Is the Patient-centered Medical Home the Same as “Primary Care”?: Measurement Issues

Barbara Starfield, MD, MPH

NCVHS
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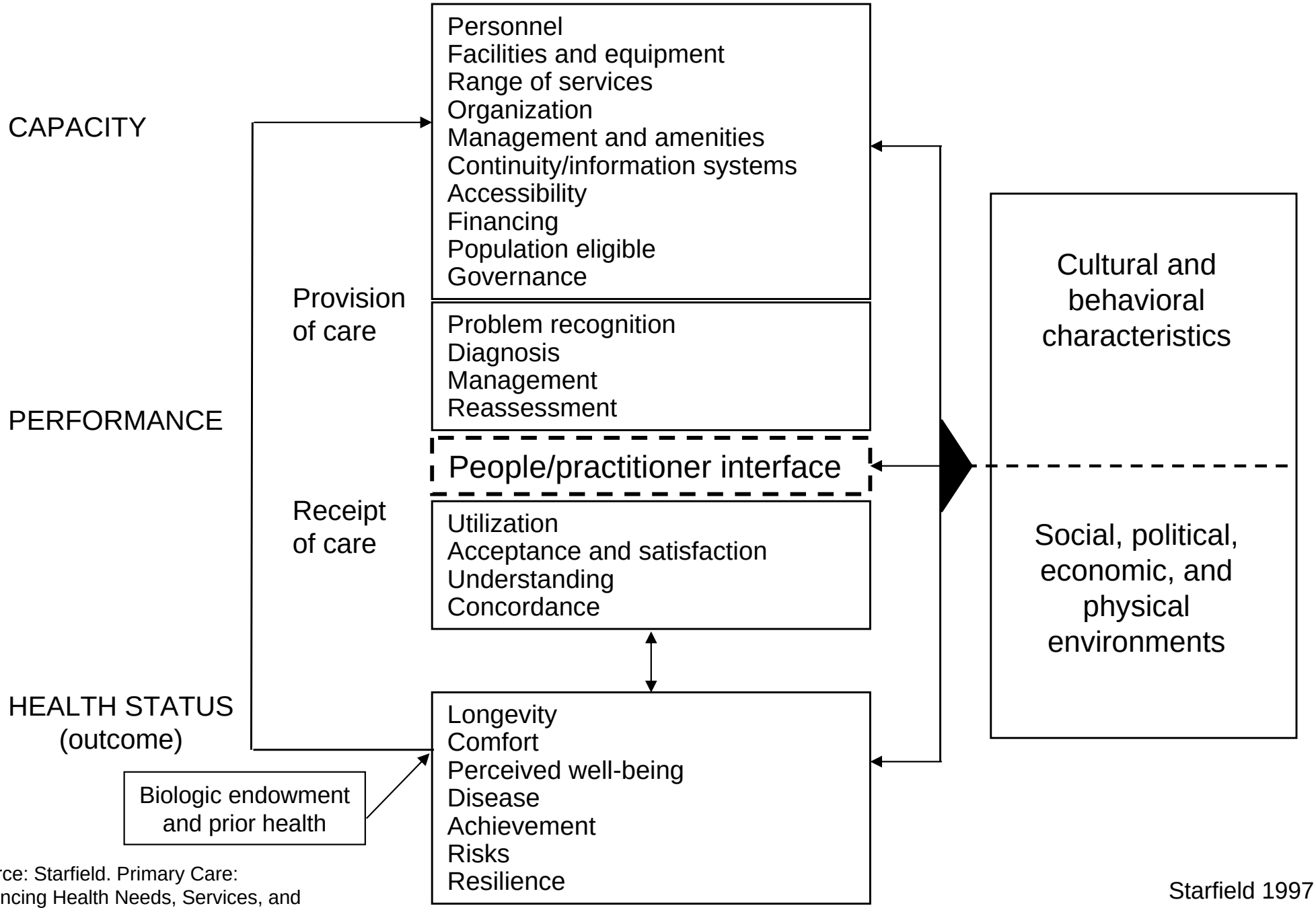
Primary health care “works” because it has definable functions that provide the policy context for primary care.

Primary care “works” because it has defined functions that include structural and process features of health services that are known to improve outcomes of care.

A framework based on structure, process, and outcome is helpful in describing and measuring the components of health services systems.

The Health Services System



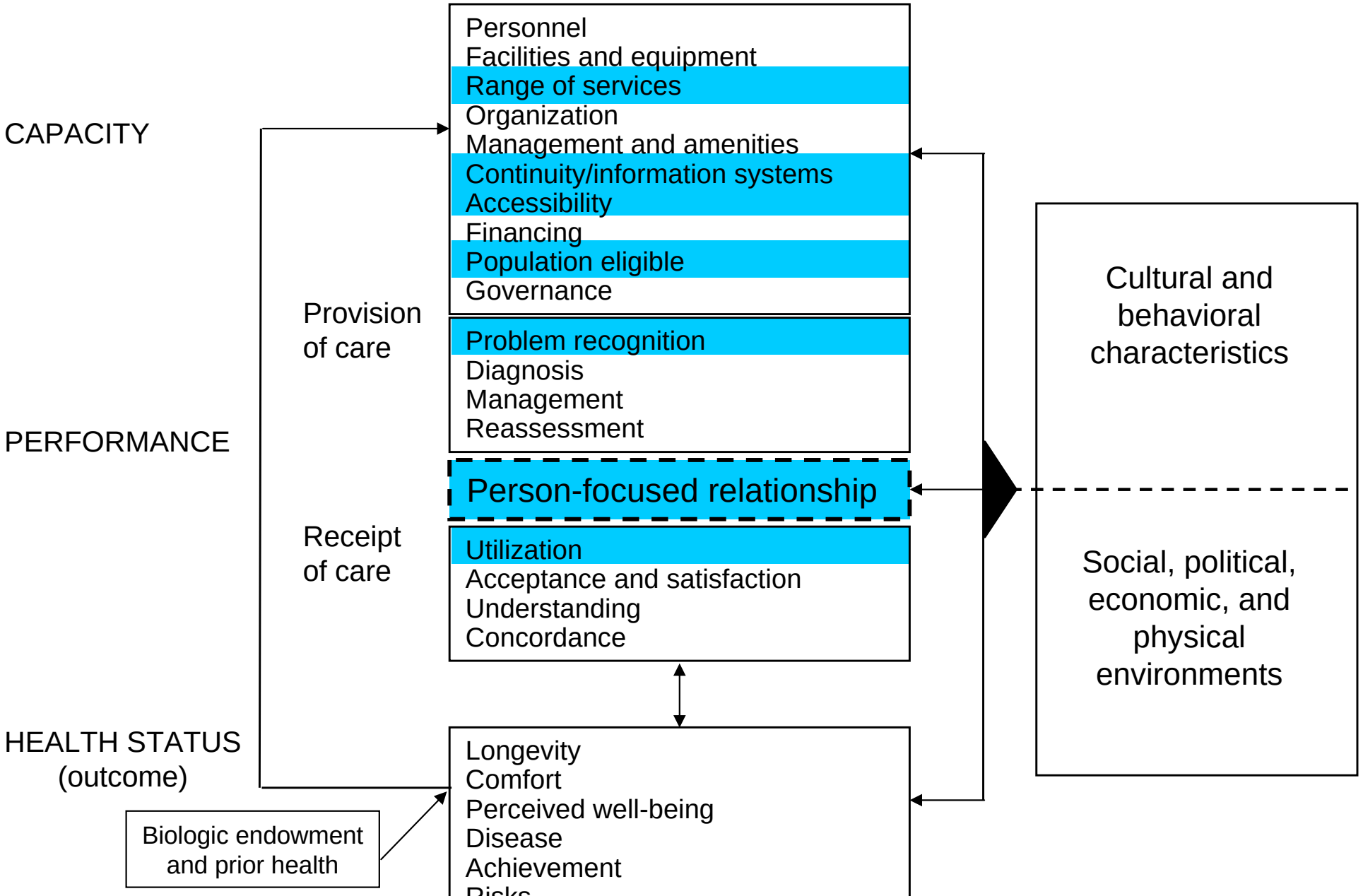
Source: Starfield. Primary Care: Balancing Health Needs, Services, and Technology. Oxford U. Press, 1998.

Starfield 1997
HS 1064 n

Primary Care

First Contact	• Accessibility • Use by people for each new problem
Longitudinal	• Relationship between a facility and its population • Use by people over time regardless of the type of problem; person-focused character of provider/patient relationship
Comprehensive	• Broad range of services • Recognition of situations where services are needed
Coordination	• Mechanism for achieving continuity • Recognition of problems that require follow-up

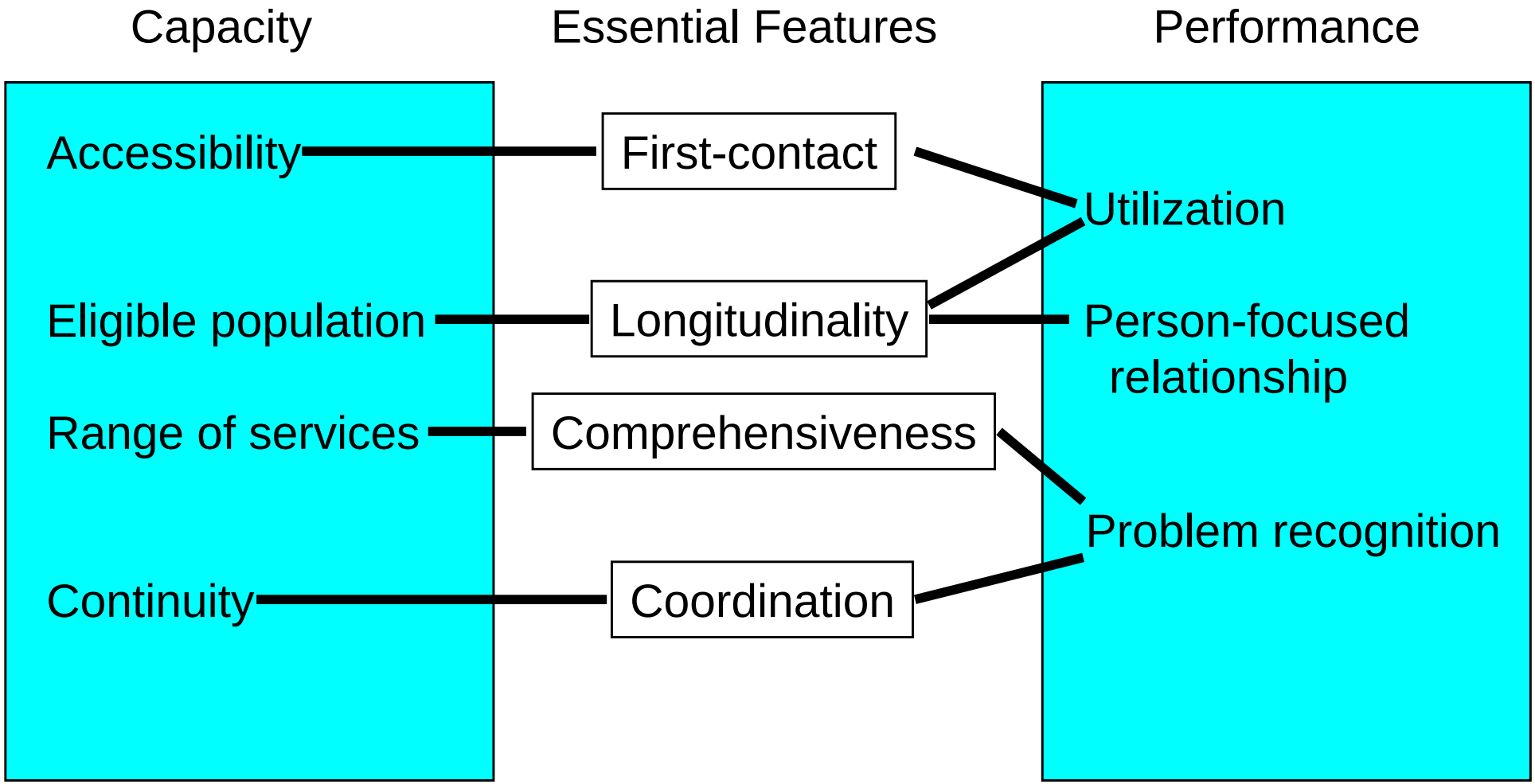
Primary Care Oriented Health Services



Source: Starfield. Primary Care: Balancing Health Needs, Services, and Technology. Oxford U. Press, 1998.

Starfield 04/08
HS 4009 n

Structural and Process Elements of the Essential Features of Primary Care



Starfield 04/97
EVAL 1108 n

There is no formal quality assessment approach that includes the critical feature of problem-recognition, despite the evidence that patients are more likely to improve when they and their practitioner agree on what their problem is.

Sources: Starfield et al, JAMA 1979; 242:344-46.
Starfield et al, Am J Public Health 1981; 71:127-31.

There is no formal quality assessment approach that includes range of services, despite evidence that a broader range of services provided in primary care is characteristic of stronger primary health services systems.

Starfield 04/08
Q 4010

Criteria for Comprehensiveness

In US studies: universal provision of extensive and uniform benefits for children, the elderly, women, and other adults; routine OB care; mental health needs addressed; minor surgery; generic preventive care

In European studies: treatment and follow-up of diseases (e.g., hypothyroidism, acute CVA, ulcerative colitis, work-relate stress, n=17); technical procedures (e.g., wart removal, IUD insertion; removal of corneal rusty spot; joint injections); taking cervical smears; group health education; family planning and contraception

PRIMARY CARE ORIENTED COUNTRIES HAVE GREATER COMPREHENSIVENESS (RANGE OF SERVICES).

Sources: Starfield &Shi, Health Policy 2002; 60:201-18; Boerma et al, Br J Gen Pract 1997; 47:481-6; Boerma et al, Soc Sci Med 1998; 47:445-53.

Comprehensiveness in Primary Care

Wart removal	IUD insertion IUD removal Pap smear
Suturing lacerations	Tympanocentesis
Removal of cysts	Vision screening
Joint aspiration/injection Foreign body removal (ear, nose) Setting of simple fractures Sprained ankle splint	Age-appropriate surveillance Family planning Immunizations Smoking counseling
Remove ingrowing toenail	Hearing screening
Behavior/MH counseling	Home visits as needed
Electrocardiography	Nutrition counseling
Examination for dental status	OTHERS?

Limitations of Current Assessments of Primary Care

- NO assessment of the critical feature of problem recognition
- NO assessment of comprehensiveness of either primary health care (system level) or of primary care (clinical level)
- Overemphasis on “quality” of care for specific diseases; little assessment of person-focused measures
- Underdevelopment of the concept and measurement of coordination

Enhancements to Primary Care

- Health information systems: primary care/system-wide
- Analysis of variations in care
  - with variations in use of secondary care
  - with variations in type of payment
  - with focus on patients versus diseases (P4P)
- Subspecialization in primary care
- Patient-centered primary care (poorly conceptualized)
- “Chronic care model”: self-management support; delivery system design; decision support; clinical; information systems

ALL REQUIRE EVALUATION.

Primary Care and the Medical Home

- Primary care
  - 90-year-old concept
  - Precise definition
  - Standardized measurement
- Medical home
  - 40-year-old concept (different application)
  - Imprecise definition
  - Unstandardized measurement

How do we know if ways of delivering services are essentially the same, fundamentally different, complementary, or supplementary?

At the very least, we need to know the essential principles and functions.

Joint Principles of the Patient-centered Medical Home

- Personal physician: ongoing relationship for first contact, continuous, comprehensive care
- Physician directed medical practice
- Whole person oriented
- Coordinated and/or integrated care
- Quality and safety
- Enhanced access
- Added value payment

Source: AAFP/AAP/ACP/AOA. Joint Principles. March 2007.

Physician-practice Connections: the PPC-PCMH Standards

- About 230 items have to be recorded.
- Most of these assess structural elements of the practice.
- Most are simply good medical care, not specifically primary care.
- Little or no evidence of usefulness of many if not most elements
- NO ELEMENTS ADDRESSING INTERPERSONAL INTERACTIONS, RECOGNITION OF PATIENT/ POPULATION PROBLEMS, FOLLOW-UP TO ASSESS IMPROVEMENT, OR COMPREHENSIVENESS OF CARE (EITHER APPROPRIATE RANGE OF SERVICES OR COMPREHENSIVENESS OF CARE PROVIDED)

Distribution of Items: PPC-PCMH Standards Spring 2008

- Access and communication: 12 + 5 = **17**
- Tracking and registry: 18 + 11 (x 2) + 7 + 3 + 7 = **57**
- Care management: 3 + 4 + 4 + 11 (x 3) + 10 = **54**
- Patient self-management: 2 + 7 = **9**
- Electronic prescribing: 2 + 15 + 2 = **19**
- Test tracking: 6 + 8 = **14**
- Referral tracking: 4 = **4**
- Performance reporting: 4 + 4 + 2 + 2 + 10 + 10 = **32**
- Advanced electronic communication: 6 + 6 + 2 = **14**

Source: NCQA, spring 2008.

At the very least, any instrument to assess the quality of primary care (or “medical home”) ought to include assessment of

- Comprehensiveness (range of services available and offered when needed)
- A coding system that captures patients’ problems, i.e., the International Classification of Primary Care (ICPC)

Measurement of Primary Care: The PCAT (Primary Care Assessment Tool)

PCAT Versions

Primary Health Care

Systems assessment (policy makers and managers)

Primary Care

Adult consumer long/short

Child consumer long/short

Facility long/short

Provider long/short

PCAT Languages

- English
- Spanish
- Catalan
- Portuguese
- French (Quebec)
- Korean
- In progress: Mandarin, Maltese

Conclusion

If the United States is serious in pursuing the World Health Organization (2008) goal of Primary (Health) Care, it must come to grips with defining and assessing health services according to evidence-based functions associated with primary care systems and practices. So far, this has been lacking on a system-wide basis.

Primary Health Care and Primary Care

Primary health care is a system-wide approach to designing health services based on primary care.

Primary care is the representation, on the clinical level, of primary health care.

Primary health care oriented countries

- Have more equitable resource distributions
- Have health insurance or services that are provided by the government
- Have little or no private health insurance
- Have no or low co-payments for health services
- Are rated as better by their populations
- Have primary care that includes a wider range of services and is family oriented
- Have better health at lower costs

Sources: Starfield and Shi, Health Policy 2002; 60:201-18.
van Doorslaer et al, Health Econ 2004; 13:629-47.
Schoen et al, Health Aff 2005; W5: 509-25.

Key factors in achieving an effective health system in both developing and industrialized countries are:

- Universal financial coverage, under governmental control or regulation
- Efforts to distribute resources equitably (according to degree of need)
- No or low co-payments
- Comprehensiveness of services
- Skilled delivery attendants
- Immunization coverage

Sources: Starfield & Shi, Health Policy 2002; 60:201-18. Gilson et al. Knowledge Network on Health Systems. Commission on the Social Determinants of Health. Centre for Health Policy, University of Witwatersrand, 2007.

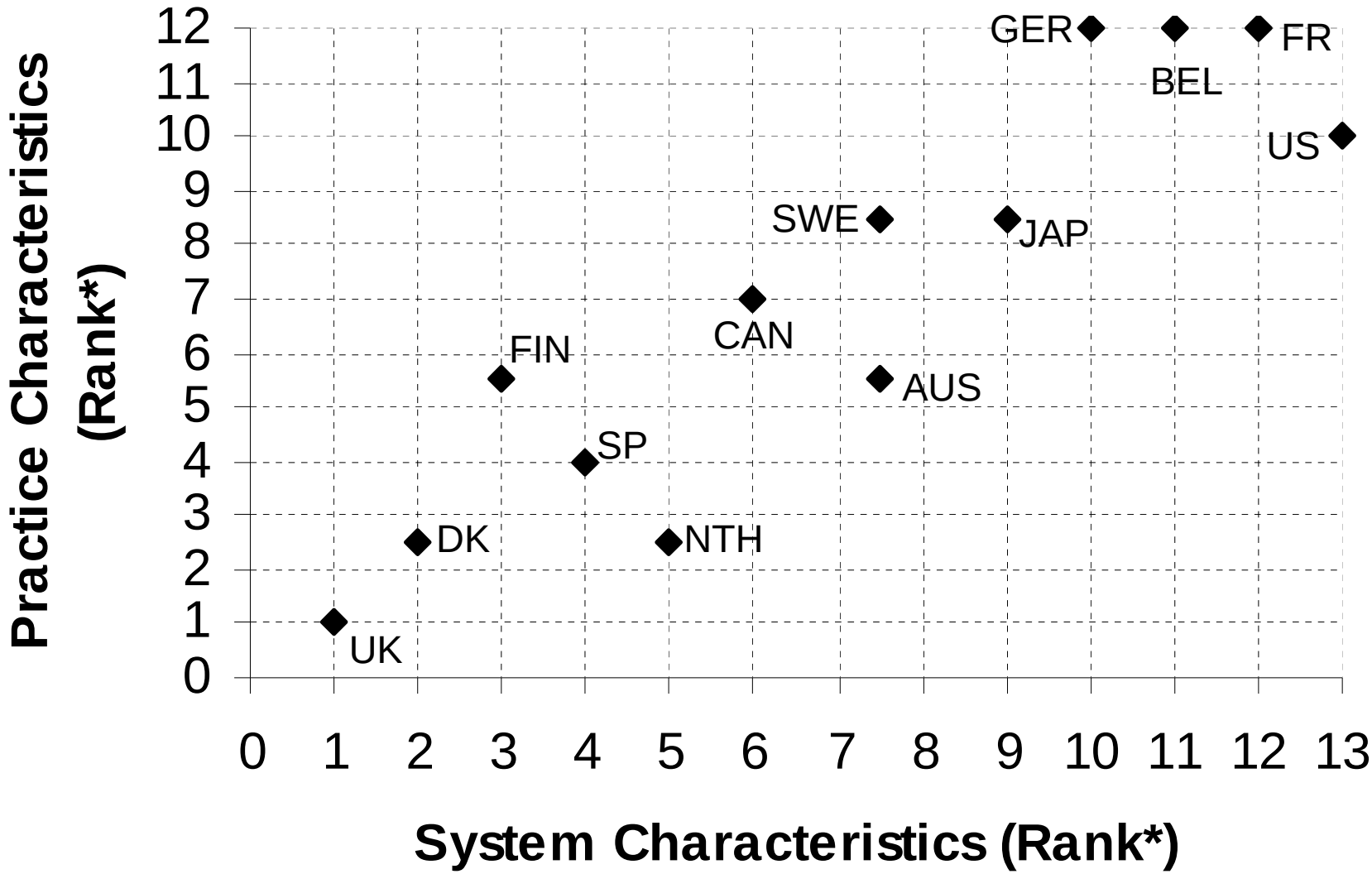
System Features Important to Primary Health Care

	Resource Allocation (Score)	Progressive Financing*	Cost Sharing
Belgium	0	0	0
France	0	0	0
Germany	0	1	2
US	0	0**	0
Australia	1	2	2
Canada	1	2	2
Japan	1	2	1
Sweden	2	2	1
Denmark	2	2	2
Finland	2	2	1
Netherlands	2	0	2
Spain	2	2	2
UK	2	2	2

*0=all regressive
1=mixed
2=all progressive
**except Medicaid

Sources: Starfield. Primary Care: Balancing Health Needs, Services, and Technology. Oxford U. Press, 1998. van Doorslaer et al. Equity in the Finance and Delivery of Health Care: An International Perspective. Oxford U. Press, 1993.

System (PHC) and Practice (PC) Characteristics Facilitating Primary Care, Early-Mid 1990s



*Best level of health indicator is ranked 1; worst is ranked 13; thus, lower average ranks indicate better performance.

Based on data in Starfield & Shi, Health Policy 2002; 60:201-18.

Starfield 03/05
ICTC 3099 n

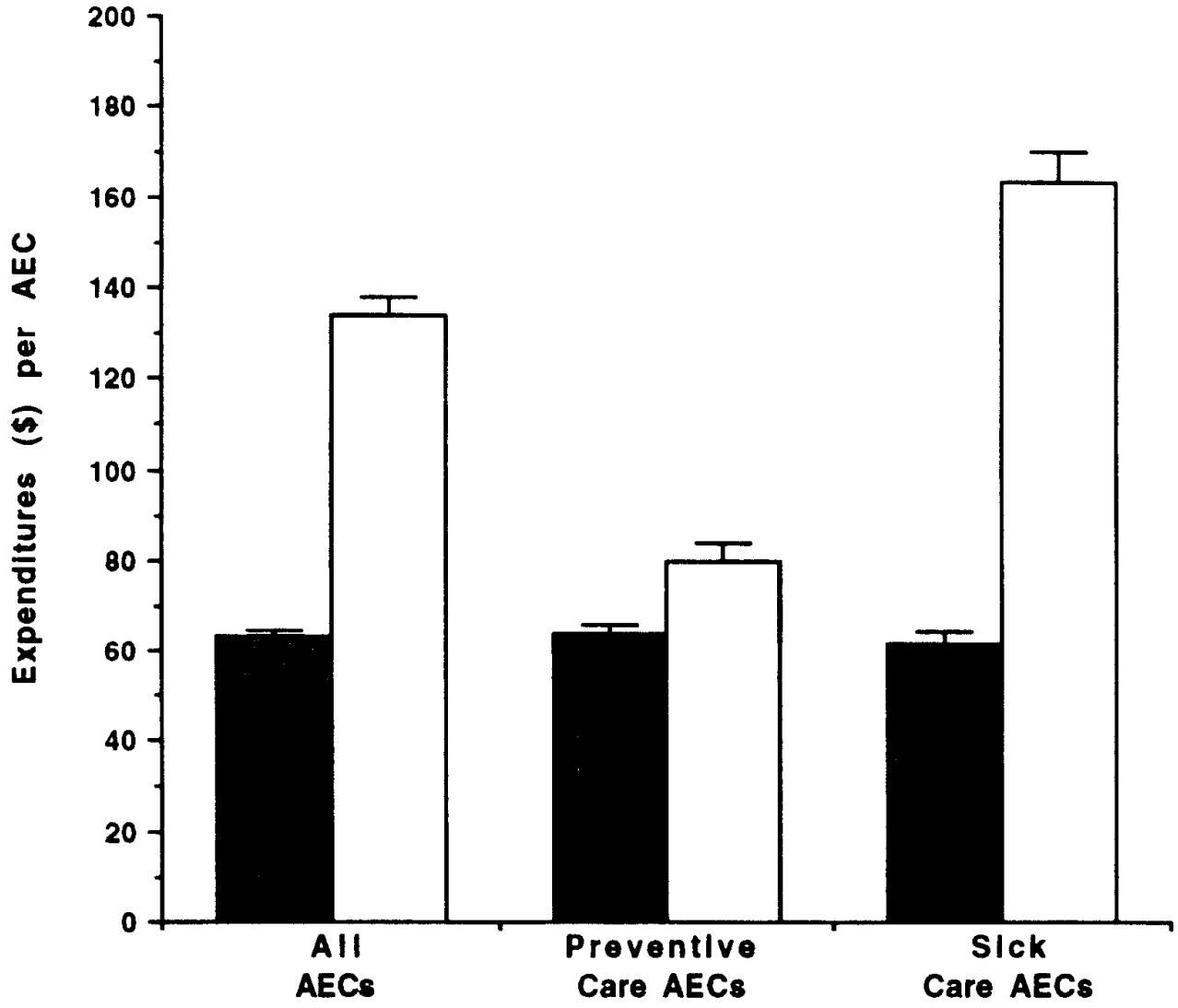
At the clinical level, the critical structural features are Accessibility, mechanisms of Continuity/Information Systems, and the Range of Services provided.

The process features are Problem Recognition on the part of practitioners (both for initial problems and for reassessment), and utilization of primary care services, both over time and for first contact for new problems.

There are structural, process, and outcome features that characterize primary HEALTH care, that is, primary care at the policy level.

The critical structural features are equitable distribution of resources (Personnel and Facilities); government control or regulation of financing and low or no copayments for primary care services (Financing); and Definition of the Eligible Population. A remaining question is the extent of importance of mechanisms of Governance, which have been poorly studied.

First Contact Care and Health Spending



Based on Forrest & Starfield, J Fam Pract 1996; 43:40-8.

Benefits of Longitudinality, Based on Evidence from the Literature

	Identification with a Person	Identification with a Place
Better problem/needs recognition	++	
More accurate/earlier diagnosis	++	
Better concordance		
Appointment keeping	++	++
Treatment advice	++	
Less ER use	++	
Fewer hospitalizations	++	+
Lower costs	++	+
Better prevention (some types)	++	++
Better monitoring	+	
Fewer drug prescriptions	+	
Less unmet needs	++	+
Increased satisfaction	++	

++*Evidence good*

+*Evidence moderate*

Source: Starfield. Primary Care: Balancing Health Needs, Services, and Technology. Oxford U. Press, 1998.

In New Zealand, Australia, and the US, an average of 1.4 problems (excluding visits for prevention) were managed in each visit. However, primary care physicians in the US managed a narrower range: 46 problems accounted for 75% of problems managed in primary care, as compared with 52 in Australia and 57 in New Zealand.

Source: Bindman et al, BMJ 2007; 334:1261-6.

Coordination

Coordination requires transfer of information (a structural element) and the recognition of that information in the ongoing care of a patient (a process element).

Modes of transfer are multiple: conventional medical records, patient-held records; smart cards; electronic medical records; multidisciplinary teams with specified complementary, supplementary, and substitutive functions of each team member.

These different types have not been compared with regard to effectiveness and efficiency, but developing countries (in particular) are exploring the potential of community workers in assuming explicit responsibility for a variety of primary care tasks in conjunction with personnel in health centers where they exist.

Sources: Starfield, Primary Care: Balancing Health Needs, Services, and Technology. Oxford U. Press, 1998. Brown, Lancet 2007; 370:1115-7.

The Chronic Care Management Model (CCM): pursuant to or different from primary care?

Is chronic care management pursuant to primary care or separate from it?

- Person-focused?
- Contributory to at least one of the four main features of primary care?

Is CCM part of primary care or separate from it?

- If the need for it is uncommon (as the data suggest), it is a referral function and not part of primary care.
- If the need for it is common, it is a way of enhancing some important and heretofore neglected element of care, possibly problem recognition.

Question: What critical process of care is served by CCM? Problem recognition? Follow-up and reassessment? If not, what?