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The Medical Home – Avoiding the Rush to Judgment

Growing Model is a Transformative Process Requiring Perseverance, Patience … and Time

Body of Evidence Illustrating Success is Surging

An Accreditation Association for Ambulatory Health Care

WHITE PAPER

Controversy regarding a host of initiatives and issues runs rampant in the health care arena today. Such debates focus on dramatic changes in the landscape exemplified by the Affordable Care Act and the massive revamping of medical coding prescribed by ICD-10,or address more evergreen subjects like the ongoing dialog about pharmaceutical costs and the dangers of playing football.

Surprisingly and unfortunately, drawn into this maelstrom at times is a progressive model of health care that's expanding across the country – the Patient-Centered Medical Home (PCMH). As often is the case when an ambitious undertaking begins to shake up the health care environment, progress is accompanied by naysayers and skeptics. What must be understood is that evaluation of such endeavors requires time and patience. It is critical to do so because, in theory and practice, the PCMH is a win-win-win for the trio of parties involved – patient, provider and payer.

Yes, several obstacles to attain such success do exist and such challenges have fueled criticism. What we are witnessing today, however, is a growing body of evidence that, when viewed collectively, presents an overwhelming stamp of approval on the Medical Home model.

This white paper will present both sides of the debate. The valuable role proper accreditation brings to the evolution will be covered as well. To ensure this is not a lengthy treatise, the focus will be on the patient-clinical impact, not the economics, the latter worthy of its own paper.

What will become clear is the imperativeness for the profession to avoid a rush to judgment on this well-conceived approach to health care delivery. Achieving success for the Medical Home model will be a transformative process that must allow for adjustments and refinements to meet the highest of standards.

Medical Homes Empower Patients, Foster Relationships

In some ways, the beauty of the Medical Home concept is its simplicity: A formalized model of health care delivery led by a physician or other qualified provider that emphasizes a lifelong, personal relationship between patient and doctor working with an established health care team. The compassionate and caring element of this approach is portrayed quite well by Sean Murphy, Brig Gen, USAF, Air Force Medical Operations Agency Commander, San Antonio, Texas, when he told Medical Home News, "All I can think about is the old 'Cheers' TV series, where everyone knows your name."[1]

As outlined by the Patient-Centered Primary Care Collaborative (PCPCC) in its January 2014 Annual Update,[2] the Medical Home offers features that create significant, positive impacts for patients:

- Patient-Centered. Medical homes help patients and families to manage, organize and participate in health care decisions as fully informed partners in their care. This leads to patients seeking the right care, from the right place, at the right time. It empowers patients to contribute to their own health and wellness.

- Comprehensive Coordination. The team of care providers is wholly accountable for the patient's physical and mental health care needs, which include the entire spectrum of care from prevention and wellness to chronic, long-term care. Care is organized across the broader health care system should patients require a hospital stay or a visit to a specialist. This level of comprehensive coordination means patients are less likely to delay care and enables providers to deliver more efficient treatments.

- Accessibility. Medical homes can reduce wait times, increase patients' access to their doctor and keep better electronic health records. Such accessibility can lead to more preventive care, reducing the incidences and severity of chronic diseases.

- Commitment to Quality and Safety. Thanks to enhanced health IT programs and other tools, the Medical Home team is ideally equipped to help patients make informed decision on treatments, best and safest use of medicines, fewer ER visits and hospitalizations, and timely scheduling of vaccinations and exams.

For providers, a Medical Home creates an environment that enhances their abilities to deliver quality care through:

- Focused Care. The staff can more easily focus on the needs of each patient in a cooperative manner through shared, open communication, thereby improving treatments and diagnoses.

- Stronger Relationships. The essence of the Medical Home philosophy that fosters a patient's involved, comprehensive care from a lead doctor will nurture relationships and build trust. From a physician's perspective, the importance of such relationships is a critical element in providing the care a patient needs.

- Efficiencies. The health care team benefits through the coordinated use of e-communications, telemedicine and other tools to be more efficient and effective in treating patients.

Combine these upsides and it becomes evident why nearly 7,000 primary care practices have officially been accredited as PCMHs, and thousands of other providers have adopted features of Medical Homes, according to the May 2014 Medical Home Bulletin.[3]

And, according to the PCPCC, "More than 90 commercial and not-for-profit health plans, including the nation's largest, are leading initiatives grounded in the philosophy of patient-centered care and PCMH. Dozens of the nation's largest employers, including Boeing, IBM, Intel, Safeway and Lockheed Martin, are offering advanced primary care and PCMH benefits to thousands of employees."[4]

The organization also notes that in the public sector millions of beneficiaries today receive such care through a variety of programs, and large numbers of people similarly benefit from private entities.

New Paradigm Presents Challenges

Despite this significant progress, the path to such growth includes several roadblocks. The fact that the Medical Home model itself presents a different paradigm for delivering health care is an ever-present challenge. The concept is not necessarily intuitive nor can it be adapted easily or quickly. More providers are involved, and buy-in is needed from them. Similarly, patients need to embrace the model. Core to the model is a mindset that incorporates both preventive and immediate care.

Those "in the trenches" acknowledge such challenges. For example, David T. Tayloe Jr., MD, of Goldsboro Pediatrics, Goldsboro, North Carolina, said, "The hardest part was convincing primary care providers to buy into the program. It is easy for providers who are paid fee-for-service to ignore the Medical Home agenda that entails care coordination and integration of care into the health, human services and education sectors of the community."[5]

Patient engagement has been one of the most difficult factors in the Medical Home transformation process, according to Ed Rippel, MD, at Quinnipiac Internal Medicine, Hamden, Connecticut. He noted two key contributors: health care expense cost shifting to patients through higher deductibles and copays, and inadequate health care literacy that finds many patients without a clear understanding of their benefits.[6]

"Getting our information systems to provide useful population health data" has been the greatest challenge at Eisenhower Argyros Health Center, La Quinta, California, said Joseph E. Scherger, MD, vice president, primary care. "Forming our teams, increasing patient communication and doing care coordination were not difficult …. (but) our information systems lag behind our work processes."[7]

As evidenced by these perspectives and others in the field, the need for over-communication, development of new skills and teamwork cannot be underestimated.

Sharing this insight, Michael Millenson, a long-time health care journalist, consultant and now president of Health Quality Advisors, recently wrote that patient-centered care "represents a new paradigm more than a new pill. Emerging care delivery models demand that individuals actively manage their health and health care and that providers and purchasers help them do so. Both sides are still adjusting."[8]

Uncertainty reigns for a number of reasons, including the shift to a more collaborative type of relationship between patient and doctors, the advances in online health information and the communications challenges these and other changes engender.

Millenson adds that such changes demand a cultural shift among all involved, developing not only new structures and processes, but new roles, responsibilities and expectations. He concludes, "Difficulties, disruption and discomfort will inevitably ensue; we are, after all, upsetting deeply established practices … Though there will be criticisms and course changes, the journey to a more patient-centered health care system nonetheless promises extraordinary clinical, economic and ethical gains."[9]

Indeed, with so many "moving parts," critiques of the Medical Home model and demands for evidence to demonstrate its value and validity are present today. One perspective that captured the attention of many in early 2014 was a report from RAND Corporation, which evaluated the Southeastern Pennsylvania Chronic Care Initiative, one of the nation's earliest and largest Medical Home pilots. Based on data that compared primary care practices in the pilot to those not participating, the study found improvements in one of 11 quality measurements (e.g., asthma care, cancer screening, ER visits, among others). In addition to the report's publication in The Journal of the American Medical Association,[10] the findings (rejected by many, discussed below) gained widespread prominence after The New York Times highlighted the study in an article headlined, "Study Finds Limited Benefit to Some Medical Homes."[11]

Just three months after issuance of the RAND study, the Commonwealth Fund on its website featured a story from the newsletter CQ HealthBeat with the rather incendiary headline, "Full Promise of Medical Homes Could Be Years Away, Experts Say."[12] Reporting on a briefing on Medical Homes by the Alliance for Health Reform, the article spotlighted the RAND study, although noting doctors involved in the project dispute the findings. The article did provide some balance to the coverage, stating that with the implementation of Medical Homes, there will be mixed signals, as doctors and insurance companies work through major changes in the coordination and delivery of care.

One of those changes is the need for physicians to integrate care coordination into their workflows. According to George Lowe, MD, medical director, Maryland Family Care, Lutherville, Maryland, primary care providers who see 50 patients a day in a 10-hour day may find it difficult to provide time for care coordination, medical record reviews or extra counseling.[13]

But once physicians see their first success with the care coordination model, things start to flow, Lowe says.

Even a leading standard bearer for Medical Homes, the PCPCC, acknowledges one will at times find mixed results. The organization wrote in its recent annual update that although the latest studies demonstrate a number of constant, positive outcomes, a gap exists in reporting on the impact on clinician satisfaction.

Growing Evidence Illustrates Positive Impacts

However, reports on Medical Home outcomes citing research significantly more current than those in the much publicized RAND report are, in fact, increasing in numbers. The dated criteria used in the RAND report is one of its major shortcomings, according to many experts. Some have noted the findings were based on standards set in 2008 that have since changed dramatically. One critic of the study said it's like "using a review of the iPhone 2 when you already own an iPhone 5."[14] And another noted that despite how the study grabbed headlines, "no single study should evaluate the wide body of work being done to transform primary care across the country."[15]

What can and should be done is to review studies that objectively evaluate Medical Home implementation based on more recent goals and standards. The literature is becoming vast, and is enlightening and revealing. Here are just a few highlights of the latest data:

- In the January 2014 PCPCC annual update, "The Patient-Centered Medical Home's Impact on Cost & Quality," an analysis of 20 of the most recent studies on Medical Home initiatives demonstrated improvements across a number of metrics in peer-reviewed (academic) and industry-generated studies. The most common reported metrics cited decreases in the costs of care, reductions in the use of unnecessary or avoidable services, improvements in population health indicators (e.g., blood pressure), increases in preventive services, improvements in access to care and improvements in patient satisfaction.[16]

- The January 2014 "Vermont Blueprint for Health 2013 Annual Report" detailed how people who received care in Medical Home settings had a number of favorable outcomes versus those in comparison groups, including reductions in annual expenditures per capita for traditional health care, reductions in inpatient hospitalizations, reductions in pharmacy expenditures and a shift toward less specialty care with high utilization of primary care services.[17]

- As described in the January 2014 Minnesota Department of Health's "Health Care Homes: Annual Report on Implementation," a University of Minnesota evaluation conducted in 2013 showed certified HCHs had higher scores than non-certified primary clinics on a number of quality measures and had overall lower Medicaid expenditures than non-HCH clinics. (Minnesota uses the term Health Care Homes to represent the "nationally known Patient Centered Medical Homes.")[18]

- A November 2013 report on the Oregon Coordinated Care Organizations/Oregon Health Authority initiative cited a reduction in ER visits and spending, reduction in inpatient admissions with increases in outpatient primary care visits and sharp increase in Medical Home enrollment.[19]

- In the December 2013 publication on the Horizon BlueCross BlueShield New Jersey PCMH Pilot Monmouth County Public Employees program, it was reported that during the 2012-2013 time frame, there was a 33 percent increase in colorectal screenings (versus 10 percent in non-PCMHs) and a 23 percent increase in breast cancer screenings (versus 3 percent increase in non-PCMHs).[20]

- A study recently published in the Annals of Internal Medicine unveiled the findings of research that compared the quality of care of 675 primary care physicians in three groups in the Hudson Valley of New York, revealing Medical Homes performed 6 percent better than non-PCMH practices that use electronic health records and 7 percent better than non-PCMA practices that use paper records.[21]

- In research that addresses health care organizations' interest in Medical Homes in general, more than three-quarters of respondents in a Medical Home News survey said their involvement in Medical Home issues increased in 2013 when compared to 2012. The same survey showed a majority (57 percent) believe that widespread adoption of the Medical Home model would increase quality and lower costs.[22]

Surveys of consumers also reveal patient acceptance of the Medical Home model. In early 2014, the John A. Hartford Foundation surveyed adults 65 and over and learned that an overwhelming majority (83 percent) of those who receive team care report it has made a difference for them in improving their health. And among those respondents who don't receive team care presently, large numbers (73 percent) said they would like to have such care.[23]

And, in a guest article Modern Healthcare titled, "Don't let lack of evidence delay patient-centered changes," Planetree president Susan Frampton emphasizes that based on her group's research for the past decade, there is ample evidence to spur adoption of practice change to include "patient-preferred practices" as exemplified in the Medical Home model. Frampton said, By not limiting ourselves to the traditional definition of evidenced-based 'best practices,' we "position ourselves to accelerate the work of creating a truly patient-centered healthcare system."[24]

The Critical Role of Accreditation

A key contributor to ensure the ambitious goals of a Medical Home are attained is the accreditation process. Establishment of standards customized for the Medical Home model is essential to foster best practices.

A review of the key principles applied by the Accreditation Association for Ambulatory Health Care in this process – with its appropriate emphasis on the patient's role and perspective – provides a blueprint for how Medical Homes can succeed:

- Focus on the physician/patient relationship. This evaluates how the patient and spouse or partner work with the Medical Home team to make health care decisions and how involved the team becomes in each patient's total well-being.

- Make the patient the center of care. It's not the disease, the diagnosis or payer, but the patient who is part of the team that decides what interventions are likely to succeed. Considerations must be given to the patient's history and respect his or her needs and preferences.

- Provide accessible, comprehensive, continuous care. Here, the accreditation process should survey how the patient has access to care 24/7, affirm seamless transitions are in place from episodic treatment of sickness to preventive care and maintenance of wellness, and ensure care always is well documented.

- Emphasize data understandable to the patient. In addition to comprehension, this encompasses quality assessments, use of patient dissatisfaction to improve services and patient accessibility to information and services.

With such criteria in place, it is best to assess an organization at the point of care. This approach underscores a key concept of the model itself, which finds practitioners and patients collaborating and fully engaged in all aspects of the health care cycle.

The review must go well beyond checks on a clip board or computer screen. It should involve a peer-review process and be consultative. Evaluations should not be punitive; instead, they should provide direction, guidance and recommendations to help the organization fulfill its responsibilities and commitments to each patient and the health care team.

It Takes Vision

Like most initiatives with great vision, the Medical Home that each organization adopts will require ongoing evaluation, refinements and time to succeed. The challenges can be overcome. Criticism is to be expected, should be recognized, analyzed and then, as appropriate, used to make improvements and enhancements. Research on outcomes is paramount to uncover key learnings and create new, fact-driven strategies. And the accreditation process, when adhering to key principles and consultative peer-driven, on-site reviews, can further strengthen the bonds between patients and physicians.

When this transformative process is completed, and the Medical Home concept is implemented to the highest of standards across the country, we can deliver on the promise of a health care system that truly puts patients first.

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