Medical homes improve primary care delivery

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April 13, 2010

Medical homes have emerged as a leading model for improving the quality and accessibility of health care. A medical home is not a physical location, but rather a comprehensive approach to primary care that emphasizes coordination of care and fosters a more collaborative physician-patient relationship.

Fee-for-service reimbursement has encouraged physicians to focus on the episodic treatment of disease. In contrast, a medical home takes a holistic, coordinated view of patient care, which results in healthier patients and a reduction in avoidable health care costs.

Specifically, in a medical home:

- Each patient has an ongoing relationship with a personal physician who leads a team that collectively coordinates the patient's care (including acute and chronic care and preventative services).
- The practice utilizes information technology to support performance measurements, patient education, disease registries, enhanced communication and optimal patient care.
- Patient care is guided by evidence-based medicine and clinical decision-support tools.
- The practice educates patients and encourages patient involvement to increase compliance with care management plans.
- Patient access to care is improved by utilizing open access scheduling, expanded hours and new options for patients to communicate with their physician-led team.

Transforming into a medical home

After assessing its current operations, a practice should formulate a plan to transition to a medical home that manages and coordinates comprehensive patient care. Such a plan will include:

- building a team of clinical and non-clinical providers that will manage and coordinate patient care and identifying specific responsibilities for each team member;
- implementing electronic health records that are linked with the hospital and specialty referral physicians;
- ensuring the practice has appropriate IT capabilities (e.g., disease registries, patient tracking, patient communication);
- implementing evidence-based standards for delivering patient care;
- enhancing patient outreach and education programs (particularly for patients with chronic conditions);
- expanding patient access to care; and
- working with specialty referral physicians and hospitals to strengthen their relationships.

Impact on hospitals

Because medical homes keep patients healthier, hospitals have raised concerns about the impact on hospital volume. Initial studies indicate that medical homes can lower emergency department visits, urgent care visits and "preventable hospitalizations;" however, such admissions are often the least profitable admissions.

Payment

As payment continues to shift from fee-for-service to reimbursement methods

that reward coordinated and cost-effective care, medical homes will be well-positioned for financial success. Medical homes can also proactively negotiate with payers for reimbursement that reflects the added value of coordinated patient care. In addition, many states have multi-payer medical home initiatives and, under the newly passed federal health care reform legislation, the Center for Medicare & Medicaid Services may test medical home models for certain individuals.

Part of a larger integration strategy

Medical homes offer a comprehensive approach to primary care that benefits the patients and providers while helping to reduce avoidable health care expenses. Further, the medical home can invigorate the local providers' integration strategy and serve as a building block for the creation of an Accountable Care Organization.

For more information regarding transforming primary care practices into medical homes or any other health care issues, please contact Nancy Brigner Waite at 614.462.5015 or nwaite@szd.com, Stephen Kleinman at 614.462.2287 or skleinman@szd.com or any member of SZD's Health Care Practice Group.