

Patient-centered medical home: Making care coordination work for your practice

PCMH model brings challenges and rewards for physicians

May 23, 2014

By [Pamela Lewis Dolan](#)

The centerpiece of the [patient-centered medical home \(PCMH\) model](#) is a multi-disciplinary team that has everyone working at the top of their license to provide the right care, at the right time, in the most appropriate setting. But the success of a PCMH relies on a practice's ability to track the care patients receive across the various components of the medical home using care coordinators and technology.

Judith Steinberg, MD, MPH, recently had a male patient who was diagnosed with AIDS. Making matters worse, his wife was found to be HIV-positive. The couple was overwhelmed and scared as their nightmare unfolded in the exam room. After discussing both diagnoses with the couple, Steinberg opened the exam room door, a behavioral health specialist stepped in, and counseling started immediately.

The case became more complicated when a cancer diagnosis was later added to the male's list of problems. As his care plan was put into action, Steinberg was always aware of his health status even as he moved between inpatient, outpatient and specialty care settings because a care coordinator was in charge of making sure all the information made it into his record.

How the case was handled is a textbook example of what a PCMH is, says Steinberg, deputy chief medical officer for UMass Medical School's Commonwealth Medicine division, which participated in a multi-payer PCMH demonstration project that ended on March 31.

"When I describe the patient-centered medical home to practices, providers, or to anyone—all of us are patients at one point or another—I like to say it's really the way we, as patients, would like to see our care delivered," says Steinberg.

"It makes such perfect sense that our care is focused on us as an entire individual, not as individual diseases or organ systems. That our care is well-coordinated and communicated across many settings and there's an attention to quality and we are all partners in our care," she added.

The biggest misnomer about medical homes, says Michael Meucci, director of transformation and improvements at the Burlington, Massachusetts-based healthcare consulting firm Arcadia Healthcare Solutions, is that being a PCMH means you received a certification. Practices with this mindset are more focused on passing a test than [changing the way they practice](#), says Meucci.

Some practices are already doing things considered to be concepts of a medical home, not to check items off a [certification checklist](#), but to provide better care, he says.

The five vital features of a patient-centered medical home (PCMH) are:

Comprehensive care	The PCMH is designed to meet the majority of a patient's physical and mental healthcare needs through a team-based approach to care.
Patient-centered care	Delivering primary care that is oriented towards the whole person. This can be achieved by partnering with patients and families through an understanding of and respect for culture, unique needs, preferences, and values.
Coordinated care	The PCMH coordinates patient care across all elements of the healthcare system, such as specialty care, hospitals, home healthcare, and community services, with an emphasis on efficient care transitions.
Accessible services	The PCMH seeks to make primary care accessible through minimizing wait times, enhanced office hours, and after-hours access to providers through alternative methods such as telephone or email.
Quality and safety	The PCMH model is committed to providing safe, high-quality care through clinical decision-support tools, evidence-based care, shared decision-making, performance measurement, and population health management. Sharing quality data and improvement activities also contribute to a systems-level commitment to quality.

Next: PCMH benefits and rewards

PCMH benefits and rewards

One of the main drivers for physicians participating in the PCMH model at Lutherville Personal Physicians in Maryland is the [financial rewards](#) offered by the largest payer in Maryland: CareFirst BlueCross BlueShield, according to George Lowe, MD, medical director of Lutherville and Maryland Family Care, the family care healthcare organization to which Lutherville belongs.

When doctors sign on as a PCMH participant, they automatically get a 12% increase in reimbursement for primary care services. If at the end of the year there are [calculated savings](#), physicians receive an incentive that is determined by a formula that includes the total amount of savings and quality scores. In some cases, physicians have seen a 50% increase in reimbursements, Lowe says.

“If we could keep the quality flat and produce savings, that would be an acceptable model. But a double winner would be cost savings and improved outcomes and quality measures,” says Lowe. “And I think the verdict is still out on that. It depends on what metrics you are looking at.”

Marci Nielsen, PhD, MPH, chief executive officer of the Washington, D.C.-based Patient-Centered Primary Care Collaborative (PCPCC), agrees that success depends on the metrics that are evaluated. One of the goals of the PCPCC is to gather evidence of how PCMHs are affecting healthcare cost and quality. Nielsen said that while many plans are starting to use the concept, it's been a little harder convincing employers because it often takes several years before the savings are quantifiable.

The PCPCC published a report in January that examined 20 peer-reviewed studies on PCMHs and cost and utilization from the previous 17 months. “We found ... 61% of the time, if the study looked at cost and utilization, they, in fact, found cost reduction,” Nielsen says. While that is positive, there are always caveats.

“We scientists are very reluctant to say anything as bold as ‘this works.’ That’s just too declarative as a statement. What we like to say is, ‘It works under these circumstances, under these settings, if you do these 15 things.’ That’s how we’re trained and that’s appropriate, but employers want the bottom line.”

Until employers and payers see the bottom-line evidence, the impact PCMHs will have on a practice's finances is not entirely clear. Few have an ongoing commitment from their payers like the one Lutherville physicians have from CareFirst. However, Lowe expects that in the near future physicians who aren't helping CareFirst save money will likely see their incentives go away.

Over the past several years, payers have experimented with various incentive and payment models through PCMH demonstration projects. None have yet emerged as the most sustainable.

Achieving the goals of the PCMH model requires aligning three vital components:

Health information technology	Health information technology (IT) can support the PCMH model by collecting, storing, and managing personal health information, as well as aggregate data that can be used to improve processes and outcomes. Health IT can also support communication, clinical decision making, and patient self-management.
Workforce	A strong primary care workforce including physicians, physician assistants, nurses, medical assistants, nutritionists, social workers, and care managers is a critical element of the PCMH model. Amid a primary care workforce shortage, it is imperative to develop a workforce trained to provide care based on the elements of the PCMH.
Finance	Current fee for service payment policies are inadequate to fully achieve PCMH goals. Providers are not routinely compensated for care coordination or enhanced access, contributions of the full team are often not reimbursed, and there is no incentive to reduce duplication of services across the care continuum. Payment reform is needed to achieve the potential.

Source: Agency for Healthcare Research and Quality

Next: Risks and benefits

Risks and benefits

Many leaders of PCMHs say that once their physicians adopt the model, they would not go back. But that's not to say there aren't challenges getting them to that point.

The care coordination aspect is one for which many physicians are not prepared, either financially or from a time management perspective. Many of the payer-initiated PCMHs provide money for care coordinators. But practices that don't have this support must move employees and shift job responsibilities around to provide this service. Many physicians have found it challenging to work care coordination into their workflows, according to Lowe.

"It's symptomatic of primary care physicians across the country," says Lowe. "Primary care providers who are seeing 50 patients a day in a 10-hour day, there is no time for care coordination. There is no time for medical record reviews. There is no time for extra counseling. They are just trying to keep up with the demands of people who are coming in who are sick."

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



This is not a technical change with financial costs. This is a cultural change with a personal cost. So it really is about the people, and reorganizing how you work."

Christine Johnson, PhD, PCMH quality improvement and transformation director at UMass Medical School's Commonwealth Medicine division, witnessed such a success story. A physician who resisted working with case managers had a complicated patient arrive for a post-hospitalization follow-up. Before the patient arrived, the case manager had already reconciled all of the patient's medications and had the report ready for the doctor's review. The physician described the experience as "going from baggage to first class," according to Johnson.

A fear that keeps practice leaders awake at night is that money will be spent on changes such as extending office hours, hiring staff members to help coordinate care, and adopting the needed technology, and the practice won't realize any benefits. This is especially worrisome for physicians who assume risk for their patients' decisions.

In the PCMH model at the Center for Children and Women in Houston, Texas, which is part of the Texas Children's Health Plan, a health maintenance organization, physicians are paid a per-member, per-month premium by the state, says Heidi Schwarzwald, MD, MPH, medical director of pediatrics at the Center for Children and Women. Therefore, providers assume the risk for whatever happens to that patient. "So if a patient of mine goes to the emergency room, I pick up that risk," says Schwarzwald.

Via Christi Clinic, a 53-family-doctor practice in Wichita, Kansas, doesn't have payer support for its PCMH. It hired three full-time employees and reassigned existing staff members to take on care coordination roles, and built its data collection systems from the ground up, says Terry L. Mills, MD, FAAFP, medical director of patient care services at Via Christi.

There was a financial cost to becoming a PCMH, says Mills. "The problem is when people ask, 'What's it going to cost me to become a medical home?' they are looking for a dollar amount that doesn't exist. It really is a cultural question that people want a financial answer to," says Mills.

Next: More than one way to set up a medical home

Because the PCMH concept continues to evolve, there is no definitive answer as to whether it will produce the desired outcomes, despite numerous studies of models from all across the country. A recent study of a PCMH in Pennsylvania received a great deal of attention from both opponents and proponents of the PCMH model.

The study, which appeared in the February 26, 2014 issue of the *Journal of the American Medical Association*, found that after three years, the PCMH failed to reduce costs and improve outcomes. The findings led to several declarations that the PCMH model was a failure.

Subsequent rebuttals pointed out the limitations of the study, most notably, that the PCMH was formed in 2008 using guidelines from the National Committee for Quality Assurance (NCQA) that have since been updated twice.

Also, participants in the PCMH were offered incentives to achieve NCQA recognition, not to reduce costs.

More than one way to set up a medical home

PCMHs all tend to have similar themes of care coordination, increased access to care, and an eye toward improved outcomes and reduced costs. How each practice achieves those goals will vary, however.

Patients in almost every practice have only 15 minutes with the physician, says Jeanette Ball, RN, executive consultant for CTG Health Solutions, a Buffalo, New York-based healthcare

consulting firm. “You want that 15 minutes to be the best 15 minutes you can give,” she says. It’s up to each team to figure out what they can do to make things run as efficiently as possible, says Ball.

The most important member of the team, says Nielsen, is often the one who is forgotten about during PCMH implementation: the patient. When she talks to physicians about bringing patients in as practice advisers, “they look at you like you have two heads.” But physicians who have done so have found that patients have some of the best ideas, she says.

As to whether a practice should pursue accreditation, Nielsen suggests talking to payers, finding out what programs they have in place, and which ones require accreditation. But most importantly, each practice should forge its own path and think less about the checklists and more about the benefits they want to achieve.

“This is not a technical change with financial costs. This is a cultural change with a personal cost,” says Mills. “So it really is about the people, and reorganizing how you work and how you communicate and how you even think about what you do. And everybody comes to that place of adapting at their own rate and time. You can’t force it, you just have to keep working through it.”