Ensuring That Patient-Centered Medical Homes Effectively Serve Patients With Complex Health Needs

Question: How can decisionmakers help smaller primary care practices become effective patient-centered medical homes for patients with complex health care needs, such as the frail elderly and people with disabilities?

Answer: Strategies must address barriers that primary care practices face in trying to provide high-quality, comprehensive, coordinated, and accessible care to patients with complex needs by:

- **Reforming primary care practice payment policy.** Current fee-for-service arrangements do not provide adequate support for the many care coordination activities and resources needed to serve this population.
- **Supporting programs that collaborate with primary care practices to enhance their clinical capacity and offering care managers and other resources to help patients and their families coordinate services.** Additional staff, clinical decision support, and other resources help to manage myriad conditions and disabilities in this population and overcome high levels of competing demands on primary care clinicians' time.
- **Supporting additional research.** Further studies are needed to identify effective payment and delivery models for serving patients with complex needs in patient-centered medical homes and to understand how to adapt models to local context and resources in diverse communities and practices.

The patient-centered medical home (PCMH) is a promising model that aims to strengthen the health care system by reorganizing the way primary care practices provide care.[1,2] The medical home concept, supported by health information technology and payment reform, rests on five pillars:[3]

- **A patient-centered orientation** toward each patient's unique needs, culture, values, and preferences; support of the patient's self-care efforts; and involvement of the patient in care plans.
- **Comprehensive, team-based care** that meets the majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care and is provided by a cohesive team.
- **Care that is coordinated** across all elements of a complex health care system and connects patients to both medical and social resources in the community.
- **Superb access to care** that matches patients' needs and preferences, including care provided after hours and by email and telephone.
- **A systems-based approach to quality and safety** that includes gathering and responding to patient experience data, committing to ongoing quality improvement, and practicing population health management.

Patients with complex needs, including the frail elderly and adults with physical disabilities, use more health services than the general population, get them from many different health professionals, and receive care in multiple settings. Their heavy use of health services puts them at greater risk of receiving fragmented or poor-quality care. It also increases their need for help in coordinating services across multiple providers. In addition, patients with complex care needs frequently require social and mental health services and supports. Many have functional limitations and need long-term assistance with activities of daily living such as eating, dressing, and using the toilet. They may get this help from family members, social service providers, or community-based organizations, which all need to be partners in the care team.

PCMHs could help improve health outcomes and lower health care costs for patients with complex needs by coordinating the medical care they deliver with a wide range of social and mental health services. Primary care practices that enhance their capacity to serve patients with complex needs may also become more effective in recognizing needs and coordinating services for the broader patient population.

Primary care practices face many barriers to providing PCMH care to patients with complex needs.

Primary care clinicians and their staff often face barriers to providing comprehensive, coordinated, high-quality care to patients with complex needs. First among them are problems with the way most clinicians are reimbursed. The most common form of payment—fee-for-service (FFS)—covers procedures, tests, and clinic visits. It does not compensate clinicians for time spent assessing the need for long-term services and supports, or time spent developing and implementing patient-centered care plans. Generally, FFS payment rates also do not cover the extra time needed to coordinate patient care across multiple providers or to evaluate patients with complex physical, mental, or communication problems either in the clinic or in the home.

In addition, evidence on effective care can change rapidly, making it difficult to keep up with the latest developments in medical care and social supports for a wide array of disabling conditions. Primary care practices must also prioritize acute care problems that often bring patients with complex needs into the clinic, drawing attention away from important, but less urgent, care needs. These issues are magnified in practices with five or fewer physicians, which often lack time and resources to integrate medical and social services, and do not have practice team members with expertise in managing complex needs.

Innovative programs support primary care practices to improve care for patients with complex needs.

A variety of programs across the country are using innovative approaches to help primary care practices deliver better care to patients with complex needs. These programs, reviewed in a recent paper prepared for AHRQ[4], offer useful lessons for decisionmakers who want to support PCMHs in providing better care to these patients. The programs share the following features:

- **Focusing on the most costly patients.** Most are eligible for Medicaid or Medicare or both programs because they have very low incomes and are over age 65 or disabled. In an effort to lower total care costs, State Medicaid agencies, along with a few demonstration programs funded by Medicare and private health plans, have begun to pay primary care practices for time spent providing comprehensive and coordinated care to these patients.
- **Placing case managers/care coordinators in primary care practices.** Case managers/care coordinators are typically nurses, social workers, or other professionals who work as a team with the primary care clinician. Case managers/care coordinators extend the reach and capacity of primary care clinicians to provide more proactive care by making home visits, providing 24-hour on-call advice, and helping patients find and secure community-based services.
- **Allowing flexibility in matching staff to the needs of each practice.** These staff include case managers/care coordinators, as well as specialists in geriatrics, nutrition, mental health, and assistive technology. In many programs, staff rotate among several primary care practices, but if a practice has enough patients with complex needs, support staff can be assigned to just one.
- **Helping primary care clinicians manage patients with complex care needs alongside their regular patients.** Most of the programs help reorganize workflow and systems; identify and proactively track complex or high-risk patients via registries; conduct in-home assessments; staff 24/7 telephone lines to complement the practice's after-hours coverage; set up electronic health records, Web-based IT registries, and referral tracking systems; monitor utilization and

quality indicators to identify areas for improvement; and engage practices in peer learning collaboratives.

- **Paying additional fees to compensate primary care practices for time required to care for people with complex care needs.** Most of the innovative programs augment current payment to primary care practices with a monthly amount per patient, sometimes adjusted to reflect disease or condition complexity, which enables the practices to spend time on comprehensive assessment and care coordination.

Decisionmakers can support smaller primary care practices in becoming effective PCMHs for patients with complex needs.

Decisionmakers can help overcome barriers that primary care practices encounter in becoming effective PCMHs for patients with complex needs. Policies and strategies require action on three fronts:

1. **Reimburse practices for the time and skills needed to serve patients with complex care needs effectively.** Reforms to primary care payment policy in the Medicare and Medicaid programs, as well as in private health plans, should be designed to give primary care practices resources and incentives to deliver accessible, comprehensive, coordinated care for patients with complex needs. Within FFS systems, primary care practices could receive additional payments that allow practice transformation to be geared toward care coordination and enhanced access for patients with complex needs. Bundled or global payments, which give providers flexibility to deliver care in the least costly setting, are an alternative approach. For example, global fees can allow providers to make timely in-home assessments for patients who have difficulty getting out of the house and to coordinate medications and services across settings. The experience of innovative programs suggests that enhanced primary care payments and global fees may lower overall health care costs by reducing unnecessary hospitalizations and nursing home admissions, while improving quality and patient satisfaction. Other payment reform options include bonuses that reward primary care practices for more patient-centered and evidence-based care. Aligning payment policies across payers would also help smaller practices by standardizing the incentives to become PCMHs and to improve care for patients with complex needs.

2. **Support programs that collaborate with primary care practices to enhance clinical capacity, and offer case managers/care coordinators and other resources to help patients and their families coordinate services.** Case managers/care coordinators who work in partnership with primary care practices can help clinicians provide more patient-centered and comprehensive care. Team members who can proactively assess and coordinate patients' and families' medical and nonmedical needs as well as facilitate access to community-based long-term services and supports are critical members of the expanded primary care team. Primary care clinicians value readily available, specialized expertise—for example, from nurse care managers—to help them develop personalized care plans and provide evidence-based care for uncommon conditions. Additionally, decision-support tools and specialists available in real time during patient visits—for example, via online applications or phone or video consultation—can spare patients from further visits to specialists. Programs that offer 24/7 on-call triage services staffed by nurses who have access to patient records can also ensure that patients with complex needs receive timely and appropriate care in the proper setting.

3. **Conduct further research to identify payment and delivery models that will succeed in different types of communities.** Promising program models exist, but gaps remain in our understanding of payment methods and organizational models that work best. Research can help determine how much, and how best, to structure payments to primary care practices to compensate them for the extra time and resources involved in patient-centered care for complex needs patients with widely varying conditions, disabilities, and levels of severity. Studies can also help identify effective ways to harmonize primary care practice payment with funding for community support organizations, and optimize team-based care for this population. Given the diversity of communities across the country, research could also help

learn which models are most effective for practices of varying sizes and patient mixes, as well as those that operate in urban versus rural settings and rely on different types of support organizations. Finally, much research remains to be done on strategies and supports necessary to transform primary care practices as they implement these models.

Looking ahead

Primary care clinicians working in smaller practices can find it challenging to care effectively for people with complex care needs. Improving care delivery through use of the patient-centered medical home model has the potential to provide better quality care at lower cost for all patients, but those with complex needs stand to benefit the most. Decisionmakers can offer targeted support and resources to help smaller primary care practices achieve these aims.

Endnotes

[1] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of a patient-centered medical home. March 2007. http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat/022107medicalhome.pdf. Accessed September 28, 2011.

[2] Rittenhouse DR, Shortell SM, Fisher E. Primary care and accountable care—two essential elements of delivery-system reform. N Engl J Med 2009;361(24):2301-13.

[3] Adapted from Agency for Healthcare Research and Quality's medical home definition. http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/what_is_pcmh_. Accessed September 28, 2011.

[4] Rich E, Lipson D, Libersky J, Parchman M. Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Final paper submitted to the Agency for Healthcare Research and Quality, July 22, 2011.

The brief was prepared by Debra Lipson, Eugene Rich, and Jenna Libersky (Mathematica Policy Research) and Michael Parchman (Agency for Healthcare Research and Quality). A companion white paper commissioned by AHRQ contains additional details on challenges and promising approaches for improving the capacity of primary care practices to deliver coordinated and comprehensive care to patients with complex needs. It also highlights the key features of five innovative programs that serve these patients. Access to these publications is available on the AHRQ Web site at http://www.ahrq.pcmh.gov.

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