Understanding the Patient-Centered Medical Home: A Town Hall Meeting

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Dave Hutchinson, MD
George Schoephoerster, MD
Pat Fontaine, MD
Keith Stelter, MD

The Case for Health Care Reform

- Costs issues
- Quality issues
- Commonly accepted concerns with current system

Cost Issues

- Health Care Costs: 17% of GDP
- St. Cloud Times: Wednesday, Feb. 25
  1. Obama: Health Care, Schools, Environment
  2. Pawlenty: The State of Minnesota's share of spending on health care increasing by 20% annually

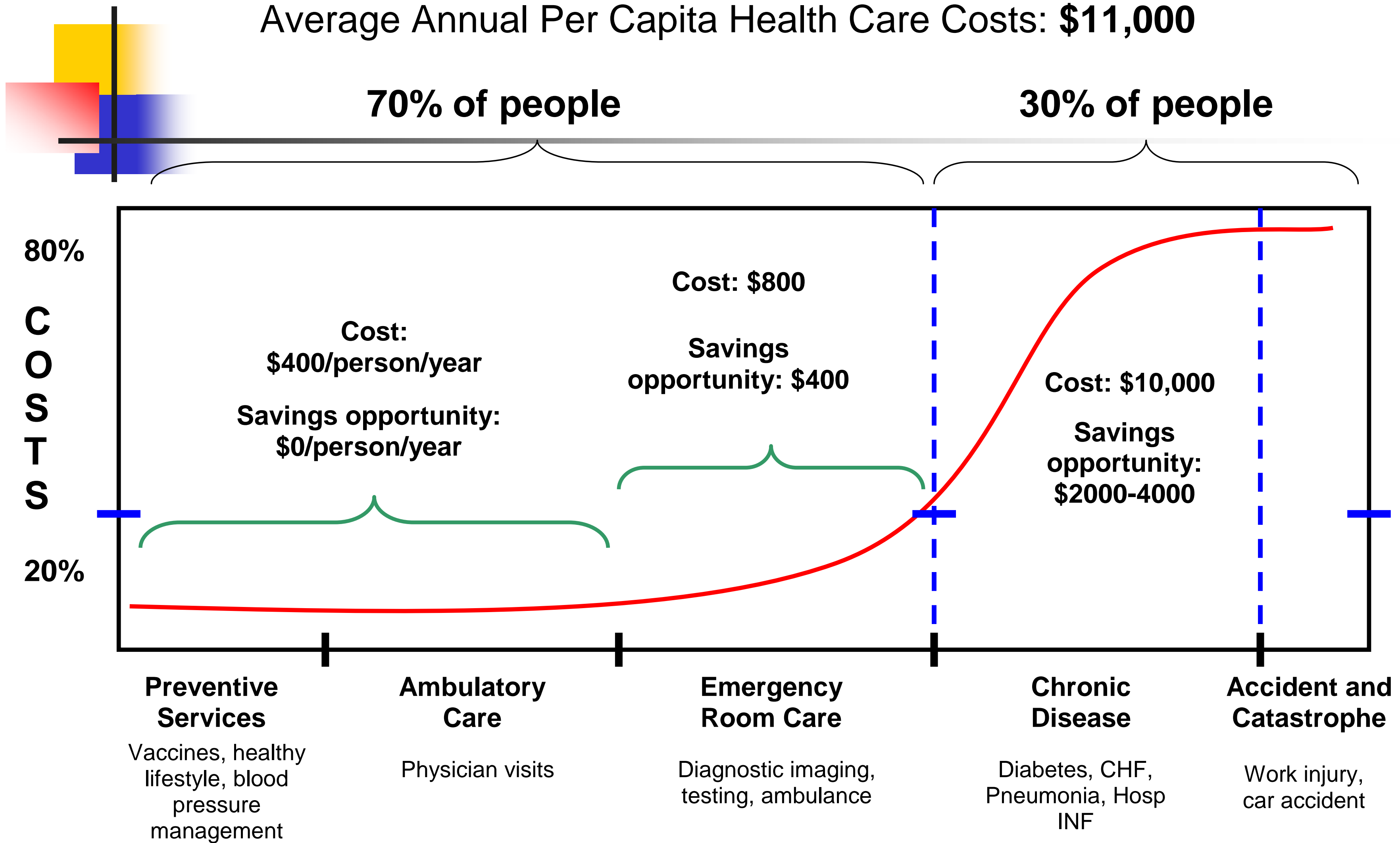
Quality Issues

- Per cent of time that Americans receive effective care: 50%
  - McGlynn et al., New England Journal of Medicine, 2003)

Commonly accepted issues

- Aging population
- Disparities in access and quality
- Fractured health care system
- Chronic disease management: 130 million Americans with at least one chronic disease

Focused Efforts: Concentration of Health Care Costs



What are we trying to fix?

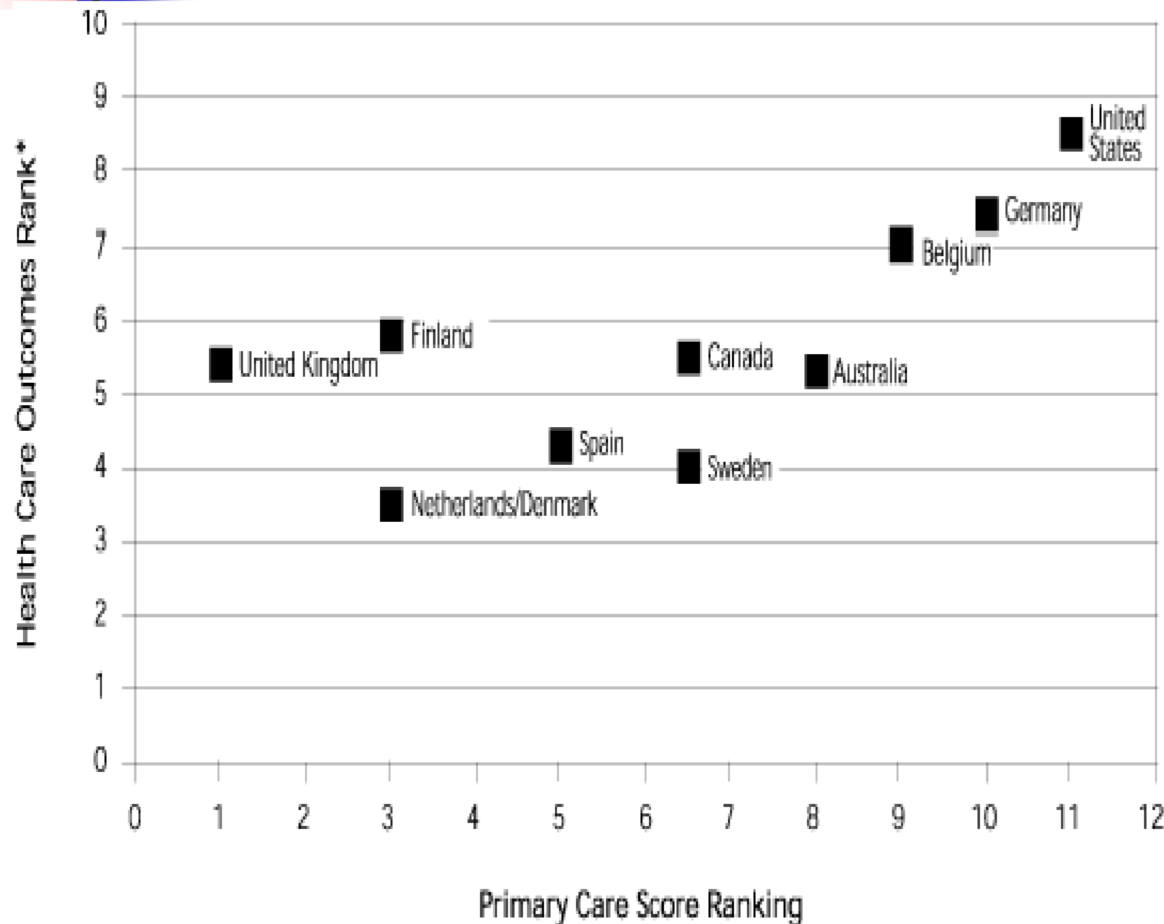
- Fragmented care
- Confused, frustrated patients
- Confused, frustrated providers
- Poor coordination of services
- Poor communication at all levels
- “Silo’s” of delivery of care
- Poor outcomes in many areas
- “Hamster Medicine”

AMA Response:
2008 Interim Meeting—

- Adopt “Joint Principles of Patient-Centered Medical Home”—AAFP, ACP, AAP, AOA on February, 2007
- So why a Medical Home?
  - To better support “primary care”

Evidence supporting a more primary care-based system

(Phillips, AFP, Oct. 15, 2003)



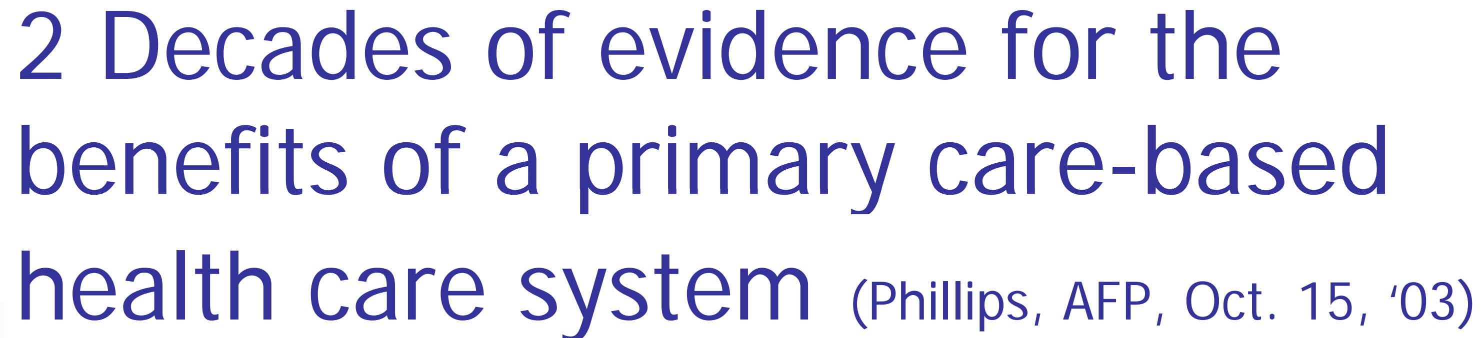
- Based on patient satisfaction, expenditures per person, 14 different health care indicators, and # of medications per person.

Barbara Starfield, MD,
Professor of Health Policy & Management at John Hopkins
(Health Affairs, March 15, 2005)

- In the US, a 20 % increase in the number of primary care physicians is associated with a 5 percent decrease in mortality.
- Adding 1 more FP per 10,000 is associated with 70 fewer deaths per 100,000, a 9 percent reduction in mortality!

Evidence for Continuity of Care and the Role of a Personal Physician

- Effect of Improved Primary Care Access on Quality of Depression Care, Solberg, Annals of Family Medicine, Jan./Feb., 2006, Vol. 4, #1.
- Advanced access needs to enhance continuity of care.



2 Decades of evidence for the benefits of a primary care-based health care system (Phillips, AFP, Oct. 15, ‘03)

- **Evidence of Effectiveness**

  1) Reduced all-cause morbidity and mortality caused by cardiovascular and pulmonary diseases (11)

  2) Less use of emergency departments and hospitals (12,13)

  3) Better preventive care (14,15)

  4) Better detection of breast cancer, and reduced incidence and mortality caused by colon and cervical cancer (16-18)

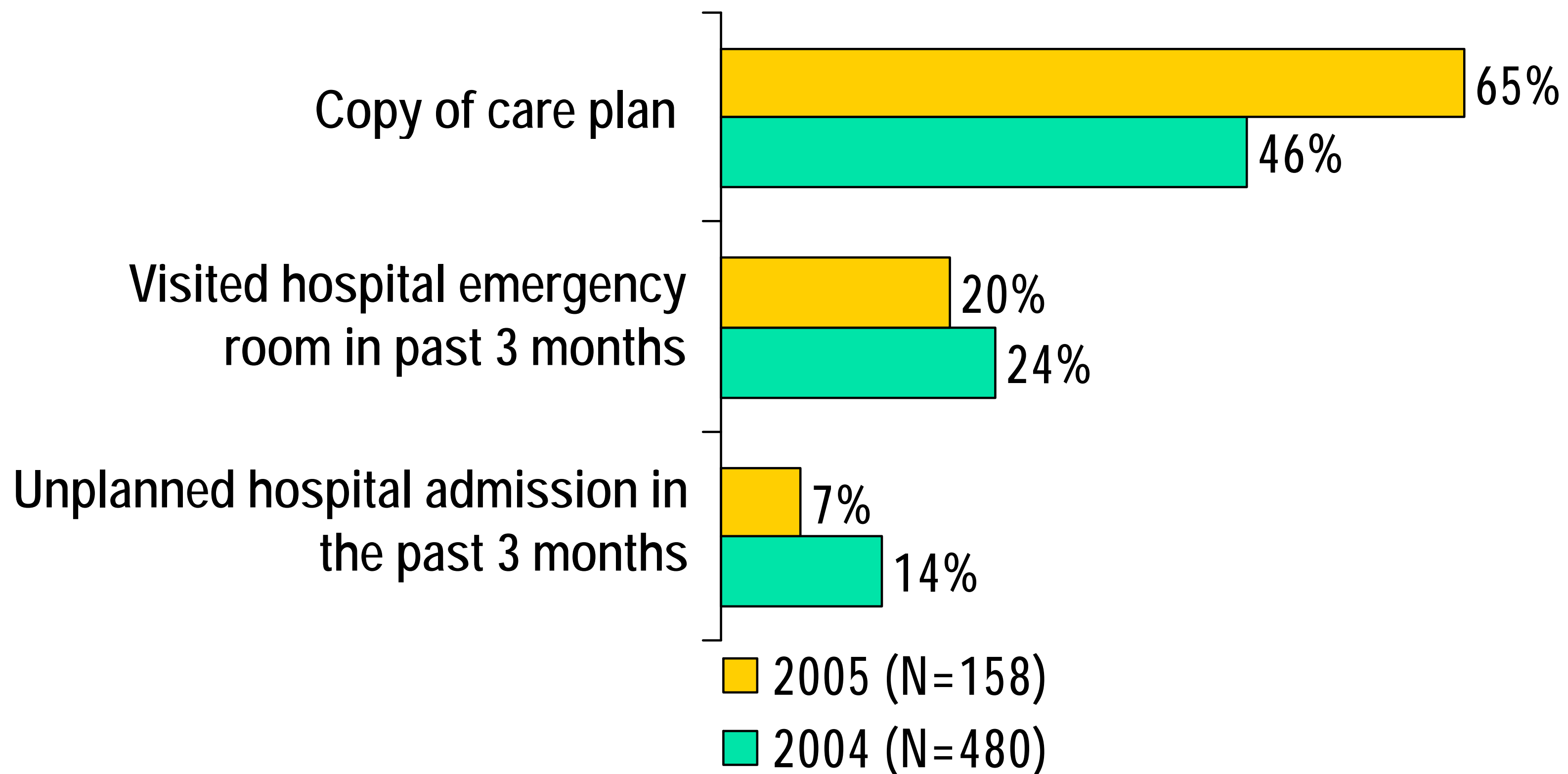
- **Evidence of Efficiency**

  Fewer tests, higher patient satisfaction, less medication use, and lower care-related costs (19,20)

- **Evidence of Equity**

  Reduced health disparities, particularly for areas with the highest income inequality, including improved vision, more complete immunization, better blood pressure control, and better oral health (21-23)

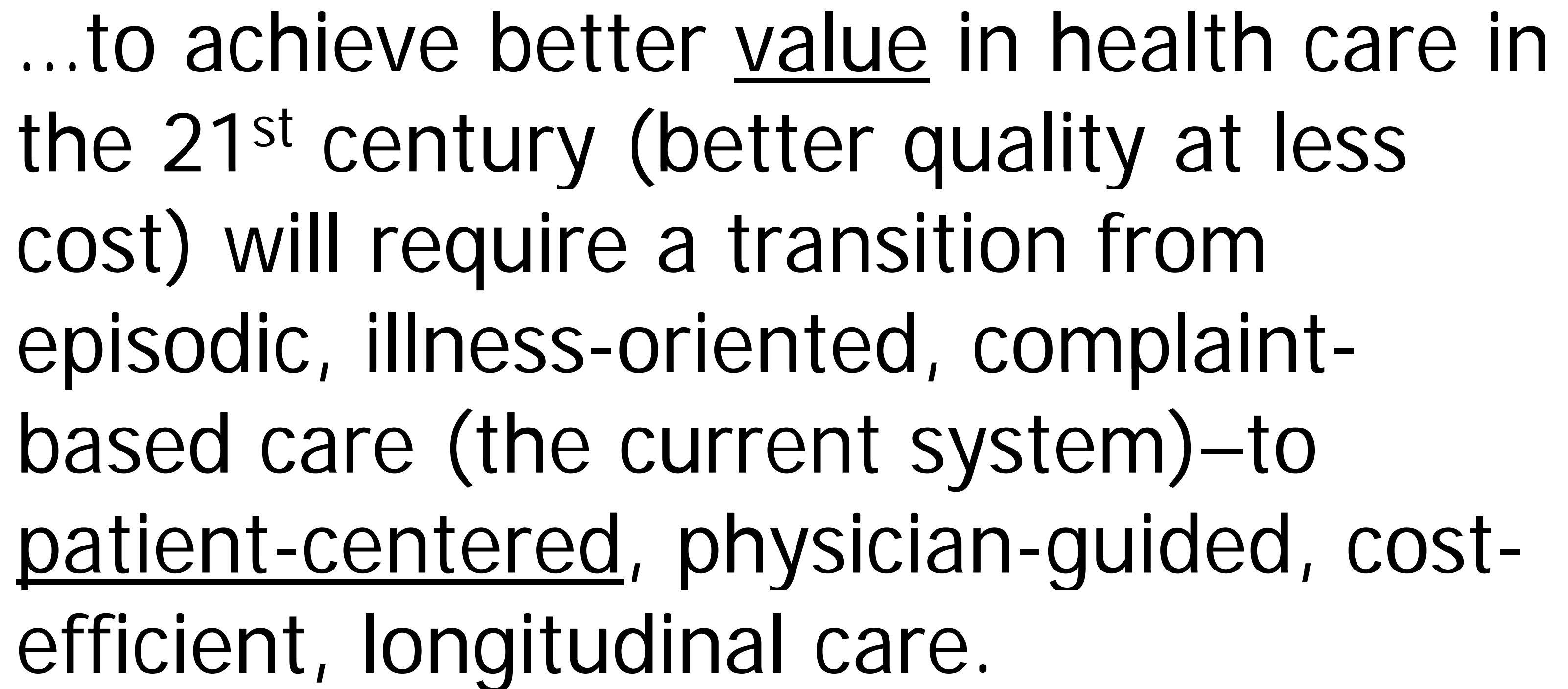
DHS Minnesota Home Collaborative: CentraCare Pediatrics Overall results for 2004-2005



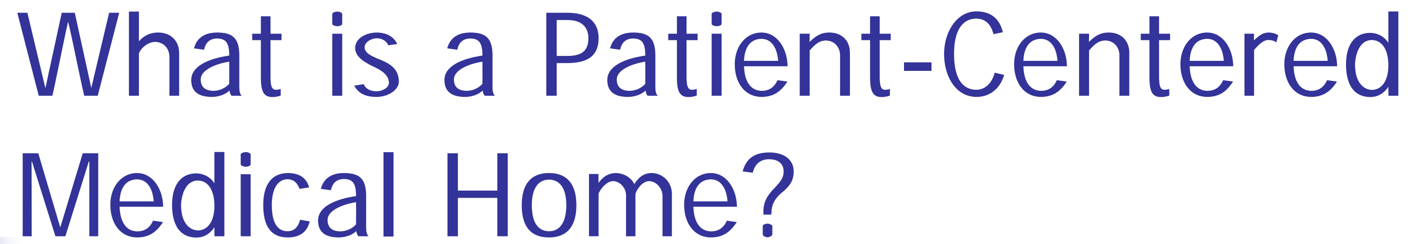
Savings Estimates

- Shift in location of care
  - Savings from elimination of unnecessary emergency department and hospital care
- Savings in intensity of care
  - Reduced use of unnecessary ICU care
- Alteration in use of preference sensitive care
  - Reduced use of unnecessary procedures & technology
- Savings could range from 10-30% of total cost

The Patient-Centered Medical Home Model…



…to achieve better value in health care in the 21st century (better quality at less cost) will require a transition from episodic, illness-oriented, complaint-based care (the current system)–to patient-centered, physician-guided, cost-efficient, longitudinal care.



What is a Patient-Centered Medical Home?

- A Medical Home is not a place or an actual concrete structure, like a house or a building:
  1) It is an approach to the care of patients.
  2) It is the system of support for the physician in providing patient-centered primary care.

Primary Care Physicians

Per Cassell

Doctors who are capable of simultaneously utilizing both the longitudinal knowledge of the patient and their own knowledge of the science of medicine to apply it in the care of that patient

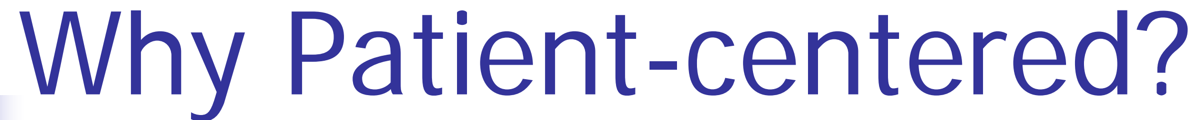
Fundamental principles of Primary Care

- First contact
- Continuity of care—personal physician
- Comprehensive
- Coordination of essential care
- Caring in context (of personal, family and community values—the culture)
- Continuous quality improvement (PFP)

Origins of Medical Home

(A House is not a Home, by Berenson, Health Affairs 27, #5 (2008): 1219-1230)

- Pediatric Medical Homes
- Information technology
- Wagner's Chronic Care Model
- Patient-centered Primary Care



Why Patient-centered?

- Crossing the Quality Chasm—IOM, 2001
- Dartmouth Project, John Wennberg, MD
  - Preference Sensitive Care

Crossing the Quality Chasm (IOM) 6 Aims for System Performance

- Safety
- Effectiveness
- Timeliness
- Efficiency
- Equity
- Patient-centeredness
  - responds to the needs, values, and expressed preferences of the patient

John Wennberg, MD
Dartmouth Project

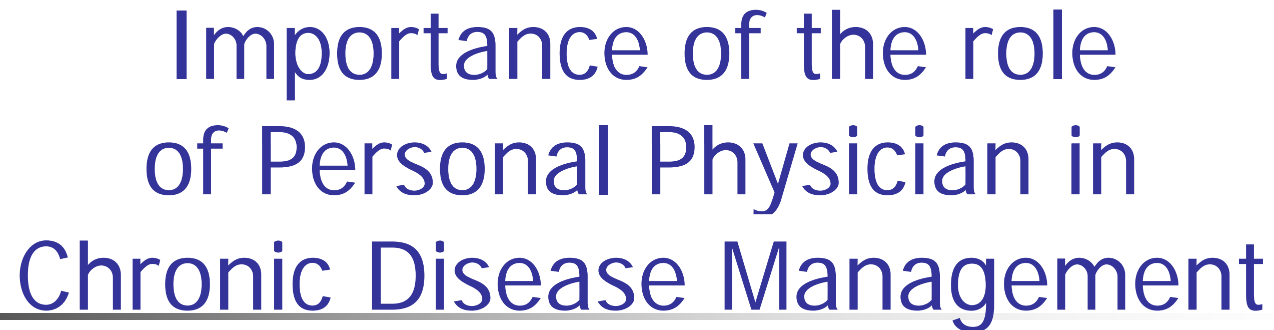
When patients make choices that truly fit their own personal values, the choices are more cost effective for the system & provide greater satisfaction and better results for the patient.

Comprehensiveness is key in the value of Primary Care

- Either provide the entire health care of a patient or facilitate the coordination of certain portions of that care, which includes effectively communicating that patient's health care story
  - (Personal report Starfield, March 21, 2008)

Role of Care Continuity in accomplishing Comprehensiveness

- Assures that all care is:
  - Evidence-based: that it really works
  - Patient-centered: consistent with the patient's values and preferences
  - Makes it of value to the patient: relevant to them and their life
- Instills trust in the patient in the outcome—confirmed by research showing less malpractice claims



Importance of the role of Personal Physician in Chronic Disease Management

- What does the science say works and how does that get accomplished safely? (patient's needs)
- What is important to the patient, so that they can figure out how to put lowering their A1C into the context of their life? (patient's values)
- Then what are the choices, how does the patient prioritize them and eventually eliminate barriers to accomplishing their choices? (patient's preferences)

Medical Homes—what they are not!

- Misconceptions
  - *Primary care "capitation"*
    - Payments are for care coordination
    - No other services/providers to be paid for with fee
    - No financial incentive to withhold care/limit referrals
  - *Primary care "gatekeeper" model*
    - Relationship-focused
    - Coordination of care for complex/chronic patients
    - Thus a care facilitation model

Medical Homes—what they are!

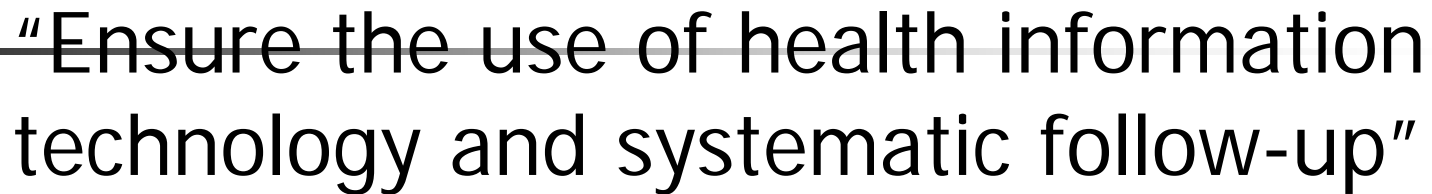
- An opportunity
  - *Eliminates the "hamster medicine model"*
    - Get off that treadmill
    - Get back into relationship with your patients
  - *Provides you the structure and support to make that happen*
    - Relationship-focused
    - Coordination of care for complex/chronic patients
    - Thus a care facilitation model

Minnesota's Health Care Home: Recent Developments

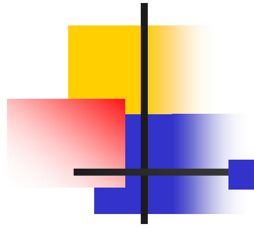
- May 2008 MN HC reform legislation passed
- Dec-July Certification criteria developed
- July 2009 Certification of HCHs begins
- Jan 2010 Payment system completed
- July 2010
  - Payments to providers for public programs and state employees begins
  - Private plans must include HCH in network, pay care coordination fee for enrollees who choose HCH

A MN Certified HCH will

- Focus initially on patients with complex or chronic conditions
- “Emphasize, enhance and encourage the use of primary care” “consistent, ongoing contact”
  - A personal clinician
  - A care coordinator and team
  - Patient and family-centered care plan



- “Ensure the use of health information technology and systematic follow-up”
  - Registries
    - 24/7 access to a basic patient profile
  - Tracking for tests, referrals, discharge summaries
- An electronic record is not mandatory at this time



- Focus on high-quality, efficient and effective health services
  - Provide “scientifically based health care,” i.e. evidence based
- A HCH collaborative will be established and HCHs must participate in QI and best practices
  - Select a QI project: measure, track, analyze
  - Send a representative to the collaborative