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Can Patient-Centered Medical Homes Transform Health Care Delivery?

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Now that President Obama has set aside $634 billion in his budget for health reform, national policymakers need not only to outline overarching reform strategies but also consider how the system will work from the ground up. While much focus has been on how affordable coverage will be achieved, an equally important aspect of reform will be an overhaul in the delivery of care. This new delivery system must be built on a solid foundation of primary care.

Enter the medical home, a building block needed to ensure accessible, patient-centered, and coordinated primary care. The medical home is an approach to primary care organized around the relationship between the patient and the personal clinician. First championed by the American Academy of Pediatrics, the medical home is broadly defined as primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."

Why the U.S. Needs Medical Homes

In 2007, four primary care specialty societies—representing more than 300,000 internists, family physicians, pediatricians, and osteopaths—agreed on the Joint Principles of the Patient-Centered Medical Home:

- personal physician;
- whole-person orientation;
- safe and high-quality care (e.g., evidence-based medicine, appropriate use of health information technology);
- enhanced access to care; and
- payment that recognized the added value provided to patients who have a patient-centered medical home.

Today, few Americans say they have a source of care with these features. In fact, the Fund's 2008 National Scorecard on U.S. Health System Performance found that only 65 percent of adults under age 65 reported that they have an accessible primary care provider; there were wide variations by race, income, and insurance status. Only half of the overall group said they had received all recommended screening and preventive care. Among adults who were uninsured all year, just 30 percent had received the appropriate preventive care. A 2008 Fund survey showed almost half of U.S. adults report a lack of care coordination, such as a specialist not receiving basic information from their primary care provider and vice versa, or never being called about test results. The Fund's 2008 Scorecard shows that only a little more than half of all Americans report open and clear communication with their primary care clinician. When there is good communication, and care is delivered in a timely and coordinated manner, patients are more likely to adhere to treatment plans, fully participate in decisions, and receive better care overall.

Creating medical homes throughout the country will clearly require a significant restructuring of our existing health care delivery "system." Whereas most doctors' offices and hospitals are currently isolated from each other—electronically and otherwise—providing patients with around-the-clock access

to coordinated care will require that providers are linked and working together. For example, small physicians' offices could pool with other offices to provide regional urgent care centers that would be open from 5 p.m. to 9 a.m. Individual practices also will need support to redesign their practices or clinics as medical homes. A recent study of primary care practices in Massachusetts showed that many practices do not currently have the information systems, personnel, or continuous quality improvement initiatives in place to function as medical homes.

While the medical home is not a "magic bullet" that will provide an immediate return on the investment, studies have demonstrated tangible benefits, including improved quality, lower costs, and fewer disparities in care.

Medical homes are associated with better preventive care and improved chronic disease management (chronic diseases are a major source of high health care costs). Forty-two percent of people with a medical home have regular blood pressure checks, for example, compared with 20 percent without a regular source of care or medical home, according to the Fund's 2006 Health Care Quality Survey. Furthermore, patients with medical homes are more likely to report better access to care, better coordination of care, improved communication with their primary care provider, and fewer medical errors. The quality survey also showed that medical homes do not just improve, but actually eliminate, disparities in getting needed medical care.

Medical homes also produce efficiencies. U.S. adults with medical homes were less likely to have medical reports unavailable during a visit or to have to undergo duplicative tests, according to the Fund's latest international survey. A Fund case study of a system offering medical homes, the MeritCare System in North Dakota, demonstrated that pilot programs addressing the management of chronic diseases such as diabetes and asthma resulted in substantive costs savings.

Ongoing Fund-supported demonstration and evaluation projects, including a new initiative to transform safety-net clinics into patient-centered medical homes, will generate more information about the value of medical homes and how to turn practices into medical homes. Additionally, several ongoing rigorous evaluations of medical home demonstrations will help determine if they improve quality and slow the rate of health care expenditures. The evaluations vary considerably, from a randomized, controlled trial with one commercial payer to multistate, multipayer efforts that involve national health plans collaborating with the Medicaid program to support new reimbursement and delivery models for medical homes. All of the studies will examine the impact of the medical home on clinical quality, patient experiences, clinician/staff experiences, and health system costs. A Patient-Centered Medical Home Evaluators' Collaborative is under way to encourage investigators to work together to reach consensus on a core set of standardized measures that will facilitate cross-study comparisons.

Measuring Medical Homes

Developing metrics to recognize and monitor medical homes is an ongoing process that was kicked off by the National Committee for Quality Assurance (NCQA) in 2007. According to NCQA's national measures, to qualify as a patient-centered medical home a practice must demonstrate proficiency in at least five of the following 10 areas:

- written standards for patient access and patient communication;
- use of data to show they are meeting this standard;
- use of paper-based or electronic charting tools to organize clinical information;
- use of data to identify patients with important diagnoses and conditions;
- adoption and implementation of evidence-based guidelines for three conditions;
- active support of patient self-management;
- tracking system to test and identify abnormal results;
- tracking referrals with paper-based or electronic system;
- measurement of clinical and/or service performance by physician or across a practice; and
- reporting performance across the practice or by physician.

These measures, which were created in collaboration with the four primary care specialty societies, offer an excellent starting point in the process of developing comprehensive medical home standards. With Fund support, NCQA continues to develop and test additional measures that would

make the standards more patient-centered and inform future iterations of the measurement set. Areas under development include excellence in patient experience, shared decision-making, family and community involvement, coordination of primary care and specialty physicians, functioning of the staff as a team, and services to address limited English proficiency.

Another key aspect of the medical home model is reforming physician payment to strengthen and reward primary care. Current reimbursement is biased in favor of procedures, such as surgery or imaging, and does not adequately pay for time spent with patients to take their medical history or follow-up after the appointment. For successful implementation, primary care practices would submit to a voluntary and objective qualification process to be recognized as a medical home. In exchange, the medical home would be supported with an enhanced or additional payment to support the improved care management, infrastructure, and care coordination. Rather than following a strictly fee-for-service model, purchasers in the Bridges to Excellence Medical Home Initiative, for example, will pay primary care physicians $125 a patient if they meet medical home metrics and chronic care guidelines. In the Medicare Medical Home demonstration planned by the Centers for Medicare and Medicaid Services (CMS), physician practices will receive a risk-adjusted monthly care management fee that, on average, ranges from $40.40 to $51.70 per member per month, depending on the capacity and infrastructure of the physician practice. Such financial support should help bolster the field of primary care as well as improve care. Today, primary care physicians are undercompensated relative to specialists.

Encouraging the adoption of medical homes in small practices and large systems will require national cooperation and federal support for infrastructure, such as health information technology and health information exchanges. With better information technology, practices will have enhanced capacity to summarize the needs of their patients, identify patients who are overdue for appointments, obtain feedback from patients through e-mail and Web portals, or review test results remotely. However, technology is just a tool, and unless the information generated is used to better meet the needs or preferences of patients, it is a disruption that does not improve care.

Multipayer, public–private demonstrations—and there are several getting started—will offer the best glimpse at how practices and patients respond to the medical home. According to a survey by the National Academy for State Health Policy, 31 states are exploring the medical home concept for their Medicaid enrollees. To build more robust experiments, CMS should join commercial and Medicaid payers in these demonstrations.

Getting on the Path to High Performance

The patient-centered medical home can play an integral role in improving quality in the health care system. But we must pursue a number of policies simultaneously. The Commonwealth Fund's Commission on a High Performance Health System has outlined five strategies for high performance:

- extending affordable health insurance to all;
- organizing care to ensure accessible, patient-centered, coordinated care;
- aligning financial incentives to enhance value and achieve savings;
- meeting and raising benchmarks for high-quality, efficient care; and
- ensuring accountable national leadership and public/private collaboration.

The Commission envisions a care system where patients have personal providers who know them, serve as advocates to help them get needed care, help coordinate care, and are accountable for the best possible health outcomes and prudent use of resources. Toward this end, the Commission recommends the following policies:

- **New Per-Patient Medical Home Payment**
  Qualified providers who elect to participate in the program would receive a per-member, per-month medical home fee, in addition to all currently covered fee-for-service payments. The amount of the per-member, per-month payment would vary depending on the severity of illness of the enrolled patient.

- **Qualifications for Medical Home Status**
  To qualify for participation in the program and for the medical home payment, primary care providers would need sufficient capacity. Qualifying factors would include:
  - providing enhanced access (e.g., 24-hour coverage, timely appointments);
  - using information technology to improve patient care (e.g., electronic health records with registries, reminders, e-prescribing, and clinical decision support);
  - offering care management and care coordination services; and
  - reporting quality and patient experience measures.

- **Incentives for Patients**
  Positive incentives would be provided to encourage patients to enroll and designate a primary care practice. Beneficiaries would receive a discount on their premiums, have their deductibles waived, or enjoy lower cost-sharing for primary care as an incentive to designate a primary care medical home.

- **Incentives for Providers**
  Physicians would also participate in the incentive program, under which savings in total health spending for enrolled groups would be shared by patients, providers, and payers. Participating providers could receive their share of savings as year-end bonuses based on their performance as judged by clinical quality and patient experience. Evaluation measures might include, for example, the proportion of patients who are up-to-date with recommended preventive services and percentage of patients with chronic conditions who are adequately controlled.

This year we have a historic opportunity to fundamentally change health care in the United States. We hope our country will seize this chance to improve access and care, and lower costs, so that the health system will work well for everyone for generations to come.