

# **The Patient Centered Medical Home**

**A New Look at Managing Care**

**A FOX White Paper**



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## The Patient Centered Medical Home

After decades of double-digit increases in medical spending, a new concept is beginning to take hold in the United States in a big way. The concept of a Patient Centered Medical Home (PCMH) was introduced in 1967 by the American Academy of Pediatrics as a central location for archiving a child's medical record. The concept gained more clarity in 2002 when it included these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

More recently, the American College of Physicians (ACP), the American Academy of Family Practice (AAFP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA), have further embraced the medical home concept by providing additional definition:

*The medical home is a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient's health care needs and, when needed, coordinating care across the health care system. A medical home also emphasizes enhanced care through open scheduling, expanded hours and communication between patients, physicians and staff.*

These groups of physicians have also developed the following joint principles to describe the characteristics of the PCMH and establish the Patient Centered Primary Care Collaborative (PCPCC) [www.pcpcc.net](http://www.pcpcc.net):

- **Personal physician.** Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
- **Physician-directed medical practice.** The personal physician leads a team of individuals at the practice level that collectively takes responsibility for the ongoing care of patients.
- **Whole-person orientation.** The personal physician is responsible for providing all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, such as acute care, chronic care, preventive services, and end-of-life care.
- **Coordinated and integrated care.** Medical care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange (HIE), and other means to assure that patients get the indicated care when and where they need it and want it in a culturally and linguistically appropriate manner.
- **Quality and safety.** These are hallmarks of the medical home, and include ongoing education, evidence-based medicine, and clinical decision tools.
- **Enhanced access to care.** Care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, personal physicians, and practice staff.
- **Payment.** Payment appropriately recognizes the added value provided to patients who have a patient centered medical home.

## Why Pursue a Patient Centered Medical Home Concept?

While the PCMH is not the total solution to health care in America, it does begin to address some of the underlying issues of episodic care delivered in piecemeal fashion. It offers opportunities for better health outcomes, higher patient satisfaction, and cost savings. In a review of 40 studies, a continuous healing relationship with a personal physician has been shown to significantly improve health outcomes.<sup>1</sup> Our current health care system, and its existing incentives, does not encourage prevention. Therefore, patients seek health care only when they are sick. Administration of health care may occur in emergency departments or hospitals, and it is generally more expensive, poses significantly more risks due to the deteriorating condition of the patient, and may require extensive testing to determine a diagnosis. Patients not under continuous care or who are not responsive, may not be aware of the medications they are taking, nor may they be aware that medications received from various disparate providers may not be compatible. Once emergency care is provided, patients return to their homes without adequate follow-up care to prevent similar occurrences.

This type of care has been a hallmark of the fee-for-service system of care. It is prevalent in Medicare, Medicaid, and many health plans. Patients choose when to see their providers and they choose what providers to see. The result may be repeated laboratory work or studies, multiple medications that may be incompatible, little attention to other underlying conditions (such as diabetes or hypertension), little opportunity for follow-up care, and no place to capture the whole patient record, or the concept of the whole patient. Patients may see a host of specialty providers, but may have no idea who to call when they develop new symptoms, so they again seek care in an emergent care environment.

The PCMH seeks to change this cycle by managing medical care, not simply managing cost. The PCMH becomes the place of first contact between the patient and provider. The medical record is immediately available and information already exists regarding medications, test results, and health history. Expanded hours and open scheduling assure that the patient can be seen in an outpatient environment within 24 hours, unless emergency situations dictate. Each episode of care is fully documented and contained in an ongoing care plan to address its relationship to earlier care or existing conditions. The program makes it possible for patients to email their medical home with questions they may have and receive information and laboratory results via secure email. If necessary, an appointment is scheduled, which may include appointments with specialists that are part of the PCMH practice team. In all cases, the patient becomes a partner in his or her health care. If appointments or testing are due, the patient is reminded by the PCMH and encouraged to schedule appointments.

## Does It Work?

There are projects initiated in over 30 states regarding medical homes; however, 10 states have made significant progress in their initial projects. Two states, Rhode Island and North Carolina, have well-developed medical home initiatives. Eight other states (Colorado, Louisiana, Minnesota, Idaho, New Hampshire, Oklahoma, Oregon, and Washington) are leading the way with medical home initiatives in either their Medicaid or Children's Health Insurance Programs (CHIPs), or both.<sup>2</sup> The processes and results for these 10 projects are well documented in the National Academy for State Health Policy, but North Carolina has the most impressive results.

*North Carolina Medicaid reduced spending by \$244 million over 2 years while improving overall health outcomes between 2004 and 2006. For example, its asthma program resulted in a 40% reduction in hospital admissions and a 16% reduction in emergency department visits. Its*

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<sup>1</sup> Saultz, JW; Lochner, J., Department of Family Medicine, School of Medicine, Oregon Health and Science University, Portland, OR

<sup>2</sup> Kaye, Neva and Takach, Mary. *Building Medical Homes in State Medicaid and CHIP Programs*. National Academy for State Health Policy, June 2009.

*measurement criteria indicated that 93% of clients were using appropriate maintenance medications. A total of \$231 million was saved in fiscal year 2005-2006.<sup>3</sup>*

## **Is a Medical Home Different than a Primary Care Provider (PCP)?**

In some respects, the medical home is similar to a primary care provider (PCP); however, the two differ in the fact that a medical home accounts for greater accessibility and shared responsibility among a team of health care providers. Medical homes often include specialists, care managers, nurses, and affiliations with other team providers who participate in the concept. The National Committee for Quality Assurance ([www.ncqa.org](http://www.ncqa.org)) Physician Practice Connections Primary Care Medical Home (NCQA PPC PCMH) has established criteria and scoring to determine if a practice qualifies as a medical home and to establish three levels of performance. These criteria fall into the following categories and some contain required functionality:

- Standard 1: Access and Communication
- Standard 2: Patient Tracking and Registry Functions
- Standard 3: Care Management
- Standard 4: Patient Self Management Support
- Standard 5: Electronic Prescribing
- Standard 6: Test Tracking
- Standard 7: Referral Tracking
- Standard 8: Performance Reporting and Improvement
- Standard 9: Advanced Electronic Communications

## **How Would a State Get Started with a Medical Home Program?**

Medical home demonstration and initiation projects have begun in many states with many reasons, incentives, and requirements. Nonetheless, it would appear that some common themes or strategies have surfaced that bear some consideration.

1. ***Form partnerships with key players.*** For providers to go through the implementation process to qualify as a medical home, they would prefer to provide the same types of services for all payers. For the benefit of clients and the coordination of benefits process, it would be valuable to have the same payment strategies for this type of practice. Those projects that have been most successful have built partnerships with providers, provider organizations, other payers, and other government entities to encourage the project to become successful and to iron out small issues before they become obstacles.
2. ***Establish a definition of medical home and define provider expectations.*** Some states have chosen to accept the NCQA definitions and performance levels, while other states have determined that those criteria focus too much on technology and do not consider factors that the state feels are equally important. They have written their own definition of medical home and published it in their provider manuals and on their web sites. Along with the definition, the successful project requires that the state establish its own concrete expectations, from which they will identify the medical home and pay accordingly. For example, if the state expects the medical home to provide extended hours, then that expectation must be stated up front in measurable criteria.
3. ***Align reimbursement strategies to support and reward practices that meet the state's expectations for medical home.*** Some states have instituted a \$2 to \$5 per member per

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<sup>3</sup> Ibid.

month (PMPM) fee for managing the care in a medical home. Others have additionally added a rate increase for procedures, such as early periodic screening, diagnosis, and treatment (EPSDT) visits, or evaluation and management-specific tasks, so that providers do not need to change their existing billing processes. Still, others have added a more substantial monthly fee for care of individuals with multiple chronic conditions. Finally, some states have leveraged their managed care purchasing processes to modify selection criteria or contracts to reward Managed Care Organizations (MCOs) that support medical homes. Although there is general agreement that there needs to be increased financial support to encourage more primary care physicians to participate as medical homes, the American Medical Association (AMA) does not support that increase to the detriment of specialists. This issue will need to be determined over time by payers and providers. The PCPCC recommends a three-tiered reimbursement approach: 1) A risk-adjusted monthly fee to avoid adverse selection; 2) Visit-based fee-for-service; and 3) Performance-based reimbursement for demonstrations of quality and efficiency.

4. **Support processes that advance patient centered care.** Within the NCQA guidelines, there are a number of standards that express the ongoing need to improve the ability to advance patient centered care, such as Electronic Health Records (EHRs), charting tools to organize clinical information, electronic prescribing (ePrescribing), test tracking tools, referral tracking systems, etc. Many of these take advantage of advances in technology that may be expensive for small provider practices. Support for the implementation of these tools or linking of smaller practices to larger providers (such as hospital systems) may improve the availability of medical homes (see Strategy #1).
5. **Measure results: Assess whether or not the efforts are succeeding in containing costs, improving the quality of care, or contributing to patient satisfaction.** Two of the MITA Program Management business processes address this need: 1) Develop and Manage Performance Measures and Reporting, and 2) Monitor Performance and Business Activity. As states improve their capabilities in these business processes, it may become easier to define the qualities that measure the results of medical home projects and monitor those results over time. Early projects have certainly shown the medical home to be an improvement in medical care, generally an improvement in member satisfaction, and certainly a cost-containment venture. Whether or not these impacts continue over time, or increases in some measurements outweigh decreases in others, remains to be seen as more projects evolve.

## What Are the Issues and Barriers to Implementing a Medical Home?

As with all new processes, it is likely that initiation of medical home projects will encounter some issues and barriers. It is impossible to foresee all of them, but these have already surfaced, and some have been mitigated in some of the early projects.

- **Agreeing on the definition of medical homes, measurement criteria, and expected outcomes may prove difficult.** For states that have implemented medical homes, each has had to establish these criteria in light of their own state's demographics.
- **Health plans and providers have been accustomed to competition, and collaboration is not something that comes easily.** Still, some states have worked this out to the advantage of all involved.
- **Reimbursement strategies don't change easily.** Some may be defined in regulation or are restricted to primary care providers as single entities. Reimbursement for technology, or pay for performance (P4P), is still in its infancy in many states.
- **Some medical homes use physician extenders, such as nurse practitioners or physician assistants.** While this works in some rural areas of some states, it might not exactly meet the

original definition or intention of the medical home. This is a decision for states to make specifically related to their circumstances.

- ***Patients don't always accept the medical home concept.*** Medicaid members who are used to using the emergency room at their discretion may not readily accept the medical home concept. In general, the medical home is a well-accepted concept, but measuring patient satisfaction or dissatisfaction will be an ongoing effort.
- ***There are a limited number of primary care physicians.*** This is generally due to falling reimbursement over the past 10 to 20 years. While the medical home concept might improve the numbers of primary care physicians, it will take time. In the meantime, there may be significant geographic access issues in some states.
- ***Technology is expensive and other factors may be deemed more important.*** Innovative states have tackled this issue by establishing criteria that is not necessarily standardized across the nation. Nonetheless, it may be difficult to establish criteria that expects technology in some areas, and does not require it in others.
- ***Systems to track measurement criteria and policies to establish what those measurement criteria are, may not be in place in some states.*** MITA maturity may improve the situation, but it is a business process as well as a systems issue. Measurement criteria must be developed and systems must be able to capture the data. Likewise, systems in provider practices and payers must have the ability to track payments and administrative costs related to medical homes in order to demonstrate their effectiveness and assure accounting for the money that has been spent.
- ***Medical home practices must commit to an ongoing learning process.*** Some of the Quality Improvement Organizations (QIO) in states have established learning collaboratives, practice coaches, and technical assistance, but if those don't exist, it will be necessary to manage that process in other ways. States must make their information available to inform medical home practices. Sharing of administrative data, prescription information, and provider profiles may help improve the process.
- ***Patients must be engaged as collaborative partners in their own health in a medical home concept.*** Education is necessary to teach patients to participate in updating their personal health records (PHRs), emailing providers, reading lab results and understanding them, learning about health and wellness activities, etc. This is a mindset issue, as well as a resource issue for education and workshops. Access to computers is not always as big of an issue as it may appear, but it may be necessary to identify the availability of publicly accessible computers and to encourage their use. States may also look to this as an opportunity for surplusing of outdated computers.

## Summary

Is a patient centered medical home the answer to all of the health care problems facing America? It is not the total solution, but it does go a long way toward improving some of the issues that currently plague the health care system. Episodic care, delivered in piecemeal fashion, does little to prevent illness or the major complications of untreated illness. In medical homes, the provider team takes responsibility for managing the patient and navigating the complex health care system. The patient also becomes a partner to participate in his or her own health and wellness. Finally, the payer joins the partnership to establish expectations and measurements, and to share information and funding necessary to make the process worth doing. Taken in total, these components have demonstrated in numerous projects that a medical home improves patient outcomes, increases patient satisfaction, and results in cost containment. The PCMH is a new and beneficial way to look at managing care.

## Where Can I Get More Information?

National Committee for Quality Assurance [www.ncqa.org](http://www.ncqa.org)

Patient Centered Primary Care Collaborative [www.pcpcc.net](http://www.pcpcc.net)

## About Fox Systems, Inc.

Fox Systems, Inc. (FOX) is a nationally recognized consulting practice that provides information systems and operations consulting services to public and private sector health care clients. FOX specializes in consulting services related to large-scale information systems that support state Medicaid programs, Managed Care Organizations (MCOs), Pharmacy Benefit Managers (PBMs), and Clearinghouses. Incorporated in California in 1987 by Susan J. Fox, Ph.D., FOX is a privately held corporation, with woman-owned certification in several states. FOX maintains corporate headquarters in Scottsdale, Arizona, and has numerous field offices throughout the United States to facilitate the completion of major health information technology contracts.

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