NBCH action brief

MARCH 2012

Patient-Centered Medical Homes:
A New Era in Primary Care

The patient-centered medical home (PCMH) is an important strategy within larger efforts to revamp the way care is delivered and paid for. By centering an individual's health care experience around strong primary care, PCMH seeks to bring order to a health care system that is dangerously fragmented. This Action Brief outlines the scope and impact of PCMH as well as how health plans are supporting the transformation based on data from eValue8™—a resource used by purchasers to track health plan performance. Also provided are actions employers can take to play an important role in the prevalence and strength of PCMH.

WHAT'S THE ISSUE?

CARE COORDINATION IS OFTEN NON-EXISTENT, NEGATIVELY IMPACTING QUALITY OF PATIENT CARE.

DEFINING PCMH

While there is no standard definition, PCMH is not a place—it is the "model of the organization of primary care that provides the core functions of primary care."[1]

- **COMPREHENSIVE CARE**—Care is provided through an integrated team of practitioners ranging from doctors to dieticians.
- **COORDINATED CARE**—PCMH provides vital links between all components of the health care system including specialty care and community services.
- **ACCESS**—Access to care is emphasized through convenient hours, shorter wait times, and 24/7 phone or electronic access.
- **PATIENT-CENTERED CARE**—Care is rooted in personal relationships and oriented toward the patient. While the partnership between patients and providers includes family members and respects unique circumstances, the personal physician is ultimately responsible for providing and/or managing health care during all stages of life.
- **QUALITY**—PCMH uses clinical decision-support tools and engages in evidence-based health care, performance and patient satisfaction measurement and improvement, and population health management. Public disclosure of quality and safety data demonstrates a system-level commitment to quality.[2]

PRIMARY CARE IN CRISIS

- Because the health care system directs greater rewards toward volume of care, (e.g., the number of tests and

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MEASURING UP

***eValue8* RESULTS FROM 2011 SHOW THAT WHILE 87% OF PLANS REPORT BEING INVOLVED IN SOME MEDICAL HOME PILOTS, ONLY 7% INCENTIVIZED MEMBER PARTICIPATION IN PCMH.**

- Among plans reporting a PCMH in their market:
- While 93% offer some educational support to help PCMH practices with their efforts at transformation, less than two-thirds (62%) offer participation in multiple-session learning collaboratives focused on PCMH.
- Less than half (44%) provide personnel dedicated to care management that can be shared by the practices.
- Even fewer plans (40%) offer coaching by trained practice coaches.
- Less than two-thirds (62%) designate a range of chronic clinical conditions in which the PCMH practice must adequately case manage.

HEALTH PLAN HIGHLIGHT

Kaiser Permanente's Southern California Region's focus is to improve the consistency and quality of preventive and chronic patient care. The Proactive Office Encounter (POE) program was created to engage staff and physicians to proactively address both preventive and chronic care needs before and during each patient encounter in primary, specialty care, and across the continuum of health care services. The POE program supports alignment of care roles to allow the care team to interact with the patient in addressing care gaps. This includes receptionists, medical assistants, nurses, physicians and clinical pharmacists, for example.

POE, a practice that has been implemented across Kaiser Permanente's Southern California facilities, has contributed to

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Primary Care in Crisis CONTINUED

procedures performed) and not coordination of care, primary care consequently suffers lower reimbursement rates.

- Primary care physicians earn considerably less than their specialist counterparts over a lifetime.[3]
- This perverse payment system leads to a decreasing supply of primary care providers—less than 2% of current medical students are interested in general internal medicine.[4]
- Pair this reality with an increasing demand for primary care as baby boomers grow older [5] and the fact that 65 million Americans currently live in designated primary care shortage regions.
- Of those with access to primary care, half of all adults do not understand what they are told due to short visit times, and nearly three-quarters have difficulty contacting their primary care physician by phone.

THE EMERGENCE OF PCMH

- A robust body of evidence—not to mention common sense—indicates that strong primary care systems make for better outcomes, reducing emergency room visits and hospitalizations, and subsequently lowering overall health care costs.
- A study in the *Annals of Family Medicine* showed that implementing medical homes would likely decrease health care costs by 5.6% resulting in a savings of $67 billion dollars each year.[6]
- Already, one-fifth of all small- and medium-sized practices employ PCMH processes such as team-based care, care coordination via electronic health records, nurse care managers, and patient satisfaction monitoring.[7]

TAKE ACTION

Action Item #1: Get educated, engaged, and transformative

Employers should emphasize the importance of primary care as a critical component to overall wellness, health improvement and health care transformation. With resources like the Patient-Centered Primary Care Collaborative's (PCPCC) *Center for Employer Engagement,* employers can access educational tools and best practice strategies on issues associated with interest in and implementation of PCMH.

Partner with like-minded stakeholders to host educational programs for employees and dependents, insurers, providers, and state government on PCMH and its benefits. Lastly, to truly spur change and help transform your local market into one firmly rooted in primary care, sponsor or participate in a pilot—there may already be one in your area. Visit the PCPCC's *Pilot Guide* for more details.

Health Plan Highlight CONTINUED

sharp improvement in clinical quality performance, including 30% increase in colon cancer screenings, 11% increase in breast cancer screening, 5% increase in cervical cancer screening, and 13% percent improvement in cholesterol control. The region has improved disease screening and treatment rates, which lower long-term health costs by preventing or successfully managing problems. Most importantly, these improved health outcomes save lives—Kaiser estimates they will save more than 15,000 lives over a decade thanks to their care delivery transformations.

Action Item #2: Hold your health plan accountable

Require your plan to participate in at least one PCMH pilot and provide appropriate support to practices and patients, and encourage the use of physician incentives. Add questions to your health plan RFP or RFI to gauge support of the PCMH model, and track your plan's progress on PCMH, anticipating slow but steadily improving measurement findings. For more details on holding your plan accountable, see the PCPCC's *Purchaser's Guide.*

Action Item #3: Support PCMH with value-based insurance design (VBID)

While PCMH supports providers in the delivery of better quality and more efficient care, VBID incentivizes *patients* to use higher-value services (e.g., lower or no co-pays for preventive care) and discourages the use of lower-value, non-evidence-based services. Many employers are developing ways to achieve synergy between VBID and PCMH through the assessment of data and health plan readiness tools such as *eValue8.*[8] A PCPCC and NBCH collaboration, *Aligning Incentives and Systems* presents the mechanics of both strategies and reviews the evidence for their clinical and economic value. The guide also includes the business value case for employers and the steps employers can take to implement this strategy.

Action Item #4: Join your local business health care coalition

The *coalition movement* is a proven vehicle for meaningful change at the local level. Coalitions leverage the voice and power of their employer purchaser members by serving as community leaders working to advance change. Many coalitions are already involved in PCMH pilot efforts and can likely support your interests in PCMH and broader efforts in health care delivery improvement.

Endnotes

1 Agency for Healthcare Research and Quality. "What is the PCMH?" November 2011. http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/what_is_pcmh_

2 Ibid.

3 Vaughn, B. et al. "Can We Close the Income and Wealth Gap Between Specialists and Primary Care Physicians?" *Health Affairs*. May 2010.

4 Tulshyan, R. "Primary Care Doctors: Saying No to $191,000 a Year." *Time.* August 2010. http://www.time.com/time/business/article/0,8599,2012443,00.html?hpt=C2

5 Michigan Primary Care Consortium. "Primary Care Is In Crisis." 2009.

6 Healthcare Intelligence Network. *Model Medical Homes: Benchmarks and Case Studies in Patient-Centered Care*. 2009.

7 Rittenhouse, D., et al. "Small And Medium-Size Physician Practices Use Few Patient-Centered Medical Home Processes." *Health Affairs.* August 2011.

8 NBCH and PCPCC. "Aligning Incentives and Systems: Promoting Synergy Between Value-Based Insurance Design and Patient-Centered Medical Home."

NBCH gratefully acknowledges the support of Sanofi for development of this action brief.