The Patient-Centered Medical Home
Some Open Issues

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Patient Centered Medical Homes - Building Healthy Communities

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Why PCMH?

Some Problems With Current System

- **Primary Care Physicians**
  - Unsatisfying work
  - Poorly paid
  - Unable to spend time w/ pts.

- **Patients**
  - Access
  - Relationships
  - Fragmentation

- **Purchasers/Payers**
  - Costs (esp. chronically-ill)
  - Quality
  - Experience
Some Trailing Issues

• Market Segmentation

• Uptake and Spread

• Where to, from Here?
Market Segmentation
Typical Panel of 3,000 Patients, $12.9 M Spend

PCP Panel Demographics

% ages of Patients and Spend

Healthy, 930

At Risk, 855

Stable, 639

Multiple Chronic Conditions, 441

Advanced Illness, 135

Medical / Pharmacy Spending

Advanced Illness, $4,076,716

Multiple Chronic Conditions, $4,270,231

Stable, $967,574

At Risk, $3,186,547

Healthy, $399,931
Market Segmentation

• **In the real world, product design is based on**
  – understanding market segments being served
  – and their specific needs

• **PCMH serves distinct segments:**
  – The “well”
  – The acutely ill
  – The chronically ill

• **The Innovation:**
  – **PCMH responds to the needs of each of these different subpopulations, who**
    • Have different expectations and needs
    • **Use the health care system quite differently**
The “well”

**Want:**
- access
- support for wellness and health promotion
- rapid, well-coordinated access to specialty ambulatory care, when needed

**PCMH**
- improves access
- applies evidence-based approaches to control and manage early-stage chronic diseases
- delays / prevents progression to more advanced illnesses
- reduces the care costs for this population, going forward
The acutely ill

• **Want:**
  – Rapid, expert diagnosis of their problem
  – Acute care of high quality and safety
  – Seamless coordination of care among specialists
  – Close management of care transitions.

• **PCMH focuses on**
  – Care coordination, support of patients/families during
    • Specialty referrals
    • Care transitions.
The (often multiply) chronically ill

- **Want:**
  - a solid, long-term relationship with a provider understands their needs
  - who helps them manage their problems
    - often numerous spanning medical and social services
    - helps them navigate a complex care system
    - helps them to manage their chronic illness.

- **PCMH responds to high-risk/high-cost patients and families**
  - focus on population health,
  - use of registries, and
  - application of evidence-based care,
  - Coupled with two “new” functions:
    - ongoing care (and relationship) management
    - patient education and engagement
PCMH
Uptake and Spread Across NYS
Over 5,000 in NYS as of Sept. 2012
Half Each, in NYC and ROS

New York State PCMH Providers
September, 2012 (N=5,312)

NYC 2,768
Non-NYC 2,544
Over 40% Growth 2011-12 Most Non-NYC

Growth in NCQA-Recognized PCMH Providers NYS
July, 2011 - Sept 2012

Non-NYC PCMH
- July, 2012: 1,480
- Sept., 2012: 2,544

NYC PCMH
- July, 2012: 2,261
- Sept., 2012: 2,768
Upstate, Most PCMHs are Level 3
(2008 Standards)

Non-NYC PCMH Providers by Region, Level
Sept 2012 (N=2,544)
Same Phenomenon, NYC

NYC PCMH Providers by Region, Level Sept 2012 (N=2,678)
Organized Physician Groups Are the Largest Cohorts of PCMH

New York State PCMH Providers by Type
Sept 2012 (N = 5,312)
Upstate, Physician Groups Are a Much Stronger Force

Non- NYC PCMH Providers by Practice Type
Sept 2012 (N = 2,544)
In NYC, It’s Hospitals, Health Centers and AMC Faculty Practices

NYC PCMH Providers by Practice Type
Sept 2012 (N = 2,768)

- Group: 309
- Health Ctr: 593
- HHC: 689
- Hosp Clinic: 509
- Hosp Px: 399
- Practice: 269
PCMH Composition Varies by Region
Upstate

Non-NYC PCMH Providers by Region, Practice Type
Sept 2012 (N = 2,544)

Healthfirst 2013 Spring Symposium
Patient-Centered Medical Home: Building Healthy Communities
PCMH Composition Varies by Region in NYC, as Well

NYC PCMH Providers by Borough, Practice Type
Sept 2012 (N = 2,768)
NY State Ratio of PCMH Providers
to Estimated Primary Care Physicians by County,
September 2012

Ratio of PCMHs to PCPs

Footnotes:
PCMH Provider: NCQA Database, September, 2012
Estimated PCPs: Center for Workforce Statistics, 2008
Some Open Issues
What Are the PCMH’s Active Ingredients?

• **Core Competencies:**
  – Expanded access,
  – The creation of effective care teams,
  – Better coordination of care across the continuum,
  – Robust quality improvement program focused on the application of evidence-based medicine

• **Together, these will**
  – produce better and safer care, and
  – improve the experience of care for all patients
Which Really Makes the Difference?

• **Two of PCMH’s “patient-facing” functions are of particular value in caring for the chronically ill:**
  – Care management
  – Patient engagement

• **These are “new tricks”, not in a traditional primary care practice**
  – Need to be developed, supported, and embedded in (or very closely connected to) the practices,
  – Integrated as effective members of the expanded care team

• **They have particular value for patients (and families)**
  – with multiple complex chronic conditions
  – facing potentially disruptive and dangerous care transitions
Care Management

• Care Management: a core competency of PCMH
  – For managing populations of chronically ill patients,
  – Who often use multiple specialists and providers of mental health and social services

• PCMHs have care management
  – Staff specifically focused on that activity
    • “care managers,” “care coordinators,” “navigators,” “coaches” and the like
  – Supported by systems, including registries to identify, stratify, and track patients with specific health, mental health, or social service needs
  – Systems/processes (phone and internet contact, home visits, and in-home monitoring) to monitor their status and care needs, identify “gaps” in care requiring attention.
Care Management

• Most important part of care management: its human face
  – The establishment of meaningful, longitudinal, supportive personal relationships between the patients and an individual on the care team (the care manager)
  – Who knows them, understands their problems and assets,
  – Has clear responsibility for providing them and their families with ongoing assistance in navigating a complex care system, and
  – With extra assistance when they are facing particular problems, such as care, or life transitions
Patient Engagement

• **Patient Engagement is critical to the PCMH**
  – Engaging patients and families as partners in the care process,
  – Involving them in shared decision making

• **Providers need to**
  – Teach them about their health, their health problems and their role in maintaining (or regaining) wellness; and
  – Provide them with the tools for self-management.

• **Patients and families need to**
  – Embrace a larger role as partners in the care process,
  – Adjust to an active role,
  – Recognize ways their own behavior affects their health, and
  – Become “activated” in their own care
Care Management, Patient Engagement
Some Open Issues

• Clearer definition of what each includes

• Levels and types of staff involved
  – What core competencies are required
  – Who should be providing these services

• Training, certifying, deploying and managing care managers
  – Who trains and certifies them; who employs them; who pays for them; to whom should they report?
  – If “shared,” how to allocate their time, effort, and expense?

• What model works best, for which types of patients?
  – Operation (centralized or distributed)
  – Location (plan, practice or community-based)

• What it costs to develop and provide these services?
  – How best to pay for those services?

• Who’s managing all the Care Managers?
Scale
One Rate-Limiting Step

- Practice Transformation is a non-trivial effort
- PCMH growth to date in NYS has been focused in specific types of primary care practices, with scale:
  - FQHCs and forward-thinking clinics
  - Large multi-specialty groups
  - IPAs
- We’re working to spread PCMH model to the teaching clinics, but
  - Who’s helping the remaining PCPs to get there
  - What’s the right approach to do it?
Multi-Payer Alignment and Support
The Other Rate-Limiting Step

- **PCMH involves NEW costs (EMRs, registries) and some new and unfamiliar staff and functions**
  - These are largely un-affordable to practices without scale, or resources

- **These added costs need to be recognized and supported by purchasers and payers**
  - Broadly
  - Consistently
Multi-Payer Support for PCMH

• **Providers need “enough” of their patients to have PCMH payments**
  – They need to be able to cover costs
    • Initial investment in Transformation
    • Ongoing costs of operation
  – Not a natural act for competing payers
    • But without it, PCMH will be hard to scale and sustain

• **And, they need reasonable consistency**
  – In care model and evolving standards (NCQA ?)
  – In measures of success
  – In methods of payment
    • Care management fee
    • Quality / P4P
    • Shared savings, down-stream
The “Other” Market Segment

- Some folks don’t appear to actually want a meaningful relationship with a high-quality primary care team
  - The young, the really well
  - The fatalistic, the un-concerned
  - Folks with other priorities
  - Episodic users of convenience
- For them, the PCMH doesn’t have much appeal
  - Minute-clinics are just fine, thank you
- Might be more of them than we, the PCMH-believers, want to think about
  - Another “market-niche”: The Medical Motel?
The Challenges
Balancing Now and Then

• **PCMHs been sold as a way to improve quality and cost**
  – But cost is the marker most folks are watching, and
  – Cost-savings, near-term, drive off improved care for the chronically-ill, and transitions; reduced ED visits and admits

• **PCMH is a practice-wide investment**
  – Makes things better for all patients; but near term payback comes from one, small segment: the chronic’s
  – Long-term payback will come from prevention of the next-generation of chronic illness;
  – But who’s paying attention to the long-term?

• **The challenge:**
  – Can we achieve enough “ROI” by caring better for the sick
  – To justify to payers and purchasers the added costs of practice-wide investments, to prevent “tomorrow’s” high-cost patients?