PCMH-N
Patient Centered Medical Home Neighbor

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Co-Chair Task Force on
Specialty Care Co-ordination (PCMH-N)
Council of Subspecialty Societies, ACP

President, Joint Council on Allergy Asthma Immunology
History of PCMH

• American Academy of Pediatrics (1967)
• AAFP (2004)
• ACP (2005)
• Patient Centered Primary Care Collaborative (2006)
  – IBM and 500 members of industry
• Joint Principles of PCMH – AAP, AAFP, ACP, AOA (2007)
Dissatisfaction at Multiple Levels

- Patients: problems with access, poorly coordinated care, errors
- Physicians: Primary care with inadequate time & compensation; Specialty care inequities; poor quality of referrals; difficulty coordinating care
- Purchasers/Employers: High cost of care, poorly coordinated care, suboptimal outcomes
- Payers: suboptimal outcomes, mediocre performance on key metrics, paying for duplication
Day in the life of Primary Care

Tyranny of the urgent

• Mid afternoon. Running behind. Seen 20 patients.
• 55 y.o. male with DM requesting refills and routine visit. Not seen for 9 months.
• Also has dizziness, a rash and knee pain
• No recent labs for over a year
• Med list not up to date
• Does not know last retinal exam
• You evaluate dizziness, look at the rash, briefly discuss arthritis, order labs, refill meds, discuss OTC meds. No diabetic education or foot exam. Not sure when you will see him again.
Day in the life of Primary Care

Tyranny of the urgent

And what about prostate exam, colonoscopy, immunizations, lipid panel and renal assessment......

And expected at same time to
  Refill prescriptions
  Confirm prior authorizations
  Review referrals
  Review Lab Reports
  Etc.
Primary Care is Impossible

• A primary care physician with a panel of 2500 average patients will spend
  – 7.4 hours per day doing recommended **preventive** care [Yamal et al Am J Public Health 2003]
  – 10.6 hours per day doing recommended **chronic** care [Ostbye et al Annal of Fam Med 2005]
  – With **Acute** Care trumping it all
Research Shows Need to Improve Communication

• Disconnect between PCP and specialist

• PCPs report sending information 70% of the time; specialists report receiving the information 35% of the time\(^1\)

• Specialists report sending a report 81% of the time; PCPs report receiving it 62% of the time\(^1\)

• 25%-50% of referring physicians did not know if patients had seen specialist\(^2\)

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...and GAPs in the Perception of the GAPs


<table>
<thead>
<tr>
<th>Perception</th>
<th>Reality</th>
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<tbody>
<tr>
<td>• 69.3 % of PCPs reported they &quot;always&quot; or &quot;most</td>
<td>• 34.8 % of specialists said they receive it &quot;always&quot; or &quot;most of the time.&quot;</td>
</tr>
<tr>
<td>of the time&quot; send notification of a patient's history and reason for consultation to specialists.</td>
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<tr>
<td>• 80.6 % of specialists said they &quot;always&quot; or &quot;most</td>
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<td>of the time” send consultation results to the referring PCP</td>
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<tr>
<td>•</td>
<td>• 62.2 % of PCPs reported getting it &quot;always&quot; or &quot;most of the time.”</td>
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Patient Centered Medical Home

• Change from acute care model to the Chronic Care/Expanded Care Model
  – *First Contact, Comprehensive, Continuous and Coordinated Care*

• Requires team care and population management:
  – Shift from the model of the physician doing everything
  – Utilize staff at “top of their license”

• Requires payment reform
  – care management fees + “performance-based” payments + FFS

• Patient-Centered Care
  – the patient is the center of care (“what is best for the patient”)
  – the team cares for each patient and their population of patients (vs. task oriented mindset)
Medical Home Model

Chaos → Organization

- Acute Episodes of care
- Doc works alone
- Hamster wheel practice
- Tyranny of the Urgent
- No time > multiple referrals

- Chronic Care Model
- Patient-Centered
- Team Care/Communication
- Registries
- Improved Access

Well-tuned team machine
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."

• Whole Person Orientation
  – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals."
2011 NCQA PCMH Standards

- Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Self-Management Support
- Track and Coordinate Care
- Performance Measurement and Quality Improvement
2011 NCQA PCMH Standards

- Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Self-Management Support
- Track and Coordinate Care
- Performance Measurement and Quality Improvement
Population Management: Use of Registries

• Use registries
  – Team members enter data
  – Use the data to see who needs f/u preventive or chronic care testing such as eye exam, lipid panel, renal function
  – Standing orders /protocol per staff
  – Identify patients with top 10 highest A1c or BP
    • Planned visit/ shared decision making/ goal setting
    • Care managers
Now 22,000 clinicians 4,600 sites

NCQA Recognized PPC-PCMH Sites

As of 12/31/10

1,506 PPC-PCMH SITES

- 0 Sites
- 1-20 Sites
- 21-60 Sites
- 61-200 Sites
- 201+ Sites
Why does the PCMH need a neighbor?
Patient Centered Medical Home Neighbor

• Council of Subspecialty Societies, ACP recognizes need for specialty/subspecialty care coordination with PCMH.

• Workgroup of CSS representatives includes
  – Dan Ein MD, ACAAI
  – Richard Honsinger MD, AAAAI
  – Sheila Heitzig, AAAAI

• Co-Chairs
  – Carol Greenlee
  – Richard Honsinger
ACP leadership asked the question: “How do Specialty practices work within the PCMH model?”

- 2006: ACP’s Council Of Subspecialty Societies
  – 2007: CSS Workgroup on PCMH-N formalized
    • Patient vignettes
    • Review of literature
      – PCMH
      – Transition of care consensus conference data
      – Forrest’s “typology”
    • Aiming for the ideal while recognizing what was feasible
    • Provide standardization yet allow flexibility for local variation
THE PATIENT-CENTERED MEDICAL HOME NEIGHBOR  
THE INTERFACE OF THE PATIENT-CENTERED MEDICAL HOME WITH SPECIALTY/ SUBSPECIALTY PRACTICES

American College of Physicians
A Position Paper
2010
PCMH-Neighbor Model/Policy Paper

• **Supports** the importance of Medical Neighbors
  – An infra-structure or **framework** to support Care Integration and Information Exchange
  – Improve Care Transfers and Transitions to enhance Safety and Stewardship
  – Restore Professional Interactions needed for Patient Centered Care

• **Definition** of PCMH-Neighbor

• **Describes the Types of Interactions** between PCMH practices & Specialty Practices

• **Principles Care Coordination Agreements**
PCMH-Neighbor Definition

Practices that:

• Communicate, coordinate and integrate bidirectionally with PCMH as well as with patient
• Ensure appropriate & timely consultations and referrals
• Ensure effective flow of information
• Address responsibility in co-management situations
• Support patient centered care
• Support the PCMH practice as the “hub” of care and provider of whole person primary care to the patient
How Does PCMH-Neighbor Model Work?

Care Coordination Agreements

– The “structural elements” of the Neighbor model (the guide or standard for what is expected)

– Intended to serve as a “grid” upon which care integration and communication can be built (‘the norms’)

– Establish common definitions and expectations

– Are designed to allow flexibility based on what works at the local level

– Details of what should be included are in the Principals of Care Coordination Agreements section of the policy paper
PRINCIPLES OF SERVICE AGREEMENTS

1) Define the **types of referral and co-management agreements**
2) Specify who is **accountable for which processes and outcomes**
3) Specify the content of a patient **transition record/core data set**
4) **Define expectations** regarding the **information content... and timeliness within the referral process**
5) Specify how **secondary referrals** are to be handled
6) Maintain a **patient centered approach**
7) Clarify **in-patient processes** and transitions into/out of hospital
8) Allow for **emergency care**
9) Include mechanisms for review and documentation & communication of real or perceived **breaches**
Definitions

• Types of Referrals-defining roles
• Secondary Diagnosis
• Secondary Referrals
• The Referral Process
  – The Referral Request
  – The Referral Response
  – The clinical question/synopsis of events & the Response
  – Closing the Loop
1) Define the types of referral and co-management agreements available

• fluid (dynamic) to adapt to changes in patient or disease status
• clearly communicated and understood by all parties including the PCMH and the specialty practice as well as patients and their families and caregivers.
Outline

• Where did this come from?
  – Physician derived, ground up effort
  – History

• Components
  – Definition of a medical neighbor
  – Care Coordination Agreements
    • Standardized definitions and expectations
      – Types of Referrals
      – Referral Process
        » Referral Request
        » Referral Response
Case Management

• Pre-consultation
• Formal Consultation
• Co-Management
  – Shared
  – Principal Care
  – Principal Care for Specified Time
• Transfer of Care
NCQA
National Committee for Quality Assurance
(Non-profit started 1990)

• Healthcare Effectiveness Data and Information Set (HEDIS)

• Accreditation Programs
  – Accountable Care Organization (ACO)
  – Wellness & Health Promotion (WHP)
  – Health Plan Accreditation
  – Behavioral Health Organization

• Recognition Programs
  – Patient Centered Medical Home (PCMH) 2011
  – Patient Centered Medical Home-Neighbor (PCMH-N) March 2013
Accreditation

• Accreditation Association for Ambulatory Health Care.
  – Accreditation for Medical Home - 2009
  – Site visits

• NCQA
  – Standards and Guidelines – 2011
  – Survey tool available
  – Recognition Process
Non-face-to-face Encounter
Pre-consultation Exchange / E-referral

• Intended to expedite/prioritize care
• Referral guidelines
  – Recommendations for what preparation and/or data will best facilitate the referral evaluation and/or management
  – Utilize providers at the top of their license
• Expedite care
  – Urgent cases
• Avoid unnecessary specialty visit
  – Answer clinical question
  – Identify inappropriate referral
Formal Consultation

• **Cognitive consultation (advice)**
  - To obtain specialist’s opinion on a patient’s diagnosis, abnormal lab or imaging study result(s), treatment or prognosis
  - Limited to one or a few visits that focus on answering a discrete question.

• **Procedural consultation**
  - To obtain a technical procedure for diagnostic, therapeutic or palliative purposes
  - Include detailed report back to referring physician

• *Examples*: Colonoscopy, Bone Marrow Biopsy, MRSA infection with recurrent carbuncles
Cognitive Consultation (Advice)

• To obtain specialist’s opinion on a patient’s diagnosis, abnormal lab or imaging study result(s), treatment or prognosis:
  – For unusual, uncommon or uncertain problems
  – For common problems with unusual manifestations
  – Evaluate the need for a new medication or treatment
  – Get reassurance that the diagnosis is correct and/or the most effective treatments are being applied
  – Patient request
  – Medico-legal concerns

Arch Int Med 2009; Forrest
Procedural Consultation

- To obtain a technical procedure for diagnostic, therapeutic or palliative purposes:
  - Minor surgery
  - Major surgical procedures
  - Invasive procedures (e.g. cardiac catheterization, endoscopy, invasive radiology)
  - Procedures that require the use of complex equipment (e.g. optical refraction)
  - Pathological evaluations
  - Anesthetic interventions
Co-Management

- **Shared Care for the disease** (PCP responsible for Elements of Care) (PCP leading)
- **Principal care for the disease.** (Specialist responsible for Elements of Care for that disorder or set of disorders)
- **Principal care of the patient** for a consuming illness for a limited period of time *(specialist serves as first contact but patient maintains PCP as Home)*
Building from Patient-Centered Medical Home

• Specialty groups seek PCMH Recognition
  – Some are medical homes for the **majority** of patients – e.g. HIV providers
  – Some provide care management for **some** patients – e.g. nephrologists, oncologists, obstetrics/gynecology, community mental health centers
  – Most provide specialty care management for **most** patients

• State and private payer PCMH initiatives include specialists (e.g. VT, BCBSNC)

• Challenge may be to motivate specialists to participate
Specialty Practice Recognition

- Relationship of PCMH with specialists important - based on literature and anecdotal evidence
  - Two-way communication and patient collaboration
  - Potential to reduce costs, improve care and patient satisfaction
  - Emphasis on access, communication, coordination of care, agreements and reduced duplication of services

- Specialty practice roles vary: advise PCPs, co-manage, temporary/permanent management

- State and private payer PCMH initiatives include specialists
Specialty Practice Program

• Potential program would include:
  1. Patient access
  2. Agreements with PCP to coordinate care
  3. Timely information exchange with PCP
  4. Timely referral summary
  5. Care plan coordination with PCP
  6. Communication with patient and PCP
  7. Reduced duplication of tests
  8. Measure performance

• Specialty practice program connects PCMH 2011 and ACO
### Patient-Centered Specialty Practice vs. PCMH Primary Care

<table>
<thead>
<tr>
<th>Patient-Centered Specialty Practice</th>
<th>PCMH Primary Care</th>
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<tbody>
<tr>
<td>Coordinates care</td>
<td>Whole-person care</td>
</tr>
<tr>
<td>Population and individual health but comprehensive for single disease</td>
<td>First contact for most problems</td>
</tr>
<tr>
<td>Usually not first contact</td>
<td>Comprehensive, coordinated care</td>
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<tr>
<td>Continuous care for active disease</td>
<td>Continuous care</td>
</tr>
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<td></td>
<td>Focus on population and individual care</td>
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**NCQA**: Measuring quality. Improving health care.
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<tr>
<th>First</th>
<th>Last</th>
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<th>Title</th>
<th>Organization</th>
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<tr>
<td>Bruce</td>
<td>Bagley</td>
<td>MD, DO</td>
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<td>family practice</td>
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<tr>
<td>Maureen</td>
<td>Corry</td>
<td>MPH</td>
<td>Executive Director</td>
<td>Childbirth Connection</td>
<td>OB/GYN</td>
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<td>John</td>
<td>Cox</td>
<td>DO, MBA</td>
<td>Practicing Physician</td>
<td>Texas Oncology - Methodist Dallas Cancer Center</td>
<td>Oncology</td>
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<td>Trina</td>
<td>Dutta</td>
<td>MPP, MPH</td>
<td>Public Health Analyst</td>
<td>SAMHSA</td>
<td>Mental health/ substance abuse</td>
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<tr>
<td>Craigan</td>
<td>Gray</td>
<td>MD, MBA, JD</td>
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<td>NC Department of Health and Human Services</td>
<td>OB/GYN</td>
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<td>Carol</td>
<td>Greenlee</td>
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<td>Craig</td>
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<td>Peds - allergy/ clinical immunology</td>
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<td>Neil</td>
<td>Kirschner</td>
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<td>Carrie</td>
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<td>Ronda</td>
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<td>J. Kersten</td>
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<tr>
<td>David</td>
<td>May</td>
<td>MD, PhD</td>
<td>Practicing Physician</td>
<td>Cardiovascular Specialists, PA</td>
<td>Cardiology</td>
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<tr>
<td>Lee</td>
<td>Partridge</td>
<td>*</td>
<td>Senior Health Policy Advisor</td>
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<tr>
<td>Craig</td>
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<td>MD, MHS</td>
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<td>Richard</td>
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<td>MD</td>
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<td>Josh</td>
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<td>PhD</td>
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<td>Office of the National Coordinator for Health Information Technology, HHS</td>
<td>Peds – neurology</td>
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<tr>
<td>Fan</td>
<td>Tait</td>
<td>MD</td>
<td>Associate Executive Director</td>
<td>American Academy of Pediatrics</td>
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**CSS Workgroup Members**

**Allergy/Immunology**
Specialty Practice Recognition

• 1. Access
• 2. Patient Information
• 3. Referral Process, Agreements, Content, Process
• 4. Electronic Prescribing
• 5. Test Tracking
• 6. Measure Performance
1. Access

- For Patient Appointments
- For non-visit consultation
- For advice when office closed
- Electronic access
2. Patient Information

- Database
- PCMH or PCP information
- Practice Relationship
  - Consult
  - Co-management
  - Transfer
3. Referral

- Agreements with PCMH
- Policies
4. Electronic Prescribing

• Meets meaningful use criteria
5. Tests

- From the PCMH
- To the PCMH and others
- To the Patient
6. Measures

- Clinical Measures (Meaningful Use)
- Utilization Measures
- Satisfaction Measures
NCQA PCMH-N Recognition

- Three levels of recognition
- Score on application
- There will be some MUST PASS standards
- Score will qualify for level of recognition
- Lowest level will not require a fully integrated electronic health record.
- Integrated with Meaningful Use criteria
Meaningful Use for Electronic Records

• Stage 1
  – 2010-2012

• Stage 2
  – 2012-2014
  – Reporting starts January 2015
  – Penalties start 2015

• Stage 3
  – TBA
Meaningful Use Core Objectives

1. Computerized provider order entry (CPOE)
2. E-Prescribing (eRx)
3. Report ambulatory clinical quality measures to CMS/States
4. Implement one clinical decision support rule
5. Provide patients with an electronic copy of their health information, upon request
6. Provide clinical summaries for patients for each office visit
7. Drug-drug and drug-allergy interaction checks
8. Record demographics
9. Maintain an up-to-date problem list of current and active diagnoses
10. Maintain active medication list
11. Maintain active medication allergy list
12. Record and chart changes in vital signs
13. Record smoking status for patients 13 years or older
14. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
15. Protect electronic health information
Meaningful Use: 10 Menu Set Objectives
--may defer 5 of 10
1. Drug-formulary checks
2. Incorporate clinical lab test results as structured data
3. Generate lists of patients by specific conditions
4. Send reminders to patients per patient preference for preventive/follow up care
5. Provide patients with timely electronic access to their health information
6. Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
7. Medication reconciliation
8. Summary of care record for each transition of care/referrals
9. Capability to submit electronic data to immunization registries/systems*
10. Capability to provide electronic syndromicsurveillance data to public health agencies*

* At least 1 public health objective must be selected.
Clinical Quality Measures
38 available – must do 3

6. Pneumonia Vaccination Status for Older Adults
15. Asthma Pharmacologic Therapy
16. Asthma Assessment
17. Appropriate Testing for Children with Pharyngitis
20. Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies
35. Use of Appropriate Medications for Asthma
Meaningful Use Stage 2

• All of Meaningful Use Stage 1 Core Objectives
• Plus Additional Measures Including Patient Portal
• Plus 3 Additional Set Objectives
NCQA Webinars

• Specialty Practice Webinars (PCMH-N)
  – April 30, 2013
  – May 7, 2013

• www.ncqa.org for information
PCMH-N for the Patient

- COORDINATED CARE
- MORE MEANINGFUL REFERRALS
- CONTINUED ACCESS TO SPECIALISTS
- ACCESS TO QUALITY
PCMH-N for the Practitioner

- More patients have access
- Relationship with referring doctor
- Meaningful use compliance
- Maintenance of certification (PIMs)
- Be prepared for the future
PCMH-N for Health Care

- Better Data
- Better Outcomes
- Physician Directed
- Cost Control (?)