Physicians, employers, legislators and payers think medical homes may be the key to health system reform.

THE MEDICAL HOME

An Idea Whose Time Has Come ... Again

Leigh Ann Backer

Family physicians have always known the value of a medical home, even when there was no term to describe it. Now, 60 years after the AAFP was founded, others are recognizing that medical homes may be the key to getting better value from the U.S. health care system. In recent months, a wide range of stakeholders including legislators, large employers, patient groups and organized medicine have begun championing medical homes as the centerpiece of a primary-care based approach to health care reform.

The medical home that these plans envision is both old-fashioned and thoroughly modern – a blend of the personalized, comprehensive care that family physicians have been offering for decades and coordinated care that capitalizes on new technology and helps patients make sense of the increasingly complex health care system. Whether the concept takes root may depend on two key issues: whether payers can be convinced of the value of medical homes (and the need to pay more for them) and whether physicians can deliver what the medical home promises. This article describes progress in both areas. A future article will offer suggestions for physicians interested in further developing their practices' medical home characteristics.

What is a medical home?

The American Academy of Pediatrics (AAP) introduced the medical home in 1967 as a way to enhance the care of children with special needs. The Future of Family Medicine Project expanded on the concept in 2004 when it called for every American to have a "personal medical home."[1] The AAFP developed a related policy statement the same year, and the American College of Physicians (ACP) introduced the "advanced medical home" in 2006. Earlier this year, in an effort to put more muscle behind their advocacy initiatives, the AAFP and ACP teamed with the AAP and the American Osteopathic Association (AOA) to draft and disseminate Joint Principles of the Patient-Centered Medical Home.[2] According to the principles, patient-centered medical homes should have these characteristics: a personal physician, physician-directed medical practice, whole-person orientation, coordinated care, quality and safety, enhanced access and adequate payment.

A fact sheet developed by the organizations paints this picture of the medical home: "In this new model, the traditional doctor's office is transformed into the central point for Americans to organize and coordinate their health care, based on their needs and priorities. At its core is an ongoing partnership between each person and a specially trained primary care physician. This new model provides modern conveniences, like e-mail communication and same-day appointments; quality ratings and pricing information; and secure online tools to help consumers manage their health information, review the latest medical findings and make informed decisions. Consumers receive reminders about necessary appointments and screenings, as well as other support to help them and their families manage chronic conditions such as diabetes or heart disease. The primary care physician helps each person assemble a team when he or she needs specialists and other health care providers such as nutritionists and physical trainers. The consumer decides who is on his or her team, and the primary care physician makes sure they are working together to meet all of the patient's needs in an integrated, 'whole person' fashion."

With today's payment models, most physicians can't afford to provide the amount of non-face-to-face work required for this type of care, much less the technical infra-

structure required to support it. As a result, the linchpin of several developing medical home initiatives is a per-member-per-month care management fee that would be paid in addition to fee-for-service reimbursement. This is seen as a promising development by many family physicians and by the AAFP, which has advocated for a care management fee for years. Whether the concept gets implemented the way the Academy hopes it will remains to be seen.

"Financing the changes necessary to provide all the services of a medical home isn't cheap, and I'm not convinced that there's any 'new money' to be had from payers," says Lee Mills, MD, of Newton, Kan., who chairs the AAFP Commission on Practice Enhancement and serves on the *FPM* Board of Editors. "Still, structuring care and payment around medical homes is the first reorganizing concept for primary care that has gained traction with payers, the public and the government. It gets us moving forward, even though it may take a lot of trial and error to develop a formula that serves the interests of all the stakeholders."

Welcoming the medical home

Medical home demonstration projects and pilot programs have proliferated in the last year, and more are expected:

Medicare has a legislative mandate to implement a medical home demonstration project; the Tax Relief and Health Care Act of 2006 requires that this project commence by 2010. Centers for Medicare & Medicaid Services staff have already begun the work of defining a CPT code for care management that will facilitate payment to medical home practices as called for by the legislation.

Private payers aren't waiting to follow Medicare's lead. In August, United Healthcare announced plans for a medical home pilot project that would pay participating physicians a per-member-per-month care management fee in addition to regular fee-for-service payments for offering medical home services in their practices. The program will be launched in Florida.

CIGNA, Humana, Wellpoint and Aetna have expressed interest to the AAFP in developing their own medical home pilot projects, and the Blue Cross Blue Shield Association has developed a model demonstration project that could be adopted by their member plans. A few Blues plans have developed chronic disease management pilot programs involving care management payments to primary care physicians, and several others have medical home pilot programs in the works.

Large, self-insured employers want to study medical homes as well. IBM is working with the AAFP to develop a medical home initiative that would occur in a community where a large number of IBM employees and their families live. In Washington state, the Boeing Company is implementing a medical home pilot involving high-risk employees who require intense care coordination in primary care practices.

IBM, Boeing and the AAFP are members of the **Patient-Centered Primary Care Collaborative**, a coalition representing 50 million American workers and 330,000 doctors that advocates for primary-care-based health system reform. The coalition's goals include working to stimulate additional medical home pilots by large, self-insured employers and legislation at the state and federal levels. The group has worked to get medical home language into several bills pending in Congress, according to Kevin Burke, AAFP's director of government relations.

The **AAFP** has invested $8 million in TransforMED, a national demonstration project launched in June 2006 that is focused on helping participating practices implement a new model of care that includes medical home components (see "TransforMED Tries to Rebuild Family Medicine," *FPM*, May 2007). ➤

About the Author

Leigh Ann Backer is managing editor of *Family Practice Management*. Author disclosure: nothing to disclose.

CHRISTINE SCHNEIDER

The patient-centered medical home is a new idea for health care reform focused on primary care.

Plans call for physicians who provide medical homes to receive a per-member-per-month care management fee in addition to regular reimbursement.

A growing number of **state governments** are interested in incorporating medical homes into the health care programs they fund. Seventy-seven bills have been introduced in 21 states and the District of Columbia, according to Greg Martin, state policy analyst for the AAFP. "These bills run the gamut from a mere passing use of the term 'medical home' to bills creating medical home demonstration projects or systems of care," Martin says.

Many states would like to follow in the footsteps of **Community Care of North Carolina** (CCNC), a program in which physician-led networks offer medical homes to Medicaid enrollees. CCNC pays each network $3 per Medicaid patient per month, and each physician receives an additional $2.50 per month for each of his or her Medicaid patients. The program was launched in 1998 with nine pilot networks covering 250,000 enrollees and has since been rolled out across the state. CCNC saved the state $60 million in Medicaid costs in 2003 and $120 million in 2004, according to one analysis.[3]

NCQA PATIENT-CENTERED MEDICAL HOME DESIGNATION PROGRAM

To qualify as a medical home under the NCQA program, practices would need to meet at least five of the 10 "priority criteria":

- Has written standards for patient access and patient communication;
- Uses data to show it meets its standards for patient access and communication;
- Uses paper or electronic charting tools to organize clinical information;
- Uses data to identify important diagnoses and conditions in practice;
- Implements evidence-based guidelines for at least three conditions;
- Actively supports patient self-management;
- Tracks tests and identifies abnormal results systematically;
- Tracks referrals using a paper-based or electronic system;
- Measures clinical or service performance by physician or across the practice;
- Reports performance by physician or across the practice.

Practices would also need to select and meet additional criteria from a longer list, still under development. Each criterion would be associated with specific processes, and at least half of the processes would need to be in place. A yet-to-be-determined application fee and documentation that the practice meets the criteria would also be required. Practices could pay a small fee for access to an online self-assessment module before submitting a formal application.

Of course cost is only half of the value equation, and proponents of the medical home concept expect to demonstrate improved quality as well. Several studies have established that having a regular source of care and continuous care with the same physician over time leads to better health outcomes as well as lower costs,[4-6] and medical homes are designed to provide this type of care. A recent survey by the Commonwealth Fund concluded that adults who have medical homes have enhanced access to care and receive better quality care.[7] The survey defined medical homes as regular health care providers that offer timely, well-organized care and enhanced access.

How do we get there from here?

As interest in medical homes has grown, so have definitions of what it means to provide one. "It's a diffuse concept, and it will help to develop a single definition that all the stakeholders can operationalize," Mills says.

To this end, the AAFP and the other primary care specialty societies have been working with the National Committee for Quality Assurance (NCQA) to reach consensus on a set of measures that would provide a uniform way of implementing the concept of the medical home, according to Phyllis Torda, vice president of product development for NCQA. The AAFP Board of Directors recently voted to support pilot testing of an NCQA program titled Physician Practice Connections – Patient-Centered Medical Home, which will use the agreed-upon measures to qualify practices as medical homes. United Healthcare intends to use the program in its medical home pilot, according to John Swanson, director of the AAFP's Practice Support Division. (See the NCQA criteria at left.)

"Fair and consistent assessment of whether practices qualify as medical homes is critical, and it's reasonable to expect that payers will require that an independent organization do this work," Mills says, although he has mixed feelings about giving up control of the process and the data to an outside organization. "It may be a necessary evil."

Karen Smith, MD, of Raeford, N.C., a member of the AAFP Commission on Practice Enhancement, recently reviewed the proposed NCQA criteria in detail. She is

confident that her rural solo practice would qualify as a medical home, although not at the highest level without some additional work. "We really embraced the Future of Family Medicine recommendations when they came out several years ago, including adopting an electronic health record system, so we're performing or are capable of performing many of the medical home functions," Smith says.

Her practice has also been participating in the Community Care of North Carolina program for several years, and she believes the program's care management fee (described on page 40) has helped her to improve her practice's quality and efficiency. "It has provided us with an incentive, but it's not enough to finance big changes," she says.

The care management fee will be pivotal in a practice's ability to function as the kind of medical home that payers want, Mills says. "The amount should be more than enough to simply cover the associated costs."

Mills and Smith are confident that many practices could qualify as medical homes, although research suggests that relatively few now have the characteristics associated with medical homes. According to the AAFP's 2006 Practice Profile Survey, the most commonly offered medical home components are chronic disease management (47 percent of practices), electronic health records (41 percent), Web-based information for patients (38 percent) and open-access scheduling (31 percent). Rates of adoption are lower for other services:

- 25 percent use a team approach to care.
- 24 percent use registries or patient tracking systems.
- 22 percent use e-mail to communicate with patients.
- 22 percent use e-prescribing.
- 13 percent use clinical practice guidelines software.
- 13 percent do outcomes analyses.
- 12 percent use Web-based consults or e-visits.

In addition to needing an adequate care management fee, practices will need education to help them redesign their systems of care to meet medical home criteria, Smith says. Learnings from the TransforMED demonstration project and CME opportunities focused on medical homes will be instrumental in enabling practices to achieve these goals. "I'm very optimistic that with this help, an incentive, and a better understanding among patients and other providers of the value that a medical home provides, we can redesign our practices in a way that will serve everyone well," she says.

The medical home concept centers on characteristics that drew many family physicians to the specialty, including the opportunity to provide patient-centered, coordinated, comprehensive care to patients of all ages over time in the context of their family and their community. However, the pressures of managed care have made this vision harder to achieve. Only time will tell whether the medical home movement will bring these values, and the value of family medicine, back into focus. FPM

Send comments to **fpmedit@aafp.org.**

1. Future of Family Medicine Project Leadership Committee. The future of family medicine: a collaborative project of the family medicine community. *Ann Fam Med.* 2004;2(suppl 1):3-32. Available at: http://www.annfammed.org/content/vol2/suppl_1/. Accessed July 23, 2007.

2. Joint Principles of the Patient-Centered Medical Home. Available at: http://www.aafp.org/pcmh/principles.pdf. Accessed Aug. 20, 2007.

3. Arvantes J. Medical homes, physician-led networks can improve care, cut costs. *AAFP News Now.* March 6, 2007. Available at: http://www.aafp.org/news-now/government-medicine/20070306northcarolina.html. Accessed July 23, 2007.

4. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *The Milbank Quarterly.* 2005;83(3):457-502.

5. Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics.* 2004;113(suppl 5):1493-1498.

6. Shi L, Macinko J, Starfield B, Wulu J, Regan J, Politzer R. The relationship between primary care, income inequality, and mortality in the United States, 1980-1995. *J Am Board Fam Pract.* 2003;16(5):412-422.

7. Beal AC, Doty MM, Hernandez SE, Shea KK, Davis K. Closing the divide: how medical homes promote equity in health care: results from the commonwealth fund 2006 health care quality survey. New York: The Commonwealth Fund; 2007. Available at: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=506814. Accessed July 23, 2007.

RELATED CONTENT IN *AFP*

The Sept. 15 issue of *American Family Physician* features two editorials about medical homes, including one by AAFP President Rick Kellerman, MD. Read them online at http://www.aafp.org/afp.

- A variety of payers and employers are funding medical home pilot programs to evaluate the model.
- A definition of the medical home is developing.
- Many practices may have to redesign their systems of care to meet medical home criteria.