



Patient-Centered Medical Home (PCMH)

Overview

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[Reed Abelson, NY Times, 2/6/2009]

“In this experiment, UnitedHealth has worked closely with the doctors. And perhaps most importantly, the insurer has agreed to bear some of the initial costs of developing a medical home, including hiring a consultant to advise doctors on how to change their practices.”

[Quote from Dr Jim Dearing, in the NY Times 2/6/2009]

“This [UnitedHealthcare’s PCMH pilot in Arizona] gives us the opportunity to create a model to allow family physicians to practice the way we used to practice in the past,” said Dr. Jim Dearing, a family practitioner in Phoenix who is among the physicians who have agreed to participate.

- Current transaction-based model and reimbursement does not recognize the value of and specifically reimburse for individualized, comprehensive, coordinated and comprehensive care management.
- Poor access for consumers to Primary Care
 - Significant reductions in physicians entering into and remaining in Primary Care Specialties
- Escalation of care unnecessarily into higher cost settings – specialty and hospital proportion increasing
- Suboptimal resource management (unnecessary and duplicative testing and treatment)
- Diminished health outcomes – particularly for those with chronic disease and behavioral health issues
- Erosion of Primary Care Capacity*
 - Population demands exceed current PC physician base
 - Too few medical students are choosing PC
 - Collapse will lead to higher cost of care in general

* ACP Report January 30, 2006 – “The Impending Collapse of Primary Care Medicine and its Implications for the State of the Nation’s Health Care”

Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care of adults, youth and children. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

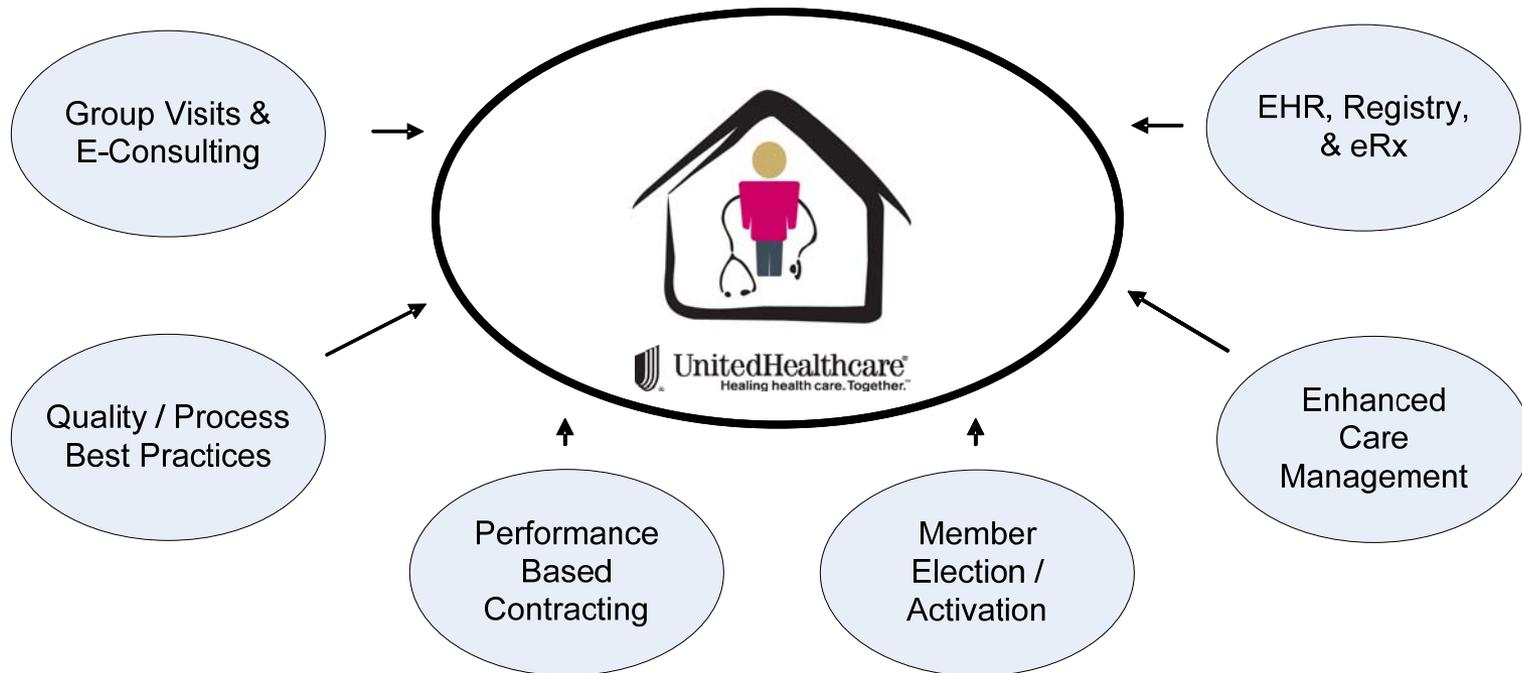
Principal Characteristics of PCMH:

- Personal Physician
- Physician Directed Practice
- Whole Person Care Orientation
- Coordinated Care
- Quality and Safety **
- Enhanced Care Access
- Full Value Payment
- Optimization through HIT integration (eRx, patient registry)

* As originally defined by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians, American Osteopathic Association (AOA)

** To include a voluntary recognition process by an appropriate non-governmental entity to demonstrate that practices have the capabilities to provide patient-centered services consistent with the medical home model.

Medical Home is the Foundational Program to Achieving Primary Care Transformation



**“Systemness” → Reduced Variation → Higher Quality
Higher Quality → More Affordable, Safer Health Care**

- **Transformed primary care practice team** that commits to expanding patient access & engagement, improving chronic condition population management, team-based care that focuses on care transitions & coordination, monitoring performance on key quality/utilization measures and effectively utilizing available technologies including patient registries and ePrescribing
- **Primary care practice supported** (either by the pilot convening organization, the state QIO, or participating payers) to:
 - Assist in the practice transformation and acquiring NCQA PPC-PCMH certification
 - Provide enabling technologies and timely/actionable patient clinical data
 - Care coordination support
- **Enhanced reimbursement to the primary care practice** that is aligned with the benefits of transformed, comprehensive primary care
- **Activated consumer** that is engaged by the PCMH pilot stakeholders

PRACTICE QUALIFICATIONS (Based on NCQA PCC-PCMH)

<p>Enhanced Access</p> <ul style="list-style-type: none"> ▪ Timely Appointment Scheduling ▪ Evening, Weekend and Holiday Hours ▪ After-Hours Support 	
<p>Care and Chronic Condition Management</p> <ul style="list-style-type: none"> ▪ Specialty Referral Coordination and Tracking ▪ Disease and Case Management Enrollment 	
<p>Team Care</p> <ul style="list-style-type: none"> ▪ Physician-directed team both in and outside of the practice setting ▪ Management of Care Transitions across the Health Care Continuum 	
<p>Performance Measurement, Assessment & Improvement</p> <ul style="list-style-type: none"> ▪ Practice in accordance with clinical evidence ▪ Performance Evaluation Based on Medical Best Practices ▪ Measurement of Clinical Processes and Outcomes 	
<p>Clinical Information Systems</p> <ul style="list-style-type: none"> ▪ Care Management ▪ Decision Support ▪ Electronic Prescription Filling 	

Benefits

- Improved Quality at Lower Cost
- Enhanced Patient Satisfaction
- Improved Patient Safety
- Care Continuity & Improved Care Transitions
- Improved Practice Profitability and Satisfaction
- Value-based Payment
- Simplified and Coordinated Health Care Experience

UHC OFFERS: ENABLING TECHNOLOGY & CLINICAL SUPPORT

<p>Technology & Tools</p>  <ul style="list-style-type: none"> ▪ Personal Health Record ▪ Point of Care Information ▪ Electronic Prescriptions ▪ In-depth reporting 	<p>Care Coordination Management & Support</p>  <ul style="list-style-type: none"> ▪ Health plan care & disease management ▪ Educational Materials ▪ Patient Activation Tools 	<p>Transformation Support</p>  <ul style="list-style-type: none"> ▪ Assigned facilitator ▪ Online tools ▪ "Boots on the ground" resources
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Approach	Market & Description	Status
<p>1. Proof of Concept Pilot</p> <p>❖ Led by UnitedHealthcare</p>	<p>Arizona: partnership with IBM and other large ASO group(s), selection of high-volume practices. Inclusion of other product lines including Secure Horizons Medicare and AmeriChoice Medicaid.</p>	<ul style="list-style-type: none"> • Seven primary care practices in Tucson and Phoenix • Pilot kick-off February 2009 • Practice transformation started Q1 2009 • Enhanced reimbursement, clinical data sharing to begin Q2 2009
<p>2. Participate in multi-payer collaborative</p> <p>❖ Led by Colorado Clinical Guidelines Collaborative</p>	<p>Colorado: UnitedHealthcare is one of 5 payers convening around common practices. Other 2009 collaborations may include Ohio and New York</p>	<ul style="list-style-type: none"> • Study (measurement) vendor is Harvard Public School of Health; funded by Commonwealth • Inclusion of second market (Ohio) as part of study • Collaborative working through common processes, measures, and practice selection • Targeted start Q2 2009
<p>3. Regional or local efforts</p> <p>❖ Led by Chronic Care Sustainability Initiative (QIO)</p>	<p>Rhode Island: locally driven with national SME oversight; responding to local market dynamics.</p>	<ul style="list-style-type: none"> • Five practices identified for initiative. • Care coordinator positions placed and enhanced reimbursement started Q4 2008 • Q2 2009 finalize study requirements and practice clinical data sharing

Physician & Patient Experience

- Patient Experience Satisfaction
- Access to Care
- Self-Reported Patient Health
- Physician and Care Team Satisfaction

Quality

- Preventive and Chronic Care Screening
- Behavioral Health Coordination
- Use of EBM Guidelines
- Medication Adherence
- Coordination of Care Transitions: ER, IP, and Specialists
- Use of Q&E Specialists and COEs

Resource Use

- Hospital
- Emergency Care
- Pharmacy
- Imaging
- Physician Office, Specialty Care
- Comprehensiveness of services

Data Sources: Claims Data, Clinical Data, Qualitative Interviews with Physicians, Observation, Qualitative Surveys of Physicians and Patients

- Maintain or achieve UnitedHealth Premium Designation “quality” designation.
- Practice is motivated to participate in the pilot and has strong leadership to champion the effort.
- Practice assigns a program manager to the project to facilitate interaction with the UnitedHealthcare and practice redesign project teams.
- Achieve at least Level 1 NCQA PPC-PCMH prior to the initiation enhanced payment.
 - Reach next level NCQA PPC-PCMH at pilot mid-point (actual timing TBD).
 - Perform at high levels on the following NCQA dimensions: access, care coordination, evidence-based care delivery, communication.
- Perform effective care transition management, particularly for complex patients and end to end care coordination of inpatient events back to ambulatory care.
- Actively participate in a practice transformation program.
- Willingness to share key performance data and participate in performance feedback (data sharing).
 - Support and participate in program measurement.
 - May involve collection of high prevalence clinical measures and satisfaction data.

FEE FOR SERVICE

+

PMPM FEE

+

PERFORMANCE
BONUS

=

TOTAL REIMBURSEMENT

Total Reimbursement builds on the current Fee for Service (FFS) with a PMPM Fee and a bonus option based on practice performance.

- Physicians remain on current contracted fee schedules and continue to be reimbursed based on actual services provided
- Quarterly, prospective PMPM supplement based upon quality, efficiency, and satisfaction improvements anticipated under the PCMH Model – contract addendum required
- PCMH is grounded in providing more comprehensive, coordinated care and reducing the delivery of services in suboptimal settings; it is not about delivering less care to the patient (not capitation).
- Pilot practices will be eligible for a quarterly performance bonus that aligns with clearly defined clinical quality and operational measures that will be developed collaboratively with the pilot practices.

- **UnitedHealthcare’s savings model** assumes increased access, improved care coordination, and a patient-centric approach to ensure the right care, from the right provider, at the right time.
- The **increased primary care reimbursement** is generated from an anticipated reduction in avoidable and duplicative services and clinical practice in accordance with the evidence.
- **Six primary benefit levers** for utilization and medical/ pharmacy cost spend are expected to be impacted by the transformed, comprehensive primary care practice.

	Avoidable Inpatient Utilization	Avoidable Outpatient ER Utilization	Sub-optimal Network Utilization	Sub-optimal Pharmacy Spend	Inappropriate Radiology Utilization	Chronic Care Patient Resource Use
Target Reduction	10%	15%	25%	3%	2.5%	2%
Gross Savings Contribution	50%	15%	5%	10%	5%	15%



Organize the delivery of care for all patients with sub-specialists, disease management and community resources and other care venues (Emergency Room, Hospital, Skilled Nursing Facility)

Use **evidence-based medicine** and clinical decision support tools

Coordinate care in **partnership** with patients and families

Provide enhanced and convenient **access** to care

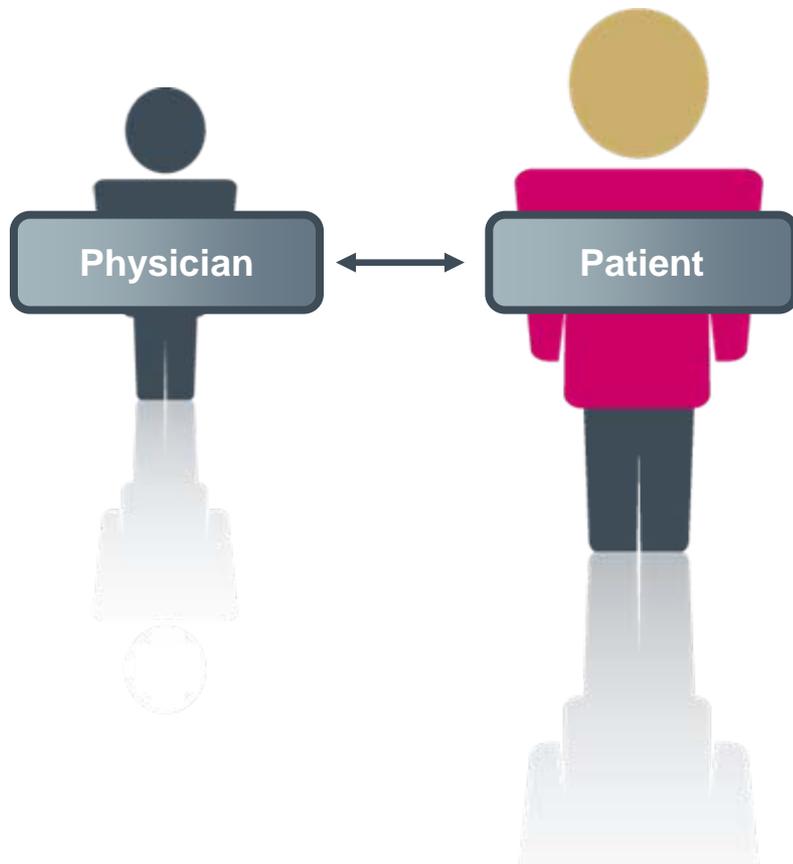
Implement **non face-to-face care** processes

Identify and measure key quality indicators

Use **health information technology** that supports population management, clinical decision support and health information exchange

Participate in programs that provide **feedback on performance & accept accountability for process improvement and outcomes** (resource utilization, quality and member satisfaction)

Source: Michael S. Barr, MD, MBA, FACP, American College of Physicians, presentation to the THINC Quality & Clinical Committee on November 29, 2007



Actively participate in medical decisions with their physician and other medical home providers

Use the Medical Home as the **primary site of care** for preventive check-ups and sick care

Take ownership of their own health and making good health decisions

- Follow up on care team recommendations
- Take medications as prescribed
- Manage symptoms
- Read educational materials
- Utilize self-management tools
- Engage with disease management programs as appropriate
- Feel empowered to ask about care options



Demonstrate leadership in the need for primary care reform

Support **payment transformation** through contributions to physician payment

Insist on well structured research and **measurement of the value** of the medical home model

Assist in development of employee/patient **engagement and activation** strategies

- Benefit design
- Employee/Member education
- Incentives for behavior changes