



Patient-centered, Physician-directed Medical Home

The Patient-centered Medical Home—a New Revolution

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Thomas Jefferson said, “Every generation needs a new revolution.” For patients, physicians, payers, legislators, practices and health systems, the patient-centered medical home (PCMH) has the potential to be the multidimensional revolution that changes the face of healthcare in the United States.

Family physicians have long understood the importance of healthcare that is accessible, continuous and coordinated around the needs of patients and their families. Now, American Academy of Family Physicians (AAFP), working in concert with other primary care physician specialty societies, has defined the PCMH in order to promote the importance of primary care to payers, legislators and patient groups. The AAFP board of directors (AAFP BOD) recently approved a definition of the PCMH:

A PCMH integrates patients as active participants in their own health and well-being. Patients are cared for by a personal physician who leads a medical team that coordinates all aspects of preventative, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience and optimal health throughout their lifetimes. (Approved by AAFP BOD, May 2008)

The PCMH is rapidly becoming a key component of meaningful healthcare reform in the United States. This approach to reform is led by the Patient-centered Primary Care Collaborative (PCPCC), founded in 2006 to create a more cost effective and efficient model of healthcare. Large national employers (such as IBM) reached out to the primary care groups asking for help to achieve meaningful, bold healthcare reform that recognizes the value of primary care. PCPCC has a goal to change the present payment system that does not work for patients, providers or purchasers. Currently PCPCC has more than 100 member organizations.

Within PCPCC there are four project centers:

- (1) e-Health information exchange and adoption;
- (2) Multi-stakeholder demonstrations (pilot programs);

- (3) Promoting public payer implementation; and
- (4) Health benefit redesign and implementation

No less than two of these project centers include primary care payment reform as a core requirement of the reform model. When fully implemented, the model pays family physicians in medical homes for care coordination services that presently go unpaid and account for up to 25 percent of family physicians’ professional services. The PCMH model continues fee-for-service payments while new money coming to family physicians will promote appropriate pay-for-performance quality initiatives and care coordination.

Recently, the Collaborative released a health plan purchasing guide for employers which is aimed at helping businesses advance the medical home model. This information is available on the PCPCC Web site at <http://www.pcpcc.net>. Individual physicians can join the PCPCC and receive routine updates on activities to promote the medical home.

The medical home message is getting a lot of attention; in July 2008, an article in *USA Today* stated:

“The pay boost rewards doctors who reshape their practice to re-create an era when a trusted family physician helped patients through hospitalizations, coordinated specialist care and provided routine screenings.”

Most family physicians, and other primary care physicians, are in agreement with the principles upon which the PCMH is founded. Many feel as if they are already a medical home. Frankly, this is not the case. Our greatest challenge may be meeting the expectations of enhanced PCMH services as medical home pilots go live across the country even with significant payment reform. For example, in order to reach the highest level PCMH as recognized by National Committee for Quality Assurance (NCQA), your practice must include at least four of the following technology components:

- Electronic health record system
- e-Prescriptions

- e-Appointment scheduling
- Disease/population management software
- Evidence-based decision support
- Web-based information sharing with patients
- e-Visits

Another key element to transforming your practice would be to establish a formal patient feedback process in which to evaluate the patients' experience/satisfaction.

Once implemented, the PCMH model operates as a physician-led team which facilitates enhanced patient services while allowing physicians to work smarter, not harder. If your practice does not have at least four of the above components, it would be a positive, beneficial challenge to start reforming your office in advance of the real promises on the horizon developing from PCMH. Currently, there are many medical home pilot projects springing up around the country.

Section 204 of the Tax Relief and Health Care Act of 2006 directs the Centers for Medicare and Medicaid Services (CMS) to perform a three-year Medicare demonstration project in eight states of a medical home model beginning in 2009. Although selection of the pilot states and details of the plan are not yet finalized, CMS estimated up to 86 percent of Medicare patients could qualify for participation in a PCMH model and that the typical medical home (physician practice) would have approximately 250 Medicare patients who qualify.

As part of the Medicare pilot legislation, CMS asked

the American Medical Association (AMA) Specialty Society Relative Value Scale Update Committee to develop CPT G codes for the medical management component of the medical home. The table below lists these codes for three levels of medical home services and its estimated payment rates based upon the current value of the Medicare conversion factor.

Tier	Physician Time	Work RVUs	Estimated \$\$ Value
1	6.5 minutes	0.25	\$30
2	7.8 minutes	0.30	\$40
3	9.2 minutes	0.35	\$50

Billed monthly for an estimated 250 Medicare patients per physician medical home, potential new payments to these physicians functioning in a tier two medical home would be \$120,000 annually.

In developing the PCMH model of care to promote the value of services delivered by primary care physicians and their teams, the PCPCC thought it was important to have an independent measurement of the medical home. NCQA reacted to this need as a response to what they perceive as a crisis in primary care. NCQA transformed an existing NCQA certifications program to become the Physician Practice Connections® - Patient-centered Medical Home (PPC-PCMH™.) The joint principles of the PPC-PCMH

are essentially those of the medical home as developed by AAFP and the other primary care specialty associations. In an unprecedented move, NCQA acknowledged the need for payment reform by stating, "Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home." NCQA PPC-PCMH certifies the practice at one of three levels of a medical home based upon 10 elements. For a level one, the practice must earn at least half of the points for each of five elements. Most family medicine practices should be able to reach level one recognition even without an electronic medical record.

A complete discussion of NCQA PPC-PCMH is beyond the scope of this article. However, family physicians

are encouraged to review the information on the NCQA Web site at <http://www.ncqa.org/tabid/631/Default.aspx>.

Additionally, TransforMED® (see pp. 30-31), a subsidiary of AAFP offers a free "Medical Home Implementation Quotient Online Self-Assessment" on its Web site at www.transformed.com. Practices are encouraged to complete the assessment to gauge how close they are to being a medical home. This is an excellent first step toward reaching medical home recognition.