Patient Centered Medical Home:

Vision to Implementation for the Massachusetts Safety Net

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Outline for Today

- **Context for the Patient-Centered Medical Home (PCMH) in MA**
  - Why the PCMH?
  - EOHHS goal and legislative mandate
  - Rationale for multi-payer approach
- **MA PCMH Initiative**
  - Multi-stakeholder design approach
  - Core competencies and expectations for practices
  - Support for practice transformation
  - Payment model
- **Current Status and Next Steps**
  - Progress report and timeline
- **Linkages to Broader Health Reform**

Context for the PCMH in MA

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boston.com

THIS STORY HAS BEEN FORMATTED FOR EASY PRINTIN

GLOBE EDITORIAL

The Boston Globe

The Marcus Welby shortage

April 30, 2009

ONE OF THE hopes of healthcare reformers in Massachusetts has been that extending insurance to nearly all residents would cause the previously uninsured to seek treatment with primary care physicians and rely less on hospital emergency rooms for routine problems. Unfortunately, early indications are that the success of the state's three-year-old universal coverage program has not led to reduced dependence on emergency rooms. For that to happen, the state will need to provide more primary care physicians.

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Practicing Primary Care Today Is Challenging

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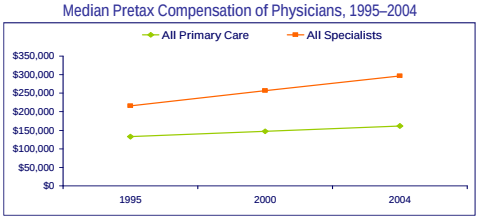
- Low reimbursement compared to non-PCP peers (see chart)
- Chaotic practice environment
- Low satisfaction
- Uncoordinated care transitions

Median Pretax Compensation of Physicians, 1995–2004



Adapted from Bailit 2008

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Proof of the Challenge

- "If you (PCPs) had to do your career over again"*:
  - 28% would choose primary care again
  - 41% would be a specialist
  - 27% would not be a physician
- 2% of medical students planning on being general internists; 2.3% med-peds and 4.9% family practice**

From Stuart Pollack presentation 2009
*Physician's Foundation 10/08
**Hauer, et al, JAMA 9/10/08

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"Like Hamsters on a Treadmill"

MassHealth

"Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stand still…

The result of the wheel going faster is not only a reduction in the quality of care but also a reduction in professional satisfaction and an increase in burnout among physicians."

(Morrison and Smith, BMJ 2000; 321:1541)

Thanks to: Robert A. Berenson, Alliance for Health Reform presentation, 22 September 2008

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In Summary…

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Current practice environment does not maximize outcomes, contain costs, or ensure access to primary care.

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What is a Medical Home?

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A Medical Home is "a community-based primary care setting which provides and coordinates high quality, planned, patient and family-centered health promotion, acute illness care, and chronic condition management."

Center for Medical Home Improvement, 2008

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The Medical Home Is Not New

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- **1967: *Introduction***
  - American Academy of Pediatrics (AAP) introduces "medical home" as a central location for archiving a child's medical record
- **1980-present: *Refinement***
  - AAP refines concept to relate especially to kids with special needs
- **2000-present: *Extension***
  - AAFP and ACP develop and extend the concept to include care for all patients, "patient centeredness"
- **2006-07: *Metrics and Linkages***
  - AAFP, AAP, ACP and AOA (with input from NCQA) develop common metric for recognizing the "patient-centered medical home" (PCMH), link PCMH to physician payment reform

Source: Pawlson, NCQA, 2007

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Across the Nation, Experience with PCMH is Building…

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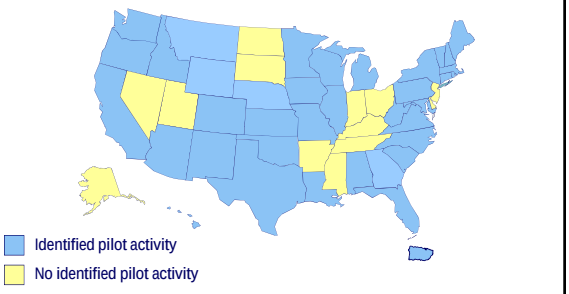

Source: National Association of State Health Policy web site: http://www.nashp.org/med-home-map

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…and Evidence is Mounting

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- A primary care-oriented system:
  - Reduces mortality; offers better preventive care, fewer tests, higher patient satisfaction; and reduces health disparities*
- More "medical homeness" is associated with:
  - fewer hospitalizations ER visits for kids with chronic conditions**
- Group Health Cooperative PCMH Pilot in Seattle, 2009 Study***
  - Fewer ER visits
  - Better on 6 of 7 patient experience scales
  - 10% provider burnout compared with 30% for controls
  - Significant gains in composite quality measure
  - No significant differences in overall costs (all PCMH investment recouped in first year)

Sources: *Philips R, Starfield B. Why does a U.S. primary care physician workforce crisis matter? *American Family Physician* Aug 1, 2004; Bailit, M. PCPCC; 2008; Shih 1992, 1994; **Cooley et al. *Pediatrics*. Vol. 124 No. 1 July 2009 ; *** Reid et al 2009

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MA PCMH Initiative

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Mission and Goal for Secretary of EOHHS

Mission

- Design and implement a system to support high-performing, patient-centered primary care delivery across the Commonwealth of Massachusetts

Goal

- Transform all primary care practices into high-performing, advanced medical homes by 2015

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Legislative Mandate for Medical Homes

- Chapter 305, Section 30 of Acts of 2008 required MassHealth to establish a medical home demonstration
  - Restructure payment system to support primary care practices using medical home model
  - Support practices in their transformation
  - Work with other Medicaid payers and other stakeholders
- Legislation notes that prevalent fee-for-service payment system does not adequately support practice transformation

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Rationale for Multi-payer Approach to Medical Homes

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- Medical home model requires fundamental changes in how providers care for all their patients and run their practices
- Multi-payer participation gives providers more support for making these changes
- Incentive alignment improves the likelihood of successful practice transformation and sustainability of the new model over time

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Multi-payer Approach: The PCMH Initiative Council (PIC)

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Co-Chairs

- JudyAnn Bigby, MD, Secretary of EOHHS
- John Fallon, MD, Senior VP and Chief Physician Executive, BCBSMA

Purpose

- To advise EOHHS in its role as convener and overseer of the PCMH Initiative. **The Council *shall recommend a design, including payment models and practice transformation strategies*** to support a large-scale roll-out of public-private multi-payer medical homes across the Commonwealth.

Membership

- Public and private payers
- Purchasers/employers
- Clinical professional societies/providers
- Researchers, consumer advocates and other stakeholders

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PIC Members by Organization

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Public and Private Payers

- Blue Cross Blue Shield of MA
- Boston Medical Center HealthNet Plan
- Div. of Health Care Finance and Policy
- Fallon Community Health Plan
- Harvard Pilgrim Health Care
- Health New England
- EOHHS/MassHealth
- Neighborhood Health Plan
- Network Health
- Tufts Health Plan

Providers/Professional Societies

- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Physicians
- Beth Israel Deaconess Medical Center
- Boston Senior Home Care
- Brigham and Women's Hospital Primary Care
- Children's Hospital
- Joseph M. Smith Community Health Center
- MA Coalition of Nurse Practitioners
- MA Council of Community Hospitals
- Mass Hospital Association
- Mass League of CHCs
- Massachusetts Medical Society
- Partners HealthCare
- Senior Whole Health
- Society for General and Internal Medicine
- Williamstown Medical Associates

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PIC Members by Organization

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Purchasers / Employers

- Associated Industries of Massachusetts
- Commonwealth Care Alliance
- Evercare Massachusetts
- Group Insurance Commission
- MA Health Connector

Researchers, Consumer Advocates, and Others

- ARC of Massachusetts
- Blue Cross Blue Shield of MA Foundation
- Boston Public Health Commission
- Health Care for All
- Home Care Alliance of Massachusetts
- Mental Health and Substance Abuse Corporations of Massachusetts
- MetroWest Center for Independent Living, Inc.
- New England Quality Care Alliance
- REACH
- The Boston Foundation

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Core Strategy for the MA PCMH Initiative

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Use public-private, multi-payer approach to…

- Define objectives and tactics, including core competencies for practices and performance measures
- Support practice transformation
- Recommend a new PCMH payment model
- Monitor and evaluate results

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Core Competencies for Practices

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Practice Redesign

- Multi-disciplinary team-based approach to care*
- Planned visits and follow-up care*
- Population-based tracking and analysis with patient-specific reminders*
- Integration of quality improvement strategies and techniques
- Evidence-based care delivery using clinical guidelines/protocols

Consumer Engagement

- Patient involvement in goal setting, action planning, problem solving and follow-up*
- Enhanced access*
- Patient/family-centeredness
- Patient and family education
- Self-management support by all members of the practice team

Clinical Care Management and Care Coordination

- Care coordination across settings, including referral and transition management
- Integrated care management focused on high-risk patients*

* Identified by the PIC as a high-priority element for Learning Collaboratives and practice coaching activities

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Implementation by Practices

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- In the MA PCMHI, practices will work toward mastery of the Core Competencies through such activities as:
  - Regular meetings of a practice care team that leads overall PCMH transformation
  - Providing clinical care management, including monitoring, follow-up, and clinical management of high-risk patients
  - Reporting on progress, in monthly narrative reports and clinical data reports
  - Participating in an evaluation being conducted by UMass
  - Establishing best practices and methods most appropriate to that particular practice

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Support for Practice Transformation

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- Demonstration practices will receive considerable help in becoming PCMHs
- The Commonwealth will provide key resources, including:
  - Medical Home Facilitators, who work one-on-one with practice teams to achieve transformation goals and track progress
  - Learning Collaboratives, where practices learn from expert faculty and each other at in-person conferences, and continue learning via online information-sharing and reporting
  - Patient Registry Development and Use, technical assistance for practices without fully functional patient registries

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PCMH Payment Model

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- Payment model has been developed with input from the full PIC membership
- Details remain in discussion, but may include:
  1. Start-up payments to support initial costs (e.g., setting up patient registries)
  2. Two streams of ongoing supplemental payments for:
     - Clinical care management
     - Other traditionally non-reimbursed services
  3. Shared savings payments if practice performance results in net cost reduction

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Medicare Demonstration May Offer Additional Opportunity

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- Medicare is a major payer in MA that is not currently involved in the PCMHI
- In the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, CMS proposes to join state PCMH initiatives
- MA plans to apply for the demonstration through CMS's RFP process

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Current Status and Next Steps

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Status Update

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- PIC finalized White Paper in mid-November, and Steering Committee met through mid-February 2010 to decide additional design details
- MassHealth will soon issue a competitive procurement to select practices to participate in the PCMHI
- Technical assistance for practices being planned (Learning Collaborative, registry capabilities, etc.)
  - Bailit Health Purchasing and UMass Medical School, Commonwealth Medicine Division, providing expertise and resources
- Throughout this process, EOHHS also working closely with the Mass League under the Qualis/Commonwealth Fund Safety Net Medical Home Initiative to coordinate efforts

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Next Steps

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Linkages to Broader Health Reform

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Elements of the MA Health Reform Landscape

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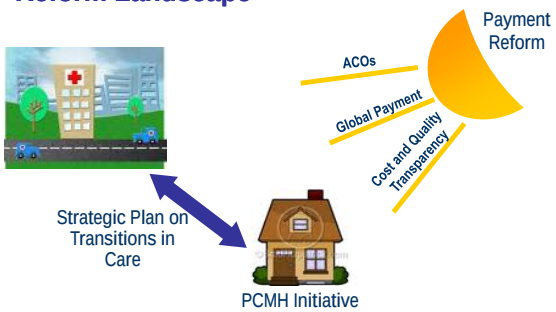

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Medical Home Is the Foundation for Reform

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- The MA Special Commission on Payment Reform recognized this:

> *"In large part, the characteristics that will define an ACO—an emphasis on cost-effective primary care, clinical integration, and attention to quality as measured against common performance metrics—require medical home capacity."*

- By all indications, **the medical home will be the foundation for health reform in MA, not a passing fad**

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