PCMH: Why All the Hype?

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Learning Objectives

- Review core concepts of the patient-centered medical home (PCMH) model
- Summarize current body of evidence pertaining to PCMH
- Discuss why the literature may be mixed on PCMH
- Understand practical issues to consider prior to and during PCMH implementation

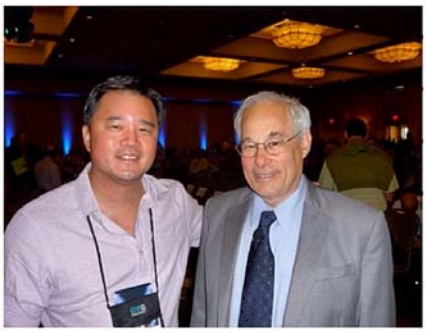
"My practice/group is implementing the PCMH model."

- No way!
- No, how?
- Thinking about it
- Yes, we are in the process
- Yes, we are certified

Patient-centered | Physician-directed

The Triple Aim + 1

- Value (quality/cost)
- Patient experience
- Population health
- Physician/patient care team fulfillment



"A goal is not always meant to be reached, it often serves simply as something to aim at."

Bruce Lee

On which aim does implementation of PCMH have the most impact?

- Value (cost/quality)
- Patient experience
- Population health
- Physician/team fulfillment
- All of the above

Patient-Centered Medical Home

- Yes!
- No!
- Maybe?

Yes!

- Practice coaching increases PCMH components
- Enhanced “adaptive reserve”
- Improved access
- Better prevention and chronic disease management
- Improved staff experience
- Reduction in ED visits
- Non-PCMH practices unchanged or worse over time

Yes!

- Reduction in total cost of care
- Lower hospitalizations
- Improved patient access
- Improved patient experience
- PCMH has reached tipping point with broad private and public sector support
- PCMH may narrow health inequities

No!

- Disappointing lack of improvement in quality metrics
- Widespread implementation with limited data will lead to failure
- No association between PCMH and patient experience

No!

- Decrease in patient ratings, though not statistically significant
- Higher operating costs
- Majority of practices do not currently have necessary infrastructures to be robust PCMH's

Maybe?

- With or without practice coaching, 70% PCMH components achieved
- No change in health status, satisfaction with service relationship, patient empowerment, comprehensive care, coordination of care, personal relationship over time, or global practice experience

Maybe?

- No reduction in hospitalization
- No cost savings
- No changes in utilization

"Why is the evidence mixed for the effects of PCMH implementation?"

1. PCMH is just a money-making scheme for accrediting organizations and consultants.
2. PCMH does not work.
3. PCMH works but only for certain practice types and patient populations.
4. PCMH will work; this area of research is complex and still new.
5. PCMH works and it will solve all U.S. health care system woes.

5 reasons why the PCMH literature is mixed

- No standard yet established for how best to study PCMH
- Heterogeneity of implementation methodologies
- One size does not fit all practice types
- Applicability to general population vs specific populations
- Payer-mix

Grumbach: PCMH is not a pill

- To justify FDA approved, would need to demonstrate safety and therapeutic benefit
  - No luck for PCMH: not enough to be non-harmful and demonstrate some degree of efficiency
- Pharmaceutical products can be manufactured with uniform specifications and delivered in a standardize manner
  - PCMH is a multi-faceted intervention
    - Changes in organization, structure, process, culture and financial model of practice
    - More in common with CQI than rigid clinical trial protocol

Grumbach: PCMH is not a pill

- Research limitations: sufficient analytical power, heterogeneity of methodology, appropriate timeframe
- PCMH being judged on whether or not it is a “3-run homer achieving the triple aims of better health, better patient experience, and lower costs.”

Grumbach: PCMH is not a pill

- Policymakers must not wait for incontrovertible scientific evidence that PCMH is “a magic triple aim pill with a large and immediate financial return on investment.”
- Organizations must make strategic decisions based on best available information using a collage of scientific evidence, case studies and their own hunches.

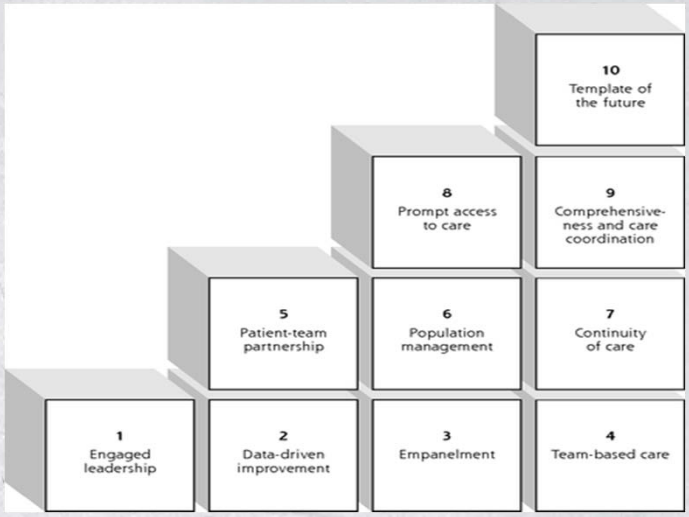
After reviewing the literature…

- No way will I implement PCMH
- I better understand PCMH but will not be implementing
- Still thinking about it
- The evidence may be mixed, but I will begin the process
- So what if the evidence is mixed? I will prove the naysayers wrong

Practical considerations

- PCMH accreditation: To be or not to be?
- Does this align with your/your organization's mission?
- Readiness for change/transformation.
- Evaluate your financial resources/adaptive reserve.
- Do you play well with others? Consider a consultant vs a collaborative.
- Shall we play a game? Have a strategic game plan.

Building Blocks



Bodenheimer et al, Annals of FM 2014

"The best way to invent the future is to invent it."

Peter Drucker

28 STUDIES: OVERVIEW OF PCMH EVIDENCE, 2013-2014

14 PEER-REVIEWED STUDIES

- 10 reported on cost, 6 found improvements
- 13 reported on utilization, 12 found improvements
- 3 reported on quality, 2 found improvements
- 4 reported on access, 4 found improvements
- 4 reported on satisfaction, 4 found improvements

"Reported on" indicates that a peer-reviewed study either evaluated that measure as an outcome variable, or the article reported additional information on that measure outside the scope of the study.

7 STATE GOVERNMENT EVALUATIONS

- 7 reported cost savings
- 6 reported reductions in utilization
- 6 reported improvements in population health/preventive services
- 5 reported improvements in access
- 3 reported improvements in patient or clinician satisfaction

7 INDUSTRY REPORTS

- 4 reported cost savings
- 6 reported reductions in utilization
- 3 reported improvements in population health/preventive services
- 1 reported improvement in access
- 1 reported improvement in patient or clinician satisfaction

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News

FOR IMMEDIATE RELEASE
January 26, 2015

Contact: HHS Press Office
202-690-6343

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

To make these goals scalable beyond Medicare, Secretary Burwell also announced the creation of a Health Care Payment Learning and Action Network. Through the Learning and Action Network, HHS will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs. HHS will intensify its work with states and private payers to support adoption of alternative payments models through their own aligned work, sometimes even exceeding the goals set for Medicare. The Network will hold its first meeting in March 2015, and more details will be announced in the near future.

"Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people. Today's announcement is about improving the quality of care we receive when we are sick, while at the same time spending our health care dollars more wisely," Secretary Burwell said. "We believe these goals can drive transformative change, help us manage and track progress, and create accountability for measurable improvement."

"We're all partners in this effort focused on a shared goal. Ultimately, this is about improving the health of each person by making the best use of our resources for patient good. We're on board, and we're committed to changing how we pay for and deliver care to achieve better health," Douglas E. Henley, M.D., executive vice president and chief executive officer of the American Academy of Family Physicians said.

Strategic
Arranger
Futuristic
Ideation
Self-assurance

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