ACHIEVING PERSON-CENTERED PRIMARY CARE: THE PATIENT-CENTERED MEDICAL HOME

Melinda Abrams, MS

Assistant Vice President

The Commonwealth Fund

One East 75th Street

New York, NY 10021

mka@cmwf.org

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ACHIEVING PERSON-CENTERED CARE:
THE PATIENT-CENTERED MEDICAL HOME

Melinda Abrams

Thank you Chairman Kohl, Senator Smith, Senator Casey and the Members of the Committee for this invitation to testify about medical home in your hearing about care for older Americans. I am Melinda Abrams, assistant vice president at the Commonwealth Fund, and responsible for the Patient-Centered Primary Care Initiative. The Commonwealth Fund is a private, grantmaking foundation that aims to promote a high performing health care system that achieves better access, improved quality and greater efficiency, particularly for society's most vulnerable populations, including elderly adults.

The principle driving patient-centered care is relatively simple: the health care system should be designed around the person – not around administrators, physicians or financing. The Commonwealth Fund 2007 International Health Policy survey showed that an overwhelming majority of Americans want care that is accessible, well-coordinated and family-centered.[1] And yet, today's health care system has difficulties focusing on the patient. Care is generally reimbursed with little or no regard for medical outcomes, physician offices rarely schedule patient appointments in the evenings or week-ends convenient to patients and there is little coordination between primary and specialty care providers.

In this testimony, I am going to discuss how a medical home, by providing patient-centered primary care, can improve health outcomes. I will define the concept, present evidence showing its value and review policy options for future Congressional action.

Defining the Patient-Centered Medical Home

A patient-centered medical home is an approach to primary care that organizes care around the relationship between the patient and the personal clinician. Although the concept was first introduced by the pediatricians, their broad definition is relevant to other populations, especially older adults with multiple chronic conditions – a medical

[1] C. Schoen, R. Osborn, M.M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adult's Health Care Experiences in Seven Countries, 2007", *Health Affairs* Web Exclusive (Oct. 31 2007); 26(6):w717-34.

home is a practice that provides primary care and is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective."[2]

In February 2007, four primary care specialty societies – representing more than 300,000 internists, family physicians, pediatricians and osteopaths – released Joint Principles defining the Patient-Centered Medical Home with the following characteristics:[3]

- ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- ***Team Care*** **–** the physician directs team of professionals and staff who collectively take responsibility for the ongoing care of patients.
- ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).
- ***Quality and safety*** – practices use evidence-based medicine and clinical decision-support tools to guide decision-making. Physicians advocate for their patients defined by care planning and partnership with patietns. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met Patients and families participate in quality improvement activities at the practice level.
- ***Enhanced access*** to care is available through availability of same-day appointments, expanded hours of operation and new options for communication between patients, their personal physician, and practice staff.
- ***Payment*** that recognizes the enhanced value from care coordination, health information technology and team-based care.

So what does this mean in practical terms? In a medical home, a patient could expect to obtain care from the physician practice on holidays, evenings and week-ends without going to the emergency room. The patient could have medical questions answered by

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[2] American Academy of Pediatrics, "The Medical Home: Medical Home Initiatives for Children with Special Needs Project Advisory Committee" *Pediatrics*, 1 Jul 2002; 110(1):184-186.

[3] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association, "Joint Principals of the Patient-Centered Medical Home", March 2007.

telephone or email on the same day that she contacts the office. Non-urgent care appointments could be scheduled one or two days ahead of time, instead of weeks or months. In a medical home, care coordination is vastly improved. The primary care clinician helps the patient select a specialist and (with support from staff) proactively follows up with both the providers and the patient about test or examination results. In a medical home, the personal physician reviews treatment options with the patient and her family to help understand or resolve conflicting advice received from multiple providers. Patient-centered medical homes require improved infrastructure – such as electronic health records, patient registries, ability to review test results remotely and electronic prescribing or referrals – to deliver primary care effectively. The medical home patient could expect to receive email or telephone reminders from the practice about overdue appointments as well as telephone notification about test results with the option to view her patient record online through an Internet link. Patient could expect to routinely complete surveys or participate in focus groups to report on the care experience. The medical home practice would use that information, along with data about clinical quality, to improve how the practice is structured or managed. Patients must perceive that the medical home serves their needs to be truly patient-centered.

The patient-centered medical home also requires fundamental payment reform that is intended to strengthen and reward primary care. For successful implementation, primary care practices would submit to a voluntary and objective qualification process to be recognized as a patient-centered medical home. In exchange, the medical home would be supported with an enhanced or additional payment to support the improved care management, infrastructure and care coordination.

I want to emphasize the importance of the revised approach to payment and practice to helping older Americans. Approximately 125 million Americans are living with chronic illness.[4] Among the Medicare population, 86 percent of the nearly 40 million beneficiaries have one or more chronic conditions and 23 percent have five or more chronic conditions.[5] In a medical home, patients would receive individual care that is integrated and coordinated across all providers, which would reduce duplication of service and ensure consistency of a care plan for patients with multiple conditions.

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[4] G. Anderson and J. Knickman, "Changing The Chronic Care System to Meet People's Needs", *Health Affairs,* November/ December 2001, 20(6): 146-160.
[5] M. Maxfield, et al., "Design of the CMS Medical Home Demonstration", submitted to the Office of Research Development and Information at the Centers for Medicare & Medicaid Services, June 19, 2008.

Evidence Demonstrating the Value of the Patient-Centered Medical Home

Evidence on Medical Home Improving Quality of Care

Health care systems with a strong foundation of primary care can reduce costs and improve quality. People with primary care clinicians are more likely than those without to receive preventive services, to have better management of chronic illness and report better experiences with their care.[6] States with more primary care providers have lower total mortality rates, lower heart disease and cancer mortality rates and higher life expectancy at birth compared with states that have few primary care providers.[7] In contrast, increases in specialist supply are associated with increased cost, but not improved quality.[8]

Edward H. Wagner, MD, MPH, director of the MacColl Institute for Healthcare Innovation, developed the Chronic Care Model, which has shown that an effective way to help people with chronic conditions is to structure care around productive interactions between "an informed, activated patient" and a "prepared, proactive practice team". Achieving this effective dyad requires organization and support of individual practices in ways that are equivalent to a patient's having a medical home. Self-management support and appropriate health information systems are necessary components of the practice infrastructure. The literature shows that implementation of these elements improves quality of care for patients with diabetes, asthma, and depression.[9,10,11, 12]

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[6] Dartmouth Atlas Project. 2006. The Care of Patients with Severe Chronic Illness: An Online Report on the Medicare Program. Hanover, N.H.: Dartmouth Medical School, Center for the Evaluative Clinical Sciences.

[7] B. Starfield, L. Shi and J. Macinko. "Contribution of Primary Care to Health Systems and Health", *Milbank Quarterly*, September/October 2005, 83(3): 457-502.

[8] B. Starfield, L. Shi, and J. Macinko, *Health Affiars,* Web Exclusive (March 15, 2005), w97–w107.

[9] M.W. Batersby, "Health Reform Through Coordinated Care: SA HealthPlus, British Medical Journal, 2005 March 19; 330:662-665.

[10] P. Lozano, J.A. Finkelstein, V. Carey, E.H. Wagner, et al., "A Multisite Randomized Trial of the Effects of Physician Education and Organizational Change in Chronic-Asthma Care", Archives of Pediatrics & Adolescent Medicine, September 2004; 158(9): 875-883.

[11] G. A. Piatt, T. J. Orchard, S. J. Emerson, et al., "Translating the Chronic Care Model into the Community", *Diabetes Care*, April 2006; 29(4):811-817.

[12] M. Dwight-Johnson, K. Ell, P.J. Lee, "Can Collaborative Care Address the Needs of Low-Income Latinas with Comorbid Depression and Cancer? Results from a Randomized Pilot Study", Psychosomatics, June 2005; 46: 224-232.

Two recent Commonwealth Fund surveys show a number of benefits of having a medical home. [13, 14] In both studies, presence of medical home was determined by specific patient experience reports. The Commonwealth Fund's 2007 International Health Policy Survey defined medical home if respondents reported

a) They had a regular doctor or source of primary care,

b) A provider who had information about their medical history,

c) Their provider could be contacted by phone during office hours and

d) The provider coordinated their care.

Based on these criteria, only half of all adults in the United States have a medical home. Across all seven countries that participated in the survey, patients with a medical home compared to those that did not were more likely to report positive care experiences. Specifically, patients with a medical home were more likely to experience better access to care on holidays, evenings and week-ends; greater involvement in care decisions; more time with their doctors; fewer duplicative tests and assistance in selecting a specialist. Among adults with chronic illness, patients with a medical home were less likely to report medical errors (e.g., medical mistake or wrong medication) and more likely to have a written care plan to manage their illness at home and receive reminders for preventive or follow-up care. The 2006 Healthcare Quality Survey showed similar benefits of the medical home for adults with the added advantage of demonstrating substantial reduction of racial and ethnic disparities.[15]

Evidence on Medical Home Reducing Health Care Costs

The Commonwealth Fund is supporting rigorous evaluations of several medical home demonstrations to determine if they slow the growth of health care expenditures. Preliminary data from one medical home pilot and results from a few studies suggest that widespread adoption of patient-centered medical homes can reduce health system costs and achieve better quality and health outcomes.

The Geisinger Health System, an integrated delivery system in northeast and central Pennsylvania, shows positive, early results from its medical home pilot. The health system encompasses 40 community practice sites, several specialty hospitals and multiple

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[13] A.C. Beal, M.M. Doty, S.E. Hernandez, K. K. Shea, K. Davis, "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey" (New York, NY: The Commonwealth Fund, June 2007).

[14] C. Schoen, R. Osborn, M.M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adult's Health Care Experiences in Seven Countries, 2007", Health Affairs Web Exclusive (Oct. 31 2007); 26(6):w717-34.

[15] A.C. Beal, et al., "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey", 2007.

tertiary medical centers. All clinicians and practice sites are connected through a fully integrated electronic health record. As part of the patient-centered medical home pilot, Geisinger expanded patient care to include ongoing telephone monitoring and case management, telephone follow-up post-hospital discharge and post-emergency department visits, easy access to clinicians by telephone, group visits, educational services and personalized tools such as chronic disease report cards. Participating providers were paid an additional fee for the improved access and care coordination. After one year, preliminary findings show a decrease in hospital admission rates, ranging from a 14 percent reduction in Lewisburg Community Hospital to a 20 percent drop in Lewistown. Hospital readmission rates also declined dramatically. The Lewistown hospital demonstrated a 12 percent decrease in hospital readmissions while Lewistown declined by 48 percent. [16]

Although not serving a large proportion of elderly patients, a few state Medicaid programs have demonstrated that medical homes can reduce health care costs across a system of care. The North Carolina Medicaid program, called Community Care of North Carolina, enrolls beneficiaries in local, primary care networks of medical homes. An analysis by Mercer Consulting found that a $10.2 million investment resulted in savings of $225 million when compared to traditional, Medicaid fee-for-service.[17] In Iowa, Medicaid beneficiaries were enrolled in a primary care case management (PCCM) program, which slowed Medicaid spending by 3.8 percent (saving $66 million) over an eight-year period, with the effects strengthening over time.[18] Under this model, primary care clinicians are paid an additional per-member-per-month fee to manage and coordinate patient care beyond the standard care covered by traditional fee-for-service payments.

Recently, the Commonwealth Fund issued a report, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, which includes 15 options for slowing the growth in health care outlays while improving access and quality of care. One option estimated the savings accrued if all Medicare beneficiaries in traditional fee-for-service were required to enroll in a medical home for primary care. In

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[16] G. Steele, "AHRQ: Who Should Pay for Health IT? Institutional Commitment to Health IT", Presentation at AcademyHealth Annual Research Meeting (June 9, 2008).

[17] M. Lodh et al., "ACCESS Cost Savings—State Fiscal Year 2004 Analysis," Mercer Governmental Human Services Consulting letter to Jeffrey Simms, State of North Carolina, Office of Managed Care, (March 24, 2005), https://www.communitycarenc.com/PDFDocs/Mercer%20SFY04.pdf (accessed July 21, 2008).

[18] E.T. Momany, S.D. Flach, F.D. Nelson et al., "A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program", Health Service Research 41, pt 1 (2006): 1357-71.

recognition of the enhanced services (care management, care coordination, patient education and same-day access to appointments), physicians would receive a per member per month fee in addition to the regular fee-for-service payments. Under the policy option, the projected net cumulative savings to national health expenditures is $60.0 billion over five years and $193.5 billion over 10 years. Most of the savings were derived from a decrease in hospital and physician expenses as a result of higher-quality and more-efficient care delivered by medical homes.

Challenges Facing Implementation of the Patient-Centered Medical Home

Successful implementation of the patient-centered medical home must overcome many challenges, but two in particular require immediate attention – our current reimbursement system and the capacity of our current clinical workforce to staff medical homes.

Many medical home services (such as care coordination or care management) and infrastructure (health information technology or registries) are reimbursed either inadequately or not at all in the current fee-for-service system. Current reimbursement is biased in favor of procedures (such as surgical operations or imaging) and does not adequately pay for time spent with patients to take their medical history, conduct an examination or follow-up before or after the next appointment. In their June 2008 report, the Medicare Payment Advisory Commission summarized the problem: "In consideration of the devaluation of primary care services, the Commission is concerned that these services risk being underprovided, as physicians view them as less valued and less profitable. Yet, primary care services and – perhaps more importantly – primary care clinicians, are critical to delivering more coordinated, high-quality care to the Medicare population." [19] Further, many technical procedures become more efficient, or take less time, with improvements in technology. If reimbursement levels stay constant, then payment effectively increases. However, similar efficiencies are rarely realized in primary care, since less time with patients might mean compromising patient-centered care.

Another challenge is a shortage of primary care physicians to staff medical homes. Due to lower reimbursement, the average medical or surgical sub-specialist makes almost twice the annual salary of the average primary care physician, and the primary/specialty

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[19] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Reforming the Delivery System, June 2008, Pg..27.

care income gap is growing over time.[20] This income disparity has led to declining numbers of medical students to select residencies in primary care. Other factors are perceived to exacerbate the decline in primary care physicians. For example, sub-specialty physicians are perceived to enjoy a better lifestyle – more regular hours, less on-call responsibilities – than their primary care colleagues. For the Medicare population, a dwindling workforce could threaten access to primary care services for elderly Americans.

Intense National Interest in the Patient-Centered Medical Home

The patient-centered medical home is not just a pipe dream derived from survey results or econometric models. The evidence showing the quality and cost gains from stronger primary care through medical homes has galvanized a broad array of stakeholders. In addition to the four primary care specialty societies, the medical home has been endorsed by large employers, including IBM and WalMart; labor and consumer organizations, including AFL-CIO and AARP; and is being tested in several demonstrations by major private health plans, including Blue Cross Blue Shield and Aetna.

Public payers have also recognized the potential value of stronger, well-coordinated primary care and authorized new payment models to promote the patient-centered medical home. As you know, The Tax Relief and Health Care Act of 2006 instructs the Centers for Medicare and Medicaid Services to develop an 8-state demonstration of the medical home under Medicare.[21] The recently passed Medicare Improvements for Patients and Providers Act of 2008 provides an additional $100 million dollars to augment that demonstration.[22] I commend the Congress for its willingness to test this promising approach.

The states have been equally active on the topic of medical home. In Pennsylvania, Governor Rendell and the legislature have begun a statewide "roll-out" (not a demonstration) of the patient-centered medical home model.[23] And in Massachusetts, a bill was introduced last week that would permanently restructure financing of Medicaid plans to provide a supplemental fee to primary care practitioners working in qualified

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[20] T. Bodenheimer, R. Berenson, and P. Rudolf, "The Primary Care-Specialty Income Gap: Why It Matters", *Annals of Internal Medicine*, 2007; 146:301-306.

[21] Tax Relief and Health Care Act of 2006 (Dec. 20, 2006) Division B, Section 204.

[22] Medicare Improvements for Patients and Providers Act of 2008 (Jul. 15, 2008) Part 1, Section 133.

[23] Chronic Care Management, Reimbursement and Cost Reduction Commission, "Prescription for Pennsylvania, Strategic Plan", February 2008; http://www.rxforpa.com/assets/pdfs/ChronicCareCommissionReport.pdf (accessed July 21, 2008).

medical homes.[24] Under a Commonwealth Fund grant to the National Academy for State Health Policy, a survey of Medicaid and SCHIP directors revealed that 23 states have efforts underway to test the patient-centered medical home in state Medicaid programs.[25]

The Commonwealth Fund is actively engaged and closely monitoring many of the national and state medical home activities around the country. We are supporting a demonstration with safety net clinics, the further development of measures to qualify a primary care practice as a medical home, evaluations of several medical home demonstrations and the development of policy and payment options. Of course, the patient-centered medical home cannot fix all of the quality and cost problems of our health system. Through our evaluations, we will learn the impact of the medical home on clinical quality, patient experience and health care costs. It will be years before we have any answers, since it takes time to achieve both practice transformation and a positive return on investment. However, the Commonwealth Fund's substantial investment in the medical home demonstrates our commitment to the approach as central to establishing a strong foundation for primary care that can help the United States health care system achieve higher performance.

Policy Options for Congressional Consideration

As the committee considers legislative and regulatory strategies to encourage person-centered care for older citizens, there are a number of steps Congress could take. They are:

> **Ensure transparency of the Medicare medical home demonstration**
> Demonstrations take several years to get underway, be completed and publish results. Congress' interest in careful implementation of the CMS Medicare medical home demonstration is evidenced by your recent passage of the Medicare Improvements for Patients and Providers Act of 2008 in which you allocated $100 million dollars to allow the Secretary to expand the demonstration. In light of the keen interest from numerous state and commercial payers to test and expand the model, regular reporting to Congress and the public about the progress and early lessons from the Medicare medical home demonstration can inform similar initiatives around the country. Routine updates could also encourage timely release of evaluation results, which will shape future program implementation. I am not suggesting interference with Medicare's operation of the demonstration,

[24] Commonwealth of Massachusetts Senate, Bill No. 2526, Section 44 (proposed).
[25] N. Kaye, M. Takach, Preliminary State Scan Summary Results, Unpublished data (1/25/08).

but rather recommending a mechanism for public review and discussion of the Medicare medical home experience to help shape policy and practice.

Direct the Centers for Medicare and Medicaid Services to join commercial and state public payers in the Medicare medical home demonstration.
Several commercial payers are willing to change payment rates to primary care practices to test the patient-centered medical home. Although there are examples of partnerships between state Medicaid and commercial payers on current medical home demonstrations (e.g., Rhode Island, Colorado), there is no active collaboration between commercial payers and Medicare. With explicit encouragement from Congress, there is an opportunity to facilitate such a partnership.

Pursue intermediate and incremental financing changes to promote medical home components, such as care coordination.
Two options include:

- Authorize a separate payment for discrete services associated with key care coordination functions, such as discharge planning, which could help reduce unnecessary hospital readmissions. The physician or clinical care team's role could be clearly defined – preparation of discharge summary, medication reconciliation, a post-discharge status update with patient and patient's family – and verified with documentation.
- Increase payment levels for evaluation and management services provided by primary care clinicians to help support care management and care coordination. The Medicare Payment Advisory Commission made a similar recommendation in their June 2008 report, suggesting "The Congress establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary care-focused practitioners."[26]

Implement scholarships or educational loan forgiveness programs to encourage medical students to choose careers in primary care.
Increasing tuition expenses and lower salary projections contribute to fewer medical students choosing careers in primary care. Tuition assistance – in the

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[26] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Reforming the Delivery System, June 2008, Pg..27.

form of debt forgiveness or medical school scholarships – could reduce the financial burden and enable more students to enter the field of primary care.

Thank you for this opportunity to participate in today's hearing and to address questions of the Committee.