Patient-Centered Medical Home Initiative

Lessons Learned from Others

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Introduction

A medical home is an approach to providing medical care that is patient or family-centered, accessible, coordinated, continuous and comprehensive (Robert Graham Center, 2007). The term "medical home" was coined in 1967 by the American Academy of Pediatrics to describe their new concept for pediatric care, particularly the care of children with special needs. The Institute of Medicine adopted this phrase in the 1990s to provide a strategy for achieving primary care goals set by the World Health Organization at Alma Ata (1978). The Future of Family Medicine: A Collaborative Project by the Family Medicine Community in 2002, declared that every American should have a medical home to meet their acute, chronic and preventative needs (Robert Graham Center, 2007).

Since 1967, various medical home and similar models have been created and tried. One initiative that has been proven to increase quality and cost-effectiveness is the chronic care model created by Dr. Wagner (Robert Graham Center, 2007). In February of 2007, the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), the American Academy of Pediatrics (AAP) and the American Osteopathic Association (AOA) together issued a statement of joint principles for a medical home. Correspondingly, the National Committee on Quality Assurance issued a set of standards to evaluate medical homes (2008).

In recent years, several medical home projects have begun across the country. As part of Access HealthColumbus' Patient-Centered Medical Home Initiative, we have gathered advice and important lessons from those who have already transformed primary care centers into medical home networks. Interviews were conducted with five leaders of demonstrations in New Hampshire, Seattle, rural North Carolina, upstate New York and the Philadelphia region. Each project was unique and as such, each supplied different lessons. From the data collected, relevant recommendations were identified and highlighted.

General Recommendations

Interviews from leaders in five different medical home projects provided the advice for these recommendations. Each project studied was unique and together the five projects encompass several types of medical home concepts. Key lessons from each project were compiled in this table of general recommendations.

Recommendations	Lessons Learned
Create a standard research design for the medical home demonstration with both control and experimental groups.	Strong quantitative evidence of health savings is difficult to find. The North Carolina project had to wait several years for data and then estimate decreased rate of growth for spending, rather than money not spent.
Do not blindly implement the National Committee for Quality Assurance (NCQA) standards for a patient-centered medical home, but rather use them as a guideline for designing a well-thought out system.	Leaders from the Boeing and CIGNA agreed that there are things that can be done in practice that are more practical than following NCQA standards.
Design a project with multiple payers, rather than a single-payer system.	Dr. Dobson from North Carolina worries that single-payer projects are creating more work and time constraints for providers who have multiple payers.
Establish routes of open communication between payers and providers.	The initial success of CIGNA's project is the increased collaboration and sharing of vital information to help coordinate care that has been developed between CIGNA and Dartmouth-Hitchcock.
Utilize the latest technology to ease the coordination of care and create interoperable medical records.	CIGNA uses their new computer modeling system to report to providers which benefits their consumers. THINC RHIO operates with the belief that electronic health records are essential for the coordination of care.
Make sure the patient-centered medical home network encompasses mental health and disease management.	Boeing has benefited from their efficient outsourcing of mental health services and disease management coaching.

Table 2. General Recommendations

Actionable Recommendations

The following three recommendations were prioritized from the general recommendations as actionable recommendations for Access HealthColumbus' Patient-Centered Medical Home Initiative.

Recommendation 1

The NCQA standards for a patient-centered medical home will serve a guideline and not a mandate for development.

(a.) Gather input from providers during design process as to which interventions will create desired clinical outcomes for patients

(b.) Reimbursing practices based solely on achieving NCQA standards is counterproductive as it encourages providers to meet written standards rather than focus on individual patient needs that can be met

Recommendation 2

Establish open communication between payers and providers.

(a.) Overcome mistrust and strained relations between providers and payers.

(b.) Share information that will help both parties track the care that patients are actually receiving and identify gaps that may exist

(c.) During the demonstration phase, encourage both entities to collaborate on changes that may enhance the quality of service and refine the medical home structure

Recommendation 3

Utilize the latest technology as a basis for coordination of care. This should include a system or systems that incorporate the following:

(a.) Electronic health records

(b.) Lab and referral tracking capabilities

(c.) Electronic prescribing

Provider input is crucial in choosing IT systems as these purchases require practices to make significant investments. Also, it may be frustrating for providers to learn new systems other than those which they had grown accustomed

Appendix: Lessons Learned From Other Medical Home Projects

CIGNA/Dartmouth-Hitchcock, New Hampshire	
Contact:	Harriet Walsh, RN, Network Clinical Performance Improvement, CIGNA
Type:	Patient-Centered Medical Home, Single-payer system
Inception:	CIGNA's national medical director Dick Salmon, a founding member of the Patient-Centered Primary Care Collaborative, approached one the Dartmouth-Hitchcock provider network. CIGNA developed a modeling system for informatics and then planned modes of communication with providers.
Overview:	This is a three-year pilot begun in June 2008, involving all CIGNA patients who receiving primary care at the Dartmouth-Hitchcock Clinic in Lebanon, N.H. Each provider office meets the NCQA standards of a medical home. Care coordinators are embedded in each office. Together, CIGNA and Dartmouth defined evidence-based measures to improve clinical outcomes and agreed upon goals for cost improvement.
Payment:	Each provider receives an upfront payment from CIGNA for using care coordination model with his or her patients. A pay for performance component will be added. Integration of a bonus model based on pay for performance is planned.
Information Technology:	CIGNA developed new patient modeling tools specifically for this PCMH project. They are able to give Dartmouth periodic reports on patient benefit utilization which can highlight gaps in care.
Evaluation:	Data from the first year of the study will be available in June of 2009.
Lessons Learned:	1. The collaborative relationship between the payer and the providers and its benefits are crucial. 2. Access to care influences quality and affordability as gives providers current information about their patients. Because of their financial input in their care, quality and affordability are critical to patients. 3. NCQA standards are not a rule; they are a guideline to help find practical solutions that will improve quality of care and the patient's affordability.
Related Links:	CIGNA's article describing the initiative: http://newsroom.cigna.com/article_display.cfm?article_id=914

Boeing Company, Seattle-Everett-Renton, Washington	
Contact:	Theresa Helle, Health Care Quality and Efficiency Initiatives Manager, Boeing Company
Type:	Ambulatory Intensive Care Unit model done on outpatient basis; single employer payer system
Inception:	Creating a chronic care model project was suggested to Boeing by Mercer Human Resources several years ago as a way for Boeing to get a better return on its investment in employee health. Puget Sound area was chosen because there were many employees there and well-organized medical offices serving large groups of employees.
Overview:	Initially, Boeing chose its highest risk employees and their dependents based on estimates from Regence Blue Shield. Then the three providers groups involved in this project conducted chart reviews and providers were encouraged to recommend patients whose chronic conditions could be improved. Each patient meets monthly with a nurse who acts as his or her care coordinator and must communicate with the patient's primary care provider. The care coordinator also sends a clinic report to Boeing each month.
Payment:	Physicians recommend patient and receive a PMPM payment from Boeing in addition to their FFS from insurers.
Information Technology:	Sites do not have innovative databases, one site has Excel database that nurse created, one recently purchased Epic, one has another database that doesn't adapt well
Evaluation:	Functional and mental health surveys were conducted as pre-tests and will also be done post pilot. Patient utilization of hospitals and ERs is already being tracked by Boeing's insurer for the region, Regence.
Lessons Learned:	1. It is important to address mental health and disease management within the medical home concept. Boeing has separate contracts for a mental health insurer and an agreement with Mayo for disease management programs for their workers. 2. The NCQA makes it too easy for providers to check the box for disease management. They think they are providing disease management, but really, they don't have the time and/or money.
Related Links:	Renaissance Health (developers of the AICU model) http://www.renhealth.net

Governor's Office of Health Care Reform, Pennsylvania	
Contact:	Phil Magistro, IT Director, Governor's Office of Health Care Reform, Pennsylvania
Type:	Mix of Chronic Care and Patient-Centered Medical Home Models, Multi-Payer system
Inception:	The Pennsylvania model moved quickly; it began with a plan for diabetes, which led to Governor Rendell's creation of Chronic Care Management, Reimbursement and Cost Reduction Commission in Sept 2007. The Commission developed a strategic plan which included demonstrations in four regions.
Overview:	Implemented in Southeast region of Pennsylvania in May with 33 practices and 200,000 patients. Rollouts in three more regions are planned by next April with a finally tally of 150-200 practices and 500,000 patients. Insurers were brought in to provide incentives for providers' participation. The Chronic Care model aspects ensure that patient teaching and community support are components in this demonstration
Payment:	Practices are reimbursed for complying with NCQA level 1 requirements. Soon meeting levels 2 and 3 components will be required
Information Technology:	Each participating practice is provided with web-based patient registry that is NCQA level 2 ready. The CCM practices do receive any provisions for EMRs. PCMH that had EMRs continued to use the registries because EMRs weren't sufficient
Evaluation:	Performance metrics from the chronic care models will be evaluated at 18 and 36 months. Data from Providers have been very enthusiastic about the model; patient surveys are currently being conducted.
Lessons Learned:	Think about how incentives are structured. Originally, the financial incentive plan for this project included payment for NCQA recognition and this made the practices focus on meeting those standards rather than transforming care. Now practices have a year to transform before they can receive a bonus for achieving NCQA standards.
Related Links:	RX for Pennsylvania: http://www.rxforpa.com

North Carolina Division of Medical Assistance (Medicaid)	
Contact:	Dr. Allen Dobson, Assistant Secretary for Health Policy and Medical Assistance, North Carolina Department of Health and Human Services
Type:	Patient-Centered Medical Home, Single-Payer System
Inception:	Efforts began in late 1999 as a way to reduce the growth of health care costs for the state's Medicaid program. The 2001 recession resulted in a mandate to expand the project.
Overview:	Initial state appropriations supported the coordination of 14 local networks encompassing 100 counties. Substantial investments by the state were made to strengthen the local infrastructure—volunteer doctor hours, free clinics, etc. The local networks must create non-profit organizations and recruit hospitals, providers, and social services. Each practice recruited becomes a medical home and is responsible for call coverage, arranging hospitalizations, working with the local network and participating in disease management. To accomplish these tasks they are assisted by case managers who work for the networks and are shared between practices.
Payment:	Providers are paid PMPM for those Medicaid patients involved in the demonstration project.
Information Technology:	This pilot has been done without robust IT. There is a program for physicians and case managers to communicate. However, physicians have trouble using one IT system for an EMR as they have multiple payers. The state would be open to using a system that the physicians choose.
Evaluation:	A study conducted by Mercer Consulting found that this program saved the state between $425-475 million in 2003 and 2004 over the traditional fee for service payment system. Also from 2000-2002, the medical home format saved the state $3.3 in care for patients with asthma and $2.1 million care of diabetes patients.
Lessons Learned :	1. Volunteer networks aren't a long-term solution to the uninsured, they are a stopgap effort to decrease cost shift and lower insurance premiums for all. A better solution for uninsured populations is needed. 2. Primary care is generally willing to cooperate as long as this system doesn't require more effort than seeing a private-paying patient. Hospitals participate because they will save money in the end. However, access to pharmaceuticals, specialty care and mental health are speed bumps in the programs. 3. Medical home movement is surprising and taken a different twist to be more about communities. Single insurers creating a medical home is counterintuitive, layering more on same infrastructure. Have several systems working to pay, not just public payers boxed in.
Related Links:	Article about this project from *Annals of Family Medicine*: http://www.annfammed.org/cgi/content/full/6/4/361

THINC RHIO, Hudson Valley, New York	
Contact:	Dr. John Blair, President and CEO, Taconic IPA
Type:	Patient-Centered Medical Home, Multiple-Payer System
Inception:	The idea to create a medical home was generated by THINC RHIO which is a community collaborative organization. Thinc Rhio had already partnered with Taconic IPA just over a year ago to create advanced medical record.
Overview:	Demonstration relies on sophisticated technology that provides individual medical homes with electronic health records, e-prescribing, provider portals, data aggregation and analytics and interoperable elements to ensure continuity of care between hospitals and providers. This project is designed as a true research study where participants sign IRB reviewed waivers and practices are put into one of the following three groups: • Control group of 500 doctors, half million patients • Second group with electronic health record utilization incentives in place, composed of 250 doctors, 250,000 patients • Third group has incentives for electronic health record utilization and medical home set-up, also 250 doctors, 250,000 patients
Payment:	Incentives are provided by several area insurers involved in the project. Incentive starts at 10,000-15,000 per doctor, but will grow according to quality as the trial progresses.
Information Technology:	Taconic IPA developed a model for this system that meets NCQA level 2 standards including: a certified systems registry, management for chronic disease, lab and referral tracking capability and advanced electronic prescribing.
Evaluation:	Both quality and utilization are the most important metrics for evaluation identified by Mr. Blair. Quality can be measured by tracking clinical outcomes. Utilization, analyzed by understanding the total utilization per patient of all services and the total cost of care, helps estimate cost per patient.
Lessons Learned :	Electronic health records maintenance has very quickly become essential to improving health care.
Related Links:	Taconic Health Information Network and Community: http://www.thincrhio.org

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Additional Research

Access HealthColumbus is compiling a knowledge-base of news articles, journal articles, and other media that address the concept of a patient-centered medical home. This compilation will contain a brief summary and a citation for each article. This deliverable will be completed in November 2008 and will provide stakeholders of our local medical home initiative with additional information on the work of others.