

Patient-Centered Medical Homes

- I. Introduce myself
 - a. Presenting on PCMH to give an update in NM.
- II. Methodology
 - a. Basic research on PCMH
 - b. Interviews (see Attachment 1)
- III. What is a Patient-Centered Medical Home?
 - a. Overview (Attachment 2):
 - i. The Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. (NCQA)
 - ii. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. (NCQA)
 - iii. From Section 27-2-12.15 NMSA 1978: primary medical care that is continuous, comprehensive, coordinated, accessible, compassionate and culturally appropriate. Not simply primary care.
 - iv. Case/care Management: links patients with health care, psychosocial support, and other services. The coordination and follow-up of medical treatments is an important role in medical case management. For specialty populations can include specific services. (from SW Care Center)

- v. PCMH is still being evaluated in a variety of settings – from primary care medical offices, to public health offices to settings that involve specialty populations. Assessments of some of these examples show that decreased costs and better quality can be achieved in the PCMH setting.
- b. PCMH is different for every practice. It is essentially what works for the practice to make patient care more coordinated. (Dr. Gordon)
- c. Issues with above statement: accountability and payment. Payers need to have some way to figure out who is a PCMH.
- d. Trend is NCQA recognition (National Committee for Quality Assurance-a private organization) (see Attachment 3).
 - i. Three levels, 1, 2 and 3: Level 1 focuses on basic structures and operations which some practices in NM already have in place; 2 is where the PCMH really starts moving toward increased efficiency and quality
 - ii. Potential issue: NCQA does not allow for providers other than MD to be central provider
- e. Other models
 - i. From Section 27-2-12.15 NMSA 1978: MD, PA, NP, osteopathic physician, osteopathic PA, pharmacist clinician – NM has been a leader in expanded roles, and this may be what we need in NM
 - ii. Specialty/OB-Gyn/HIV/chronic diseases/public health offices where people receiving other services like WIC
 - iii. RN, MA, Community Health Workers could also be involved

IV. How does PPACA promote PCMHs?

- a. PPACA does not mandate PCMH, but is encouraging and facilitating their promotion and development
- b. Summary of Michael Hely's presentation (Attachment 4)
 - i. HHS contracts with Community Health teams to support PCMH
 - ii. Medicaid "health home" demonstration projects for people with chronic conditions or mental illness
 - iii. A CMS center for Medicaid and Medicare innovation which will test payment and delivery models including PCMH
 - iv. HHS grants for training for primary care physicians in PCMH
 - v. Reporting requirements on quality of care for both group and individual health insurance carriers
- c. PPACA is giving the states an opportunity to start to find ways to change and fix our delivery system. PCMH require accountability, quality and efficiency. A start to fix a broken system.

V. Status Report of PCMHs in NM

- a. Hospitals/Provider organizations:
 - i. UNM-54 Level 1 MDs (as of 8/27 on NCQA website, all Level 1 MDs and clinics are at UNM HCS, but interviewees reported that their MDs are Level 1 in other parts of state). Currently has 8 clinics recognized at Level 1 through NCQA. Working to set up patient advisory councils.

- ii. Hidalgo Medical Services- a new project to provide care using community health workers looking at the outcomes of patient health, community health, cost, and economic health.
 - iii. SW Care Center – uses a PCMH model for care of HIV positive patients. Includes case managers, MDs do referrals, and specialty tests and providers that are important to this population. Funding with federal grants and most patients have insurance coverage (covered through NM high risk pool).
 - iv. Sandoval Co. Health Commons with HSD – “virtual” medical home. Had many funding sources, grants. Community health workers were important. Provided services for women and families also receiving social services at the public health office
 - v. Taos-pilot program with multiple funders, integrated electronic medical records. Challenges during the transition: money for start up costs and disruptions to practice with staff training needs.
- b. Health plans
- i. Molina – initially helping to fund NCQA applications. Now smaller steps, funded module program including electronic medical records; Patient Tracking and Registry Functions, Test Tracking, Referral Tracking; e-Prescribing; Access and Communication; and Performance Reporting and Improvement. Where they only had a few takers on initial NCQA project, now have 28 for the modules

- ii. Lovelace Health Plan has start up grants for creating PCMH although not many applicants. Currently they are doing the case management of the patients in the plans.
- iii. Presbyterian Medical Group has one pilot site with internal funding. Rio Bravo Family Health Care Center. Collecting data to look at quality and costs.

VI. Summary

a. Challenges to move towards PCMH

- i. leadership at all levels: practice, community, and state-need visionaries at every level who will create innovative ideas and people willing to fund those innovations
- ii. NM is a rural state. Providers are spread out and have varying capabilities. For example, some practices have electronic medical records while others use paper records. Do different practices need different incentives to make this change?
- iii. Payment is an important issue. Message from almost everyone I spoke with including health plans is that PCMHs may not be sustainable without reimbursement reform. It's possible that if reimbursement reform happens first, the delivery system reform may follow. Reimbursement reform includes reasonable care management fees. One health plan is offering \$4/member/mo. Successful NC model ranges from \$3.50 to \$100/member/mo. which help support the infrastructure needed for sustainable PCMH.

b. Consider ACOs---- may help with limitations of PCMH model (payment issues, administrative structure-doesn't have to be PCP)

- c. There are successful models elsewhere in the country, including NC, VT, OH. Also models done by employers and health care organizations.
- d. Because PPACA does not address cost control, the states will HAVE to do this. One way is to start with more accountable and efficient models of health care delivery and to let the people in the state who have the good ideas give them a try. Additionally, Medicaid can incentivize these changes (example: 5% increase in pay for Level 2 PCMH. Add incentives for practices that can prove improved quality of care)
- e. The costs of healthcare are skyrocketing. If health care delivery and payment systems continue the way things are now, we will run out of money. PCMH is widely viewed as a chance to improve quality and efficiency while lowering costs. Motivated people in the state are working to transform the delivery system and collect information on the outcomes of that change.

Prepared by:
Nancy Eisenberg
University of New Mexico Masters in Public Health
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Attachment 1 – Interviews

Dr. Carolyn Voss, Vice President of Clinical Affairs, University of New Mexico

Dr. Jeannette Velarde, Senior Medical Director, Lovelace Health Plan

Dr. Lowell Gordon, Medicaid Medical Director, New Mexico Human Services Department

Catherine F. Kinney PhD, Kinney Associates LLC

Dr. Richard Madden, Presbyterian Medical Group

Charlie Alfero, CEO, Hidalgo Medical Services

Dr. Dan Derksen, Family and Community Medicine, University of New Mexico, Past President of New Mexico Medical Society

Leora Jaeger, Sandoval County Community Health Alliance

Jeff Thomas, MSW, Executive Director, Southwest Care Center

Dr. Eugene Sun, Chief Medical Officer, Molina Healthcare

Questions asked: What is your organization's history with PCMHs? What is the current status regarding PCMHs in your organization? What are the challenges? Any messages you want me to give to the legislators?

Attachment 2: Main characteristics of a PCMH

1. *Personal physician* – serves as the primary contact and coordinator of care for a patient.
2. *Physician directed medical practice* –personal physician directs the practice team to ensure continuous, comprehensive patient care.
3. *Whole person orientation* – in which the personal physician arranges and oversees care throughout patients’ various stages of life. This includes acute care; chronic care; preventive services and end of life care.
4. *Care is coordinated and/or integrated* – by the personal physician in connection with specialists and across settings facilitated by information technology and other appropriate tools.
5. *Quality and safety* – serve as primary guideposts for all aspects of a patient’s medical care. Evidence based. Patient self-management/decision making.
6. *Enhanced access* – using tools such as open scheduling, extended hours, and various modes of communication between patients and providers.
7. *Payment* – is value driven and reflective of case mix, enhanced technologies, quality improvements, and shared savings achieved by successful patient management. Perhaps higher payments for primary care.

From NCQA, the joint principles, created and supported by the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP) and the American Osteopathic Association (AOA). <http://www.ncqa.org/tabid/631/Default.aspx>

Attachment 3: NCQA PPC-PCMH Content and Scoring for recognition as a PCMH

• Access and Communication	• Patient Self-Management Support	• Performance Reporting and Improvement
• Patient Tracking and Registry Functions	• Electronic Prescribing	• Referral Tracking
• Care Management	• Test Tracking	• Advanced Electronic Communications

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

** Must Pass elements

PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 – 100	10 of 10
Level 2	50 – 74	10 of 10
Level 1	25 – 49	5 of 10

From: NCQA, PPC-Patient-Centered Medical Home, <http://www.ncqa.org/tabid/631/Default.aspx>