

# Patient-Centered Medical Home

The Patient-Centered Medical Home (PCMH) is an approach for providing comprehensive care to patients by facilitating partnerships between patients and their physicians. Each patient has an ongoing relationship with a personal primary care physician who, in turn, leads a team that takes collective responsibility for each patient's care. The PCMH model:

- enables and strengthens the primary care physician-patient relationship
- replaces illness-based episodic care with coordinated care
- emphasizes better integrated care coordination and delivery
- offers preventive care services that help patients live healthier lives

A growing shortage of primary care physicians and the increasing prevalence of chronic diseases are important factors in the growing interest in the medical home model. Fewer physicians are entering into and remaining in primary care. As a result, consumers are experiencing diminished access to primary care and are using higher-cost settings such as the emergency room, urgent care and specialty care for situations more effectively serviced by primary care clinics and physicians.

"More than half of Americans with serious chronic conditions have three or more different physicians, leading to duplicate testing, conflicting treatment advice and prescription drugs that are contraindicated. Obama will support providers to put in place care management programs and encourage team care through implementation of **medical home** type models that will improve coordination and integration of care of those with chronic conditions."<sup>1</sup>

## Historical Perspective

The 2001 Institute of Medicine report, *Crossing the Quality Chasm: A new Health System for the 21st Century* (IOM, 2001), describes the state of the health care system in the United States, and details how it could be improved. The report suggests that improving the systems that support health care is paramount to achieving quality – with the goal of providing health care that is safe, effective, patient-centered, timely, efficient, and equitable.

<sup>1</sup> Barack Obama: Plan for a Healthy America; 2008

## What are Others Doing?

The American Academy of Pediatrics (AAP) believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the “medical home.”<sup>2</sup>

In November 2007, the Council of State Governments passed a resolution to encourage states to implement and fund pilot programs to demonstrate the quality, safety, value, and effectiveness of the PCMH.

On November 11, 2008, the American Medical Association (AMA) voted to adopt the “Joint Principles of the Patient-Centered Medical Home,” joining the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association in endorsing the principles. The PCMH facilitates partnerships between individual patients and their personal physicians and – when appropriate – the patient’s family. The Joint Principles define these key characteristics of the PCMH:

- **Personal physician** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- **Quality and safety** are hallmarks of the medical home.
- **Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

In 2008, the National Committee for Quality Assurance (NCQA) launched a new version of its Physician Practice Connections (PPC<sup>®</sup>) program, designed to assess how medical practices are functioning as patient-centered medical homes. The new Physician Practice Connections<sup>®</sup> – Patient-Centered Medical Home<sup>™</sup> emphasizes the systematic use of patient-centered, coordinated care management processes. The program includes nine standards for medical practices to meet, including use of patient self-management support, care coordination, evidence-based guidelines for chronic conditions and performance reporting and improvement. To be recognized as a patient-centered medical home, practices must demonstrate the ability to sufficiently meet the criteria of these standards.

<sup>2</sup> <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/1/184>

## UnitedHealthcare Participation in PCMH Initiatives

UnitedHealthcare believes programs such as the PCMH are critical to helping improve the quality of health care and reducing medical costs for all Americans. The PCMH is a concrete example of how UnitedHealthcare is working to fulfill its brand promise of “healing health care”. The pilot programs will focus on testing the underlying PCMH assumptions per the guiding principles in different practice settings to help prove or validate each model component. The PCMH model offers:

- improved quality at lower cost
- increased physician and patient satisfaction
- improved patient safety
- care continuity and improved care transitions
- improved practice profitability and satisfaction
- value-based payments for physicians
- simplified and coordinated health care experience

UnitedHealthcare plans on participating in at least five PCMH pilot programs by the end of 2009. We are committed to provide the infrastructure, tools and support to help implement the patient-centered medical home model in physician practices. The key findings from these pilots will help to inform and shape future expansion of the program.

### Planned pilot programs include:

**Arizona, 2009:** Seven primary care practices in both Phoenix and Tucson are participating in this single-payer PCMH pilot. UnitedHealthcare will assist these practices with technology and infrastructure support and NCQA application fee credits. Additionally, UnitedHealthcare will fund practice transformational assistance and redesign. In addition to helping these practices achieve NCQA recognition, the consultant support provided by TransforMED, LLC provides additional benefits for the practice. TransforMED:

- helps the practices assess clinical workflow processes for greater efficiencies;
- provides recommendations to leverage technology to improve service delivery;
- conducts a payer-neutral confidential practice assessment that includes recommendations for financial back-office process improvement; and
- helps tie work flow process changes to sound financial principles and sustainability.

“This [UnitedHealthcare PCMH pilot in Arizona] gives us the opportunity to create a model to allow family physicians to practice the way we used to practice in the past,” said Dr. Jim Dearing, a family practitioner in Phoenix who is among the physicians who have agreed to participate.<sup>3</sup>

The Arizona pilot program includes customers insured through UnitedHealthcare commercial insurance, self-insured commercial customers who elect to participate, as well as Medicare SecureHorizons membership. IBM is partnering with UnitedHealthcare in the Arizona pilot as a PCMH thought leader partner and as a

<sup>3</sup> Quote from Dr Jim Dearing, in the NY Times 2/6/2009; Dr Dearing is running for national president of the American Academy of Family Physicians (AAFP)

participating customer. UnitedHealthcare is IBM's largest health plan in Arizona, serving nearly 11,000 beneficiaries. In support of the pilot, IBM will encourage these employees to seek primary-care services from the physicians participating in the pilot program.

**Colorado, 2009:** UnitedHealthcare will participate in a multi-payer (six payers) PCMH pilot, driven by the Colorado Clinical Guidelines Collaborative (CCGC), beginning in May 2009. Colorado's Patient-Centered Medical Home (PCMH) Pilot, one of numerous pilots in the country, marks the first time that all major health insurers within the state are voluntarily participating. The 2 year pilot following a six month ramp-up is expected to reduce fragmentation and improve health care through the implementation of systems and processes, using evidence-based clinical guidelines. There are 16 participating practices at 17 locations – it is estimated that there will be 25,000 members from all participating plans covered by this pilot. CCGC will serve as the convening organization and provide technical assistance for the pilot including in-office coaching, technology, and shared learning networks. The results of the pilot will be evaluated by the Harvard School of Public Health.

**New York, 2009:** UnitedHealthcare will participate in a 5-year multi-payer pilot in the mid-Hudson Valley area. In New York, The Taconic Health Information Network and Communities (THINC) Regional Health Information Organization (RHIO) will be overseeing what it terms a pay-for-performance/medical home project in the Hudson Valley region of New York State. THINC RHIO is currently recruiting up to 250 physician practices. Those that achieve NCQA PPC-PCMH recognition will be eligible for enhanced payments based on a) structural measures: NCQA PPC-PCMH Level 2 recognition, implementation of a CCHIT-certified EHR, and interfaces with the regional health information exchange (HIE) and b) performance on 10 HEDIS clinical process and outcome measures. The project is designed as a five-year pilot with a control group, and is to be evaluated by Cornell University researchers.

**Ohio, 2009:** Evaluation for a multi-payer pilot program is being planned for late 2009 or 2010. In Ohio, the convening authority for the multi-payer, multi-stakeholder is the Aligning Forces for Quality / RWJF project; sponsored by The Greater Cincinnati Health Care Collaborative. This pilot is partnered with the CCGC pilot to support a common external, third-party study. This pilot will leverage much of the approach and lessons learned from the CCGC program in Colorado. Transformation and technical coaching will be sponsored by the convening authority. TransforMED is providing consultative support during the planning stages of this program.

**Rhode Island, 2008:** UnitedHealthcare has been participating in the Rhode Island state-sponsored PCMH initiative with one other commercial carrier since October 2008. The scope of this pilot includes five large primary care practices and includes a study by the Harvard School of Public Health to assess clinical outcomes for conditions including diabetes, cardiovascular disease and depression.

Other state-sponsored collaborative PCMH initiatives are locally driven and funded, similar to the Rhode Island initiative. Others may develop as local funding is secured and strategic alignment is apparent.