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Patient Centered Medical Home

A Foundation for Delivering Better Care, Better Health, and Better Value

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Patient Centered Medical Homes (PCMH) are increasingly becoming a foundational model for optimizing care and reducing health expenditures. In a PCMH model, providers coordinate care throughout the health system to ensure optimal benefit for patients, providers, and payers. With health expenditures reaching a tipping point, the Centers for Medicare and Medicaid Services (CMS) and private payers have rolled out pilot projects

that portend changes in the role of the primary care physician. Early results show the model's promise. Consider the following:

Colorado's Medicaid and State Children's Health Insurance Program (SCHIP) reported that 72% of children in medical homes received well-child visits compared with 27% of children in non-medical home practices.[1]

In early 2012 WellPoint and Aetna enhanced reimbursement to primary care providers in medical homes by between 10-15%.

Geisinger Health System reduced total hospital admissions by 14% relative to controls and trended toward a 9% reduction in total medical costs at 24 months using a medical home model.[2]

Primary care physicians have been the linchpin of healthcare delivery throughout modern history, influencing a significant portion of healthcare spending through direct care, referrals, admitting activities, orders, and other influencing behaviors.

Despite their integral role in treating and directing patient care, the market realities of increasing operating and capital costs coupled with declining reimbursement has challenged independent primary care practices nationwide. As a result, physician talent has been fleeing to more lucrative specialties; physicians have increasingly sought employment relationships with hospitals, health systems, and other institutional actors. Primary care shortages abound and are broadening in many markets.

At the heart of the issue lies a legacy fee-for-service system (FFS) that inadequately reimburses providers for continuum-of-care management. As the emphasis of the delivery system moves from volume of services provided to the value of health outcomes, a broad base of primary care physicians is more important than ever. One thing is clear; physician leadership needs to be at the forefront of health system transformation.

Physicians are searching for sustainable business models that allow them more flexibility to care for the whole patient and reward their hard work. Mounting evidence suggests that PCMH models offer great hope for both primary care physicians and patients.

Under the PCMH model, physicians and other caregivers—collectively members of a healthcare team—are financially rewarded for improving outcomes and reducing costs through well-orchestrated care coordination.

Early adopters of the approach have demonstrated improved quality and lower costs by promoting prevention, coordinating physician services, and reducing unnecessary ED visits and hospitalizations. The PCMH optimizes value by granting patients, especially those with costly chronic, co-morbid conditions, unfettered access to the highest quality, lowest cost combination of services, diagnostics, and other modalities.

CMS and many of the nation's largest private insurers are moving rapidly to offer financial incentives that promote the proliferation of the PCMH. These financial incentives encourage PCMH organizations to build the appropriate technology-enabled infrastructure and to align the right mix of caregivers.

Recognizing the critical importance of PCMH, in early 2012 WellPoint and Aetna

enhanced reimbursement to primary care providers by between 10-15%.[3] Each of these programs plan to grow rapidly—WellPoint intends to make the program available to 100,000 physicians by 2014, while Aetna will increase payments to 55,000 providers that meet patient access and care coordination standards by the end of 2012.[4,5]

Tenets of the Patient Centered Medical Home

The American Academy of Pediatrics (AAP) introduced the PCMH concept in 1967, defining an organizational structure that supports centralizing each child's medical information.

By 2002, the AAP had expanded the medical home concept, and the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) put forward medical home models. In 2007, the American Osteopathic Association (AOA) joined these three professional societies to issue the Patient Centered Medical Home principles.

Today, 19 medical specialty societies as well as the American Medical Association (AMA) endorse the following core PCMH principles:[6]

Ongoing partnership between the primary care physician and patient that encourages patient engagement and emphasizes the patient's shared responsibility for care

Physician-directed medical practice in which the provider leads the healthcare team in coordinating proactive and holistic care centered around patient needs

Whole-person orientation of care in which the provider communicates with all referral sources throughout the patient's life cycle

Coordination of care in which the provider embraces all elements of the complex healthcare system and uses information technology, health information exchange, and patient registries

Quality and safety focus that includes continuous quality improvement, adherence to evidence-based guidelines, and active performance reporting driving behavior change

Enhanced access to care to anticipate open scheduling, expanded hours, and communication among the care team

Restructured payment system that recognizes provider performance and added value by rewarding providers for performance and for systematizing the necessary coordination and communication activities, such as enhanced patient communication and remote patient monitoring

The medical home model establishes the expectation that providers and patients share responsibility and accountability. The "home" metaphor is not considered ideal even by some of the model's proponents because it denotes a physical location; CMS uses the moniker "advanced primary care practice." Certainly the primary care physician's practice location serves as the nucleus of the care model, yet the core concept revolves around the principal-agent relationship between the patient and the healthcare team in which the primary care

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physician operates as the team's captain.

Payers have begun to reform reimbursement to providers who use some or all of the PCMH principles. Healthcare prognosticators have stated that insurers are more likely to choose National Committee for Quality Assurance (NCQA) PCMH-credentialed centers and physicians over the uncredentialed.

To prepare for that potential eventuality, more than 4,000 centers and 20,000 clinicians have received NCQA PCMH recognition through March 2012.[7] From 2009 to 2010, each category increased more than three-fold. The model has appeal for primary care physicians because it rewards them for making a measurable difference in their patients' lives – which, for many, was a primary motivation to enter medicine.

The DNA of a Successful PCMH

Integral to any successful PCMH initiative are patients who engage in their own care, a healthcare team focused on holistic care and population health improvement, core technology that optimizes transitions of care, and financial conditions that favor adoption of new models.

PATIENT ENGAGEMENT INCREASES CARE EFFECTIVENESS AND PRACTICE THROUGHPUT

A central driver of the medical home model is that the patient must play an active role in his or her own healthcare. Research has shown that web-based patient portals, which allow patients to view parts of their health records and to connect electronically with providers, decrease unnecessary visits.

Kaiser Permanente studied secure physician-patient messaging in their Northwest region using patients enrolled in its portal. Kaiser found a 9.7% decrease in annual office visit rates and a 13.7% increase in annual documented telephone contact rates.

The Kaiser study also reviewed quality and found an association between increased secure patient-physician email use and improved performance for all Healthcare Effectiveness Data and Information Set (HEDIS) measures.[8,9]

The care team, the patient engagement concept, and other elements of the PCMH model have the potential to greatly improve outcomes while reducing costs.

These patient engagement examples illustrate a number of benefits for patients and providers. By handling routine problems electronically, providers can open their schedules to the sickest patients, resulting in many benefits: allowing providers to function at their highest levels of training, boosting practice throughput which can help to ameliorate the country's challenge of insufficient access to primary care, and providing physicians reimbursement at higher levels for tending to those needing the most care.

A HOLISTIC CARE TEAM IMPROVES PATIENT OUTCOMES AND REDUCES SYSTEM-WIDE COSTS

Medical home principles also point to the need to shift from episodic care to preventive and coordinated care guided by specific quality targets. Today, primary care visits account for 57% of all physician visits yet comprise only 6% to 7% of total healthcare expenditures. In contrast, hospital admissions account for less than 1% of all physician visits and comprise 31% of total health costs.[10]

In a medical home model, which is more

collaborative by design, the primary care physician leads a review of a patient's chart with other members of the care team. Several levels of teamwork need to be formed: the provider-patient team, the internal care team that includes the members within a healthcare organization, and the team that includes the primary care provider and members of the healthcare community.

The healthcare community consists of the primary care physician, specialists, hospitals, pharmacists and allied-health professionals—all of which contribute to the coordination of patient care.

Care teams at medical homes tend to deliver more complete care and, with the assistance of advanced technology, are more likely to incorporate improvements to the care model into daily practice as they uncover better ways to practice medicine.

As a result, preventive and coordinated care as practiced in the medical home model has been shown to reduce the rate of unnecessary hospitalizations and ED visits. If an ED visit or hospitalization does occur, the team's goals shift to ensuring appropriate follow-up care and helping the patient comply with discharge instructions, medication schedules, and follow-up visits to prevent further hospitalizations.

Fewer hospitalizations and ED visits are certainly better for patients and, as knowledge of this benefit spreads, patient demand for medical home practices will likely rise. Third-party payers also benefit from lower system-wide expenditures, and many are actively encouraging practices to embrace the medical home model.

TECHNOLOGY ENABLES THE TRANSITION

Experts agree that health information technology can help clinicians coordinate patient care. Current technology, including EHRs and interoperability solutions such as Health Information Exchanges (HIEs), although still emerging, gives providers the tools to manage patients, resulting in the proliferation of the PCMH model. Critical functionalities include:[11]

- **Patient registries** used to collect, store, and manage relevant patient health information, including patient-generated data that are ready for exchange
- **Secure messaging tools** used among providers, patients, and the care team
- **Provider decision-support tools** for laboratory diagnostics, treatments, prescriptions, and other therapeutics
- **Patient outcomes reporting** used to analyze care processes and demonstrate quality outcomes achieved for individual and population performance
- **Patient education tools** regarding health and medical conditions and facilitating patient self-management with provider input

While EHR adoption rates are rising, including the integration of decision support and care plans into work flows, there is still a long way to go.

Merely having an electronic health record system is not enough. The system itself must be optimized, and practices must use it to achieve the goals of coordination and high quality of care.[12] As of 2011, only 35% of physicians had an EHR with features that can realize the potential of improving healthcare.[13]

When used optimally, technology can be the backbone of effective care coordination. WESTMED, a physician group in

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PCMH: HOW TO GET STARTED

The journey to become a patient-centered medical home yields many benefits to patients, providers, and payers. These 8 steps can get your practice started:

1

Assess Readiness

Review a PCMH readiness self-assessment form, such as the one found **here**, for an in-depth look at what it takes to become recognized as a PCMH.

2

Gain Commitment

Gain upfront agreement from the organization's key stakeholders to transform the philosophy from episodic care to an integrated care delivery system, in which the patient is the primary focus. These changes require a commitment to continuous improvement of the care model and a willingness to deliver care even if that requires a transaction without payment.

New York, is a leading example of using technology to enable care transformation. WESTMED participates in numerous quality outcomes reporting initiatives and has received NCQA Level 3 status, the highest possible PCMH certification. Having an advanced EHR with informatics capabilities in place will make achieving level 3 certification significantly easier.

WESTMED uses informatics to develop and distribute comprehensive quality and financial dashboards to its physicians. On the secure WESTMED intranet, physicians view their patients' medical home metrics, which are updated daily.

Further, WESTMED compares clinical measures to practice-wide quality enhancement goals. If physicians find that they have not met their goals, they can easily review patient records to identify specific areas for improvement. "Informatics is critical for our patient-centered medical home accomplishments," says Simeon Schwartz, M.D., president of WESTMED.[14]

Yet simply identifying areas for improvement is insufficient for enhancing care; providers must act to incorporate lessons learned into day-to-day practice.

EHR systems with the right complement of features offer concrete benefits that practices can leverage to improve clinical workflows and to achieve PCMH milestones. For example, practices that purchase EHRs with the ability to add and to modify forms will position themselves to implement and update workflows as practice guidelines change either through regulation or new clinical evidence. One such example includes the care of diabetics and foot examinations.

To ensure that all foot exams become a proactive, yet routine, component of patient care, providers can customize forms with discrete data fields prompting timely care.

FINANCIAL INCENTIVES REWARD QUALITY CARE AT LOWER COST

Transforming the healthcare delivery system will require making payment reform an unmitigated priority. Fifty-seven percent of U.S. physicians agreed in a recent survey that changing the way they are paid is "an important step to improve the healthcare system."[15]

Physicians require sound business reasons to invest the time to change the processes by which they coordinate care and achieve quality. Recent Medicaid medical home innovations show the diversity of financial incentives used to better coordinate care. For example, many states have begun compensating physicians with care coordination payments that average $3-4 per patient per month.

Other programs provide enhanced fee-for-service payments. In New York, enhanced payments are differentially based on the three NCQA levels. Lump sum payments allow practices to hire needed staff and invest in infrastructure. For instance, in Southeast Pennsylvania, practices receive lump sum payments to assist with patient registry software, NCQA survey and application fees, and the delay of revenue caused by workflow changes.[16]

Geisinger Health System (GHS) has shown that incentives can catalyze an entire health community to coordinate care in ways that improve health and lower costs. GHS, an integrated health services organization, serves more than 2.6 million residents throughout 44 counties in central and northeastern Pennsylvania.

GHS has developed and implemented innovative care models among in-network providers, including ProvenHealth Navigator, an advanced medical home model, and ProvenCare, a program to ensure

detailed best practices for specific treatment regimens.

GHS has created an incentive pool based on differences between the actual and expected costs of care for medical home enrollees, and provider payments from this pool depend on meeting quality indicators. Under this program, GHS compensates each physician $1,800 monthly and pays medical practices transformation stipends of $5,000 per thousand Medicare members each month.[17]

Optimism Translated: Better Care, Better Physician Compensation

Physicians innately want to drive system change in a way that allows them to deliver very high quality care, improve patient experiences, and create appropriate economic opportunities for themselves and their partners.

Many physicians have grown disenchanted with a system that provides only marginal value and increasingly puts them at risk legally and economically. Physicians want more—they want hope; they want to make an impact; and they want to improve the lives of their patients. They are searching for business models that support this mission. The medical home model has gained traction as a viable response to a broken and expensive delivery system, a model that provides financial rewards, improves care, and reduces costs. Recent studies show that the medical home model delivers on the promise of enhancing value. Examples include:

HealthPartners Medical Group **reduced appointment waiting time by 350%, decreased emergency room visits by 39%, and decreased admissions by 24%.**[18]

Intermountain Healthcare Medical Group, part of an integrated delivery system in Utah, began implementing a PCMH redesign model in 2001. They experienced an **absolute reduction in 2-year mortality of 3.4%.**[19]

On January 1, 2011, Maryland's CareFirst Blue Cross Blue Shield began the nation's largest PCMH experiment.[20] Based on the premise that primary care providers influence referrals yet have no economic interest in controlling their costs, the insurer developed a PCMH model with the primary care provider at the center, arming them with an economic interest in patient outcomes.

Under the model, CareFirst enables several small-group primary care practices to build panels consisting of 10 to 15 providers. Joining the PCMH program panel results in a 12% increase in the FFS schedule simply for agreeing to operate under the program's terms. In addition, for each new patient care plan a provider develops, the provider receives $200; and for each quarterly review and/or care plan the provider revises, the provider receives $100. Roughly 10-15% of a panel requires a care plan.

Chet Burrell, CareFirst's CEO and the program's architect, describes the thought process leading to the focus on primary care. "In the top 10 percent of the people covered, you have, broadly speaking, 50–60 percent of all the dollars spent… [These patients] are often treated by multiple specialists. You go to the cardiologist for your heart problem, and your internist for something else, and—depending on what you have—an orthopedist, nephrologist, or pulmonologist. It's a highly fragmented health system with no coordination."

Burrell's group then asked themselves, "'Is there one provider in the best position

3

Involve Payers

Involve payers in the planning process upfront and negotiate enhanced reimbursement in exchange for demonstrated improvements in outcomes.

4

Form a Care Model Team

Form a care model team who will become the stewards of best care practices and process improvements.

5

Evaluate Patients' Access

Form a task force to evaluate and improve patients' access to care both during and after hours.

6

Find partner with experience

Partner with a vendor or consultant who has PCMH experience and who can be your resource during this transition.

7

Identify Appropriate EHR

An effective EHR helps users collaborate on

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patient care, increase patient engagement, run sophisticated analyses of structured data, benchmark their clinical outcomes against other practices, and adapt workflows as the care model improves actions that can accelerate the practice to Level 3 recognition.

8

Develop Project Plan

Develop a detailed project plan outlining the steps necessary to become certified as a patient centered medical home.

to understand the patient holistically—particularly the chronic disease patient or one at high risk for chronic disease?' The answer clearly was the primary care physician, particularly for patients with multiple chronic diseases."[21]

A Path for the Future

Patient Centered Medical Homes have all the ingredients that physicians crave—a comprehensive, holistic approach to care coordination, an emphasis on the primary care physician-patient relationship, and a variety of significant and aligned financial incentives. Furthermore, without the boundaries created by FFS medicine, the medical home encourages creativity and ingenuity, demonstrated by encouraging open access for patients as well as transparency and information-sharing for all stakeholders. The medical home fits the bill as a foundational element of sustainable, accountable care as it supports financial and clinical integration. Increasingly, the physician-powered medical home model will play a leading role in improving patient outcomes and reducing overall healthcare costs—ultimately fulfilling the promise of the CMS triple aim – better care, better health, and better value.

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[4] http://www.aafp.org/online/en/home/publications/news/news-now/practice-professional-issues/20120201wellpointplan.html

[5] http://www.aetna.com/news/newsReleases/2012/0130-Aetna-Launches-National-Patient-Centered-Medical-Home-Program.html

[6] http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

[7] NCQA's letter to CMS on Stage 2 MU, May 7, 2012 http://www.ncqa.org/LinkClick.aspx?fileticket=p9q5ZF-HPLI%3D&tabid=177

[8] "HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 76 measures across 5 domains of care." http://www.ncqa.org/tabid/187/default.aspx

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[10] http://content.healthaffairs.org/content/29/5/806.full.pdf+html?sid=249962d7-c2d8-4f0c-8afc-be97db235946

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[15] http://www.markle.org/publications/1445-roughly-half-doctors-say-pay-reform-important

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[18] See note 1 above.

[19] See note 1 above.

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