

# Center the Care on the Patient

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# Learning Objectives

Upon completion of this presentation, learners should be better able to:

1. Redesign clinical programs to meet requirements for Patient Centered Medical Homes
2. Develop partnerships with other community partners to maintaining coordinated care in the changing practice environment of healthcare reform
3. Define a role for consumers in a patient centered medical home



# Question 1

Patient-centered medical care is best defined as care in which:

1. Patients are allowed to decide what care they receive
2. Care provides the most benefit to the patient
3. All communication regarding patient care is directed to the patient
4. Care is designed in a way that is respectful of and responsive to patient's values and preferences

# Question 2

## Establishment of a Patient Centered Medical Home:

1. Makes the patients responsible for their treatment outcomes
2. Is possible only in boutique medical practices
3. May be feasible given the incentives available for certified practices
4. Is recommended only for patients with private insurance plans

# Question 3

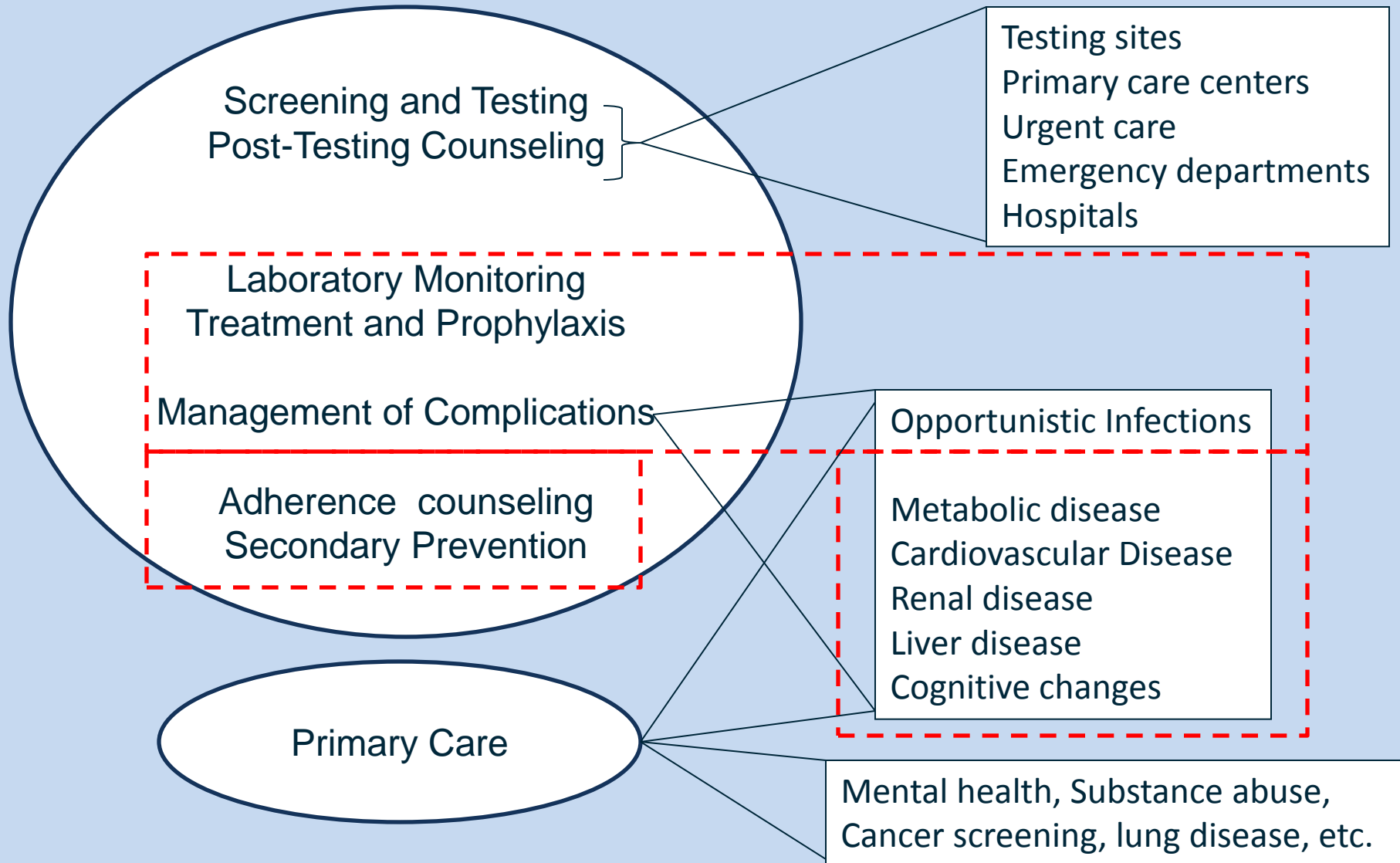
## Consumers in healthcare:

1. Can be adequately represented by their physicians who know them
2. With support, play a critical role in guiding development of clinical programs
3. Are not adequately educated to guide policy setting for specialized medical care
4. Are well represented in policy decision-making

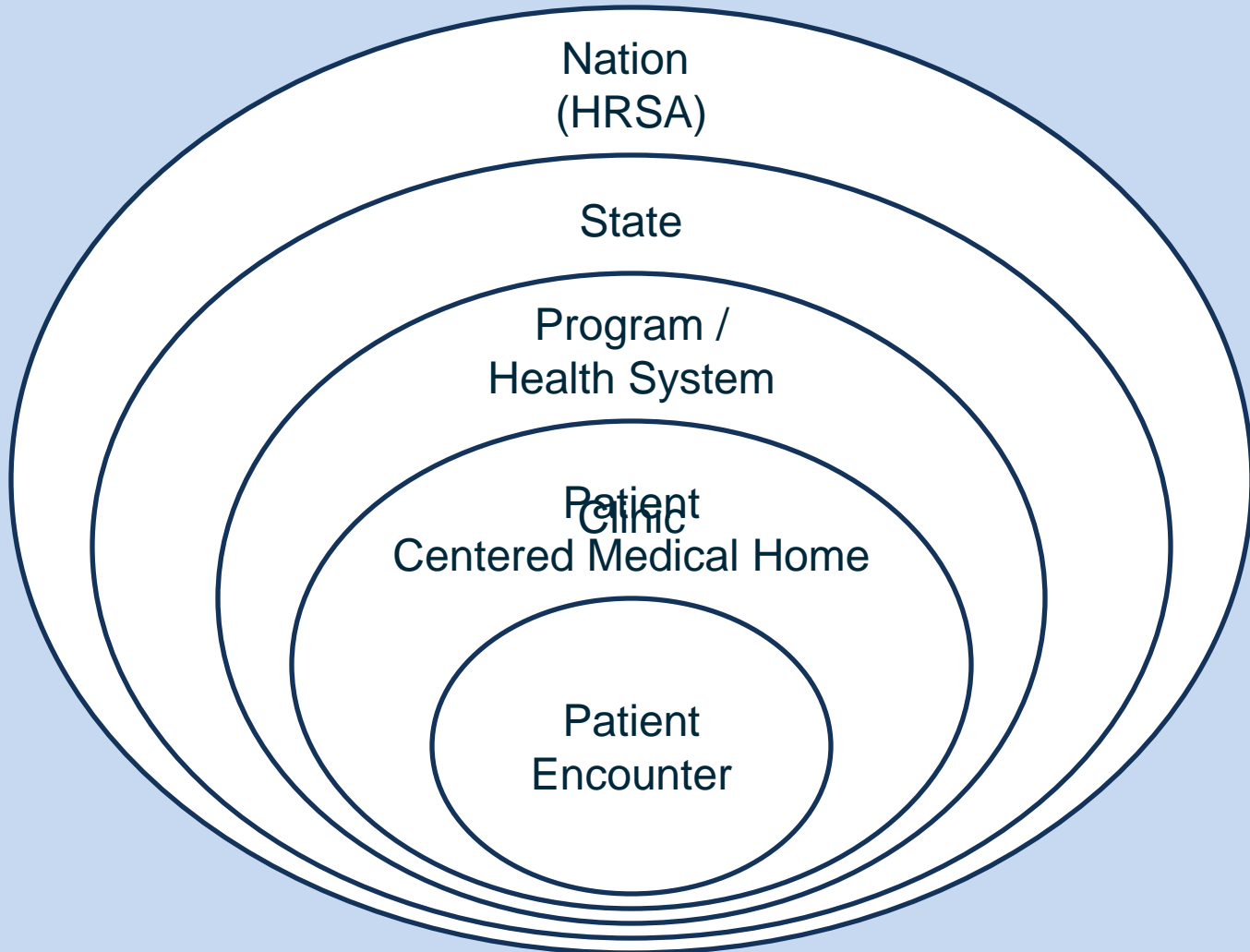
# Outline

- What constitutes HIV care?
- At what levels do we impact the quality of care?
- What is patient centered care?
- When is it important?
- What can we do as providers, as practices, and as members of a health system to support patient centered care?
- How can we make patient centered care sustainable?
- What is the role of the consumer in patient-centered care?

# What Constitutes HIV Care?



# Levels of Care



# What is Patient-Centered Care?

- Defined by the Institute of Medicine as "care that is respectful of and responsive to *individual patient preferences, needs, and values.*"
- Patients become active participants in their own care and receive services designed to focus on their individual needs and preferences, in addition to advice and counsel from health professionals



# Shouldn't All Care Be Patient-Centered?

- Patient-centered approach has greatest role when there is no clear best choice and patient preferences guide care
  - When to start ARV's
  - Frequency of laboratory monitoring
  - Choice of treatment modality for depression
- By contrast, less integral where desire for treatment is clear and limited choice exists
  - Treatment for cryptococcal meningitis

# Patient S

- Patient S is a 51 year old male, history HIV dx 1995, not on ART. His most recent CD4 count is 14. He has consistently refused ART. He has not previously been on ART though he has known people who have. He is not concerned regarding the side effects. He expresses understanding of the potential for ART to extend his life, but he does not feel that additional time is important to him. Despite having incongruous beliefs regarding what constitutes appropriate care, he is cheerful and appropriate with no discernible evidence of cognitive impairment.

# Priorities

Public  
Health

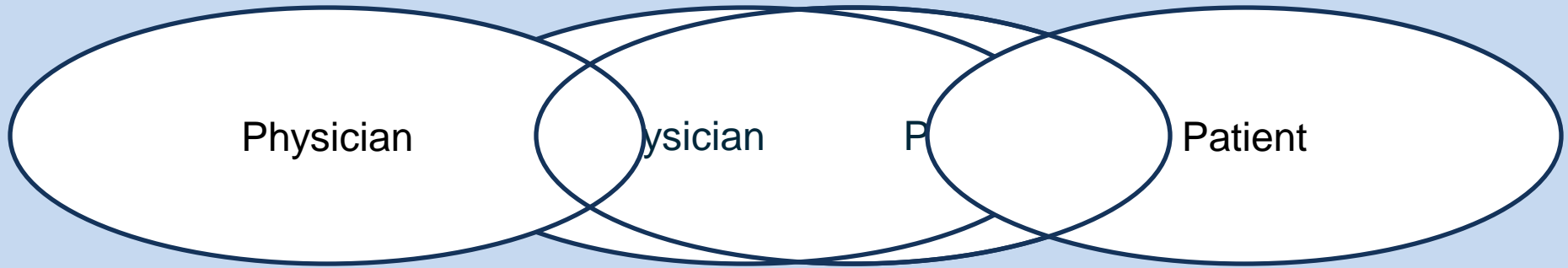


Patient  
Preferences

- Reduce transmission
- Reduce viral load
- Prevent development of resistance
- Minimize costs associated with treating late stage illness

- Weigh emotional and physical impact of treatment against expected benefits
- Substance use vs abuse
- Cost of medical monitoring
- Burden of frequent visits
- Subjective benefit of life gained

# Meeting the Patient in the Middle



# Patient Centered Interviewing

## Negotiating Treatment Goals

- **Agree on the problem.**
- **Negotiate reasonable goals.**
- **Generate options.**
- **Decide on a mutually agreeable and feasible regimen. Test the patient's knowledge.**
- **Screen for readiness.**
  - "On a scale of 1 to 10, how important do you think it is for you to do the things we've been talking about?"
  - "On a scale of 1 to 10, how confident are you that you can adhere to this treatment regimen?"

# Principles of the Patient Centered Medical Home

- Personal physician in a physician-directed medical practice
- Whole person orientation
- Coordinated care, integrated across settings
- Quality and safety emphasis
- Enhanced patient access to care
- Supported by payment structure that recognizes services and value

# NCQA Standards for Patient Centered Care

## Standards

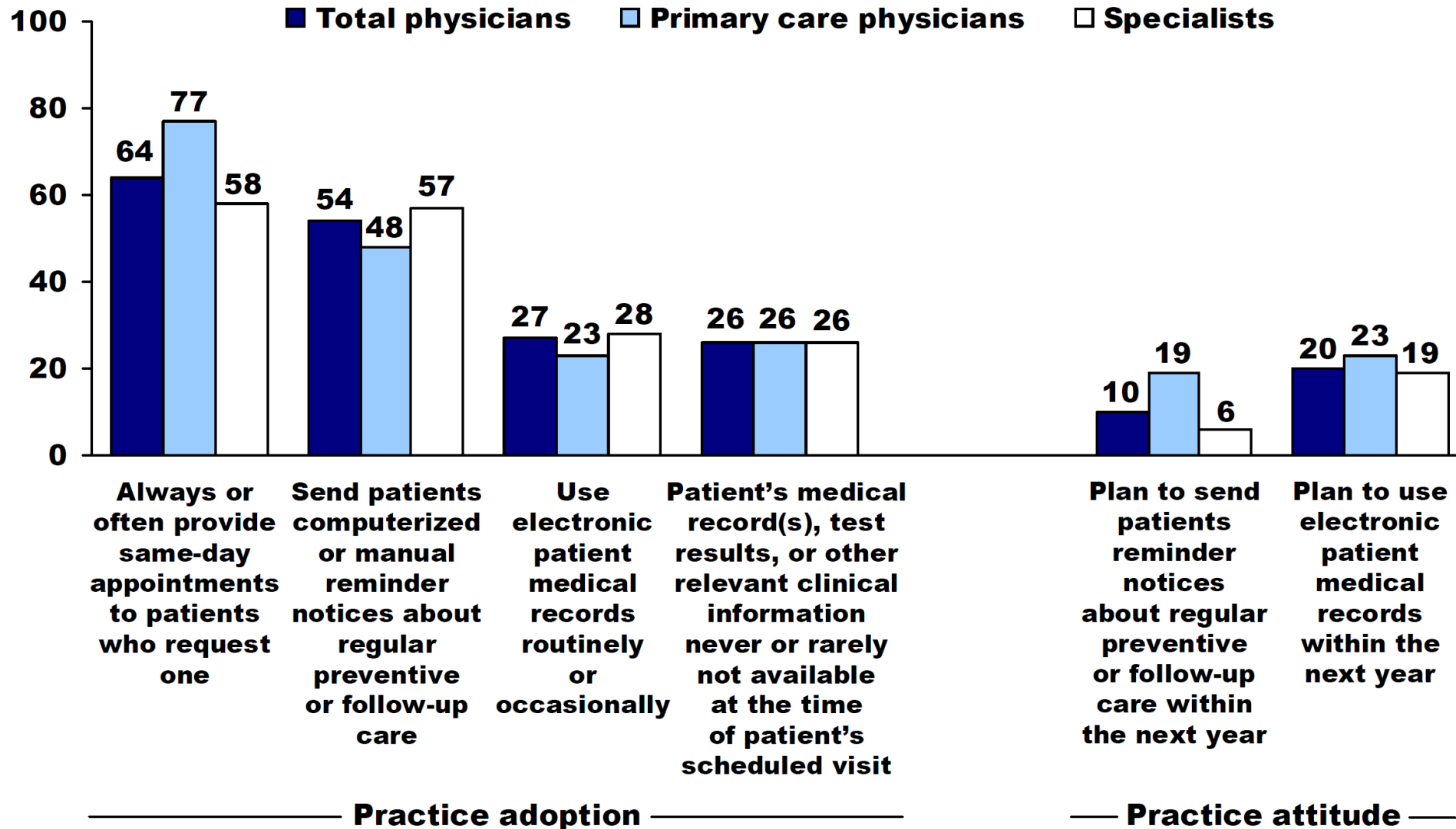
1. Enhance Access and Continuity
2. Identify and Manage Patient Populations
3. Plan and Manage Care
4. Provide Self-Care and Community Support
5. Track and Coordinate Care
6. Measure and Improve Performance

## Must Pass Elements (>=50%)

1. Element A: Access During Office Hours
2. Element D: Use Data for Population Management
3. Element C: Care Management
4. Element A: Support Self-Care Process
5. Element B: Track Referrals and Follow-Up
6. Element C: Implement Continuous Quality Improvement

# Physician Adoption and Attitudes Toward Specific Patient-Centered Practices

Percent

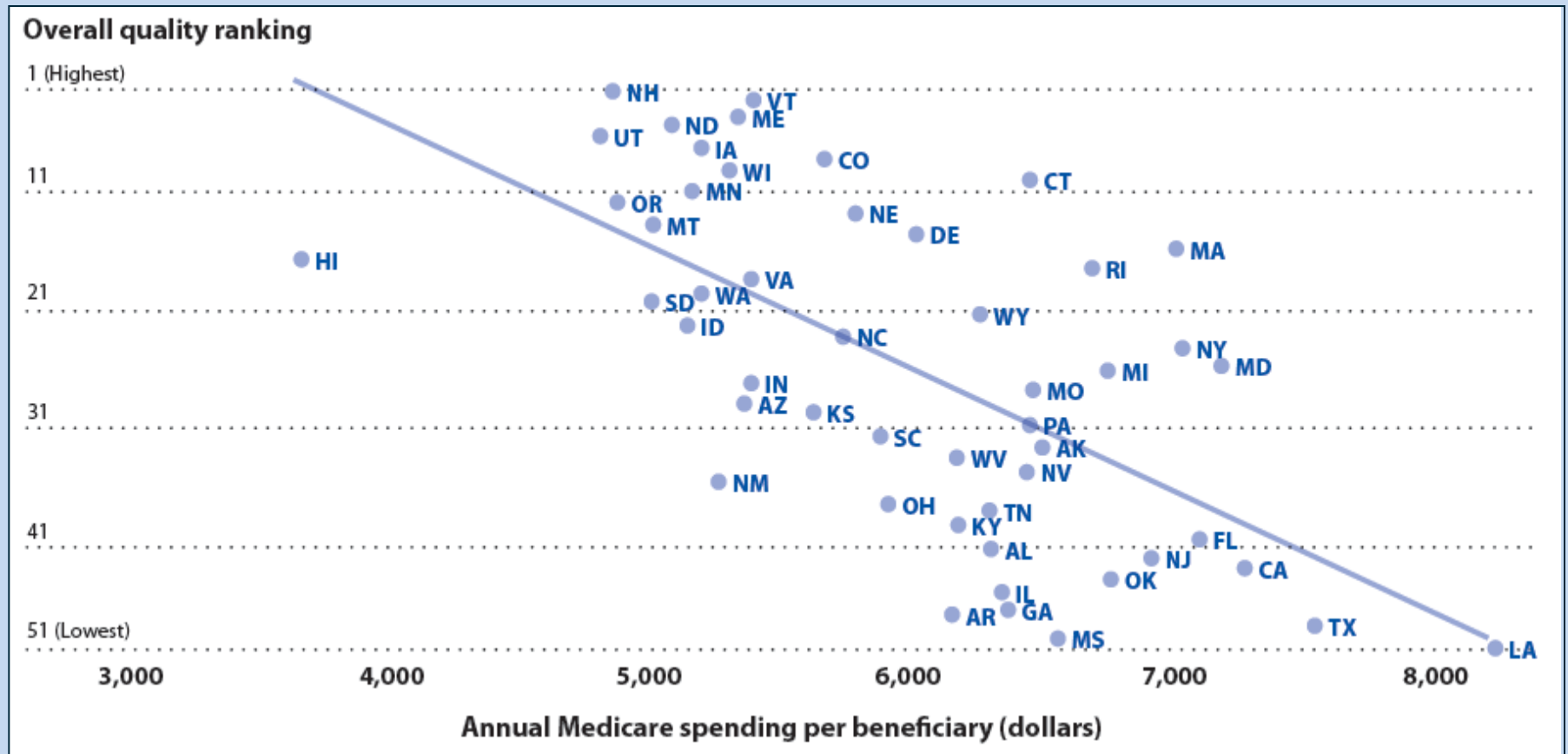


Adapted from A.-M. J. Audet, K. Davis, and S. C. Schoenbaum, "Adoption of Patient-Centered Care Practices by Physicians: Results from a National Survey," *Archives of Internal Medicine*, Apr. 10, 2006 166(7):754–59.

# Why the Delays in Adopting PCMH?

- Challenges
  - Upfront costs: EMR and system development
  - Uncompensated administrative time
  - Expanded time required within patient encounters
  - Who wants to work expanded hours?

## Relationship Between Quality of Care and Medicare Spending: As Expressed by Overall Quality Ranking, 2000–2001



Data: Medicare administrative claims data and Medicare Quality Improvement Organization program data. Adapted and republished with permission of *Health Affairs* from Baicker and Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care" (Web Exclusive), 2004.

Source: McCarthy and Leatherman, Performance Snapshots, 2006. [www.cmwf.org/snapshots](http://www.cmwf.org/snapshots)

# Incremental Costs of PCMH

## Estimated Spending by PCMH Score Category

Type of Spending per MD (\$1,000s)	PCMH Score Category		
	Low	Mid	High
Support Staff	152	157	154
General Operating	120	122	134
IT	5	8	11
Physician	206	193	195
<b>Total</b>	<b>513</b>	<b>514</b>	<b>525</b>
<b>Per Patient-Month:</b>			
Support Staff	\$4.80	\$4.96	\$4.86
General Operating	\$3.79	\$3.85	\$4.23
IT	\$0.16	\$0.25	\$0.35
Physician	\$6.50	\$6.09	\$6.16
<b>Total</b>	<b>\$16.19</b>	<b>\$16.22</b>	<b>\$16.57</b>

Sources: National Committee for Quality Assurance (NCQA) Physician Practice Connections–Patient-Centered Medical Homes (PPC-PCMH) recognition tool (2008) and Medical Group Management Association (MGMA) Cost Survey or the American College of Physicians (ACP) Practice Management Checkup Tool for 2006.

# Financial Incentives

- Preferential contracting (BCBS)
- Meaningful use incentives
- Pay for performance incentives
- Improved efficiency through effective use of electronic medical records
- Capitated payments and rebates of cost savings
- Specific payments for chronic disease management

These will offset the increased costs but may not eliminate them altogether

# Can We Solve These Problems as Providers?

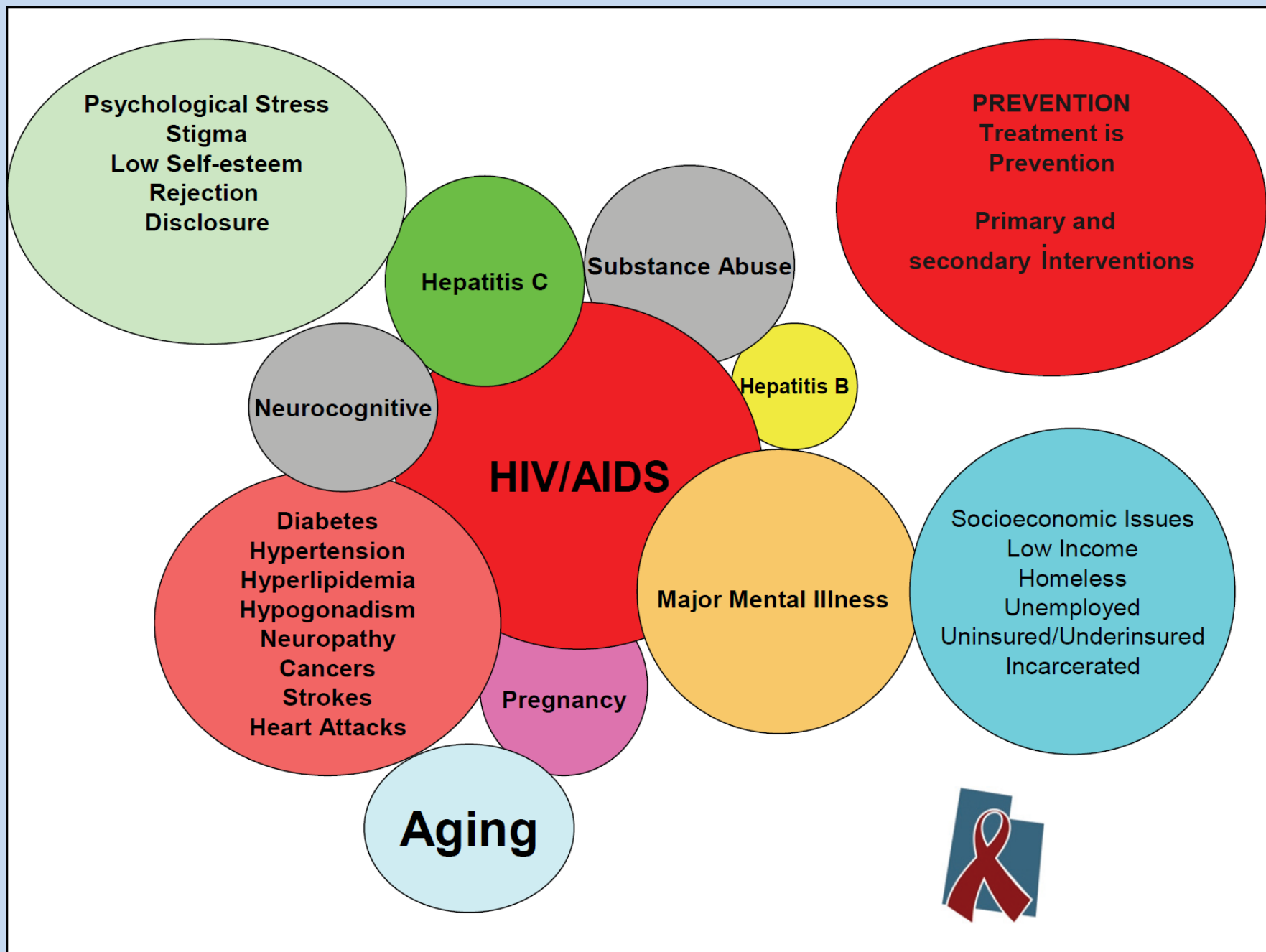
- Uptake to testing and linkage to care?
- Retention in care?
- Adherence?
- Substance abuse?
- .....
- Engaging patients is critical to successfully address these issues

# Where is the Voice of the Consumer?

- Satisfaction surveys
- Consumer advisory boards
- Consumer representatives on CQI committees
- Need to set a higher standard for consumer involvement in care
  - Identify consumer priorities
  - Consumer engagement in quality improvement teams
  - Is there a role for peer navigators and community-based care initiatives?

# Supporting Patient Centered Care Across the System

- Ryan White are model programs for coordinated care
  - Ambulatory care
  - Medical and non-medical case management
  - Social support and housing services
  - Mental Health
  - Oral Health
  - Transitional care
  - Structured programs for obtaining consumer input
  - Mandates for CQI programs
- Federally Qualified Health Centers mirror this model in many respects



# What Policy Supports Are Needed?

- Recognition of incremental costs of PCMH and allocation of appropriate funding
- Reconsideration of payment system and needed restructuring to support new model of care
- Support for patients as they transition between insurance payers who may offer less comprehensive care
  - Preserve access to ancillary services such as housing, case management, mental health and substance abuse treatment

# Summary

- Patient centered care and medical homes are being increasingly recognized as standards for healthcare delivery
- Redesign of the payment system may be necessary to make this care sustainable
- Engaging consumers is a critical aspect of the success of patient centered medical homes
- Ryan White care programs provide an important model for patient centered and coordinated care across the health system

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# Patient-Centered Medical Home: Proposed reimbursement models

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- Modified RBRVS payment system<sup>1</sup>
- Visit-based system using diagnostic groups +/- risk sharing<sup>2</sup>
- Multi-component risk-adjusted systems<sup>1,4,5</sup>
- Comprehensive monthly risk-adjusted payment<sup>1,3</sup>
- Evidence-based case-rate model<sup>1</sup>
- Provider group model<sup>1</sup>
- Care management organization plus physician model<sup>1</sup>