PATIENT CENTERED MEDICAL HOMES AND THE 10 BUILDING BLOCKS OF PRIMARY CARE

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November 8, 2018

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Center for Excellence in Primary Care

Who are we?

The UCSF Center for Excellence in Primary Care identifies, develops, tests, and disseminates promising innovations in primary care to . . .

- improve the **patient experience**,
- enhance **population health** and **health equity**,
- reduce the **cost** of care, and
- restore **joy and satisfaction** in the practice of primary care.

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Overview

1. The context for transformation in primary care
2. Evidence on primary care and the triple aim
3. What are patient centered medical homes (PCMH)?
4. Implementing transformed primary care

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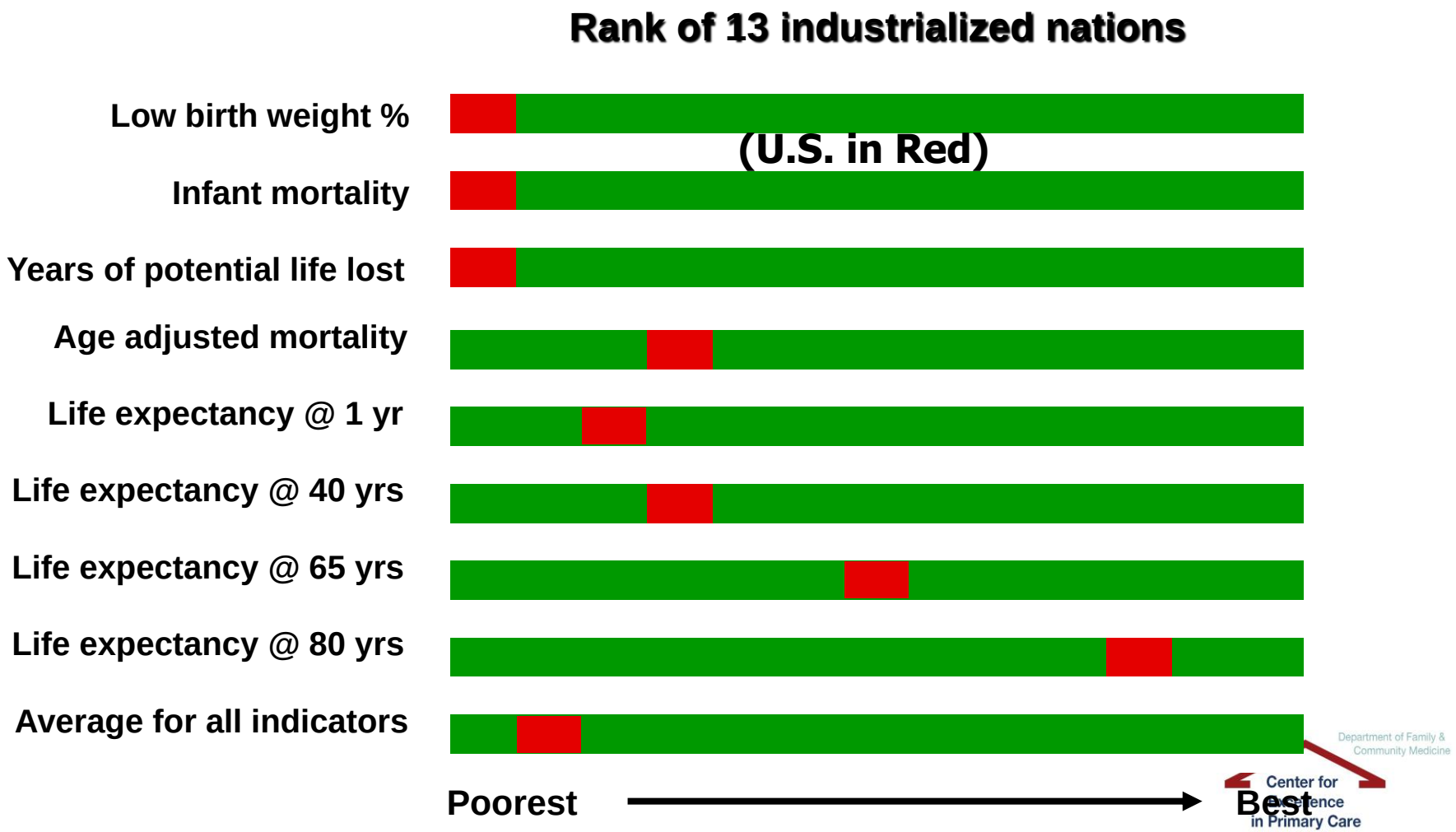
We Should Be Doing Much Better

WHO ranks US 37th out of 191 countries in overall health measures



We Forgot About the Importance of Having a Personal Doctor

"It used to be that most of us had a family doctor; you would consult with that family doctor; they knew your history, they knew your family, they knew your children, they helped deliver babies. How do we get more primary physicians, number one; and number two, how do we give them more power so that they are the hub around which a patient-centered medical system exists, right? "

- President Obama, June 8, 2010, Town Hall with Seniors

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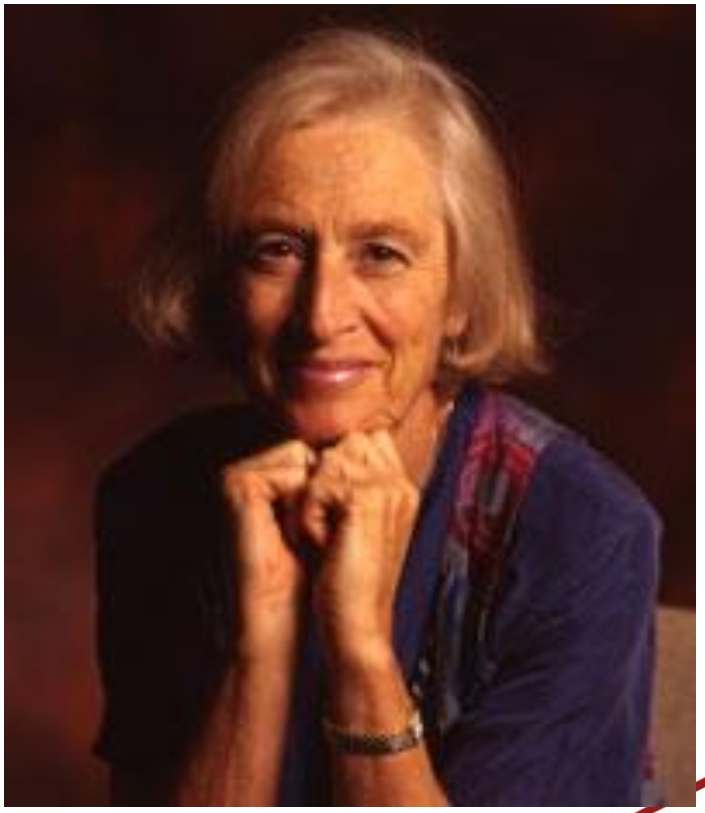
Primary Care
"4C" Functional Definition

Dr. Barbara Starfield

- first Contact
- Comprehensiveness
- Continuity
- Coordination



United States Government Accountability Office

GAO

Testimony

Before the Committee on Health, Education, Labor, and Pensions, U.S. Senate

For Release on Delivery
Expected at 2:30 p.m. EST
Tuesday, February 12, 2008

PRIMARY CARE PROFESSIONALS

Recent Supply Trends, Projections, and Valuation of Services

Statement of A. Bruce Steinwald, Director
Health Care

- "Ample research concludes in recent years that the nation's over reliance on specialty care services at the expense of primary care leads to a health system that is less efficient…research shows that **preventive care, care coordination for the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve better health outcomes and cost savings**."

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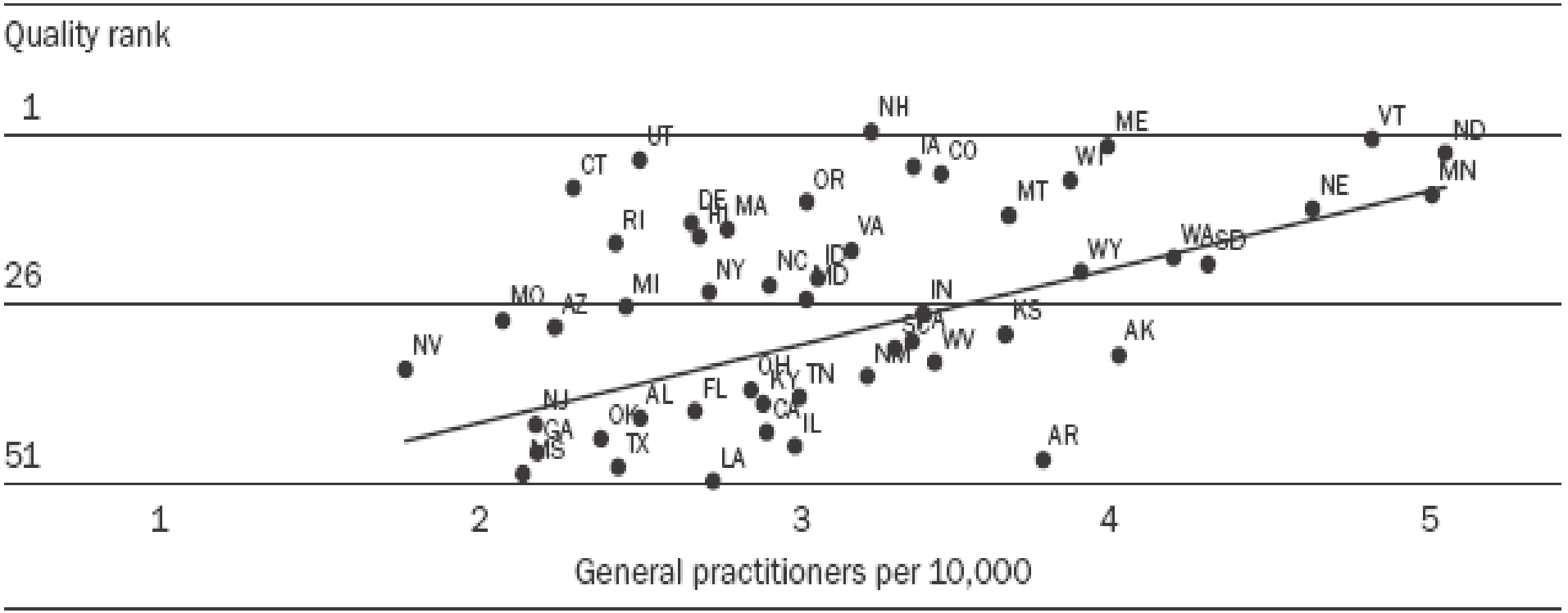
EXHIBIT 8

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004

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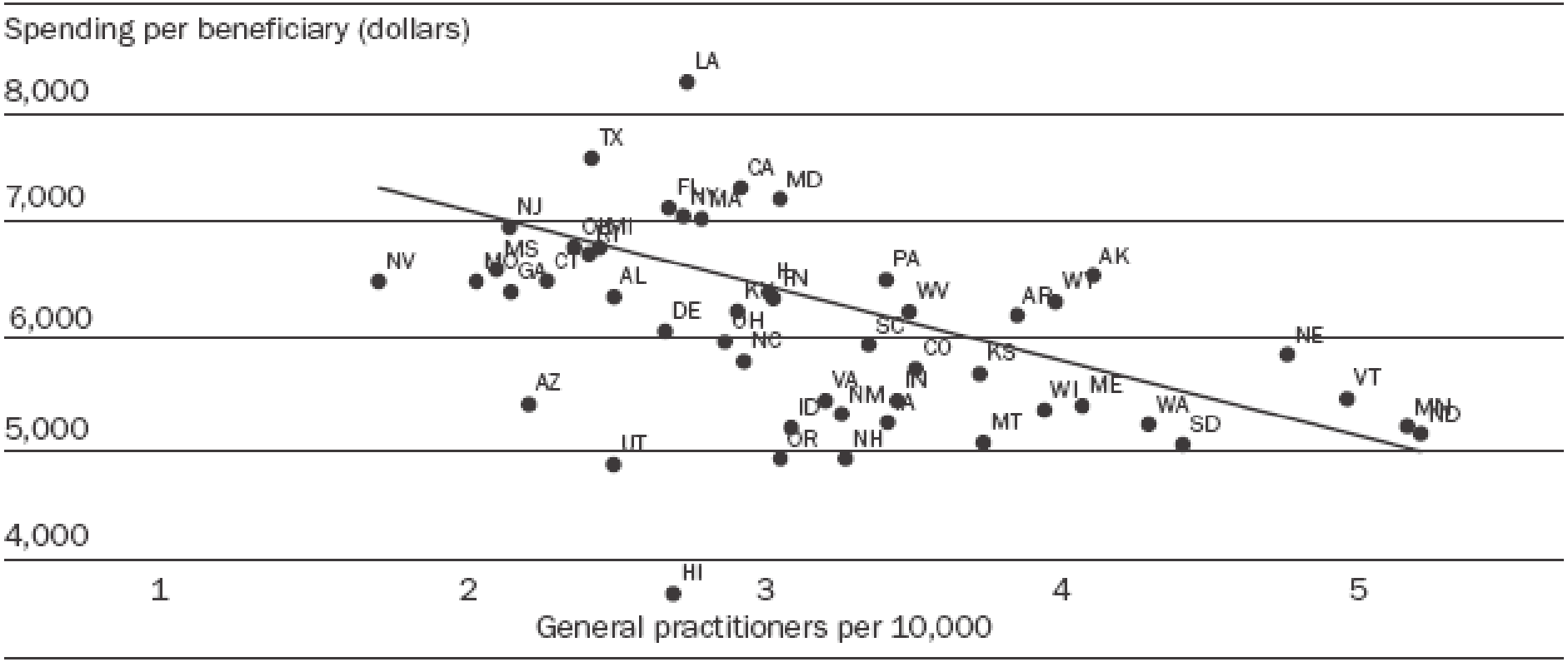
EXHIBIT 9

Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004

Heightened Need Confronts Inadequate Capacity

People who have a regular primary care provider are more likely to…

- Receive preventive services
- Obtain medical treatment before serious problems
- Have fewer preventable emergency department and hospital visits

But in the U.S. …

- One third of adults do not have access to a primary care provider
- 3 out of 4 have difficulty getting an appointment, telephone advice, or off-hours care
- Plummeting numbers of new physicians entering primary care

Source: Davis et al. How the affordable care act will strengthen the nation's primary care foundation. J Gen Intern Med 2011.

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The New Math of the 15 Minute Primary Care Visit

- Average primary care panel in US is **2300**

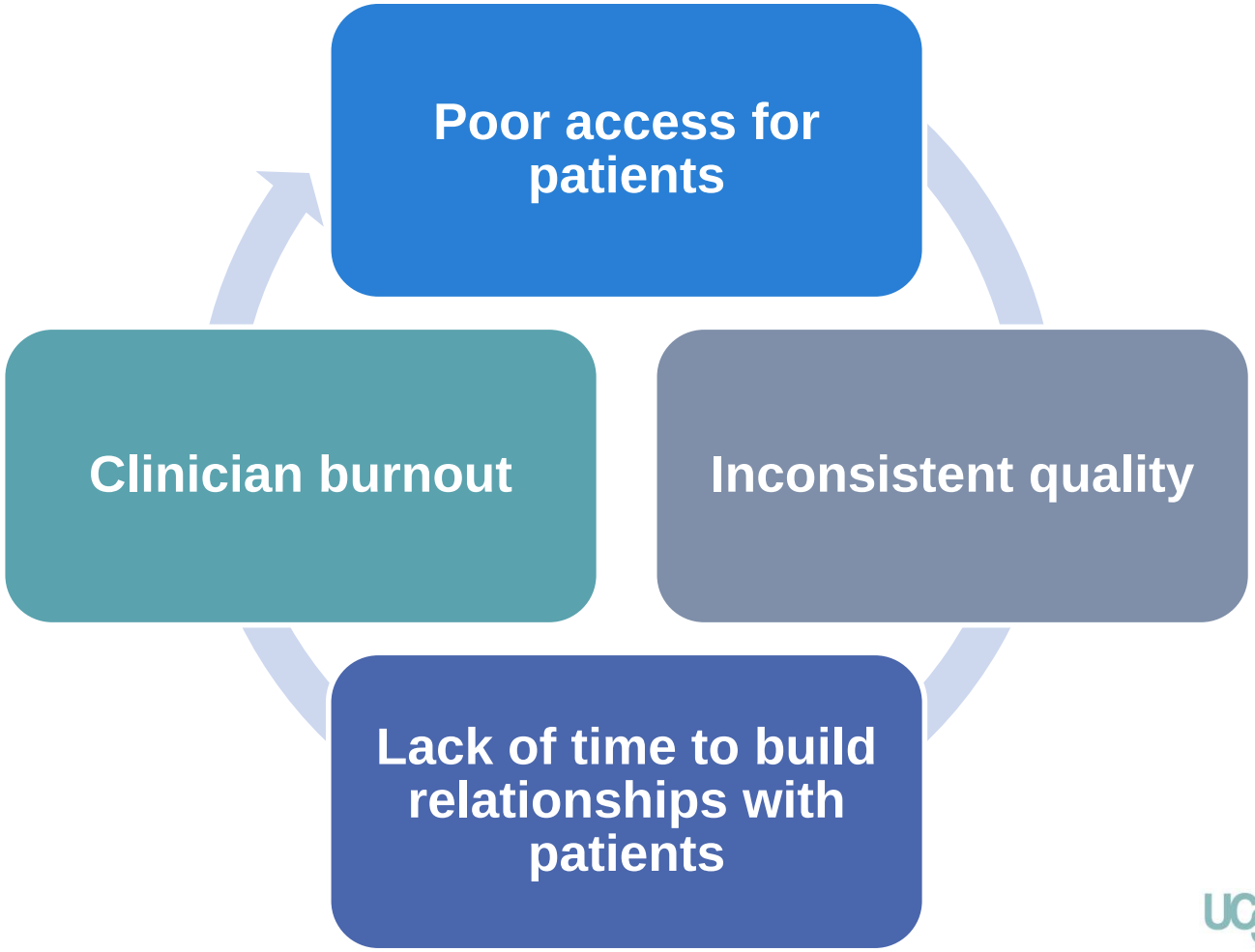
- PCP with panel of 2500 average patients will spend **7.4 hours per day** doing recommended preventive care

  [Yarnall et al. Am J Public Health 2003;93:635]

- PCP with panel of 2500 average patients will spend **10.6 hours per day** doing recommended chronic care

  [Ostbye et al. Annals of Fam Med 2005;3:209]

Results of Imbalance



Sources: Linzer et al. Annals of Internal Medicine 2009;151:28-36; Dyrbye, JAMA 2011;305:2009; Murray et al, JGIM 2001:16,452; Landon et al, Med Care 2006;44:234.

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PRIMARY CARE TRANSFORMATION

Patient-Centered Medical Homes and
High Performing Primary Care

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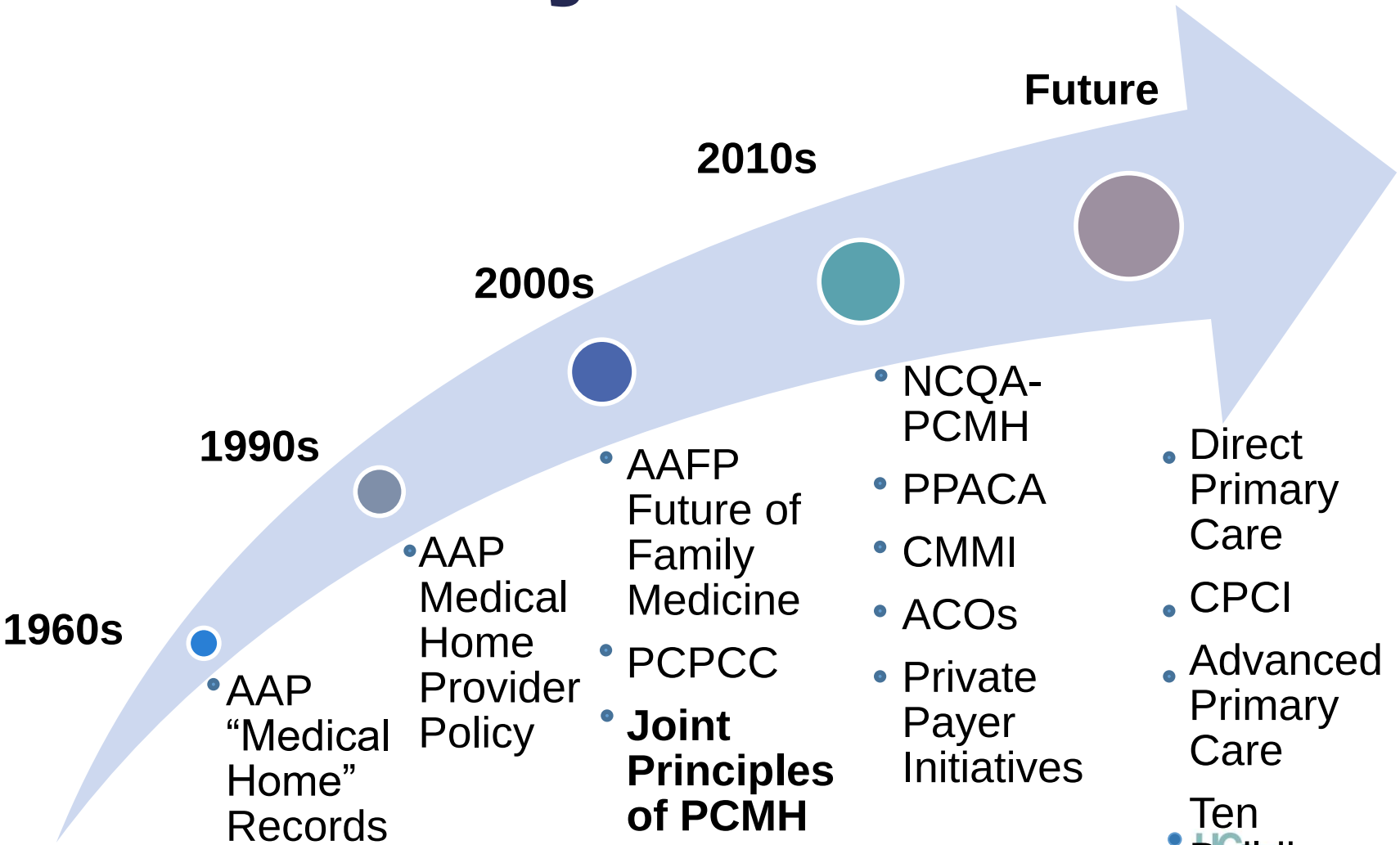
Brief History of the PCMH



PCMH Defined - AHRQ

Comprehensive

Patient-centered

Coordinated

Accessible

Quality & Safety

Source: Agency for Healthcare and Research Quality

Standards and Incentives

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PCMH 2011 Content and Scoring

PCMH1: Enhance Access and Continuity		Pts
A.	**Access During Office Hours****	**4**
B.	After-Hours Access	4
C.	Electronic Access	2
D.	Continuity	2
E.	Medical Home Responsibilities	2
F.	Culturally and Linguistically Appropriate Services	2
G.	Practice Team	4
		20

PCMH2: Identify and Manage Patient Populations		Pts
A.	Patient Information	3
B.	Clinical Data	4
C.	Comprehensive Health Assessment	4
D.	**Use Data for Population Management****	**5**
		16

PCMH3: Plan and Manage Care		Pts
A.	Implement Evidence-Based Guidelines	4
B.	Identify High-Risk Patients	3
C.	**Care Management****	**4**
D.	Manage Medications	3
E.	Use Electronic Prescribing	3
		17

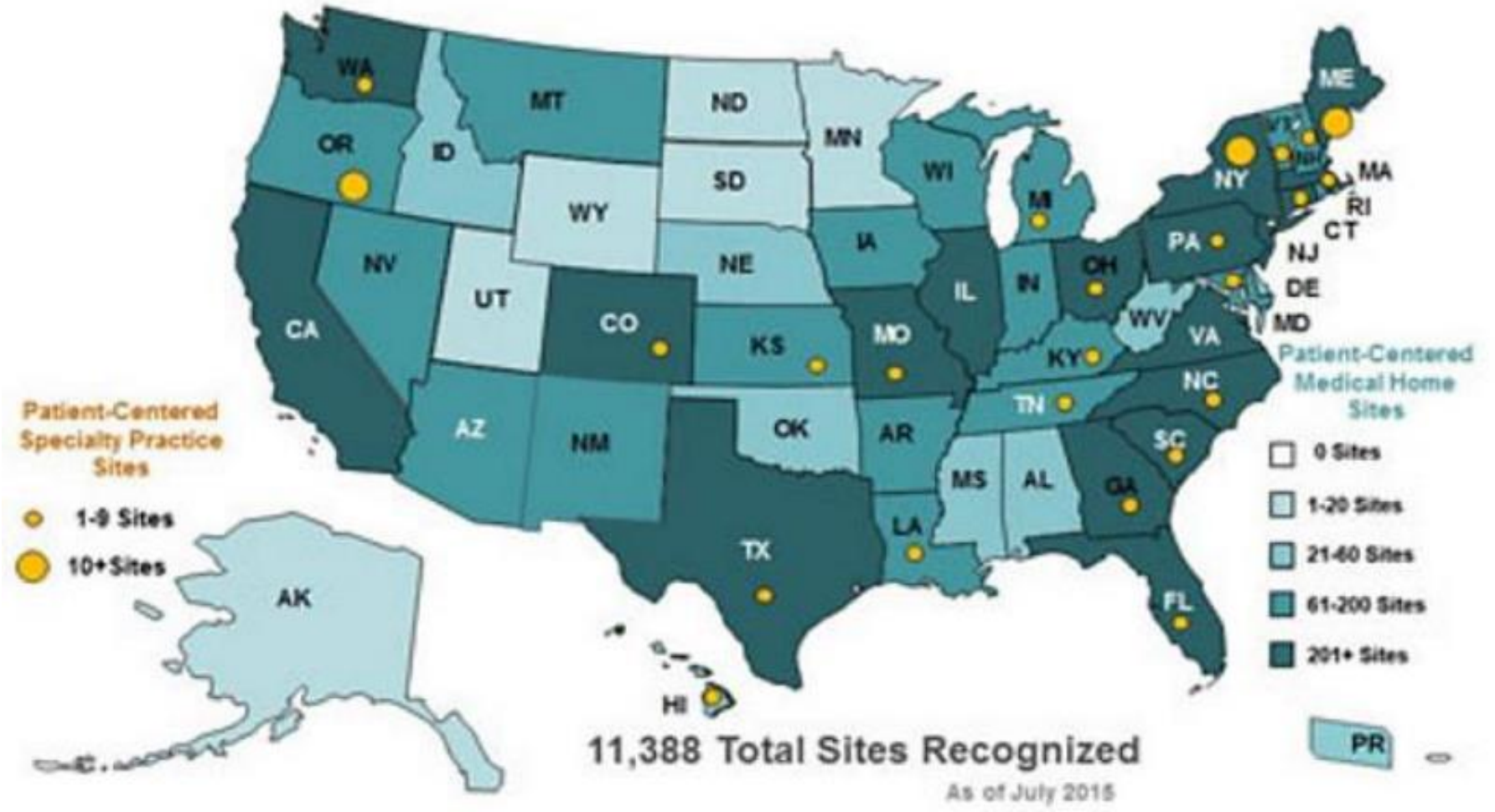
PCMH4: Provide Self-Care Support and Community Resources		Pts
A.	**Support Self-Care Process****	**6**
B.	Provide Referrals to Community Resources	3
		9

PCMH5: Track and Coordinate Care		Pts
A.	Test Tracking and Follow-Up	6
B.	**Referral Tracking and Follow-Up****	**6**
C.	Coordinate with Facilities/Care Transitions	6
		18

PCMH6: Measure and Improve Performance		Pts
A.	Measure Performance	4
B.	Measure Patient/Family Experience	4
C.	**Implement Continuously Quality Improvement****	**4**
D.	Demonstrate Continuous Quality Improvement	3
E.	Report Performance	3
F.	Report Data Externally	2
		20

****Must Pass Elements**

NCQA-Recognized Practices Across the United States - 2015



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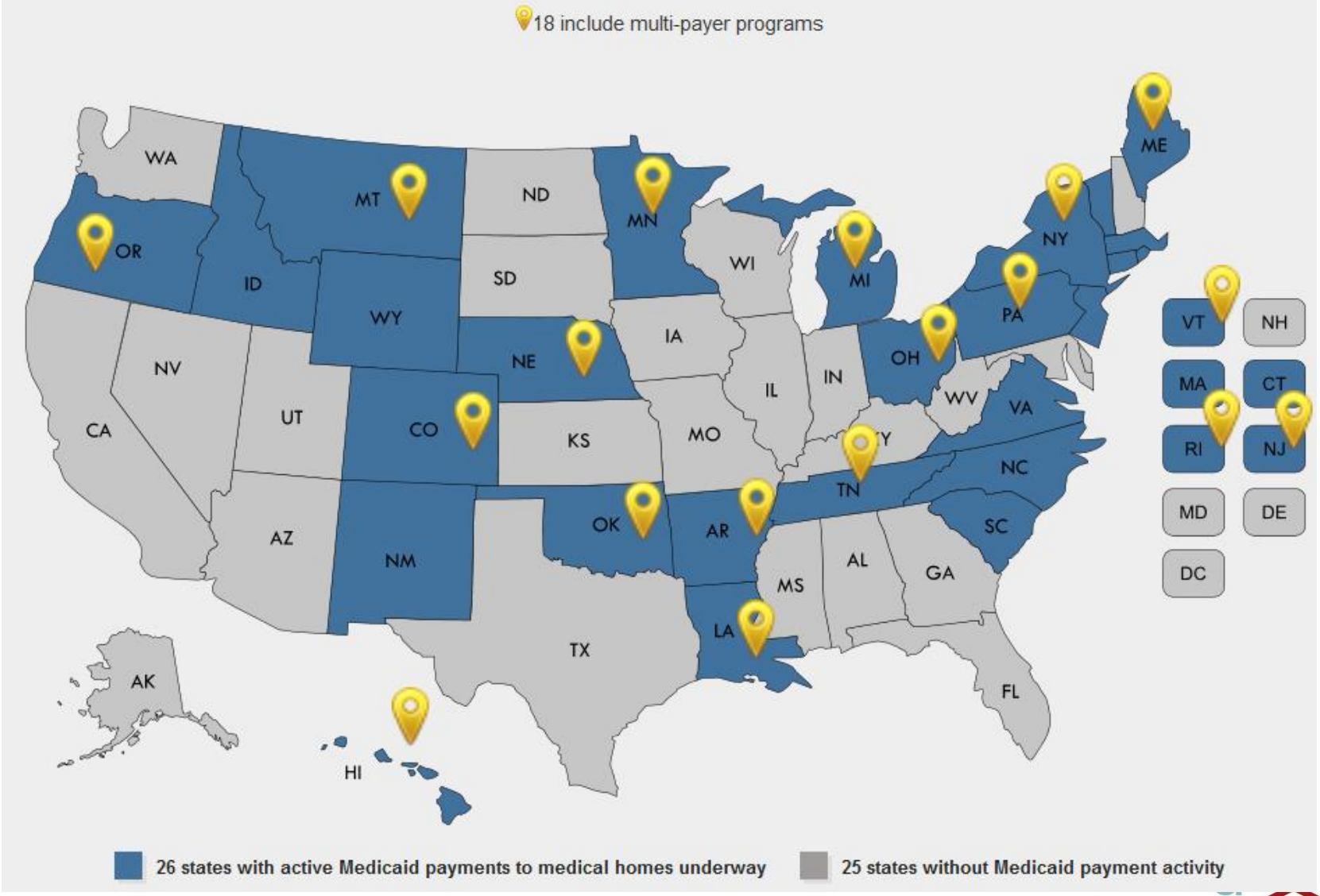
State Incentives



Source: https://nashp.org/state-delivery-system-payment-reform-map/

THE LANDSCAPE: PCMH MOMENTUM

90+ commercial and not for profit health plans leading PCMH initiatives

Largest U.S. employers offering APC and PCMH benefits to employees

Public sector expansions of PCMH care – 25 state MCD, FEHBP, MCR, US Military, VA

Private practices, CHCs, hospital practices, IPAs

Remember…

PCMH on paper

PCMH in reality

10 BUILDING BLOCKS OF PRIMARY CARE

What “good primary care” looks like

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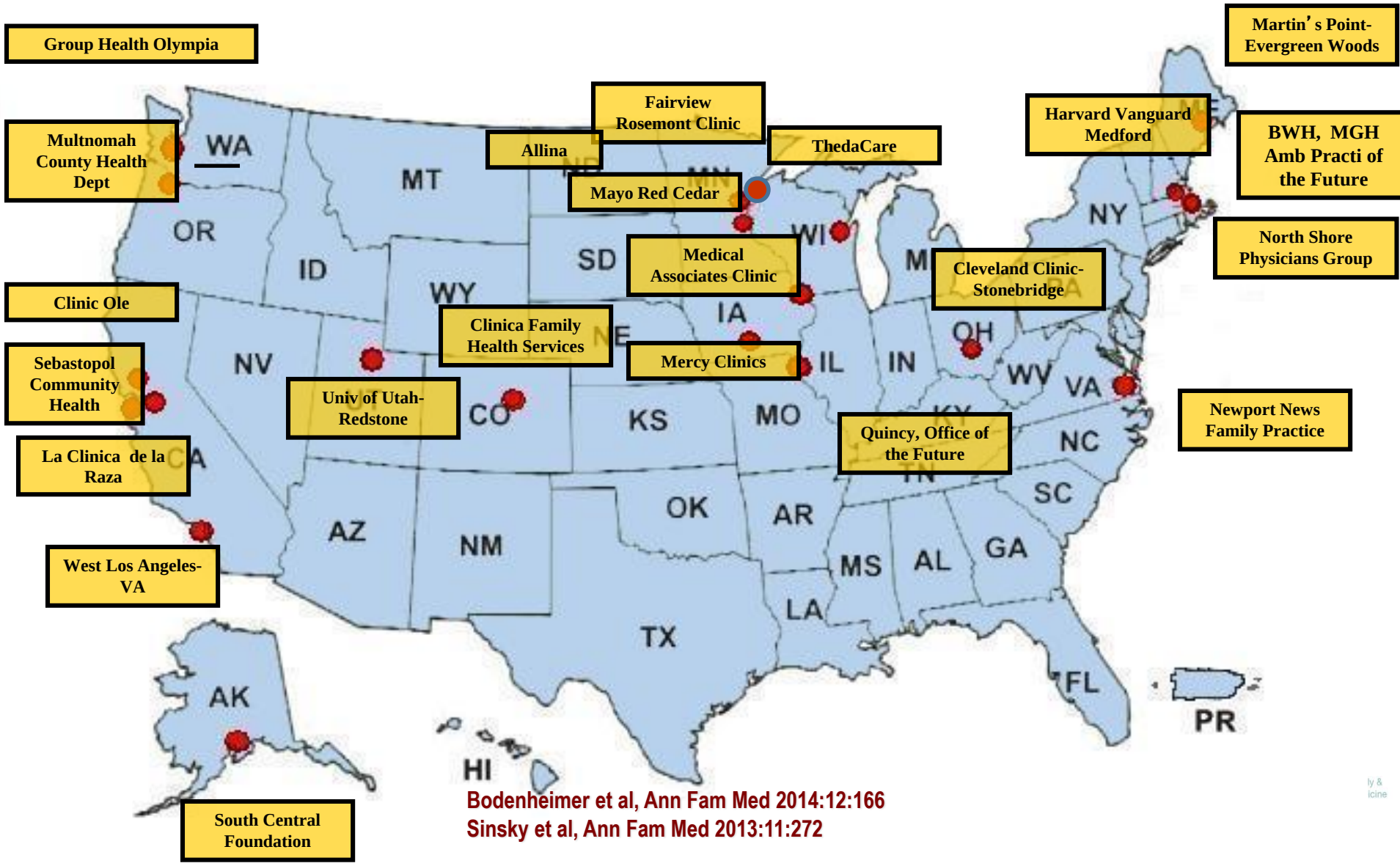
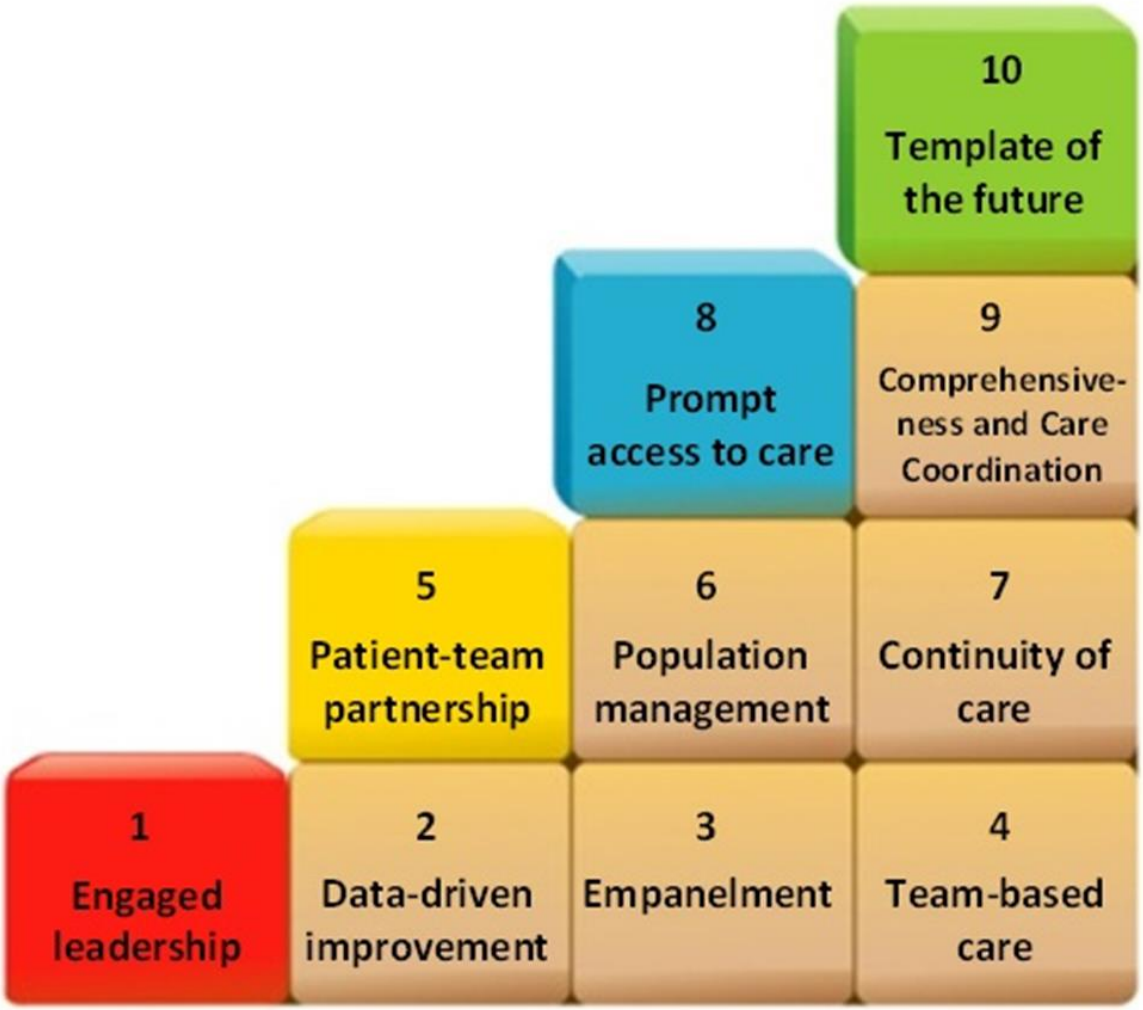
23 High Performing Practices

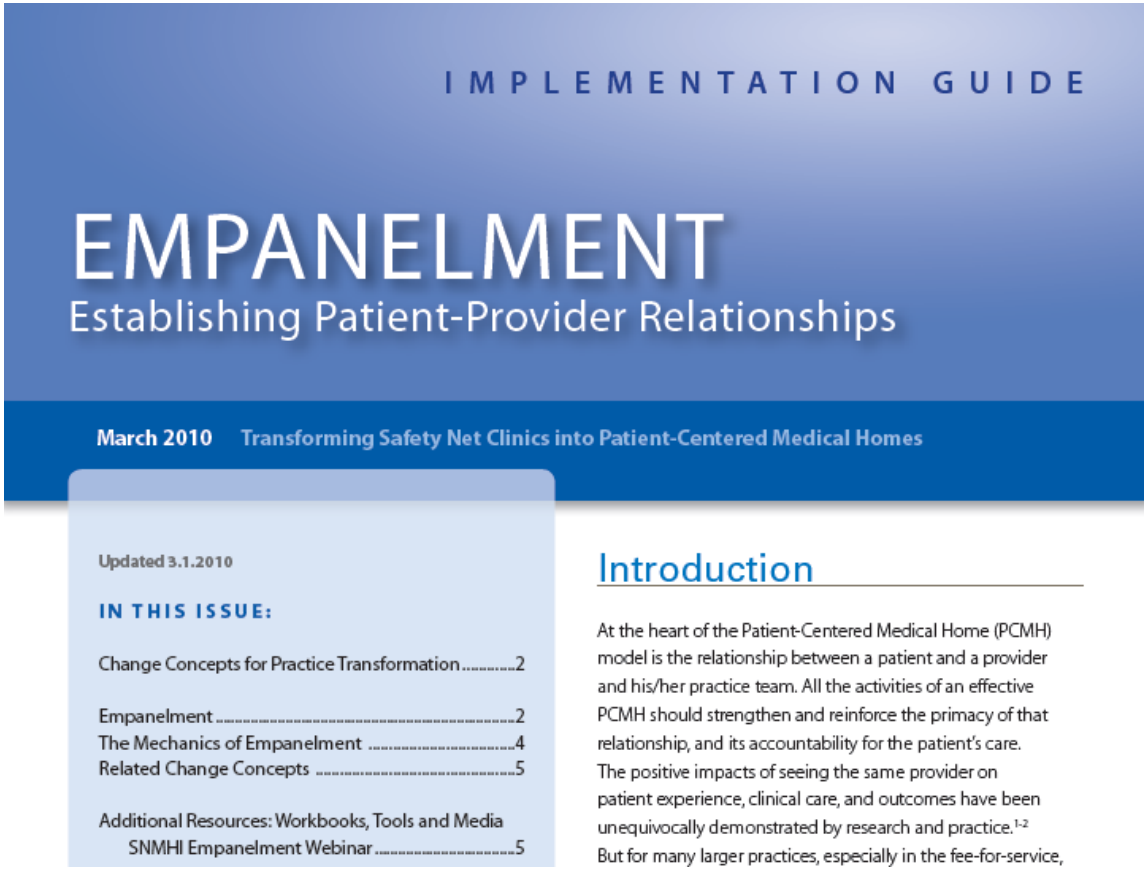


Bodenheimer et al, Ann Fam Med 2014:12:166
Sinsky et al, Ann Fam Med 2013:11:272

10 Building Blocks of Primary Care



3. Empanelment and panel size management



IMPLEMENTATION GUIDE

EMPANELMENT

Establishing Patient-Provider Relationships

March 2010 Transforming Safety Net Clinics into Patient-Centered Medical Homes

Updated 3.1.2010

IN THIS ISSUE:

Introduction

At the heart of the Patient-Centered Medical Home (PCMH) model is the relationship between a patient and a provider and his/her practice team. All the activities of an effective PCMH should strengthen and reinforce the primacy of that relationship, and its accountability for the patient's care. The positive impacts of seeing the same provider on patient experience, clinical care, and outcomes have been unequivocally demonstrated by research and practice.[1-2] But for many larger practices, especially in the fee-for-service,

Safety Net Institute. Empanelment implementation guide. Available at http://www.improvingchroniccare.org/downloads/empanelment.pdf

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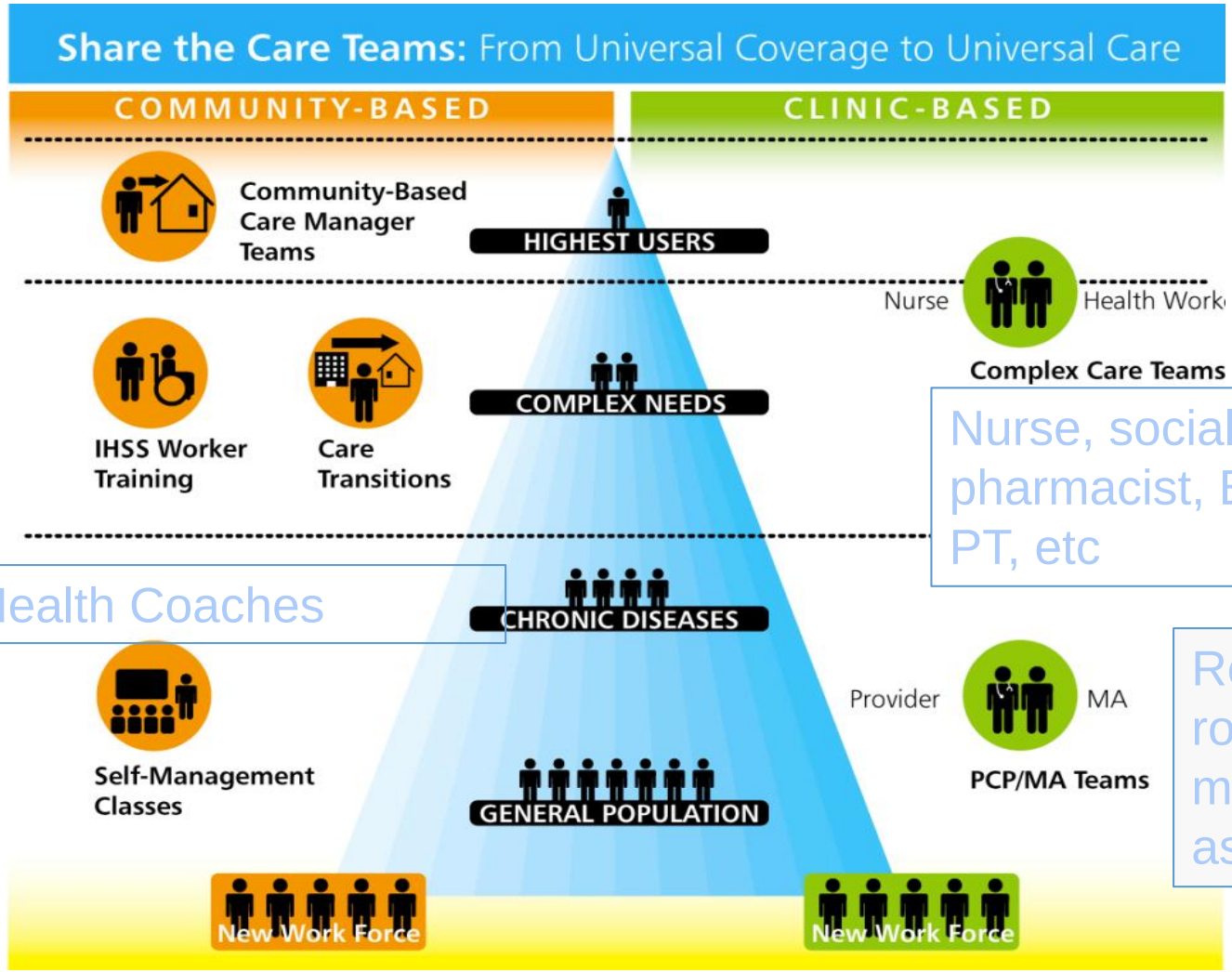
4. Team-based care



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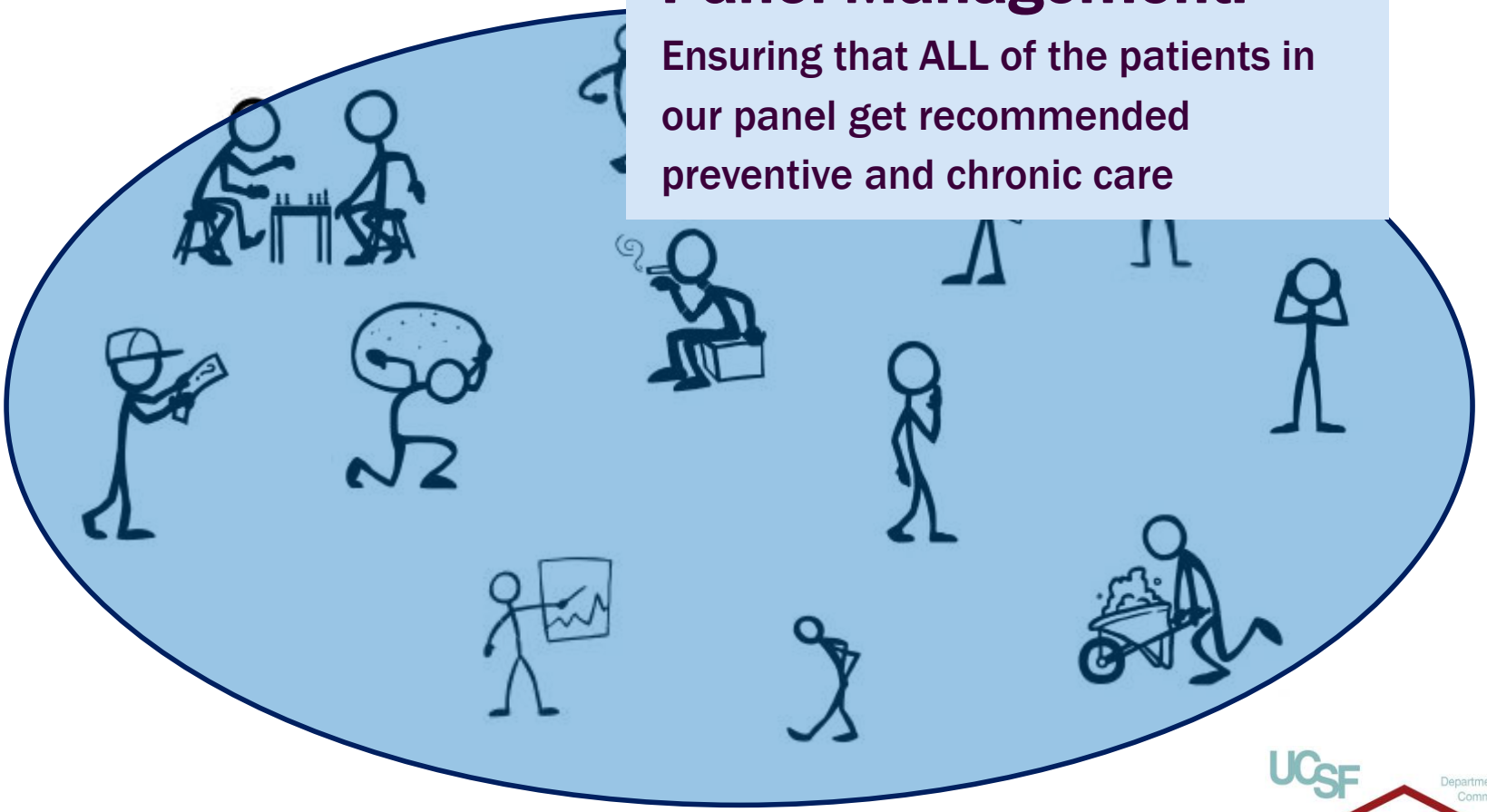
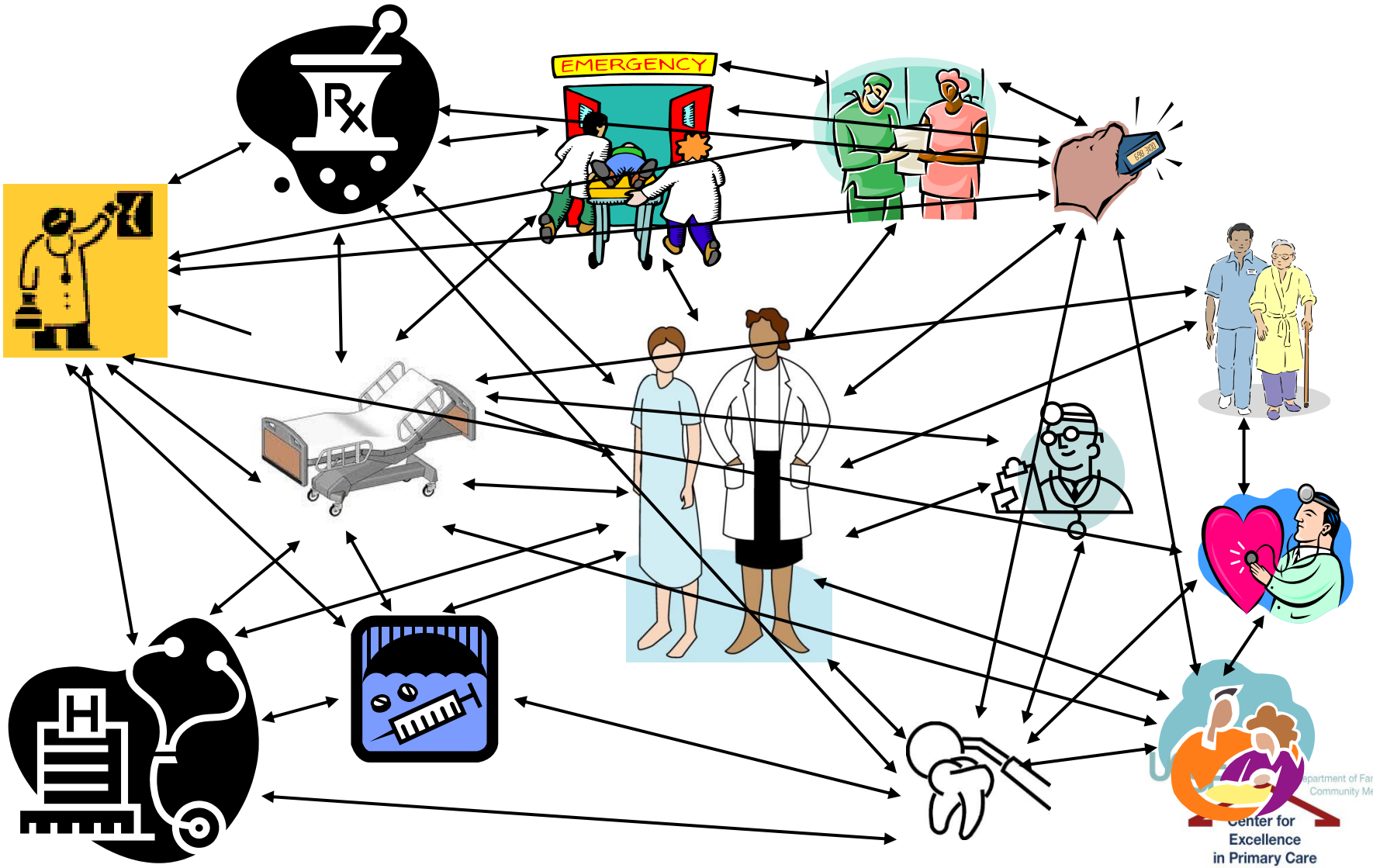
6. Population-based management



Panel Management:

Ensuring that ALL of the patients in our panel get recommended preventive and chronic care

9. Coordination of Care



Template for the Future

Time	Primary care physician	Medical assistant 1	RN	Nurse Practitioner	Medical Assistant 2
8:00	Huddle				
8:10	E-visits and phone visits	Panel manage-ment	RN Care manage-ment	Acute Patients	
8:30					
9:00	Complex patient				
9:30	Complex patient			E-visits and phone visits	Panel manage-ment
10:00	Coordinate with hospitalists and specialists	BP coaching clinic			
10:30	Huddle with RN, NP		Huddle with MD		

Courtesy of David Margolius

- 30 patients are seen or contacted in the first 3 hours of the day

INVESTING IN TRANSFORMING PRIMARY CARE

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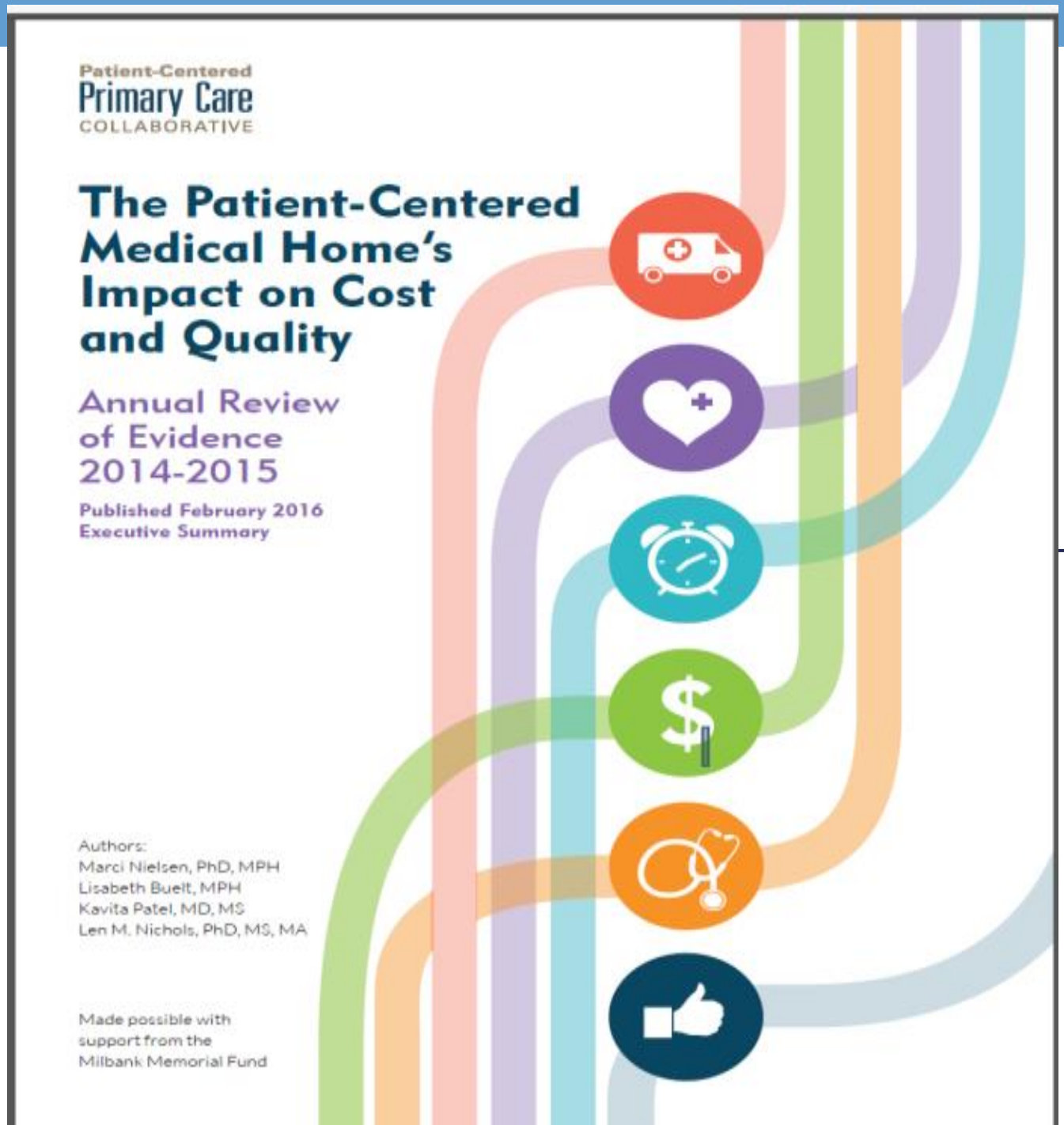

Patient-Centered
Primary Care
COLLABORATIVE

Milbank Memorial Fund

in Primary Care

RESULTS: TRENDS

(n^1 = Improvement in measure/n^2 = Measure assessed by study)

Aggregated Outcomes from the 30 Studies

21 of 23 studies that reported on cost measures found reductions in one or more measures

23 of 25 studies that reported on utilization measures

found reductions in one or more measures

#PCMHEvidence

Payment Reform and Investment of Resources are Required to Support High Performing Primary Care

- Beyond fee for service
  - Blended models FFS + capitation (“care coordination fee”)
  - More comprehensive population based payment models, full capitation
  - Direct funding of team resources (e.g., behavioral health)
  - P4P (Pay For Performance)
  - Support for practice coaching and technical assistance

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UCSF Health PC Transformation

- Based on 10 BB Model
- Steady, impressive gains in quality, access, patient experience
- Medi-Cal Waiver public delivery system reform incentives (DSRIP->PRIME) have been critical for motivating and resourcing primary care improvement at UCSF Health
- Aligned with growth of UCSF Health ACO programs with commercial payers and Medicare which emphasize population health care model and shared financial risk

CMS CPC+ Initiative: Public + private payer collaboration

Comprehensive Primary Care Plus

Share

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.).

Select anywhere on the map below to view the interactive version

Source: Centers for Medicare & Medicaid Services

There are 2,900 primary care practices currently participating in Comprehensive Primary Care Plus

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CMS CMMI PTI

CQC California Quality Collaborative
Breakthroughs for Better Healthcare

Practice Transformation Initiative (PTI)

PTI will build capacity within provider organizations to accelerate and sustain practice transformation across their clinician networks by:

1) Training and mentoring practice coaches hired by Provider Organizations (POs) to support practice transformation

2) Convening and coaching PO leaders to improve systems to continually improve patient care at the practice site

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CQC PTI: participating practice groups

CQC
California Quality Collaborative
Breakthroughs for Better Healthcare

Provider Organizations

Provider Organization	# committed to enroll in PTI	Organization Type	#of Medicare and Medicaid Patients	Total # of Patients
Adventist Health Physician Services	1000	Not for Profit	228,506	443,472
AltaMed Health Services Corp.	425	FQHC	90,053	157,786
Central Valley Health Network	250	Health Center Network	340,034	595,069
Community Foundation Medical Group (Sante)	80	Medical Foundation	111,280	449,647
Hill Physicians	408	IPA	97,646	288,446
North Coast Information Network (Humbolt-IPA)	45	Not for Profit	50,000	110,000
Health Care LA IPA, managed by MedPoint	400	IPA	322,807	334,697
Molina Medical Group	188	Medical Group	87,341	88,101
Partnership HealthPlan of California	193	Public Health Plan	514,304	514,304
Physicians Medical Group of San Jose	510	IPA	69,500	91,500
Prospect Medical	300	IPA	86,356	201,340
Sharp Rees-Stealy	200	Medical Group	30,000	258,000
University Health Alliance	200	Medical Foundation	19,674	74,929
Total (Commitments)	4,199		2,047,501	3,607,291
Total (Physician Network Size)	17,535			

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Covered California

HEALTH AFFAIRS BLOG

Moving The Needle On Primary Care: Covered California's Strategy To Lower Costs And Improve Quality

Lance Lang, Peter V. Lee, Kevin Grumbach

JUNE 14, 2017 10.1377/hblog20170614.060590

- Benefit Design
  - For most tiers, neither primary care nor specialty ambulatory care visits are subject to deductible
- A Primary Care Physician For Every Enrollee
  - Require all enrollees including in PPO products be empaneled with a primary care clinician
- Payment Reform: encouraging payers to move to CPC+ model
- PCMH Recognition
  - Requires health plans to ensure a progressively larger share of enrollees receive primary care from PCMH recognized practices

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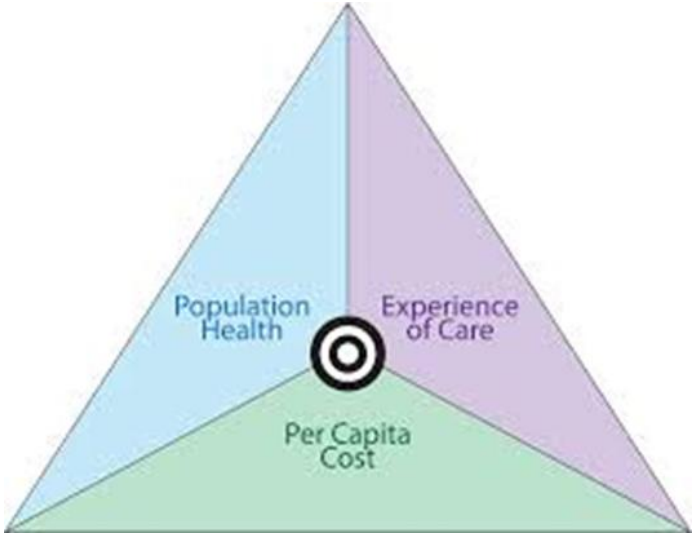
Conclusions

- Strong primary care is the foundation for better healthcare
- PCMH is a model of transformed primary care to improve quality, patient experience, and reduce costs
- Payment reform and investment of resources are required to support high performing primary care



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Information and resources

Contact us:

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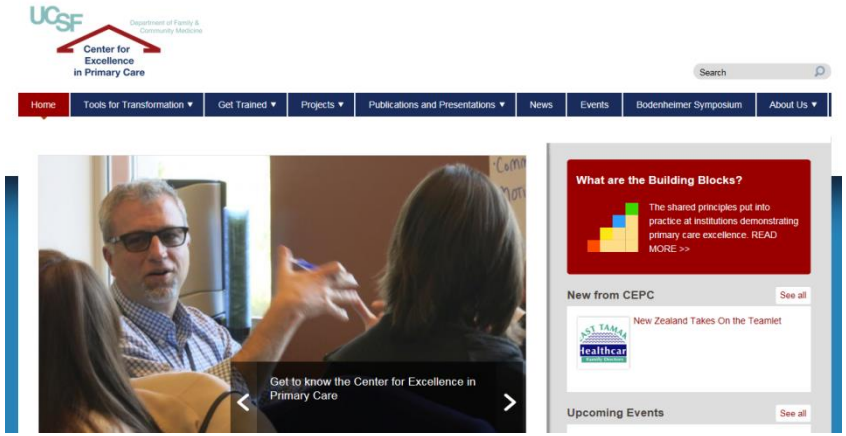

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