EXECUTIVE BRIEFING 1

By Howard Larkin

The Patient-Centered Medical Home

The major thrust of health reform, both public and private, is reducing costs while improving quality, patient safety, patient satisfaction and clinical outcomes. And the tool of choice is payment schemes that put hospitals, physicians and other providers jointly at risk for the quality and overall cost of patient care.

Broadly known as "value-based purchasing," these include penalties for high hospital readmission rates; accountable care organizations that reward hospitals and physicians if they keep total costs for a patient population below trend while meeting quality standards; bundled payments for episodes of care, such as cardiac bypass surgery, that providers divvy up among themselves; and outright capitation, where providers share a flat payment per member per month for all services. Medicare, Medicaid and most major private insurers are aggressively implementing these strategies across the country.

Succeeding with value-based payment requires that hospitals coordinate services with other providers to ensure efficiency and manage financial risk. It also means that hospitals must be managed more as cost centers rather than profit centers. Instead of filling beds, the major goal will be preventing avoidable admissions and providing services at lower-cost locations whenever possible — all while meeting specific, evidence-based quality requirements for the integrity of care processes, patient outcomes and patient satisfaction.

It's a tall order. But several health systems and state Medicaid programs have done it by adopting the patient-centered medical home model of care coordination and delivery. Some believe that all hospitals will have to adopt at least the basic tenets of the medical home model to survive under value-based payment.

Medical homes provide comprehensive primary care, including patient education, prevention and nursing support to help patients stay on treatment plans. They also facilitate shared decision-making among multiple providers, patients and their families, and coordinate services from physician specialists, labs, outpatient clinics and hospitals.

As a result, when medical home programs are implemented, physician visits, care coordination, information systems and nurse outreach costs often rise. However, these increases typically are more than offset by reducing avoidable hospital emergency visits and inpatient stays, and duplicate tests.

Strictly defined, the medical home does not require hospital leadership or even active hospital participation. Theoretically, physician groups can implement it alone. However, research suggests that in the real world, hospitals can — and perhaps must — play a major role in establishing medical homes. A two-year pilot program sponsored by the American Academy of Family Physicians found that even with extensive technical support, most primary care practices lacked the financial, management and leadership resources to transition successfully to the medical home model. IT costs and complexity, supervising outreach teams and nurses to provide 24-hour patient support, and refocusing physicians to work as part of a team were challenging issues.

Moreover, the AAFP program analysts concluded that "fixing primary care in the midst of a still-broken system will not be sufficient or possible." Indeed, the report noted that the success of integrated systems in adopting medical home components "strongly suggests that integrated models of health care, such as the accountable care organization, may be fruitful for leveraging resources for practices if they sufficiently value the contribution of primary care to a high-value health care system. New business models are needed that are appropriate to primary care and that foster integration across the whole health system."

As such, the medical home model offers hospitals an opportunity to partner with primary care physicians. It is based on a highly credible clinical concept and its cost and quality benefits are proven. Hospitals can provide the organizational and financial resources, leadership and management needed to make medical homes work.

Board leadership is required to set a medical home physician partnership

IMAGE FROM SHUTTERSTOCK

strategy, marshal the resources to support it and develop new corporate or governance structures required to execute it. This article examines the opportunity and issues for hospital trustees.

WHAT IS A PATIENT-CENTERED MEDICAL HOME?

Since its origination in the 1960s, the patient-centered medical home concept has evolved. But the term always refers to the provision of comprehensive primary care that facilitates communication and shared decision-making among the patient, primary care providers, any other providers and the patient's family. It creates a single point of access to help patients navigate the health system and receive services appropriate to their specific needs.

Over the past decade more than 100 medical home programs have been established for primary and chronic disease care. A recent analysis of seven public and private medical home models found a wide range in populations and conditions targeted, use of electronic records and payment models. But all included four critical characteristics — they used dedicated, nonphysician care managers to coordinate care; they provided extended patient access outside regular hours; they used real-time analytic tools to track and improve performance; and they used incentive payments to encourage physicians to take on care coordination duties.

Care typically is provided by a team, which may include nurses, care technicians, therapists and other clinicians led by the patient's personal physician, who provides continuous, coordinated care for the patient across the primary care team, and collaborates with specialists, hospitals, therapists, pharmacists and other providers. Care managers may work with more than one physician practice. At all times, services focus on patient needs and wants.

Several official definitions of the medical home model also exist. In 2007, principles for the patient-centered medical home were codified jointly by the AAFP, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association. A medical home must include: a personal physician; physician-directed medical practice; whole-person orientation; coordinated and/or integrated care; quality and safety improvement; enhanced patient access; and payment for care coordination and other patient services.

Based on these principles, the National Committee for Quality Assurance's Physician Practice Connections developed patient-centered medical home standards. Programs can be rec-

How Hospitals Can Promote Medical Homes

The patient-centered medical home concept does not explicitly include hospitals as a partner provider. Still, achieving the goals of coordinating care across the continuum and creating shared savings — much of which will come from controlling hospital use by improving primary care — requires collaboration among hospitals, physician groups and other providers. This makes incorporating the medical home model into an integrated system including hospitals a logical step.

Because care coordination in this model originates in the primary care setting, hospitals may find they can do the most good playing a supportive role. Hospitals can support primary care practices by:

Convening physicians: Access to a network of specialists to collaborate with primary care physicians is essential for medical homes to meet their obligation to track and coordinate specialty care, and to minimize avoidable hospital and ancillary costs. Specialists also can help create and coordinate evidence-based care protocols that more effectively involve primary care teams. Hospitals may be able to link their specialists to medical homes, which also provides a platform for implementing an accountable care organization.

Providing capital and IT infrastructure: Few primary care physicians have the IT capability to communicate seamlessly with hospitals and other providers. Hospitals can offer expertise and financing to medical homes to build a robust information exchange.

Offering staff resources and other functions: Most of the members of "health teams" called for by the Affordable Care Act already exist at hospitals, including specialists, nurses, pharmacists, care coordinators, therapists, behavioral health providers and others. Hospitals may be able to offer these services to medical homes. Hospitalists also might help to coordinate inpatient care in collaboration with the medical home. And, they may be able to organize contracted subacute, long-term and home care and lab, diagnostic and other services that medical homes may need to manage patient care.

Sharing administrative and management expertise: Physicians may not have the management or change management skills needed to transform unaffiliated practices and resources into coordinated care teams. Hospitals may be able to provide these skills, as well as leadership in articulating a coordinated system vision for the medical home.

Administering bundled payments: Hospitals may be able to use their management capacity to develop payment allocation methods for component services covered by a bundled payment.

Enabling access to contracts: Hospitals may be able to offer medical homes access to commercial contracts they might otherwise lack the clout to obtain.

Hospitals may be tempted to dedicate available resources to developing an ACO or other system integration strategy rather than use them to support primary care. But keep in mind that a medical home not only is compatible with an ACO or integrated network, it also may be essential to control costs and hospital utilization under value-based payment methods. — *H.L.*

ognized at basic, intermediate or advanced levels, but all must include 10 "must-pass" elements. These include adopting and implementing evidence-based guidelines, tracking referrals and measuring clinical performance. The Accreditation Association for Ambulatory Care also offers patient-centered medical home accreditation.

The Affordable Care Act also includes provisions for medical home services through interdisciplinary primary care teams, which may include physicians, specialists, therapists, social workers and other providers. These teams will receive capitated payments to provide services, including prevention, care management and patient education, to patients with chronic conditions.

Most of these standards are based on tools and processes that have been shown to improve quality. But strengthening the patient-provider relationship is essential. Research shows that engaging the patient in collaborative decision-making about the care plan and execution promotes both better clinical outcomes and lower overall care costs. Experience at existing medical homes shows that reducing primary care patient loads can help foster better relationships and improves performance. Less burnout by physicians and professional staff is another benefit.

This makes the patient-centered medical home an attractive strategy for integrating primary care physicians with hospital or health system operations. However, to succeed it must be approached as part of a comprehensive plan for improving population health, and system quality and efficiency. This takes time, money, leadership and expertise. Devoting sufficient resources to accomplish the transition is critical.

CURRENT MEDICAL HOME MODELS

A wide range of public and private medical home models are in place, and many more are coming. For example, 31 states are planning or implementing medical home pilots within Medicaid or the Children's Health Insurance model. Some states are transitioning Medicaid to a medical home model. Many private sector efforts exist, sponsored by payer and provider organizations. Depending on how they are structured and with whom they are affiliated, these programs may present an opportunity to collaborate, or a challenge from a competitor.

Federal Medical Home Demonstrations

Multipayer Advanced Primary Care Practice: Beginning in 2011, CMS is participating in state-sponsored Advanced Primary Care, defined as prevention, health information technology, care coordination and shared decision-making among patients and their providers. Participating providers receive enhanced payments for Medicare patients.

Department of Veterans Affairs: The VA is adopting the medical home model nationwide at its clinics, with the expectation of 80 percent participation by 2012 and full participation by 2015. Core features include team-based care, a larger role for nurses in care coordination, email and other alternative forms of contact with patients, and increased attention to behavioral health.

State Medical Home Models

Colorado Children's Healthcare Access Program: Launched in 2006 as an 18-month pilot, CCHAP provides enhanced Medicaid payments for providing preventive services, as well as support services to providers, including care coordination, a resource hotline and Medicaid billing assistance. The program has increased immunization rates, reduced emergency department use and reduced overall Medicaid costs in affiliated practices.

Community Care of North Carolina: Operating since 1998, CCNC builds community health networks organized collaboratively by hospitals, physicians, health departments and social service organizations to manage care. Enrollees are assigned to specific primary care providers, and network case managers work with physicians and hospitals to identify and manage care for high-cost patients. A study by the University of North Carolina found that the program saved roughly $3.3 million in the treatment of asthma patients between 2000 and 2002, while reducing patient hospitalizations. In 2006, the program saved the state roughly $150 million to $170 million.

Private-Sector Medical Home Programs

TransforMED National Demonstration Project: TransforMED, an AAFP subsidiary, launched the NDP in 2006 as a two-year experiment to analyze the medical home model. Thirty-six family practices received ongoing assistance from a change facilitator, consultations from economists, health IT and quality improvement training, and regular group conference calls. Evaluators found that the focus on implementing IT components took away from the patient experience. Some argue that NDP showed a need to focus on patient-centered care and proven primary care practices instead of disease management and IT improvements.

Group Health: In 2006, Group Health, which provides insurance and care to 500,000 residents in the Pacific Northwest, piloted a medical home redesign at one Seattle-area clinic. As part of the pilot, Group Health decreased the number of patients for whom each primary care doctor was responsible from 2,300 to 1,800, giving physicians more time with patients and to coordinate care. Group Health also invested $16 more per patient per year to staff the medical home pilot clinic. The model reduced physician and care team burnout; improved quality scores; and reduced emergency, specialty and avoidable hospitalization use and costs.

INTEGRATING HOSPITALS WITH MEDICAL HOMES

As with any physician or outside provider partnership, hospitals and health systems must ensure that arrangements to support medical homes comply with fraud and abuse laws, self-referral bans and, for nonprofits, inurement prohibitions. Several common organizational structures, including physician employment, joint ventures and risk-sharing contracts, meet these criteria. But first, hospitals must assess their own capabilities and

needs to determine the resources required to establish a medical home. Mary Witt of the Camden Group suggests the following questions:

- How many primary care physicians do you have, and how many are needed to provide medical home services?
- What is your current care model? How quickly do you see patients and how easy is it to access care? What kind of support will existing or new practices need to transition to a medical home? IT? Care coordination? Additional staff?
- What is the hospital's capacity to meet these needs, and at what cost? What additional infrastructure is needed to provide real-time clinical management information and care coordination?
- Is current practice leadership capable of transitioning to a medical home? If not, what additional skills and leadership resources will be needed?
- Does the payer community support medical homes? How can it be brought on board?

Often, significant investments in IT, developing and implementing evidence-based protocols, and physician practice leadership development are needed. Conversations with medical leadership, including specialists, and payers are a good place to start. All players need to agree on overall goals and objectives for the project.

Structures that can support a medical home include:

- **Physician employment.** This gives hospitals significant leverage over practice leadership and management, though maintaining a collaborative relationship with physicians is important.
- **Affiliated medical group.** An existing or new affiliated medical group can organize and harness physician leadership while creating a robust supporting infrastructure for medical homes.
- **Joint ventures.** An existing medical services organization, physician hospital organization or affiliated independent practice association may provide a vehicle for supporting physician medical homes.
- **Contracted services.** Existing or new physician groups may be contracted to provide medical home services with hospital infrastructure support.
- **ACO or managed care plan.** A structured risk-sharing arrangement can bring together multiple providers with medical homes taking the lead in care coordination.

In many cases, hospitals will need to combine these approaches. For example, an employed group coupled with a management services organization may help bring community physicians or independent practice associations toward the medical home concept. Let your community needs and system resources be your guide.

AS COMMUNITY LEADERS, BOARD MEMBERS PLAY AN IMPORTANT ROLE IN CEMENTING HOSPITAL RELATIONSHIPS WITH PHYSICIANS.

GOVERNANCE ISSUES

Value-based purchasing and the need to coordinate care through medical homes or other mechanisms will have a profound effect on hospital operations, finances and even corporate structures. They truly require a new business model for hospitals. Organizational change of this magnitude requires extensive board leadership and involvement. Major issues trustees should consider include:

Hospital mission, long-term strategy and community needs: What does the hospital need to do to continue its mission? How do medical homes fit in? How will they affect the existing medical community? Should mergers with other organizations be considered, or is the mission best served by remaining independent and building an integrated delivery network? It is trustees' responsibility to address these fundamental questions of organizational identity, strategy and governance.

Resource allocation: Making the transition to medical homes and integrated care requires enormous financial and management resources. Ensuring that such large expenditures further system strategy and protect long-term viability is a central board function.

Building community and physician partnerships: As community leaders, board members play an important role in cementing hospital relationships with physicians. Developing direct governance and management relationships with physicians can help enlist their support for developing care coordination protocols and shared-risk arrangements.

System structure and governance: Structural and governance options for partnering more closely with physicians and other providers should be considered, including involving physicians more in the health system board, ad hoc health system membership on physician group boards, or creating joint ventures with health system and physician board participation.

System leadership and accountability: Establishing organizational goals and methods of accountability, including regular reports to the board, has been shown to increase the chances of success in major culture shifts. Your active leadership is essential.

CONCLUSION

The medical home model is being embraced by public and private reform movements. While it does not explicitly include a role for hospitals, the broad scope of care coordination centered in primary care practices for which the model calls has profound implications for hospital operations and finances. Integrating medical homes into a system strategy is an attractive option to partner more closely with physicians in improving care and lowering health care costs. T

Howard Larkin *is a contributing editor at* Hospitals & Health Networks *magazine.*