Taconic Health Information Network and Community

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Frequently Asked Questions
THINC's Pay-for-Performance Medical Home Project

1. What is a medical home?

In 2007, five of the nation's largest primary care physician organizations, together representing about one-third of U.S. physicians, agreed on a set of Joint Principles of the Patient-Centered Medical Home. The document defines the patient-centered medical home (PCMH) as "an approach to providing comprehensive primary care for children, youth and adults…in a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family." Within this model the primary care physician, in a trusting relationship with the patient, guides both preventive and episodic care, including referrals to specialists when needed. Elements of the PCMH model include vital services such as care coordination, the use of health information technology, enhanced access to care using email and telephone messaging, and a team approach to care.

2. Why should health plans play a part in practice transformation?

Health plans have been very interested nationwide in pursuing the medical home model because it has demonstrated improved health outcomes and patient satisfaction while lowering costs. Improved care management and other medical home elements have been shown to reduce hospitalizations and emergency room visits, especially for patients with chronic illness. The medical home is a win-win for patients, providers and payers.

3. What does this mean to the patient?

In evaluations of the medical home thus far, the model has delivered a much better coordinated approach to care. Quality of care is greatly enhanced when a primary care physician takes responsibility to guide patients through the care system, when providers work as a team instead of in independent silos of care, and when care is a collaborative process that puts the patient at the center of decision making. For details of outcomes of the PCMH model, see

PCMH practice transformation benefits all the patients served by a practice. Adoption of the medical home model was shown in a national demonstration project to improve measures of quality of care by 8.3 to 9.1 percent and measures of clinical preventive and chronic care services by 5 percent. Outcomes from independent demonstration projects across the country have produced reductions in emergency room visits of as high as 39 percent because of better care for chronic conditions, and significant cost savings.

4. **What makes this project important?**

The scale of the project and the shared vision among competing health plans to work side by side to improve care make this project unique. Six health plans that cover roughly 65 percent of the commercial insurance market in the Hudson Valley provided incentives for the physician practices to undergo transformation to the PCMH model. That means the benefits of the medical home extend to patients in a PCMH-recognized practice regardless of whether they have a certain type of insurance. PCMH practice transformation benefits all the patients served by a practice—in this case, the total number of patients served by the 236 physicians approaches half a million residents of the Hudson Valley.

5. **What role did THINC play?**

Broadly speaking, THINC acts as a neutral convener for health care quality improvement in the Hudson Valley. THINC's Quality Committee developed the project goals and implementation. THINC managed the project and worked with the payers to determine the incentive payment process and goals.

6. **How long did it take?**

Planning for the project began in 2006. Intensive medical home transformation took place over a 10-month period in 2009, after which the practices submitted their data for NCQA approval. Data collection and analysis is ongoing for quality and utilization measures. Incentive payments were made to physicians in 2010.

7. **Which practices participated?**

Eleven primary care practice groups (seven medical groups with multiple practice locations and four single-site practices) completed the project. As of August 2010, this represented 236 primary care physicians, or 44 percent of total Level 3 clinicians in New York, and nearly 10 percent of all practices at this level across the country. The practices are

- Bridge Street Family Medicine in Saugerties, NY, six physicians;
- Clarkstown Pediatric Associates, headquartered in New City, NY, nine physicians at three sites;
- Community Primary Care in Hopewell Junction, NY, solo physician;
- Crystal Run, headquartered in Middletown, NY, 42 physicians at six sites;
- Hudson River HealthCare, headquartered in Peekskill, NY, 28 physicians at 11 sites;
- Hudson Valley Primary Care in Wappingers Falls, NY, two physicians;
- Imtiaz A. Mallick, MD, FACP in Fishkill, NY, solo physician;
- Institute for Family Health, headquartered in New Paltz, NY, 27 physicians at five sites;
- Mount Kisco Medical Group, headquartered in Mount Kisco, NY, 59 physicians at 11 sites;
- Open Door Family Medical Group, headquartered in Ossining, NY, 16 physicians at four sites; and
- WestMed Medical Group, headquartered in Purchase, NY, 45 physicians at seven sites.

8. **Which health plans participated?**

Aetna, CDPHP, Hudson Health Plan, MVP Health Care, UnitedHealthcare and WellPoint participated with incentive bonus payments..

9. **How were payments established?**

Each health plan pursued its own payment methodology and payment amounts.

10. **What role did HIT play?**

Because health IT is a foundational tool for many aspects of the medical home model, THINC worked with physician practices that were already robust users of health IT. The medical home is facilitated by use of patient tracking and registry tools, electronic prescribing, electronic medical records, electronic communication and scheduling tools, and other means to assure that patients get the indicated care when and where they need and want it.

11. **What is next?**

The project is ongoing with a focus on improving care coordination. The 11 physician practices that earned medical home recognition are training staff to become certified in the Johns Hopkins University Guided Care program. The health plans will reward the practices for this training in addition to other quality triggers: The practices must also conduct most of the elements of the Consumer Assessment of Healthcare Providers and Systems survey and participate in expanded quality monitoring in order to earn the next round of incentive payments.

12. **What research is being done to validate that this model is better than previous model?**

The health plans are working with THINC to collect data that will evaluate patient satisfaction, physician satisfaction and quality outcomes (the data include 10 measures from the Healthcare Effectiveness Data and Information Set). Data are being evaluated by researchers at Weill Cornell Medical College. By measuring these values before the project began, then over the course of the PCMH transformation project and then on an ongoing basis, a reasonable measure of the value of the medical home model should become clear.

13. **Where can I find out more?**

To find out more about the Hudson Valley Initiative, visit the web site, http://hudsonvalleyinitiative.com. An issue brief offers background about the project and the Hudson Valley Initiative, and is available at http://0101.netclime.net/1_5/124/288/09c/HVIbriefRevInCollaboration.pdf.