Patient Centered Medical Home and ACO:
Emerging US care models – and what might Canada have in common?

M. Turner Billingsley MD FACEP
Chief Medical Officer, InterSystems
• Patient Centered Medical Home and Accountable Care Organizations:
  – High level review of these models
  – Organization and governance
  – Potential for cost savings and improved outcomes using these models

• How might these models translate to Canada?

• Technology use cases
  – Sample cases for these models
  – Potential value and applicability
Patient Centered Medical Home

• What is it?
  “The patient-centered medical home is a model of care that holds significant promise for better health care quality, improved involvement of patients in their own care and reduced avoidable costs over time”

• Seeks to strengthen the physician-patient relationship by organizing and coordinating care
  – Replace episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship
  – Each patient has an ongoing relationship with a personal physician who leads a team that takes collective clinical and, in many cases, financial responsibility for patient care
  – The physician-led care team is responsible for providing all the patient’s health care needs and, when needed, arranges for appropriate care with other qualified physicians
Key Components of the PCMH Model

- **Personal physician**
- **Physician directed medical practice**
- **Whole person orientation**
- **Care is coordinated and/or integrated** across all elements of the complex health care
- **Quality and safety** are hallmarks of the medical home:
- **Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.
NCQA: “Must Pass” Qualification (Higher levels of qualification require more elements/higher compliance)

• PCMH 1, Element A: Access During Office Hours
• PCMH 2, Element D: Use Data for Population Management
• PCMH 3, Element C: Care Management
• PCMH 4, Element A: Support Self-Care Process
• PCMH 5, Element B: Track Referrals and Follow-Up
• PCMH 6, Element C: Implement Continuous Quality Improvement
• Legal Structure
• 5000 beneficiary minimum – must have adequate primary care physicians to support
• Minimum three year agreement
• Must share “sufficient” information with HHS necessary to support beneficiary assignment and determine payments for shared savings
• Leadership and management structure that includes clinical and administrative systems
• Defined processes to:
  – Promote evidence-based medicine
  – Report necessary data to evaluate quality and cost measures
  – Coordinate care
• Meet patient-centeredness criteria
Accountable Care Systems – Key Attributes

- Organized care
  - Alignment of physicians/hospitals/other providers/entities in a community
    - May include tightly aligned (IDN) models, i.e. employed physicians and owned care entities versus “looser” organizations of independent groups/providers
    - Take responsibility/financial risk for care of an entire population of patients
- Strong emphasis on primary care and “patient centered” care (PCMH model)
- Alignment of payment incentives
  - Various models, all include degrees of “shared savings” and “shared risk”
  - Risk versus potential shared savings linked
- Organizational and financial structure to manage payments and distribute payments among providers/entities
- Performance measurement
  - Will require analytics/metrics to measure and report both quality/outcomes data and cost data
Do the US and Canadian HC Systems have some things in common?

- Persistent gaps between providers
- Imperative to slow growth in costs
- Introduction of new payment models
- Need to measure and improve outcomes
- Widespread “consumer” dissatisfaction
A Shared Need: The Path to Improved Outcomes

A strategic platform of solutions is needed
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<tr>
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<th>Use Case</th>
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<tr>
<td>1</td>
<td><strong>Deliver clinical results</strong> to clinician EHRs/EMR such as discharge summaries, lab results, and image reports.</td>
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<td>2</td>
<td><strong>Aggregate patient records</strong> from multiple internal and external sources in a web based portal, such as cumulative labs, meds, allergies, problems, progress notes, etc.</td>
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<td>3</td>
<td><strong>Aggregate electronic patient records</strong> from multiple external and internal data sources and integrate into EMR as a document or structured data.</td>
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<td>4</td>
<td><strong>Provide secure clinician to clinician messaging</strong>, including Direct Messaging. Examples of content include clinical referrals, test results, consult notes between users, and notifying clinicians of events such as patient admissions and discharges</td>
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<td>5</td>
<td><strong>Enable provider to provider referrals</strong>, including referrals from and to non-network practices</td>
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<td>6</td>
<td><strong>Connect with local, state, and federal public health</strong> agencies to share immunization history, reportable labs, and other key elements.</td>
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<td>7</td>
<td><strong>Care management triggers</strong> and actions to prevent readmissions (enrollment, contact)</td>
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<td>8</td>
<td><strong>Manage and resolve patient identities</strong> across facilities (MPI)</td>
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<td>9</td>
<td><strong>Identify high risk patient sets for actions</strong> such as surveillance, case management</td>
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<td>10</td>
<td><strong>View patient appointments</strong> and deliver notifications of missed appointments.</td>
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Continuum of Potential Solutions

Capture

Understand

Share

Act

Missed Appt. Notification

Manage Patient Identities

Admit/Discharge Notification

Clinical Referrals

Care Management Triggers

Deliver Results, D/C Reports

Aggregate Patient Record & View

Connect to HIE-Public Health

Aggregate Patient Record & Integrate

Direct Messaging

High Risk Patient Event Management

Improve Efficiencies

Optimize Outcomes, Quality, Safety
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<thead>
<tr>
<th>Delivering Success:</th>
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<tbody>
<tr>
<td>All 19 <em>U.S. News</em> Honor Roll Hospitals</td>
</tr>
<tr>
<td>Kaiser Permanente, Military Health, VA</td>
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<tr>
<td>National EMR Scotland, Patient Summary</td>
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<tr>
<td>Record in Sweden</td>
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<tr>
<td>Statewide clinical care solutions in Australia, Chile, Brazil</td>
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<td>Over 3 million healthcare users</td>
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Questions?

Thank You!