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Accountable care and patient-centered medical homes: Implications for office-based practice

A *Cleveland Clinic Journal of Medicine* interview with David L. Longworth, MD

The passage of the Patient Protection and Affordable Care Act will profoundly affect the way physicians—particularly those engaged in primary care—practice medicine. Clinicians and their colleagues will be obliged to meet government-mandated performance quality measures while achieving cost efficiencies. Two concepts are central to the implementation of reform in the US health care system: accountable care organizations (ACOs) and the patient-centered medical home (PCMH). To get some perspective on what these changes mean for the practicing clinician, *Cleveland Clinic Journal of Medicine* (CCJM) interviewed David Longworth, MD, who chairs the Cleveland Clinic Medicine Institute and directs strategy and implementation of Cleveland Clinic ACO-related activities.

CCJM: Please explain briefly the concept of PCMH.

Dr. Longworth: PCMH is not a new concept; first advanced by the American Academy of Pediatrics in 1967,[1] it represents a model of care in which an individual patient has a primary relationship with one provider who manages and coordinates the different aspects of the patient's health care. The provider collaborates with a team of health care professionals. The concept caught on about a decade ago when a consortium of family medicine organizations and ultimately industry, including IBM, endorsed the concept. IBM and others created the Primary Care Consortium and began to drive the concept of PCMH.

Increasingly, care delivered through PCMH is team-based. The team coordinates the patient's care and, when appropriate, enlists specialists or subspecialists to provide necessary components of care, all while maintaining responsibility for care coordination across the continuum of care. The medical home model provides an opportunity for enhanced access and care coordination utilizing care outside of the office walls, such as through retail clinics, eVisits, online diagnostic services, phone and electronic communication, and house call services.

Patient-centered medical homes are springing up across the country. In 2008, the National Committee for Quality Assurance (NCQA) developed criteria for recognition of PCMHs.[2] It scored the sophistication of medical homes at three levels, level 1 being the lowest and level 3 the highest. Between 2008 and the end of 2010, NCQA had recognized more than 1,500 PCMHs. According to the latest figures, more than 3,000 practices have now earned PCMH recognition from the NCQA.[3]

The NCQA criteria for PCMH recognition were updated in 2011,[4] with increased emphasis on patient centeredness and alignment of medical homes with certain government initiatives, such as health information technology and the use of electronic medical records. Engagement of community services in patient care is another element incorporated into the updated criteria **(Table)**.[5]

At Cleveland Clinic, pilot projects at three family health centers that cover 60,000 persons have recently been rolled out with the goal of determining the model of team care that yields the highest value, with value defined by the equation of quality over cost. Ideally, higher quality is delivered at lower cost to increase value.

CCJM: What are the goals of ACOs?

Dr. Longworth: The term "accountable care," first used in 2006 by Elliot Fisher, Dartmouth Institute of Health Policy and Clinical Practice,[6] expresses the idea that health care organizations be accountable for the care they deliver, with the three-part aim of better health for populations, better care for individuals, and reduced cost inefficiencies without compromised care.

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With accountable care, institutions take on risk with the expectation that they will improve quality but reduce costs, and if they reduce costs and achieve certain quality targets for populations of patients, they will share in the savings accrued. The Affordable Care Act laid the groundwork for creation of ACOs. The regulation for ACOs released by the Centers for Medicare & Medicaid Services (CMS) became effective in January 2012.[7,8] Many health care organizations opposed the rule for reasons related to complexity, prescriptiveness, onerous detail around governance and marketing, and shared savings arrangements, among others. The final rule addressed many of these concerns and enabled the creation of the first wave of ACOs.[8] At present, 153 ACOs have been approved by CMS.[9] Other ACOs funded by commercial payers are also being formed in many locations.

For ACOs to be effective, I believe that the cornerstone of management has to be PCMHs.

CCJM: You mentioned that institutions will take on risk. What kind of risk are you referring to?

Dr. Longworth: Added value must be rewarded with sustainable payment models. There are two payment models in the final ACO rule from CMS. Both models require 3-year commitments and both require involvement of primary care physicians. One model for organizations that want to stick a toe in the water has no downside risk and modest potential for gain if they hit certain quality and cost targets. For those organizations that are further along and want to assume risk, the second option is a shared savings/risk payment model, which creates greater incentives for efficiency and quality. In the shared savings/risk model, the ACO can retain a portion of savings if it meets performance and expenditure benchmarks based on its performance during the previous 3 years. It is also at risk for loss if expenditures are greater than a certain amount compared with benchmark expenditures. Ultimately, the final destination for ACOs will be a risk of loss if they don't perform.

CCJM: How can these two structures—PCMHs and ACOs—optimize the use of home health?

Dr. Longworth: Home health, which is part of the postacute care continuum, will be vitally important for managing individuals and populations of patients as we move toward PCMHs and ACOs. Coordination of care will require communication between home health services and the primary care physicians who are integral to PCMHs. There will have to be an emphasis on transitions of care, from the hospital to home, from skilled nursing facilities to home, and so forth.

Accountable care organizations are responsible for a population of patients, and ACOs receive a fixed amount of money per year to cover an individual life in that population. Thus, managing quality and controlling cost is the name of the game no matter where the patient is in the health care continuum—the office, the emergency room, the hospital, a skilled nursing facility, or a home health setting. For some chronic diseases, managing patients in the home health setting may be vitally important to prevent unnecessary trips to the emergency room and hospital readmissions, thereby reducing expenditures while providing quality care.

CCJM: Do you expect an increase in the number of PCMHs and ACOs to increase the demand for home health services?

Dr. Longworth: Given the necessity of optimizing quality at lower cost, I anticipate a push to deliver as much care as we can in the least expensive "right" setting, which might be the home in some situations. Certainly, we don't want to send patients home prematurely only to have them return to emergency departments or hospitals, but I think the demand for home health will increase as we try to decrease the number of days in skilled nursing facilities, which are expensive, and to move care from skilled nursing facilities to the home setting.

TABLE
Revised patient-centered medical home standards[5]

1. Enhance access and continuity: Accommodate patients' needs with access and advice during and after hours, give patients and their families information about their medical home, and provide patients with team-based care.
2. Identify and manage patient populations: Collect and use data for population management.
3. Plan and manage care: Use evidence-based guidelines for preventive, acute, and chronic care management, including medication management.
4. Provide self-care support and community resources: Assist patients and their families in self-care management with information, tools, and resources.
5. Track and coordinate care: Track and coordinate tests, referrals, and transitions of care.
6. Measure and improve performance: Use performance and patient experience data for continuous quality improvement.

CCJM: Is there evidence that integrated delivery models such as PCMHs deliver value?

Dr. Longworth: The Patient-Centered Primary Care Collaborative demonstrated quality improvements in selected outcomes domains while also realizing savings through reductions in admissions, emergency department visits, skilled nursing facility days, and pharmacy costs.[10]

CCJM: What challenges do PCMHs and ACOs present to home health agencies and the way they provide services, and how will these challenges affect patients and clinicians?

Dr. Longworth: One challenge will be communication between home health services and primary care providers during transitions of care. A second will be managing costs for home health, which entails leveraging new technologies such as in-home devices and telemedicine to provide optimal and ideal monitoring of patients at the lowest potential cost. Home health, like other players along the care continuum, will face increasing scrutiny regarding quality metrics. Home health agencies will likely need to distinguish themselves from one another on the basis of performance measures such as emergency department utilization, unnecessary hospital readmissions, medication errors, and quality of service to patients as well as to primary care providers.

Primary care physicians especially will be under increasing pressure to care for populations as opposed to individual patients.

CCJM: How does personalized health care fit into the PCMH model?

Dr. Longworth: Personalized health care, which includes the use of genetic testing in certain situations, is an emerging field that is still in its infancy. Like PCMHs, personalized health care is proactive rather than reactive. Application of personalized health care can help deliver value with better prediction of disease and appropriate use of targeted therapies to improve outcomes for certain individuals. Such individualized treatment not only enables higher quality of care but wiser use of resources. For instance, genetic markers can be used to predict drug metabolism and adverse drug events for certain medications. In the field of oncology, the expression of genetic mutations in certain tumor types can help identify patients most likely to respond to specific targeted therapies. In these ways, personalized health care is patient-centered health care. As part of its proactive nature, personalized health care, beyond genetic testing, also implies advance planning of appointments with a focus on chronic care and keeping patients in the care system.

CCJM: How does participation in a PCMH or an ACO benefit the primary care provider? Are there any disadvantages to participation?

Dr. Longworth: In the current fee-for-service world, primary care physicians and all providers are paid on a widget-by-widget basis. Some primary care physicians and other specialists fear moving to this new world in which they will ultimately be accountable for quality and cost. Not everyone has embraced the concept, but I do think it is inevitable. Primary care physicians especially will be under increasing pressure to care for populations as opposed to individual patients. They will need to redesign the care delivery model to provide team-based, proactive care focusing on the highest-risk patients to try to keep them out of the emergency department and hospital. There will also be a greater emphasis on wellness moving forward, in an attempt to prevent the development of chronic diseases such as diabetes and obesity in individual patients and populations. All of these changes represent a different paradigm for the delivery of care, compared with the present model.

The benefit of participation for a primary care physician depends on the structure of an ACO, particularly the amount of personal financial liability an individual practitioner might have. In a staff-model, fixed-salary institution, primary care physicians would probably be more immune to financial liability than they would in other markets or other compensation models in which salary can fluctuate.

CCJM: What are some of the barriers to ACO implementation that are relevant to office-based practice, and how can they be overcome?

Dr. Longworth: There are a number of barriers to ACOs and true PCMHs. The barriers revolve around redefining workflows and moving away from reactive care—a physician-centric model in which a patient comes into the office with a problem and the physician reacts—to proactive care with the goal being to recognize how the patient is doing over time to prevent unnecessary trips to the emergency department and, ultimately, hospitalization. It is a fundamentally different mindset that involves proactive outreach targeted

at high-risk patients whose chronic diseases are managed through a team-based approach. An essential feature of primary care practice will be care coordinators who will manage and proactively anticipate the needs of medically complex, high-risk patients who use a disproportionately large share of services.

In addition, a greater emphasis on wellness will be necessary to prevent the development of chronic diseases such as diabetes, obesity, and hypertension in the large segment of the population that is reasonably healthy.

CCJM: What steps can a clinician take to prepare his or her practice for ACO implementation?

Dr. Longworth: Small practices will be challenged. It is difficult to imagine accountable care without an electronic health record. To understand the population, the practitioner will need to do continuous performance management, which can't be done without access to data from a population of patients. An increasing number of physicians are aligning with organizations that have the necessary infrastructure to provide the myriad data required to measure quality, to enable continuous improvement in performance, and to enhance the patient experience. Small practices may not have the resources to complete the administrative work necessary to become part of an ACO.

There are ways to align with an ACO that do not constitute full employment; for example, the Cleveland (Ohio) Quality Alliance has aligned with community-based physicians to provide informatics support. Linking with larger organizations that have the resources to provide quality measurement and contracting support will permit smaller community-based physicians' practices to be part of the game.

CCJM: What steps should PCMHs and ACOs take to leverage and optimize home health services among other parts of the medical neighborhood?

Dr. Longworth: Frankly, the postacute continuum is a challenge for most systems across the country because postacute care is fragmented. Our strategy at Cleveland Clinic is to identify and align with preferred providers of home health services. The criteria that I look for are commitment to quality and transparency, service that is oriented to both patients and PCMHs, and openness to innovation for leveraging health care technology to deliver care at the best value. Home health providers need to think about how to best accomplish these results to position themselves to partner with ACOs.

CCJM: How do PCMHs and ACOs apply to special patient populations and their needs? Is there a population that's best suited for the medical home model?

Dr. Longworth: Certain populations of higher-risk patients are ideally suited to home health coupled with chronic disease management using care coordinators. Some examples are children with asthma and children with intellectual and developmental disabilities (eg, autism) who have high utilization of emergency services. Another population is patients with heart failure who are often in and out of the emergency department and hospital; there has been a concerted effort to reduce 30-day readmission rates, which are as high as 30%, for this group. (Also see "Home-based care for heart failure: Cleveland Clinic's 'Heart Care at Home' transitional care program," page e-S20.)

CCJM: What are the specific expectations for patient involvement in the PCMH setting?

Our challenge lies in how best to motivate patients and engage them in their own care.

Dr. Longworth: Our challenge lies in how best to motivate patients and engage them in their own care, especially patients who have chronic diseases. We all struggle to resolve the engagement question. Coaching and patient engagement are functions of PCMHs and at every point along the care continuum. Home health providers can serve as health coaches to promote adherence to medications, healthy lifestyles, and follow-up visits with patients' doctors—these all need to happen to better engage patients. How to engage patients and motivate them to be more involved in their health is a basic challenge.

CCJM: Along similar lines, how can home health providers work with physicians to achieve patient-centered care?

Dr. Longworth: They can communicate early when they think that things are amiss, serve as health coaches, create technologic solutions that enhance efficiency of communication, and anticipate care needs of patients in the home setting.

CCJM: How might bundling affect the financial picture of PCMHs and patient care?

Dr. Longworth: When one talks about bundling, the devil is in the definition. In bundling, one gets

paid for an episode of service. So, for example, a total knee replacement might be compensated by a 30-day bundle that covers only the surgery and the immediate postoperative period. Or it might be a 90-day bundle that includes hospitalization and perhaps some days in skilled nursing facility, but ideally transitioning from hospital to home. In the latter example, the bundle, or the total payment, will be split between the hospital and the home care services. If home health is included in a bundle, there will be tremendous pressure on the home health service to prevent readmission and emergency room visits and to eliminate waste of care. Home health's vulnerability will depend upon how a bundle is defined for specific service.

CCJM: Who defines the terms of the bundle?

Dr. Longworth: Whoever is applying for the bundle—usually, a health care system, hospital, or ACO. It may be that home health services will subcontract for a flat fee in order to immunize themselves against risk, and shift all of the risk to the contracting organization. If I were a home health provider, I might try to minimize my own risk, but still offer my services at a price that is financially viable.

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