

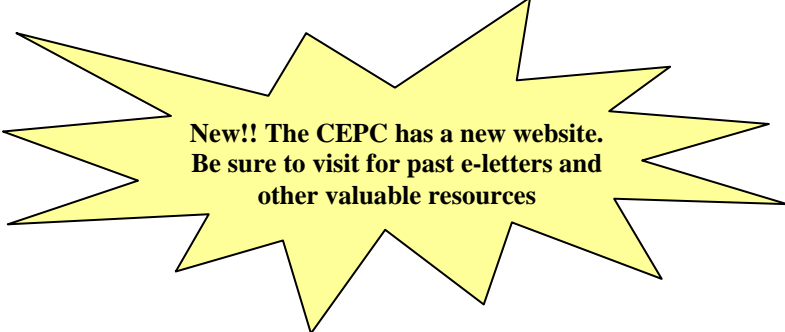


A collaboration between the Department of Family and Community Medicine, University of California, San Francisco, and The Permanente Medical Group

Primary Care e-Letter

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MEDICAL HOME

Interview with Dr. Anne Beal

Dr. Anne Beal, the Assistant Vice President for the Program on Quality of Care for Underserved Populations at the Commonwealth Fund, is the co-author of the Commonwealth Fund's June, 2007 report on Primary Care Medical Homes entitled: Closing the Divide: How Medical Homes Promote Equity in Health Care.

The report can be found at:

http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=506814

Or you can link directly to the report here:

http://www.commonwealthfund.org/usr_doc/1035_Beal_closing_divide_medical_homes.pdf?section=4039

Or link directly to the report from our site

[Anne Beal Closing Divide Medical Homes](#)

Clemens Hong (CH) interviewed Anne Beal (AB) on September 17, 2007 to discuss this report and the emerging concept of Patient-Centered Medical Homes

CH: Dr. Beal, thank you for taking time out of your schedule to speak with me. Your report on patient centered medical homes has generated a lot of buzz and we greatly appreciate the opportunity to learn more about it. Please describe the patient centered medical home?

AB: The concept has been around for 3 decades. Pediatric providers started talking about this concept a long time ago – and defined it as accessible care that coordinates care for patients and includes longitudinal relationships and shared-decision making with the provider. The pediatric model also included culturally competent care and involved understanding community needs and how patients function within their communities.

More recently, other primary care organizations have been promoting this concept including the American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American Academy of Pediatrics (AAP), and American Osteopathic Association (AOA). The organizations created a joint set of principles that moved the model out of the realm of pediatrics and family practice and into a larger primary care consciousness. It was a statement that we in primary care think that this is a promising model for delivering high quality care to our patients.

A current question is how to put it into practice. In operationalizing this concept for our study, we wanted to take a broad perspective - to be inclusive - and use measures of access, coordination of care, comprehensiveness and shared decision making. However, from an analytic perspective, we needed to narrow the definition, so we focused on measures of access and accessibility. We started with whether the patient has a regular provider, and then looked for enhanced access based on evening and weekend availability and ability to contact the provider on the phone. Next, we looked at measures of overall office function. Does it run on time? How is the practice organized? In the end, we defined the Medical Home by four indicators of timely, well organized care that provided enhanced access to providers.

- 1) Regular provider or source of care
- 2) Not difficult to contact provider over telephone
- 3) Not difficult to get care or medical advice after hours
- 4) Doctor's visits are always or often well organized and running on time

If respondents said their provider had all of these characteristics, we defined them as having indicators of a medical home and found there were significant improvements in the quality of their health care:

CH: You found in your survey that 27% of those surveyed receive care at practices that meet all 4 indicators of a medical home. Where can we find practices that meet all 4 components of being a medical home?

The media asked the same question. This model sounds ideal, but does this even exist? I am pleased to say that it does exist. As you noted one quarter of people have some type of medical home. The question was how to find them. I went to the National Initiative for Children's Healthcare Quality (NICHQ) list-serve and to the Primary Care Development Corporation here in New York and asked if there are primary care practices that function as medical homes. In this way, we identified a number of practices in a variety of settings that included public and private settings, as well as urban and rural settings.

Here is a listing of the practice sites we identified as models for this report:

http://www.commonwealthfund.org/usr_doc/closing_the_divide-medical_home_examples.pdf?section=4059

Or link directly to the models from our site

http://www.ucsf.edu/cepc/_pdf/eLetters/examples_closing_divide_with_Medical_Home.pdf

CH: Medical homes are a hot topic these days. Why are they being pushed? What are the benefits to the model?

AB: First, from a stakeholder perspective it is a concept everyone can buy into. It is a commonly held view that there is problem in healthcare and everyone—particularly patients and providers – are saying that they want to be in practices that meet the criteria for a medical home. There is also increasing evidence for cost savings associated with medical homes, so purchasers are starting to talk about it too.

For example, the ERISA Industry Committee is very interested in this concept. The ERISA Industry Committee represents the employee benefit and compensation interests of many of America's major employers. They are interested in this model and its potential benefits and have been working together with numerous organizations to promote patient-centered medical homes as a type of care that the purchasers should buy for their employees. Another example comes from the largest single purchaser of healthcare in the US, the Centers for Medicare and Medicaid Services (CMS); they are also doing a medical home demonstration project in several states across the US.

Primary care is not doing well and people know it. There is an aligning of the stars right now and universal appeal around this concept

Second, there is increasing evidence that this is a good model for care. Our report was one of the first to show the clinical benefits of the medical home model. Other studies have looked at components of the medical home – for example, care coordination and case management. These studies have demonstrated the benefits of coordinated care in terms of cost, utilization, and clinical outcome, particularly for chronic disease management. But this was the first study to look at the medical home globally and to determine the impact on several aspects of primary care—not just chronic disease management and outcomes.

The report started out as a disparities report, but instead of simply looking at it as a description of the problems in healthcare disparities and quality, we wanted to include a possible solution. We did find disparities in access to medical homes. However, we also found that in all aspects of primary care, having a patient centered medical home decreases, and often eliminates, disparities in quality. For example, when minorities have a medical home, there are no racial and ethnic differences in access to medical care. We found that three-quarters of Whites, African Americans and Hispanics with medical homes report they get the care they need, when they need it in our study. The elimination of disparities was also demonstrated in preventive care with absolutely no racial differences seen in rates of preventive care reminders based on race, ethnicity or insurance status. We also found that adults in medical homes had much better rates of good chronic disease self-management and specialty/primary care coordination.

Basically what we found was that if you provide minorities access to high quality healthcare settings, you can go a long way toward improving health care and reducing healthcare disparities.

We still have a long way to go, with only 21% of Community Health Center's and public clinics and 32% of private doctors' offices having all 4 features of a medical home. However we can promote this as a model of high performing primary care and use it as one way to eliminate healthcare disparities.

CH: So it sounds like there is a lot of good evidence that primary care medical homes improve primary care outcomes and promote health equity. However, the fact that only 27% of working age adults have a medical home is less than inspiring. How will we restructure health care delivery to establish primary care medical homes in the remaining 73% of primary care settings?

AB: If you sat in a room with 10 different doctors, you would get 10 different definitions of a medical home. This is where you start; we need standards for what is a medical home, both in principle and in practice. Then providers need assistance to determine how to implement medical home structures, policies and practices in their respective settings. When you get past the definitions and practices, the next challenge is reimbursement to support the changes needed to make this model a reality.

There's the old adage "you get what you pay for" and right now health care reimbursement does not support this model of care. One of the things that the ACP is talking about is how to finance new models of care

using mixed payment method for physicians certified as being medical home physicians. There are several options available. For example, one could apply an enhanced payment model where providers who are certified as medical homes would be paid more for their services. So instead of paying rate 'X', you could pay rate 'X' times 1.10 for providers whose practices meet criteria for a medical home. Then, you might mix in a pay for performance component where they look at rewarding providers for clinical outcomes and some of the structure and process measures that make a practice a medical home. We need a payment model to support this effort. Providers think that medical homes are a nice idea, but it costs money to provide this level of care. This is particularly true for small practice providers. About three quarters of physicians are in small practice settings, with 1-4 providers. After paying for nursing staff, support staff, insurance and rent many of these practices are working on very narrow margins. It would not be reasonable to ask them to take this on without proper incentive and re-imbusement to assistance with expanded access.

Once reimbursement is figured out, technical assistance is needed to make this model a reality. What does it mean to be a medical home? How do you change your practice structure to be a medical home? How do you increase phone availability, deal with a multi-lingual patient base, and implement the IT infrastructure to assist with patient follow up and tracking? What does it mean in contracts with sub-specialists? What if sub-specialists do not send back information about a patient, thus making the system of coordination break down? How do we develop the IT infrastructure to facilitate provider to provider coordination?

CH: You listed numerous challenges, but it sounds like the starting point is the definition. Who will determine the criteria for being designated a medical home?

AB: There are several standards that are being developed. During the release of the report, we heard about a community health center in upstate New York that used criteria developed by the National Committee for Quality assurance (NCQA) called Physician Practice Connections to become certified as a medical home. Community Care of North Carolina is a medical home and care coordination program for Medicaid patients that has been quite successful. Also, criteria are being developed for use in the CMS medical home demonstration project that may be used nationally. So there are several models that have been developed that can be used to establish criteria.

Looking at the NCQA Physician Practice Connections (PPC) program, they developed a set of IT criteria that can be used to identify medical homes. They have established an evaluation program that looks at IT capacity to follow patients in a longitudinal fashion and in a population-based matter. Capacity to use IT records to manage patient populations is also currently being used by the Medicare demonstration projects.

The Commonwealth Fund has also funded the NCQA to create criteria for patient centered medical homes that include assessments beyond their IT capacity. They are looking at culturally-competent and patient-centered components. For example, in the culturally-competent component, they are asking questions regarding their provision of language access services. Focusing on the patient-centered care component, they are looking at ease of access to same day appointments for patients, secure e-mail communication, and prompt return of patient phone calls, as well as patient access to their own medical records.

CH: What are the next steps? How are you putting the report to action?

AB: The concrete next step is to define medical home clearly and then figure out how to implement it. Then, once everyone knows what it means to do it and how to put it into place, you need to create the financial incentives to support the model. Wider adoption of the medical home would allow for more work to determine the evidence base supporting this model. You need to demonstrate that the medical home is a model that can lead to improvements in quality, patient experiences and in cost savings.

The Commonwealth Fund is working on this now. We are working on methods to promote medical homes in the safety net, showing that even the most vulnerable populations can have high quality primary care.

CH: Is there anything else you would like to tell us about primary care medical homes?

AB: E-letter readers are well positioned to call upon their professional organizations to ask for help in terms of technical support and promotion of new payment mechanisms for this model, and they should all lobby these organizations for this advocacy. We need to finance this model of care. Medicaid and Medicare are the two largest purchasers of healthcare in the US. If we can get Medicaid and Medicare to promote this model it could affect how healthcare is paid for and delivered in the rest of the healthcare sector. Physicians can help formulate the criteria and establish standards, develop methods for technical implementation of these models, and make the case for nationwide implementation of this model. All providers should take steps to help create medical homes for their patients.

Interview with Dr. Paul Grundy

Paul Grundy, MD, MPH is Director, Healthcare Technology and Strategic Initiatives for IBM. He and Martin Sepulveda MD, MPH, Vice President, Global Well-being Services & Health Benefits also at IBM, initiated the Patient-Centered Primary Care Collaborative, a coalition of large employers, primary care associations, and others to promote a strong primary care foundation for the US health care system.

Tom Bodenheimer (TB) interviewed Paul Grundy (PG) on September 24, 2007, asking about the Collaborative and the emerging concept of the Patient-Centered Medical Home.

TB: Can you tell me how the Patient-Centered Primary Care Collaborative (PCPCC) got started?

PG: Our company, IBM, with half a million employees, tried a number of quality improvement, disease management, pay for performance, and cost containment programs (we picked some low hanging fruit) but weren't convinced they solved our problems of inadequate care for our employees and rising costs. Dr. Sepulveda and I sat down 3 years ago to talk about it.

We saw that primary care was being strangled. We needed to transform primary care and reward primary care differently. We reached out to the health plans we contract with and said, we want to buy comprehensive, continuous, coordinated care for our employees, not the kind of episodic care they get now. The health plans said, we can't do that for you; it isn't available. We realized that primary care is an episodic-care hamster wheel to see as many patients as possible as quickly as possible, in order for a primary care practice to survive financially.

We decided it's time to stop hassling the doctors and to work with them. Rather than initiating programs and asking the physicians to respond, we started having a dialogue with the primary care physicians to see how we could help them and empower them to deliver the care they are trained for.

First we reached out to the 4 primary care national organizations: American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American Academy of Pediatrics (AAP) and American Osteopathic Association (AOA). They responded. The head of AAFP listened to us and said "Bless your heart." Now all 4 primary care organizations have joined us in a coalition – the PCPCC -- to help employers

provide better and more cost effective care to our employees by transforming and rescuing primary care. PCPCC is growing; it now includes employers insuring 50 million people, the 4 primary care associations, AARP, National Association of Community Health Centers, National Committee for Quality Assurance (NCQA), and others.

TB: What is the PCPCC doing to get this process going?

PG: The first step was to have all 4 primary care organizations agree on the principles of a patient-centered medical home. In February 2007, a common platform was agreed upon. [See Link to Medical Home Joint Principles below.] We are also talking to many different organizations, including the nation's largest health insurance plans, to get them on board. We would like to sponsor pilot demonstrations of the medical home to see how a true medical home can be built. And we are doing a lot of work with Congress.

Let us remember that the organization with the largest chokehold on the system is CMS, Centers for Medicare and Medicaid Services. Employers buy services for their employees based on what CMS buys for Medicare patients. It's hard for us to fix primary care for our employees without CMS fixing it for Medicare beneficiaries. So we need to educate Congress and CMS about what is needed. We meet with members of Congress and their staffs an average of twice a week. We have now had 30 meetings with people from Congress; the meetings used to be very small, but now they are getting larger as we become known. If you have large employers and doctors' organizations and AARP, they listen. We educate Congress that primary care is the foundation of the health system and we need to strengthen the foundation.

TB: What is your understanding of the patient-centered medical home?

PG: Let's start with the medical home. Central to the medical home idea is a meaningful doctor-patient relationship and trust in a setting where the patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. It is a whole person orientation including chronic care, preventive services and end of life care. The personal physician is responsible for providing all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals and members of the medical home team. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Let's move to the concept of "patient-centered." This is about meeting the needs of the patient, making access available via open schedules, extended schedules, email, telephone, etc. It is centered on quality and the patients' safety. Care is provided in a compassionate, robust partnership between physicians, patients, and the patient's family. Putting together "medical home" and "patient-centered," means the place where patients feel comfortable getting the care they need. Most employees don't have a precise concept of a medical home, but they do value the Marcus Welby family doctor. They want the family doctor but they don't want him/her to be a gatekeeper. They want to be able to consult specialists or other healers also. The medical home should be a gateway, not a gatekeeper.

The insurance plans need to help provide patients access to primary care. At IBM we try to get health plans in which the deductible and copayments do not apply, or are minimal, for primary care, especially for preventive services. Employees also want to be seen when they need to be seen. We feel that primary care practices that have same day 24/7/365 access, email their patients, have a registry so they can track all their patients, and have a true chronic care program at the point of care delivery should be financially rewarded.

TB: The medical home is a great idea, but isn't it a bit utopian given the panel size of most primary care practices? There are too many patients and not enough time to do all the wonderful things a medical home is supposed to do.

PG: Panel sizes are large in the US, but in places like Denmark, primary care physicians can handle similar panel sizes because everything is electronic and thus more efficient. They also have teams that can assist physicians to accomplish the things primary care needs to do. More technology, more teams, and more financing to allow those things to take place.

TB: Not every primary care practice conforms to the principles of the medical home agreed upon by the 4 primary care associations. Who will determine which practices should be designated as a medical home, and what are the precise criteria by which a practice can be considered a medical home or not?

PG: The primary care physician associations decide on the philosophy or general principles of the medical home, and the joint principles have done that. The next step is to take those principles, drill down, and create specific criteria. NCQA is working on this – putting together a set of standards that a practice would have to meet in order to be designated as a medical home. Someone, perhaps Medicare and the large national insurers would have to use those criteria to designate specific practices as being medical homes. Ideally, Medicare and the insurers would get together to make such designations. The criteria would need benchmarks, for example, does this practice provide appointments for patients who want to be seen the same day. Does this practice have a registry? Does it have an EMR? But we can't forget that at the core of the medical home is a practice that enables a meaningful doctor-patient relationship, and that is not easy to convert into operational standards. A meaningful relationship includes clinical outcome measures, but it's more than that. It isn't necessarily liking your physician; it is respecting your physician, feeling that the physician cares about your welfare.

TB: Let's say there are standards for designating a practice as a medical home. Does that mean that some practices will be "in" and others will be "out"? And if you're in you get better reimbursement than if you're out?

PG: It makes more sense to have a continuum. A practice starts down the road to becoming a medical home. That practice gets some financial reward, for example, for having a registry, for having same-day scheduling, for having an EMR. Then the bar is raised higher, and the practice does even more, and gets even more reward.

Another way of managing the transition to medical homes is to provide up-front funds for a practice to start down this road. If a primary care practice or clinic agrees it wants to become a medical home, Medicare or an insurer pays that practice to get a registry, implement an EMR, etc. That is what the Geisinger Health System in Pennsylvania is doing – investing in primary care practices to get an EMR and to hire more staff to help physicians get their work accomplished. Who would make this investment? It should be employers who pay more through their contracts with insurance plans. Ultimately the employer should save money as hospitalizations and inappropriate emergency department visits are reduced.

TB: You made a critique of primary care as providing mainly episodic care. Could you describe what would be your alternative vision of comprehensive care?

PG: Of course. First, we view primary care physicians as "comprehensivists" – they look at the entire human being and family. In contrast, we call specialist "partialists" – they look at only part of the human being. We need both types of physicians, but they have very different outlooks.

Second, we don't see comprehensive, non-episodic care as just being care for individual patients. Comprehensive care means care for your entire panel. Doctors should know their panel of patients: how many patients, their diagnoses, how patients are doing with their disease markers, whether they are up-to-date with their preventive care. So, medical homes need a registry. The registry tells a practice how many patients are in the panel, how many have hypertension, how many have diabetes, how many have asthma, etc., and it tells what percent of those with diabetes have HbA1c levels under 7, between 7 and 9, and over 9. Similarly with hypertension, lipids, etc. Then, knowing all these things, the practice needs to be proactive to motivate the patients in the panel to get their preventive and chronic care services and to improve their disease control. That means that to be a medical home requires a change in what physicians are responsible for, and also a change in patients, who need to partner with the medical home to protect and improve their health.

TB: As you are well aware, in the 1990s many primary care physicians were anointed as gatekeepers and HMOs gave them incentives to keep patients away from specialists and expensive diagnostic studies. Do you see primary care physicians in the medical home as gatekeepers? Is the medical home a reversion to the gatekeeper system that patients dislike?

PG: The answer is absolutely not, the medical home is not a gatekeeper system. But it's also tricky. We want to encourage patients to access their care through their medical home. But we don't force them to do so the way gatekeeper systems did. Some patients will go to specialists without going first to the primary care practice. Some will go to in-store clinics in Walgreens or CVS. We do not stop them from doing so. What will minimize that kind of fragmented care is the deepening of the relationship between the physician and the patient. If patients trust their primary care physician, and if patients can get prompt access to see their physician, those patients are less likely to seek care outside the medical home. If a patient goes directly to a cardiologist and you, the primary care physician, finds out about it later, what do you say to the patient? You say, "I'm glad you went to see the cardiologist. Would it be OK for me to speak with him/her so we can coordinate your care." It is those things that enable us to call it the patient-centered medical home.

TB: As I understand it, the American College of Physicians feels that specialists can serve as a patient's medical home and act as their personal physician. If these specialists are truly "partialists," how can they provide the comprehensive care that is the hallmark of the medical home?

PG: There are medical subspecialists "partialists" who trained first as general internists and then subspecialized. They have had training as comprehensivists. If they have retained the skills and the attitude of a comprehensivist, and want to follow the principles of what a medical home is, then they could be a medical home physician. If they never trained in the skills of comprehensive care – and there are very definite skills involved – then they should not participate as a medical home. We could say that most primary care physicians and some specialists who want to provide comprehensive care could be qualified to be "medical homists."

Abstracts and Links

"The Ideal Medical Practice Model: Improving Efficiency, Quality and the Doctor-Patient Relationship", L. Gordon Moore, MD and John H. Wasson, MD, *Family Practice Management*, September 2007, p. 20-24.

This article shares what the authors have learned to date as part of a national collaborative project designed to demonstrate the viability of the ideal medical practice model (IMP), also referred to as the ideal *micro*

practice model, a low-overhead, high technology practice. The upshot of the collaborative project: although the majority of practices are less than five years old, they are netting an average of \$123,000 per physician per year and seeing just 11 patients per day and getting great patient reviews on quality. The article is the first in a series that will focus on efficiency, access, quality and care coordination.

Davis K et al. A 2020 vision of patient-centered primary care. J Gen Intern Med 2005;20:953-957.

[Davis – Patient-Centered Home](#)

Patient-centered care has received new prominence with its inclusion by the Institute of Medicine as 1 of the 6 aims of quality. Seven attributes of patient-centered primary care are proposed here to improve this dimension of care: access to care, patient engagement in care, information systems, care coordination, integrated and comprehensive team care, patient-centered care surveys, and publicly available information. The Commonwealth Fund 2003 National Survey of Physicians and Quality of Care finds that one fourth of primary care physicians currently incorporate these various patient-centered attributes in their practices. To bring about marked improvement will require a new system of primary care payment that blends monthly patient panel fees with traditional fee-for-service payment, and new incentives for patient-centered care performance. A major effort to test this concept, develop a business case, provide technical assistance and training, and diffuse best practices is needed to transform American health care.

[Medical Home Joint Principles](#)