The Patient-Centered Medical Home:

Still a Work in Progress

Pilot projects are producing encouraging results as well as new challenges.

Leigh Ann Backer

When the results of the TransforMed national demonstration project (NDP) were published recently in a supplement to the *Annals of Family Medicine*,[1] they generated surprisingly little buzz. Given the high profile of TransforMed, an $8 million practice redesign initiative funded by the AAFP and inspired by the foreboding conclusions of the Future of Family Medicine project[2] to test a new model of care, it was reasonable to expect a lively discussion of the NDP final report, particularly in light of what some might characterize as unimpressive results: After about two years, implementation of the patient-centered medical home (PCMH) components was associated with "small improvements in condition-specific quality of care but not patient experience," according to the research (see a brief summary of the findings on page 33). But in the four years since its launch, the NDP seems to have been largely eclipsed by the patient-centered medical home movement it helped to create – a movement that now involves numerous pilot projects and other practice redesign efforts across the country.

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One predictable but pivotal finding of the NDP research – that payment reform is essential to achieving the transformation that will position practices to deliver the kind of care that the model requires – is now being tested in pilot programs that incorporate new ways of paying primary care physicians for enhanced care and services. This is the new arena in which the medical home movement is playing out, and it's one that family physicians cannot afford to ignore.

Piloting payment reform

At least 27 multistakeholder pilots are underway in 20 states, according to the Patient-Centered Primary Care Collaborative, a diverse coalition of large employers, primary care societies including the AAFP, 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.[3] The majority of pilots are single-payer projects, but some, including one in Colorado, involve as many as a handful of payers.

Funded with a three-year, $1.4 million grant from The Colorado Trust and a $225,000 grant from the Commonwealth Fund for formal evaluation, the Colorado pilot was among the first off the ground when it began providing technical assistance to participating practices in December 2008. In total, pilot projects involve over 14,000 physicians in nearly 5,000 practices caring for nearly 5 million patients, according to research by Bitton et al recently published in the *Journal of General Internal Medicine*.[4]

TransforMed continues to be right in the middle of patient-centered medical home development, using lessons learned from the NDP and subsequent work to offer consultation and facilitation services and products to primary care practices and payer-supported pilots as well as to health systems and large medical groups that want to redesign primary care delivery. TransforMed is involved in some capacity with the majority of pilots underway across the country and has been engaged by the Centers for Medicare & Medicaid Services (CMS) to assist with an upcoming medical home pilot focused on federally qualified health centers, says TransforMed CEO Terry McGeeney, MD, MBA.

One condition of TransforMed's engagement in new initiatives is that they offer enhanced payment to participating primary care physicians, McGeeney says, and most of the pilots do. The potential for additional revenue reported by the pilots that Bitton et al studied ranged from approximately $1,000 to more than $90,000 per physician per year, with most of the increase resulting from fixed case-management fees.[4]

Recognizing medical homes

Pilots are commonly designed to offer payment to practices that achieve recognition as medical homes by the National Committee for Quality Assurance (NCQA). The process can take months or even years for some practices to complete, depending on their baseline capabilities and what kind of assistance they have available. As a result, many pilots have not yet been fully implemented.

Blue Cross and Blue Shield of Kansas City is in the early stages of developing a pilot that launched in November 2009, according to family physician Blake Williamson, MD, vice president and senior medical director. One of the 13 participating practices, Clay-Platte Family Medicine, an eight-doctor group in Kansas City, Mo., has achieved NCQA recognition as a level-3 patient-centered medical home (the highest level). Williamson is hoping the other practices will be ready to apply for NCQA recognition in early 2011.

In Colorado, where only one group in the pilot has more than a handful of providers, all 17 of the independent primary care practices are NCQA-recognized patient-centered medical homes, the large majority of them at level 3, according to Marjie Harbrecht, MD, chief executive

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officer of Health TeamWorks (formerly the Colorado Clinical Guidelines Collaborative), which organized the pilot. Tracy Hofeditz, MD, whose Lakewood, Colo., practice also includes a family nurse practitioner (and, as of last month, a second physician), achieved level-3 patient-centered medical home recognition while simultaneously implementing an electronic health record (EHR) system.

While Hofeditz's achievement demonstrates that NCQA recognition is attainable even for the smallest of practices, he emphasizes that the personal investment, both in emotional and financial terms, was huge. Hofeditz, A.J. Delaney III, MD, MBA, of Clay-Platte Family Medicine, and Joseph Mambu, MD, MPH, a Lower Gwynedd, Pa., family physician who participated in the TransforMed NDP and whose three-doctor practice subsequently achieved level-3 patient-centered medical home recognition, all describe their efforts as a "leap of faith" that they took without the certainty of a pay-off down the road. Delaney's group, which pursued NCQA recognition even before a pilot was available in their Kansas City, Mo., area, added two full-time staff to lead the effort. Hofeditz and Mambu invested in staff and in EHR systems as well, and they benefited from professional facilitators whose services were paid for by the pilots they were involved with.

The patient-centered medical home model is being tested in numerous pilot projects that incorporate primary care reform.

TransforMed is helping to develop many of these projects and is applying lessons learned from its own national demonstration project.

Practices are seeking patient-centered medical home recognition from the National Committee for Quality Assurance, a requirement for participating in many pilots.

The TransforMed NDP research found that facilitation plays an important role in practice transformation,[5] particularly in regard to the development of human infrastructure and "adaptive reserve," which refers to the practice's capability to make and sustain change, according to Carlos Jaén, MD, PhD, the principal investigator of the TransforMed NDP evaluation team and professor of family and community medicine at the University of Texas Health Science Center in San Antonio. "We learned that implementing this model of care is really difficult and that the change requires facilitation, development work in the practice and leadership skills before it can happen." Roughly two-thirds of pilots employ facilitators.[4]

Getting paid

Both Mambu and Hofeditz submit monthly quality data and narrative reports as a condition of their participation in the pilots, and yes, they are getting paid for their efforts. Since joining the Pennsylvania Chronic Care Initiative, a multipayer pilot spearheaded by Pennsylvania Gov. Ed Rendell's Office of Health Care Reform, Mambu has seen his practice's revenue grow by about $100,000 a year, a 10-percent increase that is nearly equal to the personal savings he invested in the EHR he purchased in 2007.

Hofeditz is receiving "significant" payments as a result of his participation in the Colorado pilot. He says that the money currently available is "enough to inspire any practice to begin the transformation process and the application process for recognition as a medical home," even though he received no up-front payment to finance these efforts. He cautions, though, that the payments are "not nearly enough to fully compensate practices for providing the level of care that we're expected to sustain over time."

Harbrecht says that adjusting the blended payment model so that it works for the small, independent practices where 70 percent of primary care physicians work is a challenge that keeps her up at night. "Even with extra payment, we've got some practices that are struggling with viability," she says. "The fee-for-service component is still weighted too heavily in comparison to the per-member-per-month care management fee and the pay-for-performance incentives. We think there needs to be a bigger up-front payment to enable

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these physicians to get off the treadmill and get them the time and money necessary to develop the medical home infrastructure. If the per-member-per-month payment is unpredictable or they're just waiting for pay-for-performance payments or a gainshare at the end, they're not going to have the resources to build what they need to get there.

"It's exciting to see the model working in large integrated delivery systems like Geisinger and Group Health where they're able to support their primary care practices, but we've got to figure out how to make this work in the current environment."

Mambu warns that "The money and education needed to make this happen must precede the transformation, or the transformation will be slow and incomplete." Jaén says this was evident in the TransforMed NDP as well, even among the "heroic," highly motivated, early adopters that the project attracted.

"Without there being a broader sense that payment will be available to practices to assist with the transformation process, I worry that a lot of the efforts to engage practices will not be fruitful and there will be a level of discouragement on all sides," Hofeditz says. He wants insurers to offer enhanced payment to any practice that achieves NCQA recognition. "It will be a watershed event when this happens, and I believe that interest from primary care practices will be much greater then."

In fact, Independence Blue Cross recently announced that on Jan. 1, 2011, it will begin offering additional incremental reimbursement to NCQA-recognized patient-centered medical homes. About 1,800 primary care physicians in the plan's southeastern Pennsylvania network will be eligible to participate, including Mambu.

Reforming health care

The medical home movement may gain additional momentum with the January 2011 opening of the new Center for Medicare and Medicaid Innovation, which was established by the Patient Protection and Affordable Care Act. The new center, which will be part of CMS, will be responsible for researching and developing the many reform models specified in the law, many of which relate directly or indirectly to patient-centered medical homes.

Anthony Rodgers, deputy administrator of CMS' Center for Strategic Planning, described the new center's focus this way in a presentation at a Patient-Centered Primary Care Collaborative conference in June:

- Build on the current foundation of medical homes,
- Integrate patient-centered medical homes with accountable health care organization strategies,
- Invest in advanced optimization of medical homes' scope of service, capacity and capabilities,
- Continue to test various payment meth-

CONCLUSIONS FROM THE TRANSFORMED NATIONAL DEMONSTRATION PROJECT

The TransforMed NDP results were published in June 2010 in a 92-page supplement to the *Annals of Family Medicine* that can be read online (see http://www.annfammed.org/content/vol8/suppl_1). Carlos Jaén, MD, PhD, principal investigator of the NDP research team, encourages family physicians to read the supplement, as the results are best understood when considered in context. The following conclusions appeared in the final article, "Summary of the National Demonstration Project and Recommendations for the Patient-Centered Medical Home":[1]

"Primary care transformation is more about learning how to become a learning organization that creates an emergent future than it is about learning from experts on how to build something already known. The level of change needed is daunting and requires tremendous motivation of all practice participants, defining new roles, understanding the local landscape, and paying attention to multiple relationships. Future PCMH recognition and certification processes should focus more on patient-centered attributes and the proven, valuable key features of primary care than on the features of disease management and information technology. The PCMH represents the essentials for better primary care, the improved delivery of chronic care, and active partnership with informed patients synergized by appropriate use of information and communication technology.

"Nevertheless, the PCMH model is still evolving and will need adequate capital funding from a combination of federal, state, local, insurance industry, and health system sources. Expecting practices to front the cost of transformation with the hope of more appropriate reimbursement in the future is unlikely to succeed. Ultimately, for the PCMH to spread and become the norm, the delivery system must be reformed to support this approach to care."

1. Crabtree BF, Nutting PA, Miller WL, Stange KC, Stewart EE, Jaén CR. Summary of the national demonstration project and recommendations for the patient-centered medical home. *Ann Fam Med*. 2010;8(Suppl 1):S80-S90. http://www.annfammed.org/content/vol8/suppl_1. Accessed Aug. 15, 2010.

ods to support medical home expansion.

Three CMS-sponsored medical home demonstrations are already in development. According to the CMS web site, the Multi-Payer Advanced Primary Care Practice Demonstration will be implemented first, followed by the Federally Qualified Health Centers Advanced Primary Care Practice Demonstration and the Medicare Medical Home Demonstration, which has been on the drawing board since 2007.[6]

Becoming a patient-centered medical home requires a considerable investment of time and financial resources.

Mining the data

There is optimism that these national efforts will help bring into focus a working model that physicians and payers can put into practice and patients can appreciate. In the meantime, a confusing array of pilots have emerged that vary significantly in size, scope and design, and evidence of what works and what doesn't is in short supply. With the notable exception of the TransforMed NDP results, the few published studies of PCMH pilots focus on primary care redesign and payment reform in large, integrated delivery systems (Geisinger,[7] Group Health Cooperative of Puget Sound[8] and Intermountain Healthcare[9]) and North Carolina Medicaid.[10] This shortage of comparative data may be the result of several factors, including the fact that robust evaluation has not been incorporated in pilot designs[4] or is still in the early stages because pilots have gotten off to a slower than expected start.

Physicians are receiving enhanced payments for participating in pilots, but they say more upfront payment is needed to fund practice changes, especially for small, independent practices.

As it turns out, physicians aren't the only players that lack the infrastructure required for participating in pilots. Health plans do too.

The Centers for Medicare & Medicaid Services is developing three demonstration projects that focus on patient-centered medical home implementation.

Data collection problems in particular have hampered the Colorado pilot, according to Harbrecht. As it turns out, physicians aren't the only players that lack the infrastructure required for participating in pilots. Health plans do too. The Colorado pilot was extended by a year "primarily because of the struggles that health plans are having trying to get cost data to the evaluator for aggregation, and to the practices to identify patients with high utilization, particularly in hospitals and emergency departments," Harbrecht says. "It's resource-intensive for the health plans to get the data out of the complex information systems. The practices are submitting quality data on a monthly basis, and because they can analyze this regularly, they have made some very good strides on quality in a short time. But if they don't have the utilization and cost data from the plans, it's hard for them to know that their hard work is making a difference. We have to find a way to make this much easier because the continuous feedback loop to the practices is critical."

Data issues (and health plan designs that don't require patients to designate a primary care physician) have also made it difficult not only to attribute patients to physicians, which is the basis for calculating the per-member-per-month care-management fee, but to determine if a patient has gone to a specialist or ER so they can at least coordinate care and reduce redundant tests which increase cost, Harbrecht says.

It hasn't been easy to get quality data from the practices either. "After all this time, it's still hard to get data out of EMRs. We've been working for several years to get data out of these black boxes, and this has to change," Harbrecht says. TransforMed facilitators have had the same difficulties in practices they've worked with, according to McGeeney. "Getting data out of a multitude of EMRs has never been easy. Now we typically use separate registry capabilities that can pull information from the payers and the practices to create a centralized database," he says.

Getting it right

Once the technical challenges of building medical homes, paying them appropriately

and analyzing their performance are sorted out, a key question will remain: Are patients, physicians and staff more satisfied with this model of care? At this stage, studies of satisfaction are mostly unpublished or, as in the case of the TransforMed NDP's analysis of patient satisfaction, unconvincing.[11] However, McGeeney reports "dramatic improvements in both physician and staff satisfaction at the one-year anniversary of the pilots" that TransforMed has engaged with and surveys at least every six months. "In spite of all the change, physicians are saying over and over again that they're finally getting to do what they went to medical school for." Hofeditz, whose small practice is now bearing the fruits of his labor, says he's yet to rediscover the joy of practicing primary care but he's cautiously optimistic and committed to the patient-centered medical home movement.

Harbrecht says she senses growing urgency among those with a stake in the patient-centered medical home movement. Over the past year, under the leadership of Craig Jones, MD, director of the Vermont Blueprint for Health, Harbrecht and other representatives from eight states (Maine, Massachusetts, Minnesota, New Hampshire, Pennsylvania, Rhode Island, Vermont and Colorado) that are among the most experienced in working with primary care practices and the PCMH model have been meeting regularly to learn from each other and prepare for the upcoming Medicare Multi-Payer Advanced Primary Care Practice demonstration project.

"All of us are involved in projects at different stages of implementation, but we share a strong commitment to produce common assessments, participate in comparative learning and support, use this process to guide delivery system reforms, evolve toward common informatics and reporting platforms, and more rapidly transform primary care," Harbrecht says.

"We're learning as we go, and we don't have a lot of time. We need to be honest about what we're finding, take what works and keep moving forward," Harbrecht says. "We need to be careful not to throw the baby out with the bath water. If we keep starting over, we'll never get there."

Lately another new model of delivering and organizing health care known as accountable care organizations (ACOs) is capturing the attention of payers and policymakers. Patient-centered medical homes and ACOs aren't competing models; in fact, ACOs may be the "medical neighborhoods in which medical homes reside," Jaén says. Still, after years of declining payment and dysfunctional models that keep many family physicians on the treadmill and drive others away altogether, it will be important to keep the focus on primary care for as long as it takes to get it right. FPM

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- Results of pilots are emerging slowly.
- Data collection has been a significant challenge.
- It may be too soon to judge satisfaction with the PCMH model, but commitment to testing it is strong.