

An abstract blue background featuring a 3D puzzle piece in the center-left, surrounded by wavy, glowing lines. The scene is illuminated from the top right, creating a bright glow and casting shadows on a curved surface below.

# Transform Primary Care Practice and Payment

Presented by Kevin L. Piggott, MD, MPH

Sept 29<sup>th</sup>, 2009

# Is Primary Care Needed?

- ↑ supply of primary care,
    - ↓ age-specific and all-cause mortality
    - ↓ Disease specific mortality
      - Cardiac
      - Cancer
      - Stroke
- The top 3 leading causes of adult mortality
- ↓ incidence of low birth rate, neonatal and infant mortality
  - The addition of one primary care physician per 10,000 population could avert as many as ~127,000 deaths
    - the 4<sup>th</sup> leading cause of adult mortality – chronic lower respiratory tract disease caused 122,000 deaths in 2000

Proclivity  
for  
specialist  
care

acute  
care  
model for  
all visits

\$2.4  
trillion

Perverse  
payment  
system

**Underperformance**

**Over and under utilization of services**

**Poorer population health outcomes**

**Too few primary care providers**

# Hamster wheel medicine



“Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stand still... The result of the wheel going faster is not only a reduction in the quality of care but also a reduction in professional satisfaction and an increase in burnout among doctors.”

Morrison & Smith. BMJ 2000; 321: 1541.

# Ready To Cross?

“Americans can have a health care system of the quality they need, want, and deserve... Higher quality cannot be achieved by further stressing current systems of care. The current systems cannot do the job. Trying harder will not work. Changing systems of care will.”

IOM 2001 – *Crossing the Quality Chasm*





## Do we have to?

*“Evidence that the current medical system is not sustainable, particularly in the U.S., has been long available, but powerful players are now taking action. The rise of personal health accounts, technology driven design, and other changes – along with the crisis of workforce cost and recruitment, marked decreases in employer commitment to health care coverage, and looming federal budget pressures – assure that the health system nationally and internationally is changing rapidly, and will continue to do so.”*

Institute for Healthcare Improvement.  
*Healthcare Transformation, 2006*


# What is transformation?

## Transformation Is:

*“A profound change in form, structure, and/or character. It is the emergence from what you were to something radically different. A caterpillar to a butterfly – many things are changing at once in an integrated and systematic manner.”*



Institute for Healthcare Improvement.  
*Healthcare Transformation,*  
2006



# Purpose of a Transformed System

“to continually reduce the burden of illness, injury and disability, to improve the health and functioning of the people of the United States and to control costs.”

Institute of Medicine,  
*Crossing the Quality Chasm, 2001*

The goal is population-wide improved health and a better value/result for the patient, family, and community over time.

Institute for Healthcare Improvement.  
*Healthcare Transformation, 2006*

**S**afe

**T**imely

**E**fficient

**E**ffective

**E**quitable

**P**atient centered



# Infrastructure



# What comes first?

- The Chicken

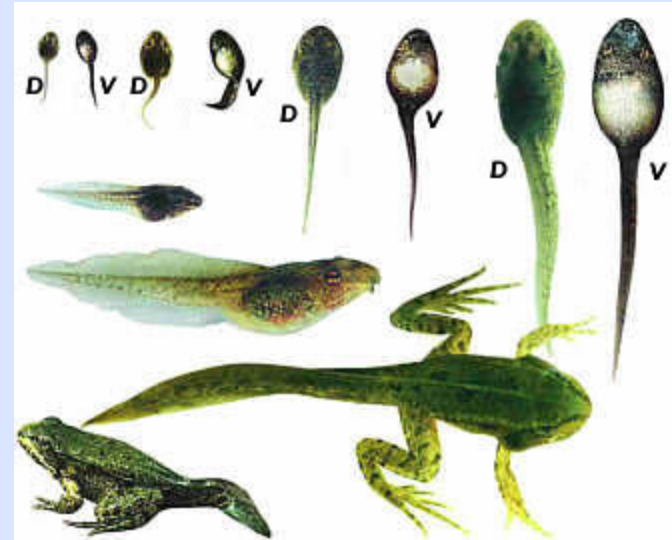
or

- The Egg



# What comes first?

- Practice Transformation  
or



- Payment Reform

# Transform into what?

## PCMH - Joint Principles

1. Personal Physician\* (provider)
2. Physician directed (led) medical practice
3. Whole person orientation
4. Care is coordinated, and/or integrated
5. Quality and Safety are hallmarks
6. Enhanced access
7. Payment reform

\*A personal physician may be of any specialty but, to be considered a Patient-Centered Medical Home, the practice must meet all Patient-Centered Medical Home requirements. It shall be recognized that there may be situations in which a physician is not on-site and the patient's relationship is with a certified nurse practitioner (NP) or physician assistant (PA) who provides the principal or predominant source of care for a patient. In those instances, the NP or PA provider, in collaboration with a physician, may perform the responsibilities of first contact, continuous and comprehensive care if he or she is otherwise qualified by education, training, or experience to perform the selected acts, tasks, or functions necessary where the acts, tasks, or functions fall within the certified nurse practitioner's or the physician assistant's scope of practice.

# How does Traditional Care and PCMH differ?

- **Traditional Model**

- Systems often disrupt the patient provider relationship
- Provider is center stage
- Unnecessary barriers to access by patients
- Care is mostly reactive
- Care is often fragmented
- Paper medical record
- Unpredictable package of services is offered
- Individual patient oriented

- **AAFP's New Model**

- Systems support continuous healing relationships
- Patient is center stage
- Open access by patients
- Care is both responsive and prospective
- Care is integrated
- Electronic health record
- Commitment to providing directly and/or coordinating a defined basket of services
- Individual and community oriented

# How does Traditional Care and PCMH differ?

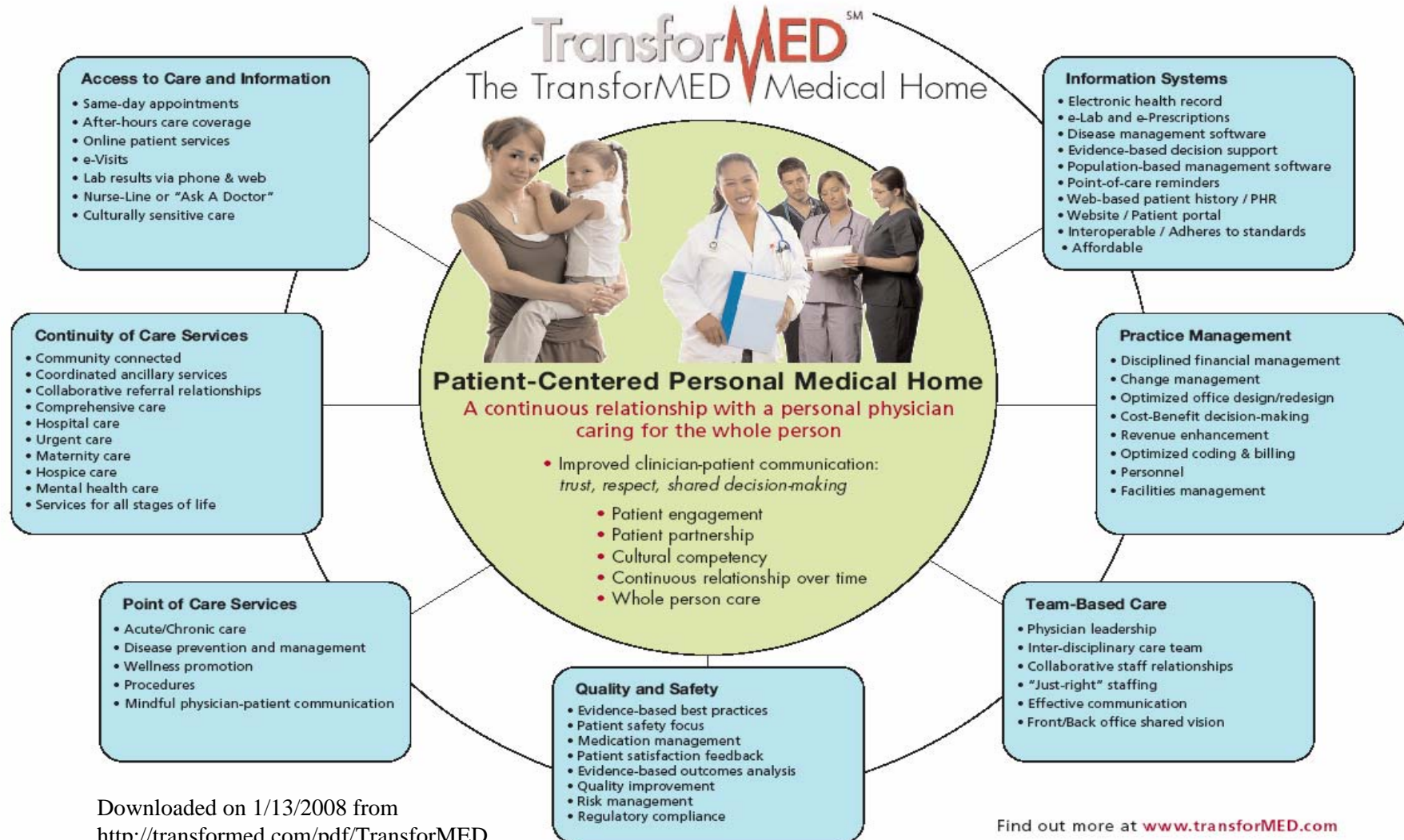
## • Traditional Model

- Communication with practice is synchronous (in person or by telephone)
- Quality and safety of care are assumed
- Provider is the main source of care
- Provider-patient visits
- Consumes knowledge
- Experience based
- Haphazard chronic disease management
- Struggles financially, undercapitalized

## • AAFP's New Model

- Communication with the practice is both synchronous and asynchronous (e-mail, Web portal, voice mail)
- Processes are in place for ongoing measurement and improvement of quality and safety
- Multidisciplinary team is the source of care
- Individual and group visits involving several patients and members of the health care team
- Generates new knowledge through practice-based research
- Evidence based
- Purposeful, organized chronic disease management
- Positive financial margin, adequately capitalized

# AAFP's TransforMED Medical Home





# AAP's Medical Home

- Combines place, process, and people
- Patients and families are known and remembered
- Ideas, customs, and beliefs are respected
- Care is coordinated
- Information is shared across specialties
- Proactive, team approach
- Assists with transitions in care
- Improve health outcomes
- Improve quality of life for patients and families
- Improve the experience of providing care
- Partnering with patients and families results in better care
- Practice-wide improvement
- Connects patients and families to community services
- Offers safe, efficient care

Adapted from material downloaded on 1/13/2008 from <http://www.medicalhomeinfo.org/publications/Downloads/CMHI-ExplainMH-Final01-19-06.pdf>



# ACP's Advanced Medical Home

- “Use evidence-based medicine and clinical decision support tools to guide decision making at the point of care based on patient-specific factors”
- “Organize the delivery of that care according to the Chronic Care Model (CCM) but leverage the core functions of the CCM to provide enhanced care for all patients with or without a chronic condition”
- “Create an integrated, coherent plan for ongoing medical care in partnership with patients and their families”
- “Provide enhanced and convenient access to care not only through face-to-face visits but also via telephone, email, and other modes of communication”

Adapted from material downloaded on 1/13/2008  
from [http://www.acponline.org/hpp/adv\\_med.pdf](http://www.acponline.org/hpp/adv_med.pdf)



# ACP's Advanced Medical Home

- “Identify and measure key quality indicators to demonstrate continuous improvement in health status indicators for individuals and populations treated”
- “Adopt and implement the use of health information technology to promote quality of care, to establish a safe environment in which to receive care, to protect the security of health information, and to promote the provision of health information exchange”
- “Participate in programs that provide feedback and guidance on the overall performance of the practice and its physicians”

Adapted from material downloaded on 1/13/2008  
from [http://www.acponline.org/hpp/adv\\_med.pdf](http://www.acponline.org/hpp/adv_med.pdf)

# NCQA Patient-Centered Medical Home Certification

## PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts	Standard 5: Electronic Prescribing	Pts
A. <b>Has written standards for patient access and patient communication**</b>	4	A. Uses electronic system to write prescriptions	3
B. <b>Uses data to show it meets its standards for patient access and communication**</b>	5	B. Has electronic prescription writer with safety checks	3
	9	C. Has electronic prescription writer with cost checks	2
Standard 2: Patient Tracking and Registry Functions	Pts		8
A. Uses data system for basic patient information (mostly non-clinical data)	2	Standard 6: Test Tracking	Pts
B. Has clinical data system with clinical data in searchable data fields	3	A. <b>Tracks tests and identifies abnormal results systematically**</b>	7
C. Uses the clinical data system	3	B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
D. <b>Uses paper or electronic-based charting tools to organize clinical information**</b>	6		13
E. <b>Uses data to identify important diagnoses and conditions in practice**</b>	4	Standard 7: Referral Tracking	PT
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3	A. <b>Tracks referrals using paper-based or electronic system**</b>	4
	21		4
Standard 3: Care Management	Pts	Standard 8: Performance Reporting and Improvement	Pts
A. <b>Adopts and implements evidence-based guidelines for three conditions **</b>	3	A. <b>Measures clinical and/or service performance by physician or across the practice**</b>	3
B. Generates reminders about preventive services for clinicians	4	B. Survey of patients' care experience	3
C. Uses non-physician staff to manage patient care	3	C. <b>Reports performance across the practice or by physician **</b>	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5	D. Sets goals and takes action to improve performance	3
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5	E. Produces reports using standardized measures	2
	20	F. Transmits reports with standardized measures electronically to external entities	1
Standard 4: Patient Self-Management Support	Pts		15
A. Assesses language preference and other communication barriers	2	Standard 9: Advanced Electronic Communications	Pts
B. <b>Actively supports patient self-management**</b>	4	A. Availability of Interactive Website	1
	6	B. Electronic Patient Identification	2
		C. Electronic Care Management Support	1
			4

**\*\* Must Pass Elements**

# Chronic Care Model

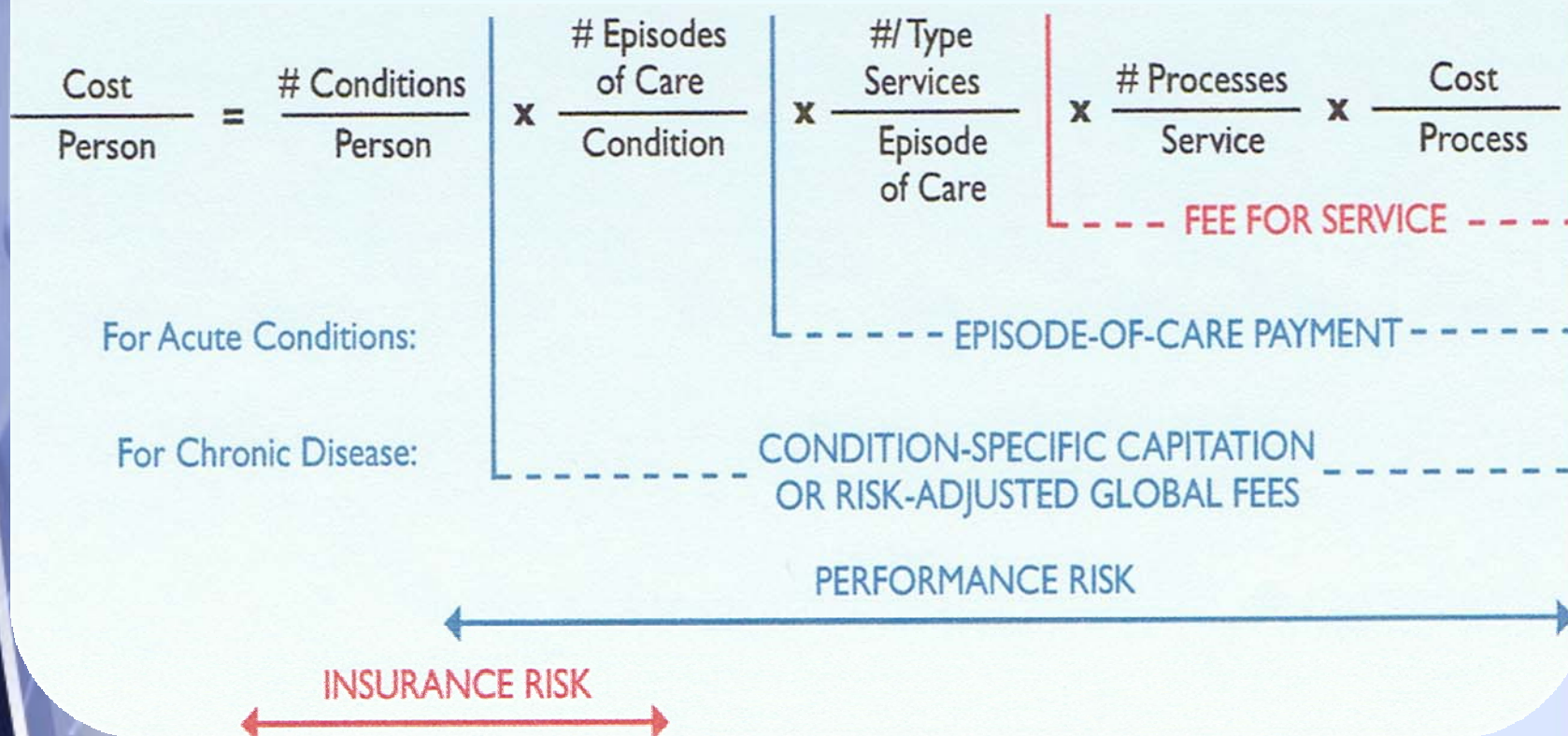




# Payment Reform

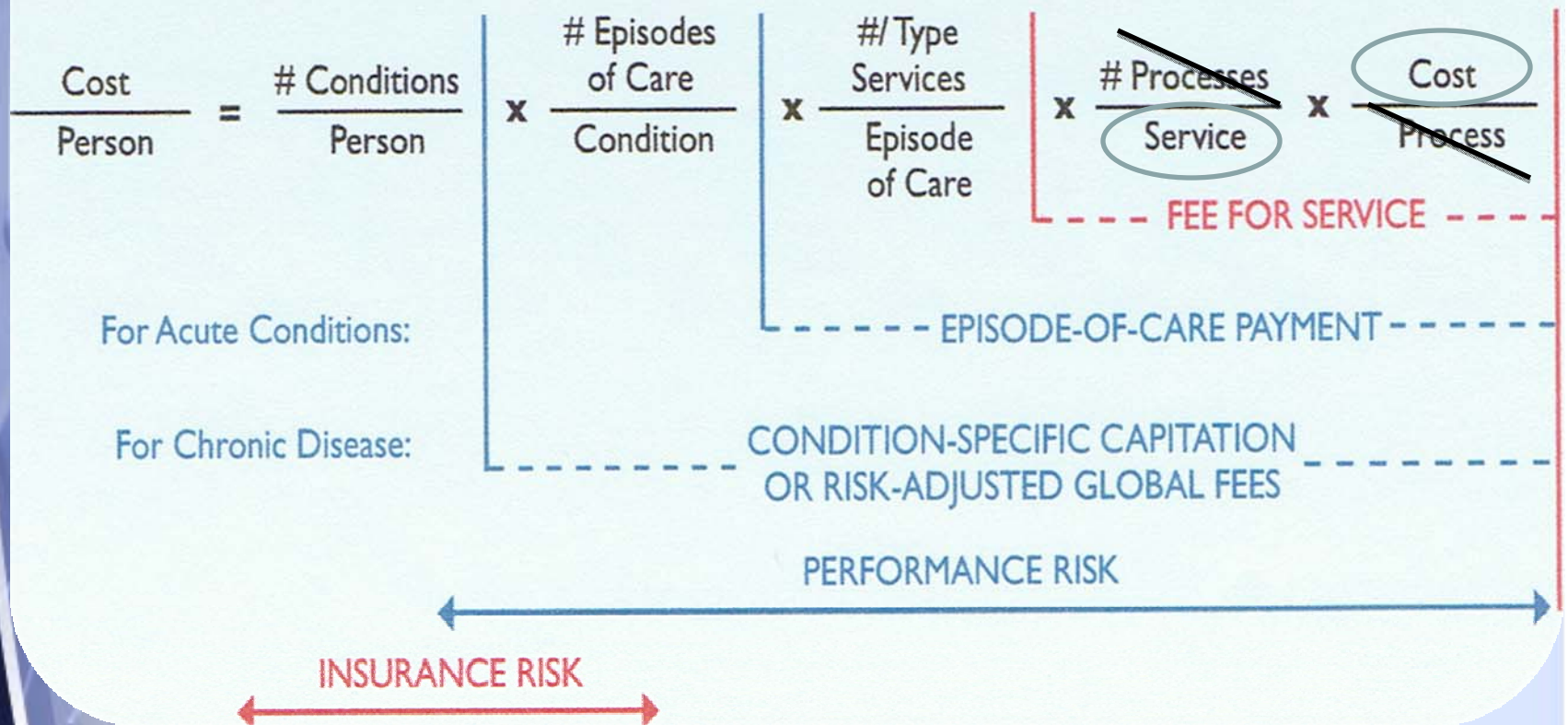
- Currently technical skills (procedures) are reimbursed significantly more than intellect (office visits, care management) and interpersonal skills
- Volume of care is reimbursed by Fee-for-service and not quality/value of care
  - In fact, providing higher quality/value of care can be financially detrimental

# Payment Reform



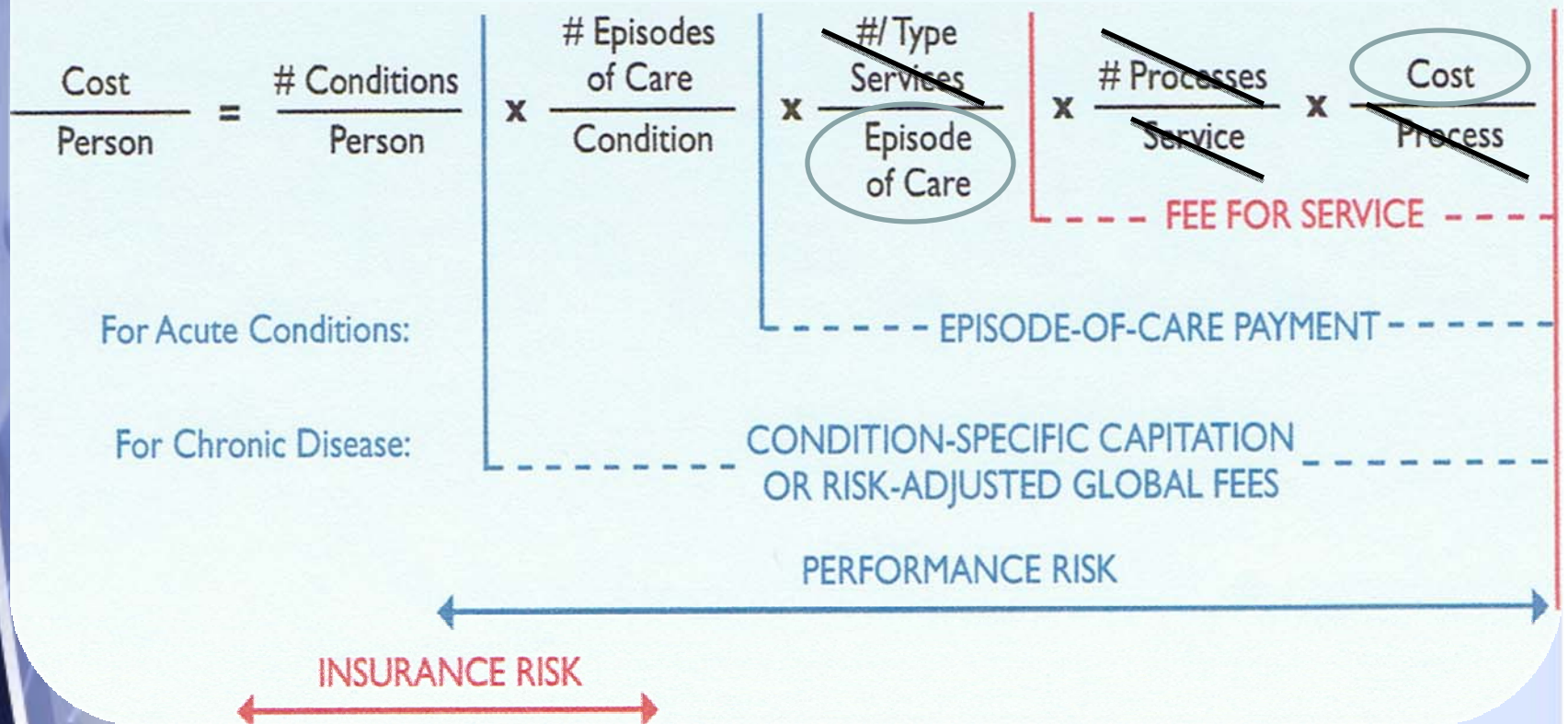
Network for Regional Healthcare Improvement's 2008 Summit on Healthcare Payment Reform by Harold D. Miller, available at [www.nrhi.org/2008summit.html](http://www.nrhi.org/2008summit.html).

# Fee-for-Service



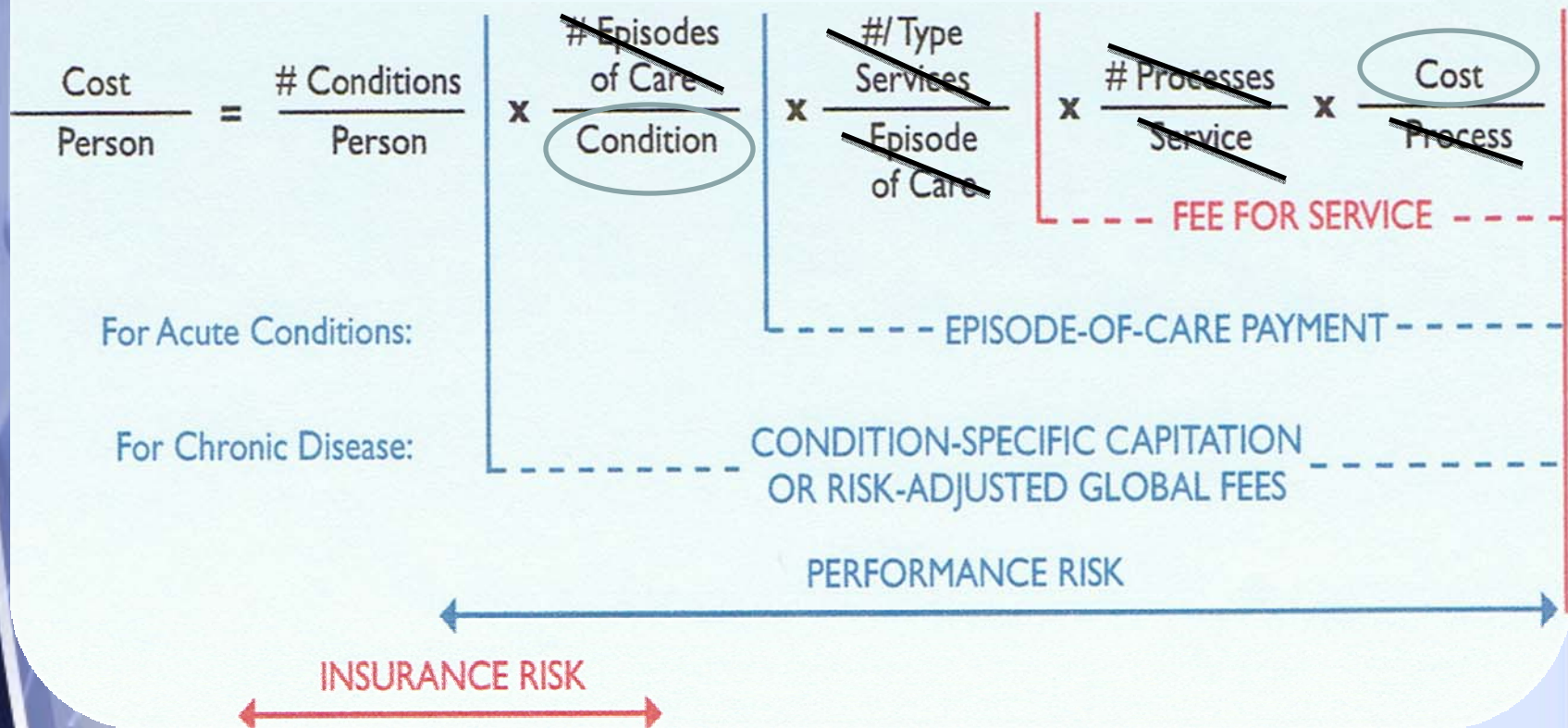
Network for Regional Healthcare Improvement's 2008 Summit on Healthcare Payment Reform by Harold D. Miller, available at [www.nrhi.org/2008summit.html](http://www.nrhi.org/2008summit.html).

# Acute Care



Network for Regional Healthcare Improvement's 2008 Summit on Healthcare Payment Reform by Harold D. Miller, available at [www.nrhi.org/2008summit.html](http://www.nrhi.org/2008summit.html).

# Chronic Care



Network for Regional Healthcare Improvement's 2008  
 Summit on Healthcare Payment Reform by Harold D. Miller, available at  
[www.nrhi.org/2008summit.html](http://www.nrhi.org/2008summit.html).

# Conditions

$$\frac{\#Conditions}{Person} = \frac{Non-preventable\ Conditions}{Person} + \frac{Preventable\ Conditions}{Person}$$



# Recent Literature

- Annals of Family Medicine – May/June 2009
  - Becoming a PCMH requires transformation
  - Technology needed for the PCMH is not “plug and play”
  - Transformation to the PCMH requires personal transformation of providers
  - Change fatigue is a serious concern even within capable and highly motivated practices
  - Transformation to a PCMH is a developmental process
  - Transformation is a local process

Nutting PA, Miller WL, Crabtree BF, et al. Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home. *Annals Fam Med.* 2009;7(3);254-260.



# Policy Recommendations

1. Assure adequate financial resources
2. Tailor the approach to the practice
3. Assist Providers with their personal transformation
4. NCQA should modify its PCMH recognition process

Nutting PA, Miller WL, Crabtree BF, et al. Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home. *Annals Fam Med.* 2009;7(3);254-260.



# Summary

- Hopefully, as we proceed with coordinating practice transformation and payment reform, an attractive practice model will result that improves;
  - The provision of care
  - Improves patient outcomes
  - Improves patient satisfaction
  - Improves provider fulfillment/desirability of the practice and,
  - ? lowers healthcare costs ?