

Is there a medical home in your hospital's future?

The answer depends on finding a profitable model

Two trillion dollars sure buys a lot of frustration in this country. That's the current figure for health care spending in the U.S., and it feels like all we have to show for it is patient confusion over navigating the system, employer agitation with rising costs, and government aggravation trying to provide affordable access to all.

In the last few years, there's been a growing interest in the concept of a Patient-Centered Medical Home as a way to combat the ills of the U.S. health care system. Proponents of this approach believe the way out of our health care conundrum is to make the primary care physician the hub of a patient's disease prevention and care coordination. In a medical home model, the primary care doctors and clinicians serve as advocates for patients, helping to avert unnecessary tests and procedures, hospital admissions and avoidable complications. Instead of a payment system that rewards procedures and volume, it would shift to one based on patient satisfaction and clinical outcomes.

While few argue with the goals of a patient-centered approach to the delivery of health care, most agree that transforming the current system will not be easy. Nor is the financial viability of this concept so readily clear. In this paper, we will discuss the impetus for Patient-Centered Medical Homes, review conceptual and existing models, and examine the financial implications to hospitals and primary care physicians.

Origins of medical homes

The birth of the medical home concept goes back to 1967, when The American Academy of Pediatrics (AAP) used the term to describe a central location for archiving a child's medical records. In the following decades, medical homes focused primarily on families with children of special needs, helping to coordinate care and information across multiple specialists and services.

By the 1990s, as the delivery of health care was becoming more complex, the role of the medical home expanded to also include the provision of comprehensive primary care for adults. Associations such as the American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP) also embraced the medical home concept and issued a joint statement of principles with the AAP in 2007.

Today, the term "medical home" is somewhat a misnomer, as it refers not to a location but to a model based on integrated care across all elements of the health care system—hospitals, nursing homes, subspecialty care, home health agencies, public and private community services and family members.

Current impetus for adoption

Interest in implementing a Patient-Centered Medical Home has been gaining traction among hospitals and physician groups over the last few years based on five main trends:

1. High prevalence of chronic conditions among adults:

Currently, 45 percent of the population has a chronic medical condition. Among the Medicare population, 83 percent of individuals have at least one chronic condition. In fact, nine of 15 diagnoses for hospital admissions are directly related to chronic conditions. More than 80 percent of medical expenses are incurred by approximately 15 percent of an employee population affected with chronic diseases such as diabetes, high blood pressure, obesity, stress and depression.¹

2. Shortage of primary care physicians:

By 2025, the Association of American Medical Colleges projects a shortage of 46,000 primary care physicians.² The growing shortage is often attributed to adverse practice conditions, something a Patient-Centered Medical Home approach could help address. Primary care physicians often know what care is needed to be effective in managing chronic patients, but they lack the necessary tools and incentives.

3. Increase in number of children with special needs:

Approximately 14 percent of children in the U.S. have special health care needs either of an emotional, physical, or developmental nature.³ Parents and other caregivers of these children need the support of an integrated model of primary care in order to lessen the stress on the family and reduce emergency room visits and hospital stays.

4. Proposals that call for payment based on quality, not quantity of care:

The system currently rewards “patchwork” care provided by multiple providers instead of encouraging quality and continuity of care. Legislators and regulators understand that there is a disconnect between incentives, the management of chronic conditions and the overall effectiveness of the nation’s health system. Recent state-led health reforms focusing on preventative and chronic care have been enacted in California, Pennsylvania, Tennessee and Texas.

5. Patient frustration with a complex, fragmented health care system:

The current health care system can be difficult to navigate when seeking primary care or advice.

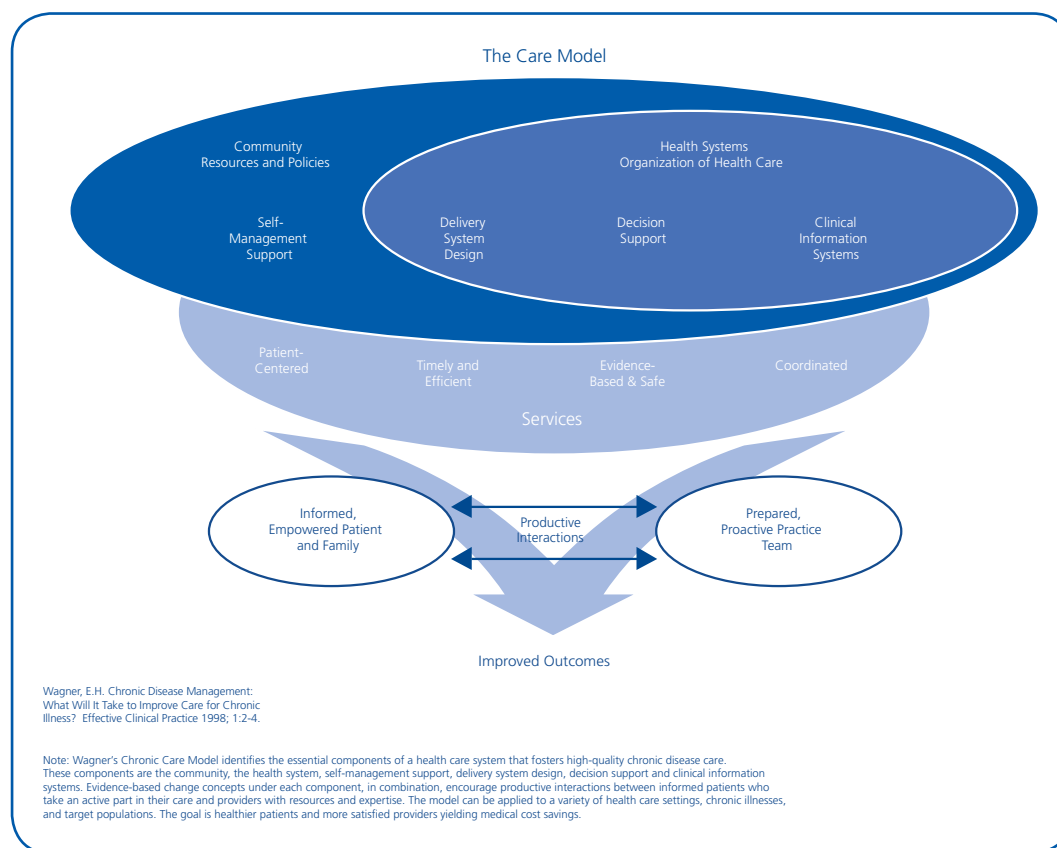
A survey of over 1,000 adults by Harris Interactive in 2008⁴ revealed that the current health care delivery system does not serve the public well – eight of 10 respondents said it needs to be fundamentally changed or completely rebuilt. Specifically, common frustrations voiced in the survey included:

- Nearly three-quarters (73 percent) had difficulty making timely doctors’ appointments, getting phone advice, or receiving after-hours care without having to visit the emergency room
- Nearly one-third (30 percent) reported difficulties getting same- or next-day appointments with their doctor when they are sick. An even larger share (41 percent) had difficulties getting advice from their doctor by phone during regular office hours
- Six out of 10 said it was difficult to get care on nights, weekends, or holidays without going to the emergency room
- Nearly half of all adults reported at least one failure of care coordination. More than half (56 percent) of those seeing three or more doctors experienced poorly coordinated care
- One third of all adults (32 percent) and 40 percent of those in fair or poor health thought they received either duplicative tests or unnecessary care

Definition of a Medical Home Model

In 2002, the American Association of Pediatrics expanded its definition of a Medical Home Model to include operational characteristics: “the medical home offers accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.”⁵

Since then, the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have developed models referred to as “advanced medical homes” (ACP, 2006) and the “medical home” (AAFP, 2004). Both build upon the AAP model by integrating care coordination features with pay for coordination and performance, as outlined in Wagner’s Chronic Care Model shown below.⁶ This model identifies the essential components of high-quality chronic disease care: the community, the health system, self-management support, delivery system design, decision support and clinical information. The goal is healthier patients and more satisfied providers which results in medical cost savings.



In February 2007, the ACP and AAFP were joined by the American Osteopathic Association (AOA) in issuing joint principles for a Patient-Centered Medical Home where each patient has a relationship with a personal physician who will:

- Lead a team of individuals at the practice level that collectively take responsibility for the ongoing care of the patient
- Provide first-contact, continuous and comprehensive care
- Take responsibility for providing for all of the patient's health care needs – including acute, chronic, preventive, and end-of-life care – or arrange for that care with other qualified professionals⁷

Existing high-performance models

In 2008, The Commonwealth Fund's Commission on a High Performance Health System released a report, "Organizing the U.S. Health Care Delivery System for High Performance", that examined the fragmentation in the U.S. health care system and offered suggestions on how to create a high performance organization based on these six attributes:

1. Information continuity

Patient information is available to all providers at the point of care and to patients through electronic health record (EHR) systems

2. Care coordination and transitions

Patient care is coordinated among all providers and transitions are actively managed

3. System accountability

Clear accountability for the total care of the patients

4. Peer review and teamwork

All providers are accountable for each other, review each other's work and collaborate to deliver high-quality care

5. Continuous innovation

There is continuous learning in order to improve the quality and value of patient care and experiences

6. Easy access to appropriate care

Patients have the information they need at all hours, there are multiple points of entry into the system and providers are culturally competent and responsive to patients' needs

Based on a review of 15 existing high performing organizations, The Commonwealth Fund's Commission divided potential delivery systems into four models:

- **Model 1:** Integrated delivery system or large multispecialty group practice, with a health plan

This integrated delivery system has its own hospitals and other providers, and often a multispecialty physician group practice and health plan. Some are "closed" models that exclusively serve patients of the health plan. Others are "open" systems that serve patients both within and outside the health plan, or mixed-model health plans that include both an integrated medical group and independent physicians in private practice. Examples of this model include HealthPartners in Minnesota, Geisinger Health System in Pennsylvania, Kaiser Permanente, Denver Health and New York City Health and Hospitals Corporation.

- **Model 2:** Integrated delivery system or large multispecialty group practice, without a health plan

This integrated delivery system has its own hospitals and other providers, and/or a multispecialty physician group practice with no health plan. Mayo Clinic and Partners Healthcare in Massachusetts exemplify this model.

- **Model 3:** Private networks of independent providers, such as an independent practice or virtual network

This model is a private association that organizes multiple independent providers, or providers who join together to share and coordinate services. Hill Physicians Medical Group in California is an example of this model.

- **Model 4:** Government-facilitated networks of independent providers

A public-private partnership in which government takes an active role in organizing independent providers, usually to create a delivery system for Medicaid beneficiaries, such as Community Care of North Carolina.

Financial implications of medical homes

The prime goals of a Patient-Centered Medical Home are to improve primary care, especially for adults and children with chronic conditions, and to reduce health care spending that occurs from unnecessary procedures, testing, emergency room visits and hospital admissions. However, there are two outstanding financial questions to the success of a medical home approach:

1. What kind of financial impact will occur when transforming a hospital and its physician practice to this approach?
2. How will a new model reward primary care physicians for outstanding care (pay for performance vs. pay by procedure)?

The Deloitte Center for Health Solutions estimates this following type of financial impact when moving from the current model of chronic care management to a Patient-Centered Medical Home model:⁸

- **For an individual primary care physician:**

Establishing a medical home program would require a one-time investment of \$100,000, and ongoing expenses could increase the final amount to \$150,000 or more. It also would require revamping practice operations and streamlining processes to focus on coordination of care and patient adherence (rather than visits).

- **For a hospital with a substantial primary care referral network:**

If the medical home model is structured within a hospital's existing primary care network, the hospital would risk losing revenue from 10 percent fewer admissions and 20 percent fewer emergency room visits. The hospital could also risk its relationships with community-based specialists whose volumes might be reduced through coordination of care.

A study by The Commonwealth Fund, "Incremental Cost Estimates for The Patient-Centered Medical Home," analyzed data from 35 current medical home practices. The study found that there was less than a \$1-per-month difference in patient costs among the medical home practices compared to the traditional practices. The one area of increased costs was IT, where the study showed the average practice spent \$8,000 per full-time physician on IT.⁹

In regards to a new model of payment necessary to make a medical home financially viable, it is critical that payment for the medical home model appropriately recognize and reward health care providers for their contributions to patient care, services coordination and condition outcomes—including payment for alternative delivery of care, such as e-mail or e-visit communications. Currently, there are several different payment structures under consideration by the medical professional associations, as well as the national and state governments. As part of the Tax Relief and Health Care Act of 2006, the Department of Health and Human Services is conducting a Medicare pilot where care management fees and incentives will be paid to physicians participating in medical home services. Results of this pilot should be available sometime in 2010.

As the American Association of Medical Colleges states in its position paper¹⁰ on medical homes (2008), further research is necessary to better understand how to best implement a medical home, how to best measure performance and the level of capital infusion necessary to achieve the goals of a successful medical home – both clinically and financially.

Sources

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