Implementing the Patient Centered Medical Home at the University of New Mexico Health System

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1

Framing the Issues

- US Healthcare system is broken
  - Highest cost of care in the world
- Not enough primary care providers
- Reactive care designed to meet acute needs, not time for planned care
- Current system rewards high volume, highly specialized care and inefficient care

"Crossing the Quality Chasm" 2001 report from Institute of Medicine

- Outlined 6 domains of quality in Medical Care
  - Safety
  - Effectiveness
  - Patient-Centeredness
  - Timeliness
  - Efficient
  - Equity
- The current quality measures for the outpatient setting do not include all these domains

3

Continued

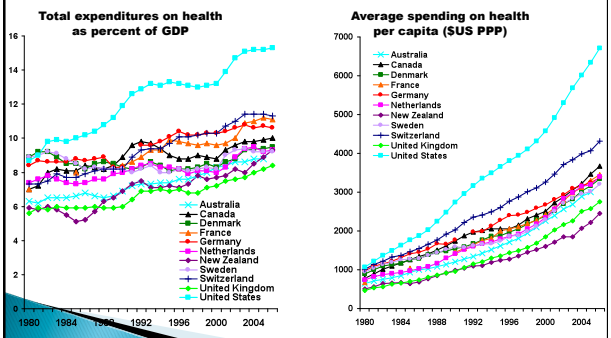
- The majority of outpatient quality measures focus on
  - preventative and chronic disease care and to some extent, timeliness of care and patients centeredness
  - not safety and high-level effectiveness
    - coordination and efficiency of care are not captured in the current measures of out patient quality.
- Clinicians who are evaluated on providing preventative and Chronic Disease management, might focus less on diagnostic accuracy and appropriateness of testing.

4

Current Model Continued

- Half of the Population Has **One or More** Chronic Conditions (i.e., Diabetes, Heart Disease, Depression, Asthma)
- **75%** of Health Care Dollars Spent on Chronic Conditions
- Chronic Conditions Account for **20%** of All Conditions
- **20%** of Conditions – **75%** of Expenditure

International Comparison of Spending on Health, 1980–2006



Data: OECD Health Data 2008 (June 20

Are You Happy With Your Health Care System?

Current Model

- Acute Care Focus
- Poor Access
- Medical Model/Provider Driven
- Not Enough Providers for Demand
- Cost One Trillion Dollars – Most Expensive in the World
- Clinical Outcomes not Proportionate to Expense

Why a Patient Centered Medical Home?

- The patient centered medical home creates a **framework** for change
- The patient centered medical home creates a **common language** for change
- The patient centered medical home creates an **opportunity** for change

What is the PCMH? Key Attributes

- **Care is evidence-based**
  - No unnecessary resource use
  - No missed opportunities for appropriate care
  - Care decisions individualized and personalized--based on patient- specific factors
- **Care is Organized**
  - Delivery of care for chronic disease structured according to the Chronic Care Model
  - Core functions applied to people without chronic illness as well, to provide enhanced care for all
- **Care is Integrated**
  - Every person has a coherent plan for ongoing medical care, developed in partnership with patients and their families

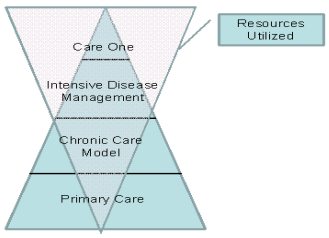
PCMH: A Systematic Review

Ann Internal Medicine 2013; 158:169-178

- **Team-Base Care**
- **The interventions include 2 or more**:
  - **Enhanced access**
    - Internet, telephone, open-access, group visits
  - **Coordinated care**
    - In-&- outpatient
    - Across subspecialties and primary care
    - Care management and referral tracking
  - **Comprehensive**
    - Preventative, acute, chronic disease, Mental health
  - **Systems-based approach to quality and safety**
    - Care planning process; evidence-based/clinical guidelines
    - e-RX, point-of-care resources, test tracking, performance measures, self-management support
    - Accountability and shared decision making

12

Ambulatory Model of care



14

How we started, how we moved forward…

- Started with many internal conversations about how to better manage our patients over many years
- Continued with a discussion related to NCQA Recognition
- Commenced with a site visit to the **Colorado Collaborative** to set the vision
- Continued with gaining consensus through Transformed retreat.
- Moving forward through ongoing implementation framework and structure…

Senior Leadership Group

- **Purpose:**
  - Assess progress toward PCMH
  - Provide direction to Implementation Team
  - Provide support
  - Strategize/Collaborate with Implementation and Vision Team to ensure alignment with state and national goals
- **Membership:**
  - CEO, VP Clinical Affairs, UNMH Administrators, Executive Medical Directors

Implementation Team

- **Purpose**
  - Study, Plan, and Design the implementation of the PCMH
  - Build on existing efforts
  - Coordinate efforts of work teams across the organization
  - Monitor and report progress to Steering committee
  - Seek resources as needed
- **Membership**
  - Executive Director Primary Care and Medical Director Primary Care, All Primary Care Medical and Unit Directors, representatives from Education, Quality and Clinical Process Improvement, Administrator and Executive Medical Director for Ambulatory Services.

Patient Centered Medical Home Implementation Structure

PCMH Implementation Team

- PCMH Pilot at one clinic with all key processes
- PCMH Intensive Project Teams
- PCMH Outcomes Dashboard Team
- PCMH Guidelines Taskforce
- PCMH Core Leadership Team
- PCMH Expanded Leadership Team
- PCMH CEO Leadership Team
- PCMH Registry Development Team

Hurdles and Redirection

- IT Systems are hard to configure for medical home
  - Most are structured for acute, episodic care.
  - Have to build registry reports, tool up systems to track "Medical home" information, etc.
- Some things, like calling patients about preventive maintenance that is overdue, becomes additive to already busy systems.
  - Need Lean to clean out existing processes. Currently working on several efforts.
- Team Management is not standard practice.
  - We have had to refine and reform teams several times.
- Access has been an enormous challenge.

MCMH Certification
National Committee for Quality Assurance (NCQA)

- Electronic Prescribing
- Care Management
- Access & Communication
- Electronic Medical Record
- Test & Referral Follow up
- Patient Self-Management Support
- Patient Tracking & Registry Functions
- Continuous Reporting & Improvement

Sites

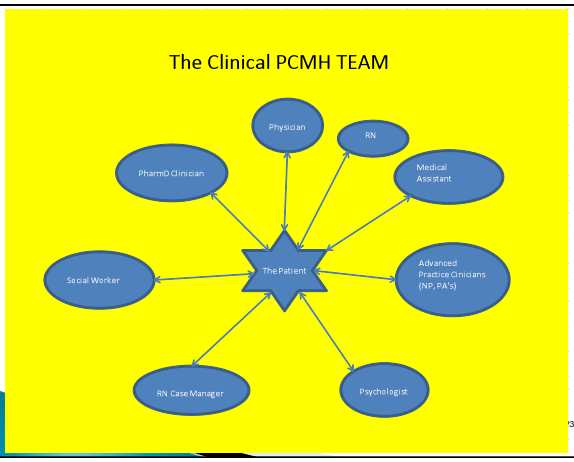
- Family Health (1209) – 7/19/2010
- Family Health (Northeast Heights) – 7/19/2010
- Family Health (Westside) – 7/19/2010
- Family Practice Clinic – 7/19/2010
- General Medicine Clinic – 7/19/2010
- Medicine Faculty Clinic – 7/19/2010
- Senior Health Clinic – 7/19/2010
- Family Health (Southeast Heights) – 7/19/2010
- Truman Street Clinic– 1/21/2011
- Pediatric Clinic (Resident)– 1/21/2011
- Pediatric Clinic (Faculty)– 1/21/2011
- Young Children's Health Center– 1/21/2011

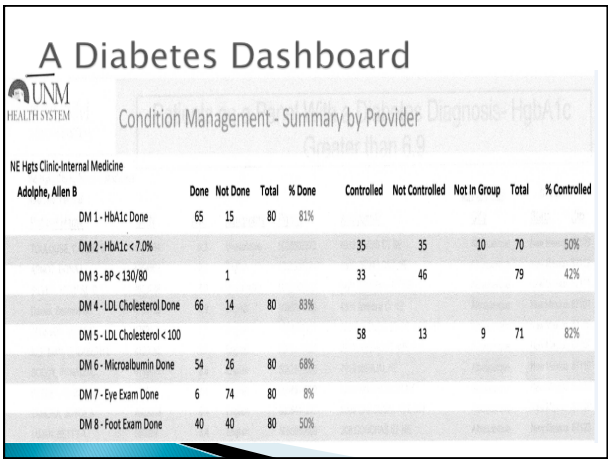
21

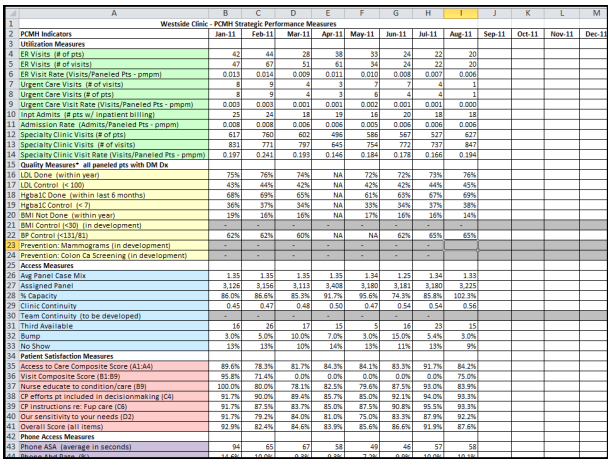
What have we been doing especially well?

- Diabetes reporting of key clinical indicators
- **Pre-work (looking up clinical values for patients coming to the office 1 week prior to visit and getting tests)**
- NCQA Recognition of 12 primary care site (level 1)
- **Nurse Facilitated Clinics doing Motivational Interviewing and Goal Setting**
- Daily Notification of Clinic Admissions and ER Visits of paneled patients
- Interpretive Language Services efforts
- Access Improvements
- LEAN redesign
  - And more…

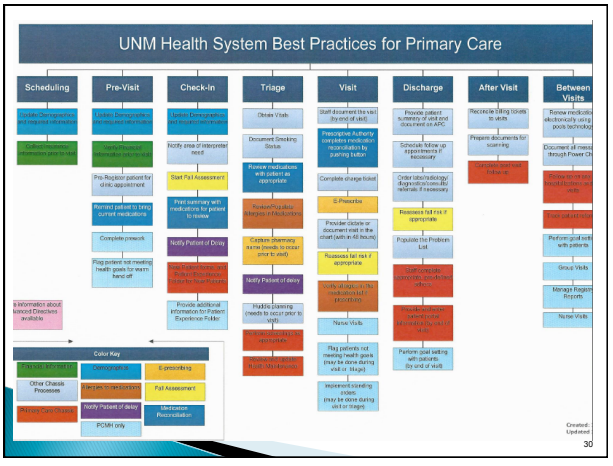
The Clinical PCMH TEAM

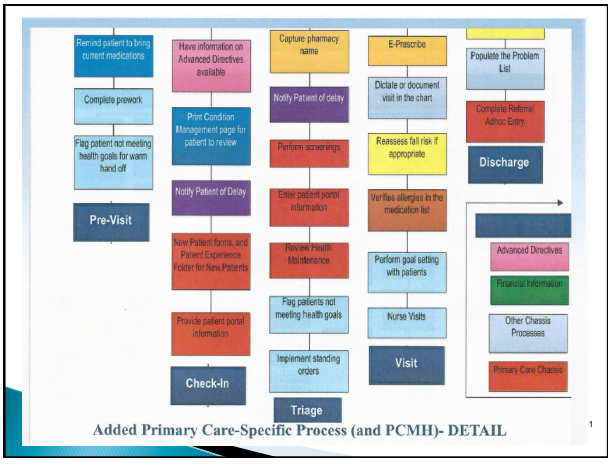


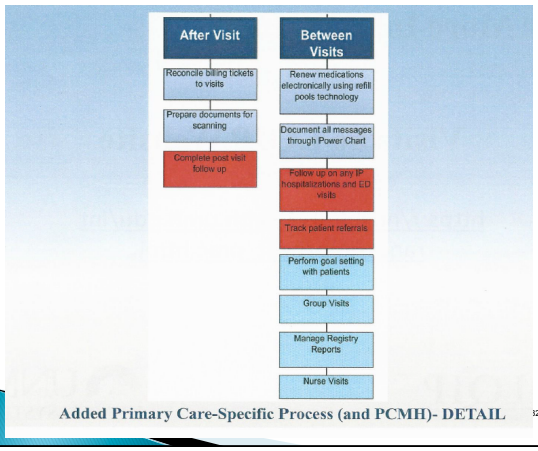




	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
Westside Clinic - PCMH Strategic Performance Measures												
PCMH Indicators												
Utilization Measures												
ER Visits (# of pts)	42	44	28	38	33	24	22	20				
ER Visits (# of visits)	47	67	51	61	34	24	22	20				
ER Visit Rate (Visits/Paneled Pts - pmpm)	0.013	0.014	0.009	0.011	0.010	0.008	0.007	0.006				
Urgent Care Visits (# of visits)	8	9	4	3	7	7	4	1				
Urgent Care Visits (# of pts)	8	9	4	3	6	4	4	1				
Urgent Care Visit Rate (Visits/Paneled Pts - pmpm)	0.003	0.003	0.001	0.001	0.002	0.001	0.001	0.000				
Inpt Admits (# pts w/ inpatient billing)	25	24	18	19	16	20	18	18				
Admission Rate (Admits/Paneled Pts - pmpm)	0.008	0.008	0.006	0.006	0.005	0.006	0.006	0.006				
Specialty Clinic Visits (# of pts)	617	760	602	496	586	567	527	627				
Specialty Clinic Visits (# of visits)	831	771	797	645	754	772	737	847				
Specialty Clinic Visit Rate (Visits/Paneled Pts - pmpm)	0.197	0.241	0.193	0.146	0.184	0.178	0.166	0.194				
Quality Measures* all paneled pts with DM Dx												
LDL Done (within year)	75%	76%	74%	NA	72%	72%	73%	76%				
LDL Control (< 100)	43%	44%	42%	NA	42%	42%	44%	45%				
Hgba1C Done (within last 6 months)	68%	69%	65%	NA	61%	63%	67%	69%				
Hgba1C Control (< 7)	36%	37%	34%	NA	33%	34%	37%	38%				
BMI Not Done (within year)	19%	16%	16%	NA	17%	16%	16%	14%				
BMI Control (<30) (in development)	-	-	-	-	-	-	-	-				
BP Control (<131/81)	62%	62%	60%	NA	NA	62%	65%	65%				
Prevention: Mammograms (in development)	-	-	-	-	-	-	-					
Prevention: Colon Ca Screening (in development)	-	-	-	-	-	-	-					
Access Measures												
Avg Panel Case Mix	1.35	1.35	1.35	1.35	1.34	1.35	1.34	1.33				
Assigned Panel	3,126	3,156	3,113	3,408	3,180	3,181	3,180	3,225				
% Capacity	86.0%	86.6%	85.3%	91.7%	95.6%	74.3%	85.8%	102.3%				
Clinic Continuity	0.45	0.47	0.48	0.50	0.47	0.54	0.54	0.56				
Team Continuity (to be developed)	-	-	-	-	-	-	-					
Third Available	16	26	17	15	5	16	23	15				
Bump	3.0%	5.0%	10.0%	7.0%	3.0%	15.0%	5.4%	3.0%				
No Show	13%	13%	10%	14%	13%	11%	13%	9%				
Patient Satisfaction Measures												
Access to Care Composite Score (A1:A4)	89.6%	78.3%	81.7%	84.3%	84.1%	83.3%	91.7%	84.2%				
Visit Composite Score (B1:B9)	95.8%	71.4%	0.0%	0.0%	0.0%	0.0%	0.0%	75.0%				
Nurse educate to condition/care (B9)	100.0%	80.0%	78.1%	82.5%	79.6%	87.5%	93.0%	83.9%				
CP efforts pt included in decisionmaking (C4)	91.7%	90.0%	89.4%	85.7%	85.0%	92.1%	94.0%	93.3%				
CP instructions re: Fup care (C6)	91.7%	87.5%	83.7%	85.0%	87.5%	90.8%	95.5%	93.3%				
Our sensitivity to your needs (D2)	91.7%	79.2%	84.0%	81.0%	75.0%	83.3%	87.9%	92.2%				
Overall Score (all items)	92.9%	82.4%	84.6%	83.9%	85.6%	86.6%	91.9%	87.6%				
Phone Access Measures												
Phone ASA (average in seconds)	94	65	67	58	49	46	57	58				







Added Primary Care-Specific Process (and PCMH)- DETAIL

12

Does PCMH work? Ann Internal Medicine 2013; 158:169-178

- Some evidence that PCMH may improve care experiences for both patients and staff
- There is some evidence that PCMH may improve care processes, especially preventive services.
- There is some evidence that PCMH may be associated with reduced ER visits for older adults *(and at UNM, a decrease in inpatient admissions)*
- In general, there is still insufficient evidence that PCMH improves:
  - Chronic illness care processes
  - Clinical outcomes
  - Overall effect on hospital admissions
  - Overall effect on costs of care

33

What is Needed

- Patient Portal for E-Visits, Scheduling, & Lab Results
- Improved Access
- Baseline Data for Clinical Indicators
- Redesign Teams in Each Clinic For Pre, During, & After Visit
- Standing Orders/Protocols
- Focus on Patient Partnership of Care
- Specialist Access in Each Clinic

What is Needed Continued

- Holistic/Integrated resources (i.e., Exercise, "Silver Sneakers")
- Dental/Vision Services/Access
- Visits Must be Planned
- Care Is Based on Evidence/Best Practice
- Patients Have the Needed Tools/Education for Self Care
- Improved Communication With Patients and Between Team Members & Other Care Providers

Patient Centered Medical Home to Focus On:

- Patient Centered/Self Management-Support
- Improved Continuous Access
- Preventative, Acute, & Chronic Care
- Quality Based on Best Practices including:
  - Diagnostic accuracy
  - Appropriateness of testing
  - Evidence-based practices
- Cost Reduction
- Patient, Staff, & Provider Satisfaction
- Patients Get All The Time They Need – More Caring Interaction With Providers
  - Lean has increased the time with the clinician

PCMH Take-Home Points

- What is PCMH?
  - The PCMH model describes mechanisms for organizing primary care to provide high-quality care across the full range of an **individual's** health care needs.
  - It focuses on teams of health care professionals providing coordinated and accessible care to an identifiable group of patients.
- The exact definitions of PCMH vary widely even with agreed-upon core concepts

37

What should PCMH models look like?

- Be organized around multidisciplinary teams with defined roles for @ member
- Address evidence-based comprehensive health needs of patients
  - Preventative care
  - Chronic Disease Management
- Develop ongoing relationships between the care team and individual patients
  - Comprehensive assessments
  - Care plans
- Enhance access to services
  - Telephone or internet visits
  - Group visits
  - Home visits
- Develop a systems-based approach to improving quality and safety
  - Identifying high-risk patients
  - Use evidence-based guidelines

38

Does it work…Continued?

In 2009 researchers found that Empire Blue Cross and Blue Shield patients who were seen at PCMH practices experienced better preventive health, higher levels of disease management and lower resource utilization and costs, compared with practices that did not pursue PCMH status. PCMH patients had 12 percent and 23 percent lower odds of hospitalization and required 11 percent and 17 percent fewer emergency department services than non-PCMH patients. Risk-adjusted total per member per month (PMPM) costs were 8.6 percent and 14.5 percent lower for PCMH-treated pediatric and adult patients, respectively (DeVries 2012).

39

HgA1C Results to date

	HgA1C done		% ↑	HgA1c control		% ↑
	May-10	Feb-13		10-May	Feb-13	
1209	63	69	6	25	42	17
Family Medicine	61	63	2	27	37	10
Northeast Heights	64	76	12	31	46	15
Westside	63	70	7	30	53	23
Southeast Heights	64	71	7	21	39	18
Senior Health	58	62	4	25	42	17
Medicine Faculty	67	70	3	34	43	9
southwest Mesa	60	65	5	20	39	19
composite			46			128
			5.75 average % gained			16 average % gained
		Feb-13			Feb-13	
ASAP PC		94			50	

LDL Results to date

	LDL done		% ↑	LDL control		% ↑
	10-May	Dec-12		2011	Dec-12	
1209	67	71	4	43	48	5
Family Medicine	62	64	2	38	42	4
Northeast Heights	77	77	0	53	51	-2
Westside	65	73	8	42	41	-1
Southeast Heights	60	70	10	38	40	2
Senior Health	61	61	0	38	39	1
Medicine Faculty	67	68	1	44	44	0
southwest Mesa	67	71	4	42	43	1
composite						
			3.6 average % gained			1.25 average % gained
		Dec-12			Dec-12	
ASAP PC		72			33	

Bottom Line:

- PCMH is a promising model for organizing primary care.
- There are still open questions about its effect on patients and on health care organizations
- The questions on the additional cost for staffing and the potential cost-savings associated with improved, evidence-based care (i.e., guidelines) has yet to be proven.
- Patient Safety
  - "Never-Events"
    - Prescribing errors leading to dangerous consequences
    - Failure to inform patients of important test results
    - Medical-setting acquired infections
    - Diagnostic error prevention

42

Thank you!