

Implementing the PCMH: The practice experience

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Patient Centered Medical Home = Driving/managing change

- FFS “guiding principle” of practice organization
 - ◆ Internal productivity/compensation metrics
 - ◆ Justification for resource decisions
- “New activities” represent real “work”
 - ◆ Longer days? Less FFS revenue? Both?
- We are really starting a “new business”
 - ◆ Space, staff, technology, organization



Radical Re-Design: Examples of “new activities”

- HIT and its management
- Creation of office policies and procedures
- (Re)-Training of (new) staff
- Protocol development and implementation
- Non-visit based care
 - ◆ E-mail, pro-active chronic disease management, population based care



New Skills are Required

- Expert diagnostician and clinician
- Patient advocate
- Effective communicator
- Team leader and an effective teammate
- Systems manager
- Effective user of health information technology and health data
- Effective change agent
- Practitioner accountable for efficient, accessible care



In Summary

- Physicians are *not* well trained or well prepared to create a PCMH
- As Med-PAC has said, resources- both short and long term- will be needed to make this work
- Will need creative support of primary care training and practice to make this work

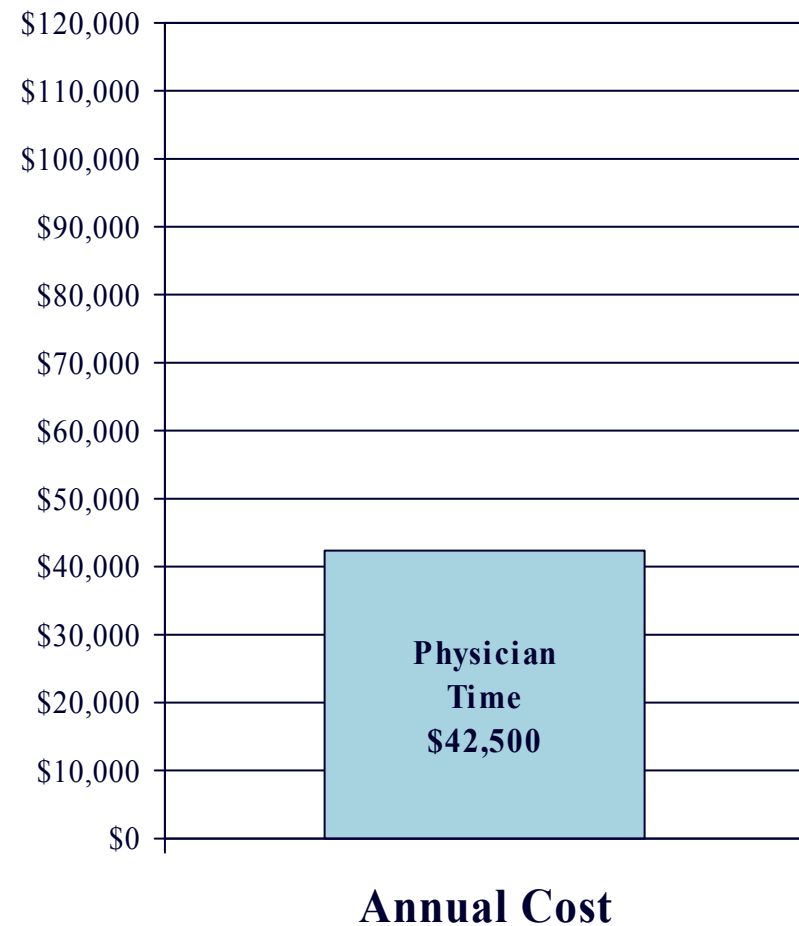


Framing Principles

- Think in terms of overall practice costs for doing this
 - ◆ Avoid the “4 foot rope for a 10 foot hole”
 - ◆ Best to think as “percentage of practice gross”
- Require – and fund- EHRs
 - ◆ Need them to activate teams/offload docs
 - ◆ Need them to manage and measure
 - ◆ Need them for enhanced communication
- Pro rata funding model (SEPA Pilot, almost) a good option for multi-payer

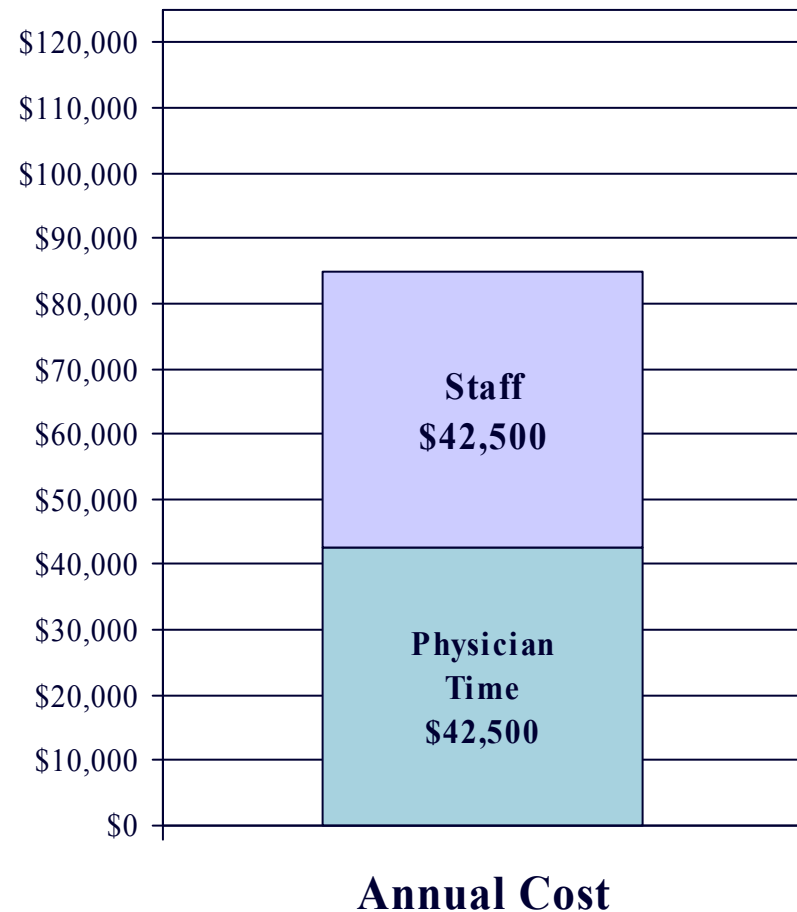
What does it cost to make it happen?

- Allocation of 10% active time per physician on “new activities”
 - ◆ No FFS revenue? That’s 10% of *practice gross revenue*, or around \$42.5K per doc



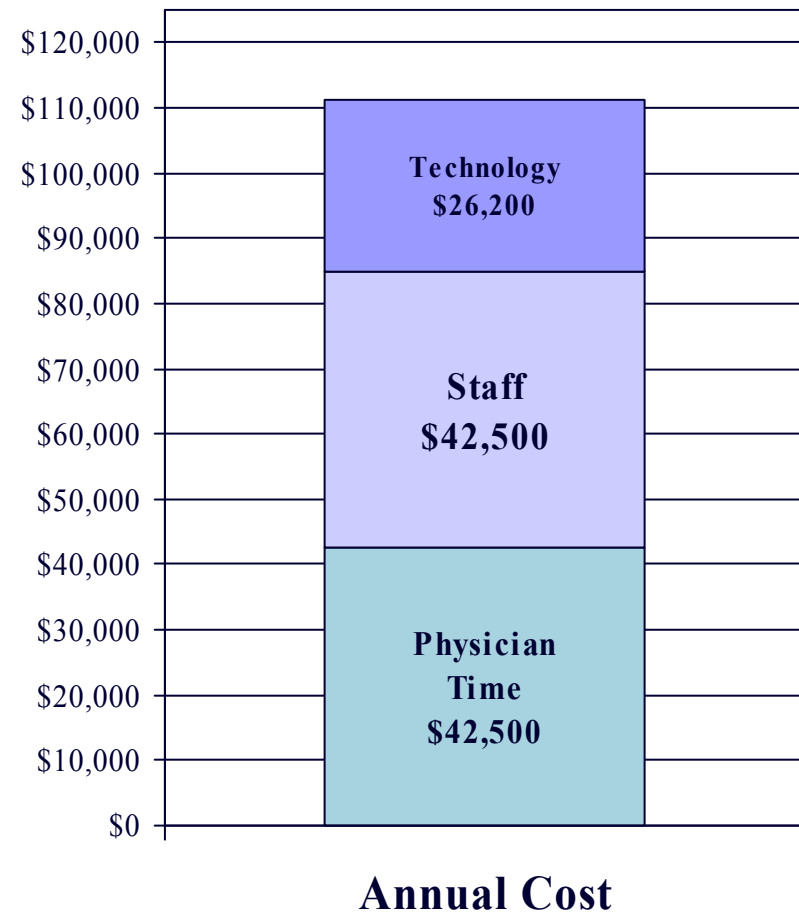
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- Add new staff
 - ◆ Health Educator \$57K plus benefits plus indirects
 - ◆ One more MA, one more Front Desk to be “activated team”
 - ◆ Maybe part of a Social Worker, maybe an NP/PA



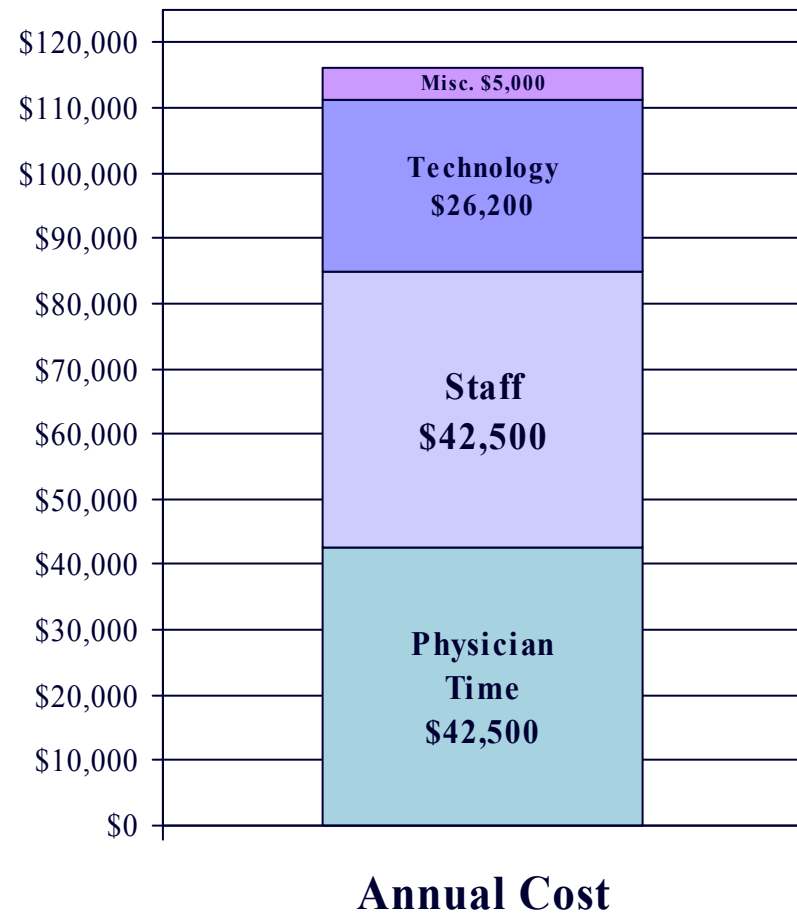
What does it cost to make it happen?

- Technology related
 - ◆ EHR acquisition and training: \$70-80K/doc
 - ◆ Ongoing support: \$12-15K/doc annually
 - ◆ Data analytics: \$25-50K/year



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- Miscellaneous
 - ◆ Space
 - ◆ Materials





What does it cost to make it happen?

Total: Around \$117,000 per FTE physician,
or 27.5% premium over usual gross

And this does NOT factor in any actual salary increase to
physicians; will ALSO need a strategy to “revitalize”
primary care . . .



What is Greenhouse doing?

- Hired a health educator
- Hiring more Front Desk/MA folks
- Not hiring an NP/PA
- Arguing about need for new space
- Interacting more with our technology
- Did our own CG-CAHPS survey
- Working toward developing more systematic non-visit based care
- Hoping to pay docs more, “recoup” EHR investment



What is ABIM Doing?

- Defining a new job description for generalists and related competencies, e.g. team skills, patient advocacy (CCIM)
- Research (CC PIM) to understand relationship between clinical performance, patient experience and the system – with a focus on the “human factors”
- Seeking partners to field CC PIM and CCIM assessments as a tool for physicians to diagnose practice strengths & weaknesses
- Making the case that MOC should be part of the PCMH



To sum up

- PCMH is not just a variation on “traditional” primary care:
 - ◆ Need new skills from the physicians
 - ◆ Need new capacities in the practice
 - ◆ Need new resources to support those capacities and reward those physicians
- The presence of **all 3** is the surest way to see an ROI from these projects