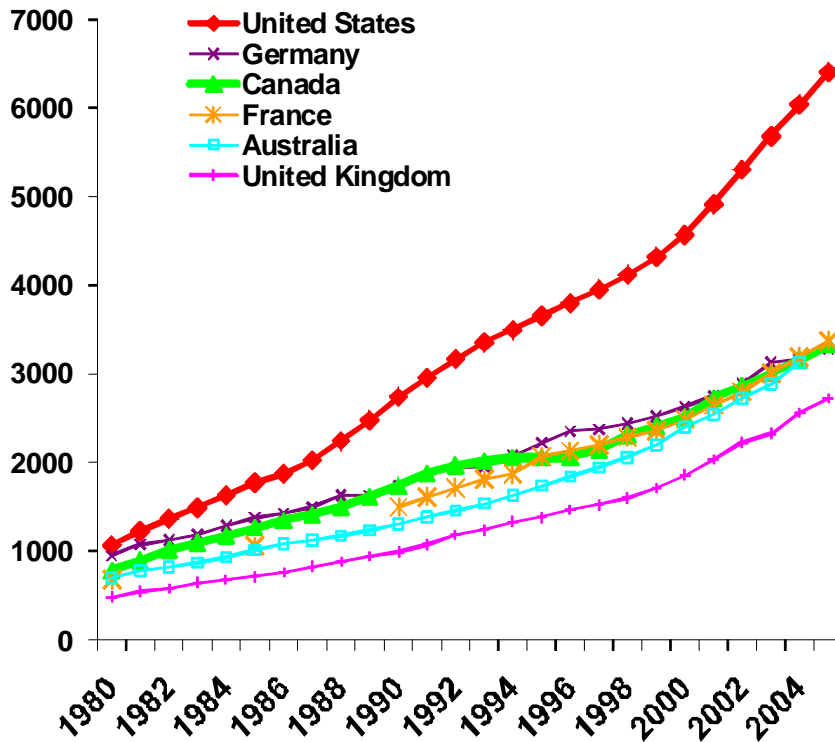


Hogan - MAHC Presentation Handout - The Patient-Centered Medical Home

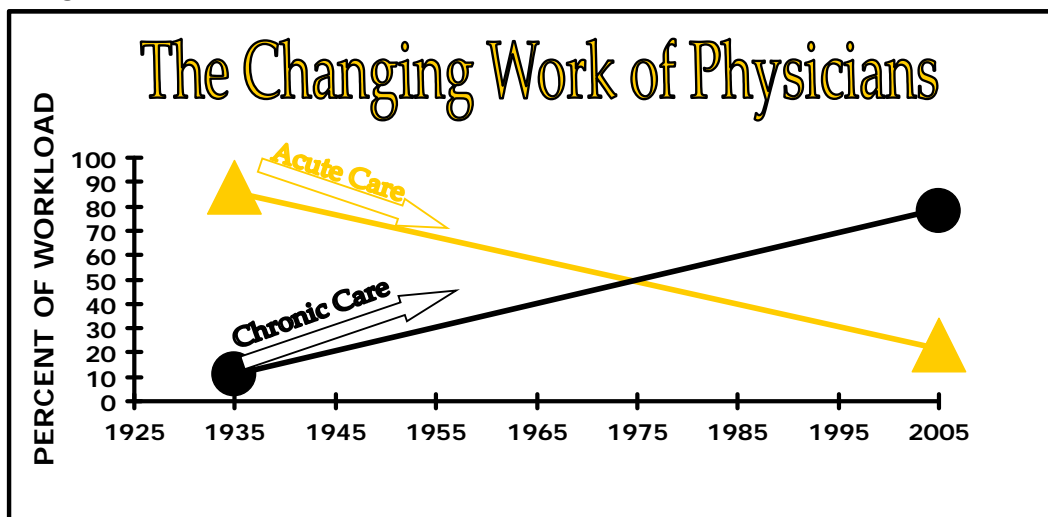
1. Comparative Cost of Healthcare



2. Current percent of recommended care (evidence-based) for adults in the United States

- preventative = 54.9%
- acute care = 53.5%
- chronic conditions = 56.1%

3. Shifting Patterns of Work



4. Chronic Illness (USA)

- 125 million with a chronic illness
- 50 million with 3 or more
- 83% healthcare budget
- Only 50% receive proven treatments

5. The Broken Healthcare System

- Chronic care and disease burden
- Aging population
- More expensive
- Boom in knowledge discovery
- Increasing uninsured population
- Nursing shortage
- Reductions in payments
- Weakened primary care base
- We don't do a great job now

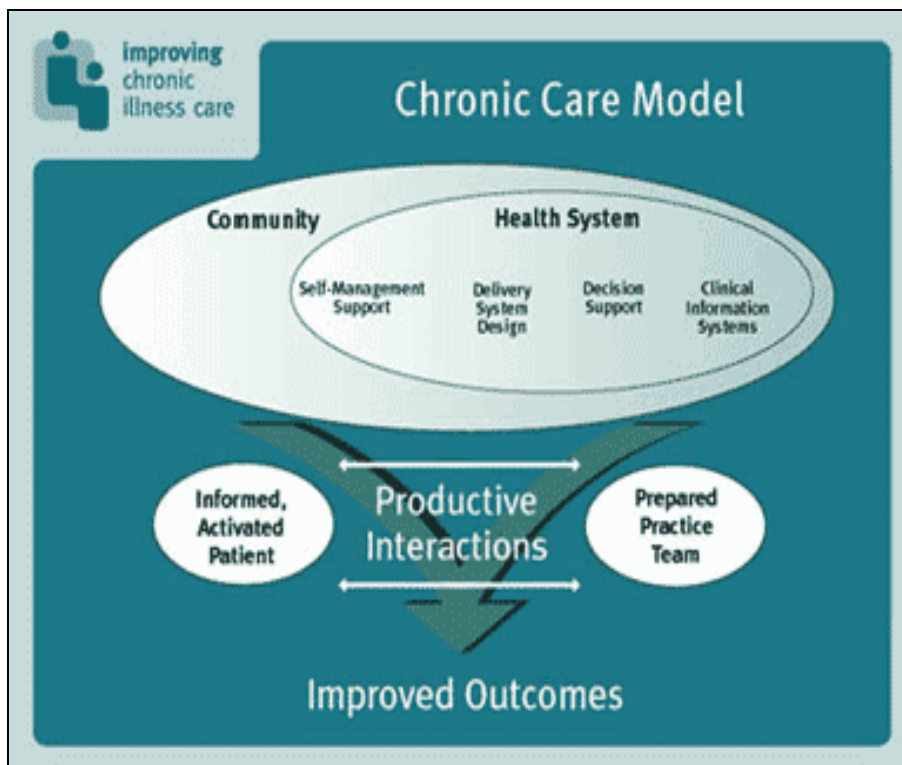
6. Institute of Medicine (IOM) AIMS

- **Safe**—avoiding injuries to patients from the care that is intended to help them
- **Effective**—providing services based on scientific knowledge to all who could benefit and refraining from providing services that will not likely benefit them
- **Patient-centered**—providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions
- **Timely**—reducing waits and sometimes harmful delays for both those who receive and those who give care
- **Equitable**—providing care that does not vary in quality because of personal characteristics, such as gender, race, ethnicity, geographic location, and socioeconomic status
- **Efficient**—avoiding waste, including waste of equipment, supplies, ideas, and energy

7. Top Chronic Conditions

- Diabetes
- Heart Failure
- Coronary Artery Disease
- Hypertension
- COPD
- Headache
- Atrial Fibrillation
- Asthma
- Depression
- Lower Back Pain
- Hyperlipidemia
- Osteoarthritis

8. Wagner's Chronic Care Model



9. Patient-Centered Medical Home (PCMH) – Joint Principles

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Payment recognizes added value

10. NCQA Practice Standards (Redesign Concepts)

PPC-PCMH Content and Scoring			
Standard 1: Access and Communication	Pts	Standard 5: Electronic Prescribing	Pts
A. Has written standards for patient access and patient communication**	4	A. Uses electronic system to write prescriptions	3
B. Uses data to show it meets its standards for patient access and communication**	5	B. Has electronic prescription writer with safety checks	3
	9	C. Has electronic prescription writer with cost checks	2
			8
Standard 2: Patient Tracking and Registry Functions	Pts	Standard 6: Test Tracking	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2	A. Tracks tests and identifies abnormal results systematically**	7
B. Has clinical data system with clinical data in searchable data fields	3	B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
C. Uses the clinical data system	3		13
D. Uses paper or electronic-based charting tools to organize clinical information**	6	Standard 7: Referral Tracking	Pts
E. Uses data to identify important diagnoses and conditions in practice**	4	A. Tracks referrals using paper-based or electronic system**	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3		4
	21	Standard 8: Performance Reporting and Improvement	Pts
Standard 3: Care Management	Pts	A. Measures clinical and/or service performance by physician or across the practice**	3
A. Adopts and implements evidence-based guidelines for three conditions **	3	B. Survey of patients' care experience	3
B. Generates reminders about preventive services for clinicians	4	C. Reports performance across the practice or by physician **	3
C. Uses non-physician staff to manage patient care	3	D. Sets goals and takes action to improve performance	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5	E. Produces reports using standardized measures	2
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5	F. Transmits reports with standardized measures electronically to external entities	1
	20		15
Standard 4: Patient Self-Management Support	Pts	Standard 9: Advanced Electronic Communications	Pts
A. Assesses language preference and other communication barriers	2	A. Availability of Interactive Website	1
B. Actively supports patient self-management**	4	B. Electronic Patient Identification	2
	6	C. Electronic Care Management Support	1
			4

**Must Pass Elements

11. Patient-Centered Medical Home Resources

- Patient-Centered Primary Care Collaborative: www.pcpcc.net
- NCQA PPC-PCMH Standards: www.ncqa.org
- American Academy of Family Physicians: www.futurefamilymed.org
- American Academy of Pediatrics: www.aapolicy.aappublications.org