Patient-Centered Medical Home (PCMH)

Overview

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“In this experiment, UnitedHealth has worked closely with the doctors. And perhaps most importantly, the insurer has agreed to bear some of the initial costs of developing a medical home, including hiring a consultant to advise doctors on how to change their practices.”
“This [UnitedHealthcare’s PCMH pilot in Arizona] gives us the opportunity to create a model to allow family physicians to practice the way we used to practice in the past,” said Dr. Jim Dearing, a family practitioner in Phoenix who is among the physicians who have agreed to participate.
• Current transaction-based model and reimbursement does not recognize the value of and specifically reimburse for individualized, comprehensive, coordinated and comprehensive care management.
• Poor access for consumers to Primary Care
  – Significant reductions in physicians entering into and remaining in Primary Care Specialties
• Escalation of care unnecessarily into higher cost settings – specialty and hospital proportion increasing
• Suboptimal resource management (unnecessary and duplicative testing and treatment)
• Diminished health outcomes – particularly for those with chronic disease and behavioral health issues
• Erosion of Primary Care Capacity*
  – Population demands exceed current PC physician base
  – Too few medical students are choosing PC
  – Collapse will lead to higher cost of care in general

* ACP Report January 30, 2006 – “The Impending Collapse of Primary Care Medicine and its Implications for the State of the Nation’s Health Care”
Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care of adults, youth and children. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.

Principal Characteristics of PCMH:

- Personal Physician
- Physician Directed Practice
- Whole Person Care Orientation
- Coordinated Care
- Quality and Safety **
- Enhanced Care Access
- Full Value Payment
- Optimization through HIT integration (eRx, patient registry)

* As originally defined by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians, American Osteopathic Association (AOA)

** To include a voluntary recognition process by an appropriate non-governmental entity to demonstrate that practices have the capabilities to provide patient-centered services consistent with the medical home model.
Medical Home is the Foundational Program to Achieving Primary Care Transformation

“Systemness” → Reduced Variation → Higher Quality
Higher Quality → More Affordable, Safer Health Care
• **Transformed primary care practice team** that commits to expanding patient access & engagement, improving chronic condition population management, team-based care that focuses on care transitions & coordination, monitoring performance on key quality/utilization measures and effectively utilizing available technologies including patient registries and ePrescribing.

• **Primary care practice supported** (either by the pilot convening organization, the state QIO, or participating payers) to:
  – Assist in the practice transformation and acquiring NCQA PPC-PCMH certification
  – Provide enabling technologies and timely/actionable patient clinical data
  – Care coordination support

• **Enhanced reimbursement to the primary care practice** that is aligned with the benefits of transformed, comprehensive primary care.

• **Activated consumer** that is engaged by the PCMH pilot stakeholders.
UHC’s PCMH Approach in Arizona

PRACTICE QUALIFICATIONS (Based on NCQA PCC-PCMH)

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<tr>
<th>Enhanced Access</th>
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<tr>
<td>Timely Appointment Scheduling</td>
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<td>Evening, Weekend and Holiday Hours</td>
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<td>After-Hours Support</td>
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<th>Care and Chronic Condition Management</th>
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<td>Specialty Referral Coordination and Tracking</td>
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<td>Disease and Case Management Enrollment</td>
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<th>Team Care</th>
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<td>Physician-directed team both in and outside of the practice setting</td>
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<td>Management of Care Transitions across the Health Care Continuum</td>
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<th>Performance Measurement, Assessment &amp; Improvement</th>
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<td>Practice in accordance with clinical evidence</td>
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<td>Performance Evaluation Based on Medical Best Practices</td>
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<td>Measurement of Clinical Processes and Outcomes</td>
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<th>Clinical Information Systems</th>
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<td>Care Management</td>
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<td>Decision Support</td>
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<td>Electronic Prescription Filling</td>
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Benefits

- Improved Quality at Lower Cost
- Enhanced Patient Satisfaction
- Improved Patient Safety
- Care Continuity & Improved Care Transitions
- Improved Practice Profitability and Satisfaction
- Value-based Payment
- Simplified and Coordinated Health Care Experience

UHC OFFERS: ENABLING TECHNOLOGY & CLINICAL SUPPORT

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<tr>
<th>Technology &amp; Tools</th>
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<td>Personal Health Record</td>
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<td>Point of Care Information</td>
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<td>Electronic Prescriptions</td>
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<td>In-depth reporting</td>
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<th>Care Coordination Management &amp; Support</th>
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<td>Health plan care &amp; disease management</td>
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<td>Educational Materials</td>
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<td>Patient Activation Tools</td>
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<th>Transformation Support</th>
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<td>Assigned facilitator</td>
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<td>Online tools</td>
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<td>&quot;Boots on the ground&quot; resources</td>
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<td>Approach</td>
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| **1. Proof of Concept Pilot** | Arizona: partnership with IBM and other large ASO group(s), selection of high-volume practices. Inclusion of other product lines including Secure Horizons Medicare and AmeriChoice Medicaid. | • Seven primary care practices in Tucson and Phoenix  
• Pilot kick-off February 2009  
• Practice transformation started Q1 2009  
• Enhanced reimbursement, clinical data sharing to begin Q2 2009 |
| ✷ Led by UnitedHealthcare | | |
| **2. Participate in multi-payer collaborative** | Colorado: UnitedHealthcare is one of 5 payers convening around common practices. Other 2009 collaborations may include Ohio and New York | • Study (measurement) vendor is Harvard Public School of Health; funded by Commonwealth  
• Inclusion of second market (Ohio) as part of study  
• Collaborative working through common processes, measures, and practice selection  
• Targeted start Q2 2009 |
| ✷ Led by Colorado Clinical Guidelines Collaborative | | |
| **3. Regional or local efforts** | Rhode Island: locally driven with national SME oversight; responding to local market dynamics. | • Five practices identified for initiative.  
• Care coordinator positions placed and enhanced reimbursement started Q4 2008  
• Q2 2009 finalize study requirements and practice clinical data sharing |
| ✷ Led by Chronic Care Sustainability Initiative (QIO) | | |
Pilot Success – Measurement Criteria

**Physician & Patient Experience**
- Patient Experience Satisfaction
- Access to Care
- Self-Reported Patient Health
- Physician and Care Team Satisfaction

**Quality**
- Preventive and Chronic Care Screening
- Behavioral Health Coordination
- Use of EBM Guidelines
- Medication Adherence
- Coordination of Care Transitions: ER, IP, and Specialists
- Use of Q&E Specialists and COEs

**Resource Use**
- Hospital
- Emergency Care
- Pharmacy
- Imaging
- Physician Office, Specialty Care
- Comprehensiveness of services

Data Sources: Claims Data, Clinical Data, Qualitative Interviews with Physicians, Observation, Qualitative Surveys of Physicians and Patients
Practice Participation Criteria

• Maintain or achieve UnitedHealth Premium Designation “quality” designation.
• Practice is motivated to participate in the pilot and has strong leadership to champion the effort.
• Practice assigns a program manager to the project to facilitate interaction with the UnitedHealthcare and practice redesign project teams.
• Achieve at least Level 1 NCQA PPC-PCMH prior to the initiation enhanced payment.
  – Reach next level NCQA PPC-PCMH at pilot mid-point (actual timing TBD).
  – Perform at high levels on the following NCQA dimensions: access, care coordination, evidence-based care delivery, communication.
• Perform effective care transition management, particularly for complex patients and end to end care coordination of inpatient events back to ambulatory care.
• Actively participate in a practice transformation program.
• Willingness to share key performance data and participate in performance feedback (data sharing).
  – Support and participate in program measurement.
  – May involve collection of high prevalence clinical measures and satisfaction data.
Pilot Reimbursement Model

Total Reimbursement builds on the current Fee for Service (FFS) with a PMPM Fee and a bonus option based on practice performance.

- Physicians remain on current contracted fee schedules and continue to be reimbursed based on actual services provided
- Quarterly, prospective PMPM supplement based upon quality, efficiency, and satisfaction improvements anticipated under the PCMH Model – contract addendum required
- PCMH is grounded in providing more comprehensive, coordinated care and reducing the delivery of services in suboptimal settings; it is not about delivering less care to the patient (not capitation).
- Pilot practices will be eligible for a quarterly performance bonus that aligns with clearly defined clinical quality and operational measures that will be developed collaboratively with the pilot practices.
• **UnitedHealthcare’s savings model** assumes increased access, improved care coordination, and a patient-centric approach to ensure the right care, from the right provider, at the right time.

• The **increased primary care reimbursement** is generated from an anticipated reduction in avoidable and duplicative services and clinical practice in accordance with the evidence.

• **Six primary benefit levers** for utilization and medical/pharmacy cost spend are expected to be impacted by the transformed, comprehensive primary care practice.

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<tr>
<th>Target Reduction</th>
<th>Avoidable Inpatient Utilization</th>
<th>Avoidable Outpatient ER Utilization</th>
<th>Sub-optimal Network Utilization</th>
<th>Sub-optimal Pharmacy Spend</th>
<th>Inappropriate Radiology Utilization</th>
<th>Chronic Care Patient Resource Use</th>
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<tr>
<td></td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
<td>3%</td>
<td>2.5%</td>
<td>2%</td>
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<tr>
<td>Gross Savings Contribution</td>
<td>50%</td>
<td>15%</td>
<td>5%</td>
<td>10%</td>
<td>5%</td>
<td>15%</td>
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**The Role of the Practice**

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<th>PCMH Practices</th>
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**Organize** the delivery of care for all patients with sub-specialists, disease management and community resources and other care venues (Emergency Room, Hospital, Skilled Nursing Facility)

**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** (resource utilization, quality and member satisfaction)

Source: Michael S. Barr, MD, MBA, FACP, American College of Physicians, presentation to the THINC Quality & Clinical Committee on November 29, 2007
The Role of the Patient

Active participate in medical decisions with their physician and other medical home providers

Use the Medical Home as the primary site of care for preventive check-ups and sick care

Take ownership of their own health and making good health decisions
- Follow up on care team recommendations
- Take medications as prescribed
- Manage symptoms
- Read educational materials
- Utilize self-management tools
- Engage with disease management programs as appropriate
- Feel empowered to ask about care options

Physician

Patient
The Role of the Purchaser

- **Demonstrate leadership** in the need for primary care reform
- Support **payment transformation** through contributions to physician payment
- Insist on well structured research and **measurement of the value** of the medical home model
- Assist in development of employee/patient engagement and activation strategies
  - Benefit design
  - Employee/Member education
  - Incentives for behavior changes