The Patient Centered Medical Home: Opportunity and Challenges

Randall Curnow, Jr, MD,
MBA, FACP, FACHE, FACPE
Chief Medical Officer
Summit Medical Group

The Patient Centered Medical Home

- Summit's Goal: Value Proposition
- PCMH: Means to an End
- Summit's PCMH model
- Commercial Collaboration
  - Creating/funding program
- Active program:
  - Observations/Challenges
- Summary

Summit Medical Group

- Physician Owned, Physician Board
- 220 Physicians
  - 150 PCPs at 50+ locations (10 counties)
  - 70 hospitalists/pulmonologists
  - Rheumatology and Cardiology
- 4 ancillary centers
- 3 Express Clinics
- EMR/E-prescribe
  - 185,000 e-scripts/month
- Medical Staff with 3 separate hospital systems (9 hospitals)

Summit's Culture/Vision

- Past becomes present:
  - Formed by independent physicians in 1996 in response to "acquisition" boom
- Philosophy:
  - Primary Care Physicians can best represent and meet the needs of PCP physicians and patients
  - Proactively engaging strategies to allow PCPs to control their future

Quality as strategy

- SMG's future will depend our ability to link comprehensive quality care to increased value for patients, purchasers, and physicians.

Quality as strategy

- With current delivery model, how do we demonstrate and financially support such a value proposition?

PCMH 101- The Big Picture

MEDICAL HOME - ITS TIME IS NOW

1967 – Pediatrics; 2002 - Family Med.; 2006 - Internal Med.

2007 - "Patient Centered Medical Home"

American Academy of Family Medicine

American Academy of Pediatrics

American College of Physicians

American Osteopathic Association

Combined membership 333,000 physicians

2008, Nov - AMA endorsement

Characteristics of a Medical Home

- Personal Physician in a Physician-directed practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety improvements are ongoing
- Enhanced access to visits, phone, or e-mail
- Payments = Enhanced Payments for Coordination, Fee for Service for direct care, Pay for Quality

Goal of Medical Home

- Improve Quality
- Improve Access/ patient satisfaction
- Improve cost and efficiency
- Bolster PCP model
  - Reimbursement
  - Clinical delivery model

Hurdles for PCMH Model

1. No direct incentives for other providers/systems to interact with PCM/PCMH
2. Most PCPS do not have financial arrangements that allow them to share in these savings.
3. Many physicians are wary of more burdens (paperwork)
4. PCPs lack resources for investment

PCMH as Means to an End

- The PCMH model aligned strongly with SMG vision and long term strategy for patient care
- Charged to create plan for PCMH adoption
- Pursue "Macro" and "Micro" systems:
  - Must have both system-wide and site level redesign to achieve success
  - Change management

“Macro” and “Micro” Strategies

- Macro:
  - Standardized systems throughout organization
  - New tools and resources to remove burden from sites
  - Require infrastructure investments
  - Initial Emphasis:
    - Short term Wins
    - Build Buy-in
- Micro Systems:
  - Site/physician level workflow redesign
  - Provide resources for PDSA led redesign
  - More burden on sites/providers
  - Implement in later stages:
    - Fold in with EMR rollout
    - Utilize momentum and built up “buy-in”

SMG's PCMH Adoption Plan

- 2009:
  - Dedicated program to increase awareness among physicians
    - Change Management/urgency
  - NCQA PCMH recognition: pilot sites
  - Initiate discussion with commercial payors about collaborative pilot program
- 2010:
  - NCQA PCMH for all sites/physicians
  - Start commercial PCMH pilot
  - Begin development of "lean teams" for site support

From Theory to Practice

SMG PCMH Delivery Model

SMG's pre-PCMH components

- E-prescribing: 160,000 scripts/month
- EMR (full) adoption: 40% by 2009
  - 100% by late 2011/early 2012
- Single Practice Management System for all 50+ sites
- Patient Access:
  - Express Clinics
  - Same day scheduling
- Clinical Registry
  - Begun 2007
  - Automated mid 2008

PCMH Assumptions

- Must attain physician buy-in
- "More burden, no deal"
- Creating global value proposition:
  - 4 "Ps": patient, physicians, purchasers, payors
- Must define metrics to assess success

“But I already do this…”

- Many physicians already make best effort to provide:
  - Care coordination
  - Whole person orientation
  - Quality and safety
- Emphasis on processes, support and efficiency (not working harder)

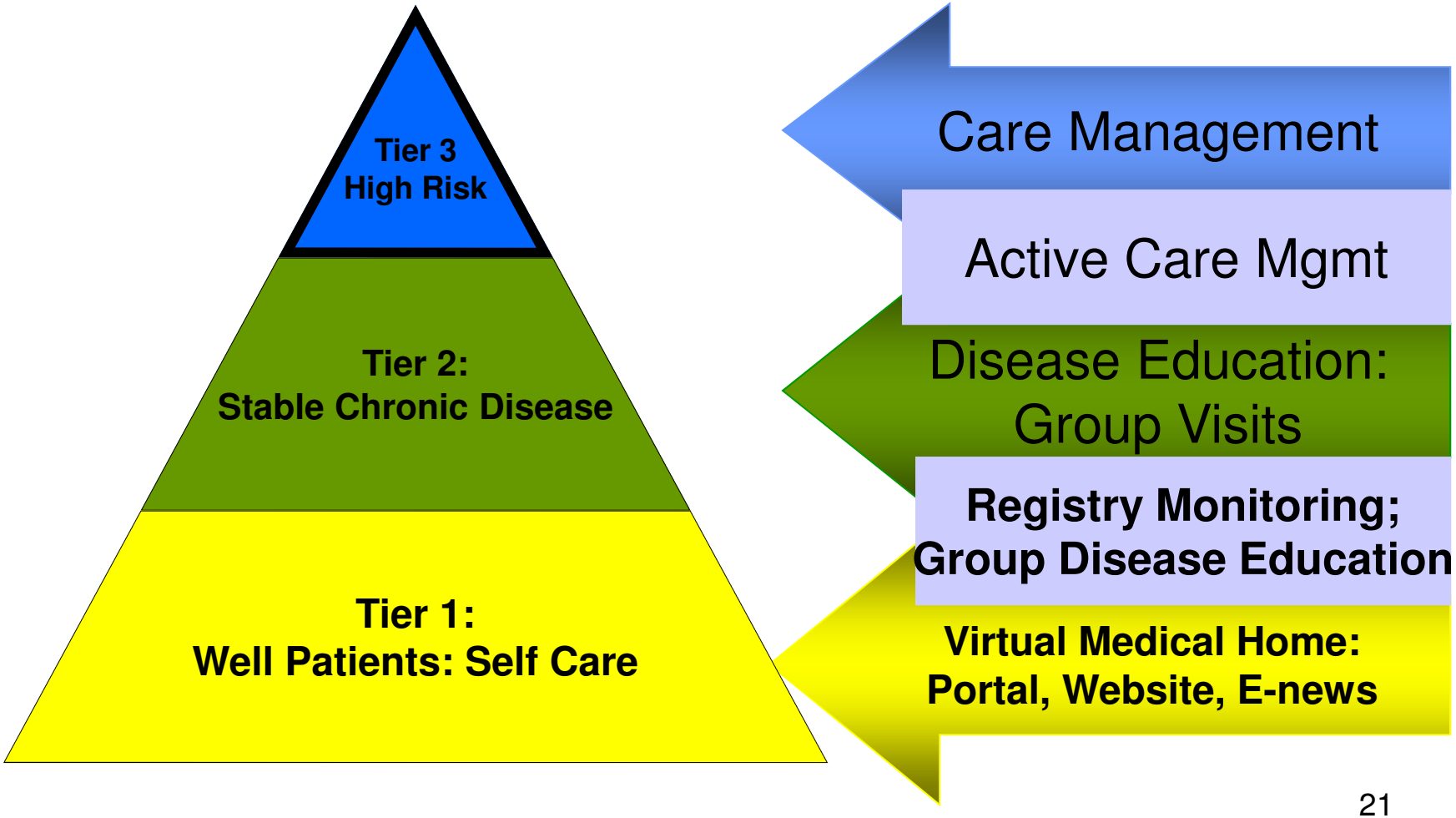
- "[Better] performance is not simply – it is not even mainly – a matter of effort; it is a matter of design"

- Don Berwick
Administrator of CMS

Summit Medical Group's Medical Home Model

- Basic Structure:
  - Care Management Coordination
    - High-risk patients
  - Improved Clinical Registry/Database
  - Reimbursement/Financial Support:
    - FFS +PMPM
    - Staffing support (Care Management)
    - Infrastructure contribution
  - UM framework

SMG's "Tiered" PCMH Model: Overview



What is Care Management?

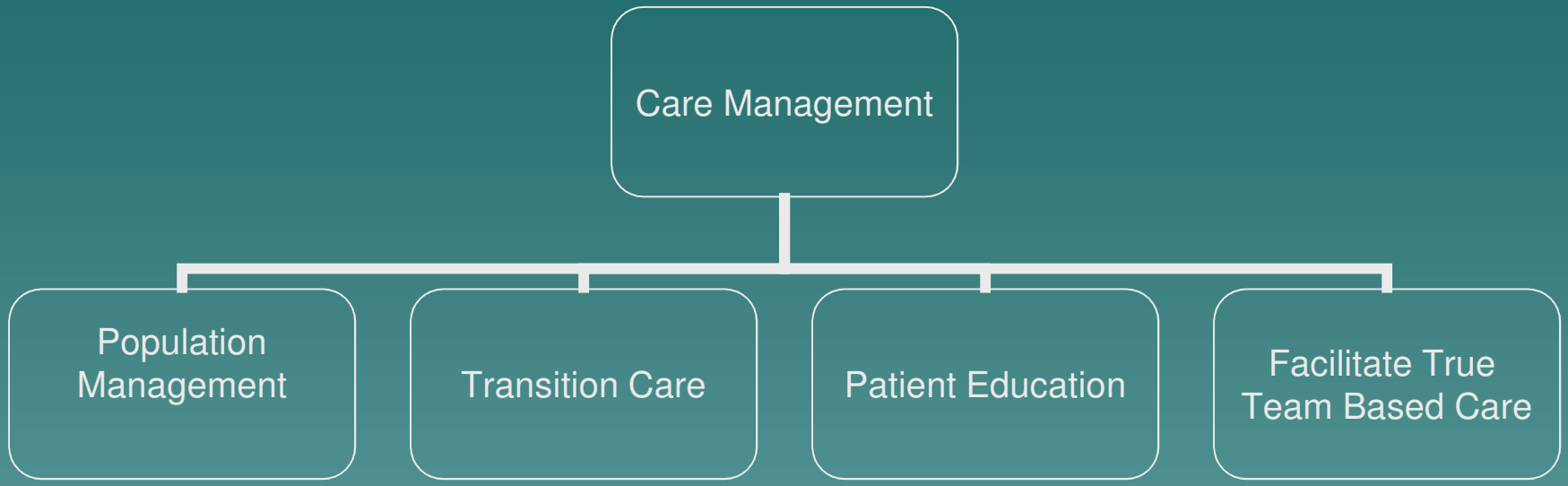
- Oversight and education activities conducted by professionals to help patients with chronic diseases better understand and live with it
- SMG specific:
  - Evidence Based service which augments/supports the physician-patient relationship to engage high risk population with goal of improving patient outcome and satisfaction

Does Care Management Provide Value?

- Components of valuable care management
  - Targeted to high risk patients
  - In person contact b/w patient and CMC
  - Close direction of CMC by PCP
  - Access to timely info on hospital/ER visits
  - RN level staffing of CMC
  - Focus on right things:
    - assessing, care planning ,educating, monitoring, coaching patients on self- management, and teaching patients how to take medications properly

JAMA. 2009;301(6):603-618

What is SMG Care Mgmt?



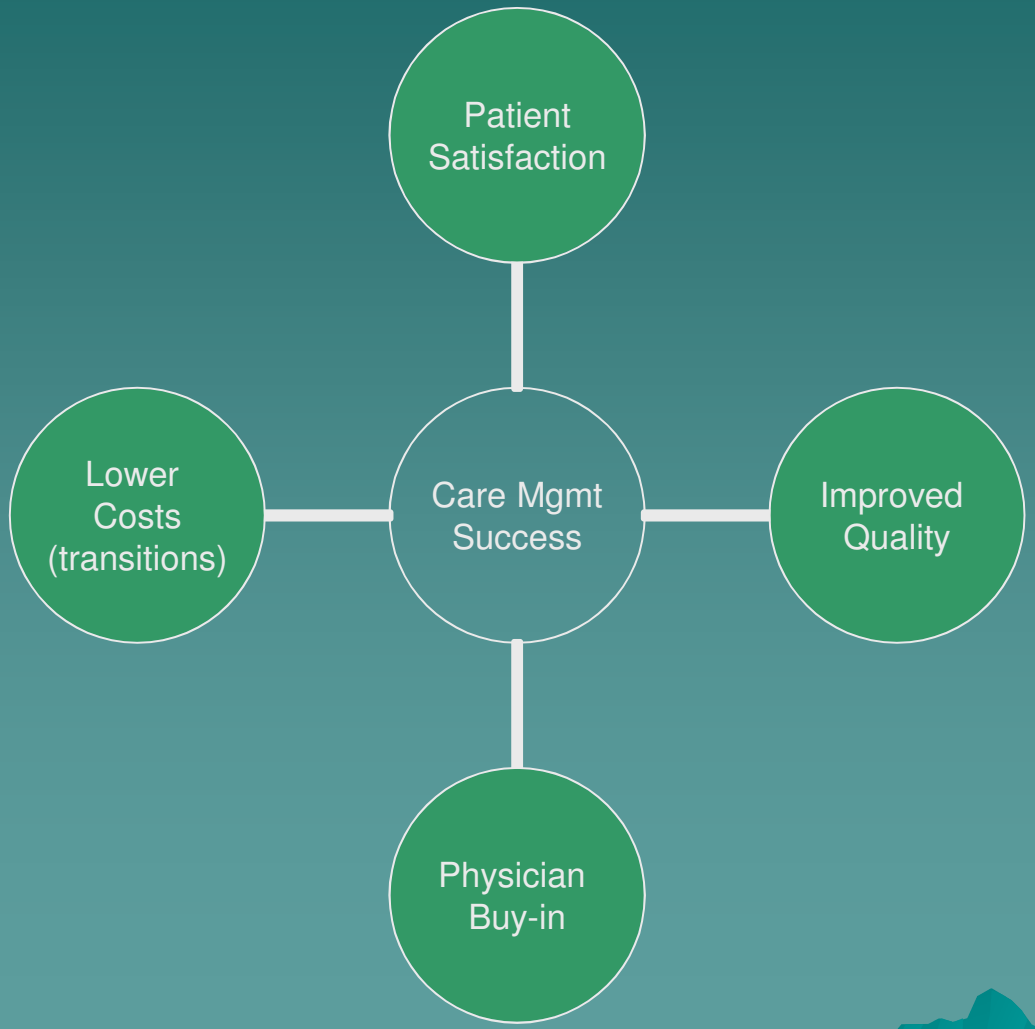
- Engaging Care Gaps
  - SMG Data
  - Hospitals
  - Payors
- Accountability

- Patient Capture
  - Hospital
  - ER
  - SNF
- Patient Engagement
- Reconciliation
- Coordination

- Self-care
- Behavior Δ
- Psychological support
- Patient participation

- Facilitate access-
  - PCP, specialist, ancillary
- Family support contact
- Ability to engage "multiple silos"
- Efficient information and communication b/w sites

How do we define success?



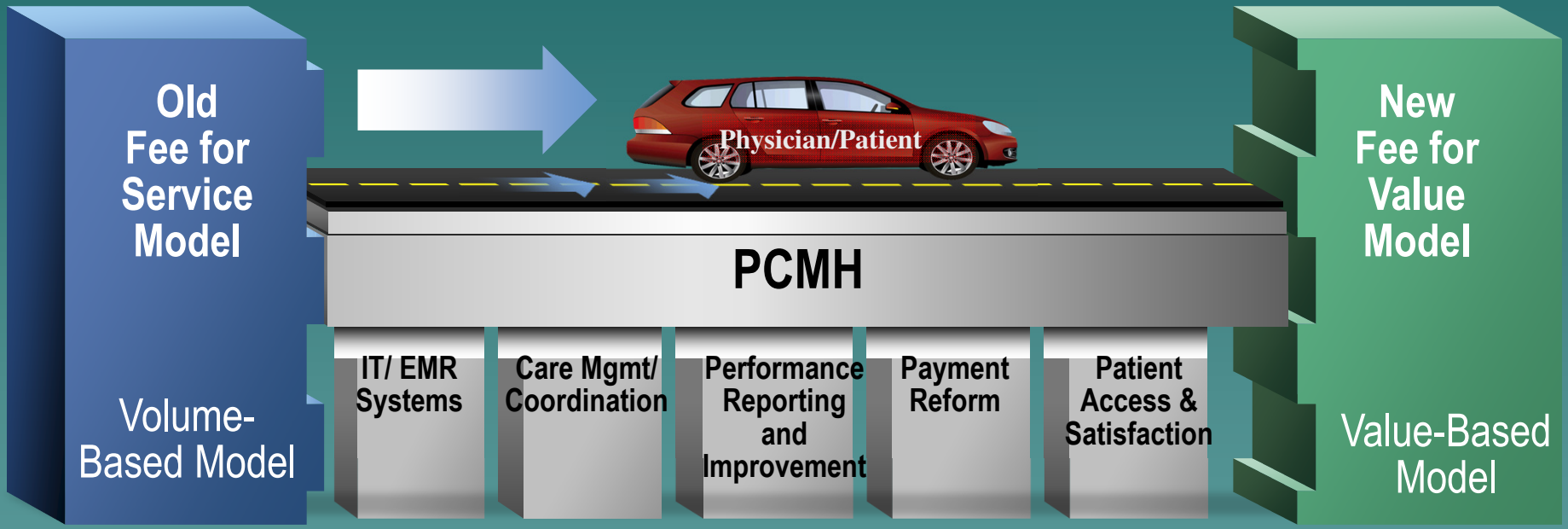
The Clinical Registry Reporting Gap

- Problem:
  - Evidence that patients get only 50% of recommended care (preventative, chronic, acute) N Engl J Med 2003;348:2635-45.
  - Cannot identify "lost opportunities"
  - Cannot efficiently report "opportunities" to sites in actionable manner

The Clinical Registry Reporting Gap: Solution

- SMG Clinical Registry
  - Integrates current databases
  - Identifies "lost opportunities"
  - Individual physician "dashboards"
- Getting the right data to those who need it when they need it
  - Patients and physicians
- Physicians "owning" quality/transparency

PCMH:
Bridge from Volume to Value



Tennessee's first NCQA Medical Home

- In December 2009, SMG became first group in TN to receive any level of NCQA PCMH recognition (Level 1):

SMG's PCMH

- In less than 1 year,
  - First recognized PCMH TN
  - One of largest NCQA PCMH groups in US
  - Initiated largest TN Payor pilot program

Engaging Commercial Payors

Collaborative Approach to Formation PCMH Pilot

Collaboration with Payors

- "One size does not fit all"
  - Tailoring pilot to SMG's philosophy
- Stick with Evidence-Based Approaches
- Must establish payor financial support (esp. Macro system) and transition from fee for service
- Recognize need for mutual value proposition (true collaboration)

SMG-Payor Pilot Summary

- Eligible patients with chronic disease
  - DM, CAD, COPD, Asthma, HTN
- 4 Pilot sites
  - 23 physicians; 1500 eligible patients
- PMPM $:
  - all eligible for 3 months
  - Only enrolled patients at 4th month
- Financial support:
  - Staff: Care Manager
  - Infrastructure: End-User Registry, Patient Portal

PCMH PILOT AT SITE LEVEL: GOALS

- Provide physician support with care management resources
  - Physicians directed/patient centered
- Test models/processes
  - Active Enrollment
  - Reimbursement (PMPM/Stipends)
- Identify strengths and weakness of process to enhance success when expanding throughout SMG
  - Feedback: Sites, patients, physicians

SMG/Payor PCMH PILOT: PHASE I UPDATE

- Patient Population
  - 1500 eligible; 340 enrolled
- Care Management- up and running
- Reimbursement: successful and on track
- Challenges:
  - Eligibility/enrollment

SMG's PCMH Experience: Looking Back

- Know:
  - Why do you want to pursue PCMH?
  - What does *you* mean by PCMH?
- Embrace Change Management:
  - Communicate Urgency
  - Short-term wins
  - Garner Buy-in
  - Recommend: Leading Change (Kotter)
- Commercial Payor Pilots;
  - Must make sense for both parties
  - Must get infrastructure support and evolve payment model
  - Active enrollment can be challenging

SMG and PCMH: Future

- Assessing outcomes: cost and quality
- Expand breadth and width:
  - More sites (Care Mgmt for all high risk)
  - $PMPM for all patients (tiered)
- Alignment with ACO
- "Lean" workflow redesign at site level

Summary

- PCMH is viable model for transforming primary care from fee for service to fee for value
- Payors are increasingly receptive to supporting the general model
- The Medical Home is a means to an end… the "ends" are quality and value

Questions/Comments