

A Patient-Centered Medical Home approach to the primary care of Alaska Seniors

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What is the PCMH?

A PCMH puts patients at the center of the health care system, and provides primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."

(American Academy of Pediatrics)



Joint Principles of the PCMH

Adopted by AAFP, ACP, AAP, AOA

- Personal Physician
- Physician Directed Medical Practice
- Whole Person Orientation
- Care is Coordinated and Integrated
- Quality and Safety are Hallmarks
- Enhanced Access
- Payment Reform

PCMH and the Providence Senior Care Clinic



- Connects with Providence Mission and Core Values: Compassionate Care to the poor and vulnerable
- Respect for the dignity of every person
- Compassion –reaching out for those in need
- Social Justice
- Excellence via high standards
- Stewardship of resources

What's Keeping Us So Busy in Primary Care? A Snapshot from One Practice

PROVIDENCE Health & Services

Richard J. Baron, M.D.

N Engl J Med 2010; 362:1632-1636 April 29, 2010

Type of Service	Total No.	No. per Visit	No. per Physician per Day†	No. per Patient per Yr
Visit	16,640	NA	18.1	2.0
Telephone call	21,796	1.31	23.7	2.6
Prescription refill	11,145	0.67	12.1	1.3
E-mail message	15,499	0.93	16.8	1.8
Laboratory report	17,974	1.08	19.5	2.1
Imaging report	10,229	0.61	11.1	1.2
Consultation report	12,822	0.77	13.9	1.5

Baron: Conclusions 1



- Physician practices play many roles
- Define physician work appropriately
- Heavy reliance on structured EHR data
- New Payment Models

Baron: Conclusions 2



- Primary Care Redesign
 - Skills of non-physician staff
 - Extent of information-technology support
 - New job descriptions (eg) RN doing "information triage"
 - Adjust staffing to patient needs related to chronic disease management

Commonwealth North Alaska Primary Health Care – Opportunities and Challenges; July 2005



- Lifestyle and Prevention
 - Personal and community responsibilities
- Access
 - Manpower, WWAMI
- Quality
 - Evidence Based Medicine, transparency
- Cost
 - EHR, transparency, legislation

UAA Institute of Social Research (ISER) Report May 2010: Primary Care for Older Alaskans: Access and Options



- Few Anchorage primary care doctors take new Medicare patients (lowest payer)
- Alaska Medicare aged population is growing and anticipated to continue to grow
- Currently 57,000 Medicare enrollees in Alaska
- Debate about what constitutes "primary care" and who should ideally deliver it
- No comprehensive workforce planning
- Options for improving access



Why?

Figure 1. Why Alaska Primary-Care Doctors Aren't Accepting New Medicare Patients

(Percent of Doctors Citing Reason)

Inadequate reimbursement 100%

Billing requirements/paperwork 78%

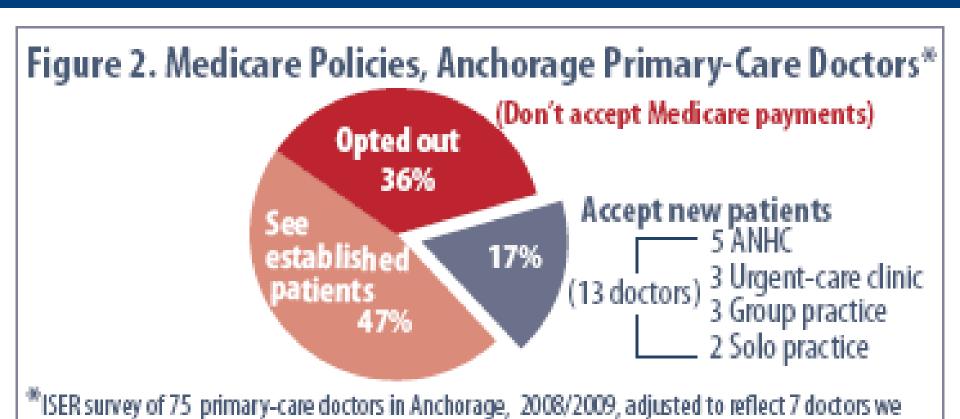
Concern about audits 61%

High clinical burden of Medicare patients 44%

Source: ISER survey of 229 Alaska primary-care doctors, 2008/2009

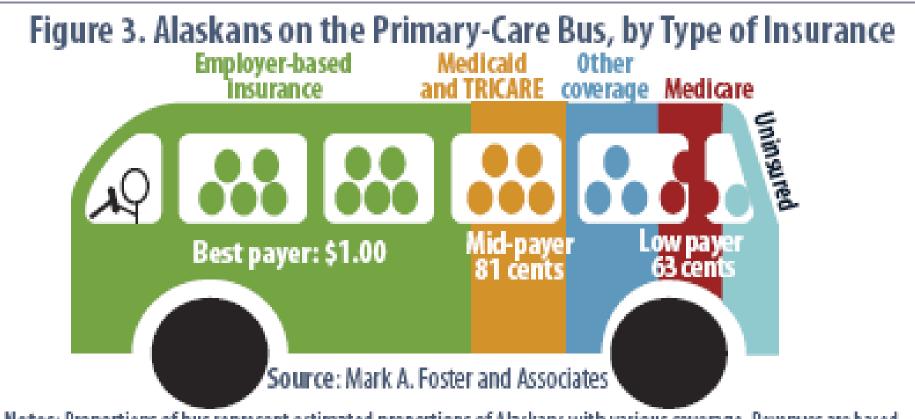
Current Office Policies





are aware of who previously saw established patients but by 2010 had opted out of Medicare.

Medicare Patients: Last on the Bus in Atask Services for Primary Care

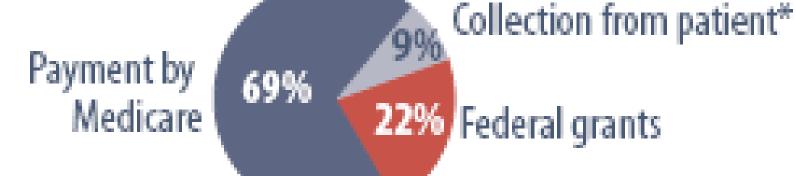


Notes: Proportions of bus represent estimated proportions of Alaskans with various coverage. Revenues are based on 2009 payments for common visits to primary-care doctors. TRICARE (for military personnel) usually pays at Medicare level, but the federal government increased Alaska TRICARE payments 35% at least through 2010.



Tip of the Iceberg





Average cost per visit, 2009: \$172

Source: Anchorage Neighborhood Health Center. Patients with incomes below 200% of federal poverty line pay on sliding-fee schedule.

What Primary Care Options do Seniors Have in Anchorage?



- Alaska Medicare Clinic (Led by Dr. Rhyneer)
- Current Resources
 - Providence Family Medicine Clinic
 - Private Practices
 - ANHC
 - -VA
 - ANMC

Anticipated Providence Senior + Care Clinic "Start-up"



- 1.6 FTE physicians (clinical) at onset (0.4 FTE Management)
- 0.4 FTE Manager
- 1.0 FTE Physician Extender at onset
- 1.0 FTE RN
- 2.0 FTE Clerical
- <u>2.0</u> FTE CMA
- 8.4 FTE total
- Budgeted first year loss: ~\$500,000

Budgeted first year loss: ~\$500,000 but...



- Decreased ED utilization for patients who in the past did not have primary care access
- Referrals for laboratory testing, diagnostic procedures, other services
- Potential for decreased re-admission rates
- Basis for future coordinated growth of the PSO



(NCQA*) and PCMH Recognition

- NCQA developed a set of standards and a 3-tiered recognition process (Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) program) to assess the extent to which health care organizations are functioning as medical home
- Obtaining recognition via the PPC-PCMH programs required completing an application and providing adequate documentation to show evidence that specific processes and policies are in place
- Recognition at three levels:
 - Level 1 basic
 - Level 2 intermediate
 - Level 3 advanced

Rationale for Seeking PCMH Recognition



- Aligns with Providence strategic plans
- PCMH increasingly recognized to yield quality improvements, improved staff/ provider satisfaction
- Leverage and refine EPIC systems of care improvements
- Potential for enhanced reimbursement
- Potential to reduce overall health care costs

The 10 NCQA "Must-Pass" Elements (2010 Standards; 2011 Standards pending)



- Written processes scheduling & communication
- Data confirmation of above functionality
- *Use of electronic charting; Population Medicine
- *Identifying important conditions
- Implementation of guidelines
- Patient Self Management
- Test tracking and follow-up
- Referral Tracking
- Measures of performance
- Reporting to Physicians (feedback)



Questions?