STRATEGIC INNOVATIONS FOR AFFORDABLE, SUSTAINABLE HEALTH CARE:

A Model for Health System Reform

*Environmental Scan*

Patient-centered Medical Home
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Patient-Centered Medical Home (PCMH) is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing 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 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. A medical home also emphasizes enhanced care through open scheduling, expanded hours, and communication among patients, physicians and staff.

**Bottom Line Findings:** A substantial evidence base is building for improved quality, improved patient and provider satisfaction, and decreased costs under the PCMH model. The concept is not new, and in many ways is a version of the classic definition of primary care, but this model leverages modern communication tools and information technology, and new reimbursement structures that realign incentives, but typically use a hybrid approach that reduces provider risk while compensating for increased costs and rewarding performance (typically FFS + PMPM fee + performance bonus). Like other innovative models of delivery, PCMH would seem to be most advantageous for systems or purchasers that can realize the benefits of cost reductions due to decreased utilization and that are already well-connected and technologically advanced. However, the model has been surprisingly adaptable to a wide variety of markets. Early lessons learned emphasize the need for time and sustained support of practice redesign that can be more transformational than incremental.1, 2

## Case Examples

### Patient-Centered Medical Home

The American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA) developed the following Joint Principles to describe characteristics of the PCMH model:

1. The PCMH model is intended to improve quality of care and reduce annual per capita health care expenditures. Quality is improved through expanded access to care, improved patient communication, and greater care coordination and care management, especially of patients with chronic conditions. Costs are reduced by keeping people healthier, providing care in more cost-effective settings (e.g., expanded access to the PCP versus care in an emergency room) and reducing unnecessary care through better coordination.

2. Over the past several years, a number of prospective evaluations of the PCMH model in a variety of settings have shown higher quality, greater patient satisfaction, improved access, and lower costs, mainly through reductions in hospitalizations and emergency department visits.4 In several cases, returns on investment were shown to be 2:1. Not surprisingly, savings were greatest for patients with chronic conditions, although savings have been documented for patients without chronic conditions as well. Some studies report increased provider satisfaction. There is also some evidence that the greater access, coordination, and care management associated with medical homes reduces health disparities.5

3. The PCMH model is applicable to all markets. PCMH has been successfully implemented in a variety of settings and for a variety of populations. For example, the American Academy of Family Physicians launched a National Demonstration Project to test the model in a purposefully diverse set of 36 practices.

4. Lack of reimbursement for additional resources (e.g., staff, HIT) to provide greater access and coordination is a significant barrier to widespread adoption beyond the PCMH demonstration projects and employer or insurer-sponsored initiatives or particular integrated delivery systems.

5. Also, while clearly influential in directing care, primary care providers have less control over the care process.
### Patient-Centered Medical Home

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<tr>
<th>Intervention Areas and Case Examples</th>
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<th>What is the research evidence regarding impact of intervention?</th>
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<td>the PCMH:</td>
<td></td>
<td>- The evidence is still being collected on increased resource use associated with the transition to a PCMH. While the concept dates back decades, specific PCMH guidelines and criteria are relatively new and are still undergoing evaluation and revision.</td>
<td>being delivered by specialists, hospitals, and other care providers, and the degree to which information is shared by these providers. In this sense, the PCMH model could potentially operate to greater effect within an integrated, innovative delivery approach such as an accountable care organization (ACO).&lt;sup&gt;8&lt;/sup&gt;</td>
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| Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. |                                               | - More generally, numerous cross-sectional comparisons across nations, states, and regions within the U.S. have shown correlations between a greater emphasis on primary care and higher quality and lower cost (e.g., the work of Starfield and others<sup>6</sup>). Studies have also shown that patients who identified a primary care physician (PCP) as their personal physician had 33% lower annual spending and 19% lower mortality than those whose personal physician was a specialist.<sup>7</sup> | Sites identified as “medical home runs,” based on achieving 15-20% reductions in risk-adjusted total health care spending with no decrease in quality:<sup>9</sup>
  - Urban Medical Group (working class urban Boston, many nursing home-eligibles, 10% HMO):
  - Leon Medical Centers (metro Miami, working class, Medicare HMO):
  - CareMore Medical Group (urban Los Angeles, working class, Medicare HMO): and
  - Redlands Family Practice (California small town, lower middle class, multiple HMOs). |
<p>| Physician directed medical practice – the personal physician leads a team of individuals who collectively take responsibility for the ongoing care of patients. |                                               |                                                               | |
| Whole person orientation – the personal physician is responsible for providing for 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, acute care, chronic care, preventive services, and end of life care.|                                               |                                                               | |
| 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 | |                                                               | |</p>
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<td>(e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.</td>
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**Other Comments**

- PCMH demonstrations are now underway in most states with broad support from government, employers, insurers, and professional organizations.
- 18 September 2009 memorandum from Office of the Assistant Secretary of Defense/Health Affairs establishes Department of Defense policy of implementation of PCMH model in all military treatment facilities.
- In January 2008, the National Committee for Quality Assurance (NCQA) released standards for the Physician Practice Connections®–Patient Centered Medical Home (PPC PCMH™) to identify primary care practices that function as PCMHs. Practices can apply to be recognized in one of three levels of PCMH implementation. Recognition may be relevant to participation in a variety of demonstrations and/or payer reimbursement programs.

| PCMH FOR MEDICAID POPULATIONS¹⁰ | Improved coordination, increasing quality of care, and reducing costs, particularly of hospitalization and Emergency Department (ED) visits. | Market is usually statewide PCMH can be more challenging to implement in state Medicaid markets because many providers are in small practices, are not connected, and are not generously resourced. However, there are a number of states overcoming these challenges and creating success, demonstrating that it is possible. Examples include:  
- Genesee Health Plan in Flint, Michigan; and  
- Colorado Medicaid and SCHIP. | |

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<td><strong>Case Example:</strong> Community Care of North Carolina</td>
<td>Developed as a way to manage Medicaid patients in rural areas to link them with a hospital and other safety net providers.</td>
<td>Evaluations from Mercer Human Resource Consulting Group comparing costs under the program with historical benchmarks indicate significant net savings for FY04, FY05, and FY06. FY06 savings, for example, were estimated at close to $300M for the state. Savings were especially high for inpatient care, and care to patients aged 0 to 1 year old.¹¹</td>
<td>This is especially applicable to rural markets with small, fragmented practices. Emphasis is on community-based system development.</td>
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<td><strong>Other Comments</strong></td>
<td>Program started in 1998 and has matured to include 3,000 physicians and 13 networks.</td>
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| **PCMH Within Large, Integrated Health Plans and Delivery Systems** | Greater quality of care, reduced costs, improved beneficiary satisfaction | There are many successful PCMH implementations in large, integrated delivery systems, including:  
  - Group Health Cooperative of Puget Sound;  
  - Intermountain Healthcare; and  
  - Geisenger Health System. | Integrated delivery systems that include an insurer have an advantage in that they are able to receive some of the benefits of cost reductions due to reduced hospitalizations and ED visits and greater coordination, offsetting reduced provider reimbursement. |
| **Case Example:** UnitedHealthcare¹² | Some lessons learned:  
  - Critical mass is fundamental – patient panel size must make business sense, often requires multi-payer collaborations;  
  - Flexibility is critical – mixed bag of technology and capabilities in practices; and  
  - PCMH takes time. | | |
| **Other Comments** | Winner of 2009 NBCH eValue8 Health Plan Innovation Award for PCMH program and Diabetes Health Plan. One of 2 winners out of over 100 programs submitted. | | |
## PATIENT-CENTERED MEDICAL HOME

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<td>PURCHASER-SPONSORED PROGRAMS AND THE PATIENT-CENTERED PRIMARY CARE COLLABORATIVE (PCPCC)(^{13})</td>
<td>The PCPCC seeks to promote the PCMH as a means for purchasers to increase the value of health care dollars spent.</td>
<td>PCPCC publishes a compilation of PCMH pilots and demonstrations by state and a summary of evaluation results. The 2009 edition covers nearly 30 projects, not including public payer pilots.(^{15})</td>
<td>Applicable to all markets. PCPCC materials describe strategies and case studies for a wide variety of markets, including statewide rural Medicaid markets and multi-payer coalitions covering major metropolitan regions.</td>
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"PCPCC is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians and many others who have joined together to develop and advance the patient centered medical home. The Collaborative has well over 500 members."\(^{14}\)

Other Comments
- Sponsored by PCPCC, NBCH developed a purchaser's guide to PCMH highlighting advantages, strategies for purchasers, and case studies.\(^{16}\)
- IBM was a leader in creation of PCPCC and is an active employer participant in PCMH programs.

## SECTION 5 • ENDNOTES


END SECTION 5
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For more information: www.altarum.org or contact Gloria N. Eldridge, PhD, MSc at gloria.eldridge@altarum.org.