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

Marianna Kong, MD
Physician Practice Transformation Specialist
Center for Excellence in Primary Care
University of California, San Francisco

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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.
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
We Should Be Doing Much Better

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

Rank of 13 industrialized nations

- Low birth weight % (U.S. in Red)
- Infant mortality
- Years of potential life lost
- Age adjusted mortality
- Life expectancy @ 1 yr
- Life expectancy @ 40 yrs
- Life expectancy @ 65 yrs
- Life expectancy @ 80 yrs
- Average for all indicators

Poorest to Best
“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
Primary Care
“4C” Functional Definition

Dr. Barbara Starfield

• first Contact
• Comprehensiveness
• Continuity
• Coordination
“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.”
EXHIBIT 8
Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000

Quality rank

1

26

51

General practitioners per 10,000

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
EXHIBIT 9
Relationship Between Provider Workforce and Medicare Spending: General Practitioners Per 10,000 and Spending Per Beneficiary in 2000

Spending per beneficiary (dollars)

8,000

7,000

6,000

5,000

4,000

1 2 3 4 5

General practitioners per 10,000

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

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  

• PCP with panel of 2500 average patients will spend 10.6 hours per day doing recommended chronic care  
Results of Imbalance

Poor access for patients

Clinician burnout

Inconsistent quality

Lack of time to build relationships with patients

PRIMARY CARE TRANSFORMATION

Patient-Centered Medical Homes and High Performing Primary Care
Brief History of the PCMH

1960s
- AAP "Medical Home" Records

1990s
- AAP Medical Home Provider Policy

2000s
- AAFP Future of Family Medicine
- PCPCC
- Joint Principles of PCMH

2010s
- NCQA-PCMH
- PPACA
- CMMI
- ACOs
- Private Payer Initiatives

Future
- Direct Primary Care
- CPCII
- Advanced Primary Care
- Ten Building Blocks
PCMH Defined - AHRQ

Comprehensive

Patient-centered

Coordinated

Accessible

Quality & Safety

Source: Agency for Healthcare and Research Quality
Standards and Incentives

State standards
Organizational standards
Joint Commission
NCQA
AAAHC
URAC
Meaningful Use
Evidence-based standards
Payer standards

Standards and Incentives
### PCMH 2011 Content and Scoring

#### PCMH1: Enhance Access and Continuity

<table>
<thead>
<tr>
<th>Element</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access During Office Hours**</td>
<td>4</td>
</tr>
<tr>
<td>After-Hours Access</td>
<td>4</td>
</tr>
<tr>
<td>Electronic Access</td>
<td>2</td>
</tr>
<tr>
<td>Continuity</td>
<td>2</td>
</tr>
<tr>
<td>Medical Home Responsibilities</td>
<td>2</td>
</tr>
<tr>
<td>Culturally and Linguistically Appropriate Services</td>
<td>2</td>
</tr>
<tr>
<td>Practice Team</td>
<td>2</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

#### PCMH2: Identify and Manage Patient Populations

<table>
<thead>
<tr>
<th>Element</th>
<th>Points</th>
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<tbody>
<tr>
<td>Patient Information</td>
<td>3</td>
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<tr>
<td>Clinical Data</td>
<td>4</td>
</tr>
<tr>
<td>Comprehensive Health Assessment</td>
<td>4</td>
</tr>
<tr>
<td><strong>Use Data for Population Management</strong></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
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</tbody>
</table>

#### PCMH3: Plan and Manage Care

<table>
<thead>
<tr>
<th>Element</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement Evidence-Based Guidelines</td>
<td>4</td>
</tr>
<tr>
<td>Identify High-Risk Patients</td>
<td>3</td>
</tr>
<tr>
<td><strong>Care Management</strong></td>
<td><strong>4</strong></td>
</tr>
<tr>
<td>Manage Medications</td>
<td>3</td>
</tr>
<tr>
<td>Use Electronic Prescribing</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

#### PCMH4: Provide Self-Care Support and Community Resources

<table>
<thead>
<tr>
<th>Element</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Self-Care Process**</td>
<td>6</td>
</tr>
<tr>
<td>Provide Referrals to Community Resources</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
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</tbody>
</table>

#### PCMH5: Track and Coordinate Care

<table>
<thead>
<tr>
<th>Element</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test Tracking and Follow-Up</td>
<td>6</td>
</tr>
<tr>
<td>Referral Tracking and Follow-Up**</td>
<td>6</td>
</tr>
<tr>
<td>Coordinate with Facilities/Care Transitions</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
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</tbody>
</table>

#### PCMH6: Measure and Improve Performance

<table>
<thead>
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<th>Element</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Performance</td>
<td>4</td>
</tr>
<tr>
<td>Measure Patient/Family Experience</td>
<td>4</td>
</tr>
<tr>
<td>Implement Continuously Quality Improvement**</td>
<td>4</td>
</tr>
<tr>
<td>Demonstrate Continuous Quality Improvement**</td>
<td>3</td>
</tr>
<tr>
<td>Report Performance</td>
<td>3</td>
</tr>
<tr>
<td>Report Data Externally</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

**Must Pass Elements**
NCQA-Recognized Practices Across the United States - 2015

11,388 Total Sites Recognized
As of July 2015
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
23 High Performing Practices

Group Health Olympia

Multnomah County Health Dept

Clinica Family Health Services

Clinica Family Health Services

Fairview Rosemont Clinic

Allina

Mayo Red Cedar

ThedaCare

Medical Associates Clinic

Mercy Clinics

Cleveland Clinic-Stonebridge

Harvard Vanguard Medford

BWH, MGH Amb Practi of the Future

North Shore Physicians Group

Newport News Family Practice

La Clinica de la Raza

Sebastopol Community Health

West Los Angeles-VA

South Central Foundation

Univ of Utah-Redstone

Quincy, Office of the Future

Bodenheimer et al, Ann Fam Med 2014:12:166
Sinsky et al, Ann Fam Med 2013:11:272
10 Building Blocks of Primary Care

1. Engaged leadership
2. Data-driven improvement
3. Empanelment
4. Team-based care
5. Patient-team partnership
6. Population management
7. Continuity of care
8. Prompt access to care
9. Comprehensive-ness and Care Coordination
10. Template of the future
3. Empanelment and panel size management

IM实PIMENTATION GUIDE

EMPANELMENT
Establishing Patient-Provider Relationships

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

Updated 3.1.2010

IN THIS ISSUE:

- Change Concepts for Practice Transformation .......... 2
- Empannelment .................................................. 2
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- Related Change Concepts .................................... 5
- Additional Resources: Workbooks, Tools and Media
  SNMHI Empannelment Webinar ............................. 5

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.12 But for many larger practices, especially in the fee-for-service,
4. Team-based care

Share the Care Teams: From Universal Coverage to Universal Care

COMMUNITY-BASED

- Community-Based Care Manager Teams
- IHSS Worker Training
- Care Transitions

COMMUNITY-BASED

- CHRONIC DISEASES
- Self-Management Classes

CLINIC-BASED

- HIGHEST USERS
- Nurse, Health Work
- Complex Care Teams

CLINIC-BASED

- COMPLEX NEEDS
- Provider, MA
- PCP/MA Teams

CLINIC-BASED

- GENERAL POPULATION
- New Work Force

CLINIC-BASED

- New Work Force

Health Coaches

Nurse, social worker, pharmacist, Beh Health, PT, etc

Reengineered role of the medical assistant
Panel Management:
Ensuring that ALL of the patients in our panel get recommended preventive and chronic care
9. Coordination of Care
## Template of the Past

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care physician</th>
<th>Medical assistant 1</th>
<th>RN</th>
<th>Nurse Practitioner</th>
<th>Medical Assistant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Huddle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:10</td>
<td>E-visits and phone visits</td>
<td>Panel management</td>
<td>RN Care management</td>
<td>Acute Patients</td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td>Complex patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>Complex patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Coordinate with hospitalists and specialists</td>
<td>BP coaching clinic</td>
<td>E-visits and phone visits</td>
<td>Panel management</td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>Huddle with RN, NP</td>
<td></td>
<td></td>
<td></td>
<td>Huddle with MD</td>
</tr>
<tr>
<td>10:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

*Courtesy of David Margolius*
INVESTING IN TRANSFORMING 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

#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
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

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.
CMS CMMI PTI

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
### CQC PTI: participating practice groups

#### Provider Organizations

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

• 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
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
Information and resources

Contact us:

Center for Excellence in Primary Care
UCSF Department of Family and Community Medicine
Marianna.kong@ucsf.edu

Visit our website:
http://cepc.ucsf.edu/