



PENNSYLVANIA ACADEMY OF
FAMILY PHYSICIANS FOUNDATION

The Patient-Centered Medical Home



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“The Patient-Centered Medical Home

is probably the most cost-efficient system of caring for our population. If a physician knows a family, has a good relationship with the family, defensive medicine costs go down. Getting appropriate, timely patient follow-up goes up, as the family will get after a non-compliant patient. Continuity for a couple of generations of a family helps streamline appropriate care.”

“The biggest thing is proactive care. When you come to my practice, I will remind you when you need a service. Like your car. If it needs a 20,000-mile checkup, you get a reminder. We haven’t done that well in medicine. Now, we’re doing proactive care. It’s continuous, comprehensive care over time. We become the one-stop shop. If done in a medical home, you can channel patients into whatever other needs they have.”

“Many physicians say, ‘We do these things.’ Many well-designed practices do. But PCMH provides a patient-centered focus with an analysis of the needs of the patient, along with an analysis of the practice’s performance in delivering those needs.”

The Patient-Centered Medical Home.

Your family physician – focused on you.

When you don't feel well, the last thing you want to do is wait. No one wants to wait for an appointment, wait to see a physician, wait for medical records, wait in line for medicine, wait for test results – they just want someone who understands them to make them feel better.

When it comes to your health care, part of the reason you wait is because those who can help need time to get up to speed. That's the reason for all those questions: "Let's see, you were here last for what reason?" "Have you seen any other doctors since you were here?" "What medications are you taking?" "When did you last have a physical?" "Is there anything in your family history we haven't discussed?"

Fortunately, there is an alternative. It's called the "Patient-Centered Medical Home," or PCMH.

More and more family physicians are practicing health care using the PCMH model. There are many advantages. For one, it works. It's better than what you are probably used to. The reason is simple: PCMH is not about maintaining a system. From top to bottom, PCMH is designed to be all about you, the patient.





PCMH is built on the premise that the best health care isn't the kind that only gets involved with you in times of trouble – when you're sick. Instead, a Patient-Centered Medical Home is a Family Medicine practice that makes full use of available techniques to develop and maintain an ongoing partnership between you and your physician.

“Patient-centered” is the key.

Unlike the old “gatekeeper” or managed care model, PCMH gives you the comfort of knowing you will get the care you need, when you need it. Your health is monitored and evaluated. Keeping you healthy is a priority. Yet, when you’re not well, your physician coordinates and communicates with everyone on your care team – non-physician health professionals as well as medical specialists – about your needs. Most importantly, you are not just “in the loop,” you’re at the center.



Here's how it works:



A Family Medicine practice using the PCMH model has, at its core, an ongoing partnership between each patient and his or her physician. Your personal physician heads a team that provides for your care in a personalized, coordinated manner.

When necessary, the team arranges for you to see an appropriate specialist who communicates what was done on your behalf, what should be monitored, and what (if any) follow up care would serve you best.

Your medical information is maintained securely and confidentially. However, state-of-the-art information technology provides the care team with fast access to your information when it's needed to help make you well.

The seven principles of the Patient-Centered Medical Home

The nation's four largest primary care physician associations,* representing some 333,000 physicians, have identified these seven characteristics of the PCMH:

- ① **Personal physician** – Each patient has an ongoing relationship with a personal physician, trained in first contact, continuous and comprehensive care.
- ② **Physician-directed medical practice** – The personal physician leads a team that collectively takes responsibility for the patient's ongoing care.
- ③ **Whole-person orientation** – All of the patient's health care needs are provided by the personal physician or arranged to be provided by other qualified professionals.
- ④ **Coordinated Care Care** – is coordinated and/or integrated across all elements of the healthcare system and the patient's community. Care is facilitated by registries, information technology, health information exchange and other means to assure care is received when and where needed.
- ⑤ **Quality and safety** – Hallmarks of the medical home.
- ⑥ **Enhanced Access** – Access is enhanced through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.
- ⑦ **Payment** – appropriately recognizes the added value PCMH brings to the patient.

* American Academy of Family Physicians (AAFP); American Academy of Pediatrics (AAP); American College of Physicians (ACP); American Osteopathic Association (AOA)
(add links to each organization, to the seven principles website, and to the individual principles)

The family physician's role in PCMH



Pennsylvanians like having a family physician.

96 percent of Pennsylvanians believe it is important to have a personal family physician. (80 percent “very important;” 16 percent “somewhat important.”)

95 percent said they are satisfied with their family physician's treatment and care.

(72 percent “very satisfied,” 23 percent “somewhat satisfied.”)

Family physicians are trained to provide comprehensive care. They care for all types of patients, often throughout their patients' entire lives. Family Medicine is the logical foundation for the Patient-Centered Medical Home.

Family physicians excel in helping patients prevent the onset of complex diseases. However, they are also trained to recognize and manage complicated acute and chronic diagnoses such as diabetes, heart disease, depression, obesity and cancer. Patients and their families, confronted with such illnesses, usually turn first to their family physician for help.

Family physicians are trained to seek to know the whole person, to know how family patterns and imbalances might affect the patient's well-being.

Family physicians are important because they:

- Care for a wide variety of medical problems.
- Coordinate care with other health professionals.
- Prioritize their patients' needs.
- Provide care to individuals within the context of family and community.
- Develop relationships over time and through multiple patient visits.
- Provide patient education.
- Use patient visits as opportunities for prevention and to identify problems.



PCMH - Established and growing throughout the nation.

Since 2008, the number of practices recognized as Patient-Centered Medical Homes has grown dramatically. At the beginning of 2011, The National Committee for Quality Assurance (NCQA) recognized nearly 7,700 clinicians and more than 1,500 sites throughout the nation as having met NCQA PCMH standards.

In a January 2011 press release <http://www.ncqa.org/tabid/1300/Default.aspx>, NCQA announced new, even more patient-focused standards for its PCMH Recognition Program, saying it had become its fastest-growing service. Clearly, as a model for delivery and monitoring of care, PCMH is rapidly changing the way patients, their physicians, health insurers and employers look at health care in America.

Standards for PCMH

NCQA was the first of four organizations to develop and implement review of PCMH standards for physician practices. The others, in various stages of implementation, are:

The Accreditation Association for Ambulatory Health Care (AAAHC), which accredits ambulatory health care organizations and managed care organizations. The AAAHC has a certification process for facilities seeking PCMH recognition.

The Joint Commission (TJC), which accredits and certifies care organizations nationally. The Joint Commission released a set of PCMH standards in mid-2011 that will enable accredited ambulatory care centers to apply for review to be accredited as a PCMH beginning in 2012.

URAC (originally Utilization Review Accreditation Commission) is an independent, non-profit accrediting organization that released standards in 2011 for a two-year practice achievement award. URAC will use independent auditors to review practice compliance.





Family practices are embracing PCMH

A spring 2011 survey of 341 primary care and multispecialty practices nationwide by the Medical Group Management Association (MGMA) gives a good indication of the high level of acceptance PCMH has gained in the medical community. MGMA reported that “almost 70 percent of respondents were already in the process of transforming or interested in becoming a PCMH while more than 20 percent were accredited or recognized as a PCMH by a national organization.”

MGMA's study found the majority of practices interested in becoming a PCMH were Family Medicine (nearly 36 percent), followed closely by multispecialty practices with primary and specialty care focuses (more than 30 percent) and pediatrics (more than 10 percent).

The study asked what processes described in the PCMH model are being adopted by the practices surveyed. Here are the top five most common ones:

- ① Assigning patients to a primary care clinician (more than 80 percent)
- ② Addressing patients' mental health issues or concerns and referring them to appropriate agencies (more than 70 percent)
- ③ Exchanging clinical information electronically with pharmacies (more than 70 percent)
- ④ Involving patients and family members in shared decision making (more than 70 percent)
- ⑤ Maintaining chronic disease registries (more than 45 percent)

How has PCMH worked so far?

Pennsylvania has been at the forefront of PCMH implementation. In just a few short years, there are early signs that it is a very effective model for health care delivery.

Pennsylvania's Chronic Care Initiative – Leading the Way

A unique project underway in Pennsylvania is building solid evidence of the benefits of a patient-centered approach to health care. The Pennsylvania Chronic Care Initiative (PCCI) was created in 2008 by the Pennsylvania Governor's Office of Health Care Reform to implement PCMH within medical practices that manage the treatment of chronic diseases, such as diabetes.

The Chronic Care Initiative is guided by the principles of the Chronic Care Model, which presumes that quality chronic care, rather than being reactive, should focus on avoiding long-term problems. It is a concept that nicely fits into the PCMH approach to patient care.

Now operating in seven regions, the Chronic Care Initiative encompasses some 162 practices and 658 primary care physicians and providers with data being reported on nearly 165,000 patients. Data from the project are being compiled and analyzed.

PCCI Outcomes – “Significant Improvement”

Early results from the southeastern region of the state showed significant improvement in the percentage of diabetes patients who received screenings for complications and who, as a result, were placed on therapies to treat them. There were also small but statistically significant improvements in blood pressure and cholesterol levels, especially in the highest-risk patients.

(For more information, see “Multipayer Patient-Centered Medical Home Implementation Guided by the Chronic Care Model,” an article published June 2011 in The Joint Commission Journal on Quality and Patient Safety
http://www.bailit-health.com/articles/062211_bhp_mpcmhi.pdf)



More evidence PCMH is making a difference – a national review by the Patient-Centered Primary Care Collaborative

The Washington, DC-based Patient-Centered Primary Care Collaborative, in a report published in November 2010, (http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf) pointed to Pennsylvania's Geisinger Health System Proven-Health Navigator as one of several national models for PCMH integrated delivery systems. Geisinger was successful in reducing hospital readmissions by 18 percent per year. It also had a 7 percent reduction in total costs per member per month relative to a matched control group also in the Geisinger system but not in a medical home.

The report further illustrated PCMH successes with examples from throughout the country of existing models in several categories:



Integrated delivery system PCMH models

(source: the Patient-Centered Primary Care Collaborative)

Group Health Cooperative of Puget Sound (Washington)

- \$10 per member per month (PMPM) reduction in total costs; total PMPM cost \$488 for PCMH patients vs. \$498 for control patients.
- 16 percent reduction in hospital admissions.
- 5.1 admissions per 1,000 patients per month in PCMH patients vs. 5.4 in controls.
- \$14 PMPM reduction in inpatient hospital costs relative to controls.
- 29 percent reduction in emergency department use; 27 emergency department visits per 1,000 patients per month in PCMH patients vs. 39 in controls.
- \$4 PMPM reduction in emergency department costs relative to controls.

HealthPartners Medical Group BestCare PCMH Model (Minnesota)

- 39 percent decrease in emergency department visits and 24 percent decrease in hospital admissions per enrollee between 2004 and 2009.
- Overall costs for enrollees in HealthPartners Medical Group decreased from being equal to the state average in 2004 to 92 percent of the state average in 2008, in a state with costs already well below the national average.

Intermountain Healthcare Medical Group Care Management Plus PCMH Model (Utah)

- Reduced hospitalizations in PCMH group; by year two of follow-up: 31.8 percent of PCMH patients had been hospitalized at least once vs. 34.7 percent of control patients.
- Among patients with diabetes, 30.5 percent of the PCMH group was hospitalized vs. 39.2 percent of controls.
- Net reduction in total costs was \$640 per patient per year (\$1,650 savings per year among highest risk patients).

Private payer sponsored PCMH initiatives

(source: the Patient-Centered Primary Care Collaborative)

BlueCross BlueShield of South Carolina-Palmetto Primary Care Physicians

- 10.4 percent reduction in inpatient hospital days per 1,000 enrollees per year among PCMH patients, from 542.9 to 486.5. Inpatient days 36.3 percent lower among PCMH patients than among control patients.
- 12.4 percent reduction in emergency department visits per 1,000 enrollees per month among PCMH patients, from 21.4 to 18.8. Emergency department visits per 1,000 enrollees were 32.2 percent lower among PCMH patients than among control patients.
- Total medical and pharmacy costs PMPM were 6.5 percent lower in the PCMH

BlueCross BlueShield of North Dakota-MeritCare Health System

- Hospital admissions decreased by 6 percent and emergency department visits decreased by 24 percent in the PCMH group from 2003 to 2005, while increasing by 45 percent and 3 percent, respectively, in the control group.
- In 2005, PCMH patients had 13.02 annual inpatient admissions per 100 patients, compared with 17.65 admissions per 100 patients in the control group.
- PCMH patients had 20.31 annual emergency department visits per 100 members, compared with 25.00 among control patients.
- In 2005, total costs per member per year were \$530 lower than expected in the intervention group based on historical trends. Between 2003 and 2005, total annual expenditures per PCMH patient increased from \$5,561 to \$7,433, compared with a much larger increase among control patients from \$5,868 in 2003 to \$10,108 in 2005.

Metropolitan Health Networks-Humana (Florida)

- Hospital days per 1,000 enrollees dropped by 4.6 percent in the PCMH group compared to an increase of 36 percent in the control group. Hospital admissions per 1,000 customers dropped by 3 percent, with readmissions 6 percent below Medicare benchmarks.
- Emergency room expense rose by 4.5 percent for the PCMH group compared to an increase of 17.4 percent for the control group. Diagnostic imaging expense for the PCMH group decreased by 9.8 percent compared to an increase of 10.7 percent for the control group. Pharmacy expense increases were 6.5 percent for the PCMH group versus 14.5 percent for the control group.
- Overall medical expense for the PCMH group rose by 5.2 percent compared to a 26.3 percent increase for the control group.



Medicaid sponsored PCMH initiatives

(source: the Patient-Centered Primary Care Collaborative)

Community Care of North Carolina

- Cumulative savings of \$974.5 million over six years (2003-2008).
- 40 percent decrease in hospitalizations for asthma and 16 percent lower emergency department visit rate.

Colorado Medicaid and SCHIP

- Median annual costs \$785 for PCMH children compared with \$1,000 for controls.
- In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median annual costs (\$2,275) than those not enrolled in a PCMH practice (\$3,404).



Other PCMH programs

(source: the Patient-Centered Primary Care Collaborative)

Johns Hopkins Guided Care PCMH Model

- 24 percent reduction in total hospital inpatient days, 15 percent fewer ER visits, 37 percent decrease in skilled nursing facility days.
- Annual net Medicare savings of \$75,000 per PCMH care coordinator nurse deployed in a practice.

Genesee Health Plan (Michigan)

- 50 percent decrease in emergency department visits and 15 percent fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees 26.6 percent lower than competitors.

Erie County, NY, PCMH Model

- Decreased duplication of services and tests, lowered hospitalization rates, with an estimated savings of \$1 million for every 1,000 enrollees.

Geriatric Resources for Assessment and Care of Elders (Indiana)

- Use of the emergency department significantly lower. The subgroup defined at the start of the study as having a high risk of hospitalization was found to have significantly lower hospitalization rates compared with high-risk usual care patients.

What Lies Ahead for PCMH?



Preliminary results from Pennsylvania and other areas of the country are encouraging. As data and outcomes information are compiled and analyzed, most observers anticipate widespread adoption of the Patient-Centered Medical Home – with family practices playing a central role.

One can't help being enthusiastic as early-adopting PCMH-based medical practices report a variety of improvements in patient population management. Patients enjoy expanded practice hours and improved communication with their physician.

Staff works with streamlined, state-of-the-art electronic records systems. Practices emphasize compliance with quality standards. All the while, there is careful coordination with the medical specialists and facilities that make up the patient's health care "neighborhood."

Patient-Centered and Physician-Enabled

Physicians and patients alike benefit from more efficient, effective use of physician and staff time. A family-physician-directed practice operating under the PCMH model brings into play every member of the patient's medical home team. Each member of the team is focused on helping patients within the highest levels of his or her skill training – practicing at the “top of their license.” Consequently, physicians are able to focus on doing what physicians do, and patients receive more quality time with their family doctor.

PCMH practices across the country are reporting reduced clinicians' caseloads, increased standard visit time, and significant increases in staffing levels for physician assistants, registered nurses, certified registered nurse practitioners, medical assistants, licensed practical nurses and clinical pharmacists.

Positive Results in Treatment of Chronic Obstructive Pulmonary Disease (COPD)

In October 2011, the Journal of Multidisciplinary Healthcare published an article (<http://www.dovepress.com/patient-centered-medical-home-in-chronic-obstructive-pulmonary-disease-peer-reviewed-article-JMDH>) on the findings of a 12-month study by Group Health Cooperative of Puget Sound, Washington. The results are encouraging.

PCMH patients made fewer emergency room and urgent care visits and had fewer hospitalizations for ambulatory-care-sensitive conditions (including COPD) than usual care patients. While overall costs were unchanged between the PCMH and usual care, staff burnout levels were significantly reduced, and quality indicators improved significantly more in the PCMH than in usual care.

“The Group Health experience exemplifies the importance of multidisciplinary contributions to PCMH success,” the report's authors said. They concluded, “The PCMH, like primary care, is worthy of support, evaluation and evolution as a fundamental building block for a high-value health care system.”

Support is Needed for PCMH's Continued Success

Pennsylvania, through its support for programs such as the Chronic Care Initiative (PCCI), the PA IPIP (Improving Performance in Practice) Residency Program Collaborative operated by the Pa. Academy of Family Physicians and other early initiatives, has moved to the forefront of PCMH implementation. It may be months or even years before hard data is available confirming the effectiveness of PCMH as a whole, but that hasn't prevented national observers from recognizing Pennsylvania's efforts.

The PA IPIP's Residency Program Collaborative recently was awarded a CDC (Centers for Disease Control) evaluation, one of two such awards and the only one awarded to a physician organization. Because of the program's promising work in preventing heart attack and stroke, the CDC will study the design and implementation of the collaborative, as well as its amassed data.

Encouraging Medical Practice Transitions

At the moment, there is no central source tracking state and national grant opportunities for PCMH development. There are some initiatives within Pennsylvania – funded through the Commonwealth Fund and the American Recovery and Reinvestment Act of 2009 (ARRA), for example – and a number of organizations across the country are undertaking projects under their own initiatives. For PCMH to grow and become universally adopted, more must be done to support it. Family Medicine practices must invest a tremendous amount of time and significant expense to document compliance with accreditation standards like those developed by NCQA.

A medical practice is a business. Good business practice dictates that expenses – such as the cost of qualifying to be a PCMH practice – must be offset by income and/or cost reductions. Fortunately, it appears the PCMH model and its improved efficiencies, not to mention increased patient and physician satisfaction, are building persuasive arguments for non PCMH practices to justify moving forward with the transition to a PCMH model of operation.

Another positive sign is the growing recognition by health insurance companies of the health-cost benefits of PCMH. Insurers, including Independent Blue Cross and the Geisinger Health Plan, have developed reimbursement incentives, such as shared savings and per-member-per-month flat dollar reimbursements for medical practices implementing the PCMH approach to health care.

Defining Forces

Clearly, patients like the concept. And why wouldn't they? PCMH puts them at the center of the health care system, as well they should be. Physicians like it, too. Linda Thomas, MD, is a member of the Pa. Dept. of Health's Chronic Care Commission Steering Committee, faculty for the PAFP Foundation's IPIP Residency Program Collaborative and president of the Wright Center Medical Group, where she serves as program director for the internal medicine residency program. The Wright Center recently received a federal grant from the Health Resources and Services Administration (HRSA) to operate as a teaching health center – rooted in PCMH.

"We're training doctors in new models, going out into community health centers in Wayne and Susquehanna Counties where there's a need," she says, calling her involvement with the PA Chronic Care Initiative "life changing."

"I went from having a thriving practice, focused on me, to having a practice focused on better care for the patients. At the end of the day, patients want great health care from a place they trust. It's all about that 'sacred' relationship with the healer. If you build teams that are rooted in the foundation of that relationship, they begin to feel its power.



"PAFP has now rolled out a residency transformation project. Our program is participating. PCMH is a brand new solution, a model being brought into health care financing. Evidence-based data may not exist as yet, but what we're searching for, we believe does exist – and PAFP and the Chronic Care Initiative will be the defining forces," says Dr. Thomas.

PCMH concepts

Access to care and information

- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

Practice-based services

- Comprehensive care for acute and chronic conditions
- Prevention screening and services
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Care management

- Population management
- Wellness promotion
- Disease prevention
- Patient engagement and education
- Leverage of automated technologies

Care coordination

- Community-based resources
- Collaborative relationships with hospitals, ERs, specialists, pharmacies, physical therapy, case management, behavioral health
- Care transition

Practice-based care team

- Clinician-led multidisciplinary team
- Shared mission and vision
- Effective communication
- Task designation by skill set
- NP/PA
- Patient participation
- Family involvement options
- Information sharing

Quality and safety

- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Health information technology

- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice website
- Patient portal

Practice management

- Disciplined financial management
- Cost-benefit decision making
- Revenue enhancement
- Optimized coding and billing
- Personnel/human resource management
- Facilities management
- Optimized office design/redesign
- Change management

Source:

TransforMED.com (<http://www.transformed.com/pdf/TransforMEDMedicalHomeModel-letter.pdf>)

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