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Patient-Centered Primary  
Care Collaborative

# Better to **BEST**

Value-Driving Elements of the Patient Centered Medical Home  
and Accountable Care Organizations

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MARCH 2011 ■ WASHINGTON, D.C.



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## Acknowledgments

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As the patient centered medical home expands its reach in dozens of demonstration and pilot programs nationwide, much attention has been paid to its proven worth in well-known models, measured in improved outcomes and lowered costs. But a number of questions remain as to the medical home's value as it is applied more broadly. Will a focus on the value-driving elements of the medical home—care coordination, access, new payment models that reward positive outcomes, and the meaningful use of health IT—enable its more rapid expansion and greater return on investment? And what will be the role of the medical home as accountable care organizations enter the marketplace, spurred by rewards promised in the Patient Protection and Affordable Care Act? How can health care leaders plan now to firmly establish the medical home within the greater “medical neighborhood” of the ACO?

These questions spurred a “meeting of the minds” of the leadership of health plans, business membership organizations, consumer groups, academia, federal health entities and policymakers as they met September 8, 2010 for a high-level, invitation-only discussion about transforming health care. Hosted by the Patient-Centered Primary Care Collaborative (PCPCC) and sponsored by The Commonwealth Fund and the Dartmouth Institute for Health Policy and Clinical Practice, the one-day Consensus Meeting fostered frank dialogue and robust discussion. By the end of the day, this group of accomplished and nationally recognized business, health care industry and thought leaders sat shoulder-to-shoulder in a powerful demonstration of solidarity to see the medical home and ACOs work

to support the Triple Aim: Better care for individuals; better health for the community; and reduce, or at least control, the per capita cost of care.

This document is a result of that meeting, and is intended to activate participants and the broader health care transformation audience to pursue the recommendations and action items brought forward to effect needed change. We would like to thank Katherine H. Capps and her colleagues at Health2 Resources who led the planning committee, managed and produced the meeting, invited speakers and participants and produced this document.

For their contributions at the Consensus Meeting, we would first like to thank Don Berwick, MD, head of the Centers for Medicare & Medicaid Services, for providing inspiration and a framework to reach consensus. We are also grateful to our moderator, Susan Denzter, for her gracious and informed leadership, and to Diane R. Rittenhouse, MD, M.P.H., for writing the foreword. Much gratitude is also extended to the subject matter experts who contributed the topic research papers that served as the background reading in preparation for the meeting, and to the presenters who crystallized key topic points and kicked off discussion around each topic. This was an amazing collaborative effort, and we are grateful to those who offered their time and expertise; the names of the presenters and contributors are listed at the right.

Thanks also are extended to our report sponsor, Milbank Memorial Fund, and for the contributions that made this report possible.

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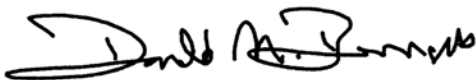
# Dear Colleagues:

As you may know, the topic of patient-centered care is dear to my heart. I believe—that, of the six IOM Aims for Improvement—safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity—“patient-centeredness” is the keystone and that, from it, the others properly devolve. To me, “patient-centered care” is care that respects each person as an individual, honoring his or her backgrounds, their families and their choices.

The Affordable Care Act calls for investments in “patient-centered care,” including medical and health homes and accountable care organizations (ACOs) so patients can receive seamless, integrated care. At the Centers for Medicare and Medicaid Services (CMS), we intend to build on the current foundation of medical and health homes and optimize their scope of services, capacity and capabilities for patients. We will be working to incorporate patient-centered medical homes with ACOs and examining various payment methods to support medical home expansion through the CMS Center for Medicare and Medicaid Innovation (Innovation Center). Along with health homes and ACOs, the Innovation Center will be tasked with evaluating the effect of the advanced primary care practice model, commonly referred to as the patient-centered medical home, in improving care, promoting health, and reducing the cost of care provided to Medicare beneficiaries served by Federally Qualified Health Centers.

One thing is for sure—we cannot do this alone. It is only through partnership with the private sector that we will accomplish our aims for integrating care. We look forward to working with you in the future.

Sincerely,



**Donald M. Berwick, MD**

*Administrator*

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# Preface

“What do you want health care to become?” was the question that opened discussion among a group of national thought leaders assembled on Sept. 8, 2010 in Washington, D.C. The answer to this question became the framework for a daylong discussion led by moderator Susan Dentzer and hosted by The Commonwealth Fund, the Patient-Centered Primary Care Collaborative and the Dartmouth Institute.

Almost eight months in planning, the journey to the September 8 meeting began during a conversation between Paul Grundy, MD, and White House health reform policy staff during a roundtable discussion on Aug. 10, 2009. The meeting showcased the evidence and outcomes<sup>1</sup> from patient-centered models of care that are transforming health care delivery. Those assembled recognized that activity around the patient centered medical home should focus not only on the Joint Principles, but on value-driving elements that would bring about long-term, sustainable changes, with primary care as a foundation. As a follow up to that meeting, the PCPCC brought in Health2 Resources, which formed a planning committee to offer a structure, outline an approach and manage a consensus meeting of engaged stakeholders. Funding to support the effort was secured from Pfizer, and Paul Grundy invited The Commonwealth Fund and Dartmouth to serve as co-sponsors.

On May 4, 2010, *Health Affairs* held a briefing at the National Press Club to introduce its special issue, “Reinventing Primary Care.” The issue was entirely devoted to the topic of advanced primary care models, making important links about value-driving elements of the medical home and the role of primary care within accountable care organizations. Recognition among thought leadership came quickly that the medical home must operate in the

greater context of ACOs—the medical home situated and functioning within a medical neighborhood. As CMS moved forward with its new charge to rapidly advance promising primary care-based models, it became clear that those supporting primary care must also move forward to create a consensus around key principles in this new context.

The desire of the group was to build a broad consensus on the foundation established by the Joint Principles of the medical home, but to bring them to action so consensus points can be used to create value for those who purchase health care and for those who deliver it within accountable care organizations.

Working from a set of clearly enunciated goals, a planning committee of thought leaders, researchers, academics and federal health agency leadership began meeting weekly for what became known as the September 8 Consensus Meeting. The desire of the group was to build a broad consensus on the foundation established by the Joint Principles of the medical home, but to bring them to action so consensus points can be used to create value for those who purchase health care and for those who deliver it within accountable care organizations. The patient centered medical home is an approach to providing comprehensive primary care that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient’s family. ACOs, value-based insurance design and multi-payer patient centered medical home demonstrations must synchronize their efforts in order to create a sustainable, long-term solution to health care cost, quality, accountability and access issues.

<sup>1</sup> These outcomes are summarized in the PCPCC document, “Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States.” <http://www.pcpcc.net/content/pcmh-outcome-evidence-quality>.

Each week during an hour-long call, the planning committee convened and discussed progress toward the meeting. A host of academic and key thought leaders spent many volunteer hours to develop background papers that illuminated each of the four value-driving topic areas the group agreed to explore in detail, within the framework of developing consensus and action steps to drive them forward within medical homes and ACOs:

1. Better care coordination
2. Better access to care (access as it relates to time, location, availability, etc.)
3. Better technology (patient portals, online access to clinicians, health IT for quality measurement)
4. Better payment models (designed to achieve accountable, high quality, patient-centered care)

Susan Dentzer, editor-in-chief of *Health Affairs*, was invited to serve as meeting moderator, and she generously volunteered her time to the effort. We also asked Dr. Donald Berwick, administrator of the Centers for Medicare & Medicaid Services, to discuss a vision for patient-centered care.

We are grateful for the significant work of Susan Dentzer and the planning committee members as they conducted research, developed the papers and presentations, briefed participants prior to the meeting, and worked to activate and engage federal agency partnerships around the meeting's goals.

And finally, we are most thankful to PCPCC President Paul Grundy, MD, whose sustaining energy has sparked all our imaginations.

The initial goal to involve 35 national thought leaders morphed to nearly 50 seated around the consensus table on September 8, with additional staff and

planning committee members in attendance very much filling the room. Interest in the meeting topics accelerated over the months of planning; it was so overwhelming that we were forced to limit the number of attendees to ensure robust discussion.

At the end of the day, we all left the September 8 Consensus Meeting sharing Don Berwick's passion for the *need to buy journeys*, recognizing that the value of the trip is entirely based on our own investment in it. The who, what, where and how statements we use to populate the coming journey is work still ahead of us. This document is a first step in drawing the roadmap we will use to navigate that journey around policy, practice and research. The broad set of consensus agreements and the specific recommendations outlined over the course of the meeting are presented here as action items so they do not sit on a shelf and become mere mementos of the trip. There are research and evaluation goals to be pursued, policies to be championed, and models to be tested and disseminated. The next leg of the journey begins today.

---

**Katherine H. Capps**

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# Introduction

The U.S. health care system is in crisis. Health care spending in the U.S. dwarfs that of other industrialized nations and threatens our fragile economy. The Institute of Medicine highlights the chasm between the quality of care we receive and the quality we should expect. Millions of Americans have no health insurance, and the rolls of the uninsured are rapidly expanding. The federal Affordable Care Act (ACA), passed in March 2010, was a herculean attempt not only to expand and reform health insurance, but also to drive quality improvements and decrease spending in health care. It is not surprising that the process that led to its passage was tumultuous. Health care is not only a massive industry consuming roughly 17 percent of our gross domestic product, but it is also deeply personal. Every person wants to be assured that they will have easy access to the care they need, when they need it, from a team of providers dedicated to maximizing their health and well-being. Meanwhile, as a society, we must find a way to increase the value of health care—better access and quality at lower costs—and this will not be accomplished by tinkering around the edges. A major overhaul is required. The health care reform debate over the past many months has been at once reasonable, rational, emotional and divisive.

Truly remarkable was the emergence from the tumult of two widely endorsed models of delivery system reform: the patient centered medical home and the accountable care organization. These models, taken together, hold promise to alter the course of the U.S. health care system. This report provides action items to propel these initiatives forward.

The patient centered medical home (PCMH) emphasizes the central role of primary care and care coordination, with the vision that every person should have the opportunity to easily access high quality primary care in a place that is familiar and knowledgeable about their health care needs and choices. The accountable care organization (ACO), also coined the “medical neighborhood,” emphasizes the urgent need to think beyond patients to

populations, providing a vision for increased accountability for performance and spending across the health care system.

Embodied in the ACO and PCMH is a shared vision for high-value health care in the U.S. The bipartisan support for inclusion in the ACA reflects a consensus that the system is broken and something can, and must, be done to fix it. The models build on decades of research and experience in a variety of practice settings and communities. Neither model dictates an ideal size or type of organizational setting, and it is not yet known exactly how the models should be operationalized in any particular setting.

But time and tide wait for no man.

Implementation is well underway, supported by a broad-based coalition of health care stakeholders from the public and private sectors. Evaluations of early initiatives demonstrate improvements in health outcomes and patient experience, with decreases in total expenditures. A new Center for Medicare & Medicaid Innovation has been established and charged with implementing ACO

**Every U.S. community can benefit from expanded access and improved care coordination spurred by health information technology and payment reforms. The question is where and how to begin.**

and PCMH demonstration projects. The Office of the National Coordinator for Health Information Technology, through the HITECH Act, has issued Meaningful Use criteria and has dedicated money to states and communities for implementation of health information technology aimed at improving population health outcomes. State governments are experimenting with the models, with an eye

toward preparing the delivery system for planned Medicaid expansions. Private health care foundations are supporting community-based demonstrations and evaluations to further our collective knowledge base. All the major national health plans have PCMH demonstrations underway, and the federal government has adopted the PCMH model within the Department of Defense and the Veterans Administration. A large federal demonstration project is targeting PCMH implementation in federally qualified health centers. Large and small physician practices across the country are looking for guidance on what these models mean for them, and where and when to begin the process of transformation.

This report presents action items for moving forward. The product of multi-disciplinary discussion and lively debate, the report delves beyond the boundaries of specific delivery system models and addresses fundamental themes essential to improving care and stemming rising costs. It presents recommendations for immediate action by stakeholders ranging from policymakers to providers and researchers.

The themes, or “value-driving elements,” that are the focus of this report are access, care coordination, health information technology and payment reform. The first two are elements of health care delivery that require urgent overhaul to maximize health outcomes at lower costs. The latter two are essential tools, without which widespread implementation of new care delivery models will not succeed. These are not the only elements of our current health care system that require attention, but progress in each of these areas is necessary to optimize value in health care. Every U.S. community can benefit from expanded access and improved care coordination spurred by health information technology and payment reforms. The question is where and how to begin.

### ***Enhanced Access and Care Coordination***

Enhancing access means increasing access to health care in ways that add value by

improving both the quality and efficiency of care delivery. Care coordination is aimed at improving the transfer of patient care information, and establishing accountability by clearly delineating who is responsible for which aspect of patient care delivery and communication across the care continuum. There is substantial evidence that enhanced access and improved care coordination result in improved health outcomes and patient satisfaction, and decreased total costs of care for a defined population.<sup>2</sup>

The presentations highlighted specific actions to enhance access that have been shown to add value, including off-hours access to primary care to decrease reliance on the emergency department; access to same-day or next-day primary care appointments; access to appointments with a personal clinician who is familiar and knowledgeable about the patient and his or her needs and preferences; expanded modes of communication between patients and providers, including advice lines, telephone appointments, electronic visits and interactive websites; and special attention to the needs of vulnerable patient populations who may face time constraints, language barriers or problems with transportation. Specific actions that define care coordination were also discussed, including regularly assessing care coordination needs; creating and updating a proactive plan of care; emphasizing communication; facilitating transitions; connecting with community resources; and aligning resources with population needs.

Enhanced access and care coordination are included in the core principles of the PCMH model, and both are essential to the success of any ACO that aims to improve health outcomes

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<sup>2</sup> Grumbach, K. and Grundy, Paul. Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States. Patient-Centered Primary Care Collaborative 2010. Accessed at <http://www.pcpc.net/content/pcmh-outcome-evidence-quality>.



for a defined population at lower total costs. This report summarizes the evidence base behind enhanced access and care coordination; describes the implementation opportunities and challenges for both PCMHs and ACOs; and presents action items to begin to answer important questions such as: “What is the role of primary care teams in enhanced access and care coordination?” and “How can incentives be aligned to drive excellence in access and care coordination across all aspects of the health care system?”

### ***Information Technology and Payment Reform***

Transformation of the U.S. health care system to deliver greater value could be stimulated by rapid advancements in two areas: widespread implementation of health information technology, and fundamental reform of the payment system for primary care services. While neither alone is sufficient, both are necessary to catalyze major delivery system reform. Electronic tools can facilitate, for example, secure messaging, referral management, shared decision support, and performance reporting, the presenters explained. Payment reforms can create financial incentives to, for example, improve care coordination across settings; implement electronic visits and expand after-hours primary care access; and minimize inappropriate use of costly interventions. This report provides a review of the challenges and opportunities for progress in health IT implementation and payment reform; their relevance to the success of PCMHs and ACOs; and action items to facilitate progress in these areas.

The PCMH and ACO models incorporate the best evidence and the best ideas to drive value in the health care system. But the forward momentum propelling these models cannot be explained by new ideas or new evidence alone. What is historic is the magnitude of the collaboration, the broad inclusion of a wide variety of stakeholders, and the diverse and dedicated leadership that spans the private and public sectors and hails from every corner of the health care sector. Much of this

success can be attributed to the hard work by leaders at the Patient-Centered Primary Care Collaborative, the Dartmouth Institute, and The Commonwealth Fund. Bravo for putting us all in a room together and challenging us to communicate across traditional boundaries, to innovate, investigate and lead—always keeping the patient at the center. Responsibility for achieving greater value in health care belongs to all of us. The action items agreed upon at the September 8 Consensus Meeting and detailed in this report provide much needed direction. The time to act is now.

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# Value Driving Elements of Health Reform

This paper summarizes a brief prepared by Melinda K. Abrams, MS, and a team at The Commonwealth Fund<sup>3</sup>

Karen Davis, Ph.D., opened the Access topic session with the observation that the goals of the Triple Aim (improved health for the population, improved care for the patient and reducing the per capita cost of care) are served by advancing access to needed health care delivery. Quoting PCPCC President Paul Grundy, MD, Davis pointed out that there is consensus on what *should* happen with patient access to care, but there is a shortfall in executing the actions needed to *make* it happen.

Seventy-three percent of Americans report having difficulty obtaining timely access to their doctor, according to a 2008 Commonwealth Fund survey. Access issues identified by those surveyed included getting an appointment with a doctor the same or next day when sick, without going to the ER; getting advice from the doctor by phone during regular office hours; and getting care on nights, weekends, or holidays without going to the ER. Health insurance access issues, while important to our nation's overall health, are not included in this discussion of access in patient centered medical home and ACO models of care delivery.

Davis offered three answers to the question of how to change problems with access:

1. "We need to get out of denial" about the U.S. health system and realize there is a gap between what we are achieving and what is possible.
2. Incentives need to change (e.g., payment reform, transparency, public recognition).
3. "We need the know-how about *how* to change."

<sup>3</sup> M. K. Abrams, G. Lawlor, S. C. Schoenbaum, K. Davis, *Creating Value: The Importance of Enhanced Access to Medical Homes and What it Means for Accountable Care Organizations*, The Commonwealth Fund, *forthcoming*.



## Creating Value: Enhanced Access to Medical Homes and Implications for ACOs

PRESENTED BY

**Karen Davis, Ph.D.,**  
*president,*  
*The Commonwealth Fund*

## PCMHs, ACOs and access

Improving patient access to primary care is central to improving the quality and efficiency of health care. It can create greater value for patients, providers and payers.

The evidence is consistently positive: When patients have access to primary care, preventive services increase, immunization rates improve, emergency department visits and inpatient hospitalizations decline and health care costs decrease.<sup>4,5</sup>

In the medical home, enhanced access to care can include a variety of attributes; Davis discussed six important ones:

### 1. Off-hours coverage

When patients cannot reach or see their primary care provider during off-hours, they tend to go to the emergency department or seek an alternate clinician, which can increase fragmentation and

compromise quality of care. An estimated 40 to 50 percent of emergency department visits are for non-urgent conditions, representing wasteful health care expenditures.<sup>6</sup> Davis relayed her own story of sitting in an ER for hours because her doctor wasn't available.

When primary care providers have arrangements for off-hours coverage, which is the expectation of a medical home, the evidence shows reductions in emergency department use, increased clinician satisfaction and improvements in patient experience.<sup>7,8,9</sup>

<sup>4</sup> J. M. Ferrante, B. A. Balasubramanian, S. V. Hudson, B. F. Crabtree. "Principles of the patient-centered medical home and preventive services delivery," *Ann Fam Med*. Mar-Apr 2010;8(2):108-16.

<sup>5</sup> B. Starfield, L. Shi, J. Macinko, "Contribution of primary care to health systems and health," *Milbank Q*, 2005;83(3):457-502.

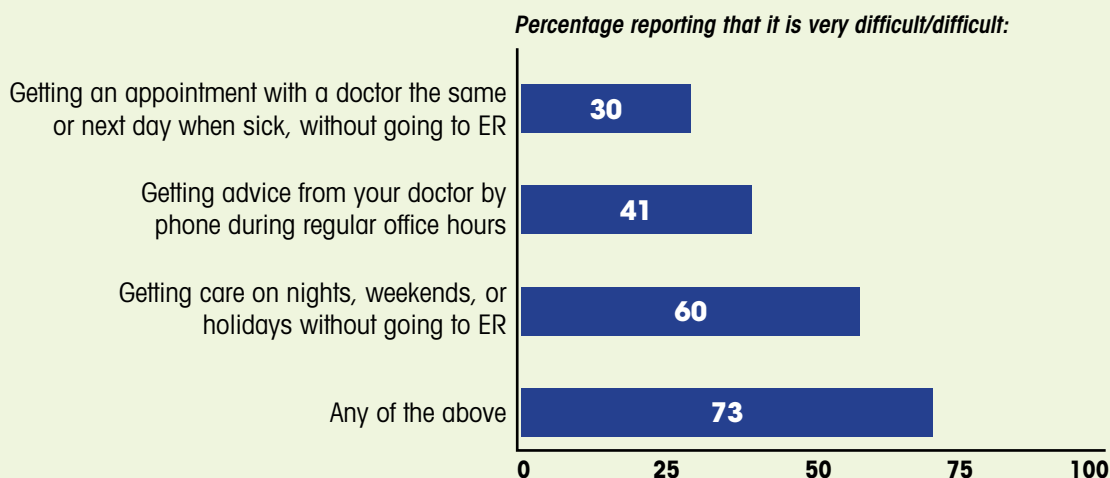
<sup>6</sup> J. M. O'Connell, J. L. Stanley, C. L. Malakar, "Satisfaction and patient outcomes of a telephone-based nurse triage service," *Manag Care*, Jul 2001;10(7):55-6, 59-60, 65.

<sup>7</sup> L. Huibers, P. Giesen, M. Wensing, R. Grol, "Out-of-hours care in western countries: assessment of different organizational models," *BMC Health Serv Res*, Jun 2009, 23;9:105.

<sup>8</sup> C. J. van Uden, R. A. Winkens, G. Wesseling, H. F. Fiolet, O.C. van Schayck, "The impact of a primary care physician cooperative on the caseload of an emergency department: the Maastricht integrated out-of-hours service," *J Gen Intern Med*, 2005 Jul;20(7):612-7.

<sup>9</sup> S. Belman, V. Chandramouli, B. D. Schmitt, S. R. Poole, T. Hegarty, A. Kempe, "An assessment of pediatric after-hours telephone care: a 1-year experience," *Arch Pediatr Adolesc Med*, Feb 2005;159(2):145-9.

## Access Problems: Three of Four Adults Have Difficulty Getting Timely Access to Their Doctor



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Off-hours coverage requires collaboration among primary care providers. ACOs may be able to take the lead, she said, “but so far, it hasn’t happened.”

## 2. Same-day or next-day access

The Commonwealth Fund’s 2009 International Health Policy Survey showed that one-fifth of Americans report waiting six or more days to obtain an appointment with their primary care physician.<sup>10</sup> Lack of timely access to primary care can not only delay diagnosis and treatment, but also signals a lack of respect for patients’ concerns and time. One strategy to reduce wait times for appointments is “advanced access” or “open access.” Research suggests this approach can decrease appointment no-shows, improve continuity of care and increase patient and clinician satisfaction.

Providing same-day or next-day appointment scheduling requires a commitment to practice redesign, and building the patient’s experience into the financial reward system, Davis said. That could involve explicitly tying bonuses or value-based purchasing to this type of access.

## 3. Appointments with a personal clinician

Ensuring the appointment is with the patient’s personal clinician is a hallmark of continuity of care and having a true medical home, but only 65 percent of U.S. adults report having an accessible personal clinician.<sup>11</sup> When patients have access to (and continuity with) their primary care provider, preventive care screening rates are higher, immunization rates are higher, emergency department and hospital visits are fewer, health care costs are lower and patient satisfaction is

<sup>10</sup> C. Schoen, “A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences,” 2009.

<sup>11</sup> The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (The Commonwealth Fund, July 2008).

## Electronic Access to Care: Evidence Shows Improvements in Quality

- Early studies suggest that electronic communication with providers and patient access to medical records over the Internet may improve doctor-patient communication and help patient self-management
- Group Health Cooperative’s “Access Initiative” included the following:
  - Secure email with MDs
  - Medical record access
  - Medication refills
  - Appointment scheduling
  - Discussion groups and health promotion information
- Results from Group Health’s Access Initiative:
  - Patients reported better access to care (e.g., time to appointment, seeing personal doctor, getting needed care)
  - Providers reported improvements in quality of service given to patients (pride in service provided)
  - Surveys did not assess patient experience with secure email communication or other Web services

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J. D. Ralston, D. P. Martin, M. L. Anderson, P. A. Fishman, D. A. Conrad, E. B. Larson, D. Grembowski, “Group health cooperative’s transformation toward patient-centered access,” *Med Care Res Rev*, 2009 Dec;66(6):703-24.

## Access to Medical Homes Reduces Racial/Ethnic Disparities

- When racial and ethnic minorities have access to a medical home, disparities in care are eliminated or substantially reduced
- Access to care must accommodate needs of vulnerable patient populations
  - For example, when limited English proficiency patients see clinicians that speak the same language, they ask more questions and report better clinical outcomes
  - When patients have professional interpreters, instead of ad hoc interpreters, they report better
    - communication (fewer errors, greater comprehension)
    - management of chronic disease
    - patient satisfaction
    - follow-up and adherence to clinical advice

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A.C. Beal et al. *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (The Commonwealth Fund, June 2007); A. C. Beal et al. “Latino access to the patient-centered medical home,” *J Gen Intern Med*, 2009 Nov;24 Suppl 3:514-20; Q. Ngo-Metzger et al. “Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use,” *J Gen Intern Med*, Nov 2007;22 Suppl 2:324-30; L. S. Karliner et al. “Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature,” *Health Services Research*, April 2007,42:2.

significantly improved.<sup>12,13,14</sup> Overall, continuity of care with a personal clinician or care team is associated with increased efficiency and better quality of care. In addition, providing better, less expensive care for patients with chronic conditions is a high-yield approach to more accountable care and the success of ACOs.

"We need to do everything we can to encourage enrollment of patients with their patient centered medical home, with their source of primary care," Davis said. But ACO "attribution," or assigning a patient to a primary care provider, isn't enough by itself: There needs to be dialogue. "Doctors and patients need to talk to each other about their mutual expectations and responsibilities."

#### **4. Ability to have clinical questions answered by telephone**

Establishing dedicated telephone appointments during office hours—when they are an appropriate substitute for in-person care—can reduce patient office visit and costs without degrading medical outcomes or patient satisfaction.

Studies show that telephone appointments have helped clinicians successfully monitor patients with depression, asthma and urinary tract infections.<sup>15</sup> A study of telephone care provided to elderly men in a clinic operated by the Veterans Health Administration showed 19 percent fewer office visits, 28 percent fewer hospital admissions and shorter hospital stays, 41 percent fewer

intensive care unit days and 28 percent less estimated total health care expenditures.<sup>16</sup>

Redesign care delivery to give physicians time in their schedules to call patients, Davis suggested, and offer a reasonable financial incentive to encourage them to do it. By introducing a structure for the activity and the reimbursement for it, we can "make the right thing to do the easy thing to do."

#### **5. Electronic access to providers and services**

Patients' access to care can be vastly improved through appropriate use of Web-based or online health care services.

Although 58 percent of U.S. adults would like to communicate with their physician by email, only 21 percent report the ability to do so.<sup>17</sup> But studies suggest that electronic communication with providers and patient access to medical records over the Internet may improve doctor-patient communication and help patient self-management.<sup>18</sup> Patients reported better access to care (e.g., time to appointment, seeing personal doctor, getting needed care), and providers reported improvements in quality of service given to patients.<sup>19</sup>

It saves time for everyone, and it lets patients and family members review the physician's recommendations at their leisure.

#### **6. Access for vulnerable patient populations**

Access to care must accommodate the needs of vulnerable patient populations, and PCMHs appear to help achieve this goal and make a difference in reducing disparities. For example, Davis pointed out that when racial and ethnic minorities have access to a medical home, disparities in care are eliminated or substantially reduced. "I was really shocked at

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<sup>12</sup> A. G. Mainous, R. J. Koopman, J. M. Gill, R. Baker, W. S. Pearson, "Relationship between continuity of care and diabetes control: evidence from the Third National Health and Nutrition Examination Survey," *Am J Public Health*, 2004;94(1):66-70.

<sup>13</sup> J. W. Saultz, W. Albedaiwi, "Interpersonal continuity of care and patient satisfaction: a critical review," *Ann Fam Med*, 2004;2(5):445-51; J. M. De Maeseneer, L. De Prins, C. Gosset, J. Heyerick, "Provider continuity in family medicine: does it make a difference for total health care costs?" *Ann Fam Med*, 2003;1(3):144-148.

<sup>14</sup> M. J. Hollander, H. Kadlec, R. Hamdi, A. Tessaro, "Increasing Value for Money in the Canadian Healthcare System: New Findings on the Contribution of Primary Care Services," *Healthcare Quarterly*, 2009;12(4):30-42.

<sup>15</sup> L.L. Berry, "Innovations in access to care: a patient-centered approach," 2003.

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<sup>16</sup> J. Wasson, C. Gaudette, F. Whaley, A. Sauvigne, P. Baribeau, H. G. Welch, "Telephone care as a substitute for routine clinic follow-up," *JAMA*, 1992;267:1788-93.

<sup>17</sup> S. K. H. How, *Public Views on U.S. Health System Organization: A Call for New Directions*, 2008.

<sup>18</sup> J. D. Ralston, D. P. Martin, M. L. Anderson, P. A. Fishman, D. A. Conrad, E. B. Larson, D. Grembowski, "Group Health Cooperative's transformation toward patient-centered access," *Med Care Res Rev*, 2009 Dec;66(6):703-24.

<sup>19</sup> *ibid*



how much the racial and ethnic disparities in access to care, quality of care, preventive care were eliminated if you were given care in a practice that met the characteristics of the patient centered medical home," she said.

For the promise of enhanced access to be realized by all patients, including the medically underserved, the strategies and methods applied will need to be tailored to meet the needs of vulnerable patient populations.

### ACOs enabling enhanced access

ACOs need a strong foundation of primary care to succeed. "The patient centered medical home is the foundation for everything that calls itself an ACO," Davis said. On that foundation, there can be different models for ACOs: "There are different ways to build the neighborhood."

Medical home care coordination and care management activities will enable the ACO to realize cost savings. PCMHs can benefit from ACO infrastructure and support (e.g., information technology, data collection and reporting, additional personnel) to help PCMHs meet their functional requirements.

ACOs can also enhance the elements of access that medical homes cannot offer on their own:

- **ACO support for off-hours coverage:** Through the infrastructure of an ACO, small practices can be networked or organized to more easily share personnel to provide after-hours care for their patients. Alternatively, hospital-based staff that is part of the ACO or under contract to it can provide telephone triage and urgent care visit services for primary care practices.
- **Facilitate online access, provide tech support:** ACOs can defray the financial and administrative investment to provide Web-based services, such as electronic physician-patient messaging, e-consultations and personal health records. ACOs can set parameters of how these systems can/should be organized as well as provide the resources to monitor

whether patients' access to care improves. ACOs can help primary care sites collect, analyze and report quality data to monitor their performance.

- **Improve access to specialty care services:** In an ACO, the complement of clinicians is held accountable for the quality of care provided to an entire population of patients. With such shared responsibility, the PCMH, specialty care providers and the ACO can work together to set up systems and agreements to ensure timely access to specialty care services.

ACOs and PCMHs "need each other," Davis said. The evidence demonstrates that when patients have enhanced access to primary care services, quality, efficiency and patient experience improve.

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## Discussion and action items

One overarching consensus item emerged early on in discussion after the initial presentation: Any discussion on the application of the elements of the PCMH—whether it be care coordination, access, use of health IT or redesign of payment models—must be framed in the context of *both* enhancing value for the patient and "bending the cost curve." Value for the patient must be informed by the consumer voice. The group consensus was that these two elements should stand as the framework for action going forward in all four discussion topic areas.

The discussion then focused on what it takes within the physician practice to provide enhanced access. Primary care capacity is a real issue; training and project management support is needed to help practices become high-access primary care sites. Investments are being made now to increase the primary care workforce, but it will take time for the pipeline to bring those newly trained professionals to the field.

The primary care workforce shortage is further complicated by differences in scope-of-practice laws across states. If each health care provider is to work at the top of his or her license to enhance access, clarity is needed regarding which practitioner is allowed to perform specific services.

### Policy Action item(s):

1. Actively support federal funding of primary care workforce training efforts across the full spectrum of primary care team members in order to ensure an adequate and well-trained primary care workforce.
2. Policies and initiatives that promote ACOs and PCMHs must incentivize innovative delivery models that ensure superb patient access to care including off-hours coverage, same-day or next-day visits, telephone and electronic access, and access to electronic medical records.

There was considerable discussion about the role of health plans and hospitals in enhancing access. These entities have resources already in place that could support physician practices, such as nurse call lines, telephonic case management and disease management programs and after-hours urgent care facilities. However, patients continue to experience problems in accessing care. Medical home and ACO demonstration projects must include collaboration between primary care practices and hospitals and/or health plans to test new ways to ensure enhanced access to primary care for all patients. These efforts will inform the future development of the medical neighborhood, which will be critical to the success of the ACO. This sort of attention to enhanced access as part of existing medical home demonstrations would require development of the “medical neighborhood” that takes in providers (including specialists, hospitals and primary care providers), payers and consumers as collaborative partners.

In particular, there is an opportunity to re-envision the role of the hospital—specifically, for hospitals to provide support of primary sites, but not through their emergency departments, which are not cost-effective delivery sites for primary care.

There was considerable discussion about the consumer voice in access and a direct challenge

to include consumers in design of demonstration projects. Incentives need to be aligned for consumers to seek care in their primary care setting, rather than turning to more costly avenues for care. Cultural differences also play a role in where and how consumers seek care.

### Demonstration Project Action Item(s):

1. Develop design principles to set up systems to enable more efficient and coordinated use of a community’s existing access resources (e.g., call-in lines, urgent care). Encourage collaboration between health plans, hospitals and primary care sites to reconfigure existing resources in order to support patients’ timely and appropriate access to their patient centered medical homes.
2. Develop a reimbursement framework of enhanced access that is both patient-centered and low-cost-in the ambulatory settings (whenever appropriate) and where it will best benefit the patient.
3. Involve consumers in design of all projects, but especially those that seek to enhance access, since it is an issue of paramount concern and interest to patients. Keep in mind Davis’ directive to “make the right thing to do the easy thing to do.”

If primary care providers are to take on new access points—telephonic and online consultation and after-hours care among them—metrics and incentives should be aligned to ensure that *better* care is being delivered, not just *more* care. There is an essential need for functional operational metrics to understand what constitutes “access.” There is further need to refine metrics to identify and monitor “appropriate” vs. “bad” access.



Once this framework is determined, there is a need to assign which caregivers constitute the access team and to define the role and function for each team member. Best practices in improved access are in the field, but the elements of access that make these practices successful need further analysis and documentation.

### **Research Action Item(s):**

1. Set up a research/learning collaborative to capture learnings on improving primary care bandwidth to expand access and to cull lessons from existing demonstrations.
2. Identify the framework for access (what needs to be done to achieve access), and then move to the roles and functions of team members (who needs to do it).
3. Develop functional operational metrics for appropriate access.

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*The original Access briefing document for the Sept. 8, 2010 Consensus Meeting can be obtained from The Commonwealth Fund and was prepared by:*

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## Creating Value: Better Care Coordination

PRESENTED BY

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Fisher and Grumbach credited **David Meyers, MD,** *director, Center for Primary Care, Prevention and Clinical Partnership at the Agency for Healthcare Research and Quality,* for playing a major role in the paper's development.

***Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.<sup>20</sup>***

The effective coordination of a patient's health care services is a key component of high-quality, efficient care. It provides value to patients, professionals and the health care system by improving the quality, appropriateness, timeliness and efficiency of decision-making and care activities, thereby affecting the experience, quality and cost of health care.

But care coordination is largely missing from the status quo. And so Kevin Grumbach, MD, began the session on Care Coordination with a stark but unsurprising assessment: The health care system is failing due to a lack of integrated, coordinated care.

Care coordination has two key operational principles, he explained: the transfer and exchange of information, and accountability. The former involves the appropriate flow of information—such as medical history, medication lists, lab results, imaging studies and patient preferences—from one participant in a patient's care to another (including the patient).

The latter, accountability, requires clarity about the responsibility of participants in a patient's care for each aspect of that care, e.g., specifying who is primarily responsible for key care delivery activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants. And it means engaging patients to develop care plans that are accountable to the patient and the care team.

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<sup>20</sup> McDonald KM, Sundaram V, Bravata DM, Lewis R, Lin N, Kraft S, McKinnon M, Paguntalan H, Owens DK. Care coordination. Vol 7 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the quality gap: A critical analysis of quality improvement strategies. Technical Review 9 (Prepared by Stanford-UCSF Evidence-Based Practice Center under contract No. 290-02-0017). AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. June 2007.

## Care coordination and primary care

Care coordination is an essential component of primary care. As conceptualized by the Institute of Medicine, primary care consists of the provision of accessible, comprehensive, longitudinal and coordinated care in the context of families and community.<sup>21</sup> More simply, it is the “four cardinal C’s”: first contact, comprehensive, continuity and coordination.

<sup>21</sup> Primary Care: America’s Health in a New Era. Washington, DC.: National Academy of Sciences; 1996.

In this conceptual model, primary care serves a critical integrating function for the diverse services a patient may need, promoting cohesive, whole-person care.

The exceptional value primary care brings to health care systems<sup>22</sup> is due in part to the care coordination provided by primary care professionals and the informed decision-making it allows them to make.

<sup>22</sup> Starfield, B., L. Shi, and J. Macinko. “Contribution of Primary Care to Health Systems and Health.” *The Milbank Quarterly*, vol. 83, no. 5, 2005, pp. 457–502.

## Value-enhancing activities

Grumbach shared six central activities within care coordination that enhance health care value that were identified in the background paper:<sup>23</sup>

- 1. Assess patient needs.** Care coordination needs are based upon a patient’s health care needs and treatment recommendations, which reflect physical, psychological and social factors. Coordination needs also are determined by the patient’s life circumstances, current health and health history, functional status, self-management knowledge and behaviors, and need for support services.
- 2. Develop and update proactive plan of care.** Establish and maintain a plan of care, jointly created and managed by the patient/family and health care team. The plan outlines the patient’s current and longstanding needs and goals for care, and identifies coordination needs and potential gaps. It clearly identifies the roles of each participant in the patient’s care. It anticipates routine needs and tracks up-to-date progress toward patient goals.
- 3. Emphasize communication.** Communication may take a number of forms (e.g., oral, electronic, face-to-face, asynchronous), and

<sup>23</sup> Fisher, Elliott; Grumbach, Kevin; Meyers, David, et al. Unpublished, September 8, 2010 Consensus Meeting Briefing Materials on Care Coordination: Issues for PCMHs and ACOs

it occurs between health care professionals and patient/family, within teams of health care professionals and across teams or settings.

- 4. Facilitate transitions.** Share information among providers and patients when the accountability for some aspect of a patient’s care is transferred between two or more health care entities. Transitions require transfer of both accountability and information.
- 5. Connect with community resources.** Provide and, if necessary, coordinate services with additional resources available in the community that help support patients’ health and wellness or meet their care goals.
- 6. Align resources with population needs.** Use a systems-level approach within the health care system to assess the needs of populations and to identify and address gaps in services. Aggregating the needs assessments conducted with individual patients is one method that should be used to identify the overall population’s needs. Care coordination and feedback from providers and patients should also be used to identify opportunities for improvement.

The integrative function—interpreting with patients the meaning of many streams of information and working with the patient to make decisions based on the fullest understanding of this information in the context of the patient’s values and preferences—is an under-recognized and under-appreciated value of primary care. Primary care thus is integral to coordination of care.

### Finding a pathway through the medical neighborhood

So where does the primary responsibility for these care coordination activities lie? Some belong in the medical home, some in the greater “medical neighborhood”—the extended health community of specialists, hospitals and other providers. (This medical neighborhood may or may not be a formally constituted accountable care organization.)

In an accompanying slide, Grumbach illustrated how the activities can be facilitated within the PCMH and greater medical “neighborhood” (in this case, an ACO).<sup>24</sup>

### Care Coordination Activities

- Determine and update care coordination needs
- Create and update a proactive plan of care
- Communicate: **PCMH**
  - Between health care professionals & patients/family
  - Within teams of health care professionals
  - Across health care teams or settings
- Facilitate transitions
- Connect with community resources
- Align resources with population needs **ACO**

<sup>24</sup> Fisher, Elliott; Grumbach, Kevin; Meyers, David, et al. Unpublished, September 8, 2010 Consensus Meeting Briefing Materials on Care Coordination: Issues for PCMHs and ACOs.

He also explained the synergistic relationship between the neighborhood and the PCMH. “There has to be a center...some glue that holds it together,” he said, referring to the need for the primary care team and the patient to serve as the nucleus of care coordination.

The patient centered medical home is the centerpiece of the medical neighborhood, but it’s only a piece. The medical home should be nested within a well-functioning medical neighborhood. That neighborhood is an accountable system that ensures everything that needs to happen does indeed happen.

Patients often need many services in addition to primary care—specialists, home care, pharmacy, workplace, and more. “It all has to fit together, and coordination is key to making this work,” Grumbach said. “There is value in having care that’s pulled together and coordinated, with the patient—and ideally the medical home—at the center.”

### Reviewing the evidence

Research appears to support this approach to care, as is detailed in the briefing document.<sup>25</sup> (For a more detailed review of the research, see the briefing document’s appendix.) Recent comprehensive efforts to strengthen primary care, including implementation of the PCMH model by Group Health Cooperative (which emphasized the core coordination functions of primary care), are demonstrating improved patient experience, improved staff experience, improved quality and reduced emergency department and hospital utilization.<sup>26</sup>

Well-designed, *targeted* care coordination interventions delivered to the right individual can improve patient, provider and payer outcomes, especially when embedded in or closely articulated with the patient centered medical home.<sup>27</sup>

<sup>25</sup> Fisher, Elliott; Grumbach, Kevin; Meyers, David, et al. Unpublished, September 8, 2010 Consensus Meeting Briefing Materials on Care Coordination: Issues for PCMHs and ACOs.

<sup>26</sup> Reid, RJ et al. The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers *Health Affairs*, 2010; (29(5):835-843.

<sup>27</sup> Ibid.

For patients with chronic conditions, particularly those at relatively high risk of poor outcomes, what appears to work best, Grumbach and Fisher suggested, is the inclusion of a designated person—often a nurse or social worker—who plays a targeted care coordination role.

Some targeted care coordination team-based models have been shown to improve health outcomes and/or reduce hospitalizations, readmissions and/or costs. In the studies reviewed, hospitalization rates dropped between 8 percent and 46 percent.<sup>28</sup> All successful models of care coordination have incorporated some—or often, more extensive—face-to-face interaction between patients and care coordinators to establish and maintain personal relationships. As reported in the background document,<sup>29</sup> almost all successful models of targeted care coordination have also incorporated some face-to-face interaction between the designated care coordinators and clinicians.

Not all care coordination programs have been shown to be effective. For example, targeted care coordination interventions have been shown to be successful for high-risk/high-need patients.<sup>30,31</sup> However, these services provided to low-risk Medicare patients have not been shown to improve the quality of care or utilization, and at times have increased overall costs.<sup>32,33</sup>

In addition, disease management services provided primarily by telephone have not been shown to be effective for Medicare beneficiaries.<sup>34</sup>

### **Bridging the PCMH, ACO perspectives: Integrated care**

Care coordination is a core activity of the patient centered medical home. Using proactive care teams, primary care medical homes are able to both coordinate care with and for patients, and use the results of effective coordination to develop appropriate care plans. For most patients in a primary care practice, the medical home team—which might contain nurses, pharmacists, physicians, medical assistants, educators, behavioralists, social workers, care coordinators and others—takes the lead in working with the patient to define care needs, and to develop and update a plan of care. The PCMH team is also responsible for ensuring communication with patients and families and across the primary care team. The PCMH's responsibility includes collaborating with professionals and teams in other settings that participate in a given patient's care, including at points of care transitions. The PCMH should also be involved in connecting with community resources and aligning those resources.

For accountable care organizations, care coordination is critical to achieving high-quality and high-value care. Building upon the care coordination efforts of PCMHs, ACOs can ensure and incentivize communication among teams of providers operating in varied settings. Additionally, ACOs can facilitate transitions and align resources to meet the clinical care and care coordination needs of populations. This work includes, but extends beyond, creating hospital discharge care coordination programs, to creating a medical neighborhood where providers share information with one another. ACOs can ensure that the appropriate transitions of accountability happen and that specialty teams are ready, willing and able to provide the requisite services. ACOs can

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<sup>28</sup> Ibid.

<sup>29</sup> Ibid.

<sup>30</sup> Peikes, Deborah, Arnold Chen, Jennifer Schore, and Randall Brown. "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials." *JAMA*. 2009, vol. 301, no. 6: 603-618.

<sup>31</sup> Peikes, Deborah, Greg Peterson, Jennifer Schore, Carol Razafindrakoto, and Randall Brown. "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 11 Randomized Trials." Draft manuscript, 2010.

<sup>32</sup> Counsell SR, Callahan CM, Clark DO, et al. Geriatric care management for low-income seniors: a randomized controlled trial. *JAMA*. 2007; 12;298(22):2623-33.

<sup>33</sup> Counsell, SR, Callahan CM, Tu W, Stump TE, Arling GW. Cost Analysis of the Geriatric Resources for Assessment and Care of Elders Care Management Intervention. *Journal of the American Geriatrics Society*. 2009; 57(8): 1420-1426.

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<sup>34</sup> Esposito, D., J. Schore, R. Brown, A. Chen, R. Shapiro, A. Bloomenthal, and L. Gaber. "Evaluation of Medicare Disease Management Programs: LifeMasters Interim Report of Findings." Princeton, NJ: Mathematica Policy Research, February 19, 2008.



also develop and support systems for care coordination for patients who reside in non-ambulatory care settings.

A concept that bridges the PCMH and ACO perspectives on care coordination is *integrated care*. “Integrated health care starts with good primary care and refers to the delivery of comprehensive health care services that are well coordinated with good communication among providers; includes informed and involved patients; and leads to high-quality, cost-effective care. At the center of integrated health care delivery is a high-performing primary care provider who can serve as a medical home for patients.”<sup>35</sup> As this definition indicates, a well-functioning primary care medical home is a necessary component of integrated care—but, alone, it is not sufficient. True integration also requires a cohesive medical neighborhood.

### Moving ahead: organizing principles

Elliott Fisher, MD, M.P.H., then identified what he and Grumbach—and the authors of the background paper<sup>36</sup>—consider the organizing principles for care coordination in PCMHs and ACOs.

First, ***care coordination is an essential function of primary care and the PCMH.*** To be successful and sustainable, PCMHs require resources that enable care coordination, including health IT and appropriately trained staff for team-based models, as well as payment models that compensate PCMHs for the effort devoted to care coordination activities that fall outside the in-person patient visit.

***All patients have care coordination needs and benefit from receiving appropriate coordination, but those with complex health needs probably have the greatest need and benefit the most.*** Effective care coordination involves the ability to meet the care coordination needs of all patients through appropriate assessment, and efficient care

coordination directs more intensive and personalized services to those with the greatest needs.

***Patients requiring complex care from multiple providers often need enhanced coordination of services***—and these services may require the support of skilled care coordinators who work closely with patients, families and clinicians. Evidence suggests that care coordinators should be supported in having face-to-face contact with patients to help build trust. Comprehensive care coordinators can be integrated into PCMH primary care teams. Coordinators who operate outside of the PCMH office should develop close and strong relationships with the PCMH team. ACOs should develop additional care coordination programs for other settings, such as hospitals.

***ACOs have the potential to improve care coordination by creating the context*** to support medical homes with a strong foundation in primary care. ACOs can provide incentives and structures that ensure coordination and cooperation across care teams and settings, and they should be able to align resources to meet population care coordination needs.

Care coordination interventions, in both PCMHs and ACOs, must be ***designed to reflect the strengths and needs of local communities.***

***Multiple models are likely to emerge, and both PCMHs and ACOs should be evaluated and the results shared widely.*** Learning from the experiences in place about what works and what doesn’t work is crucial to multiplication of successful models.

### Begin thinking about levers and metrics

Fisher then began the transition to the group discussion with an action-oriented question: “As we think about the discussion... and our work of the day, what are the levers we can identify for public payers, private payers, participants in the health care system?”

He encouraged participants to think in terms of the Triple Aim (improve the health of the population; enhance the patient experience of care; and reduce, or at least control, the per capita cost of

<sup>35</sup> Aetna Foundation, Program Areas: Specifics. 2010. (Accessed 8/2/10, at <http://www.aetna.com/about-aetna-insurance/aetna-foundation/aetna-grants/program-area-specifics.html>.)

<sup>36</sup> Fisher, Elliott; Grumbach, Kevin; Meyers, David, et al. Unpublished, September 8, 2010 Consensus Meeting Briefing Materials on Care Coordination: Issues for PCMHs and ACOs



care) as the overarching goal, and care coordination as one of the activities that will help achieve that goal.

In that context, there are multiple levers, he noted, including quality measurement levers, “to let us know if we are making a difference,” reimbursement incentives to support enhanced care coordination, and other policy levers such as regulatory issues, workforce issues and “of course, the research.”

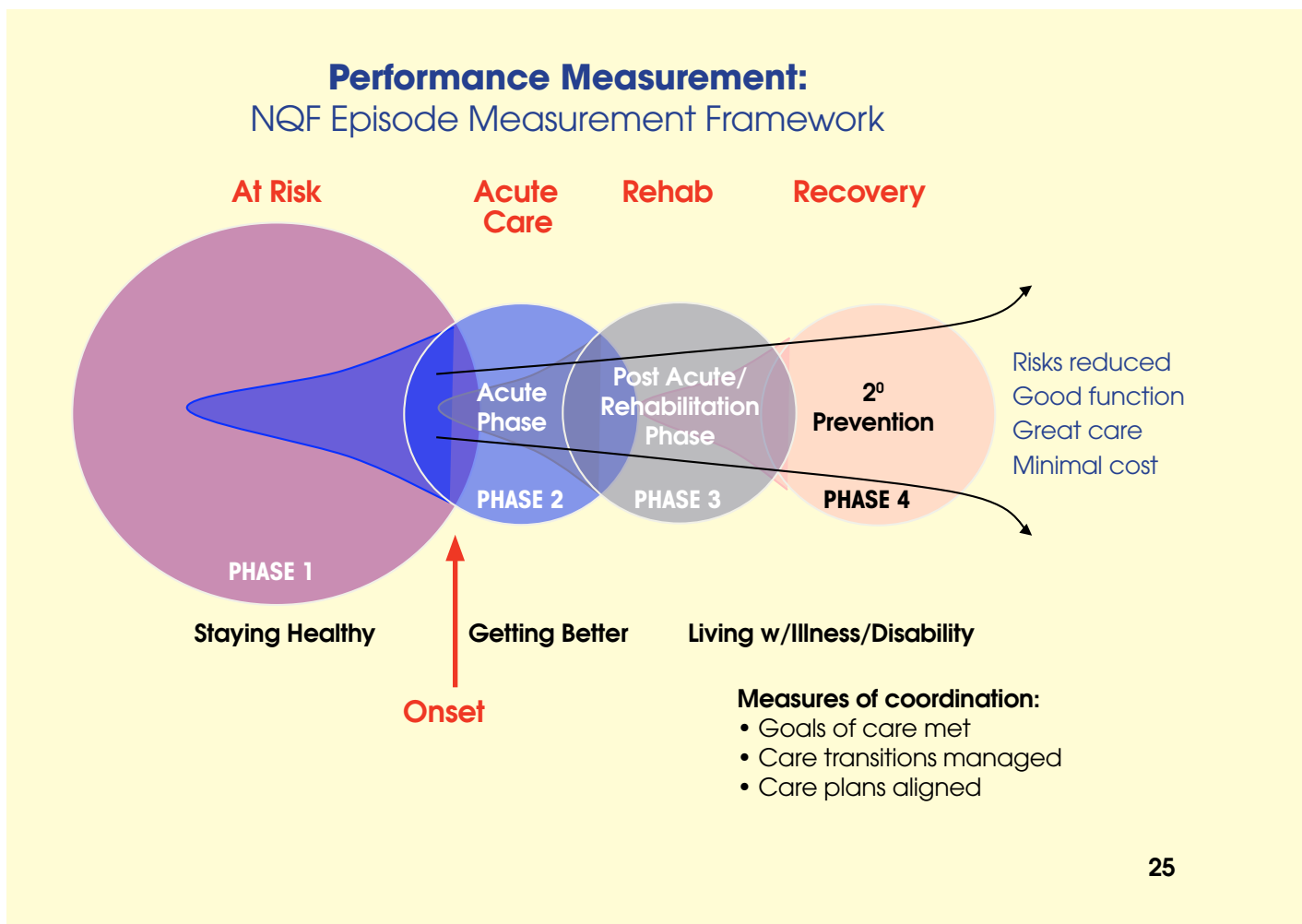
Metrics, too, are crucial, he said. Fisher briefly discussed a National Quality Forum model that looks at patients across the continuum of care needs (at-risk, acute, post acute, etc.) and shows where the system reaches in or out to the patient.

Performance measurement for care coordination is part of a larger NQF project for developing a measurement framework for evaluating efficiency, and ultimately value, across patient-focused

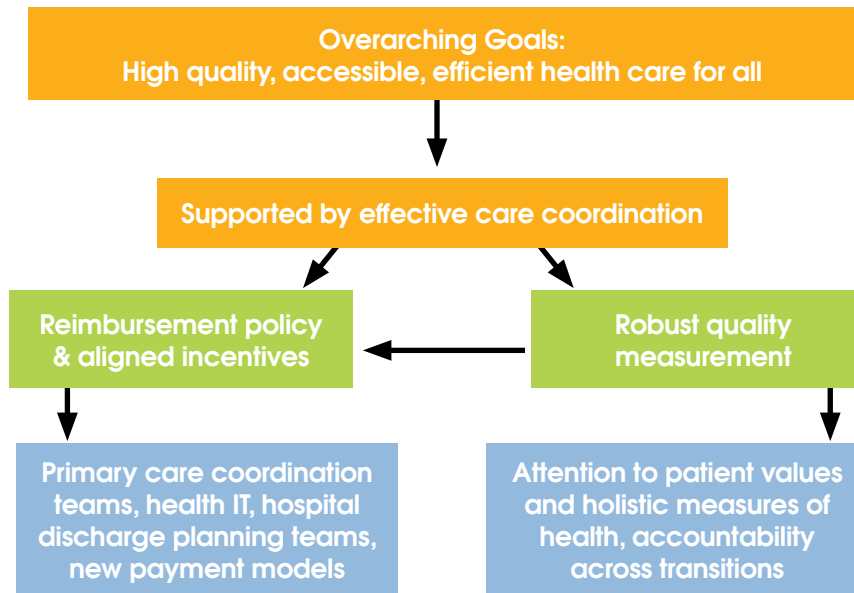
episodes of care. The framework could help identify critical gaps in quality measurement and serve “as a springboard for defining longitudinal performance metrics that include patient-level outcomes (e.g., health-related quality of life, patient experience with care), resource use (e.g., quantity of services provided to patients, true costs paid for each service), and key processes of care (e.g., shared decision making, patient engagement).”<sup>37</sup>

It could, Fisher said, “provide a foundation for understanding whether the activities of the patient centered medical home or an accountable care organization are actually achieving the promise that Don (Berwick) is asking us to step forward and focus on.”

<sup>37</sup> National Quality Forum: Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care; [http://www.qualityforum.org/Projects/Episodes\\_of\\_Care\\_Framework.aspx](http://www.qualityforum.org/Projects/Episodes_of_Care_Framework.aspx)



## Policy Levers for Better Care Coordination



### Discussion and action items

Once again, the discussion focused on the need to set a framework for discussion that emphasizes both enhanced value for the patient and the need to effectively “bend the cost curve.” Value for the patient must be informed by the consumer voice, and an eye must also be kept on cost containment.

On the policy front, discussion turned to the need to be specific about the performance metrics that will be used to measure care coordination. There is a strong need for standardization for reporting across the community, another role for policymakers in the coming months. There is also a need to include small and solo physician practices in development of care coordination standards and measurement because of the significant challenges they face in implementation.

#### Policy Action item(s):

1. Establish a measurement set that will delineate what outcomes can and should be measured for care coordination.
2. Create infrastructure that supports all physicians (including solo/small practitioners) to achieve care coordination goals.

There was considerable discussion about the difficulties with implementation of effective care coordination at the primary care practice level, which may be addressed through demonstration projects. Care coordination in most successful demonstration projects has taken the form of additional staff embedded within practices to carry out the work. For small practices, this increased capacity is a real-world challenge. Specific principles and a framework for care coordination operations for the medical home and the primary care-based ACO should be designed, perhaps in a learning cooperative environment where findings can be collected and disseminated broadly.

There was also significant discussion around the role of the patient in care coordination, especially within the ACO structure. If patients are assigned providers under an ACO model, we may see consumer pushback as they perceive their choices are being made for them, rather than in collaboration with them. There is a need for “first principles” that reinforce the power of the primary care/patient relationship, so patients clearly understand that their health is an asset worth supporting collaboratively.

### **Demonstration Project Action Item(s):**

1. Develop design principles to operationalize care coordination, at the next level of detail down from the consensus paper.
2. Set explicit objectives for care coordination around the principles of Institute for Health Care Improvement's Triple Aim: Better care for individuals, better health for the community and reduce, or at least control, the per capita cost of care.
3. Involve consumers in design of new care models to include consent around care management.

There was also discussion about defining what constitutes successful care coordination within the PCMH and ACO. Best practices in care coordination and case management are still in early stages of development. The role of the hospitalist in the care continuum has not been thoroughly explored, and implications for coordination of end-of-life care were not addressed in the paper. Improvement in these areas offers the potential not only for improved quality, but also for potential cost savings.

### **Research Action Item(s):**

1. Set up a research/learning collaborative to disseminate data and research from pilots.

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The original Care Coordination briefing document for the Sept. 8, 2010 Consensus Meeting is available at [www.pcmh.ahrq.gov](http://www.pcmh.ahrq.gov) and was prepared by:

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## Creating Value: Better Health IT

PRESENTED BY

**David K. Nace, MD,**  
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McKesson Corporation and member of  
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Co-authors were **John E. Jenrette, MD,** *chief executive and  
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To drive widespread adoption of the patient centered medical home (PMCH) model and to support the accountable care organization (ACO), a foundational shift in health IT *must occur*, said David Nace, MD. Today's technology was not developed to support role-based access to information for team care. Instead, it was developed to support a traditional fee-for-service, visit-based reimbursement model, with the focus on documentation requirements to support a billing function.

That technology is inadequate to the transformational activities required for new health care models. Anchoring the electronic health record (EHR) in the traditional visit-based care delivery model limits the potential of the medical home to generate paradigm-shifting care delivery transformation and the positive outcomes it promises.<sup>38</sup>

Health IT, Nace said, is *not* a transformer in and of itself. Rather, it is an enabler—it *enables* access, care coordination and payment reform. The use of IT on its own will not drive major transformative change in practice or outcomes. Instead, health IT must drive and support workflow, process and relationship changes; those changes will support the meaningful, and necessary, changes to practices and systems.

Health IT requires new functional capabilities, such as multiple team member access and permissions, care management workflow support, integrated personal health records, registry functionalities, clinical decision support, measurement of quality and efficiency, and robust reporting.

An interconnected health IT network with key capabilities that optimize engagement, coordinate care and support the implementation of value-based payments is required to support PCMH (practice) and ACO (enterprise) practice transformation.

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<sup>38</sup> Zayas-Caban T, Finkelstein J, Kothari, P, Quinn, M, Nace, D. Cyberinfrastructure Patient-Centered Medical Home: Current and Future Landscape—in press.

Two challenge propositions overarch the current health IT environment to support such transformation:

- Critical gaps exist in the health IT functionality currently available on the market.
- Critical gaps remain in the current HITECH Meaningful Use criteria that will need to be filled in order to support timely and effective transformation.

### Health IT-supported transformations

Several examples currently exist that detail the essential role of health IT in supporting a transformed PCMH-based practice in the context of an existing enterprise health system or ACO.

The Geisinger Health System model heavily leverages technological innovation while simultaneously realigning and incentivizing provider and care delivery reform.<sup>39,40</sup> Group Health Cooperative demonstrated that the adoption of an advanced commercial EHR did not, in and of itself, support improvements in staff morale, productivity, quality outcomes or improvements in system efficiencies. Once its care delivery model was aligned with a PCMH model, however, health IT became a critical enabler of strong results across each of these dimensions.<sup>41,42</sup>

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<sup>39</sup> Gilfillan RJ, Tomcavage J, Rosenthal MB, Davis DE, Graham J, Roy JA, Pierdon SB, Bloom FJ Jr, et al. Value and the medical home: effects of transformed primary care. *Am J Manag Care*. 2010 Aug;16(8):607-14.

<sup>40</sup> 15. Dorr DA, Wilcox AB, Bruncker CP, et al. The effect of technology-supported, multidisease care management on the mortality and hospitalization of seniors. *J Am Geriatr Soc*. 2008;56(12):2195-202. Findings updated for presentation at White House roundtable on Advanced Models of Primary Care, August 10, 2009.

<sup>41</sup> Reid RJ, Fishman PA, Yu O, Ross TR, Tufano JT, Soman MP, Larson EB. Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation. *American Journal of Managed Care*, Published Online: September 1, 2009; 15(9): e-71-87.

<sup>42</sup> Reid RJ, Coleman K, Johnson EA, Fishman PA, Hsu, C., Soman MP, Trescott, CE, Larson EB. The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers; *Health Affairs*, May 2010, 29:5, pp. 835-843.

Kaiser Permanente's experience also demonstrates the value of investing in strong health IT concurrent with changes in care process design and the introduction of a performance-based, patient-centered culture; the result has been higher quality and lower clinical costs with effective care management.<sup>43,44,45</sup>

In each example, health IT *enabled* the other value-driving activities under consideration at the meeting: access, care coordination and payment reform, Nace said. He then offered a more granular view of the enabling value of health IT vis-à-vis each of the other primary value drivers presented to transform PCMH and ACO practices.

Nace made the point clear: "None of this happens if you don't pay for it." Like health IT, payment reform activities enable and support the care coordination and access activities that can transform care delivery.

**"None of this happens if you don't pay for it." – DAVID NACE, MD**

### Recommendations for moving forward

"Our conclusions are twofold," Nace said. "Health information technology has huge potential to improve primary care," but health IT, as it exists today, will have to address multiple barriers. To overcome those barriers, he offered several specific recommendations:

**Recommendation 1:** Ensure health IT impact and innovation are closely examined during

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<sup>43</sup> Zhou Y., Kanter MH, Wang JJ, and Garrido T. Improved Quality at Kaiser Permanente Through E-Mail Between Physicians And Patients, *Health Affairs*, July 2010. pp. 1370-1375.

<sup>44</sup> Okie S. "Innovation in Primary Care—Staying One Step Ahead of Burnout," *N Engl J Med*, Nov. 2008 359(22):2305–9.

<sup>45</sup> Kaiser Permanente: Bridging the Quality Divide with Integrated Practice, Group Accountability, and Health Information Technology; Douglas McCarthy, Kimberly Mueller, and Jennifer Wrenn, Issues Research, Inc. Case Study: Organized Health Care Delivery System; The Commonwealth Fund, June 2009.



the upcoming demonstrations and pilots by **establishing a uniform set of criteria for consistent and aligned PCMH and ACO performance metrics.**

“Going forward...everything needs to be moving in the same direction,” he said. Careful analysis and clarification on how specific health IT capabilities affect the PCMH delivery model, as a foundational aspect of the ACO, will make it easier for vendors to tailor their products to meet the needs of both primary care practices and overall networks or systems that assume population accountability.

**Recommendation 2:** Ensure health IT impact and innovation are closely examined during the upcoming demonstrations and pilots by **establishing a uniform set of baseline HIT criteria. These baseline HIT criteria will ensure that the PCMH and ACO pilot metrics are consistently derived and aligned across studies.**\*

**Recommendation 3: Leverage the Meaningful Use criteria to support PCMH/ACO transformation.** Significant gaps need to be addressed in order to align and support care delivery transformation in

### SUPPORT FOR ACCESS THROUGH:

<b>Secure messaging</b>	Secure messaging allows for a confidential two-way exchange of information between patient and provider. These tools provide a platform for care coordination, enable after-hours advice and care, help close the “collaboration gap” between doctors and their patients, and provide a rapid communication platform for referrals and consultation.
<b>Telephonic/cellular</b>	Enhanced health IT capabilities can interact with current networks and communication technologies to allow preferred methods of communication to be leveraged among the patient, physician, members of the care team and family and other caregivers.
<b>Same-day/convenience scheduling</b>	Online scheduling technologies better support open-access, off-hours models and group scheduling; they drive overall patient empowerment by offering convenient access and timely feedback.
<b>Access to team members</b>	Advanced health IT platforms can connect multiple providers and family/caregivers with patients on a single platform to communicate across all disciplines and among all members involved in the patient’s care.
<b>Remote monitoring</b>	For effective and safe transitions of care and routine maintenance of high-risk chronic disease populations, health IT can support remote monitoring and automated results integration through the use of in-home, simple-to-use, wireless medical devices.
<b>PHR/EHR access</b>	Health IT can enable access to medical records, patient preferences, laboratory data, personalized medical education information and online care assessment tools that can contribute to a person meeting his or her health care goals; it can also support development of a trusting relationship between providers and patients.
<b>Access to care plans</b>	Internet-based technologies allow patients to view and share in the development of a care plan.
<b>Patient/family feedback to practices</b>	Surveys can provide feedback to facilitate practice redesign and quality improvement initiatives.
<b>Patient engagement tools</b>	Health IT can enable tools that emphasize the patient as a participant in care activities such as self-management, problem solving, planning, etc.

\*Topic leads requested that this second recommendation be added after the meeting.



the PCMH.<sup>46</sup> Most notably, the core principle of comprehensive, team-based and collaborative care among staff within a practice is not explicitly covered by the currently established Meaningful

Use concept.<sup>47</sup> To that end, he proposed the following:

- Perform a detailed gap analysis examining the differences between Meaningful Use criteria (current and proposed) and the functional health IT requirements for the PCMH.

<sup>46</sup> Moreno L, Peikes D, Krilla A. Necessary But Not Sufficient: The HITECH Act and Health Information Technology's Potential to Build Medical Homes. (Prepared by Mathematica Policy Research under Contract No. HHS290200900019I T02.) AHRQ Publication No. 10-0080-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010.

<sup>47</sup> O'Malley AS, Grossman, JM, Cohen GR, Kemper NM, Hoangmai PH. Are Electronic Medical Records Helpful for Care Coordination? Experiences of Physician Practices, J. Gen. Intern. Medicine, Dec. 29, 2009 DOI: Vol 25, No 3, 177-185, 10.1007/s11606-009-1195-2.

## SUPPORT FOR CARE COORDINATION THROUGH:

<b>Reminders/ outreach</b>	Advanced EHRs and other integrated applications can provide preventive and chronic care reminders based on patients' health conditions and status, and generate outreach reminders or personalized engagement.
<b>Team coordination</b>	Health IT functionality can connect patients, clinicians, social workers, case managers, paraprofessionals, family member caregivers and other key stakeholders, and support the identification of patient-specific care needs, resources, automated messaging, lists, etc., in order to deliver care in a coordinated manner.
<b>Referral management</b>	Tracking of referrals, including follow-up and full consideration of consultative results, can be leveraged as a "virtual" or electronic consultation in support of the overall care plan.
<b>Diagnostic results management</b>	Health IT enables clinicians and patients to receive results and evidence-based best practice recommendations on test results.
<b>Care transitions management</b>	Technology platforms can facilitate efforts to contact, coordinate and manage transitions for patients leaving hospitals or other health care settings.
<b>PHR/EHR access</b>	Health IT can enable access to medical records, patient preferences, laboratory data, personalized medical education and online care assessment tools that can contribute to a person meeting his or her health care goals; it can also support development of a more transparent and trusting relationship between providers and patients.
<b>Holistic care coordination</b>	Health IT systems can track, monitor and coordinate care between the practice and other care sites.
<b>Case/condition management</b>	Health IT systems can help with identification and management of patients with chronic conditions in alignment with evidence-based best practices. They can support optimal clinical outcomes for patients, as well as overall population health management outcomes.
<b>Care plan/ medication adherence</b>	Health IT allows access to evidence-based, best practice and key medication-related information, including decision support, medication lists and incorporation of initial prescription, medication fill and refill information.
<b>Shared decision support tools</b>	Tools for patients, physicians or care teams that support evidence-based and best practice actions regarding care plan or medication adherence; they are actionable by physicians, case managers and patients.

- Include PCMH-specific criteria in the EHR certification criteria in the Meaningful Use requirements.
- Develop and include PCMH-specific medical home health IT functionalities in the Meaningful Use eligibility criteria for stages II and III.
- Consider NCQA Level III PCMH practice recognition as proxy for stage II/III Meaningful Use certification.

**Recommendation 4:** Encourage accreditation organizations (NCQA, URAC, Joint Commission, etc.) to **align their PCMH and ACO standards with the requirements for the PCMH and ACO pilots and demonstrations, and HITECH Meaningful Use.**

#### SUPPORT FOR PAYMENT REFORM THROUGH:

<b>Tracking of non-fee-for-service activities</b>	Health IT can support payment for the additional activities the practice provides toward improving access to care and care coordination; and by engaging in other value-added activities not on the current fee schedule.
<b>Quality and efficiency measurement</b>	Health IT enables measurement and management of individual clinician, practice (PCMH) and system-wide (ACO) performance on clinical processes and outcomes.
<b>Pay-for-performance reporting</b>	Systems that support pay-for-performance incentive payments for desired quality and efficiency targets should foster accountability and transparency in cost, quality and patient experience.
<b>Integrated clinical and practice management information</b>	These tools allow for tracking, monitoring and support of advanced payment mechanisms, quality improvement activities and effective resource allocation.
<b>Gainsharing contribution tracking</b>	Enhanced efficiencies of clinical operations and processes, created by providers' collaborative efforts, lead to real cost savings that reward those providers through bonuses.
<b>Episode of care tracking</b>	Episode of care as well as global reimbursement methods for bundled services require measurement sets for appropriate distribution of funds to multiple stakeholders.
<b>Risk and acuity measurement</b>	Pay-for-performance, bundled episodes and global approaches to payment require risk adjustment to minimize actuarial risk and to prevent avoidance of high-risk patients. Stratification of risk is also required so health care resources can best be allocated.
<b>Predictive modeling</b>	Proactive identification of at-risk individuals and subpopulations provides an opportunity to use patient-specific action plans to implement timely interventions.
<b>Comparative effectiveness analytics</b>	Diagnostic, therapeutic and treatment variations can be tracked and evaluated for outcomes and cost effectiveness analysis.

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## Discussion and action items

As with previous discussion topics, a consensus from the group was that health IT must be applied not only with the health practitioner in mind, but also with the patient in mind. While workflow and usability to support PCMH and corresponding ACO activities are certainly challenges in the current health IT landscape, there is also the overarching need for patient-centric health IT tools that allow secure patient health records to be transparent and available to patients in a portable manner, billing and appointment scheduling to be convenient for patients and their designated caregivers, and education/decision-support materials to be more robust and easy to use. Value for the patient must be informed by the consumer voice. Berwick's "nothing about me, without me" mantra was modified in this context to become "nothing about my data, without my access to it."

Just as listening to the consumer voice aligns with the first point of the Institute for Healthcare Improvement's Triple Aim, population health needs and the use of health IT for support in that arena align with the second. One current weakness identified across EHR products is evident in panel management for population health, an essential activity of the PCMH.

Beyond the EHR (and tying into the third point of the Triple Aim, reducing health costs), health IT should also provide tools that provide for longitudinal registry functions and data analysis that enables system level, practice level, and provider level performance measurement, measures gaps in care, and evaluates per capita costs. Applications are needed to accomplish patient attribution, for public disclosure of performance information, and for appropriate fund distribution among providers in the pay-for-performance and ACO environment.

Robust, specific discussion was focused on the policy front, and specifically for alignment of Meaningful Use criteria with PCMH and ACO needs.

### Policy Action item(s):

1. Include PCMH-specific and ACO-specific criteria in the EHR certification criteria embedded in the Meaningful Use requirements.
2. Develop and include PCMH-specific health IT functionalities in the Meaningful Use eligibility criteria for stages II and III.
3. Foster and support aligned expectations for Meaningful Use across payment sectors—Medicare, Medicaid and private payers.
4. Develop mandatory standards for health IT exchange, with functional capability for both technical and semantic interoperability—fluid exchange of information—across whole communities.

Demonstration projects should be the proving ground for health IT applications. Testing in the field can add significantly to the body of knowledge about what works to support the PCMH now, and what may be leveraged in ACO models going forward. Particularly, there is a need for more information about timely data aggregation and its use for both population health management and per capita costs.

### Demonstration Project Action Item(s):

1. Develop demonstration project models that evaluate the effectiveness, validity and timeliness of data aggregation for population health management and contribute to understanding of per capita costs at the community level.
2. Develop multi-payer demonstration projects that allow for opportunities for data to be analyzed across data sets.

Transparency through technology is new to patients, and research has yet to reveal how much information patients want and how best to make it available. Research going forward should focus on providing information that is not only personally relevant for patients but also meaningful in its application.

### **Research Action Item(s):**

1. Support research to evaluate how to make patient information accessible, portable/downloadable (including via telephonic/mobile devices) and meaningful.
2. Research going forward should include connecting consumers to patient-specific health education and support service information.
3. Technology research should be directed towards systems that can “learn” in real time about what information patients need to make choices, and what is often misunderstood by patients. A study should be designed to capture the choices of well-informed patients to discover how they learn and make choices best.

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*The original Health IT briefing document for the Sept. 8, 2010 Consensus Meeting is available at [www.pcpcc.net](http://www.pcpcc.net) and was prepared by:*

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PLANNING COMMITTEE CHAIR  
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Presenter Allan H. Goroll, MD, didn't mince words: "It's the payment system, stupid."

Payment can be a difficult subject for primary care physicians to address. "We in the primary care community have been uncomfortable talking about payment. It's not what drove us into the practice of medicine, and talking about it always felt self-serving," said Goroll. But it has become increasingly clear that such conversations must happen. "We can barely afford to do the job we need to do today...and we certainly don't have the resources necessary to do the job expected of us going forward."

**"It's the payment system, stupid."**

—ALLAN H. GOROLL, MD

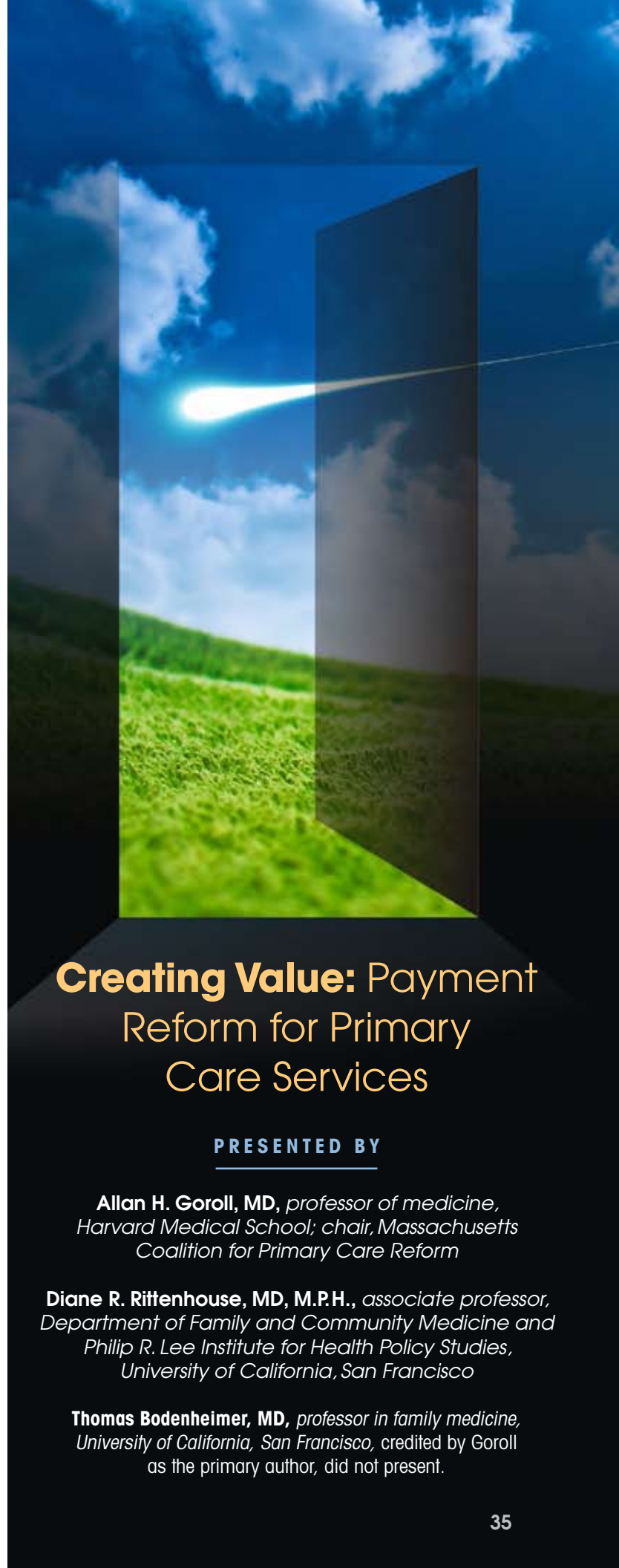
It is crucial to talk about payment not in terms of getting our share of the pie, but in terms of having the financial resources essential to carry out our mission, Goroll said, because "we get the health care system and care we pay for."

### Outlining the problems

Many of the innovations discussed in the previous sessions on access, health IT and care coordination simply are not supported by the current payment system. Diane R. Rittenhouse, MD, M.P.H., outlined several of the current problems in the payment system:

**Trainees are not choosing primary care**, at least in part due to the income disparities between primary and specialty care providers.

**Quantity is rewarded over quality.** The system encourages too much care by paying for volume, and particularly encourages too many procedural services as compared with cognitive services. Reimbursement usually only covers face-to-face, visit-based services conducted by physicians, nurse practitioners or physician assistants. As a result, many valuable—but unreimbursed—services are not done, not done well or not done enough. These include encounters such as e-visits or phone visits; between-visit care coordination; and services by RNs,



## Creating Value: Payment Reform for Primary Care Services

PRESENTED BY

**Allan H. Goroll, MD**, professor of medicine, Harvard Medical School; chair, Massachusetts Coalition for Primary Care Reform

**Diane R. Rittenhouse, MD, M.P.H.**, associate professor, Department of Family and Community Medicine and Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco

**Thomas Bodenheimer, MD**, professor in family medicine, University of California, San Francisco, credited by Goroll as the primary author, did not present.



pharmacists, health educators, social workers, health coaches or panel managers.

***It does not place most physician practices at any risk for excess costs***, nor does it reward most physician practices for keeping costs down. The payment system provides no incentives for reducing unnecessary specialty visits, brand name drugs, procedures, emergency department visits or hospitalizations, and it does little to encourage efficiency, cost effectiveness, or reductions in avoidable and wasteful spending. "In the end," Rittenhouse said, "there's very little accountability for quality or efficiency."

**"We in the primary care community have been uncomfortable talking about payment. It's not what drove us into the practice of medicine, and talking about it always felt self-serving."**

– ALLAN H. GOROLL, MD

***Payment processing places large administrative burdens on the physician and the practice.***

Although payment systems are beginning to reward quality, those rewards are often small relative to physicians' ability to earn more by increasing volume. Moreover, each plan has its own approach. Multiple reimbursement mechanisms require practices to develop an administrative bureaucracy in order to receive payment and meet the various payers' metrics. The administrative burden takes resources away from patient care and creates additional operational costs for the practice.

The goal, Rittenhouse said, is to adequately support robust patient-centered primary care, no matter what the "neighborhood" structure may look like down the road.

**Models for reform**

Goroll returned to the podium to discuss models for payment reform, noting that "There are probably as many models as there are pilots or demonstration

projects." He focused on leading models representing the spectrum of proposed payment reforms.

The PCPCC's Payment Reform Task Force's July 2010 study, "Payment Reform to Support High-Performing Practice," identified a set of consensus principles for primary care payment, building upon those in the literature, and referred to these principles in reviewing four representative models that attempt to move payment away from volume and towards value.

***The first model is the fee-for-service + management fee + performance model.*** This model keeps fee-for-service in the RBRVS system intact, but includes two additional payments. The care management fee is a severity-adjusted per-member-per-month (capitation) payment to assist practices in becoming PCMHs by paying for non-visit-based services such as care coordination.

The other additional payment rewards performance, which could include prompt access, quality, patient experience, practitioner/staff satisfaction and/or cost containment.

With fee-for-service still in place, this is the "least change" model, Goroll said. It may be a good *initial* model—and more comfortable for those unwilling to move to something more accountable—but it lends itself to primary care practice transformation.

***The second model is the episode of care, or case rate model.*** This model, one version of which was developed by Prometheus, Inc., is evidence- and episode-based. It provides payment by diagnosis for an episode of care or pays a yearly rate for chronic conditions. In the Prometheus model, payments are based on best practices, include monies for avoidance of preventable complications, and are severity- and inflation-adjusted. Quality performance bonuses also supplement payment.

Goroll noted that one weakness in this model is its complexity, especially calculating payment for evidence-based care of patients with multiple conditions. He also noted that, because the evidence is always changing, it is difficult for providers or payers to determine what the best evidence-based care may be at any particular time.

**Risk-adjusted comprehensive payment and bonus was the third model reviewed.** This model eliminates fee-for-service payment for primary care. It replaces fee-for-service with a per-patient monthly global payment for comprehensive primary care that is risk-adjusted and provides potentially large bonuses (up to 25 percent) for quality, cost containment and patient experience.

In this approach—and unlike previous iterations of capitation—“if you are shortchanging your patients, if you are not accessible, it’s going to cost you dollars,” Goroll said. Moreover, because the payment is risk-adjusted, there is no incentive to push away more complex cases.

This model is the most likely to reduce the administrative burden of billing by completely eliminating fee-for-service payment. However, it does not

specifically change payment for hospital, specialist, pharmacy or ancillary services, but primary care practices will receive larger bonuses for reducing total (not only primary care) per-patient medical costs. Nonetheless, Goroll noted, the model doesn’t work specifically to change the behavior of other providers.

**The fourth model is the accountable care organization.** This model addresses payment at the integrated network level, aiming to engage all providers, who join to take responsibility for delivering coordinated, value-based comprehensive care (including accountability for costs) for a defined population of patients.

The ACO receives a single, risk-adjusted, negotiated payment that it divides among its member providers according to decisions made within the ACO.

## Characteristics of the ideal reimbursement model

Rittenhouse discussed some principles of reimbursement reform, listing characteristics that would describe the ideal reimbursement model. Such a model would

- Reduce the disparity between reimbursement of procedural and cognitive services, and use value (quality per unit of cost) rather than just cost of delivery as a key metric in payment design; reduce the emphasis on volume.
- Provide the resources to do the job well. Reimbursement should include payment for teams and information technology and for valuable non-face-to-face work, such as e- and phone visits and care coordination.
- Reimburse practices’ encounters beyond the face-to-face visit with the MD, NP or PA. Pay for services provided by all team members (RNs, pharmacists, health educators, social workers, health coaches and panel managers) so that these aspects of patient centered medical home transformation can be rapidly and widely adopted.
- Reward desired outcomes. Choose metrics carefully so that readily measured activities do not lead to ignoring other possibly valuable activities and outcomes that are not so easy to measure.
- Risk-adjust reward payments so practices do not avoid caring for complex or needy patients—and that those that do care for complex patients aren’t penalized.
- Don’t reward solely for cost containment. Balance incentives between over- and underutilization through use of a blended payment mechanism so practices are not rewarded solely for cost containment.
- Ensure coordinated, patient-centered care by all providers. “Provide incentives that reward all providers for playing well in the sandbox together,” she said.
- Include payers in payment redesign. Bring together all payers in the payment reform effort so practices can be offered a unified payment mechanism and reduced administrative burden.
- Identify best practices. Pilot projects, innovative models in California and elsewhere—even from the HMO experience of the 1990s—can be instructive to current efforts.

**The goal is to adequately support robust patient-centered primary care, no matter what the “neighborhood” structure may look like down the road.**

– DIANE R. RITTENHOUSE, MD, M.P.H.

Cost savings are retained by the ACO. Because this model provides a strong incentive for cost containment, bonus payments would be provided for high performance in order to discourage excessive underutilization. “It’s obviously a solution to accountability,” Goroll said.

Only the ACO model directly controls total health care cost, although the other models could create incentives for primary care practices to initiate programs to reduce total health care costs for their patients. The downside of the ACO model is that ACOs could be successful in controlling costs but fail to invest in primary care: There is no requirement that the global payment support primary care.

(To help address that potential shortcoming, some models make the bonus heavily dependent on primary care outcomes.)

**Another model is a combination approach.**

Combining complementary models (e.g., risk-adjusted comprehensive payment and the ACO) may be one approach to getting the best results from payment reform. This approach would help ensure strong financial support for primary care (which the ACO does not specifically mandate) while incenting all physicians to participate in value-based care. Furthermore, it promotes the principles of patient-centered care by providing payment for those services outside of the direct patient visit, and provides incentives to coordinate care across the health care system. Appropriate coordination of care will both improve the quality of care and provide financial incentives for all providers participating in the system.

**Particular strengths of major payment reform models for the PCMH.**

	RBRVS + Management Fee + P4P	Prometheus	Risk-Adjusted Comprehensive Payment and Bonus	Accountable Care Organization
Supports transformation	++++	++++	++++	
Sustains PCMH	++++	++++	++++	
Emphasizes value over volume		++++	++++	++++
Amply rewards outcomes	++++	++++	++++	++++
Reduces pay disparities	++++	++++	++++	
Eases transition	++++	++++		
Simplifies payment			++++	++++
Engages all providers		++++		++++
Engages all-payer interest	++++	++++		++++

*NOTE: These are crude estimates only, based on qualitative review of each model’s features and early anecdotal experience from field trials. These estimates will need to be revised as more experience with these models is reported. For now, these ratings assume successful implementation of the model and adequate size of care management and comprehensive payments and bonuses.*

**PCMH** = Patient-Centered Medical Home, **P4P** = Pay for Performance, **Prometheus** = Evidence-Informed Case Rates, **RBRVS** = Resource-Based Relative Value Scale (Medicare’s fee-for-service payment system)

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## Discussion and action items

Discussion of the payment reform presentation was largely wrapped into the overall Consensus Meeting discussion. However, several overarching points emerged specific to payment reform in the discussion.

First, it was overwhelmingly agreed that payment models need to change in order for health system reform to go forward. All new payment models should be extensively and expeditiously field-tested and evaluated to inform payment policy. Consequently, discussion revolved around the need for leadership to bring federal and commercial payers into multi-payer projects to test payment systems. Providers cannot be expected to follow multiple payment systems for multiple payers, as the data collection and reporting is burdensome.

### Policy Action item(s):

1. Call on Medicare and state payers to align with payment models that are being tested across multiple payers in a region or demonstration project area; public and private payers should participate in projects together for maximum learnings and impact.
2. Call on the CMS Innovation Center to champion piloting of payment reform in conjunction with practice reform and for CMS to lead in reform efforts, partnering with other stakeholders.

While the policy action items overlapped with demonstration project action items, there was also discussion about moving forward initially with the more easily transitional fee-for-service models to get medical home demonstrations up and running rather than waiting to implement the more value-based models. There was also discussion about the importance of keeping the focus on patients in the evaluation of demonstration projects that test payment models.

### Demonstration Project Action Item(s):

1. Projects that have already demonstrated positive ROI in a short time frame (such as the Geisinger Health System and Vermont Blueprint for Health demonstrations) should be the initial focus of the learning collaborative to encourage and enable practice transformation while moving ahead to pilot and evaluate more fundamental payment reforms.
2. Pilot projects should be developed that include testing incremental changes in payment systems alongside more comprehensive payment reforms so that a range of models can be tested and compared.

Evaluation and measurement of the success of demonstration projects was intertwined in the discussion. As payment reform models are tested, there will also arise the need to rapidly disseminate results and data so successful models can be duplicated.

### Research Action Item(s):

1. Set up a research/learning collaborative to disseminate data and research regarding payment reform from pilot projects.
2. Develop metrics for payment reform success based on the Triple Aim, so the focus does not move away from the patient and only to cost containment.

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The original payment reform briefing document for the Sept. 8, 2010 Consensus Meeting is available by going to [www.pcpcc.net](http://www.pcpcc.net) and was prepared by:

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Reform of the health care system is advancing under the Patient Protection and Affordable Care Act. New care delivery service models and payment pilots are rapidly gearing up as test beds for the CMS Innovation Center, which will soon operationalize its mission to test “innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing quality of care.” The expertise of the assembled group and from other thought leaders across the country can serve as a knowledge base for these experiments to more rapidly synthesize best practices and disseminate them for testing in communities. As moderator Susan Dentzer noted, “This is a long-term process and we’re not going to get along without all stakeholders joined at the hip and working together. Everybody is determined to see this through and to work with their own sector to see it through.”

Across represented stakeholders, there is general agreement around the key elements of a high-functioning health care delivery system: It should be based on primary care, include good coordination of care, engender the flow of information, be accessible for patients and be delivered in a well-coordinated, well-articulated fashion. It should ensure that patients receive the care and coordination they need, when they need it, in a patient-centered manner and at a lower cost. Key cornerstones of advanced primary care practice—access and care coordination—must be catalyzed by useful health IT tools and effective reform of payment design.

In principle, five key consensus statements frame recommendations and actions from the group.

**CONSENSUS STATEMENT 1** We agree that the goal of both of these reforms—the medical home and accountable care organizations—is focused on the Triple Aim: Better care, better health, lower costs.

It is essential that the strength of the combined voices around the table is not diluted over time; this will require a leadership cadre that will speak loudly and clearly to support these models, and will communicate dedication to a social contract that keeps the patient at the center of care delivery. Practicing



## Closing Discussion, Group Consensus and Action Items

primary care physicians have a leadership role to play as well in persuading their colleagues who may be slow to take steps toward transformation that it is in the best interest of individual and population health to adopt advanced primary care models.

**Recommendation 1:** Develop metrics and measurement sets that are comprehensive and based on the Triple Aim, so the focus does not move away from an emphasis on individual patient health or population health and only look to cost containment.

**Recommendation 2:** Develop demonstration project models that evaluate the timeliness of data aggregation for population health management and contribute to understanding of per capita costs at the community level.

**Recommendation 3:** Set explicit objectives for care coordination and access around the principles of the Triple Aim.

**Recommendation 4:** Involve consumers in design of new care models.

**CONSENSUS STATEMENT 2** We agree on the critical role and need for measurements that capture the spirit of these aims.

**We will need to work to develop these measurements jointly, across stakeholder groups and across both private and public payers.**

We should support development of future iterations of regulations and rules around Meaningful Use and EHR certification that align with the functional requirements of the medical home and ACOs. This will require ongoing commitment among stakeholders to work together. The idea is to present cohesive measurement and evaluation metrics that will clearly define what is expected of all stakeholders as they adopt new models.

**Recommendation 1:** Establish a research/learning collaborative to capture learnings from demonstration projects, pilots and Medicare Innovation Center projects and disseminate them widely.

**Recommendation 2:** Identify a framework for identifying the functional operational elements of access and care coordination within advanced primary care models.

■ Actions:

- Establish a measurement set that will delineate what outcomes can and should be measured for care coordination.
- Establish a measurement set that will delineate what outcomes can and should be measured for access.

**Recommendation 3:** Evaluate demonstrations of the use of technology to make information more accessible to patients and providers, including how systems can aid patients and providers in decision support.

**Recommendation 4:** Ensure health IT impact and innovation are closely examined during the upcoming demonstrations and pilots by establishing a uniform set of baseline HIT criteria. These baseline HIT criteria will ensure that the PCMH and ACO pilot metrics are consistently derived and aligned across studies.<sup>48</sup>

**Recommendation 5:** Develop metrics for evaluating the payment reform models in the context of the Triple Aim, so cost containment is balanced with better patient health and better population health.

**CONSENSUS STATEMENT 3** We agree that payment systems need to change. Payment models need to be tested.

Employer leaders are willing to participate in new payment models, but over time there must be a demonstration of return on investment. Incremental changes that can be done simply, and evaluations of incremental payment models that can be studied alongside more comprehensive pilot projects and proposed system reforms, will move the whole delivery system forward at a more rapid rate. The idea is to enable multiple approaches to

<sup>48</sup> Topic leads asked that this recommendation be added after the meeting.

reform at the same time, so winning models can be disseminated at a faster pace.

**Recommendation 1:** Call on Medicare and state payers to align with payment models that are being tested across multiple payers in a region or demonstration project area; public and private payers should participate in projects together for maximum learnings and impact.

**Recommendation 2:** Projects that have already demonstrated positive ROI in a short time frame (such as the Geisinger Health System and Vermont Blueprint for Health demonstrations) should be the initial focus of the learning collaborative to encourage and enable practice transformation while moving ahead to pilot and evaluate more fundamental payment reforms.

**Recommendation 3:** Demonstration project research efforts should evaluate the effectiveness of incremental changes in payment systems, alongside more comprehensive pilots, so that all models can be tested.

#### **CONSENSUS STATEMENT 4 We agree that learning collaboratives and rapid learning environments are needed to establish an evaluation framework around these issues.**

We need to rapidly learn to evaluate aspects of these models based on what works and what does not. These lessons learned should be quickly assimilated into medical school curricula and passed along to the next generation of primary care physicians. The idea is to make medical school students today the future practicing physicians who will be inspired to stay in primary care, and to know and demand a patient-centered model when they go out into private practice. Evaluation of pilots and demonstrations should use the Triple Aim as a framework for measuring success and as a balance between improved outcomes and improved cost effectiveness.

**Recommendation 1:** Call on CMS Innovation Center demonstrations to use multiple triggers to test models: volume, access and care coordination outcomes and pay-for-performance.

**Recommendation 2:** Support research to evaluate the patient experience.

#### ■ Actions:

- Evaluate the effectiveness of the use of access technologies such as telephonic and mobile devices.
- Evaluate effectiveness of programs that connect consumers to individualized health education and support service information.
- Support research that enhances understanding of what information and tools patients need to make well-informed choices.

**Recommendation 3:** Support multi-payer demonstration projects that allow for opportunities for data to be analyzed across data sets.

#### **CONSENSUS STATEMENT 5 We agree to stay together for the long haul.**

Health plans, providers, academics, employers, federal payers, consumers and others must work together to support public policy that advances new models of care that support the Triple Aim. Multi-payer demonstrations that integrate all payer types in a region—federal payers, state payers and employers working together—will give providers the incentive to more quickly transform to PCMH and ACO models. These “all-payer” models offer primary care physicians a stable basis for practice transformation, which is otherwise a costly risk in an environment where payment systems vary or rapidly change. For their part, large self-insured employers should consider data sharing and collaborations with health plans and other employers for a community-wide data set, so community-based payment models can be based on provider performance and can be more accurately and quickly enabled. By working in concert, we can more rapidly advance adoption of new models of care that support the Triple Aim.

**Recommendation 1:** Support policy and regulatory action to align health IT standards with medical home- and ACO-specific functionalities.

■ Actions:

- Work to include these criteria in the EHR certification and Meaningful Use requirements.
- Work for development and adoption of PCMH-specific health IT functionalities in the Meaningful Use criteria for stages II and III.
- Develop, include and align expectations for Meaningful Use across payment sectors—Medicare, Medicaid, DOD, VA and private payers.
- Develop mandatory standards for health IT exchange, with functional capability for interoperability—fluid exchange of information—across whole communities.

**Recommendation 2:** Create infrastructure that supports all primary care physicians (including solo/small practitioners) to achieve care coordination goals.

■ Action:

- Support collaboration with health plans to develop practices that reallocate care coordination resources to the ambulatory setting.

**Recommendation 3:** Actively support federal funding of primary care workforce training efforts across the full spectrum of primary care team members in order to ensure an adequate and well-trained primary care workforce.







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