# 2011 Military Health System Conference

## The Patient-Centered Medical Home Neighbor: A Critical Concept for a Redesigned Healthcare Delivery System

*The Quadruple Aim: Working Together, Achieving Success*

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January 25, 2011

# Report Documentation Page

*Form Approved*
*OMB No. 0704-0188*



| 1. REPORT DATE | 2. REPORT TYPE | 3. DATES COVERED |
|---|---|---|
| **25 JAN 2011** | | **00-00-2011 to 00-00-2011** |

| 4. TITLE AND SUBTITLE | 5a. CONTRACT NUMBER |
|---|---|
| **The Patient-Centered Medical Home Neighbor: A Critical Concept for a Redesigned Healthcare Delivery System** | 5b. GRANT NUMBER |
| | 5c. PROGRAM ELEMENT NUMBER |
| 6. AUTHOR(S) | 5d. PROJECT NUMBER |
| | 5e. TASK NUMBER |
| | 5f. WORK UNIT NUMBER |
| 7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)<br>**American College of Physicians,Division of Medical Practice, Professionalism & Quality,190 N Independence Mall West,Philadelphia,PA,19106-1572** | 8. PERFORMING ORGANIZATION REPORT NUMBER |
| 9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) | 10. SPONSOR/MONITOR'S ACRONYM(S) |
| | 11. SPONSOR/MONITOR'S REPORT NUMBER(S) |

12. DISTRIBUTION/AVAILABILITY STATEMENT
**Approved for public release; distribution unlimited**

13. SUPPLEMENTARY NOTES
**presented at the 2011 Military Health System Conference, January 24-27, National Harbor, Maryland**

14. ABSTRACT

15. SUBJECT TERMS

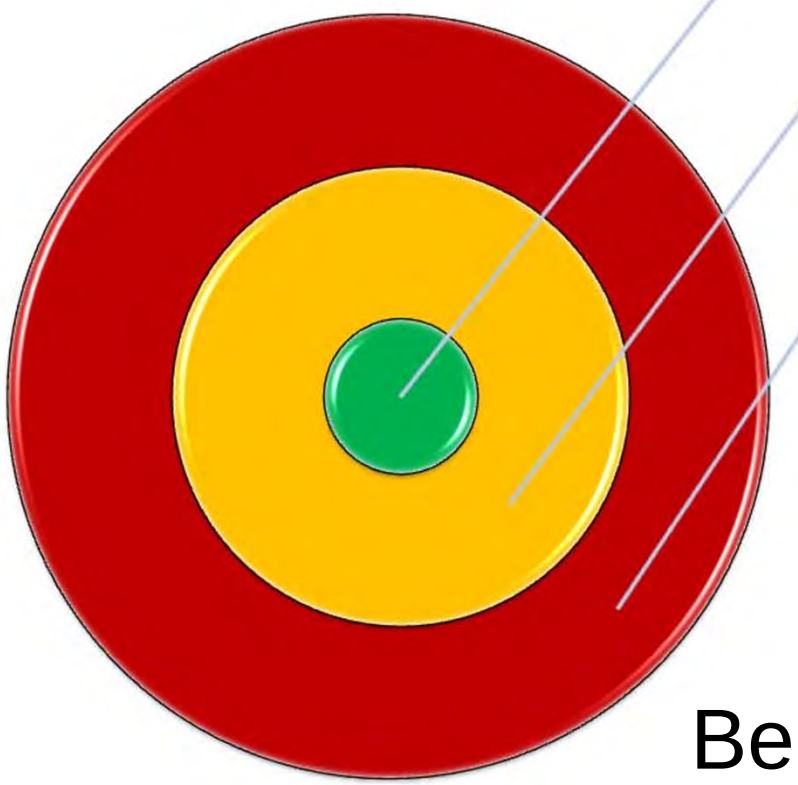
| 16. SECURITY CLASSIFICATION OF: | | | 17. LIMITATION OF ABSTRACT | 18. NUMBER OF PAGES | 19a. NAME OF RESPONSIBLE PERSON |
|---|---|---|---|---|---|
| a. REPORT | b. ABSTRACT | c. THIS PAGE | | | |
| **unclassified** | **unclassified** | **unclassified** | **Same as Report (SAR)** | **26** | |

# Strategy versus Tactics

*Strategy* without tactics
is the slowest route to victory.
*Tactics* without strategy
is the noise before defeat.

Sun Tzu – Chinese Military General, 500 BCE

# Strategy

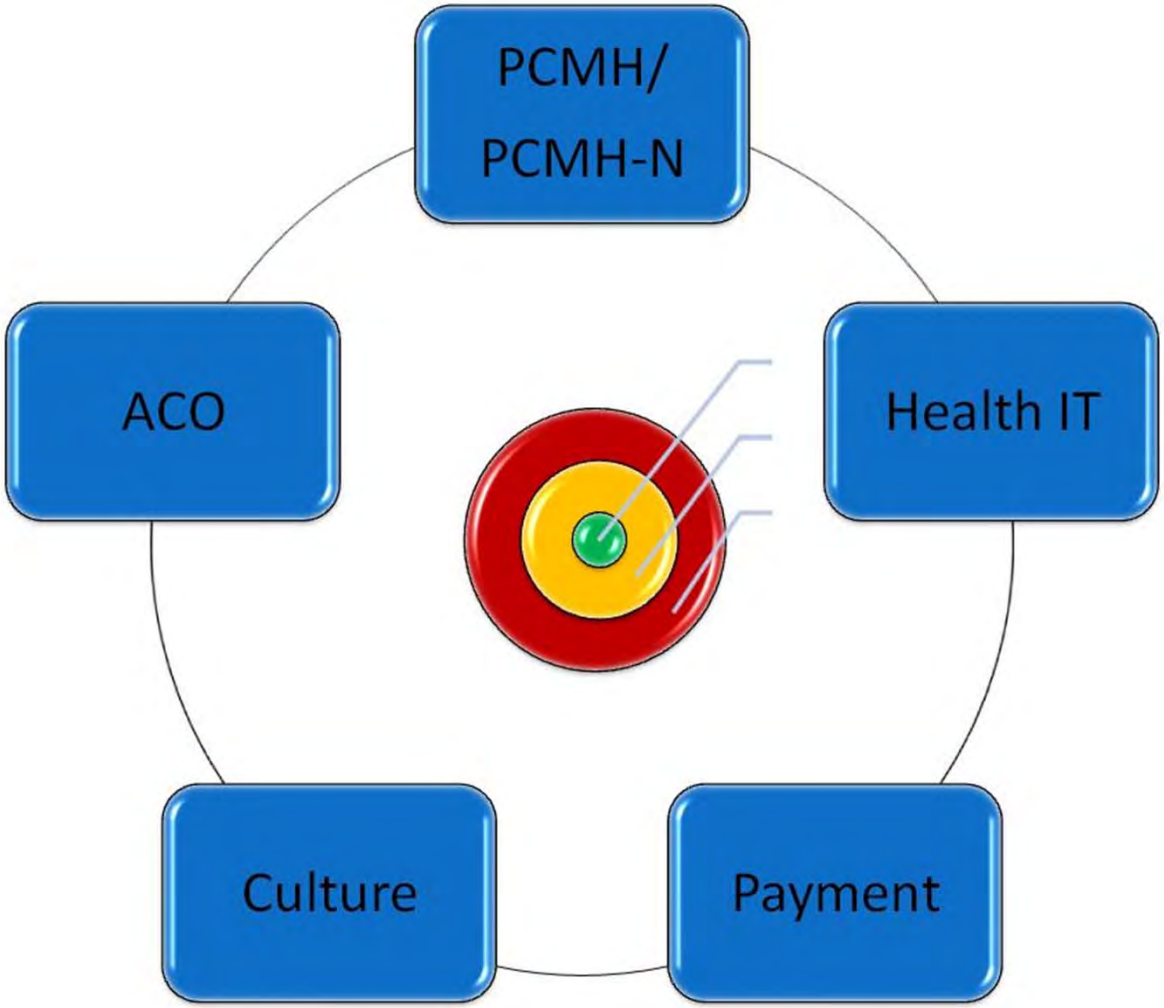



Berwick's Triple Aim



Berwick, Nolan & Whittington; Health Affairs 2008

# Tactics



# What is the Patient-Centered Medical Home?

- …a vision of health care as it should be
- …a framework for organizing systems of care at both the micro (practice) and macro (society) level
- …a model to test, improve, and validate

# Joint Principles of the PCMH

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access to care
- Payment to support the PCMH

Team-based care:
NP/PA
RN/LPN
Medical Assistant
Office Staff
Care Coordinator
Nutritionist/Educator
Pharmacist
Behavioral Health
Case Manager
Social Worker
Community resources
DM companies
Others…

# Care Coordination

"Effective care coordination…requires not only full access to all the necessary clinical information…but also a willingness by all the physicians [and their teams] involved…to participate in collaborative decision making."

-Elliott Fisher, NEJM 2008

# Fragmentation

- Typical primary care physician relates to 229 other physicians in 117 practices for Medicare FFS beneficiaries

Pham, H et al: *Ann Intern Med February 17, 2009 150:236-242*

# Teams

- Wikipedia definition: A team comprises a group of people linked in a common purpose. Teams are especially appropriate for conducting tasks that are high in complexity and have many interdependent subtasks.
- Interdependent team:
  - no significant task can be accomplished without the help of any of the members;
  - within that team members typically specialize in different tasks, and
  - the success of every individual is inextricably bound to the success of the whole team. No football player, no matter how talented, has ever won a game by playing alone.

Adapted from: http://en.wikipedia.org/wiki/Team

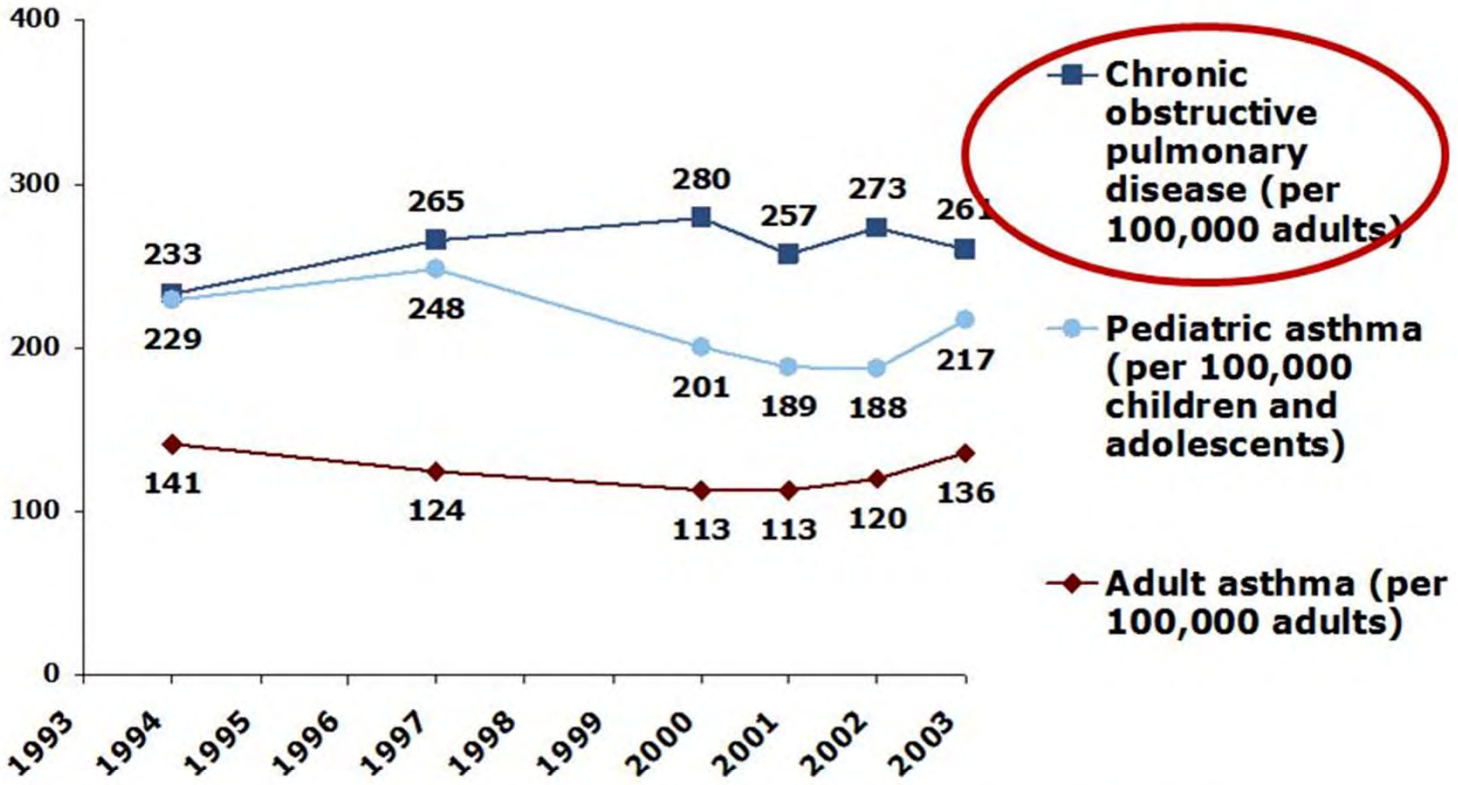
# Teams?

# Gaps in Care Coordination

- Primary care and specialists:
  - No information sent to Peds specialist **49%** of time; no feedback to primary care **55%** of time
- Emergency Department
  - **30%** of adults indicated regular physician not informed about visit
- Hospital
  - **33%** of adults with chronic condition did not have follow-up plans post hospital discharge
  - **3%** of primary care physicians discussed discharge plans with hospital physicians
  - **66%** of time primary care follow-up post discharge was done without a hospital discharge summary

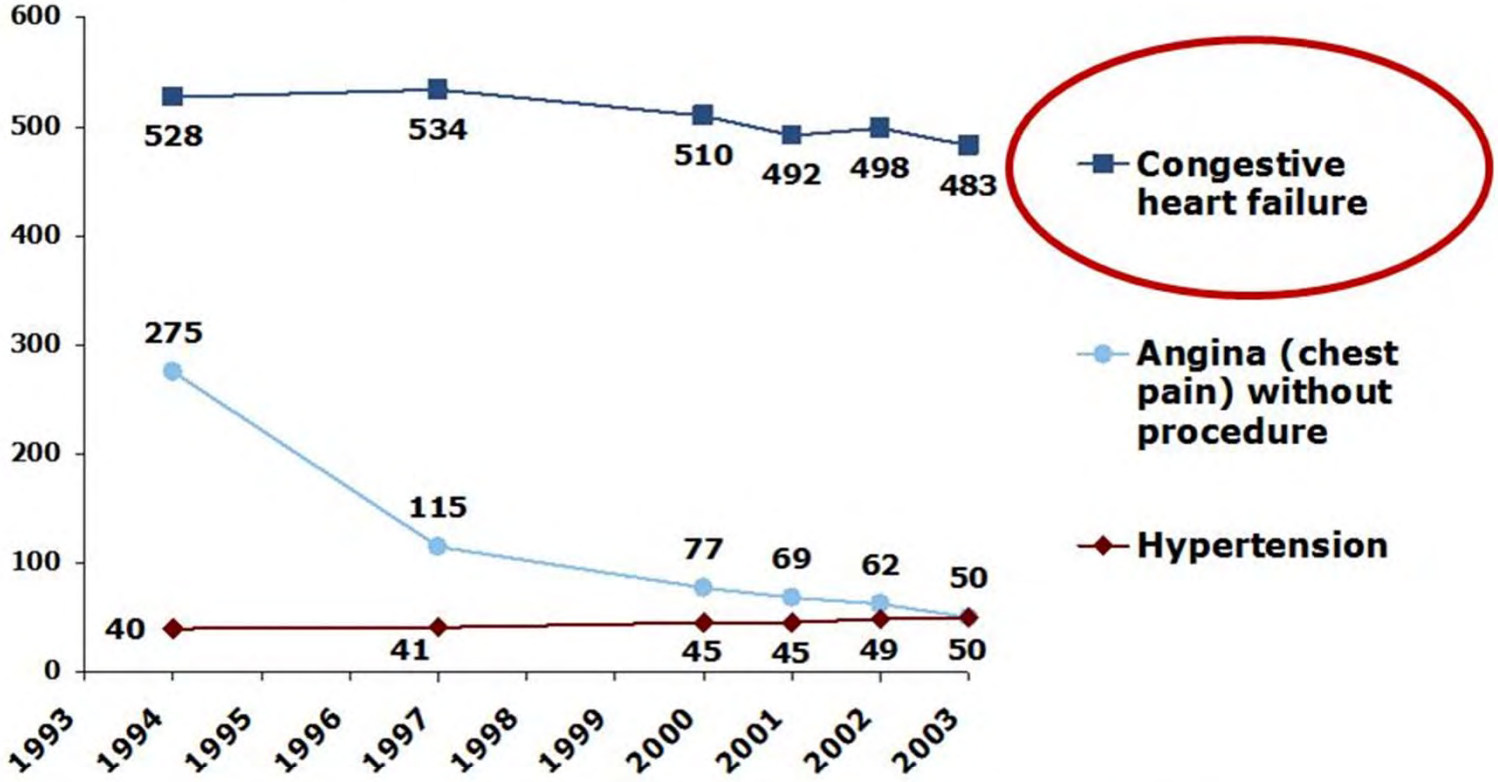
Bodenheimer, T: Coordinating Care – A Perilous Journey through the Health Care System. NEJM 2008;358:10

## Hospital Admission Rates for Chronic Respiratory Ambulatory Care–Sensitive Conditions, 1994–2003



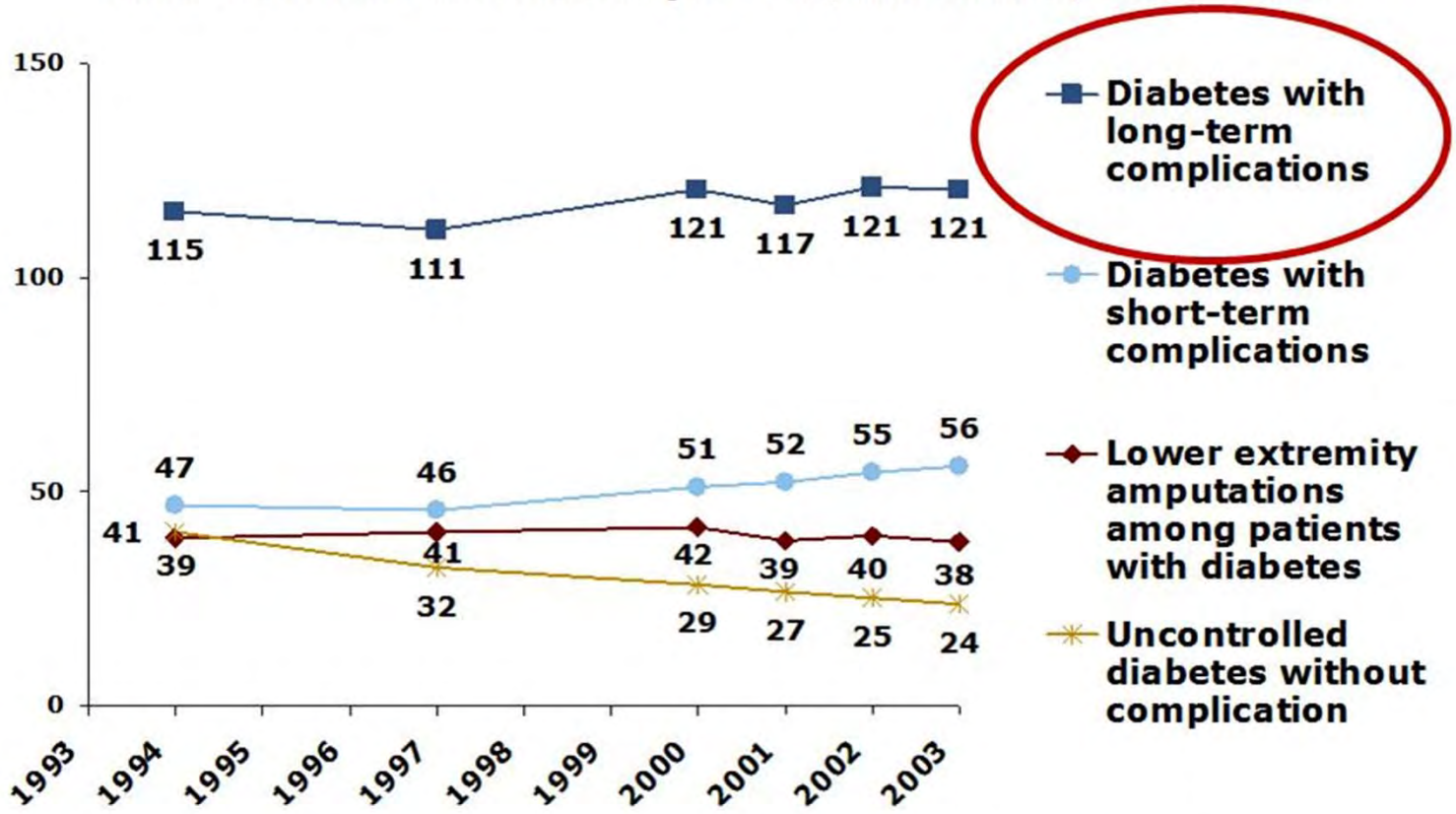

Data: Healthcare Cost and Utilization Project, Nationwide Inpatient Sample (Agency for Healthcare Research and Quality 2006). Rates were age- and sex-adjusted to the 2000 U.S. standard population. Adults mean the U.S. population ages 18 and older.
Source: McCarthy and Leatherman, Performance Snapshots, 2006. www.cmwf.org/snapshots

## Hospital Admission Rates for Cardiovascular Ambulatory Care–Sensitive Conditions per 100,000 Adults, 1994–2003



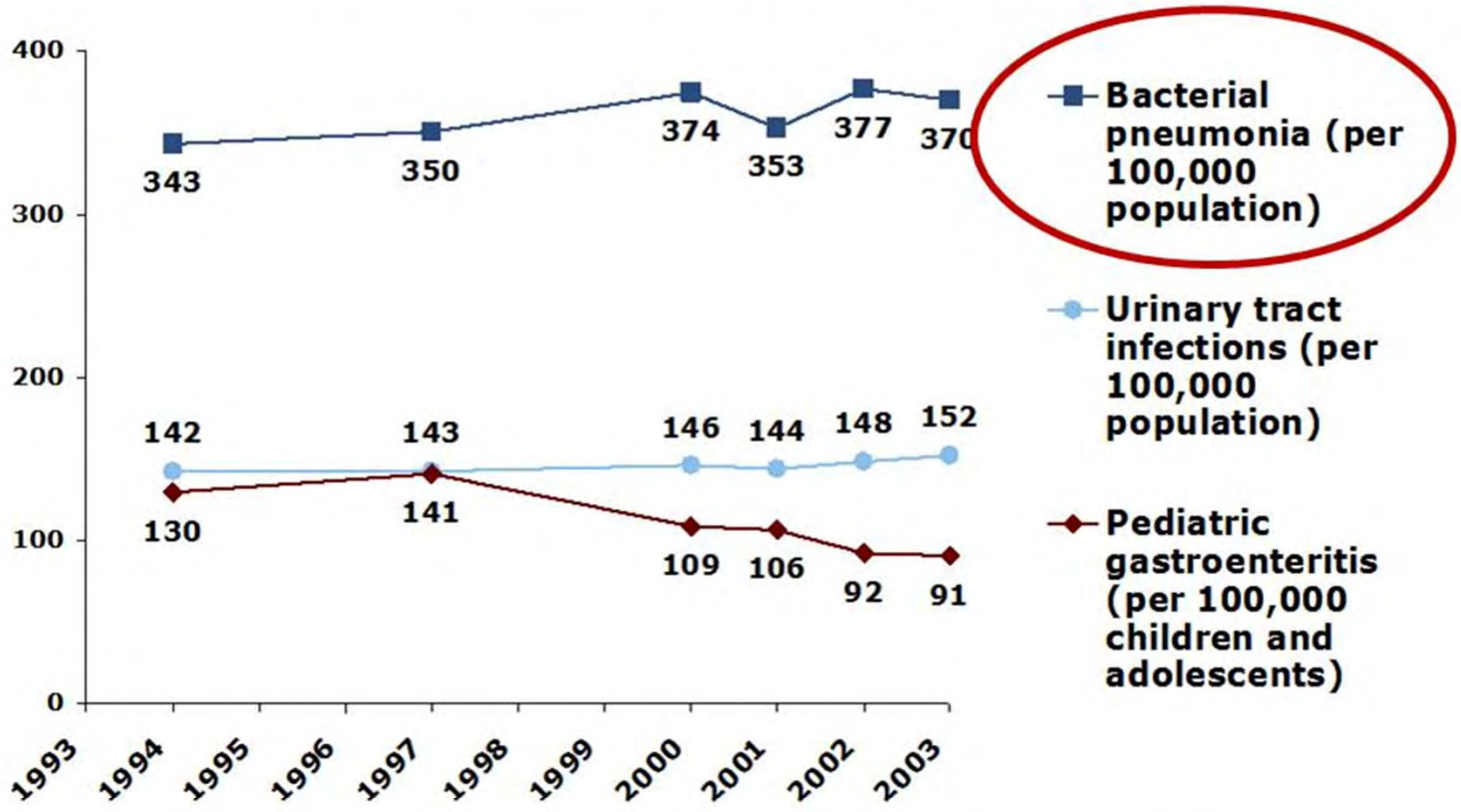

Data: Healthcare Cost and Utilization Project, Nationwide Inpatient Sample (Agency for Healthcare Research and Quality 2006). Rates were age- and sex-adjusted to the 2000 U.S. standard population. Adults mean the U.S. population ages 18 and older.
Source: McCarthy and Leatherman, Performance Snapshots, 2006. www.cmwf.org/snapshots

## Hospital Admission Rates for Diabetes-Related Ambulatory Care–Sensitive Conditions per 100,000 Adults, 1994–2003




Data: Healthcare Cost and Utilization Project, Nationwide Inpatient Sample (Agency for Healthcare Research and Quality 2006). Rates were age- and sex-adjusted to the 2000 U.S. standard population. Adults mean the U.S. population ages 18 and older.
Source: McCarthy and Leatherman, Performance Snapshots, 2006. www.cmwf.org/snapshots

## Hospital Admission Rates for Acute Ambulatory Care–Sensitive Conditions, 1994–2003




Data: Healthcare Cost and Utilization Project, Nationwide Inpatient Sample (Agency for Healthcare Research and Quality 2006). Rates were age- and sex-adjusted to the 2000 U.S. standard population. Children/adolescents mean those ages 0–17.

Source: McCarthy and Leatherman, Performance Snapshots, 2006. www.cmwf.org/snapshots

# Evolution of PCMH…

Neighbor

The Patient-Centered Medical Home

# PCMH-Neighbor Concept

- ACP convened a work group of the ACP Council of Subspecialty Societies in 2007
- Workgroup represented 16 distinct specialties/subspecialties & 22 different organizations
- Work proceeded over 3 years
- Position Paper released October 2010
- Annals of Internal Medicine published *Ideas & Opinions*, January 4, 2011

http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf

# The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices

A Position Paper of the
American College of Physicians

This policy paper, written by Neil Kirschner, PhD, and M. Carol Greenlee, contributions from the following members (with the subspecialty society parentheses) of the American College of Physicians' Council of Subspeci Patient Centered Medical Home (PCMH) Workgroup: Richard Honsinger Co-Chair, (AAAAI): William Atchley Jr., MD, (SHM); Joel Brill, MD, (AC (ASCO); Lawrence D'Angelo, MD (SAM); Tom DuBose, MD, (ASN (ACAAI); Pamela Hartzband, MD, (Endocrine Society); David Kaplan, M Leff, MD, (AGS); Larry Martinelli, MD (ID Society); David May, MD Pham, MD, (SGIM); Larry Ray, MD, (SGIM); Joseph Sokolowski, MD, ( Weisberg, MD, (RPA).The paper was developed for and approved by t Policy Committee of the American College of Physicians; Donald Hatton Tape, MD, Vice Chair; Sue Bornstein, MD; McKay B Crowley, MD; Stephan Fihn, MD; William Fox, MD; Robert Gluckman, MD; Stephen Kamholz, MD; Michael D. Leahy, MD; Joshua Lenchus, DO; Keith Michl, MD; John O'Neill Jr. DO; and James W. Walker, MD. The paper was approved by the Board of Regents of the American College of Physicians on August 1, 2010.

**Annals of Internal Medicine**

*Established in 1927 by the American College of Physicians*

IDEAS AND OPINIONS

Welcome to the Patient-Centered Medical Neighborhood

Laine

- A Primary Care Physician's View
- A Subspecialty Physician's View

Discuss on Facebook

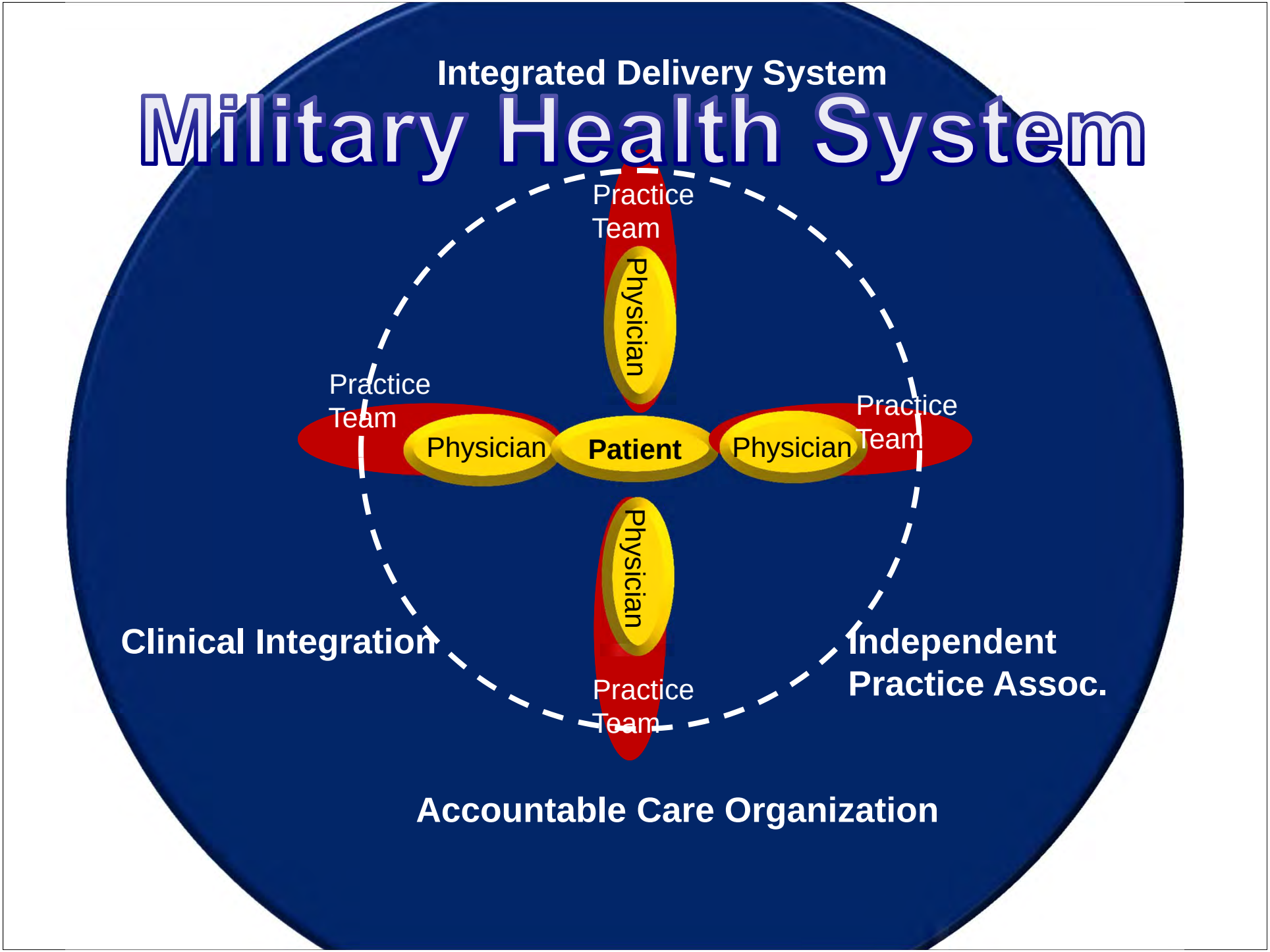
# Typology of Clinical Roles

- Cognitive consultation
  - Provide diagnostic or therapeutic advice
- Procedural consultation
  - Perform a technical procedure to aid diagnosis, cure a condition, identify/prevent new conditions, palliate
- Co-manager with shared care
  - Long-term management with primary care physician
- Co-manager with principal care
  - Assume total responsibility for long-term management
- Primary care physician
  - Provides a medical home for a group of patients

**Forrest, Christopher: Arch Int Med 2009**

# Summary Points of Paper

- Provide effective bidirectional communication with a focus on care coordination and information sharing with the PCMH
- Engage in timely and appropriate referrals/consultations
- Support patient-centered care co-management
- Establish care coordination agreements that:
  - Define roles/responsibilities/expectations
  - Provide specific parameters for secondary referrals, admissions, emergencies
- Align incentives
- Explore a PCMH-N recognition process

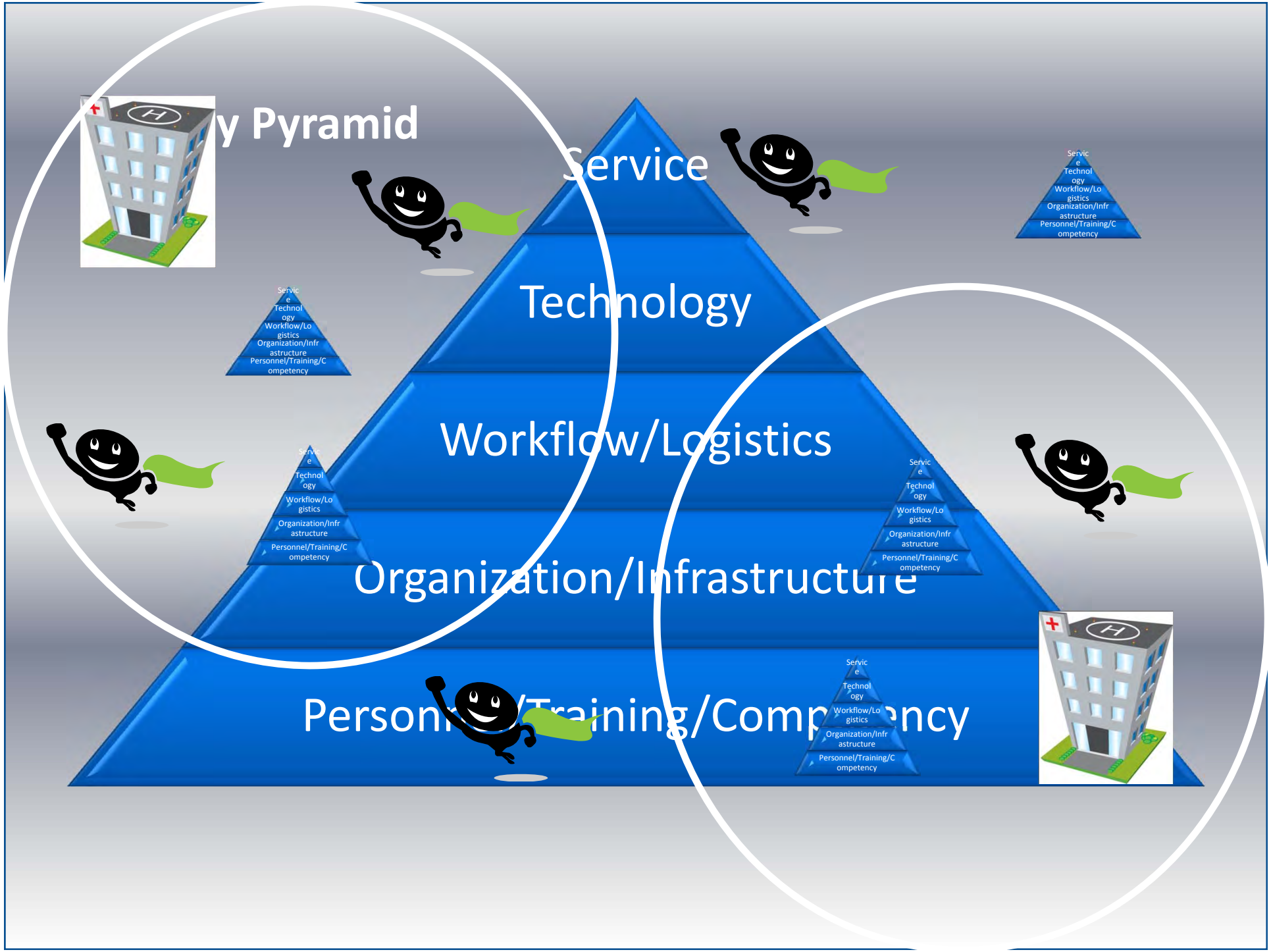

Integrated Delivery System
Military Health System
Practice Team
Physician
Practice Team
Physician
Patient
Physician
Practice Team
Physician
Practice Team
Clinical Integration
Independent Practice Assoc.
Accountable Care Organization

# Accountable Care Organization

"…consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth." [1]

MEDPAC Explanation: "…a group of physicians teamed with a hospital would have joint responsibility for the quality and cost of care provided to a large Medicare patient population…Potential ACOs include: integrated delivery systems, physician–hospital organizations, a hospital plus multispecialty groups, and a hospital teamed with independent practices." [2]

[1]McClellan et al: Health Affairs, May 2010
[2]MEDPAC June 2009 report


y Pyramid
Service
Technology
Workflow/Logistics
Organization/Infrastructure
Personnel/Training/Competency
Service
Technology
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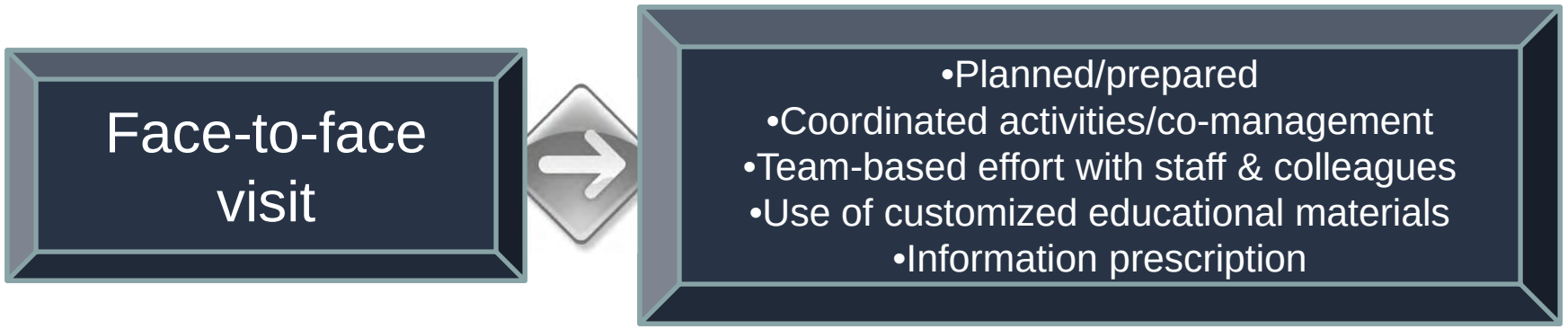
Organization/Infrastructure
Personnel/Training/Competency

# From a Patient's Perspective…



# Questions?

# Contact Information

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