Robert Wood Johnson Foundation

Reform in Action:

Can Implementing Patient-Centered Medical Homes Improve Health Care Quality?

Insights from *Aligning Forces for Quality*

- **The 2010 federal health reform law encourages the adoption of the patient-centered medical home as part of health care delivery reform – primarily through new payment policies and as part of the implementation of accountable care organizations.**

- **Through their patient-centered medical home pilot programs, *Aligning Forces for Quality* communities across the country are demonstrating and measuring the effectiveness of the model for improving the quality of health care in America.**

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in 16 targeted communities, as well as reduce racial and ethnic disparities and provide tested local models that help propel national reform.

Overview: The patient-centered medical home (PCMH) is a model for delivering enhanced primary care that relies on a team-based approach to coordinate, track, and improve care and focuses on orienting doctors' offices more towards patients' needs. Although the model has been gathering momentum for several years and is being tested nationwide with thousands of practices currently recognized as medical homes, it is soon expected to gain even greater prominence as the Affordable Care Act (ACA) includes several provisions that encourage adoption of the medical home model, including:

- **PCMH influence in accountable care organizations (ACOs).** Although the ACO provisions do not explicitly mention medical homes, many believe primary care practices belonging to an ACO will need to adopt many of the key attributes of a PCMH to keep their patients healthy and generate savings.
- **Testing of medical homes through the Innovation Center.** The new Center for Medicare and Medicaid Innovation will test the effectiveness of medical homes – along with other payment and delivery system reforms – in bringing down costs and increasing quality.
- **Allowing Medicaid to cover PCMH services.** Medicaid programs will have the option of covering services provided to patients with certain chronic conditions by "health homes" with the federal government matching 90 percent of state funds spent on these services in the first two years.
- **Allowing private medical home plans.** Health plans are permitted to provide coverage through a PCMH plan if it meets certain criteria and coordinates with the qualified health plan.
- **Requiring insurers to report if they cover medical homes.** The U.S. Department of Health and Human Services is required to establish guidelines for payment structures that incentivize desirable patient outcomes, including through the use of a PCMH.

Even with the increased push for implementation of PCMH tenets through ACA, there is not yet a set classification of what constitutes a medical home. The closest thing to an agreed-upon definition is a set of principles jointly released by four primary care physician specialty societies in 2007 (with refinements in 2011), which focus on the many attributes that make primary care a center of quality improvement: access to care, enhanced communication between patients and their health care team, and care coordination. The principles also stress the practice of evidence-based medicine, electronic health records, and payment models that support these activities.

Tenets of a Patient-Centered Medical Home

- **Enhanced access to care** – The practice offers same-day appointments, expanded hours and new options for communication with clinicians (e.g., email).
- **Care continuity** – Each patient has an ongoing relationship with a personal physician.
- **Practice-based team care** – A team of individuals at the practice level, including non-physicians, work together to manage patients' care.
- **Comprehensive care** – The practice provides or arranges for all of a patient's health care needs (e.g., acute and chronic care, preventive screening, end of life care, etc.).
- **Coordinated care** – The practice monitors all other care received by their patients and coordinates care across all elements of the health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).
- **Population management** – The practice proactively reaches out to patients with chronic diseases to make sure symptoms are under control.
- **Patient self-management** – The practice teaches patients techniques to manage their chronic conditions on a day-to-day basis.
- **Health IT** – The practice generates and exchanges electronic health information to deliver care, measure performance, and communicate with providers and patients.
- **Evidence-based** – Evidence-based best practices and clinical decision support tools that guide decision-making.
- **Care plans** – The practice strives to help patients reach goals defined in partnership with patients and their families.
- **Patient-centered care** – Care is based on the needs and preferences of patients and their families.
- **Shared decision-making** – Patients actively participate in selecting treatment options.
- **Cultural competency** – The practice ensures information is conveyed to patients in a language and method they understand, taking cultural difference into account.
- **Quality measurement and improvement** – Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- **Patient feedback** – The practice solicits feedback from patients to ensure expectations are being met and to facilitate practice quality improvement.
- **New payment systems** – The practice receives enhanced reimbursement.

Aligning Forces for Quality Case Study: Alliances Leading the Way with PCMH Pilots

As the PCMH movement continues to grow and expand, many will look to existing pilot programs for lessons learned and key insights, such as those being implemented by the alliances in 16 communities across America participating in the Robert Wood Johnson Foundation's *Aligning Forces for Quality* (AF4Q) initiative. In many AF4Q communities, medical practices are adopting the PCMH model to improve care coordination and ultimately improving outcomes. Below is a snapshot of a few of AF4Q's on-the-ground efforts.

Puget Sound

The Puget Sound Health Alliance, together with the Washington State Health Authority, launched a 32-month pilot in May 2011 that includes seven health plans and eight medical groups with 12 separate clinic locations and a total of approximately 27,000 patients. Together, they are working to prevent as many as 8,300 potentially avoidable emergency room visits among patients in participating clinics, shooting for an estimated net savings of $3.8 million. Pre-pilot results showed that up to 47 percent of all emergency department visits were potentially avoidable among the pilot participants.

Cincinnati

The Health Collaborative in Cincinnati is in its second year of a PCMH multi-payer pilot program with 11 practices and health insurers Humana, United Healthcare, and Anthem paying them on an agreed-upon,

performance-based formula. The initial program was so well received, nine additional practices joined a co-pilot program, and a third cohort of 18 practices was formed soon afterward. Humana pays a "per member per month" incentive to any primary care practice in Greater Cincinnati that is recognized by the National Committee for Quality Assurance (NCQA) as a PCMH. To date, 20 of the 38 primary care practices involved in PCMH cohorts have applied for and received NCQA recognition. By the end of 2012, the Health Collaborative estimates that there will be 100 NCQA-recognized practices in the Greater Cincinnati region.

Maine
Since 2008, the Dirigo Health Agency's Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition have led a multi-stakeholder effort to implement and evaluate the Maine PCMH Pilot as the first step in achieving statewide implementation of a PCMH model of care. The Maine PCMH Pilot includes 26 primary care practices (22 adult and 4 pediatric) across the state that have made a commitment to practice transformation. These practices receive a "per patient per month" fee on top of traditional fee for service payments and are eligible for performance bonuses from the participating commercial payers (Anthem BCBS, Aetna, Harvard Pilgrim Health Care) and MaineCare. The ultimate goal of the PCMH effort is to sustain and revitalize primary care both to improve health outcomes and to reduce healthcare costs. To date, all 26 participating practices have received NCQA PCMH recognition.

What's Next

As we move toward the implementation of health care delivery reform, the PCMH will continue to receive increased interest from physicians, payers, consumers and patient advocacy groups. The broad-based support for the model only enhances something we already know – patient experiences with our current health care system need drastic improvement.

From the work done to date, there is supportive evidence in some components of the medical home, but it is still early in the game. Some are seeing improvement in patient access and the quality of preventative care and care processes. Others show a better work environment for clinic staff. However, as with many other ideas, it may be difficult to spread an initiative that works well in certain and select environments to the broader health care system. As the *Aligning Forces for Quality* communities continue their pilots across the country, their efforts and learnings will further enhance the overall assessment of the model and help show whether or not the country is ready for and can adapt to the medical home model.

For more information, visit www.rwjf.org/qualityequality/af4q.

Sources:

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