Healthcare Policy & Politics Patient Centered Medical Home

Jerry Friedman, JD

January 15, 2010

President's Health Care Reform Principles

- **Guarantee Choice**
- **Make Health Coverage Affordable**
- **Protect Families Financial Health**
- **Invest in Prevention and Wellness**
- **Provide Portability of Coverage**
- **Aim for Universality**
- **Improve Patient Safety and Quality Care**
- **Maintain Long-Term Fiscal Sustainability**

"At present the United States has the unenviable distinction of being the only great industrial nation without compulsory health insurance."

Irving Fisher, Economist, Yale University
December , 1916

"***Everyone has the right to their own opinion, but not the right to their own facts."***

- Senator Daniel Patrick Moynihan

The Simple Facts on our Health Care "Situation"

- We have no health care "system"
- The current situation is unaffordable for individuals & unsustainable for our nation
- The definition of "vulnerable" has expanded to middle class
- Health care is a business: the business of medicine, and the business of cover
- Negatively impacts our competiveness in a global economy, innovation & individual prosperity

What's The Problem

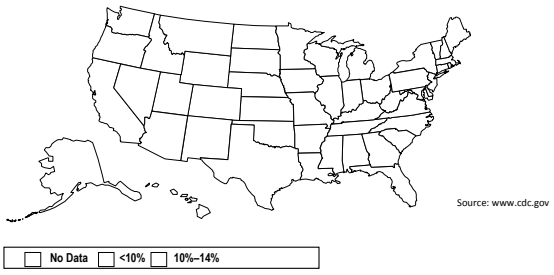
- ✓ Lifestyle & Behavior
- ✓ Coverage & Access
- ✓ Cost & Quality

The Policy Process

- Is there a problem?
- What is it?
- How did we get here?
- Who needs to be at the table?
- How do we fix and sustain it?

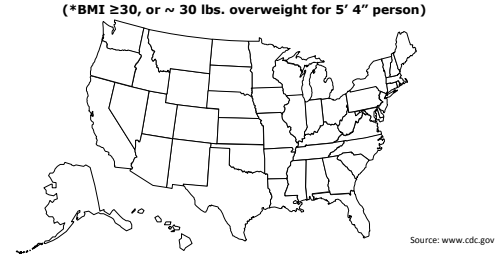
Obesity Trends* Among U.S. Adults BRFSS, 1990

(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

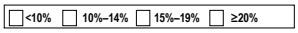


Obesity Trends* Among U.S. Adults BRFSS, 2000

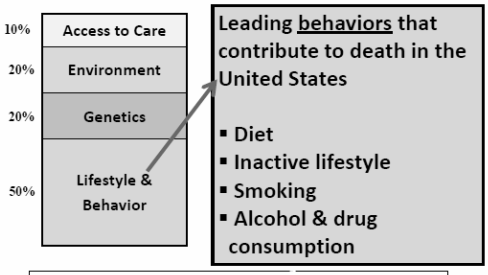
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Source: www.cdc.gov



What influences Americans' health status?

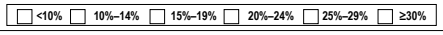


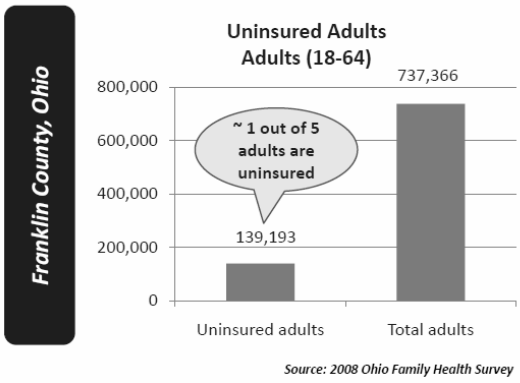
Source: Centers for Disease Control and Prevention, University of California at San Francisco, Institute for the Future
Source: National Center for Health Statistics, 2005

Obesity Trends* Among U.S. Adults BRFSS, 2008

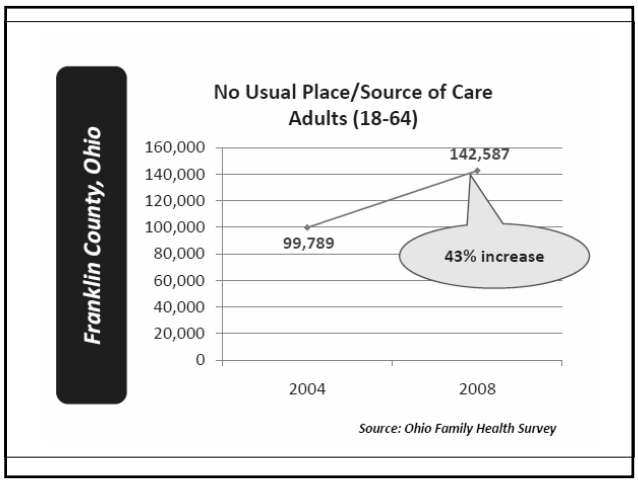
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

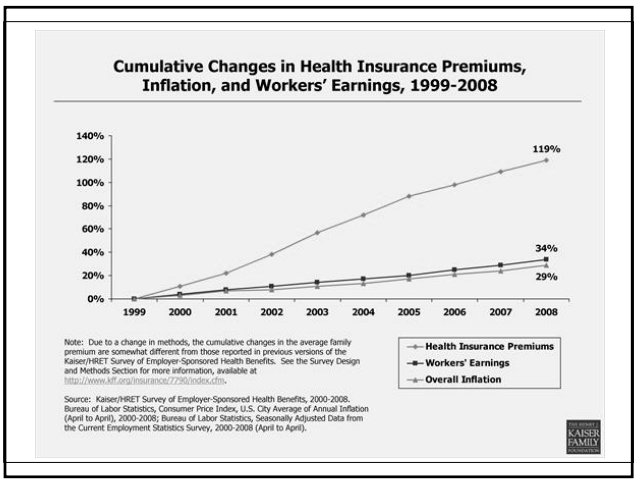
Source: www.cdc.gov





Source: 2008 Ohio Family Health Survey


Franklin County, Ohio
No Usual Place/Source of Care
Adults (18-64)
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
142,587
99,789
43% increase
2004
2008
Source: Ohio Family Health Survey


Cumulative Changes in Health Insurance Premiums, Inflation, and Workers' Earnings, 1999-2008
140%
120%
100%
80%
60%
40%
20%
0%
119%
34%
29%
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
Note: Due to a change in methods, the cumulative changes in the average family premium are somewhat different from those reported in previous versions of the Kaiser/HRET Survey of Employer-Sponsored Health Benefits. See the Survey Design and Methods Section for more information, available at http://www.kff.org/insurance/7790/index.cfm.
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008 (April to April).
Health Insurance Premiums
Workers' Earnings
Overall Inflation

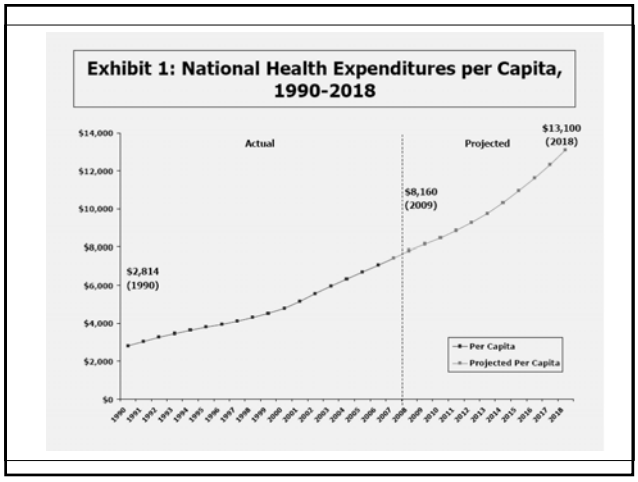
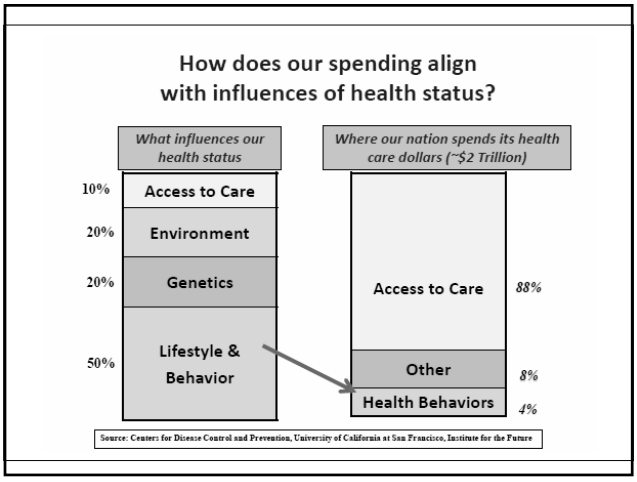


Exhibit 1: National Health Expenditures per Capita, 1990-2018
Actual
Projected
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0
$13,100
(2018)
$8,160
(2009)
$2,814
(1990)
Per Capita
Projected Per Capita


How does our spending align with influences of health status?
What influences our health status
Where our nation spends its health care dollars (~$2 Trillion)
10%
Access to Care
20%
Environment
20%
Genetics
50%
Lifestyle & Behavior
Access to Care
88%
Other
8%
Health Behaviors
4%
Source: Center: for Disease Control and Prevention, University of California at San Francisco, Institute for the Future

What's The Problem?

- Access & Quality
  - ✓ Employer Sponsored Insurance
  - ✓ Insurance biases
    - Sick Care NOT Health Care
    - Don't assume risk - Spread Risk
    - Profit Driven /Cost management

Who Needs To Be At The Table ?

- Purchasers
- Payers
- Providers
- Consumers

What's The Problem?

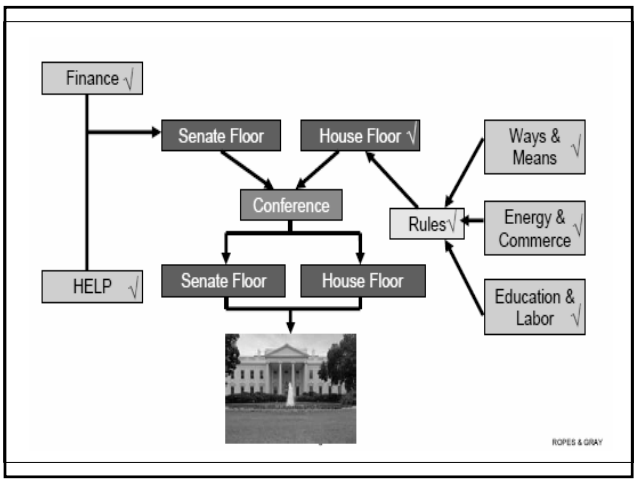
- Access & Quality
  - ✓ Misaligned incentives
    - Volume NOT Value
    - Institutional NOT Community
    - Fragmentation NOT continuity of care

Financing

- Where will the money come from?
  - ✓ Savings
    - Cost containment , including PCMH
    - Comparative effectiveness research
  - ✓ Taxes
    - Wealthy
    - High cost plans & elective services

Current Proposals

House Passed	Senate Passed
• **Improving quality/ health system performance** ✓ **Comparative effectiveness research** ✓ **Primary care incentives** ✓ **Care coordination** • **Prevention/ Wellness**	• **Improving quality/ health system performance** ✓ **Comparative effectiveness research** ✓ **Primary care incentives** ✓ **Care coordination** ✓ **Chronic care PCMH** • **Prevention/ Wellness**



Current Proposals

House Passed	Senate Passed
• **Cost containment** ✓ **Patient Centered Medical Home pilots** ✓ **Reduce payments for hospital readmissions**	• **Cost containment** ✓ **Accountable care organizations** ✓ **Reduce payments for hospital readmissions**

Desired Outcomes

- **More Access**
- **Health care NOT sick care**
- **Evidence based medicine**
- **Reduce fragmentation**
- **Caring not curing**
- **Effective use of workforce**

Outcome

"Skate to where the puck is going to be, not to where it has been."
– Wayne Gretzky

– ***Comparative effectiveness research.***
– ***Prevention and personalized medicine.***
– ***Health disparities research.***
– ***Pharmacogenomics.***
– ***Health research economics"***

- ***Francis Collins, Director,***
- ***National Institutes of Health Science, January, 2010***

"***U.S. expenditures on health care now represent 17% of our Gross Domestic Product, are continuing to grow, and are excessive as a percentage of per capita gross income compared with other developed countries.***

Yet few would argue that the quality of care is what it should be. Reinventing health care is thus an urgent national priority, and NIH can make substantial contributions…

" Americans can be counted on to do the right thing . . . after they have tried everything else."

- Winston Churchill

Resources

- Library of Congress - thomas.loc.gov
- Commonwealth Fund - cmwf.org
- Kaiser Family Foundation – kff.org
- Medicaid/Medicare - cms.hhs.gov
- Assn Am Medical Colleges - aamc.org
- Hospital Association - aha.org

History

- The Patient Centered Medical Home (PCMH) was first described by the American Academy of Pediatrics in 1967
- In 2007 joint principles were agreed to by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association

Patient Centered Medical Home

Randy Wexler, MDMPH, FAAFP

The Function of Primary Care

- First contact access for each new medical need
- Long-term person-focused (not disease-focused) care
- Comprehensive care for the majority of a person's health related needs
- Coordination of care when it must be sought elsewhere

World Organization of National Colleges, Academics and Academic Association of General Practitioner/Family Physicians (WONCA). The role of the general practitioner/family physician in health care systems. Victoria, 1991.

Benefits of Primary Care

- **Associated with an improvement in health outcomes including cancer, heart disease, stroke, infant morality, low birth weight, and life expectancy**
- **An increase of one primary care physician per 10,000 population is associated with an average mortality reduction of 5.3% as well as a reduction in cost**

Macinko J, Starfield B, Leiyu S. Quantifying the health benefits of primary care physician supply in the United States. *International Journal of Health Services* 2007;37(1):111-26.

Benefits of Primary Care

- **States with more primary care physicians per capita had lower per capita cost, and higher quality care. The opposite was seen in states with more specialists per capita.**

Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Affairs. 2004;23:w184-w197.

Benefits of Primary Care

- **Patients with a personal primary care physician (as opposed to a specialist as a personal physician) have 33% lower health costs, and a 19% lower mortality rate even when adjusted for age, sex, ethnicity, insurance status, reported diagnoses, and smoking status**

Franks P, Fiscella K. Primary care physicians and specialists as personal physicians: Health care expenditures and mortality experience. *Journal of Family Practice.* 1998;47:105-109.

Principles

- **Every patient should have a personal physician**
- **Physicians direct and lead the medical practice**
- **Care is coordinated and integrated**
- **Quality and Safety are hallmarks of the PCMH**
- **Enhanced access for patients**
- **Payment reform to reflect the value of primary care services.**

NCQA and the PCMH

- **NCQA is evaluating how to "evolve" the concept of the NCQA Physician Practice Connections Patient Centered Medical Home (PPC®-PCMH™) standards.**
- **The NCQA's current version of the PPC®-PCMH™ is designed to be feasible for use in demonstration projects to better understand relationships between standards and clinical quality.**

NCQA PCMH Essential Elements

- **Care based on continuous relationships.**
- **Customized care based on patients needs and values.**
- **The patients at the source of control.**
- **Shared knowledge and the free flow of information.**
- **Evidence-based decision making.**

NCQA and the PCMH

- **The NCQA has three levels of PCMH achievement:**
  - ✓ **Level 1= 25-49 points (must pass 5 of 10 essential elements)**
  - ✓ **Level 2= 50-74 points (must pass 10 of 10 essential elements)**
  - ✓ **Level 3= 75+ points (must pass 10 of 10 essential elements)**

NCQA PCMH Essential Elements

- **Safety as a system priority.**
- **The need for transparency.**
- **Anticipation of needs.**
- **Continuous decrease in waste.**
- **Cooperation among clinicians.**

NCQA, PCMH and What Gets Measured

- Access and Communication.
- Patient Tracking and Disease Registry Functions.
- Care Management.
- Patient Self-Management Support.
- Electronic Prescribing.

NCQA and the PCMH

- As of April 2009, there were 416 practices with 4,538 physicians who had received NCQA certification of a PCMH.
- Early Spring 2010. Review and draft modifications to PPC®-PCMH™ in conjunction with the NCQA's Committee on Physician Programs.

NCQA, PCMH and What Gets Measured

- Test Tracking.
- Referral Tracking.
- Performance Reporting and Improvement.
- Advanced Electronic Communications.

NCQA and the PCMH

- Late Spring 2010. Public comment period regarding proposed changes.
- 3rd quarter 2010. Comment analysis.
- 4th Quarter 2010. Final recommendations made to the Committee on Physician Programs.
- End year 2010. Approval and preparation for final release January 2011.

Why be a PCMH

- **Improved Patient Outcomes.**
- **More efficient care, not more work.**
- **Transition for sick care to wellness care.**
- **CMS and Private Insurers are evaluating enhanced compensation models for PCMH practices.**

PCMH Resources

- **AAFP**
  - ✓ **http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html**
  - ✓ **http://www.transformed.com/**
- **The Commonwealth Fund**
  - ✓ **http://www.commonwealthfund.org/Publications/View-All.aspx?topic=Patient+Centered+Care**
- **NCQA**
  - ✓ **http://www.ncqa.org/tabid/631/default.aspx**

Evidence of the Benefit of the Patient Centered Medical Home

- **The Group Health Cooperative of Puget Sound found that patients cared for in a PCMH had better HEDIS quality measures and a reduction in hospital admissions**
- **Community Care of North Carolina implemented a PCMH for Medicaid patients and achieved improved quality of care in asthmatics and diabetics, with reduced hospitalizations, reduced cost, and a reduction in Emergency Room use**
- **Geisinger Health System in Pennsylvanian implemented PCMH's in 2007. After two years they found improvements in care for diabetes, coronary artery disease, and prevention**