The evolution of the PRIMARY CARE MEDICAL HOME

By David Stevens, MD, FAAFM

The primary care medical home (PCMH) has emerged as one of the core building blocks of transforming the nation's health care delivery system. David Stevens, MD, FAAFM, NACHC Associate Medical Officer and Director of NACHC's Quality Center, was asked to talk about the PCMH concept, its impetus under the Affordable Care Act (ACA) and implications for America's Health Centers.

CHForum: The concept of a PCMH is not new. Yet, it appears we are only at the stage of defining its components. Ultimately, what will be the determinants of a primary medical care home?

Stevens: Although common principles of the PCMH have long been recognized, such as accessible, comprehensive, coordinated and patient-centered health care, it is true that the definition itself is evolving. For example, the nurse practitioner, not just the physician, is now recognized as a primary care clinician in a medical home.

As a bit of history – the medical home concept was first introduced in the late sixties by the American Academy of Pediatrics (AAP) to improve care for special needs children. In 2007 four groups, including AAP, the American Academy of Family Physicians, the American College of Physicians and the American Osteopathic Association set forth joint principles that today embrace the vision of the primary care medical home. Those principles include:

- A trusting relationship with a regular primary care doctor
- A team-based approach to delivering care and treating the whole person
- Care coordination and integration across all elements of the health care system and the patient's community (family and public and private community-based services)
- Quality and safety including supports that facilitate communication, information sharing and evidenced-based medicine
- Enhanced access to care in terms of expanded hours of operation, communication between physicians and patients
- Payment structures that recognize the value of primary care services
Over 100 demonstration projects are focused on the PCMH. Thirty-one states are planning or implementing medical home pilots within Medicaid or the Children’s Health Insurance Program (CHIP). At least a dozen states have medical home initiatives involving multiple payers. Also the new Center for Medicare and Medicaid Innovation created under the health reform law will begin testing and exploring new payment and delivery models, including the primary care medical home.

In addition, the National Committee for Quality Assurance (NCQA) and the Accreditation Association for Ambulatory Health Care (AAAHC) offer recognition or accreditation programs for the patient-centered medical home. The Joint Commission will also offer a program this summer. The Health Resources and Services Administration (HRSA) also announced its Patient Centered-Medical/Health Home Initiative that supports and encourages health centers to earn recognition under the medical home recognition program with the NCQA.

Most importantly, it is not about getting a plaque on the wall — documented outcomes for cost, quality, and positive patient experiences with health care are what payers and other stakeholders are demanding. Consensus on what these measures should be has not been reached yet; but it is only a matter of time. In fact, measurement of the patient experience of care with a standardized survey is now a new optional feature of the NCQA recognition program.

**CHForum:** What role do health centers play in these demonstrations?

**Stevens:** Health centers are major players. For example, the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration launched by the Centers for Medicare and Medicaid Services and the Health Resources and Services Administration will engage 500 FQHC sites across the nation. Eligible health centers must serve a minimum of 200 Medicare patients. The demo will evaluate the impact of the advanced primary care model on access, quality and cost of care provided to Medicare beneficiaries. As part of the demonstration, sites also will receive a care management fee for each Medicare beneficiary.

Another example is the Safety Net Medical Home Initiative that involves more than 68 health centers in five states (Colorado, Idaho, Massachusetts, Oregon and Pennsylvania). This five-year initiative, launched in 2008 and supported by The Commonwealth Fund, Qualis Health and others, is designed to assist health centers in the transformation of their practices into high performing medical homes with the broad goal of developing models for replication. Of the five regional coordinating centers for the initiative, four are led by Primary Care Associations in Massachusetts, Colorado, Idaho and Oregon.

Most significant is the fact that this unique initiative focuses on underserved and vulnerable populations. The design and services offered by health centers are an essential component for providing patient-centered care for our diverse communities. We contribute essential knowledge and experience for a truly equitable and community-based patient-centered home.

**CHForum:** In what way does the health reform law support the development of the primary care medical home model?

**Stevens:** The Affordable Care Act contains numerous provisions that support primary care and the development of the medical home model.

For example, there are financial incentives for primary care providers. Beginning this year primary care practitioners who participate in Medicare are eligible for a 10 percent bonus for five years. Also, down the line in 2013 and 2014, we will see Medicaid reimbursement rates raised to the level of Medicare rates for primary care services. These incentives reflect recognition of the need not only to address low reimbursement rates for primary care, but also encourage provider participation in both the Medicare and Medicaid programs.

The law further establishes a new state option to enhance reimbursement for providers designated as health homes for Medicaid patients with chronic conditions, including serious mental health conditions. Through both prevention and treatment, the primary care model can effectively stem the financial burden of chronic diseases which represent 75 percent of all health care costs. Already vast interest has been expressed on the part of states in this program for their Medicaid patient population. Integrated systems of care such as accountable care organizations (ACOs) whose development is supported in the ACA also rest on a foundation of comprehensive primary care.

In addition, the ACA provides for expansion of Medicaid eligibility to 16 million people that will most certainly increase demand for primary care. To help provide care for newly eligible people, community health centers will double their capacity in the next five years. And, this is not to overlook the simultaneous expansion of the National Health Service Corps as well as the law’s commitment to bolster training programs for primary care physicians, as well as nurses and other allied health professionals.

The ACA also creates an Innovation Center at CMS that will test “health home” and “medical home” concepts, develop models focused on improved care, care coordination, cost effectiveness and patient experience for people eligible for both Medicare and Medicaid, or “dual eligibles.” An ingenious element, the Center will address innovations in community and population health.

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Of course, health centers are the one place where comprehensive primary care and community health are joined at the hip. I expect a huge leadership role for health centers in future demonstrations.

**CHForum: What do you see as challenges for providers in moving toward the primary care medical home?**

**Stevens:** We have learned that transformation to the patient-centered medical home is not a simple or easy process. It requires time, leadership, practice redesign, and integration with other parts of the community health system. Some practices have experienced initial drops in productivity or found that the shift to a different work culture was difficult for some clinicians.

It requires total commitment on the part of staff to shift to a team approach that can lead to improved quality of care and better health outcomes. As a recent study conducted by the American Academy of Family Physicians revealed – it is a developmental process that can take as much as five years to achieve. Unfortunately, we don’t have five, or even three years to make these changes.

Supporting patient engagement in the new system of care is also important. Patient satisfaction can decline if patients do not understand the medical home concept and their role in it.

Providers need to be aware that there are structural costs in terms of IT infrastructure as well as capacity for care management, enhanced hours of operation, and care coordination. A significant challenge will be in meeting these costs and assuring support in terms of adequate reimbursement needed to function as a medical home. E-mail, telephone consultations, a per member monthly fee for care coordination, and incentive payments based on performance and outcomes are not part of the current visit-based fee-for-service system.

**CHForum: What specific challenges are ahead for health center providers?**

**Stevens:** First, health centers must be prepared to work collaboratively in a team environment. This means closer collaboration, but also reaching beyond their service sites and integrating themselves as part of their community’s health system (i.e., hospitals, emergency and local public health departments, nursing homes, specialists, and other providers). As documented in a 2009 health center survey conducted by the Commonwealth Fund, health centers that have these relationships are associated with higher levels of medical home characteristics.

Secondly, health centers must adapt to the technological world to advance greater effectiveness and efficiency as well as best practices. All of us must recognize there is a direct connect between meaningful use of EHRs to manage the care of a patient population and to participate in the exchange of health information across providers and care settings. Obviously, it will entail changes in our operations. Nonetheless, we must recognize that HIT is a vitally needed tool for the future medical home to keep pace and excel in continuous, quality improvement.

**CHForum: What is your advice for community health center leaders?**

**Stevens:** Health centers must continue to be leaders in this transition into a new era of health care. Over the years, they have defined the basics of a primary care medical home. We must maintain that leadership. We must not only meet but also exceed medical home standards and set the highest benchmarks for quality, cost and patient experience outcomes.

Taking advantage of additional HRSA support, all health centers should begin the process for formal recognition or accreditation as medical homes – leading to 100% recognized medical homes by 2015. As an outcome measurement set is being defined for medical homes, we should be on the cutting edge of testing these measures and documenting outstanding performance. We’ve done this before with the Health Disparities Collaboratives and we can do it again!