Patient Centered Medical Home

Eight Reasons Why It Makes Good Business Sense

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Many of you have probably heard of the Patient Centered Medical Home (PCMH) model of providing primary care. It was a big topic at the recent Military Health System (MHS) Conference in Washington DC and the USAFP Annual Conference in New Orleans. Many benefits exist for the patients we serve, as well as for the staff in our primary care clinics. However, because our resources are not unlimited in the MHS, it helps to be able to understand how initiatives, such as PCMH, can impact the cost of providing care, as well as to weigh the costs with significant benefits. If executed correctly, here are some reasons that PCMH makes good business sense:

1. Decreased primary care utilization: Patients who experience higher continuity with the PCMH team with whom they are empaneled should have improved control of their medical issues compared with those patients who see a different provider every time they present to a primary care clinic. This leads to an overall decrease in the utilization rate (average number of visits per year of a set population) of a panel of patients in a PCMH. While practice guidelines exist for diseases such as diabetes and asthma, significant variability still occurs in how providers choose to treat patients. By working in a PCMH model, the patient experiences a high level of continuity with their medical home team, and, therefore should not experience frequent changes to their treatment plans. This improves the quality of their healthcare and decreases their need to access the healthcare system.

2. Decreased ER visits: If patients’ care in a medical home team is more proactively managed, it should result in decreased use of the ER by those patients. Currently, patients often use the ER in military and civilian hospitals for routine primary care issues because they cannot schedule an appointment with their provider in a timely fashion. Patients are products of our current fast paced, time restricted culture. As a result, our patients demand timely and efficient care that is also convenient. If steps are taken to provide advanced access to patients in the form of easier communication via telephone and IT solutions, this may ease some of the access problems our patients face. IT solutions may include: secure email and personal medical records from which patients can access their medical information.

3. Decreased urgent care visits: For many of the same reasons mentioned above, the use of urgent care visits in the purchased care sector can be decreased when using the PCMH model. Urgent care visits are often “pop offs” from the direct care system in our clinics when access is not available for our patients. Reduction of purchased care cost is a significant benefit from a business perspective, but increased continuity and access is a significant benefit from a clinical perspective.

4. Decreased consults: Patients experience increased continuity in the PCMH, which should reduce unnecessary consults that are inevitably made when providers do not know patients and do not have time to fully explore their current treatment plan. It is very difficult for providers to fully understand a patient’s chronic illness care plan during a 20 minute visit.

5. Increased HEDIS scores: The current traditional primary care model relies on one person to direct action lists for an entire population’s HEDIS compliance. However, in the PCMH model, the team should be ensuring HEDIS issues are addressed for the patients empaneled to their team. This occurs through actively screening the patients’ appointments in the days and weeks ahead, but also actively searching the panel for those that may need HEDIS tests or procedures. In addition to establishing a healthier population in the PCMH, this will decrease cost, and increase PPS revenue from TMA.
6. Increased RVU per visit: A concern is often raised that if utilization decreases, RVUs will decrease, as well. Though the medical culture focused on productivity may be evolving into one based on outcomes, it is not the current reality so this concern is valid. If the PCMH team is working together during patient visits, RVU generation can be maintained. Non-providers should actively screen upcoming appointments, avoiding those that produce “artificial demand”. Examples of this “artificial demand” are patients returning to check lab results or to receive refills of medication. These are often low RVU producing encounters that eat up access to the clinic. Another method of maintaining RVU generation is by using a team approach to have staff assist in gathering and documenting patient information. The provider will then reduce the amount of time documenting in AHLTA. This should allow for more time to address multiple complaints from the patient and ultimately results in increased RVUs per visit. Compare this to the rushed provider who can manage only one or two complaints during a visit, and subsequently defers other issues for other appointments, inevitably decreasing access and increasing the population utilization rate. The RVUs should be similar, but the quality of care is far different.

7. Increased empanelment: Word to the wise... do not increase your empanelment until you have established a well run PCMH. The true demand of the patient population in the PCMH needs to be determined first. Once the PCMH is executed effectively, the empanelment per provider may be increased because utilization will decrease. Remember, the utilization rate of the population should decrease if their medical care is managed by the team approach focused on increasing the continuity between the patient and the PCMH team. If the team is able to address multiple patient issues during each visit, this should translate to the lower utilization rate by the team’s panel of patients. It may then be possible to increase the empanelment to the PCMH, thus reducing the cost per patient to provide care.

8. Decreased PMPM: Per Member Per Month (PMPM) is a measure of all the costs that go into providing care for a population, divided by the number of people in that population. When TMA uses this calculation, they make adjustments based on the ages of the people empanelled to a MTF, among other things. However, because of all the issues discussed thus far, the PMPM calculated cost to provide safe and high quality medical care to our population should be reduced by clinics running the PCMH model. This reduced cost is as a result of: fewer ER visits, fewer hospitalizations, and fewer specialty consults, among other things. As a result of the increasing budget deficit in our government, the future of the MHS is that we will most likely be asked to do more with less.

To summarize, the PCMH presents multiple benefits to the delivery of patient care. These examples are specific, key ones that relate to the business of delivering healthcare. In addition to making good business sense, the PCMH model benefits our patients and our staff working diligently to provide care in our primary care clinics.