Background on Enhanced Primary Care and the Medical Home Model

Medical Home Work Group
of the Maryland Health Quality and Cost Council
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Outline

1. Primary Care Practice In Maryland
2. Recommendations from Task Force on Health Care Access and Reimbursement
3. What’s Happening on the Ground
4. Challenges and Opportunities
Patient access to high-quality primary care is essential for a well-functioning health care delivery system.

- Research suggests that reducing reliance on specialty care may improve the efficiency and quality of health care delivery.

- States with more primary care physicians per capita have better health outcomes and higher scores on performance measures (1,2).

- Areas with higher rates of specialty care per person are associated with higher spending but not improved access to care, higher quality, better outcomes, or greater patient satisfaction. (3a, 3b,4)

- Cross-national comparisons show that countries with greater dependence on primary care have lower rates of premature deaths and deaths from treatable conditions, even after accounting for differences in demographics and GDP.(5)
Access to high-quality primary care is not a given in the health care system.

- Rand’s 2003 study found survey respondents received 55% of recommended primary care and 56% percent of recommended chronic. (6)

  “Deficits in adherence to recommended processes for basic care pose serious threats to the health of the American public.”

- 2007 CDC report found 1 in 5 Americans does not have a routine source of health care. (5)

- 2005 Medicare Current Beneficiary Survey found most (93%) of enrollees have a usual source of care and about 90 percent felt usual care giver was knowledgeable about conditions (7)
Challenges for primary care in Maryland

• Declining medical student interest in primary care
  – Lifestyle issues – more likely to be small practices, heavy time demands.
  – Lower expected earnings makes repaying medical education debt more difficult.
  – Not the medicine, medical schools are training students to provide.
  – Diminishing supply of PCPs, only 1 family practice program in MD.

• Growing competition for foreign medical graduates (FMGs) as income rise in developing world.
  – Maryland has maintained its PCP supply with a heavy influx of FMGs, will it continue?

• Proposals to substitute or supplement physicians with allied health professionals generates more resistance than support from patients and physicians.
Despite challenges for primary care, supply remains about constant overall growth in PCP supply kept pace with population growth.

More increases in supply attributed to growth in specialty care physicians.

Access to primary care is significantly lower for the poor residents and rural Maryland.

Study conducted by MHA/MedCHI shows significant supply shortfalls in primary care virtually everywhere by 2014. Shortages already significant in some parts of Eastern Shore (Queen Anne’s, Somerset, and Garrett Counties)

Source: MHCC analysis of AMA Masterfile from HRSA’s Area Resource File. Counts are physicians that report primary function is providing patient care. Note: FTE levels are 30-35% lower than head count measures in Maryland.
The medical home model builds on primacy care concepts\(^{(9)}\)

Central organizing principle of effective health care systems

- Accessible (First contact care)- point of entry for each new problem

- Continuous-ongoing care over time

- Comprehensive- provides or arranges for services across all of patient’s healthcare needs

- Coordinated- integration of care across a person’s conditions, providers & settings and with patient’s family and caregivers and community
To become a medical home, a practice must… (10)

• Organize the delivery of care for all patients with sub-specialists, disease management and community resources and other care sites.

• Use evidence-based medicine and clinical decision support tools.

• Coordinate care in partnership with patients and families.

• Provide enhanced and convenient access to care.

• Implement non-face-to-face care processes.

• Identify and measure key quality indicators.

• Use health information technology that supports population management, clinical decision support and health information exchange.

• Participate in programs that provide feedback on performance & accept accountability for process improvement and outcomes.
Task Force on Health Care Access and Reimbursement Examined Access and Supply Issues

- **Task Force recommends that** Quality and Cost Council be charged with **creating a statewide approach to establishing medical homes**
  1. Creating multi-stakeholder coalitions of payers, providers, and purchasers.
  2. Identifying equitable sources of start-up funding so that initial costs can be shared among providers, payers, and purchasers.
  3. Mobilizing the multi-stakeholder coalitions to compete for medical home demonstrations.

- **Task Force urges insurers to provide incentive payments for infrastructure upgrades associated with medical home adoption.**

- **Task Force urges MedCHI to develop a medical home education and outreach program for primary care physicians.**

- **Urged State to identify funds to finance delivery system formation.**
Who Is Testing/Promoting the Medical Home Model?
Demonstrations in Maryland (or near)

Single payer demonstrations are now underway

- Carefirst -- Demonstration program to launch early 2009. Practice must obtain NCQA recognition as PC-MH (any level) to participate.

- United HealthCare – working with at least one large practice in DC metro area.

- CMS – Long awaited demo is now underway. Will select up to 8 sites (states) for participation. About 20 multi-payer demos underway

- Aetna – Participates Southeastern Pennsylvania Rollout of the Chronic Care Initiative. Southern PA Demo is first stage in Health Reform Commission’s goal to implement the Chronic Care model in all primary care practices in PA. NCQA’s is used as the practice recognition tool.

- UHC participating in multi-payer demos in Rhode Island and New York

Provider Initiatives

- 2 practices have achieved recognition, a significant number of practices have achieved NCQH recognition for EHR tool

- JHUSPH lead state effort to establish a medical home demonstration for safety-net providers.
Challenges and Opportunities

- Given Maryland circumstances, what would an effective multi-stakeholder medical home program look like?
  (Multi-stakeholder approach offers the best approach to align incentives for practices.)
  - How do we translate theory into current practice? Design and evaluation of medical homes is a new discipline.
  - Who will provide the start-up funds?
  - How can providers in a multi-stakeholder model be rewarded so all share equitably in any gains?
  - What type of patients should be directed to medical homes?
  - (How) should small practices adopt the model? Even in the absence of broader delivery system redesign?
  - How do we sustain primary care and control unrealistic expectations?
    The euphoria about medical homes could suck the air out of primary care.
Sources

(1) Baicker, K., and A. Chandra. 2004. Medicare spending, the physician workforce, and beneficiaries’ quality of care. *Health Affairs*


(8) Center for Medicare and Medicaid Services, 2005 Medicare Current Beneficiary Survey


(10) Barr, Michael “The Patient Centered Medical”, presentation to the Task Force on Health Care Access and Reimbursement, June 10, 2008