



# Research Insights

## ■ Medical Homes and Accountable Care Organizations: If We Build It, Will they Come?

### Summary

The movement for a revitalized primary care infrastructure envisions transformed primary care practices featuring health information technology (HIT), innovative team approaches, and other new models of care. Key policy questions include whether small, independent office practices have the capability and capacity to undergo this type of transformation and whether creation of more organized health care delivery systems is a precondition for the transformation of medical homes and accountable care organizations. The following brief highlights the challenges likely to develop as medical homes and accountable care organizations emerge in the care delivery landscape, and discusses possible solutions to resolve those challenges.

### Growing Attention to Rebuilding Primary Care Infrastructure

Despite their role as the foundation of the U.S. health care system, fewer physicians are selecting careers in primary care. As policymakers consider ways to shore up the primary care infrastructure, there is growing attention to developing new models of organized care delivery. These models focus on a team-based approach; a radical shift from the traditional delivery of health care but one that may begin

to address the problem of a shrinking primary care workforce, create better coordination of care, and improve outcomes for patients.

### Models

#### Medical Home

While the definition of a medical home<sup>1</sup> varies by source, the general construct remains consistent. The medical home model promotes a team-based approach to care of a patient through a spectrum of disease states and across the various stages of life. Overall coordination of care is led by a personal physician with the patient serving as the focal point of all medical activity.

In 2007, four physician organizations developed seven joint principles to describe the characteristics of a patient-centered medical home:<sup>2</sup>

- *Personal physician* – serves as the primary contact and coordinator of care for a patient.
- *Physician directed medical practice* – is led by the personal physician who directs the practice team to ensure continuous, comprehensive patient care.

### Genesis of This Brief: AcademyHealth's 2009 Annual Research Meeting

At its Annual Research Meeting (ARM) in Chicago, June 28-30, 2009, AcademyHealth hosted a roundtable discussion among four experts to explore the promise and challenge of models of integrated delivery of health care. Lawrence Casalino, Weill Cornell Medical College; Carlos Jaén, University of Texas Health Science Center at San Antonio; and Diane Rittenhouse, University of California, San Francisco, participated in the roundtable discussion. Kevin Grumbach from University of California, San Francisco chaired the discussion, which serves as the backdrop for this brief.

- *Whole person orientation* – in which the personal physician arranges and oversees care throughout patients’ various stages of life.
- *Care is coordinated and/or integrated* – by the personal physician in connection with specialists and across settings facilitated by information technology and other appropriate tools.
- *Quality and safety* – serve as primary guideposts for all aspects of a patient’s medical care.
- *Enhanced access* – using tools such as open scheduling, extended hours, and various modes of communication between patients and providers.
- *Payment* – is value driven and reflective of case mix, enhanced technologies, quality improvements, and shared savings achieved by successful patient management.

The goal in the medical home is for a team of providers to care for a patient, seamlessly and efficiently, while managing costs. In a medical home, the primary care physician assists patients who need specialty care, maintains electronic records of all patient/provider interactions, communicates with all of a patient’s clinical caregivers, and tracks the patient’s progress.

### Accountable Care Organization

MedPAC has defined accountable care organizations (ACOs) as a set of providers associated with a defined population of patients, accountable for the quality and cost of care delivered to that population.<sup>3</sup> The providers could include a hospital, a group of primary care providers, specialists, and possibly other health professionals who share responsibility for the quality of care and cost of care provided to patients.

While the medical home model is centered around a single practice, ACOs are at the other end of the spectrum, housing many practices within one organizing entity. A single ACO could be quite large and cover thousands of patients. Hospitals are not a necessary part of ACOs, but may be a desirable feature.

As the structure has been envisioned, patients would not be required to get care from the ACO, but the ACO would be responsible for a patient wherever he or she elected to get care. ACO members receive a financial bonus for meeting certain prescribed targets. ACOs could seek voluntary participation by providers or mandatory participation.<sup>4</sup>

### Likely Challenges in Building Medical Homes & ACOs

While not insurmountable, converting the current delivery system to an integrated model of care composed of stand-alone medical homes or multiple medical homes housed within a large ACO structure is, as one expert noted, the equivalent of trying to transform a DC9 to a 747 while the plane is flying. The following challenges are likely to arise as medical homes and ACOs are built:

- The medical home is a patient-centered model of care. It will take a transformative shift to place the patient at the center of the delivery system, rather than the physician, and provide that patient with high quality, low cost, convenient care.
- Most health care is delivered in small, scattered office-based practice settings. It is not clear whether a delivery system transformation will be more successful by first developing individual medical homes prior to bringing practices within the umbrella of an organizational structure like an ACO.
- The size of the practice will dictate the approaches needed to effect change. Small independent practices and large integrated groups are both likely to continue to exist within new delivery models. These mixed organizational structures will require different approaches—a combination of internal capacity and external financial incentives to promote change. The challenge is determining how much and what kind of incentives are needed for particular-sized groups.
- While there is an assumption that medical homes will provide better care, it is not clear that demonstration projects will be the ideal test of a medical home’s success. First, by its very nature a demonstration is a temporary exercise, which may keep health care providers from fully embracing change. Second, until payment systems are altered to compensate practices for converting to a medical home, change will be slow. Yet, Congress needs evidence on which to base changes in payment structures to facilitate development of medical homes—a chicken and egg problem ensues.
- Timelines must be long enough to realize meaningful results. Focusing, for example, on changes within a practice’s quarterly profits may be insufficient. While there will be political pressure to show short-term results, those results may not be determinative of the long-term feasibility of medical homes. In the short term, medical homes may not yield significant positive results.
- What is the return on investment for a practice that engages in an intensive transformation, whether facilitated or internally driven? If practices embark on a transformational process and expect to see change, even two years may not be enough time because some patients are seen only once or twice a year.

- Will delivery system redesign necessitate shifting the payment structure among primary care and specialty physicians or giving greater financial support to the primary care providers? Specialists are unlikely to “go quietly into the night.”
- Transforming a physician practice into a medical home will involve restructuring numerous processes. A list of changes that is too long or cumbersome could result in “practice fatigue.”
- A key challenge includes developing structural supports, particularly with regard to staffing. There are no economies of scale for small practices in hiring additional staff.
- Another challenge is lack of knowledge and resources to expand long-term care and acute care coordination.
- Health information technology, independent of other things, is likely not the “silver bullet” needed to achieve practice change.
- Providers are not currently trained to work in teams and they are not paid to do so. A better understanding is needed of the skill set and attributes of a workforce functioning in a modern way.
- Determining the proper level of incentives to induce the development of ACOs will be challenging. Under proposed models, Medicare could look at claims experience and project costs for a coming year for a population cared for by an ACO. The ACO would be held responsible for the care and if able to deliver quality care under the projected costs, the ACO would retain the savings. What bonus is large enough to induce ACOs to participate? With large populations of patients, large incentives may be necessary.
- Primary care physicians are retiring and new medical students are not electing primary care as their specialty. If a reformed health care system is designed to be carried on the backs of primary care providers, who will those people be? Attention must be paid to those who will work in that system over the next 10-20 years. A redesigned delivery system will have a short term and long term impact and the labor force is a critical component.
- Currently, there are few redesigned delivery models in which students can train. In school, students learn the traditional practice of medicine. It is not a “teamness” type of care. Medical school faculty need to rethink the fundamental role of physicians and focus training on the team structure.
- Identifying the right measures of success will be important. It is hard to measure the physician/patient relationship. Being a good diagnostician and maintaining valuable relationships with patients is hard to measure. Yet, these may mean more than other infrastructure-based measures of success.

## Possible Solutions in Building Medical Homes & ACOs

Building successful medical homes and ACOs requires an understanding of local environments and the capacity of practices to change. Primary care is a local process and the key is adapting organizational changes to the local environment. One approach is to fund a local facilitator who becomes a member of the practice and works to improve adaptive capacity. A large infrastructure may be needed to support real change. There are parts of medical homes outside of practices, e.g. pharmacies, hospitals, etc. which are holders of information. Integrating practices within the local landscape requires involvement by related entities and connection to the community. Focus should be inside and outside of the medical practice, including seeking out economies of scale and opportunities to share resources.

For some practices, a wholesale change of the entire practice may prove most effective. Practice coaches could be employed to provide structured facilitation. Other practices may elect a piecemeal approach, making one change at a time and assessing its success. For example, some practices may begin with adjustments to the scheduling process. Others may start with development of a system for self-management support for chronic illnesses. As a general rule, some core structures of a practice must stay in place to ensure smooth transitions and minimal patient disruption.

Building capacity within a practice to be its own agent of change is key. Remaining cognizant of how one change affects other parts of the practice is essential to avoid unintended consequences. Change must be driven by leadership and embraced by all practice members. Management must be aligned in a common goal, rather than pulling in different directions. Consistent messages are necessary. Rather than focus on the notion that physician behavior must change, focus should be on moving from a personal sport to a team sport. When physicians can engage a team they trust, transformative change will happen. Practices may find it most beneficial to create top down incentivized targets, as well as flexible bottom up approaches that incorporate current practice processes. Change should be neither too prescriptive nor too open-ended.

Better coordination can be achieved without staff restructuring, including developing health information technology systems for primary care physicians to communicate with specialists and communicate lab results to patients. Large practices may have an advantage here with resources necessary to develop a robust health information technology infrastructure. However, in some situations, large practices do not have an advantage over small practices. There are some care

delivery processes that small practices do very well. Over time, small practices could engage voluntarily in a network building learning community, which serves as a hub and provides access to a larger infrastructure.

In terms of moving the development of models forward, it may be best to start with larger and hospital owned practices and bring smaller individual practices along later. Large integrated systems (e.g. Geisinger) could serve as an ACO and stand as a model for others to replicate. Other potential leaders use a shared resources model, including Community Care of North Carolina and Vermont Blueprint for Health. These groups share FTEs across practices and have collaboratively come together to share resources.

While some results may take more than two years to achieve, this should not undercut efforts to create change; some concepts have face validity despite a lack of evidence that it makes a difference.

### Conclusion

Final reform legislation is likely to include pilot programs to test the medical home and ACO models. As noted above, those developing and testing these new models face challenges. The stakes are high. Transformation of thousands of practices across the country into medical homes and ACOs is a huge undertaking. Is it worth it? Will it improve care? Can small practices do it? Most policy experts believe large multi-specialty groups are the best solution on the horizon to achieving high quality, low cost care. But there is little hard data to show that. Time will tell whether pilot programs are successfully developed and ultimately replicated.

### Endnotes

- 1 For purposes of this discussion, the author does not distinguish between Medical Home, Advanced Medical Home, Patient-Centered Medical Home, or other similar nomenclatures.
- 2 American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA). <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>
- 3 [http://www.medpac.gov/chapters/Jun09\\_Ch02.pdf](http://www.medpac.gov/chapters/Jun09_Ch02.pdf)
- 4 Ibid.