

Primary Care in the 21st Century

Nancy L. Swigonski, MD, MPH



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Current Health Care System

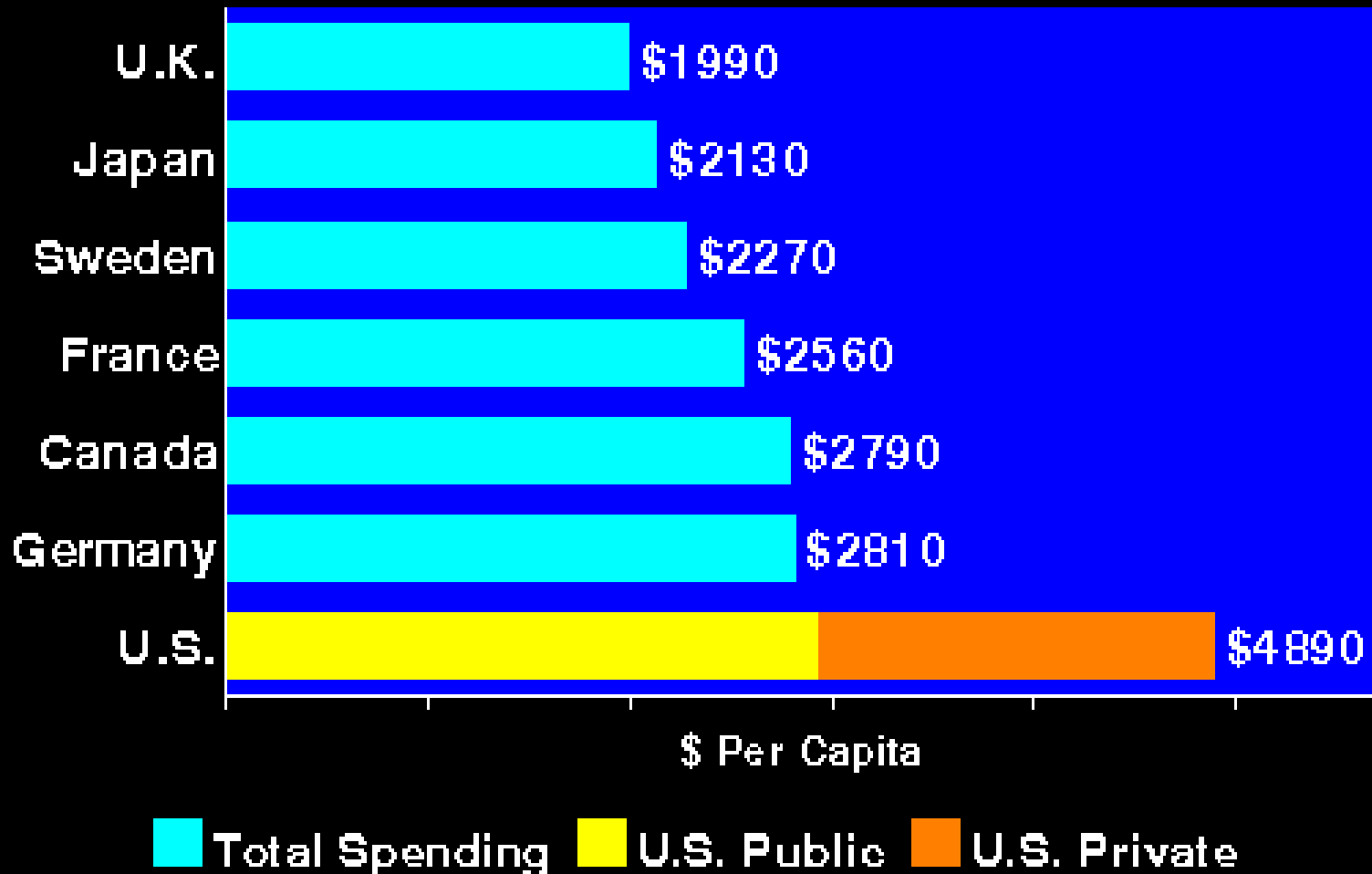


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Per Capita Spending on Health Care

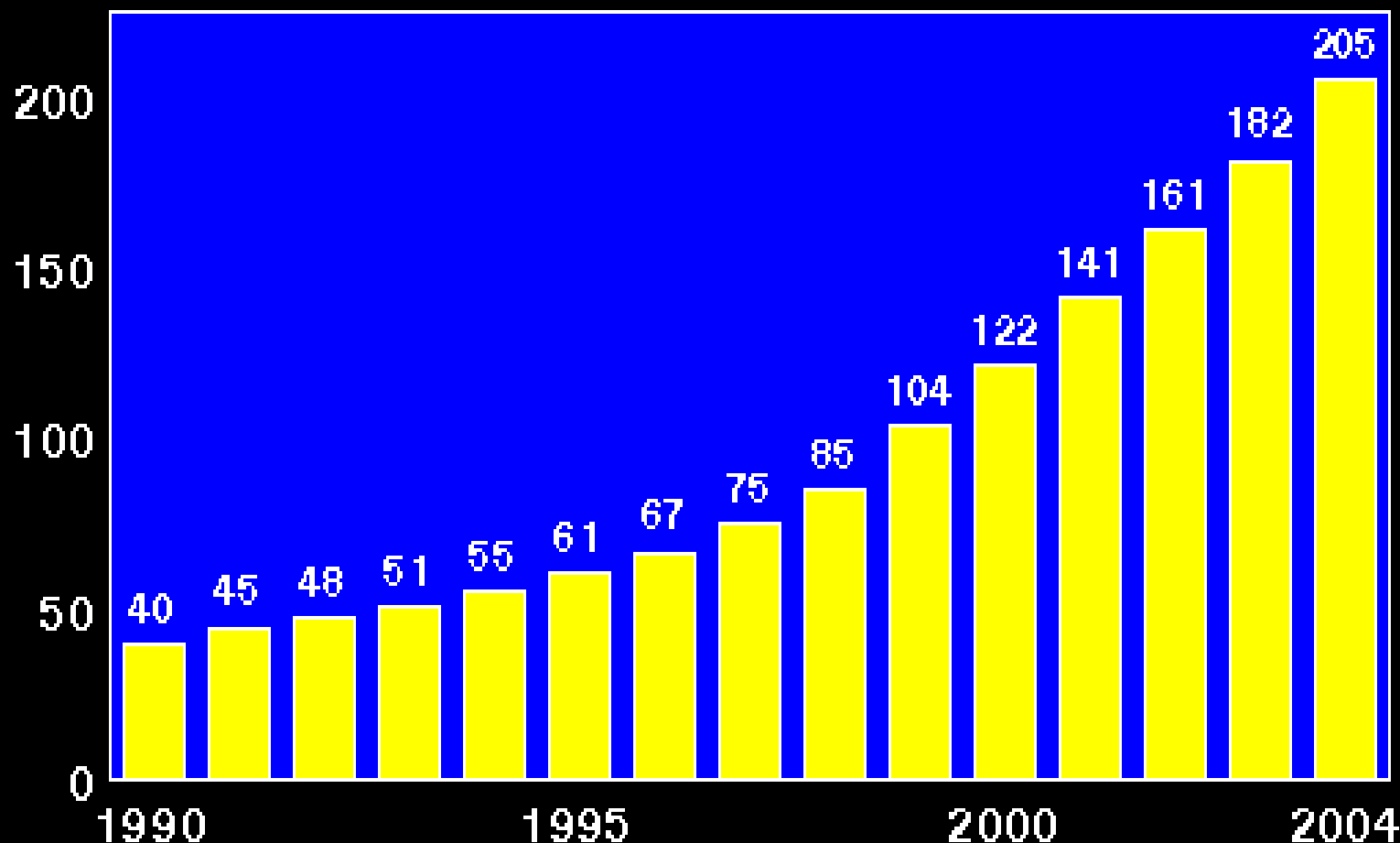


Note: Public includes benefit costs for govt. employees & tax subsidy for private insurance

Source: OECD 2003; Health Aff 2002; 21 (9):98.

U.S. Drug Spending, 1990-2004

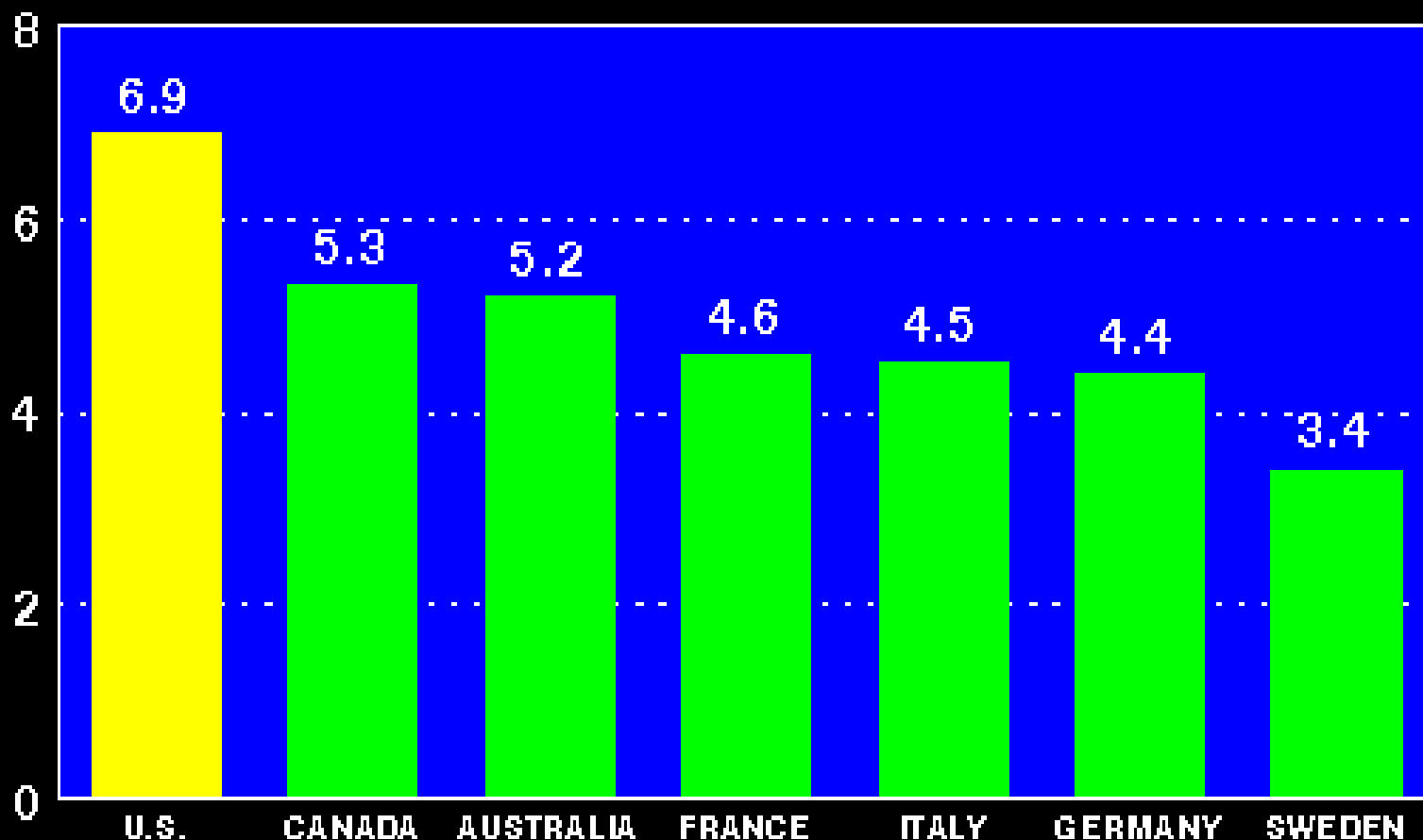
Prescription Drug Spending - Billions of Dollars



Source: CMS, Office of the Actuary - Note: 2002-2004 estimated

INFANT MORTALITY, 2000

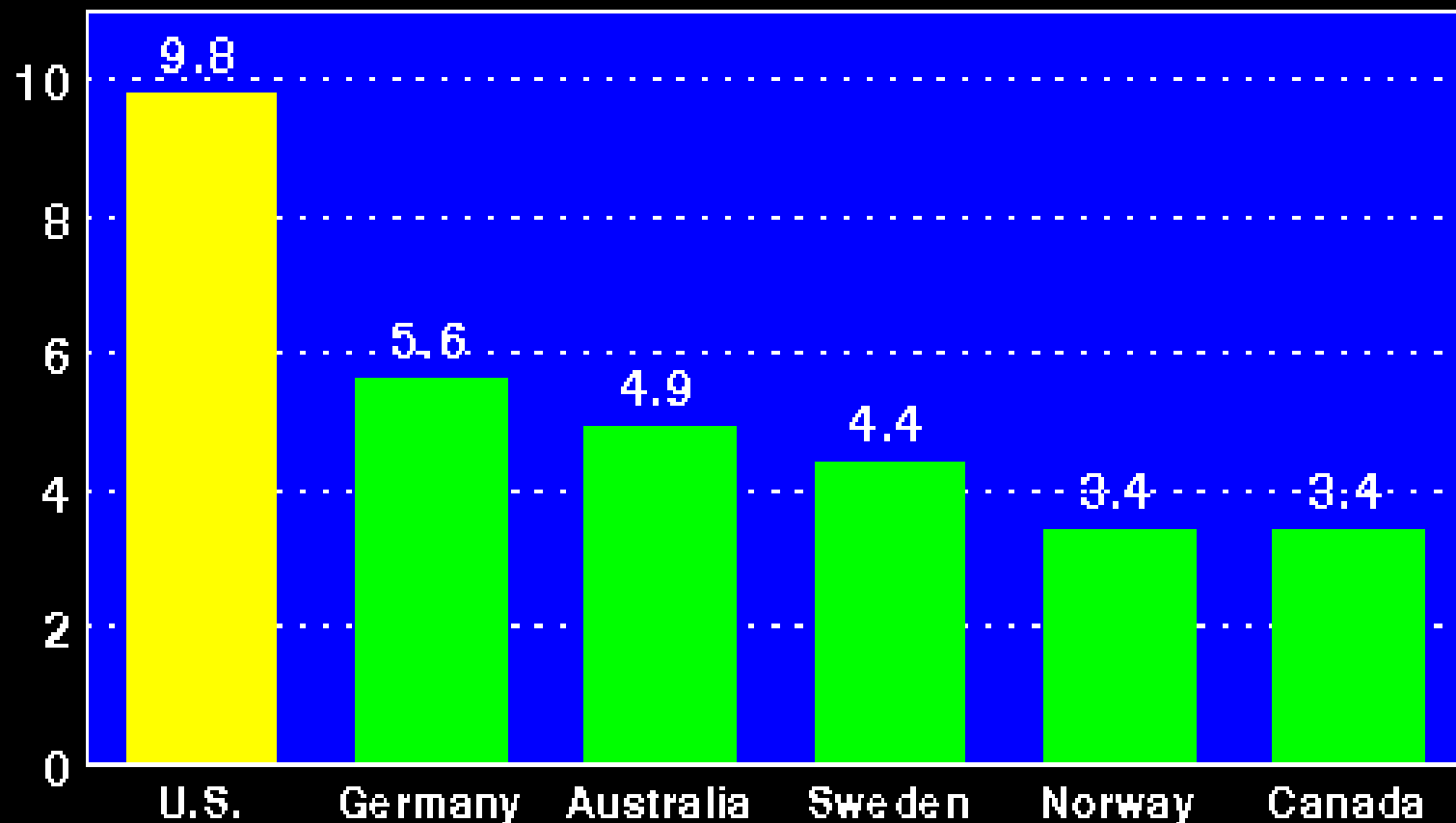
DEATHS IN FIRST YEAR OF LIFE/1000 LIVE BIRTHS



Source: OECD, 2003

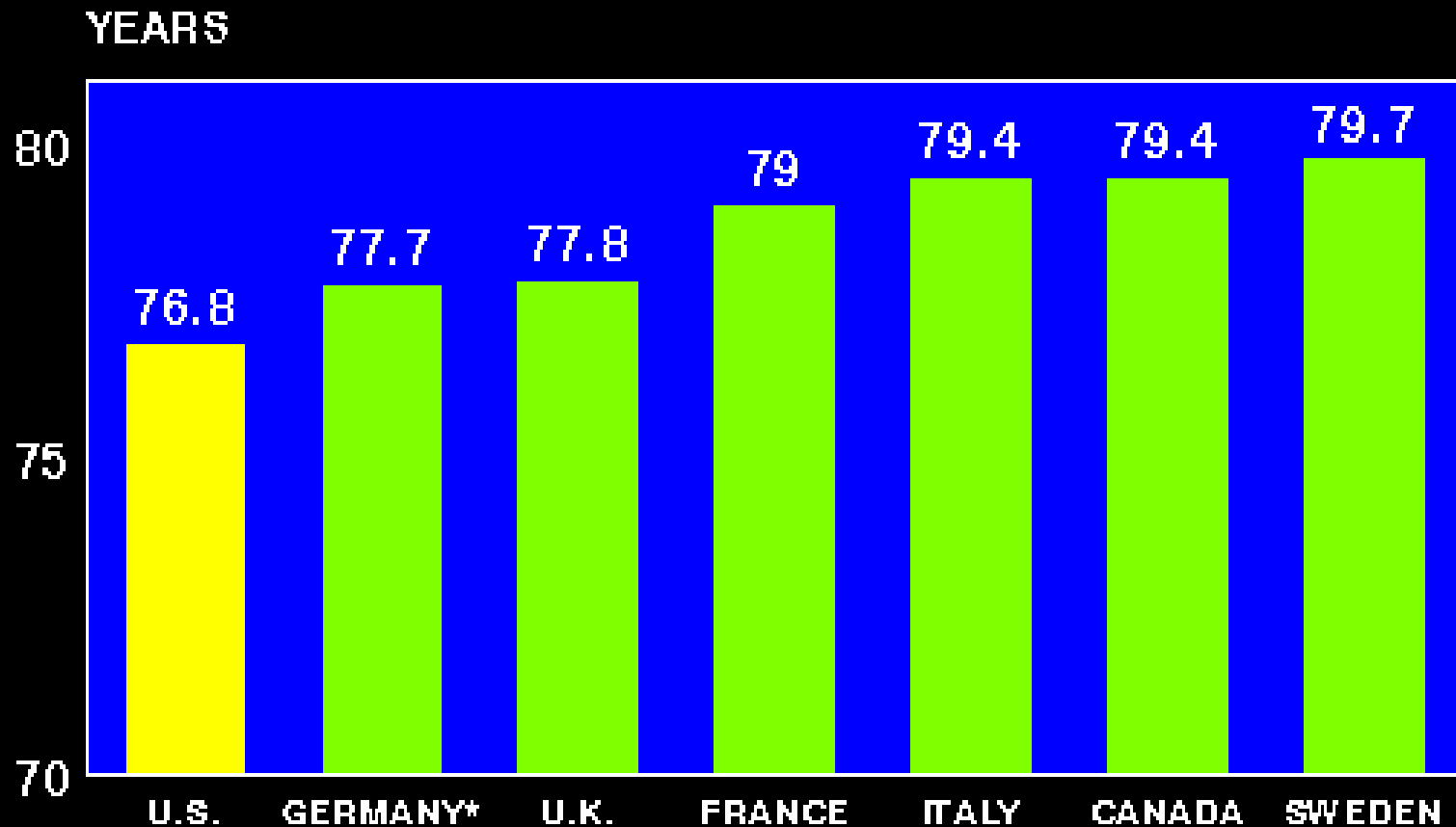
Maternal Mortality, 2001

Deaths/100,000 Births



Source: OECD, 2003 - Note data for Germany, Sweden and Canada are for 2000

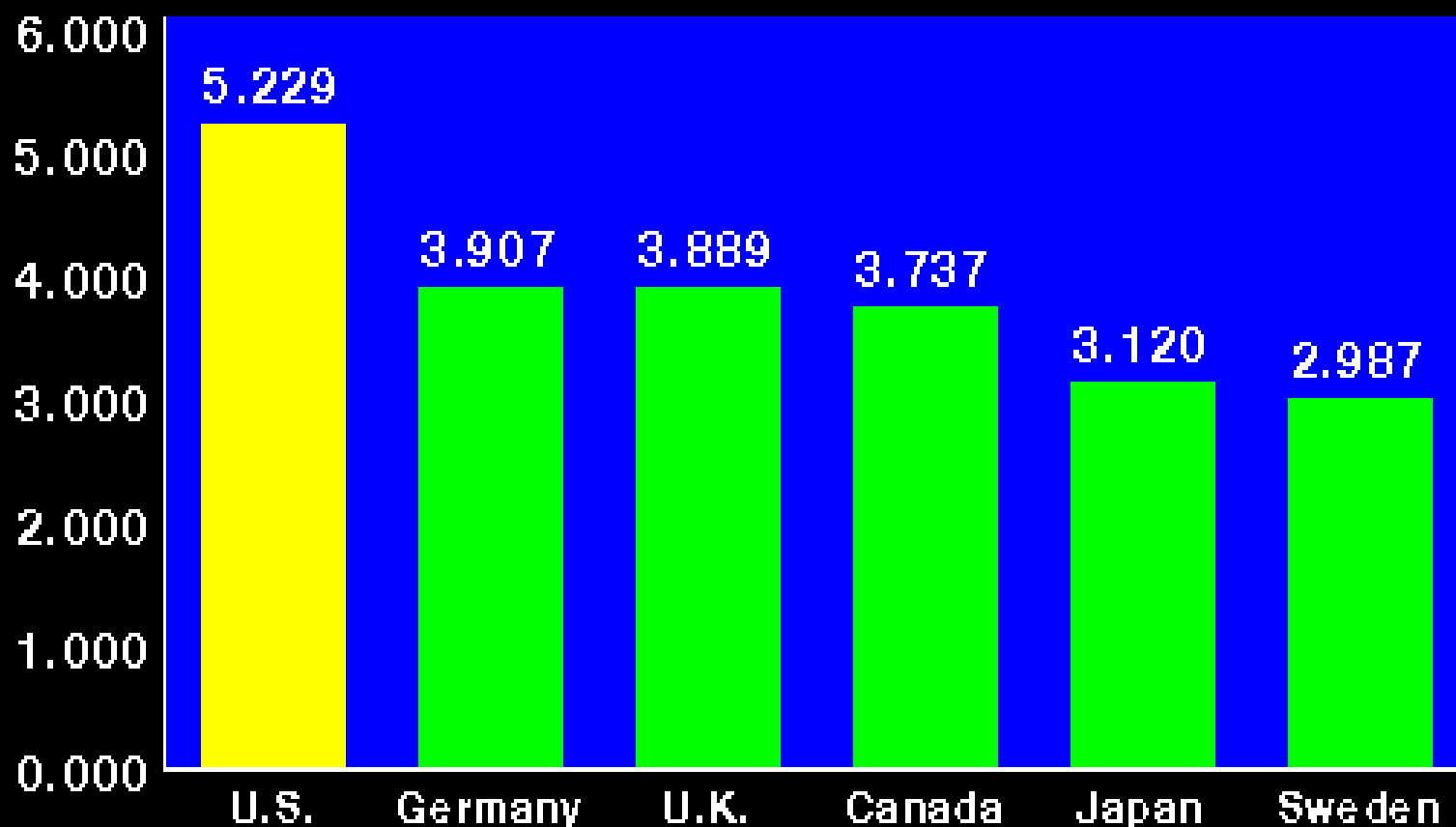
LIFE EXPECTANCY, 2000



SOURCE: OECD, 2003

* Data are for 1999

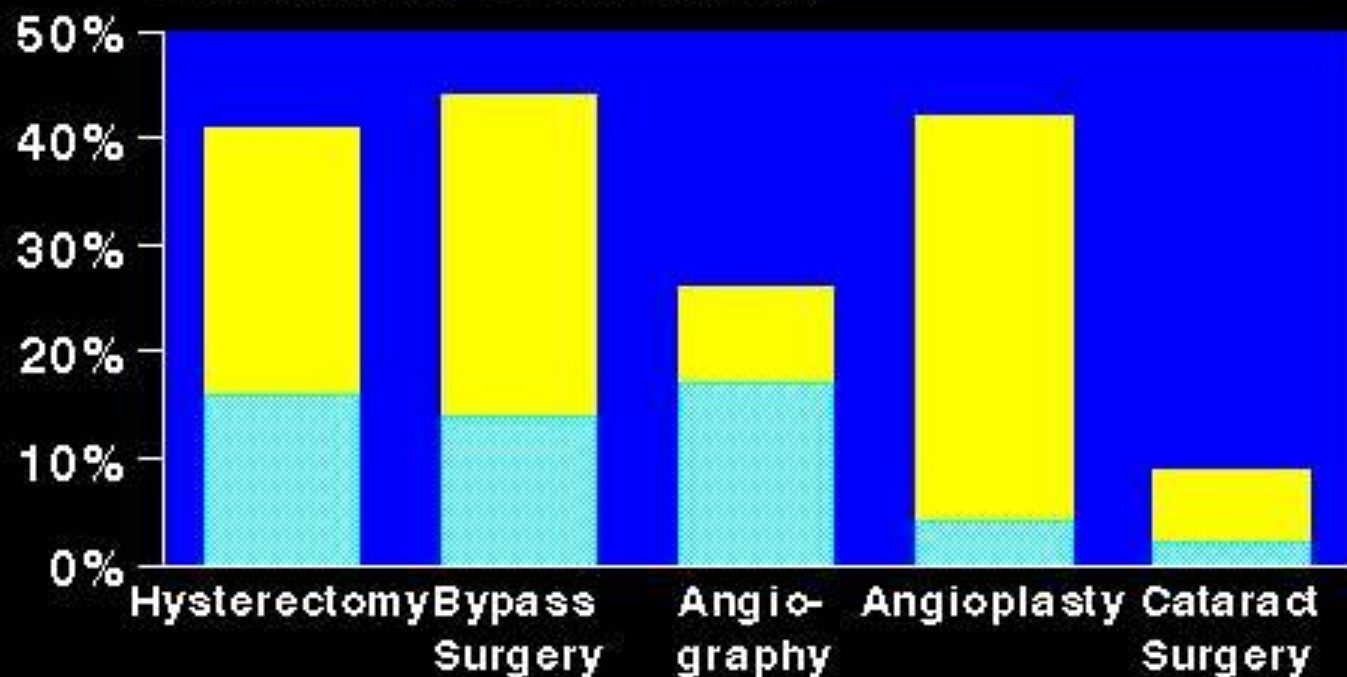
Potential Years of Life Lost per 100 People for All Causes, 1999



Source: OECD, 2003 - Note: Data for Canada are for 1998

Unnecessary Procedures

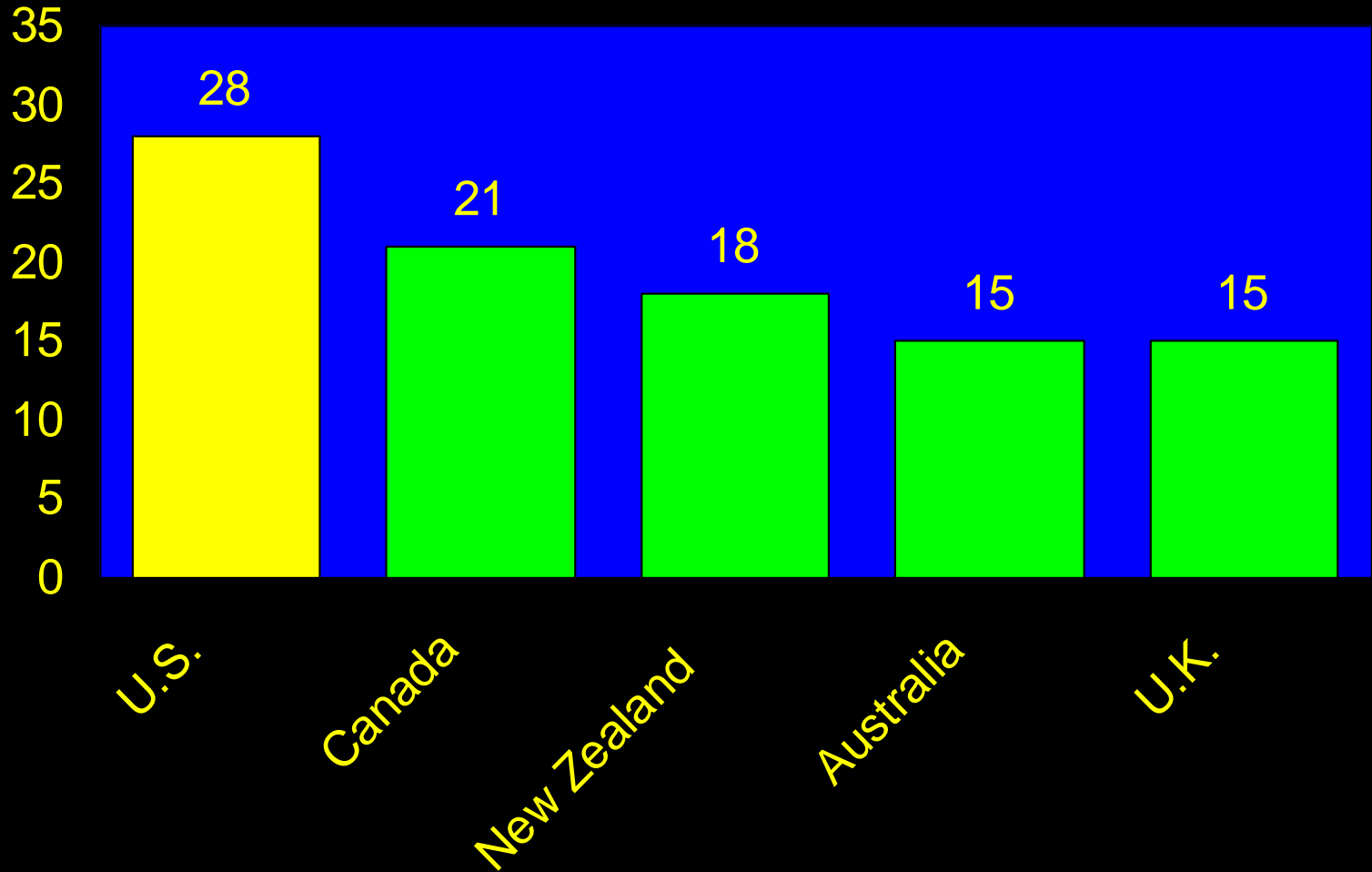
Percent of Procedures



Questionable	25%	30%	9%	38%	7%
Inappropriate	16%	14%	17%	4%	2%

Trouble Getting Needed Care

% finding it extremely, very or somewhat difficult to get care when needed



Crossing the Quality Chasm:

A New Health System for the 21st Century

Institute of Medicine, 2001

“The current care systems
cannot do the job.

Trying harder will not work.

Changing systems of care will.”

How Can the Goal be Achieved?

“Private and public purchasers should examine their current payment methods to remove barriers that impede quality improvement and to build in stronger incentives for quality enhancement.”

– *Institute of Medicine*

Primary Care



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Why Primary Care?

- Adults with PCP rather than specialists as their personal physician
 - 33% lower annual adjusted cost of care
 - 19% lower adjusted mortality

Adjusted for age, gender, income, insurance, smoking, perceived health (SF-36) and 11 major health conditions Franks, 1998

- Increased primary care to population ratios are associated with reduced hospitalization rates for 6 ambulatory care sensitive conditions Parchman, 1994

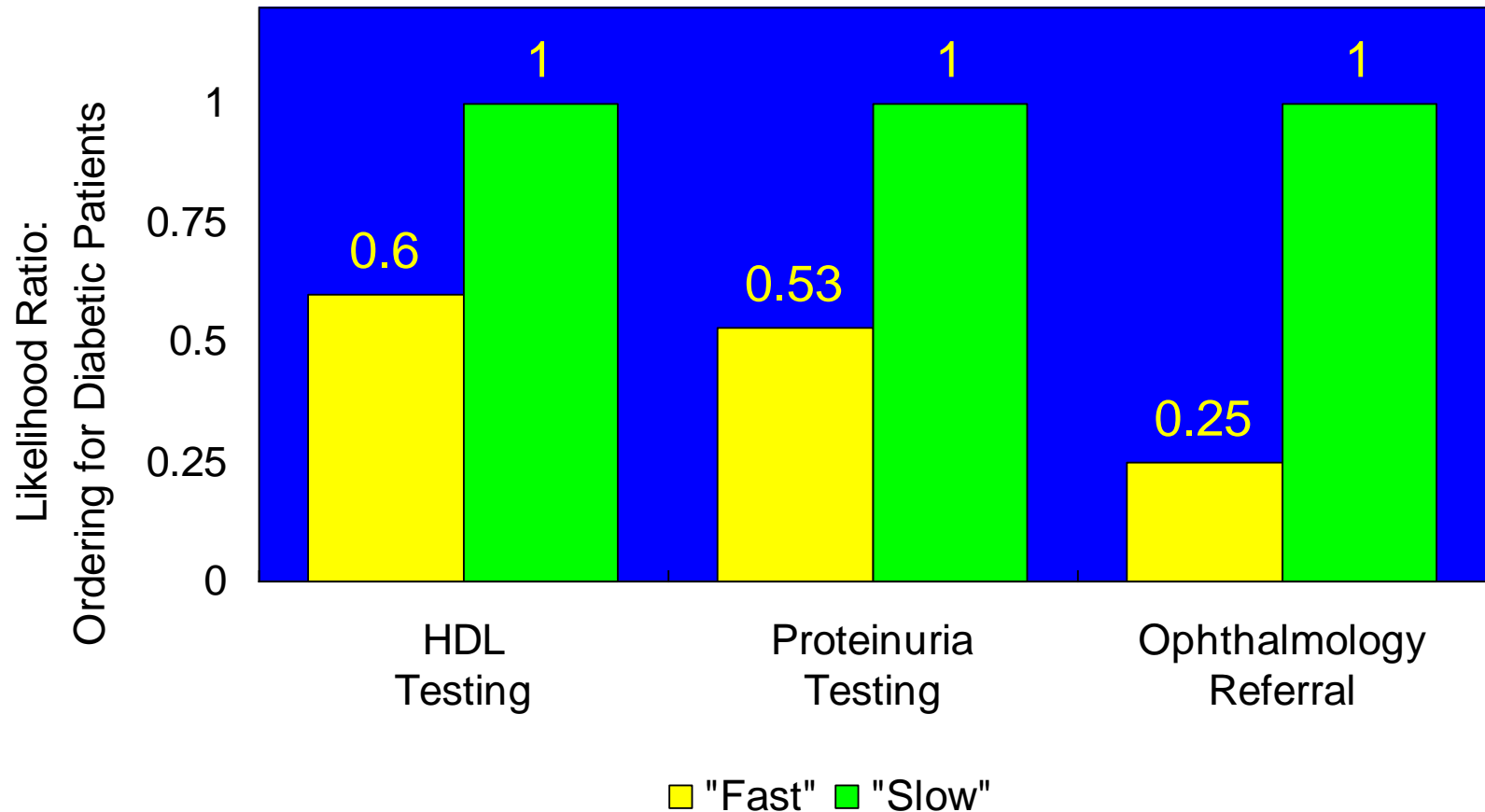
- Health care costs are higher in regions with higher ratios of specialists to generalists Welch, 1998

- Primary care physician supply associated with improved health outcomes, including all-cause, cancer, heart disease, stroke, infant mortality; low birth weight; life expectancy; and self-rated health Macinko, 2007

Rank	Index of illness or death	Underlying causes of death	Disability-adjusted years lost	life	Expenditures by diagnostic category	Causes of missed work days
1	<i>Cardiovascular</i>	<i>Tobacco use</i>	<i>Cardiovascular</i>		<i>All circulatory disease</i>	Injuries
2	<i>Cancer</i>	Diet and physical activity patterns	<i>Major depression</i>		Digestive	<i>Influenza</i>
3	<i>Stroke</i>	Alcohol use	<i>Cerebrovascular</i>		<i>Mental health</i>	<i>Infections</i>
4	<i>Bronchitis and emphysema</i>	<i>Infection</i>	Motor vehicle injuries		Injury and poisoning	Common cold
5	Injuries	Pollutants and toxins	Alcohol use		Neurologic	Digestive system
6	<i>Pneumonia and influenza</i>	Firearm injuries	Osteoarthritis		<i>Respiratory</i>	Other acute upper respiratory
7	<i>Diabetes</i>	<i>Sexual behavior</i>	<i>Lung and tracheal cancer</i>		Musculoskeletal	Acute ear infections
8	AIDS	Motor vehicle injuries	Dementia		<i>Cancer</i>	
9	Suicide	Illicit drug use	Self-inflicted injuries		<i>Genito-urinary</i>	
10	Chronic liver disease		Congenital anomalies		<i>Endocrine and immune</i>	

- 1/2 U.S. deaths occur as a result of preventable causes
- Yet > 95% of our health-care spending is committed to diagnosis and treatment as opposed to prevention

More "Productive" Physicians Provide Poorer Care



Fast physicians = those seeing more pts./hour than average
Slow Physicians = those seeing fewer pts./hour than average

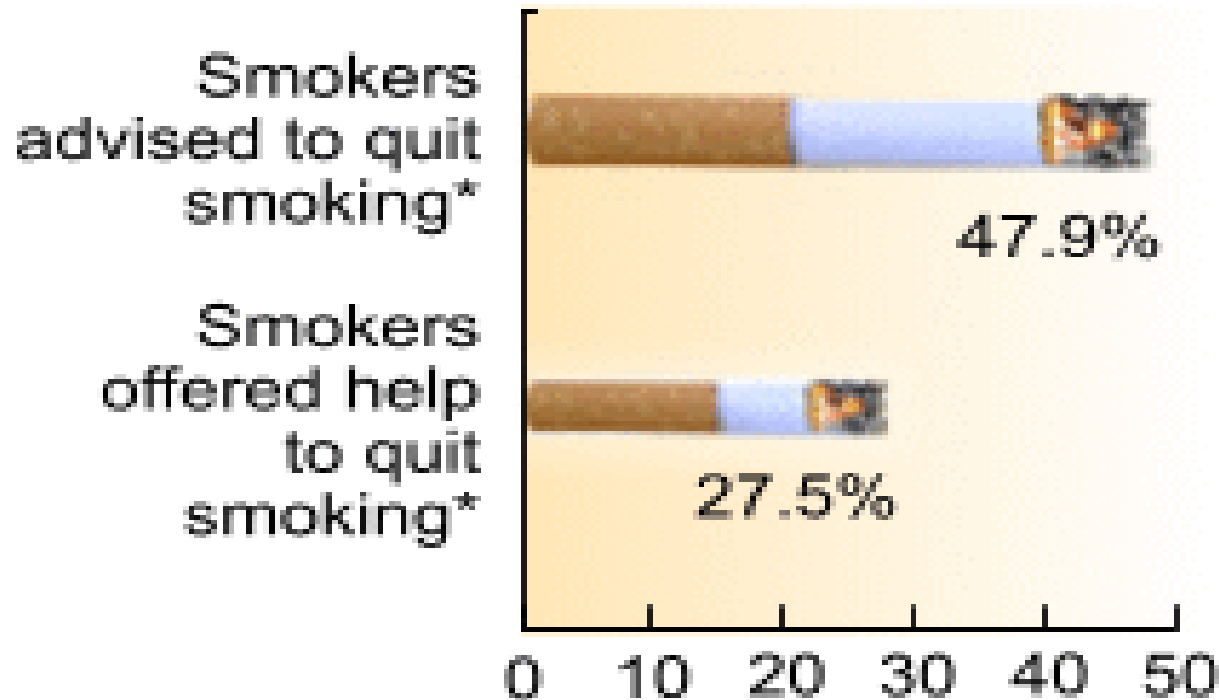
Source: Arch Int Med 1999; 159:294

Priority Preventive Services

- tobacco cessation counseling to adults
- screening older adults for undetected vision impairments
- offering adolescents an anti-tobacco message or advice to quit use of tobacco
- counseling adolescents on alcohol and drug abstinence
- screening adults for colorectal cancer
- screening young women for chlamydial infection
- screening adults for problem drinking
- vaccinating older adults against pneumococcal disease

Coffield AB, Maciosek MV, McGinnis JM, et al. Priorities among recommended clinical preventive services. *Am J Prev Med* 2001;21:1–9.

Smoking Cessation Advice and Assistance, United States, 2005



*By healthcare professionals during the past 12 months

<http://www.cdc.gov/Features/dsSmokingCessation/>

Primary Care Transformation

Evolution of the Medical Home



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1992

AAP Medical Home Policy Statement

- Accessible
- Family-centered
- Coordinated
- Community-based
- Compassionate
- Comprehensive
- Culturally effective

Case Study



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2002 Medical Home Policy Statement



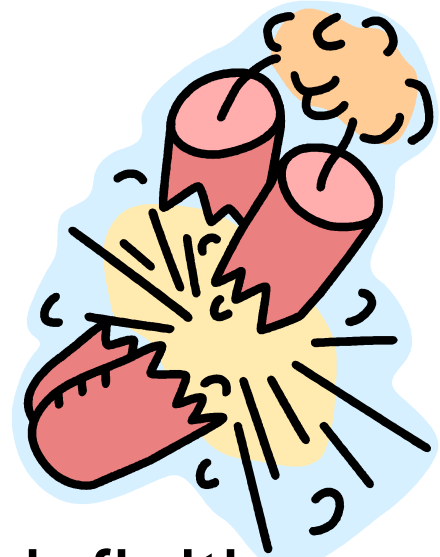
- **Primary care** (all children)
- Family-centered partnership
- Community-based, interdisciplinary approach
- Care that is accessible, family-centered, coordinated, compassionate, continuous, and culturally effective
- Preventive, acute and chronic care
- **Quality improvement**

The Chronic Care Model



Developed by The MacColl Institute
© ACP-ASIM Journals and Books

Recent Developments Medical Home Revolution



- Buyer activism
- Standardized medical home definition
- NCQA standards
- Testing of models and continued growth of evidence

Buyer Activism

Patient Centered Primary Care Collaborative (PCPCC)



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Patient Centered Primary Care Collaborative (PCPCC)

Professional Organizations

- AAP
- AAFP
- ACP
- AOA

Insurers

- Aetna
- BC/BS
- CIGNA
- CVS
- Humana, Inc
- United Healthcare
- Wellpoint

Businesses

- AFL/CIO
- Dow Chemical
- GlaxoSmith Kline
- IBM
- Medico
- Merck
- Microsoft
- Novartis
- Pfizer
- Walgreens
- Walmart
- ERIC

www. <http://www.pcpcc.net/>

Patient Centered Primary Care Collaborative (PCPCC)

Professional Organizations

- The American Academy of Chest Physicians
- The American Academy of Hospice and Palliative Medicine
- The American Academy of Neurology
- The American College of Cardiology
- The American College of Osteopathic Family Physicians
- The American College of Osteopathic Internists
- The American Geriatrics Society
- The American Medical Directors Association
- The American Society of Addiction Medicine
- The American Society of Clinical Oncology
- The Society for Adolescent Medicine
- The Society of Critical Care Medicine
- The Society of General Internal Medicine

Patient Centered Primary Care Collaborative (PCPCC)

Businesses / Insurance

- AARP
- AccessPsych
- Aetna
- Affiliated Computer Services
- AFL-CIO
- Amedisys, Inc.
- American Health Quality Association
- Amerigroup Corporation
- AMIA
- Arkansas Foundation for Medical Care
- Association of Departments of Family Medicine
- Assurance of Care
- Aurum Dx
- Automotive Industry Action Group
- Better Health Technologies, LLC
- BlueCross BlueShield Association
- Bridges To Excellence
- Borgess Ambulatory Care
- The Capital District Physicians' Health Plan, Inc.
- Carena, Inc.
- CARF International
- Caterpillar
- The Center for Excellence in Primary Care
- The Center for Health Value Innovation
- The Center for Medical Home Improvement
- Central Jersey Physician Network
- Children's Mercy Family Health Partners
- CIGNA
- Colorado Center for Chronic Care Innovations
- Community Care Plan of Eastern Carolina

Patient Centered Primary Care Collaborative (PCPCC)

Businesses / Insurance

- CVS Caremark
- Day Kimball Hospital
- Delmarva Foundation
- Deloitte
- Delphi Corporation
- The Department of Community and Family Medicine, Saint Louis University School of Medicine
- The Department for Family and Community Medicine, University of California, San Francisco
- The Department of Family and Community Medicine at the University of Texas Health Science Center at San Antonio
- Deseret Mutual
- DMAA: The Care Continuum Alliance
- DocInsight, Inc.
- The Dow Chemical Company
- eHealth Initiative
- Eliza Corporation
- Employer Health Care Alliance
- Enigami Systems, Inc.
- Equity Health Partners
- The ERISA Industry Committee
- Exelon Corp
- FedEx Corporation
- Foundation for Informed Medical Decision Making
- Froedtert/Medical College of Wisconsin Primary Care Initiative
- Geisinger Health Systems
- GE Energy
- General Mills, Inc.
- General Motors
- Genesys Physician Hospital Organization
- GlaxoSmithKline
- Gratiot Family Practice
- Group Health Cooperative

Patient Centered Primary Care Collaborative (PCPCC)

Businesses / Insurance

- Harvard Pilgrim Health Care
- Healing Hearts Inc
- Health Alliance Plan
- Healthcare 2.0 Reliance LLC
- Health Care Service Corporation
- Health Dialog
- HR Policy Association
- Humana, Inc.
- Huron Valley Physicians Association
- IBM
- Incenter Strategies
- INSPIRIS
- Institute for Clinical Systems Improvement
- Johns Hopkins Medicine Interactive
- Kaiser Permanente
- Maine Health Management Coalition
- Marathon Health
- Massachusetts Health Data Consortium
- MASSPRO
- Mayo Clinic, Center for Innovation
- McKesson Corporation
- MDdatacor
- MedAllies
- Medco
- Medem, Inc.
- Medical Group Management Association
- Medical Network One
- Medication Management Systems, Inc.
- MedLink, Inc.
- Memphis Business Group on Health
- Merck
- Metcare of Florida
- Michigan Department of Community Health, Chronic Disease and Injury Prevention Division
- Michigan Osteopathic Association
- Michigan Primary Care Consortium

Patient Centered Primary Care Collaborative (PCPCC)

Businesses / Insurance

- Mayo Clinic, Center for Innovation
- McKesson Corporation
- MDdatacor
- MedAllies
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- Medical Group Management Association
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- MedLink, Inc.
- Memphis Business Group on Health
- Merck
- Metcare of Florida
- Michigan Department of Community Health,
Chronic Disease and Injury Prevention Division
- Michigan Osteopathic Association
- Michigan Primary Care Consortium
- Microsoft
- Midmark Corporation
- MVP Health Care
- National Association of Chain Drug Stores
- National Association of Community Health Centers
- National Business Coalition on Health
- National Business Group on Health
- National Coalition on Health Care
- National Committee for Quality Assurance
- National Consumers League
- National Partnership for Women & Families
- National Retail Federation
- New England Quality Care Alliance
- New Hampshire Citizens Initiative
- New York Business Group on Health
- New York City Department of Health and Mental
Hygiene
- North Carolina Healthcare Information and
Communications Alliance, Inc.
- Novartis
- Novo Nordisk

Patient Centered Primary Care Collaborative (PCPCC)

Businesses / Insurance

- The Pacific Business Group on Health
- Partners In Care
- Pfizer
- Phytel
- Practice Transformation Institute
- Prevent Blindness America
- Priority Health
- The Proctor & Gamble Company
- Puget Sound Health Alliance
- QuadMed
- Qualis Health
- Regional Health Plans
- The Reifsnyder Group, Inc.
- Retasure - Digital Healthcare
- Revolution Health
- Rhode Island Quality Institute
- RMD Networks
- The Roger C. Lipitz Center for Integrated Health Care at the Johns Hopkins Bloomberg School of Public Health
- Saint Patrick Hospital
- Sanofi-Aventis
- Savannah Business Group
- Schering-Plough Corporation
- Service Employees International Union
- Society of General Internal Medicine
- Society of Primary Care Fellows
- Society of Teachers of Family Medicine
- The Stoeckle Center at Massachusetts General Hospital
- TeleDoc, Inc.
- THINC RHIO, Inc.
- Thomas Group, Inc.
- Taconic IPA, Inc.
- Towers Perrin
- TransforMED
- Triad Healthcare Inc.
- UnitedHealthcare
- United States Steel

Patient Centered Primary Care Collaborative (PCPCC)

Businesses / Insurance

- U.S. Chamber of Commerce
- The Vitality Group
- Walgreens Health Initiatives
- Wal-Mart
- Watson Wyatt
- WebMD
- Wegmans Food Markets
- WellPoint, Inc.
- West Michigan Physician Network
- Wyeth
- Wyoming Primary Care Association
- Xerox

Patient Centered Primary Care Collaborative (PCPCC)

- Improve the “product” that is ultimately being purchased and delivered
- Improve quality and achieve efficiencies by recognizing and supporting the value of care that is provided to patients by primary care physicians

The Problem as Defined by PCPCC

- Employers want to buy high quality healthcare for their employees, but cannot buy the model of health care they want
- The reimbursement system is inadequate, health information technology is insufficient, and accountability and incentives are not in place
- That is why we created the PCPCC and want change

Definition



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AAP, AAFP, ACP, AOA 2007 Joint Principles of the Patient-Centered Medical Home (PCMH)

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety are hallmarks of a medical home
- Enhanced access to care
- Payment appropriately recognizes the added value

AAP, AAFP, ACP, AOA 2007 Joint Principles of PCMH

- Personal physician
 - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care
- Physician directed medical practice
 - the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients

AAP, AAFP, ACP, AOA

2007 Joint Principles of PCMH

- Whole person orientation
 - the personal physician is responsible for providing or arranging for all the patient's health care needs - includes care for all stages of life; acute care; chronic care; preventive services; and end of life care
- Care is coordinated and/or integrated
 - across all elements of the complex health care system and the patient's community.
 - care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it

AAP, AAFP, ACP, AOA

2007 Joint Principles of PCMH

- Quality and safety are hallmarks of the medical home:
 - Practices go through a voluntary recognition process to demonstrate capabilities to provide patient centered services consistent with the medical home model
 - Patients and families participate in quality improvement activities at the practice level
- Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff

AAP, AAFP, ACP, AOA

2007 Joint Principles of PCMH

- Payment appropriately recognizes the added value
 - Reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit.
 - Pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
 - Support adoption and use of health information technology for quality improvement;
 - Support provision of enhanced communication access such as secure e-mail and telephone consultation;
 - It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

Standards

How do we measure PCMH?



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NCQA Recognition -- Physician Practice Connections Patient-Centered Medical Home (PPC-PCMH)

- Practices attest to 2007 Joint Principles of the Patient-Centered Medical Home
- Apply for Recognition with understanding that
 - the PPC PCMH standards assess many [but not all] of the ways in which the practice functions as PCMH
 - Concept of the medical home and how to operationalize it is evolving and will result in future versions of the Joint Principles and PPC-PCMH

PCC-PCMH Standards

Standard 1: Access and Communication

- A. Has written standards for patient access and patient communication*****
- B. Uses data to show it meets its standards for patient access and communication*****

Standard 2: Patient Tracking and Registry Functions

- A. Uses data system for basic patient information (mostly non-clinical data)
- B. Has clinical data system with clinical data in searchable data fields
- C. Uses the clinical data system
- D. Uses paper or electronic-based charting tools to organize clinical information*****
- E. Uses data to identify important diagnoses and conditions in practice*****
- F. Generates lists of patients and reminds patients and clinicians of services needed (population management).

PCC-PCMH Standards

Standard 3: Care Management

- A. *Adopts and implements evidence-based guidelines for three conditions* ****
- B. Generates reminders about preventive services for clinicians
- C. Uses non-physician staff to manage patient care
- D. Conducts care management, including care plans, assessing progress, addressing barriers
- E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities

Standard 4: Patient Self-Management Support

- A. Assesses language preference and other communication barriers
- B. *Actively supports patient self-management*****

PCC-PCMH Standards

Standard 5: Electronic Prescribing

- A. Uses electronic system to write prescriptions
- B. Has electronic prescription writer with safety checks
- C. Has electronic prescription writer with cost checks

Standard 6: Test Tracking

- A. Tracks tests and identifies abnormal results systematically*****
- B. Uses electronic systems to order and retrieve tests and flag duplicate tests

Standard 7: Referral Tracking

- A. Tracks referrals using paper-based or electronic system*****

PCC-PCMH Standards

Standard 8: Performance Reporting and Improvement

- A. Measures clinical and/or service performance by physician or across the practice*****
- B. Survey of patients' care experience
- C. Reports performance across the practice or by physician *****
- D. Sets goals and takes action to improve performance
- E. Produces reports using standardized measures
- F. Transmits reports with standardized measures electronically to external entities

Standard 9: Advanced Electronic Communications

- A. Availability of Interactive Website
- B. Electronic Patient Identification
- C. Electronic Care Management Support

Does Medical Home Work?



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Tax Relief and Health Care of 2006

Medicare Medical Home Demonstration

- 3 year demonstration in 8 states
 - Define three “tiers” of medical home
 - Determine the physician work involved in a medical home
 - Determine clinical staff time, medical supplies and practice expense required for each “tier”
- Begin Jan., 2009

What Does a Patient-Centered Medical Home Cost?

- **Start Date:** December 1, 2007 **End Date:** November 30, 2008
- **Principal Investigator:** Michael Barr, M.D., M.B.A.
- There is considerable enthusiasm among physicians and payers for the patient-centered medical home (PCMH) as a model of primary care that can provide better quality of care, improve the patient experience, prevent avoidable emergency room use and hospitalizations, and reduce total costs of care.
- But little is known about how much it costs physician practices to implement and sustain components of the medical home. This project will define incremental costs and payment options associated with the implementation and operation of a PCMH. With this information, physicians, insurers, and policymakers will be in a better position to make key decisions with regard to implementing the medical home model, compensating providers for their comprehensive services, and recognizing and promoting the PCMH as the new standard of primary care.

Evaluating a Medical Home Demonstration in Two Health Plans

- **Start Date:** December 1, 2007 **End Date:** March 31, 2010
- **Principal Investigator:** Judith Fifield, Ph.D.
- A patient-centered medical home provides coordinated care and enhanced access to physicians (for example, by phone or e-mail, or after regular hours), makes use of clinical decision support tools and health information technology, engages patients in their care, and undertakes performance measurement and quality improvement activities.
- Two large health plans in New York are conducting a demonstration to promote medical homes by helping physician practices redesign their offices and revising the way they are reimbursed for patient services. Evaluation of this demonstration will determine if it is feasible to transform practices into medical homes and to assess the impact such a change has on quality of care, patients' care experiences, and the total costs of care.

Eight state Medicaid teams selected to meet in Washington, D.C. for summit to advance Patient Centered Medical Home model

WASHINGTON, D.C. June 19, 2008 – The National Academy of State Health Policy (NASHP) and the Patient Centered Primary Care Collaborative (PCPCC) announced today that eight state Medicaid initiatives were selected through a competitive process to participate in a July summit in Washington, DC. The invitation-only Medical Home Summit is designed to rapidly advance implementation of the Patient-Centered Medical Home (PCMH) model into state Medicaid programs.

The Medical Home Summit is supported by a grant from The Commonwealth Fund and is a joint initiative of NASHP, a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, and the PCPCC, a multi-stakeholder collaborative organized to provide better outcomes for patients, more efficient payment to physicians and better value, accountability and transparency to purchasers and consumers of health care.

The July 24-25 Summit will be a learning event designed to help foster innovation and widespread adoption of the PCMH model.

Teams from these leading-edge states will share information from current medical home demonstrations and policy developments with other teams in a collaborative setting.

“State policy makers are interested more and more in developing models of service delivery that support effective, patient-centered primary care,” said Neva Kaye, Senior Program Director with NASHP. “The Medical Home Summit will help these and other states improve the availability of medical homes to Medicaid and State Children’s Health Insurance Program (SCHIP) enrollees.”

Of 30 state Medicaid programs that submitted applications, teams from eight states were selected—Colorado, Minnesota, New Hampshire, Oklahoma, Washington, Idaho, Louisiana and Oregon. Selection was based on specific criteria:

The state’s documented commitment to improving the quality and availability of medical homes to Medicaid and/or State Children’s Health Insurance Program (SCHIP) participants;

The extensiveness of the state’s initiative; and

Those states with plans already underway for improving the quality or availability of medical homes to Medicaid and/or SCHIP participants

The Train Is Moving....



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CAPITOL HILL WATCH

Increasing Medicare Physician Payments, Testing 'Medical Home' Model Could Improve Quality of Care, Experts Say at Senate Finance Committee Hearing

An increase in Medicare reimbursements for primary care, revisions to the current payment system and a pilot program to test the use of medical homes for beneficiaries could lead to major changes in the U.S. health care system, witnesses said at a Senate Finance Committee hearing on Tuesday.....

CAPITOL HILL WATCH

Testimony

... cited the need to increase Medicare reimbursements for primary care, as current payment rates have discouraged entry into the field by medical students and have led to shortages of primary care physicians, general internists and general surgeons. ...

Mark Miller, executive director of the Medicare Payment Advisory Commission, said "We must [create] new payment systems that will encourage providers to change how they interact with each other," ... to increase care coordination and be jointly accountable for quality and resource use."

CAPITOL HILL WATCH

... medical homes allow staff to "get to know the patients and their families, follow their care, help them get access to specialists and social services, follow them when they are admitted to a hospital, contact them to confirm that they are taking the appropriate medication dosages and are available for advice 24 hours a day."

Conclusions



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Conclusions

- Trying harder will not work
- Time for redesign is now
- Medical Home is THE model for primary care in the 21st Century
- Drive for change by businesses and payors must be steered by pediatricians actively advocating, promoting and adopting the medical home
- We need YOU to climb on board and show everyone how good medical care works

- 1) join the debate
- 2) offer to put our good practices on display
- 3) help design reasonable quality measures
- 4) help specify which extra services deserve extra pay
- 5) adapt and adopt better business practices
- 6) show how we partner with community resources
- 7) frankly address the access issue
- 8) learn and practice quality improvement (it is also now required for re-certification)

We need to represent the diversity and value of Hoosier pediatric practices to the business, insurance and legislative leaders involved in the new direction of primary care.

Send us an e-mail or call us:

Nancy Swigonski

nswigons@iupui.edu (317-278-0552) or

Mary McAteer

drmary2@sbcglobal.net (317-844-5351).

- What method(s) have you used to improve care in your practice and community?
- What successes have you had in negotiating fair payment?
- What systems or resources do you use to coordinate care for your patients?
- How do we get the word out to all Hoosier pediatricians?