

BUILDING the CASE for the PATIENT-CENTERED



Five years have passed since the Future of Family Medicine report warned that the position of family medicine in the United States would be “untenable in 10 to 20 years unless changes occur in the broader health system and within the specialty.”¹ To the casual observer, it may appear that not much has changed in five years, but family medicine leaders see a better future on the horizon. The focus of much of their optimism is the patient-centered medical home, a concept with origins in the “new model” of care called for in the Future of Family Medicine report. The concept – and the blended payment model that underlies it – has captured the imagination of payers, employers and policymakers, as well as many in organized medicine, and its influence is growing.

Whether patient-centered medical homes will revitalize the U.S. health care system remains to be seen, but many family medicine leaders say the widespread interest surrounding the concept has helped put primary care at the center of most health care reform discussions. As the patient-centered medical home takes shape, family physicians are watching and waiting to see what develops and what difference it might make for their practices.

Signs of progress

The concepts of patient-centered care, technology-enabled practice and insurer-paid care management fees are hardly new, but in the shape of the patient-centered medical home, they have developed into a movement that is now being advanced by a coalition known as the Patient-

Centered Primary Care Collaborative (PCPCC). The PCPCC, created in 2006, is a diverse group of large employers, primary care societies, national health plans, patients’ groups and others who support the patient-centered medical home concept, which they have described using a list of joint principles.² Notable coalition members include IBM, Wal-Mart, the American Association of Retired Persons, the American Cancer Society and the primary care societies, including the AAFP.

The movement picked up steam in November when the American Medical Association’s House of Delegates endorsed the patient-centered medical home concept by voting to adopt the PCPCC joint principles. Among the principles is one that says doctors who provide medical home services should be paid additional fees for the added value they provide to patients. The adopted resolution directs the AMA to study “funding sources and payment structures.” The AMA Board of Trustees will also examine the issue of who should provide medical homes, the result of an amendment that did not pass but was referred to the AMA Board for review.³

AAFP president Ted Epperly, MD, of Boise, Idaho, called the AMA vote “historic” and said, “As we advocate for the joint principles of the patient-centered medical home, we can do so knowing the house of medicine is firmly in support of them.”

The patient-centered medical home has also captured a lot of attention in health care policy circles, at both the state and national levels. Through the 2007-2008 legislative session, states passed 16 bills that defined the medical home or provided for a pilot project to begin implementing the concept in public health programs, according to Greg Martin, state health policy analyst for the AAFP. Many more states are studying the concept.

The idea is making inroads in Washington, D.C., as well. In its June 2008 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress increase Medicare Part-B payments to primary care physicians and expand on the medical home demonstration project that the Centers for Medicare & Medicaid Services (CMS) launched this month.⁴

A coalition is working to prove the concept and create an imperative for change.

Payers and policymakers are getting on board.

Are you?

MEDICAL HOME

In November, Sen. Max Baucus, D-Mont., chair of the Senate Finance Committee, introduced a plan for health care reform that relies heavily on primary care and preventive services to improve quality, enhance access and reduce health care costs.⁵ “Primary care is the keystone of a high-performing health care system,” Baucus wrote. Like the MedPac report, Baucus’ plan urges increases in Medicare payments for primary care services and calls for an expansion of Medicare’s medical home investigations. A comprehensive plan is expected soon from Sen. Edward M. Kennedy, D-Mass., as well.

President Barack Obama’s health care reform plan calls for strengthening the primary care workforce through loan assistance, improved payment and expanded residency training funding. His response to a presidential candidates’ survey fielded by the AAFP in 2008 suggested that he recognizes the value of medical homes as well: “As President, I will encourage and provide appropriate payment for providers who implement the medical home model ... which collectively will help to improve care for those with chronic conditions.” Obama’s nominee for Health and Human Services secretary, former U.S. Senate Majority Leader Tom Daschle, has described the primary care workforce shortage as a “huge problem” and medical homes as one strategy for improving health care quality.⁶

“This year will usher in nothing short of a revolution in health care transformation as the era of comprehensive primary care dawns,” predicts Paul Grundy, MD, MPH, director of health care transformation for IBM and chairman of the PCPCC.

Proving that it works

Even as the patient-centered medical home concept gains momentum, efforts to prove its effectiveness through demonstration and pilot projects are developing. The idea may sound good in theory, but without evidence of its viability, payers and some family physicians are reluctant to make

the investment needed to fully implement the model.

The results of the AAFP’s TransforMed initiative could be instrumental in helping family physicians understand what exactly a patient-centered medical home looks like and in helping early adopters to chart their course. The AAFP launched the two-year national demonstration project in 2006. The test phase ended last May, and an independent study of the results is underway, with publication expected this spring, according to Terry McGeeney, MD, MBA, CEO of TransforMed. McGeeney says early learnings have affirmed just how difficult practice transformation can be, even in highly motivated practices, and how essential payment reform is to the model’s success.

A growing number of insurers have found the model promising enough to invest in pilot projects that pay a care management fee to patient-centered medical homes. The goal is to determine whether patient-centered medical homes will in fact produce cost savings and quality gains. The results of these pilots will also be pivotal in helping family physicians determine what they stand to gain from transforming their practices into patient-centered medical homes. Twenty-two pilots are in development in 17 states, according to the PCPCC, with many scheduled to launch this year.⁷ One of the largest of these is a two-year project scheduled to begin in 2009 in Colorado. All major health plans in Denver, Fort Collins and Colorado Springs are participating in the pilot, which aims to involve up to 15 practices and 30,000 covered lives. CMS will launch its own three-year demonstration project this year (see “Medicare’s demonstration project” on page 16).

The National Committee for Quality Assurance (NCQA), with input from organizations including the AAFP, launched a patient-centered medical home designation program last year that has been instrumental in motivating insurers to develop pilot projects. Payers are limiting participation in the pilots to physicians whose practices have been designated as patient-centered medical homes by NCQA. To date, NCQA has received approximately 120 applications for the NCQA designation program, known as Physician Practice Connections – Patient-Centered Medical Home, or PPC-PCMH (<http://www.ncqa.org/tabid/631/default.aspx>), according to Eric Williams, NCQA product development manager.

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Practices pay NCQA \$80 to use an assessment tool that helps them determine their readiness for applying for the PPC-PCMH designation; the application fee is \$450 per physician for a practice of up to six physicians. The NCQA requirements are categorized under nine standards:

- Access and communication,
- Patient tracking and registry functions,
- Care management,
- Patient self-management support,
- Electronic prescribing,
- Test tracking,
- Referral tracking,
- Performance reporting and improvement,
- Advanced electronic communications.

Practice transformation

The most sizable investment many practices will make in becoming patient-centered medical homes is in the time they spend implementing changes and gathering the documentation the NCQA application requires. Some will also need to invest in an electronic medical record (EMR) system, which is required to achieve NCQA's level 2 or level 3 designation.

Beth Pector, MD, who practices with two part-time providers in Naperville, Ill., and uses a lower cost EMR, says the financial outlay necessary to purchase an EMR

isn't the only challenge. A lack of knowledge or support to implement related workflow changes is also an issue, Pector says. "Most of us are not IT experts. We have not had to implement, assess and improve major complex projects. ... How many hats does a primary care doc, who already has to know a little of everything in medicine, have to wear to operate an IT-enabled medical home?"

Joseph F. Mambu, MD, says that developing the IT infrastructure was by far the hardest part of the transformation to a patient-centered medical home. Mambu's small private practice in Lower Gwynedd, Pa., recently earned NCQA's highest level of patient-centered medical home designation, which he hopes will enable him to participate in an upcoming pilot project in his area. Mambu's practice participated in the TransforMed national demonstration project and credits the experience with helping his practice deliver better care more efficiently and with a much higher level of satisfaction than in the past. "We feel very confident about the quality of care and service we're offering now," Mambu says. His practice finances have not improved, however. "Without payment reform, I'm not sure this is financially viable," he says.

Same old same old?

Uncertainty surrounding the financing of patient-centered medical homes may keep some family physicians from pursuing the NCQA designation. David Hopper, MD, who practiced in Princeton, W.Va., before moving to an urgent care clinic in Greensboro, N.C., is skeptical: "For 28 years I labored hard in a small-town practice that would qualify easily for the new lingo of 'medical home' while listening to assurances that family practice would be rewarded under this or that new reimbursement scheme. Although we were rewarded in the results we saw in the lives of those with whom we worked, we never were fairly financially rewarded. We should not buy into the concept if we are believing the system will reward us for it. The only reason for doing all this is for the joy of service in patients' lives and the relationship opportunities it gives."

AAFP leaders understand the hesitation but believe that family physicians must act now to move their practices toward becoming true medical homes. They're working to build family physicians' confidence in the concept's future so that they will start preparing now.

"Not all our members are seeing the value of making this change. My greatest fear is that some of our family physician members won't transform their practices,

MEDICARE'S DEMONSTRATION PROJECT

The Centers for Medicare & Medicaid Services (CMS) began accepting applications this month from practices interested in participating in a two-year national demonstration project to study whether the medical home model produces savings and quality improvement. CMS anticipates paying physicians a management fee of between \$40 and \$51 per member per month, depending on their level of medical home designation. The fee will be adjusted according to each patient's severity of illness, which could cause some fees to be higher or lower than this range. CMS based the rates on recommendations made by the AMA/Specialty Society Relative Value Scale Update Committee (the RUC), but they should not be considered final until the Office of Management and Budget gives its approval. Practices would also be eligible to receive a share of any cost savings.

Practices chosen for the project will be required to complete the National Committee for Quality Assurance (NCQA) medical home designation program and earn the equivalent of level 2 or level 3 status. CMS will pay the required fees. At press time, CMS had not yet announced the eight states in which the project will be conducted. The project will involve about 400 practices, 2,000 physicians and 400,000 Medicare beneficiaries. The management fee will be paid from January 2010 to December 2012.

For more, go to http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_FactSheet.pdf.



USE OF PATIENT-CENTERED MEDICAL HOME COMPONENTS BY FAMILY PHYSICIANS

Electronic medical records	49.2%
Personal digital assistants (PDAs)	48.3%
Chronic disease management	46.8%
Extended office hours	42.4%
Web-based information for patients	35.7%
E-prescribing	31.7%
Open-access scheduling	28.9%
Test tracking and follow-up systems	23.4%
Team approach	22.1%
E-mail with patients	21.0%
Registries or patient tracking systems	20.7%
Performance management of processes or clinical recommendations	20.4%
Electronic performance measurement reporting	20.0%
Self-care management support	13.4%
Outcomes analyses	11.3%
Online appointments	10.2%
Patient population management	9.8%
Clinical practice guideline software	9.6%
Group visits	8.4%
Web-based consultations or e-visits	2.6%

Source: AAFP Practice Profile I Survey, July 2008.

won't be able to demonstrate the value and quality that will enable them to get paid what they are truly worth and will be left behind," says Epperly.

A research initiative to help gauge AAFP members' awareness of and interest in the patient-centered medical home concept will help guide the organization's education and communication efforts. Early findings are mixed. In an October 2008 survey designed to give focus to AAFP CME development, 71 percent of the 273 respondents said they were familiar with the patient-centered medical home model of care, and 74 percent were very or somewhat interested in having their practice recognized as a patient-centered medical home. However, qualitative research also conducted last fall uncovered a number of physician concerns and barriers to the model's adoption.

One concern is that jumping through additional hoops to prove what physicians already know about their

practices adds yet another hassle to their already overburdened businesses. "We already are in a specialty that has undergone vigorous expansion of requirements for remaining board certified, effort that has not historically led to greater pay," says Pector. "We have state and DEA and business licensure, HIPAA, CLIA, OSHA and sometimes JCAHO certifications to contend with. To add another complex certification process that may take many hours, with no potential to reimburse us for the substantial time and effort required, seems to be an insult."

Glenn Wheat, MD, of South Bend, Ind., fears that solo practices like his will have a harder time qualifying as patient-centered medical homes than larger groups and multispecialty clinics because of some of the capital- and resource-intensive requirements, like team care and enhanced access. "Requirements that don't clearly improve patient care need to be multiple choice," he says. "Making it more difficult for very good doctors to qualify does not serve the intent of increasing access to primary care."

Jen Brull, MD, of Plainville, Kan., says she's willing to jump through hoops "if it truly results in improved reimbursement," and she's confident enough that it will. She plans to pursue NCQA designation for her solo practice, but she understands other physicians' pessimism. She participated in Medicare's Physician Quality Reporting Initiative last year and ended up not receiving the incentive payment she was expecting. "Physicians may not be willing to do this, having seen other initiatives result in more work and no more money," she says. "I am optimistic by nature and tend to believe that if I work toward improving the situation in many ways, one or more of them may work out."

Data from the AAFP's 2008 Practice Profile survey suggest that the vast majority of practices do, in fact, have a long way to go to become the type of patient-centered medical homes that payers want them to be (see the table, above left). To help practices determine whether they meet the definition of a medical home, document their status and prepare for the NCQA designation process, the AAFP has published an online resource titled *Road to Recognition: Your Guide to the NCQA Medical Home*. It is available free to members at <http://www.aafp.org/pcmh>. The Academy is also emphasizing patient-centered medical home components in its CME development efforts; the AAFP's 2009 Annual Clinical Focus is on managing chronic illness.

Since TransforMed's national demonstration project ended last spring, it has evolved into an organization focused on consulting services that help practices transform their practices, says McGeeney. TransforMed's Medical Home IQ Assessment (MHIQ) (<http://www.transformed.com/mhiq>) is a free resource designed to help physicians assess their performance by measuring it against eight core sets of competencies. It provides recommendations to help practices improve their scores, and users who complete



Article Web Address:

<http://www.aafp.org/fpm/20090100/14buil.html>



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it can convert their score into an estimate of how they might score on the NCQA PPC-PCMH designation program. This month TransforMed is launching its Medical Home Network (<http://www.transformed.com/Medical-HomeNetwork>), an inexpensive, online practice improvement learning community focused on implementing the patient-centered medical home. Those who join get access to webinars, discussion lists and other resources.

If you build it, will they come?

As the patient-centered medical home movement advances, there is increasing awareness among its supporters of the need to ensure that patients understand and value what physicians in patient-centered medical homes offer them. A survey fielded by Harris Interactive on behalf of the PCPCC in September suggests that there is work to be done. Sixty-seven percent of the 2,022 U.S. adults who responded said it is extremely or very important for them and their families “to have a relationship with a doctor who takes a whole-person approach to patient care (social, mental and physical care) and who provides care for all levels of health, including unexpected illness, emergency care, chronic care and preventive services.”⁸ Other aspects of health care that one might associate with a patient-centered medical home were rated lower, including care coordination and chronic illness care, although each was extremely or very important to at least 50 percent of respondents.

Patient groups have suggested the model may need refinement. At its annual summit in October, the PCPCC held a panel discussion on consumers’ experiences with patient-centered care. In prepared remarks, panelist Jessie Gruman, PhD, president of the Center for Advancement of Health Care, wrote, “What is lacking from the model of the medical home is recognition that patients are not the object of care, but rather that they are full-fledged participants in it.”

Another panelist, Sarah Thomas, director of health care for the Public Policy Institute of AARP, urged payers and providers to expand their idea of patient-centered care to include patients’ families and caregivers. “It is not just about patients when you think about patient-centeredness; there are caregivers and family members to think about, too,” she said.

Wheet welcomes the focus on patient-centeredness,

although he’s concerned that the model will evolve into a “payer-centered” medical home. “This is a rare opportunity to remind patients that their health care should be centered on them. This could be a defining moment where we reestablish the sanctity of the doctor-patient relationship, which has been violated by payers for too many years.”

What next?

Hopes are high for the future of the patient-centered medical home, but family physicians, most of whom lived through the rise and fall of the gatekeeper model of care in the 1990s, are understandably concerned about whether things are headed in the right direction. One thing most can agree on is that the system is broken. “What we are doing now isn’t working for a large segment of family medicine, so we have to look for change,” Brull says.

Time will tell whether this change can help to restore family medicine to its rightful place at the foundation of the health care system. **FPM**

Send comments to fpm@afp.org.

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