Patient Centered Medical Home: Transforming Primary Care in Massachusetts

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Agenda

- Overview of Patient Centered Medical Home
- Massachusetts Experience:
  - MA Patient Centered Medical Home Initiative
  - Primary Care Payment Reform
- Lessons Learned for Leaders Implementing Change
Joint Principles of the Patient-Centered Medical Home

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and integrated
- Quality and safety are hallmarks
- Enhanced access
- Payment recognizes added value of patient-centered medical home

NCQA PCMH 2014: 6 standards/27 elements

<table>
<thead>
<tr>
<th>1: Enhance Access and Continuity</th>
<th>Pts</th>
<th>4: Plan and Manage Care</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. *Patient-Centered Appointment Access</td>
<td>4.5</td>
<td>A. Identify Patients for Care Management</td>
<td>4</td>
</tr>
<tr>
<td>B. 24/7 Access to Clinical Advice</td>
<td>3.5</td>
<td>B. *Care Planning and Self-Care Support</td>
<td>4</td>
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<tr>
<td>C. Electronic Access</td>
<td>2</td>
<td>C. Medication Management</td>
<td>4</td>
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<td></td>
<td>10</td>
<td>D. Use Electronic Prescribing</td>
<td>3</td>
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<td></td>
<td></td>
<td>E. Support Self-Care and Shared Decision-Making</td>
<td>5</td>
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</tbody>
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<table>
<thead>
<tr>
<th>2: Team-Based Care</th>
<th>Pts</th>
<th>5: Track and Coordinate Care</th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. Continuity</td>
<td>3</td>
<td>A. Test Tracking and Follow-Up</td>
<td>6</td>
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<tr>
<td>B. Medical Home Responsibilities</td>
<td>2.5</td>
<td>B. *Referral Tracking and Follow-Up</td>
<td>6</td>
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<tr>
<td>C. Culturally and Linguistically Appropriate Services (CLAS)</td>
<td>2.5</td>
<td>C. Coordinate Care Transitions</td>
<td>6</td>
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<tr>
<td>D. *The Practice Team</td>
<td>4</td>
<td></td>
<td>18</td>
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<td>12</td>
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<table>
<thead>
<tr>
<th>3: Population Health Management</th>
<th>Pts</th>
<th>6: Measure and Improve Performance</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Patient Information</td>
<td>3</td>
<td>A. Measure Clinical Quality Performance</td>
<td>3</td>
</tr>
<tr>
<td>B. Clinical Data</td>
<td>4</td>
<td>B. Measure Resource Use and Care Coordination</td>
<td>3</td>
</tr>
<tr>
<td>C. Comprehensive Health Assessment</td>
<td>4</td>
<td>C. Measure Patient/Family Experience</td>
<td>4</td>
</tr>
<tr>
<td>D. *Use Data for Population Management</td>
<td>5</td>
<td>D. *Implement Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td>E. Implement Evidence-Based Decision-Support</td>
<td>4</td>
<td>E. Demonstrate Continuous Quality Improvement</td>
<td>3</td>
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<tr>
<td></td>
<td>20</td>
<td>F. Report Performance</td>
<td>0</td>
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<td>G. Use Certified EHR Technology</td>
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Scoring Levels:
- Level 1: 35-59 points.
- Level 2: 60-84 points.
- Level 3: 85-100 points.

*Must Pass Elements
Pro-Active Multidisciplinary Team-based Care

Pro-Active Multidisciplinary Team-based Care
Pro-Active Multidisciplinary Team-based Care

- Primary Care Visits
- Specialty and Hospital Referrals
- Screening, Prevention
- Population Management
- Care Management
- Care Coordination
- Outreach, engagement, navigation
- Community Referrals
Pro-Active Multidisciplinary Team-based Care

National Medical Home Demonstrations & Initiatives

- Medicare Multi-Payer Advanced Primary Care Practice Demonstration
- CHIPRA Quality Demonstration Grants
- Medicare FQHC Advanced Primary Care Practice Demonstration
- Medicaid Health Homes
- CMS Comprehensive Primary Care Initiative
- VA and Military Medical Home Demos
- Safety Net Medical Home Initiative
Medical Homes across the US

- 44 states have Medicaid/CHIP PCMH initiatives
  - 35 states include payment reform
- 18 states have multi-payer initiatives

http://nashp.org/medical-home-patient-centered-care-maps/index.html#x1-tab

Evidence Base: Costs & Service Use

<table>
<thead>
<tr>
<th>PCMH</th>
<th>Costs</th>
<th>Hospital admissions</th>
<th>ER visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Care of North Carolina</td>
<td>Saved $ 1,205 mil over 7 yrs</td>
<td>Improvements in asthma care</td>
<td>23% lower ED utilization and costs</td>
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<td>21% increase in asthma staging</td>
<td>25% lower outpatient care costs</td>
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<td></td>
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<td></td>
<td>11% lower pharmacy costs</td>
</tr>
<tr>
<td>Geisinger</td>
<td>7% lower cumulative total spending (2005 – 2008)</td>
<td>25% lower hospital admissions; 50% lower readmissions</td>
<td></td>
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<tr>
<td></td>
<td>ROI of 1.7 (2006-2010)</td>
<td></td>
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<tr>
<td>CO Medicaid</td>
<td>$215pm/py lower cost for children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon Health Authority Coordinated Care Organizations (CCOs)</td>
<td>Reduced per capita health spending growth by &gt; 1% 18 % reduction in ED visit spending</td>
<td>12 % fewer hospital readmissions</td>
<td>9% reduction in ED visits 14-29% reduction in ED visits for chronic disease patients</td>
</tr>
<tr>
<td>Group Health</td>
<td>Cost savings of $17 PMPM $3.4 million in cost savings through medication use management</td>
<td>11% fewer hospitalizations for ambulatory care-sensitive conditions</td>
<td>29% fewer ED visits 30% reduction in ED use among patients with chronic disease</td>
</tr>
<tr>
<td>Veterans Health Administration Patient Aligned Care Team (PACT)</td>
<td>$593 per chronic disease patient cost savings</td>
<td>4% fewer inpatient admissions</td>
<td>27% lower hospitalizations and ED visits among chronic disease patients 8% reduction in urgent care visits</td>
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</tbody>
</table>
## Evidence Base: Quality of Care

<table>
<thead>
<tr>
<th>Program</th>
<th>Result</th>
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<tbody>
<tr>
<td>Community Care of North Carolina</td>
<td>112% increase in influenza inoculations</td>
</tr>
<tr>
<td>Geisinger</td>
<td>Improved quality of care: 74% for preventive; 22% for coronary artery disease; 34.5% for diabetes care</td>
</tr>
<tr>
<td>Group Health</td>
<td>• 18% reduction in use of high-risk medications among elderly</td>
</tr>
<tr>
<td></td>
<td>• 36% increase in use of cholesterol-lowering drugs</td>
</tr>
<tr>
<td></td>
<td>• 65% increase in use of generic statin drug</td>
</tr>
<tr>
<td></td>
<td>Improved quality of care: Composite measures increased 3.7% - 4.4%</td>
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<tr>
<td></td>
<td>Improved provider satisfaction: Less emotional exhaustion reported by staff</td>
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<td>(10% PCMH vs. 30% controls)</td>
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<tr>
<td>Oregon Health Authority</td>
<td>Better disease management among diabetics in one clinic</td>
</tr>
<tr>
<td>Coordinated Care Organizations (CCOs)</td>
<td>65% had controlled HbA1c levels vs. 45% pre-PCMH</td>
</tr>
<tr>
<td>CO Medicaid Program</td>
<td>Increased provider participation in CHIP program from 20% to 96%;</td>
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<tr>
<td></td>
<td>Increased pediatric well-care visits from 54% to 73% (2007-2009)</td>
</tr>
<tr>
<td>VA</td>
<td>Statistically significant improvement in patient and care giver experience</td>
</tr>
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</table>


## Evidence Base - Summary

- Moderately strong evidence suggests:
  - Small positive effect on patient experiences
  - Small to moderate effect on preventive care services
  - Small to moderate effect on staff experiences (low strength of evidence)

- Most studies evaluated effects in older adults with multiple chronic illnesses

- Conclusion: Current evidence is insufficient to determine effects on clinical and most economic outcomes.

Integrating Behavioral Health into the PCMH Joint Principles

Personal physician → Home of the team
Whole person orientation → Requires BH service as part of care
Care coordinated → Shared problem & med lists
Quality and safety → Requires BH on team
Enhanced access → Includes BH for patient, fam & provider
Appropriate payment → Funding pooled & flexible

Integrating Behavioral Health into the PCMH: Additional Critical Issues

- Consistent language across disciplines
- Central role of patient and family
- Defined roles and skill sets for team (PCP, BH and others)
- Interdisciplinary training
- Research the conditions of PCMH success
- Recognize and support local adaptations
- Assurance of behavioral health parity in all benefit plans
Massachusetts Experience

MA Statewide Healthcare Reform Initiatives

- Safety Net Medical Home Initiative
- CHIPRA Medical Home
- OneCare
- Primary Care Payment Reform
- Health Homes
Massachusetts Patient-Centered Medical Home Initiative

- Multi-payer, statewide initiative
- Sponsored by MA Health & Human Services, legislatively mandated
- 44 participating practices
- 3-year demonstration; March, 2011-March, 2014
- Included payment reform

**Vision:** All MA primary care practices will be PCMHs by 2015

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### MA PCMHI: Core Competencies

<table>
<thead>
<tr>
<th>Patient/family centeredness</th>
<th>Self management support</th>
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<tbody>
<tr>
<td>Team based care</td>
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</tr>
<tr>
<td>Planned visits &amp; follow-up care</td>
<td>Patient and family education</td>
</tr>
<tr>
<td>Registry use for population and patient management</td>
<td>Shared decision making, patient action plans</td>
</tr>
<tr>
<td>Care coordination</td>
<td>Evidence based care</td>
</tr>
<tr>
<td>Care management for high risk patients</td>
<td>Integration of QI</td>
</tr>
<tr>
<td></td>
<td>Enhanced access</td>
</tr>
<tr>
<td></td>
<td>Integration of behavioral health and primary care</td>
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</tbody>
</table>
Care Coordination & Care Management

**Care Coordination**
- Arrange, track and coordinate with specialists, community resources, behavioral health
- Agreements with specialists, hospitals
- Test/procedure tracking & communication
- Transitions in care

**Care Management**
- Individualized, integrated care plan
- Manage/mitigate risk and improve outcomes
- Medication management
- Care coordination for highest-risk patients

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**MA PCMHI: Incentive Alignment/ Payment Reform**

**Payment Streams:**
- Fee for Service
- Start-up Infrastructure Payments
- Prospective Payments
  - Medical Home Activities
  - Clinical Care Management
- Shared Savings

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[Image of pyramid diagram representing care coordination and management layers]
MA PCMHI: Technical Assistance

- Learning Collaborative
- Medical Home Facilitation
- Website and e-updates
- Data collection, aggregation and reporting
- Online courses, toolkits

MA PCMHI Evaluation Questions

**Question 1:**
To what extent and how do practices become medical homes?
- Extent
- Patient-family centeredness
- Care management
- Care coordination
- Access
- Teamwork
- Information technology
- Leadership
- Barriers and Facilitators

**Question 2:**
To what extent do patients become partners in their health care?
- Perceived self-management efficacy
- Patient-family centeredness by chronic and non-chronic

**Question 3:**
What is the initiative’s impact on utilization, cost, clinical quality, patient and provider outcomes?
- Emergency Department use
- Hospitalizations
- Cost
- Clinical quality measures
- Staff satisfaction
- Patient satisfaction
MA PCMHI NCQA Dashboard

97% of practices achieved NCQA Recognition

<table>
<thead>
<tr>
<th>Recognition Level</th>
<th>Number/Percent</th>
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<tbody>
<tr>
<td>Level One</td>
<td>4/9%</td>
</tr>
<tr>
<td>Level Two</td>
<td>12/27%</td>
</tr>
<tr>
<td>Level Three</td>
<td>37/61%</td>
</tr>
</tbody>
</table>

97% of practices achieved NCQA Recognition

Practice Self Assessment
Transformation: Change Over Time

Assessment tool: Medical Home Implementation Quotient MHIQ®
### Clinical Quality Measures

#### Adult Diabetes
- HbgA1c Control (<8%)
- HbgA1c Control (>9%)
- BP < 140/90 mmHg
- LDL Control < 100mg/dL
- Screened for Depression
- Self-Management Goal

#### Adult Prevention
- Adult Weight Screening and Follow-up
- Tobacco Use Assessment
- Tobacco Cessation Intervention

#### Other Adult Target
- Blood Pressure Control
- Hypertension with Documented Self-Management Goal
- Depression with Documented PHQ-9 Score
- Depression with Documented Self-Management Goal

#### Childhood Prevention
- Immunization Status Multiple vaccines
- Weight Assessment and Counseling for Children and Adolescents

#### Pediatric Asthma
- Use of Appropriate Medications for Asthma
- Persistent Asthma Patients with Action Plan

#### Other Pediatric Target
- Follow-up Care for Children Prescribed ADHD Medication
- Management Plan for Children Prescribed ADHD Medication

#### Care Coordination/ Care Management
- Follow-up after Hospital Discharge
- Highest Risk Patients with Care Plan

### Clinical Quality Measures that Showed Significant Improvement in Change over Time

*11/22 measures showed statistically significant improvement*
Transformation Resources

- 8 learning sessions, 6 on-line courses, many webinars
- Clinical Care Management Curriculum
- Medical Home Facilitator expertise
- Shared savings methodology
- MA PCMHI website: practice tools, webinars, learning sessions, online courses, links, communications
- Patient/family engagement practice toolkit
- Behavioral health integration elements, assessment and toolkit
- Physician Leadership Institute

Behavioral Health Integration Toolkit

http://pcmhl earning.ehs.state.ma.us
Primary Care Payment Reform

- *MassHealth’s flagship alternative payment program that will enable MassHealth to move from fee-for-service reimbursement towards alternative payment models.*

- **Goals:**
  - To improve access, patient experience, quality, and efficiency through care management and coordination and integration of behavioral health
  - Increase accountability for the total cost of care

- 30 participating practice organizations, approx 50 sites

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**Payment Structure**

A. **Comprehensive Primary Care Payment (CPCP)**
   - Risk-adjusted capitated payment for primary care services
   - Options for including outpatient behavioral health services

B. **Quality Improvement Payment**
   - Annual incentive for quality performance, based on primary care performance

C. **Shared savings payment**
   - Primary care providers share in savings on non primary care spend, including hospital and specialist services
Building 3 Behavioral Health Tiers into the Comprehensive Primary Care Payment

**Tier 1**
- Integrated care management
- No fee-for-service behavioral health billable services

**Tier 2**
- BH services by Master’s or Doctoral level professional
- Fee-for-service billable outpatient

**Tier 3**
- Fee-for-service billable outpatient BH services provided by prescribing clinicians and psychotherapists
- Medication management
- Psychiatric assessments
- Psychotherapy

Primary Care Payment Reform Transformation Plan

- Curriculum based on participant readiness review
- Focus on BH integration
- Member roster list
- ED utilization
- High risk members
- Raw claims feed

- Participant feedback on program implementation
- Quality reporting assistance
- Targeted technical assistance for qualified participants
Lessons Learned for Leaders
Implementing Change

MA PCMHI Qualitative Evaluation:
5 Factors Contributing to Transformation

- Sequence of core competency adoption
- Strong leadership and staff buy-in
- Focus on staff capacity and resources
- Electronic Medical Record (EMR) proficiency
- Active use of available technical assistance and peer learning
Sequencing: Build the Home from the Foundation Up

Leadership is Key to achieving Practice Transformation

- Facilitative leadership style
- Embed quality improvement – data-driven decision making
- Leaders’ important roles:
  - Setting vision
  - Aligning transformation with strategic organizational goals
  - Allocating resources, including staff time
  - Supporting full EMR implementation
  - Forming partnerships across disciplines
  - Communicating and spreading change
Qualitative Evaluation: Strategies that Facilitate Staff Buy-in

- Educate staff about the transition to PCMH
- Involve staff in decision making
- Re-shape staff roles to shift responsibilities
- Provide 1:1 coaching for slow adopters
- Establish visible leadership support

Beware of Change Fatigue: Staff Survey Key Findings

- Drop in job satisfaction among Study Group staff was seen for the \textit{clinical staff} as opposed to non-clinical staff who showed an increase in job satisfaction
Implement Care Integration in each PCMH Component

Tips for Getting Started on the PCMH Journey

- Conduct a practice assessment of the current state
- Develop a transformation plan
- Identify an interdisciplinary improvement team; include patients
- Identify the functions needed in the care model
- Assign care team members roles and responsibilities
- Invest in team functioning
- Assign patients to teams
- Invest in QI infrastructure
- Let the data guide the way
- Understand and leverage new payment models
Resources

- PCMH Checklist from AAFP:  
  file:///C:/Documents%20and%20Settings/johnstoj/Desktop/PCMHChecklist%20from%20AAFP.pdf
- PCMH-A  
  http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A_0.pdf
- MA PCMHI online courses & behavioral health toolkit  
  http://pcmhlearning.ehs.state.ma.us
- Mapping Your Route to NCQA PCMH Recognition  
  http://www.primarycareprogress.org/blogs/16/409

Conclusions

*PCMH is continuous, comprehensive, coordinated, accessible and patient-centered primary care*

- The implementation of the PCMH model is a key part of national and state health care reform initiatives
- Early evidence suggests quality improvement and cost savings
- Massachusetts PCMH initiatives are advancing payment reform and practice transformation
- A well-functioning, multidisciplinary care team is a PCMH essential
- The foundation of the Home is: Leadership Engagement, Data-driven Quality Improvement and Patient involvement in Transformation
Acknowledgments

- The MA PCMHI participating practices
- The UMass MA PCMHI team
- MassHealth and participating payers
- Bailit Health Purchasing
- Dr. Sai Cherala and Joan Johnston, UMMS

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