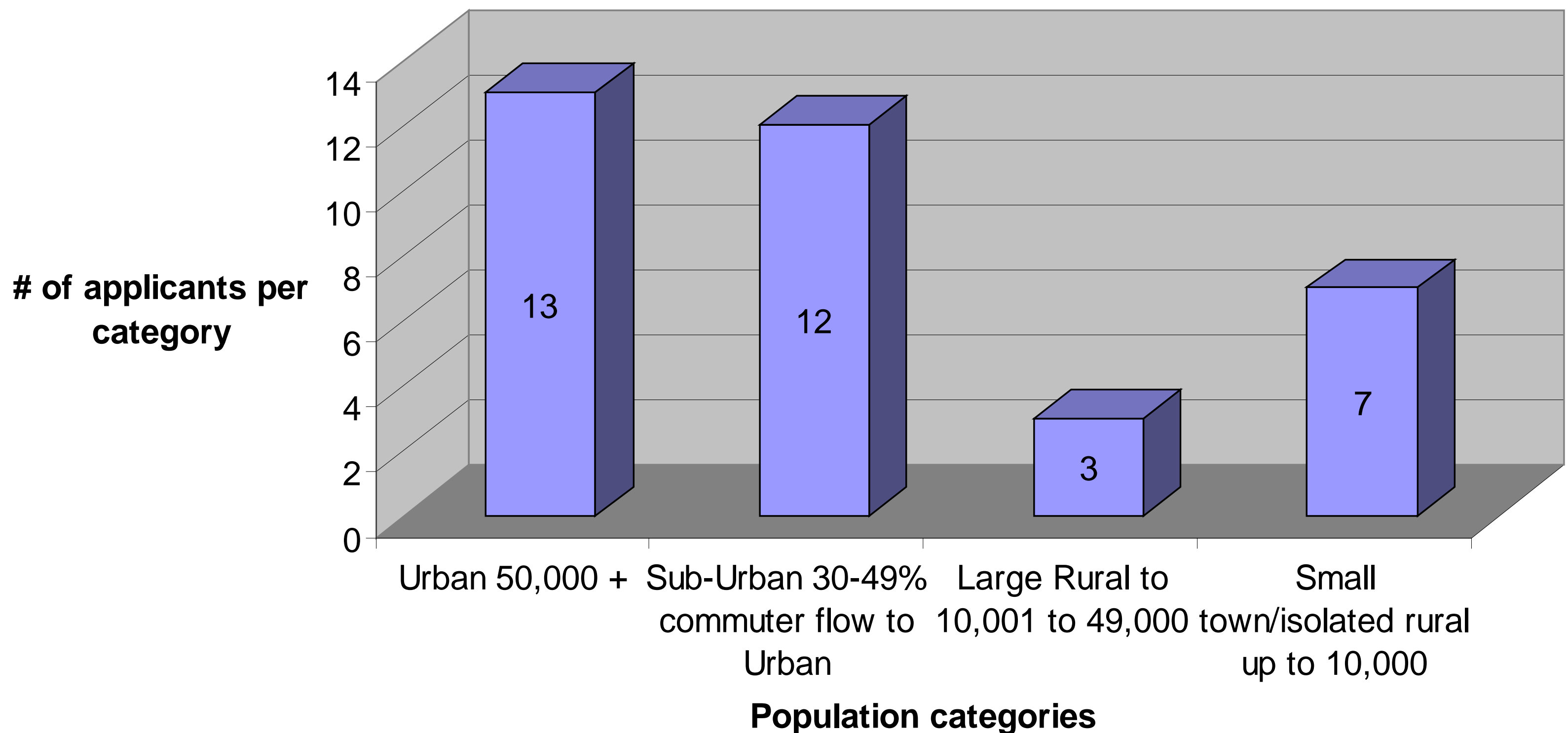
Enrollment

- First competitively scored collaborative application process for DOH
- Practices with evidence of “early adopter” traits
- 33 practices enrolled.

Practice Location



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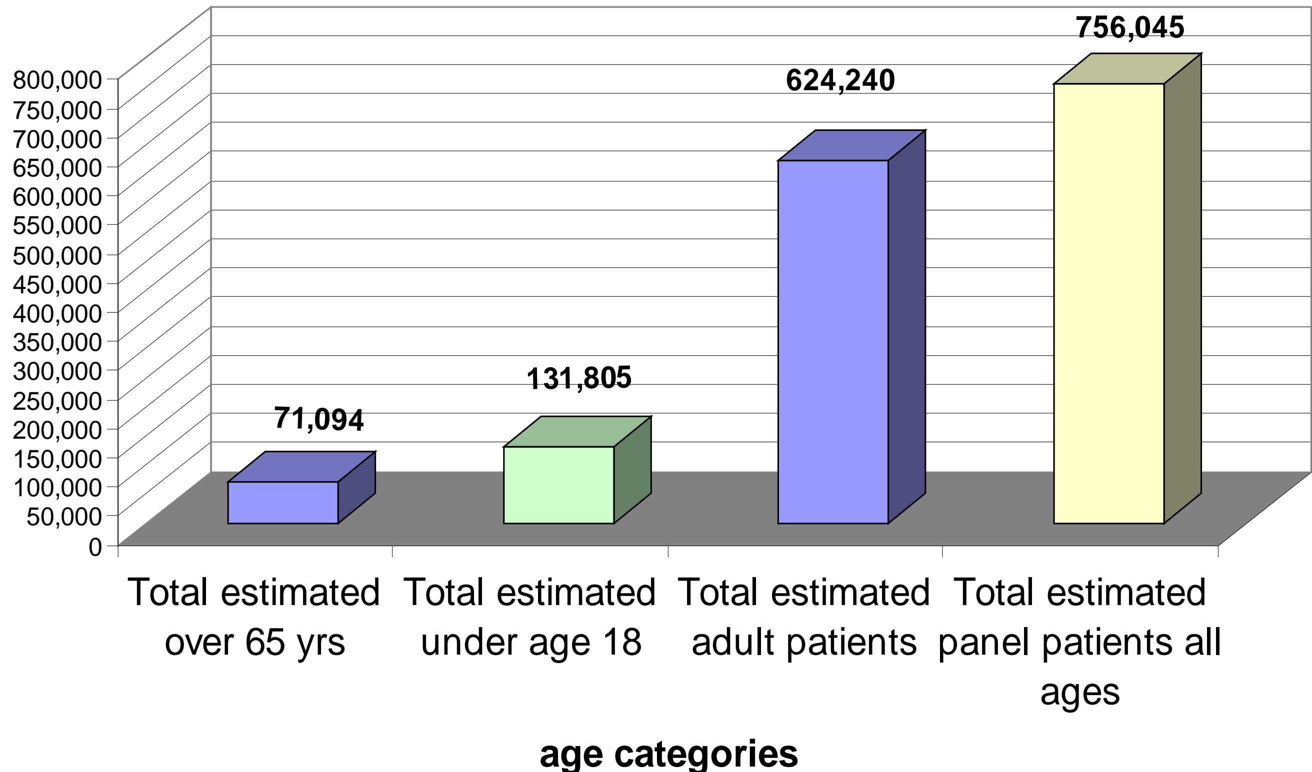
Patient Age

Ages of Applicant Patient Panels: Washington Patient-Centered Medical Home Collaborative

of estimated patients active in panels of applicants by age range groups



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The Change Package

The change package is a cohesive set of change concepts.

The change package forms the foundation for what is taught:

- Menu of choices for improvements to test
- Learning session curriculum
- Provides structure

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- Engaged leadership
- Quality improvement strategy
- Patient-centered interactions
- Organized, evidence based care
- Continuous and team-based healing relationships
- Enhanced access
- Population management
- Care coordination

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Five measurement categories

1. Patient experience
2. Provider satisfaction/burn-out
3. Degree of medical home implementation
4. Clinical outcomes
    1. Prevention
    2. Diabetes
5. Cost/utilization - independent evaluation pending grant funding for the evaluation

(Using claims data)

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The Journey

- September 2009 to September 2011
- Five learning sessions = 8 days total out of the office
- Quality Improvement Coaches making five site visits
- Monthly education, peer support, consultation
- Reporting of data and narrative reports

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The leading edge… of medical home

- Guided Care Model shows reduction in cost
  - Johns Hopkins
- Medical Homes Promote Equity in Health Care
  - Commonwealth Foundation

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Study of Guided Care Model

Multi-site randomized controlled trial

49 physicians

904 older patients

319 family members

Baltimore-D.C. area

3 year study: AHRQ, National Institute on Aging, multiple foundations

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Results of Guided Care Model

- 24 percent fewer hospital stays
- 37 percent fewer skilled nursing facility days
- 15 percent fewer emergency dept visits
- 29 percent fewer home health episodes
- Annual savings of approx. $75K per nurse
- Cost health insurers 11 percent less after paying for nurses

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Closing the Divide: How Medical Homes Promote Equity in Health Care

Based on a 2006 survey of more than 2,800 adults between 18 and 64 years of age.

Anna Beal, M.D. M.P.H., Michelle M. Doty, Susan E. Hernandez, Katherine K. Shea, and
Karen Davis
The Commonwealth Fund, June 2007
www.commonwealthfund.org
Publication no. 1035

Study indicators for a patient-centered medical home

1. A regular health care provider or place of care.
2. Report no difficulty in contacting a provider by phone.
3. Report no difficulty getting advice or medical care when needed on weekends or evenings.
4. Experience office visits that are well organized and efficiently run.

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A long way to go

- Only 27 percent of all adults report a medical home with all four indicators.
  - 28 percent of whites
  - 34 percent African Americans
  - 26 percent Asian Americans
  - 15 percent Hispanics

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Medical Homes reduce disparities in care

"When minorities have a medical home, racial and ethnic differences in terms of access to medical care disappear."

"Three fourths of whites, African Americans and Hispanics with medical homes reported getting the care they need ***when*** they need it."

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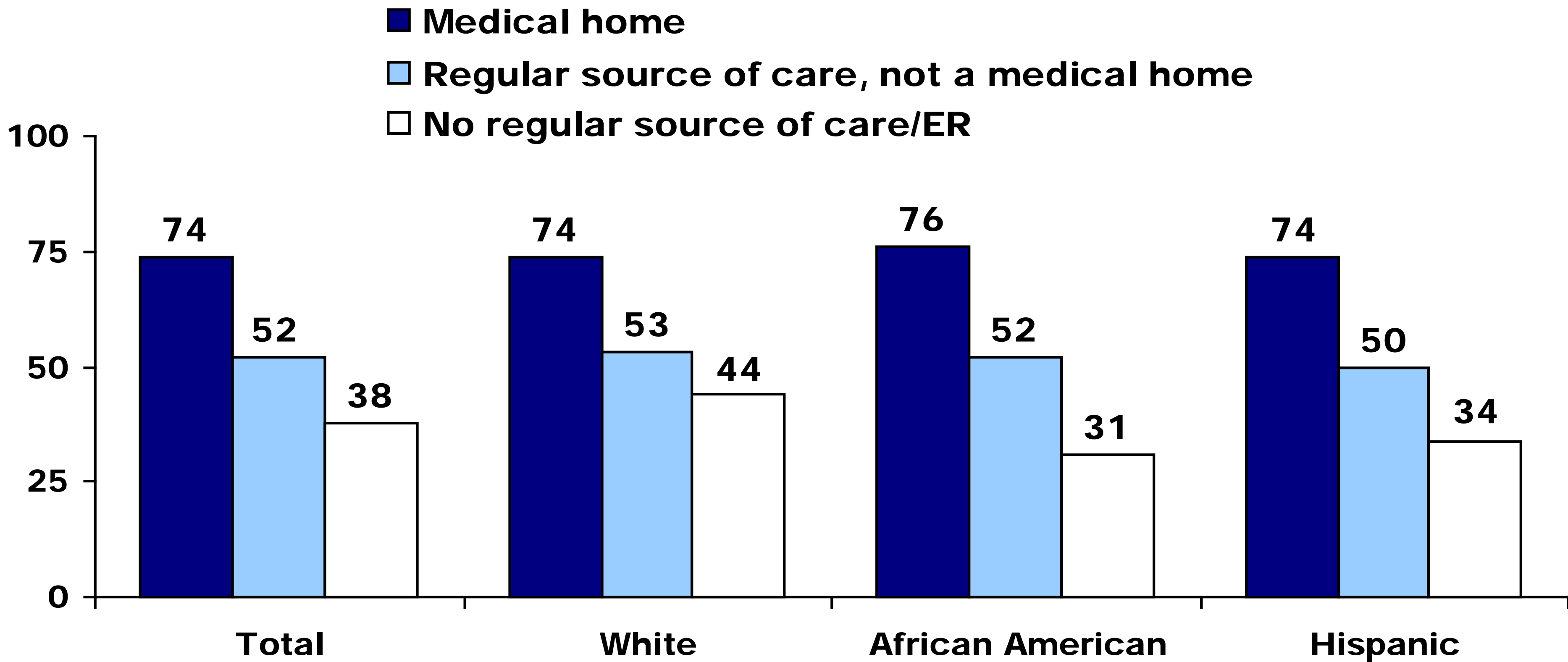
Figure 12. Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

Percent of adults 18–64 reporting always getting care they need when they need it



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

Medical Homes reduce disparities in preventive care

- Use of preventive care is associated with higher rates of preventive screening.
- Regardless of race or ethnicity, about two thirds of all adults who have a medical home receive preventive care reminders.

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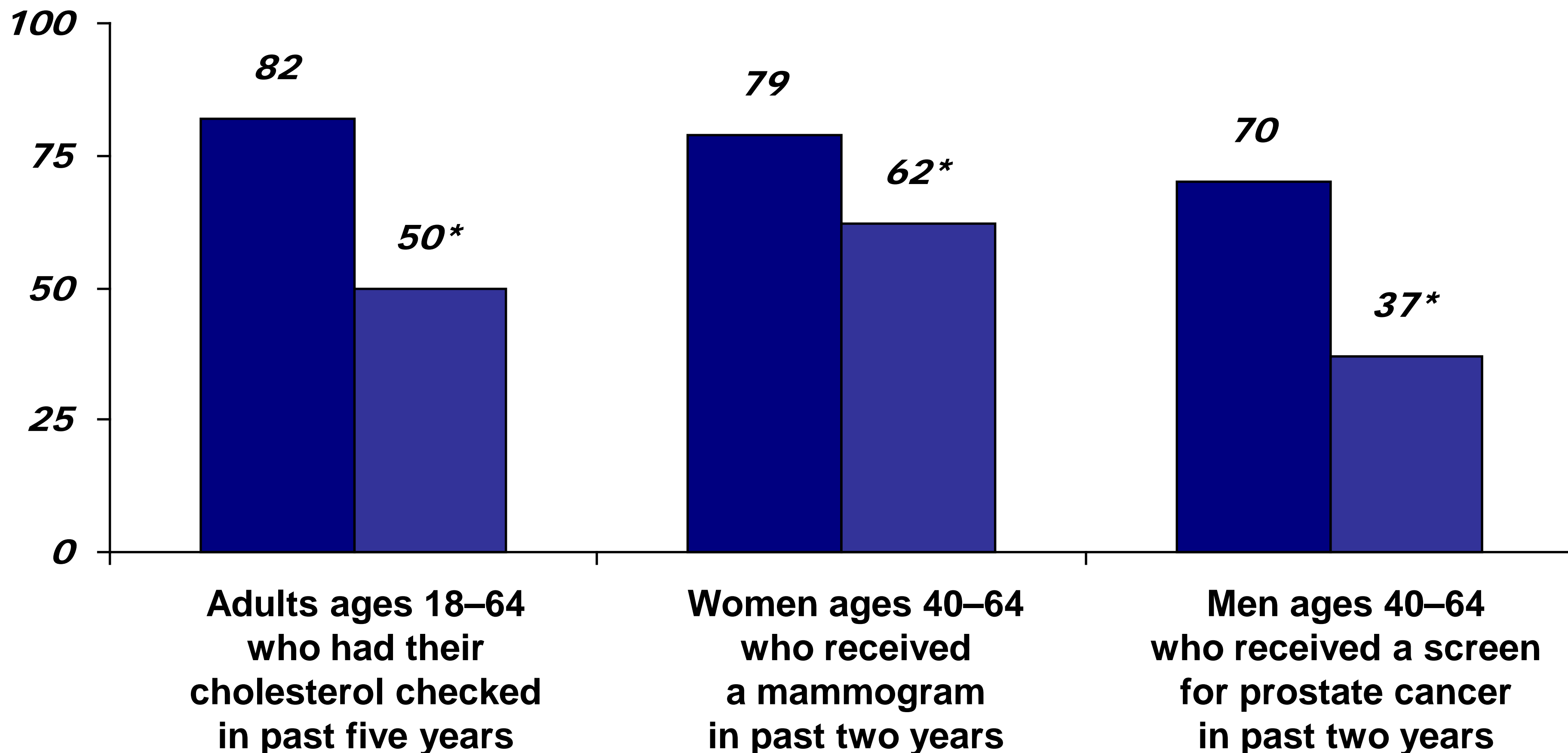
Figure 14. Adults Who Are Sent Reminders Are More Likely to Receive Preventive Screening



* statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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Figure 17. When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits

Percent of adults 18–64 receiving a reminder to schedule a preventive visit by doctors' office

	Medical home	Regular source of care, not a medical home	No regular source of care/ER
Total	65	52	22
White	66	54	23
African American	64	48	25
Hispanic	64	49	21

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Good news

Among those who have a medical home:

- Racial and ethnic differences in getting needed care disappear.
- Differences in preventive care and management of chronic conditions either reduced or eliminated.

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Looking forward

- Public health has a role to play in the improvement of health care delivery.

- Patient-centered medical home has the potential to serve as the foundation of health care reform.

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Patient-Centered Medical Home

- Reclaims primary care as the foundation
- Moves health care into the information age

- Brings public health and health care into closer alignment
  - population health management
  - improved prevention

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“Too few true primary care physicians and a surfeit of specialists is bad for population health, bad for the economy and even worse for health equity.”

Barbara Stanfield, Leyiu Shi, James Macinko

John Hopkins Bloomberg School of Public Health

Baltimore, Maryland

Health Affairs, March-April, 2009

Web Resources
Patient-Centered Medical Home

- Center for Medical Home Improvement

http://www.medicalhomeimprovement.org/

- Patient-Centered Primary Care Collaborative

http://pcpcc.net

- Improving Chronic Illness Care/Patient-Centered Medical Home

http://www.improvingchroniccare.org/index.php?p=Patient-Centered_Medical_Home&s=224

Questions?

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