

Industry Trends: Medical Homes

Attention Turns to the Patient-Centered Medical Home

Jane Martinsons, Staff Writer

If you haven't given much thought to the patient-centered medical home (PCMH), you soon will be. According to Judith Schaefer, MPH, collaborative director of New Health Partnerships (www.newhealthpartnerships.org), the growing shortage of primary care physicians and the increasing prevalence of chronic conditions in the United States are fueling momentum for the PCMH model.

What is the PCMH? In 2007, leading U.S. primary care physician organizations—the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association—jointly released the principles of the PCMH. According to these principles, all patients have the opportunity to be cared for by a personal physician or a practice team with a physician on it; care is “whole person” oriented, coordinated, and integrated; quality and safety measurements are built into the model; and patients have access to enhanced communication. Moreover, the payment system is revamped.

“The medical home approach centers on the premise that patient-centered care requires a fundamental shift in the relationship between patients and their primary care physicians,” Schaefer said. “It calls for more personalized care coordination, proactive and coordinated outreach beyond the acute-care episode, identification of key medical and community resources to meet patients’ needs, and support for the patients’ own central role in managing their health.”

Schaefer adds that in the medical home as well as in the chronic care model, primary care is managed by a multidisciplinary team in collaboration with the patient and his or her family. Chronic illness management and lifestyle modification are central themes in the medical home so that patients and families are supported in tackling tough problems such as obesity and diabetes between clinical visits.

Bruce Bagley, MD, AAFP’s medical director of quality improvement, adds that the PCMH model incorporates registries for certain diagnoses, partners with community resources, offers advanced patient education and self-management, and has a service orientation. Key to the model is information technology (IT) support. “IT support is the central nervous system of the medical home,” Bagley says, adding that such support includes electronic medical records (EMRs), electronic registries, and e-prescribing.

Bagley points to AAFP’s completed 2-year research project, TransforMED (www.transformed.com), which superimposed the PCMH model on 18 existing practices in order to study its impact on the practices’ financial and clinical performances. Today, the practices have EMRs, registries, and clinical decision support built into their electronic systems and communication portals (such as e-mail). Great emphasis is placed on support of patient self-management.

In Utah: “Care By Design”

Recently, *NAHQ E-News* asked NAHQ members via the Member Listserv about their experience with the PCMH. Among those who responded was Julie Day, MD, medical director of quality for the University of Utah Community Clinics, which

comprises 10 clinics in the Salt Lake City area. For the past 5 years, the clinics have been involved in redesigning the physician practice.

According to Day, their work has evolved into a “Care By Design” model that closely mirrors the medical home model by incorporating a team-centered approach to care, electronic health records, registries, and community outreach. Self-management is also encouraged, for example, by having patients complete their lab work prior to visits so that patients and providers can work together to set health-management goals during appointments.

The clinics have also greatly expanded the role of medical assistants (MAs). MAs are now internally trained to accompany patients throughout their entire office visit, including greeting and registering patients, evaluating their medication lists, conducting health assessments for clinicians using standardized questionnaires, and documenting the physical exam done by the provider. All are trained to draw blood for lab samples, and some MAs are even trained to take certain X rays.

Healthcare costs have remained steady under the Care By Design model, Day says. Improved outcomes have been seen in diabetic labs and a higher referral rate for colonoscopy screening, and staff cost per visit is lower in the Care by Design model than in traditional care (\$48.40 versus \$57.59), as is staff cost per provider full-time equivalent (\$89,170 versus \$101,582).

The group is currently holding discussions with community stakeholders—employers, payers, and state legislators—to see if its work can serve as a demonstration project as they consider implementing the medical-home model in their state.

Redefining Healthcare: The Best of Yesterday ... Today

Joyce E. Matsko, BSN RN CPHQ

The title of this article sums up the approach the University of Pittsburgh Medical Center (UPMC) Health Plan has incorporated into an innovative new program called the Partners Program (www.upmchealthplan.com/partners/providers.html). The principles of this program are consistent with those of the patient-centered medical home (PCMH; www.medicalhomeinfo.org/Joint%20Statement.pdf), which places the patient and physician at the center of care. Although the concept of establishing trusting relationships among all stakeholders isn’t new, it is evident that it has become necessary to reestablish and refocus resources on this critical component of healthcare—the patient-physician relationship.

Through this collaborative program designed specifically for the primary care physicians (PCPs) within the UPMC Health Plan’s network of providers, the effort to improve patient clinical outcomes focuses on providing better support to PCPs in the delivery of care. The comprehensive strategy sees the engagement of all stakeholders as critical for improving the patient experience and improving subsequent clinical outcomes. The rollout began in late 2007, with momentum building during 2008 as the program has evolved.

The Partners Program focuses on the value of coordinated, patient-centered, and physician-directed care. Some of the benefits for patients of care delivery designed according to the PCMH concept include a personal physician with whole-person orientation, greater support in making informed healthcare choices, more timely and

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appropriate care, more efficient management for those with chronic disease, and improved health and greater satisfaction with the healthcare system. The benefits of the Partners Program for physicians include the reestablishment of the patient-physician relationship at the center of care; greater enrollment and retention of patients in the practice; access to enhanced tools, materials, and services to support care; access to improved and more actionable data; improved patient outcomes; and the potential for greater reimbursement. The healthcare system receives the benefits of better communication and coordination of care among all participants, more efficient use of healthcare resources, fewer redundant and unnecessary tests and procedures, fewer errors and gaps in care, and improved overall health of the population.

The UPMC Health Plan provides dedicated resources to PCPs, including a physician account executive (PAE) who personally works with the physician and his or her office staff to identify areas of opportunities in conjunction with the Quality Incentive Reward Program and Practice Rewards Program. These programs focus on improving patient clinical outcomes that can result in a financial incentive. Other responsibilities of the PAE include providing education and support in using electronic tools available to the practices (which the UPMC Health Plan provides) to better manage gaps in care that correspond directly to evidence-based clinical guidelines. The PAE also provides education to office staff members through teleconferences and individual and regional peer meetings designed to enhance their knowledge and understanding of the importance of their role in managing improved care delivery consistent with the features of the PCMH.

The important role of the PCP and his or her office staff in improving the quality of healthcare has been long overlooked. Physician-led office teams can have an impact in establishing and maintaining quality healthcare delivery. The PCMH model (www.adfammed.org/documents/grahamcentermedicalhome.pdf) allows an opportunity to expand the responsibility of improving the quality of healthcare in this country through the division of labor among all stakeholders by effectively and efficiently managing healthcare. The collaborative efforts of the UPMC Health Plan Partners Program provide the basis for engagement of all stakeholders (patients, physicians, employers, and the UPMC Health Plan).

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Texas Medicaid Managed Care and the Medical Home

Denise Donnelly, CPHQ

The Texas Medicaid Managed Care contract requires that each enrolled member be assigned a medical home, which can be a primary care or specialty care provider that has accepted the responsibility for providing accessible, continuous, comprehensive, and coordinated care. The medical home is the first contact for members who need medical care and is responsible for coordinating continuous and “whole person” oriented, comprehensive care.

Overall, Aetna Medicaid and Children’s Health Insurance Program (CHIP) Services supports the principles of the patient-centered medical home, such as offering

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enhanced access to care (open scheduling, expanded hours, and other processes for communicating with patients) and operational systems to facilitate the provision of indicated care in a manner that is timely, convenient for the member, and culturally and linguistically appropriate.

To achieve our quality and safety goals, Aetna provides evidence-based clinical decision-support tools to guide provider decision making and outcomes measurement. We encourage providers to actively involve their patients in decision making and quality improvement activities (for example, by requesting feedback from patients about how well their expectations are being met).

Ideally, medical homes use appropriate information technology to support optimal patient care, performance measurement, patient education, and enhanced communication, but cost is a barrier for most of our small practices and rural providers. Contracted providers are expected to voluntarily accept accountability for continuous quality improvement in their practices.

Today our provider profiling system is designed to give annual feedback on utilization, quality, and member satisfaction to providers with enough members in their panel to have meaningful data. In the Medicaid and CHIP programs, we have not yet implemented pay-for-performance methodologies to offset some of the administrative cost of providing patient-centered care. We are currently surveying our providers to determine what, if any, financial and nonfinancial incentives would be most effective in motivating providers to adopt processes that support the concepts of the medical home. Using this information, we will design a program that provides more timely feedback on the key performance indicators for our priority populations, recognizes improvements, and gives rewards based on outcomes achieved.

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