Home Sweet Medical Home: Can a New Care Model Save Family Medicine?

by Chris Dimick

The medical home model puts the patient at the center of healthcare. It may also save primary care in the process.

Medicine is fighting to save the primary care physician.

With healthcare increasingly oriented around specialty physicians and large practices, market realities are leading to the decline of the primary care practice. Fewer physicians are entering family medicine; increasing costs and decreasing reimbursement have hit established practices hard.

But hope lies in a new model of healthcare, one that could transform family medicine and better the entire healthcare system, proponents say. The patient-centered medical home model may be the future of primary care.

Proponents of the model say the shift in care marks an important rethinking of patient-physician relationships. "When we talk about the patient-centered medical home, we are talking about healthcare as it needs to be versus where it is now," says Douglas E. Henley, MD, FAAFP, executive vice president and CEO of the American Academy of Family Physicians (AAFP). "It is a vision for the future that is, first and foremost, centered on the patient and not on the physician or the practice."

Several private and government demonstrations of the medical home model have recently begun. The Centers for Medicare and Medicaid Services (CMS), the country's largest payer, is testing the waters.

What Is Medical Home?

The patient-centered medical home is an approach to healthcare in which primary care physicians act as coordinators of patients' longitudinal care. The medical home physician works with and recommends specialists and other physicians as necessary and leads the medical team in coordinating a patient's preventive, acute, and chronic care needs.

The model promotes communication and access to make healthcare more convenient for patients, Henley says. Patients would be able to e-mail their physicians for treatment, have access to appointment scheduling, and take advantage of expanded office hours. The model emphasizes preventive care, with physicians actively tracking a patient's health over time.

Health information management systems play a role in the medical home. Physicians would use electronic health records (EHRs) and clinical decision support tools to improve quality and efficiency. They could offer Web portals that allow patients to access lab results or monitor a chronic disease.

A number of insurance companies, payers, businesses, and physician associations including AAFP have endorsed medical home and pledged support for the model. Studies have shown that areas with more primary care physicians in the community are healthier, Henley says. This is because primary care physicians can help integrate and coordinate medical care. Those contributions will only increase with the implementation of medical home, he says, and lead to better care with lower costs.

Curing Reimbursement Ills

Making medical home a reality requires a change in the current reimbursement structure. The ills of modern healthcare can be boiled down to various causes, Henley says, one of which is the way primary care physicians get paid.

Primary care physicians are compensated for performing services. Because reimbursement is lower than in specialty services, primary care physicians are forced to fit as many patients as possible into a single day just to pay the bills. The switch to medical home could change this, but it all starts with payers setting up a medical home payment structure, Henley says. A large factor in getting physicians to become medical homes rests on the federal government—as a major payer—agreeing to change its reimbursement structure to fund medical home.

Though several large businesses have expressed interest in purchasing healthcare delivered via the model, it is nearly impossible for an employer like IBM to request the purchase of medical home healthcare without CMS first agreeing to fund such models, according to Paul Grundy, MD, MPH, FACOEM, director of healthcare technology and strategic initiatives for IBM and chairman of the Patient-Centered Primary Care Collaborative (PCPCC).

Because so many patients are enrolled in Medicare, most physicians can't risk changing their care model without the assurance that their biggest payer will adequately compensate them for their services. Since medical home calls for a major reorganization of the way care is provided, it is essential to have Medicare on board with the model, Grundy says.

Saving Money, Reallocating Money

Proponents say the model will help contain rising healthcare costs because physicians are paid in a much different way. Traditionally, physicians are paid per patient encounter. The more procedures physicians perform and the more patients they see, the more they are paid. This results in stressed-out doctors trying to treat as many patients as possible, uncoordinated and piecemeal care, and skyrocketing healthcare costs, Grundy says. The patient-centered medical home's reimbursement structure would be much different.

Physicians would be paid a per-patient monthly fee to manage their care and reimbursed for encounters such as e-mail and telephone consultations. Some payment would be tied to pay-for-performance, some by encounter. Physicians also would be paid for using computerized systems such as EHRs and patient registries. Other changes include payment for managing a population, not just a patient, through services like group visits and registry monitoring.

The reimbursement changes associated with medical home don't necessarily create a demand for new money to be pumped into healthcare, Henley says. Instead, money that would be spent down the line on reactive medicine is shifted to the front end and used in preventive care.

In fact, one study has shown that for every $1 paid to physicians in care management fees, $6 are saved in future healthcare expenditures since preventive care avoids more costly procedures later, Henley says. "That is a pretty good return on investment," he notes. "We make the point that this care management fee is not new money. It is money that can be saved elsewhere in the system through decreased hospitalizations, decreased hospital readmissions, decreased duplication of unnecessary testing."

Roles for HIM in Medical Home

Though technology will play a big part in the patient-centered medical home, experts admit that most physicians do not have the technical infrastructure in place to host the more advanced stages of the model.

Historically, primary care physicians have had trouble seeing the direct benefits of implementing an EHR, Grundy says. But it is expected that in the future payers will offer financial incentives to those medical homes that implement EHRs and other technology. This could lead physicians to take the technological leap, he says. HIM professionals could lend skills in preparing the practice, selecting the system, and overseeing the implementation.

In a fully implemented medical home, physicians will use EHRs, e-prescribing technology, patient registries, and other health IT systems. HIM can help physicians determine how these systems integrate and produce the records necessary for care, Henley says.

HIM professionals can also assist physicians in establishing and managing structured patient registries for population health studies. They can optimize registries to maximize their potential in managing chronic disease, providing alerts and reminders, and increasing compliance with recommended services.

E-mail and electronic records will up the ante on records retention, and many physicians will need assistance navigating the uncharted waters. HIM professionals can help establish e-mail hold and destroy policies, as well as assess and manage record systems for sound business and legal requirements.

Employers Want It

It is not just primary care physicians and physician associations who are calling for the new model. Large employers are joining the medical home rally, hoping the switch will allow them to buy better, cheaper care for their employees. Some of these employers include IBM, GE, and Wal-Mart, who have joined PCPCC.

The collaborative is a group of employers, consumer groups, insurance companies, and providers lobbying for the use of medical home. IBM formed the group in 2006 in response to high healthcare costs the company pays for its employees. Large employers have joined the task of changing the system to lower their own costs and increase their competitiveness, Grundy says.

Businesses are especially interested in medical home's focus on saving costs through preventive care. "At IBM, we can buy a darn good amputation for our diabetics, but we can't buy the kind of care that would prevent you from needing the amputation," Grundy says. Joining employers are physician associations like AAFP, who feel the patient-centered medical home represents both the best care for patients and the best chance at survival for their physicians, Henley says.

Some organizations are listening, including CMS.

The Medicare Demonstration Project

In 2006 the Tax Relief and Health Care Act created the Medicare Medical Home Demonstration Project, a test of medical home-based care and reimbursement. A yet-to-be-determined number of practices in up to eight states will take part in the project beginning in 2009, when they will fully transform into a medical home and receive special reimbursement from Medicare. The project is a great first step toward nationwide medical home implementation, Henley says.

A big advancement for medical home supporters came in April when the Resources-Based Value Scale Update Committee (RUC), the group that advises CMS on reimbursement, set payment rates for medical home services. RUC recommended practices be classified in three categories based on their implementation of the model. The higher level a practice implements, the higher its reimbursement.

Practices at level 1, for example, would perform certain coordinating activities, but these would not require implementation of health IT. Getting to the next level likely would. RUC also recommended medical home physicians be paid a care management fee—per patient, per month—for care integration services as well as for other services such as e-mail communications or developing patient registries, Henley says.

CMS is not required to accept the RUC recommendations, but the committee's proposal is a good sign that CMS will follow the reimbursement structure supported by medical home proponents. The hope is medical homes would have a blended payment structure of traditional fee-for-service, pay-for-performance, and care management payments.

The structure would provide primary care physicians adequate compensation and increase their incentive to perform quality care, Henley says. In addition to the federal initiatives, at least 19 states have adopted or are considering legislation around the medical home model. Many are accepting it as their future healthcare blueprint, according to Grundy.

TransforMED

TransforMED is another medical home implementation trial developed by AAFP in 2006. The national demonstration project successfully started the implementation of medical home in 32 physician practices around the country.

For two years, TransforMED aided half of the practices in their transition to the new model, while observing the other half self-implement the change. The point of the pilot was to test how practices would have to change to successfully operate a

medical home.

The study showed that medical home could be implemented, Henley says, but not without the expected productivity disruption and challenges of practice change. A report on the project is due in 2009, which will describe the successes and hardships associated with implementing the medical home model.

Though the official trial is over, TransforMED will continue to help transform physician practices into medical homes by operating as a consulting group. As for the newly transformed medical homes, Henley says many will continue to advance their medical home implementation, bringing in more elements of the model over time.

A Long Road Home

Critics of medical home state that physicians don't have the management skills or training to effectively manage a medical home practice. That is true for some today, Grundy admits, but residency programs are slowly changing to teach the new model of care. Medical societies such as AAFP understand there is an education gap and have created programs like TransforMED to aid physicians in the transition.

"Practices are going to need certain tools and information in order to become medical homes," Henley says. "We told members, 'You can't just raise your hand and declare that you are a medical home. You are going to have to go through a designation process as a practice.'"

The RUC reimbursement recommendation was a great turning point for the medical home model and a starting point for change, Henley says. The hope is that Medicare will eventually implement the demonstration project system-wide. That could be the tipping point that causes physicians to start adopting the model, Henley says.

It will take time, and not every practice starting to transition will be a medical home from day one. But merely beginning is better than following a line of care that leads to suboptimal health and lower pay for services, Grundy says. AAFP agrees, and it is encouraging primary care physicians to start moving toward medical home even though there is not yet a promise for improved reimbursement, Henley says.

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