The Patient Centered Medical Home: 2011 Status and Needs Study

Reestablishing Primary Care in an Evolving Healthcare Marketplace

MGMA®
Medical Group Management Association

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Introduction

Medical practices throughout the country are transforming their care delivery model to provide coordinated, accessible and patient-centered care. The patient-centered care concept can be traced to as early as 1967 when the American Academy of Pediatrics first introduced it. Several terms exist today to define what it means for an organization to deliver patient-centered care. Likewise, several names define this emerging model, including a medical home, primary care medical home, advanced primary care, healthcare home or a patient-centered medical home. All share common care-delivery principles.

The Agency for Healthcare Research and Quality (AHRQ) defines the patient-centered medical home (PCMH) as a promising model for transforming the organization and delivery of primary care, describing it as patient-centered, comprehensive, coordinated, accessible and continuously improving through a systems-based approach to quality and safety. Today, several organizations use those principles to establish accreditation, certification, recognition and achievement programs for the PCMH model.

To better understand the status and needs, practice processes and intentions of primary care practices related to the PCMH healthcare delivery model, the Medical Group Management Association (MGMA) conducted a study in 2011. Responses were gathered from practices across the continuum: accredited or recognized PCMHs, organizations instituting changes or transforming to become a PCMH, and those interested in becoming a PCMH.

An online electronic questionnaire was distributed to MGMA members and customers associated with primary care and multispecialty practices. Data was collected from March 25, 2011, through April 29, 2011. This report examines the information reported by 341 respondents that completed the study. The responses represent various healthcare organizations (see Figure 1). Responses were received from 46 states representing 5,760 primary care physicians and more than 1,996 nonphysician providers in medical practices.

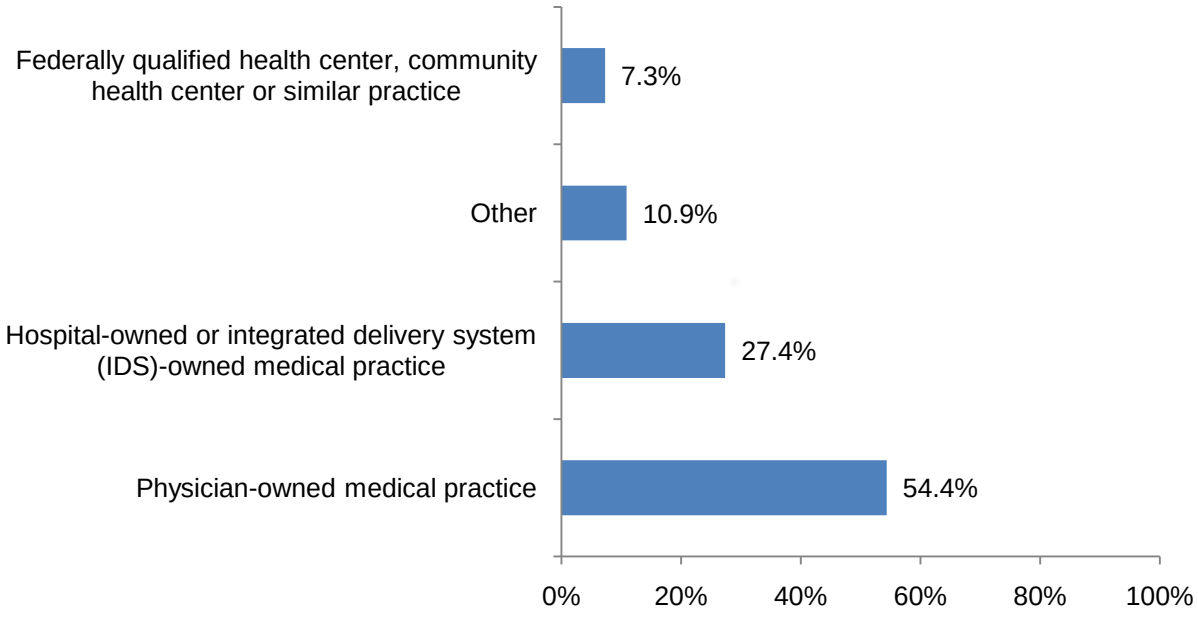
Analysis

The analysis focused on practices that have achieved PCMH recognition or accreditation, practices instituting changes to become a PCMH and practices interested in delivering care as a PCMH in the future. Throughout the report, the data are presented by PCMH status[1], organization and/or practice type to better provide the reader with relevant information based on practice specialty and status.

General demographics

We analyzed responses from physician-owned medical practices, medical practices with hospital-owned or IDS ownership, and federally qualified health centers (FQHCs). We received a few responses from medical school faculty practice plans, academic clinical science departments and other organization types, which have been included in the "Other" category in Figure 1 below. The majority, or 54.4 percent, of the responses came from physician-owned medical practices.

Figure 1: Responses by organization type



Physician-owned practices represented 53.7 percent of accredited or recognized PCMHs compared to 22.2 percent for hospital-owned medical practices, 14.8 percent for FQHCs and 9.3 percent from other categories with smaller representation. Of those transforming, physician-owned practices reported the highest percentage.

[1] Accredited or recognized PCMHs will be referenced throughout this report as existing or established PCMHs. Practices instituting changes to become a PCMH will be referenced as transforming.

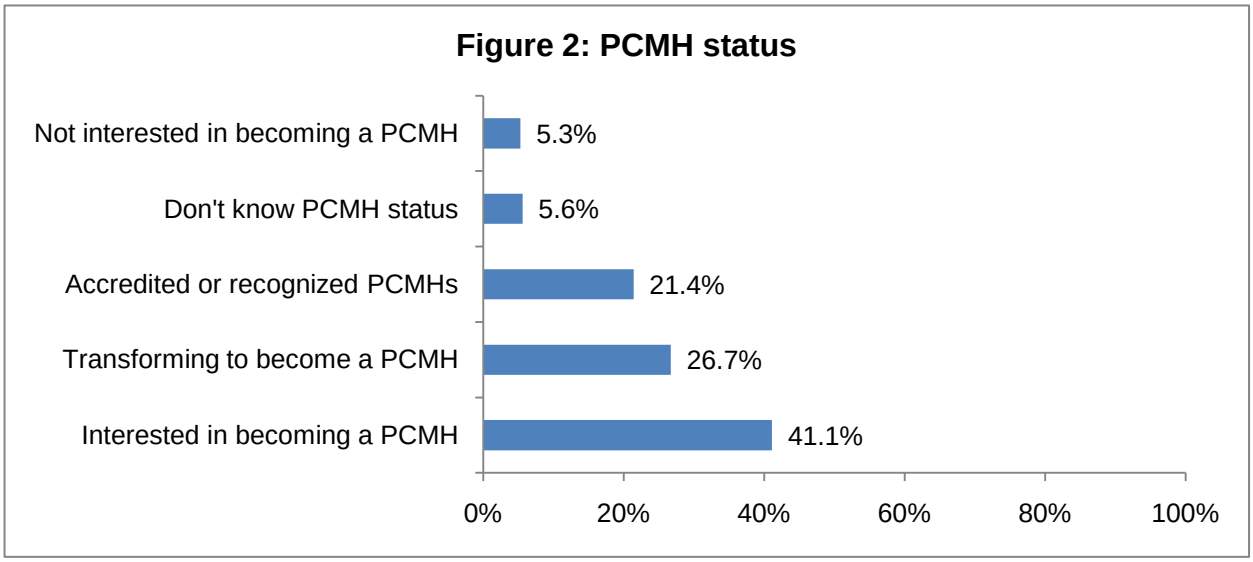
Table 1, below, shows the distribution of responses by practice specialty and size (as measured by number of primary care full-time-equivalent [FTE] physicians). In this study, most responses came from family medicine practices (35.8 percent) and multispecialty practices with primary and specialty care (32.5 percent). The smallest practices, with fewer than three FTE primary care physicians, were primarily family medicine practices (56.3 percent), while the largest practices, with 11 or more FTE primary care physicians, were primarily multispecialty practices with primary and specialty care (59.6 percent).

Table 1: Distribution of responses by practice specialty and practice size (as measured by number of primary care FTE physicians)

	Fewer than 3 FTE	3 to 5 FTE	6 to 10 FTE	11 or more FTE	Total
Multispecialty with primary and specialty care	3.1%	18.6%	17.8%	59.6%	32.5%
Multispecialty with primary care only	9.4%	5.1%	1.4%	8.7%	6.0%
Family medicine	56.3%	39.0%	45.2%	21.2%	35.8%
Internal medicine	18.8%	11.9%	16.4%	1.0%	9.7%
Pediatrics	6.3%	20.3%	15.1%	7.7%	12.3%
Other	6.2%	5.1%	4.1%	1.9%	3.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

PCMH status

Figure 2 shows that 21.4 percent of the respondents were an accredited or recognized PCMH, while 67.8 percent were transforming or interested in becoming a PCMH. The remaining 10.9 percent were not interested in this care-delivery model or did not know their PCMH status.

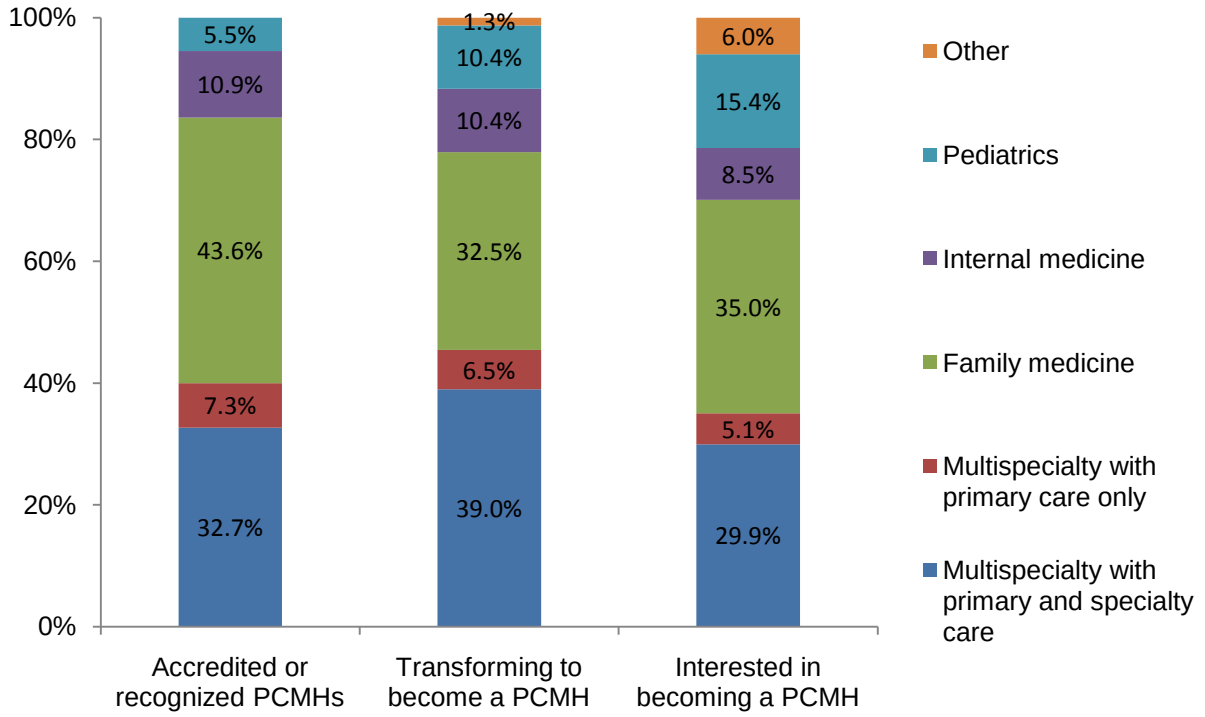


Specialty type

The majority of the respondents accredited or recognized as a PCMH were family medicine practices. Of those transforming, multispecialty with primary and specialty care reported the highest percentage.

Figure 3 breaks out practice specialty by PCMH status. Family medicine with 43.6 percent of the existing PCMHs also had significant percentages of the practices that were transforming to become one (32.5 percent) and that are interested (35 percent). Figure 3 also shows that although pediatrics practices represented only 5.5 percent of existing PCMHs, they accounted for 15.4 percent of those interested in becoming a PCMH.

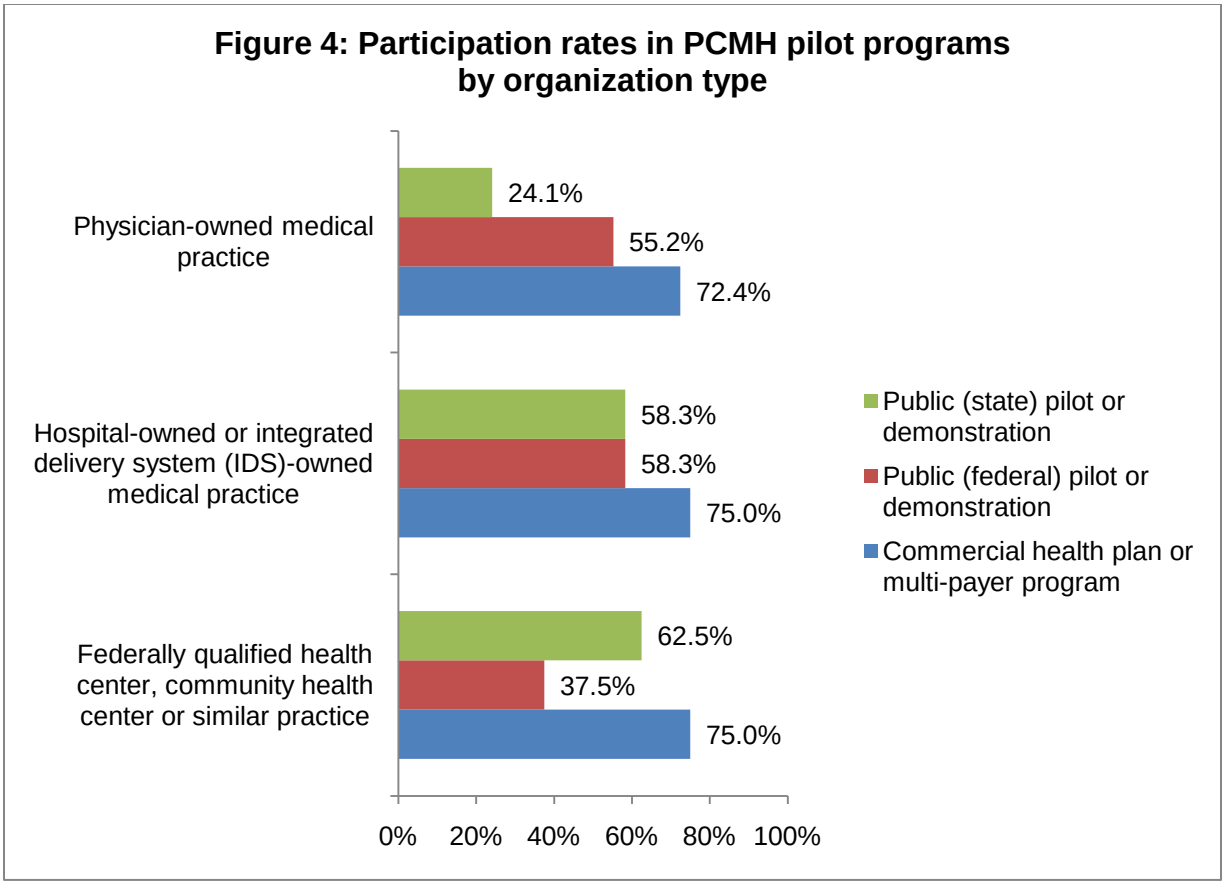
Figure 3: PCMH status by practice specialty



Pilots and demonstrations

Study respondents heavily used PCMH pilots and demonstrations. At the time of the study, there were 43 commercial health plan or multipayer pilots and demonstrations, according to the monthly PCMH briefing presented by the Patient-Centered Primary Care Collaborative[2] in April 2011.

[2] The Patient-Centered Primary Care Collaborative (PCPCC) is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, clinicians and many others that have joined together to develop and advance the PCMH. Visit http://www.pcpcc.net/ to learn more about PCPCC.

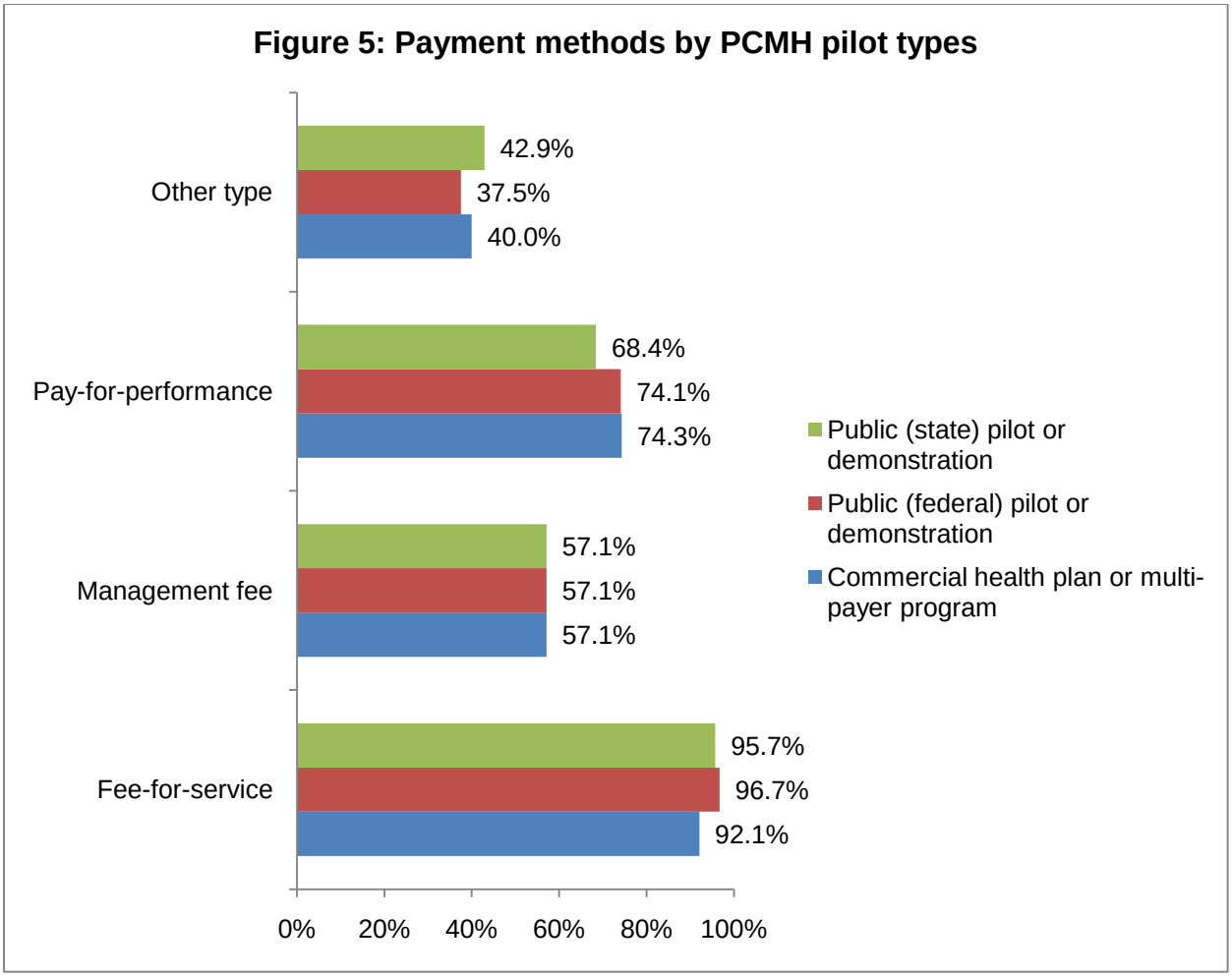


Note: Totals exceed 100 percent since the respondents were allowed to select multiple programs.

Participation in commercial health plan or multipayer programs was higher than other types of programs for all the organization types shown in Figure 4. This graph shows participation rates in the respective pilots by organization types. The lower participation of physician-owned practices in public-state pilots (24.1 percent) would indicate the lower volume of Medicaid patients they see. FQHCs, however, show a higher rate of public-state participation (62.5 percent) due to their expected larger Medicaid patient base.

The study indicates that some practices were participating in more than one pilot when they completed the questionnaire. The results show that hospital-owned or integrated delivery system (IDS)-owned medical practices had high participation rates (58.3, 58.3 and 75.0 percent) in all three types of pilots.

Figure 5 shows that more than 90 percent of participants in all pilot types indicated receiving fee-for-service payment from payers. About 70 percent received pay-for-performance payments, and close to 60 percent received management fees. A few respondents in the “Other type” category indicated that they received capitation payments.



Note: Totals exceed 100 percent since the respondents were allowed to select multiple programs.

Accreditation and recognition

Practices can receive a PCMH standing[3] from several sources, some of which are at the national level. At the time of this study, practices could become a PCMH if they received accreditation from the Accreditation Association for Ambulatory Health Care (AAAHC) or recognition from the National Committee for Quality Assurance (NCQA). The majority of the existing PCMHs in this study received their recognition from the NCQA as Level 1, 2 or 3; 70.5 percent of the practices recognized by the NCQA reported earning Level-3 recognition. A few respondents, however, indicated obtaining PCMH standing from their healthcare plans.

[3] PCMH "standing" will be referenced throughout this report to represent PCMH "accreditation, certification, recognition or achievement."

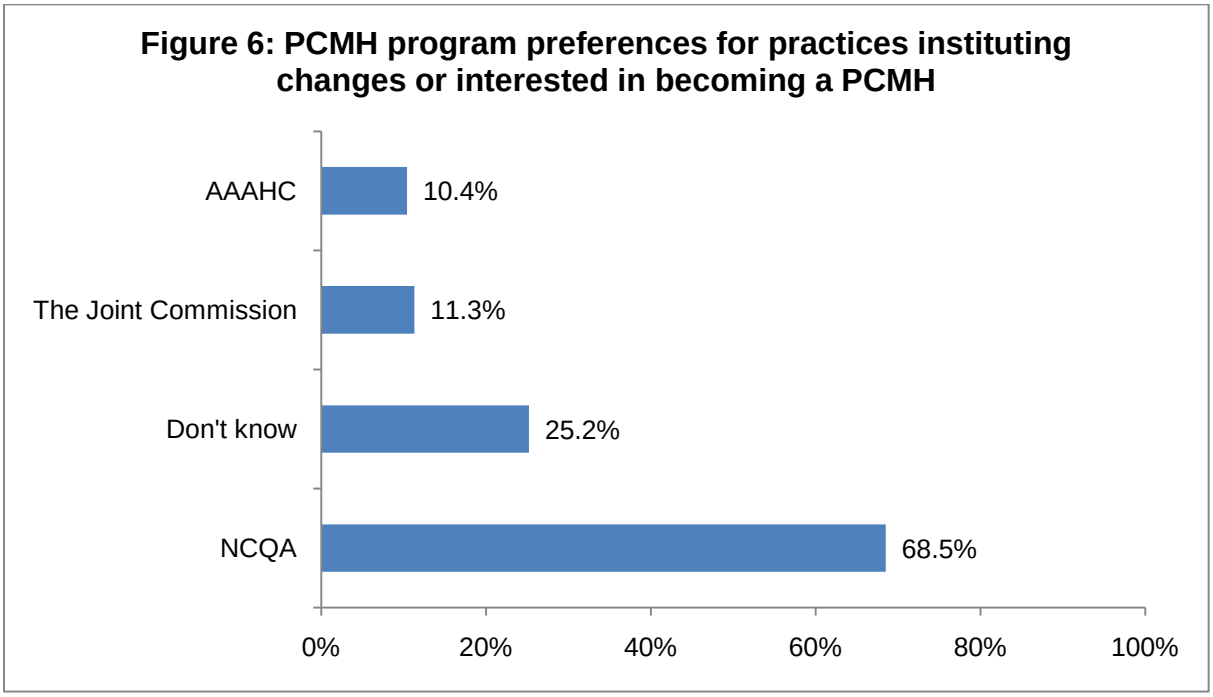
Preference between PCMH national programs

When asked about their preferences between competing PCMH programs, 91.3 percent of study respondents reported that they would like one set of standards to qualify as a PCMH. Here are some comments from the respondents:

- "Competing standards make things difficult for medical practices to implement."
- "The fundamental concept drives the recognition as a PCMH practice, and therefore the standards and recognition should be uniform."

Figure 6 depicts the PCMH program preferences of practices that are instituting changes or interested in becoming a PCMH.

Figure 6: PCMH program preferences for practices instituting changes or interested in becoming a PCMH



Note: Totals exceed 100 percent since the respondents were allowed to select multiple PCMH programs.

URAC, which began offering its Patient-Centered Health Care Home Practice Achievement following the collection of data for this study, is a new entrant into this field and is not included in this study.

In February 2011, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA) provided the *Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs*[4]. To help inform practices how the competing national programs meet the guidelines, MGMA developed an assessment tool. This document provides a neutral and transparent review of the alternative national programs. You can access a free copy of *The Patient-Centered Medical Home Guidelines: A Tool to Compare National Programs*[5] at mgma.com.

Staffing

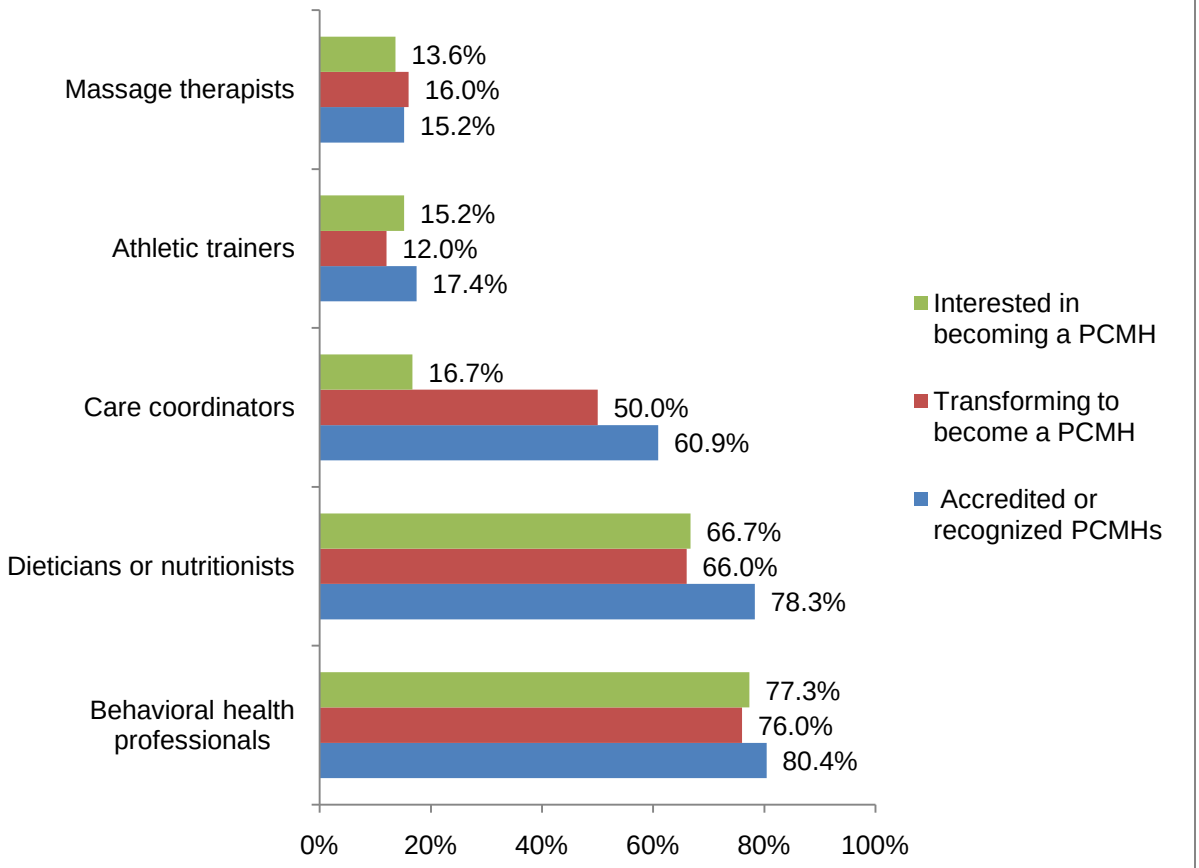
Staffing needs of a PCMH vary depending on the organization type, patient needs and other variables. Figure 7 shows the variation in healthcare professional utilization by PCMH status. The use of a wide variety of healthcare professionals, whether they were employed or contracted, was higher for existing PCMHs than for those transforming or interested in becoming a PCMH. Practices interested in becoming a PCMH should re-evaluate their use of care coordinators since that role is a key to this model of care, and only 16.7 percent now use care coordinators. Contrast this with the 60.9 percent of established PCMHs that use care coordinators.

The use of dietitians and nutritionists, behavioral health professionals, massage therapists and athletic trainers by practices is an indication of the capability to manage patient lifestyles. The "whole-patient" orientation of the PCMH model requires the practice address the activity, nutrition and mental health of the patient as well as the patient's chronic and acute physical problems, and the respondent's use of these providers is an indication of their involvement in what is being called "lifestyle medicine."

[4] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association. February 2011. *Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs.* www.aafp.org/online/etc/medialib/aafp_org/documents/membership/pcmh/pcmhtools/pcmhguidelines.Par.0001.File.tmp/GuidelinesPCMHRecognitionAccreditationPrograms.pdf

[5] *The Patient-Centered Medical Home Guidelines: A Tool to Compare National Programs.* June 2011. http://www.mgma.com/Store/ProductDetails.aspx?id=1366580

Figure 7: Healthcare professional utilization by PCMH status



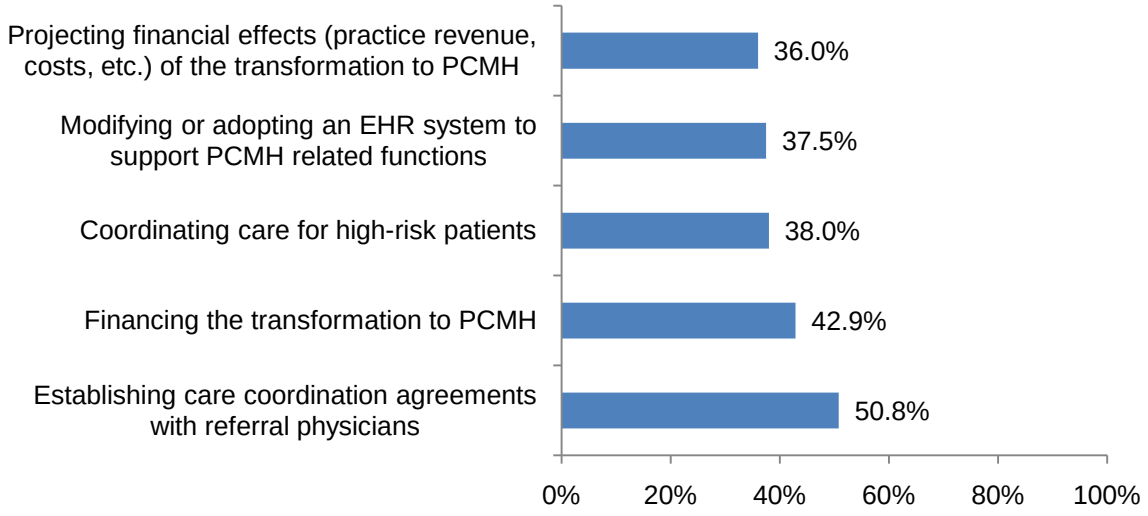
PCMH challenges

The challenges of becoming a PCMH are perceived differently depending on where practices fall on the PCMH implementation continuum. Figure 8 shows the top five challenges faced by established PCMH practices. These practices cited care coordination for high-risk patients (38 percent) and adopting electronic health record (EHR) systems to support new functions (37.5 percent) as significant challenges. Practices in the transformation process replaced the previous two challenges with the need to revise clinical workflow and to contract with health plans to fill out their top five.

Despite the use of care coordinators more often in existing PCMHs than in transforming practices, established PCMHs reported higher challenges in coordinating the care of their high-risk patients. Perhaps this is because care coordination is a challenging and expensive task that is not fully recognized as such until a practice actually attempts to do it properly. Transformation leaders need to address care coordination, a key principle in the PCMH model.

One feature of delivering patient-centered care is providing the patient with the opportunity to select a personal physician with whom to develop and maintain a relationship. The primary care clinician leads a multidisciplinary team that collaborates to provide care for the patients. The care provided must be coordinated in-house or followed up to complete that episode of care whenever a patient is referred for specialty care. Throughout the process, the patient and/or family are included in care decisions, treatment, and education.

Figure 8: Top five challenges faced by accredited or recognized PCMH practices during their transformation to become a PCMH



Note: The results are based on a 5-point scale where 1 = No challenge at all, 2 = Low challenge, 3 = Moderate challenge, 4 = Considerable challenge, and 5 = Extreme challenge. Challenge percentages represent an aggregation of “considerable” and “extreme challenge” responses.

PCMH practice processes

The four primary care physician societies (AAFP, AAP, ACP and AOA) released the *Joint Principles of the Patient-Centered Medical Home* in February 2007[6], which describe the characteristics of a PCMH. Today, PCMH programs evaluate practices seeking to achieve this status by applying these principles augmented with additional individual standards during their on-site surveys or electronic assessments.

The MGMA study showed that regardless of PCMH status, the respondents reported common key processes integral to delivery of care in this environment. The degree of utilization of the processes varied slightly between practices that reported being a PCMH and those transforming to become one. The top five processes reported were:

- Assigning each patient to a primary care clinician (82.2 percent)
- Addressing patients' mental health issues or concerns and referring them to appropriate agencies (73.5 percent)
- Exchanging clinical information electronically with pharmacies (72.7 percent)
- Involving patients and family members in shared decision-making about their care (70.2 percent)
- Maintaining chronic disease registries (46.3 percent)

Other frequently reported processes included the use of chronic disease registries to conduct population management, developing and documenting self-management care plans prepared in collaboration with patients, developing care plans for high-risk patients and exchanging clinical information electronically with hospitals and referral physicians. All of these processes are integral to delivering care in a PCMH environment as outlined by the *Joint Principles of the Patient-Centered Medical Home*[5].

Figures 9 through 11 show the status of important processes identified in this study. Status refers to whether a practice had a process in place, intended to provide a process within the next 12 months or did not provide and did not intend to provide a process. Figure 9 shows process status for established PCMHs, Figure 10 for transforming practices and Figure 11 for practices interested in becoming a PCMH. Examination of Figures 9 through 11 provides unique perspectives on these important processes.

[6] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association. February 2007. *Joint Principles of the Patient-Centered Medical Home*. www.acponline.org/advocacy/where_we_stand/medical_home/approve_jp.pdf?hp

Figure 9: Practice processes for accredited or recognized PCMHs

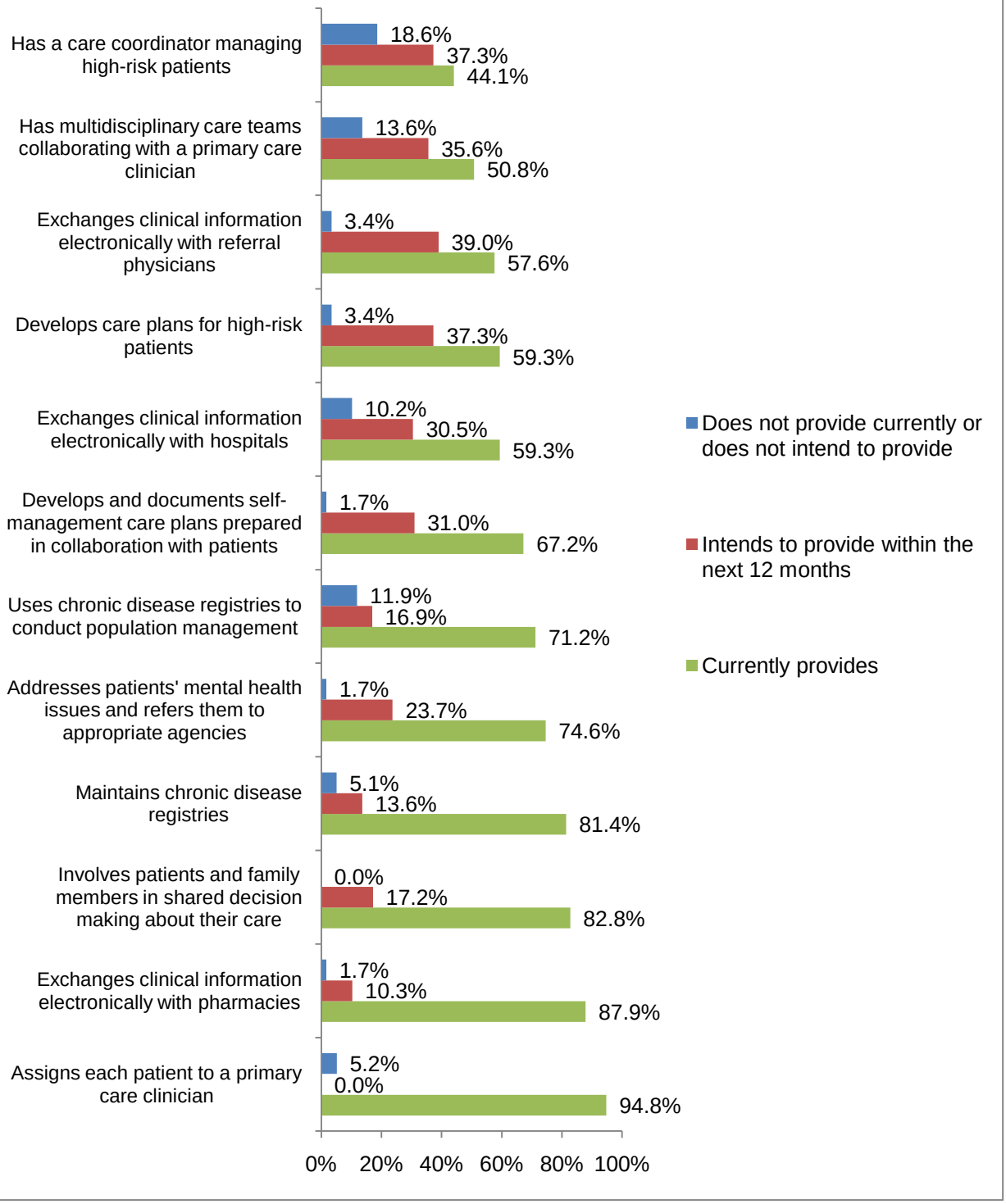


Figure 10: Practice processes for those transforming to become a PCMH

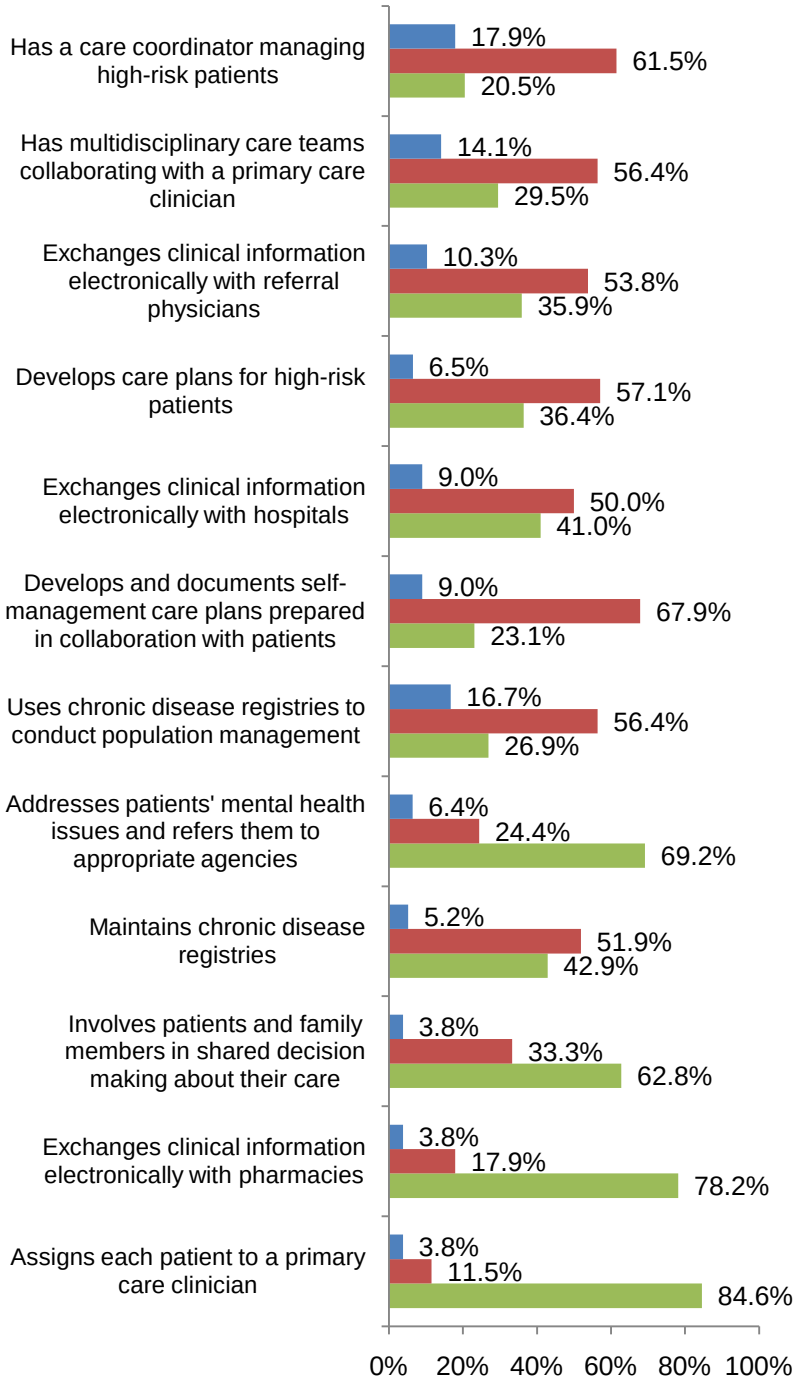
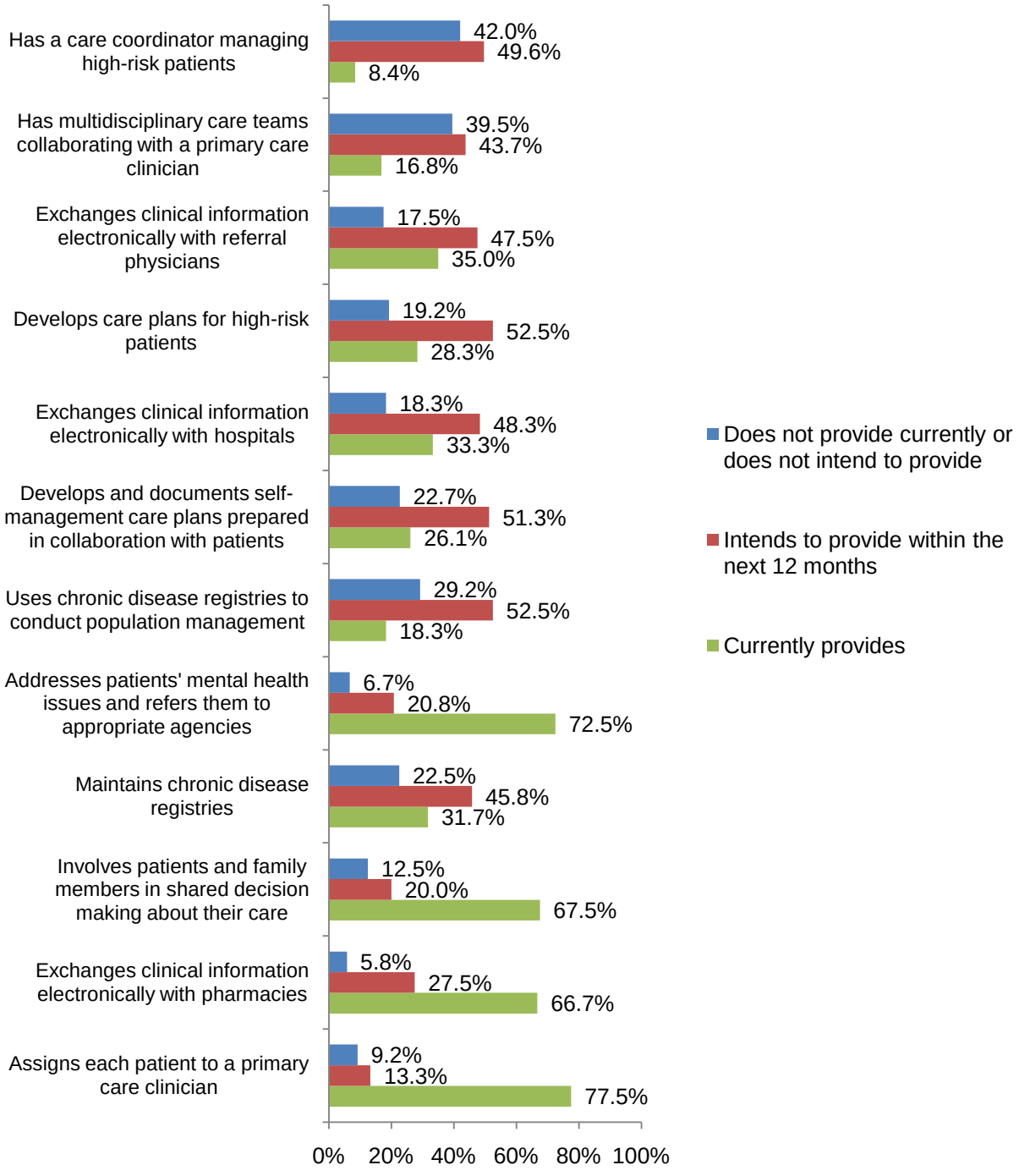
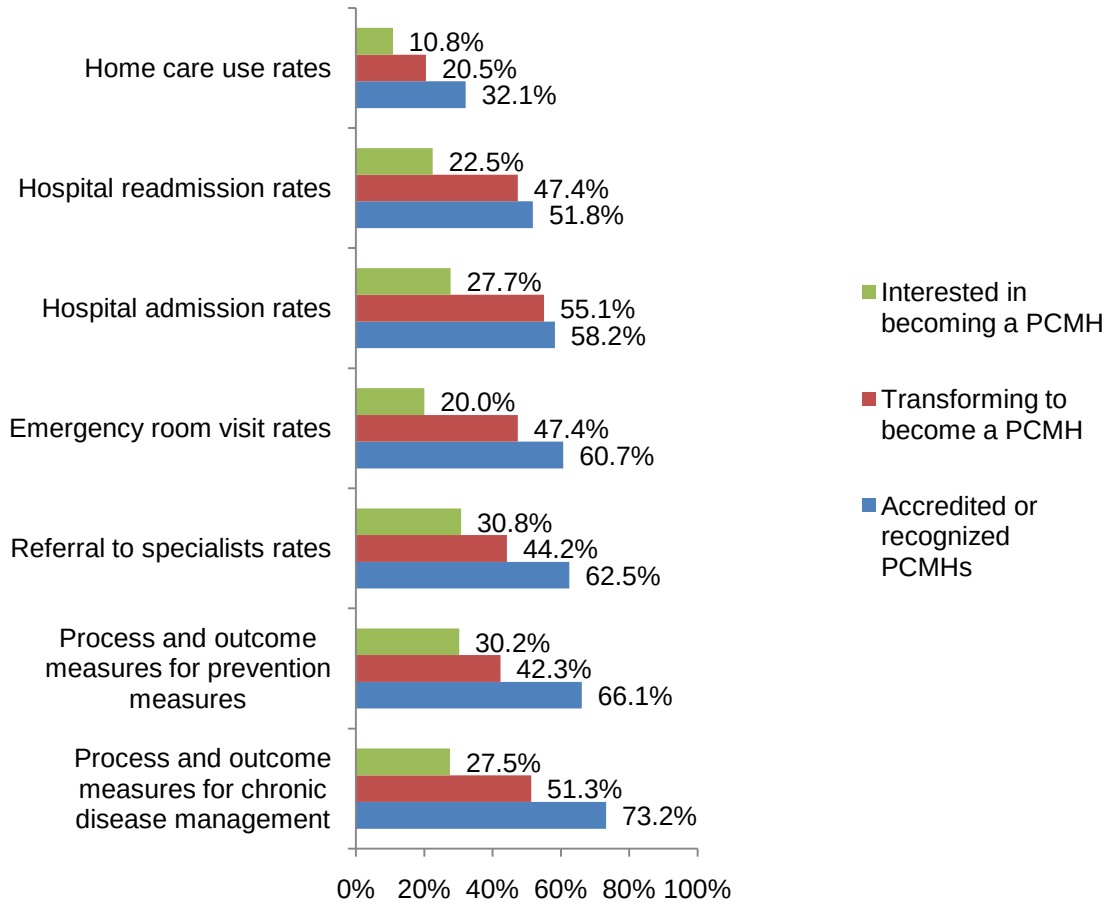


Figure 11. Practice processes for those interested in becoming a PCMH

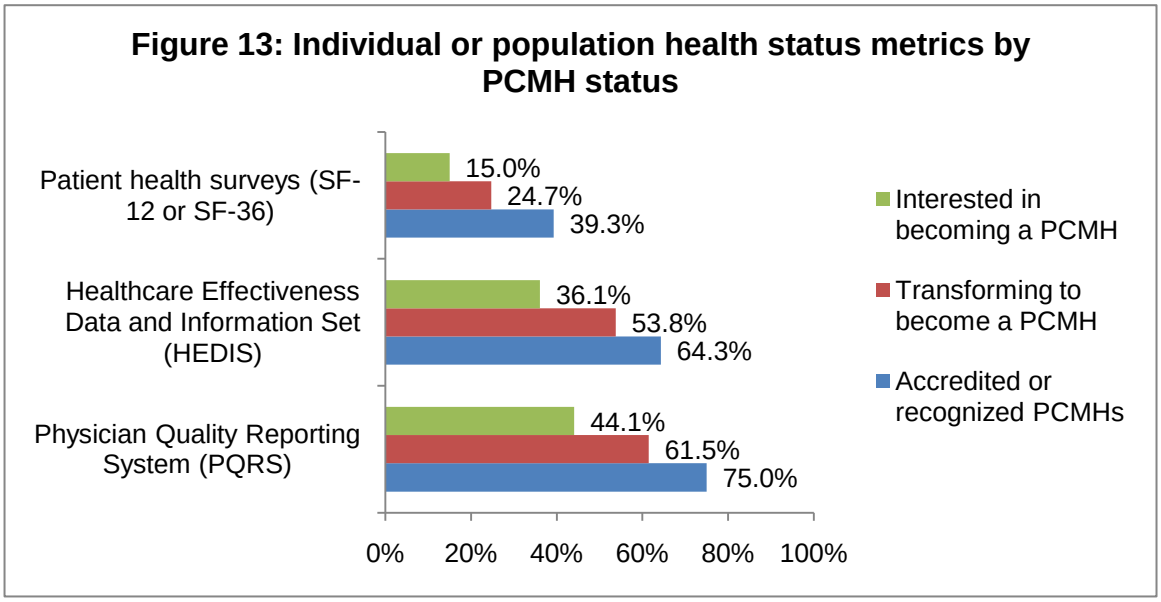


Figures 12 and 13 show the utilization of various metrics for quality and use of services by PCMH status. These quality of care and use metrics are key principles of the PCMH model. Accredited or recognized PCMHs report the highest use of these metrics. Those interested in becoming a PCMH should consider placing more emphasis on the use of these metrics in their practices to better understand their patients' health status.

Figure 12: Patients' use of health services by PCMH status



Note: Totals exceed 100 percent since the respondents were allowed to select multiple metrics.



Note: Totals exceed 100 percent since the respondents were allowed to select multiple metrics.

Education and training PCMH resources

As with any change, clinical and managerial staff may not have the expertise to execute the most effective transformation. Practices may want to consider outside assistance to help implement and adapt the PCMH transformation to the practice. The resources listed below were cited as the most frequently used by the study respondents.

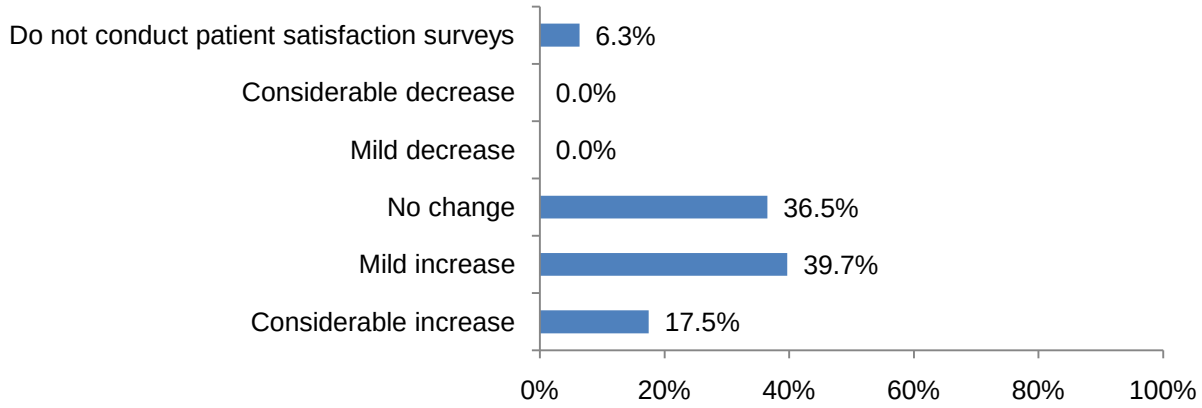
- Written materials
- Conferences
- Webinars
- Consultants
- Local support groups
- PCMH coaches

Accredited and recognized PCMHs rated conferences, written materials and consultants as being very effective. Those respondents instituting changes to their operations also highly rated the effectiveness of using PCMH coaches.

Patient satisfaction

Figure 14 shows that patient satisfaction increased for established PCMHs. A positive patient experience is integral to patient-provider continuity of care in the PCMH model, and these findings reflect that. Current standards require PCMHs to measure patient experience for quality improvement, to involve patients in the development of treatment plans, to treat all patients with cultural sensitivity and to consider and address the patient's health literacy needs and preferred language for discussing health care. These processes and others ultimately impact the overall patient experience.

Figure 14: Change in patient satisfaction as a result of PCMH transformation



Motivation to become a PCMH

Respondents said the opportunity to improve patients' health was their No. 1 motivation to become a PCMH. This was followed by the desire to provide patient-focused care and the belief that PCMH is the future of primary care. Other reasons shared for being a PCMH were:

- "Additional focus on the health of the population [that] we serve is an added emphasis within our private practice."
- "Health status of county population recently identified as the poorest county in entire state. We have to improve our patients' engagement in their care to support compliance. Remaining status quo will not get our community better results."
- "Better training platform for the residents."
- "Local health insurance plan is incentivizing patients to select a [primary care provider] that is part of a medical home by offering zero copayment. This will drive patients to those practices that are PCMH-recognized."

- "We would like to offer a more full-service healthcare delivery system for the members of our unions. We already utilize medical claims and Rx data provided to us from the union to tailor our wellness and disease management programs. We feel the [primary care provider] partnering piece as well as the community health center resources are the missing pieces to thoroughly engage our members and monitor their progress, follow up. Our goal is to facilitate a more consistent total health program for the union population who embrace our guidance because of our rejection of the 'one size fits all' approach and also because we understand their culture, which is unique and different from corporate population."

- "The concept is what we have always done but now we feel we actually need recognition."

Conclusion

The study shows that practices want to become a PCMH to help improve the health of their patients and to provide more patient-focused care. The results indicate that there was high interest in changing operations in order to deliver patient-centered care. Many respondents reported they would prefer to do so under conditions where similar standards are used by all the national PCMH programs.

While family medicine was the most frequent respondent specialty, multispecialty with primary and specialty care followed very closely. In addition, both physician-owned medical practices and hospital- and IDS-owned medical practices showed high interest in this model of care. This would indicate that there may be significant growth of the PCMH model across the spectrum of care in the near future.

Medical practices are bound to incur additional costs from potential changes to their existing processes. Some of these costs are related to enhancing access, hiring personnel with needed skill sets, increasing care coordination and optimizing EHRs for PCMH functions. Financial incentives to offset the increased costs of changes in operations are welcome by any organization undergoing change. The study participants' high level of participation in pilot and demonstration projects highlights the importance of incentive programs to help establish this model. While incentive programs do not cover all the additional expenses of operating under this model of care, they help defray some of the related costs.

Care coordination was reported as a relatively significant challenge by respondents in existing PCMHs but did not rank in the top five challenges of practices transforming to or interested in this model. The use of care coordinators was higher in existing PCMHs than in the other two categories. Care coordination is a core principle of PCMH and should be addressed at the earliest stages of any transformation to ensure that the right care is delivered at the right time by the right people.

The processes in place to deliver care as a PCMH were relatively the same for existing and transforming practices, but established PCMHs reported higher process usage rates. This report highlights the processes that need more attention from practices transforming or those practices interested in becoming a PCMH.

The PCMH model of care delivery is not new; however, changes in the healthcare marketplace are driving programs intended to provide better patient outcomes. This report provides a look into several areas for primary care practices and other specialties to consider as they embark on this voyage or engage with others delivering care under the PCMH model.

Resources

American Academy of Family Physicians (AAFP): www.aafp.org/online/en/home.html

American Academy of Pediatrics (AAP): www.aap.org/

Accreditation Association for Ambulatory Health Care (AAAHC): www.aaahc.org

American College of Physicians (ACP): www.acponline.org/

Agency for Healthcare Research and Quality (AHRC): www.ahrq.gov

American Osteopathic Association (AOA): www.osteopathic.org/Pages/default.aspx

Centers for Medicare & Medicaid Services (CMS): www.cms.gov/

Medical Group Management Association (MGMA): http://www.mgma.com/pcmh/

National Committee for Quality Assurance (NCQA): www.ncqa.org

Patient-Centered Primary Care Collaborative (PCPCC): www.pcpcc.net/

The Joint Commission: www.jointcommission.org

URAC: www.urac.org