Patient-centered medical home management
Transforming health care through a connected community of care
Can you remember a personal health care experience in which you felt distressed, confused or uncared for after a visit or hospitalization? Care, coordination, compassion and comfort are elements of a dynamic and functional patient-centered medical home (PCMH). We believe that every health care organization should be able to provide these elements to every patient, and that this is not a lofty goal, but a real, measurable and achievable outcome.

The patient- and family-centered care concept is being touted as a transformative model for health care in the US public and private sectors. It attempts to minimize negative experiences while making health care more effective and efficient. The ultimate goal is to provide an accessible physical and virtual environment where relationships with patients (and their families or support systems) are enhanced regardless of the original need. Care and empowerment are the benchmarks of the patient experience in a PCMH, along with meeting and even exceeding patients' needs and expectations.

PCMH — an old concept, renewed

PCMH is not a new concept; it dates back to 1967 when the American Academy of Pediatrics (AAP) began its pursuit of the coordination of health records and care for chronically ill children. Today, the AAP, the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) — representing more than 330,000 physicians — are influencing the implementation of the PCMH model throughout the US.

The National Committee for Quality Assurance (NCQA) has developed the NCQA Physician Practice Connections PCMH standards with input from the AAP, AAFP, ACP and AOA. The standards direct that each patient have a personal physician who directs a care team.

The heart of care — patients

PCMH aims to bring the patient back to the heart of the delivery of care. The growing base of literature supports the notion that the PCMH is a promising means to assist in the transformation of health care in America and to provide care that is meaningful, evidence-based and satisfying to both patients and the health care team. The literature shows that the PCMH approach leads to fewer errors, fewer hospitalizations and less emergency care.

However, there are challenges to implementing the PCMH model: the potential costs in practice redesign, facility structure and staffing models. Small practices or — for the Military Health System — smaller clinics or hospital commands don't see the return on this initial investment under their current operating model. For instance, the staffing model includes adding RNs, pharmacists and social workers, a large cost for small practices. Exploring and defining new payment systems, including bonus payments for keeping patients well and

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following leading practices, may help build confidence enough in the final product to justify the up-front costs of building a PCMH.

Lack of performance data to make effective operational decisions adds to provider concerns, as well as lack of incentives for chronic care coordination and preventive health programs. Information technology, implementation of electronic health records (EHR) or improving current EHR systems present separate challenges. But given the unremitting rise in health care costs and increasing emphasis on preventative care, there is no better time to combine PCMH with technology advances in information exchange, electronic record keeping and other electronic modalities like telemedicine or patient/health care provider portals. Together, they will create the health care experience of the future.

Putting “care” back in health care

Transforming how patients and families are cared for in the US, while a daunting task, is an opportunity to re-infuse the health care experience with the art of healing. The current public and private systems cannot be sustained, and although the political landscape may change or current legislation may be reshaped, there is no question that transformation is necessary and inevitable in both patient and family care and for the provider and health care team.

Meaningful change and reform must be about coordination versus fragmented care, payment or incentive for outcomes versus volume, provider accountability for patient health versus the treatment of disease, and care that is evidence-based, effective and covered.

The passage of The Patient Protection and Affordable Care Act (P.L. 111-148) is an opportunity to change how health care is delivered in the public and private sectors. P.L. 111-148 and the Health Care and Education Reconciliation Act (P.L. 111-152) provide key provisions for all facets of health care, most notably in new delivery care models and other demonstration programs (e.g., home-based primary care teams, services to overcome barriers to care).

Title III, Subtitle F, Sec. 3502, specifically outlines grants to establish the patient-centered medical home. Evidence of positive outcomes in patient satisfaction, hospitalization, emergency department access and (predominantly) chronic disease conditions in PCMH is growing rapidly. The Government Accountability Office (GAO-08-472T) has concluded that the literature supports the PCMH focus on wellness and preventative care (the dominant features of primary care, especially for the chronically ill) and that coordinated care increases patient satisfaction and can realize significant cost savings.

Healthy people, healthy country

The current state of the health of the US general public continues to create conversation and legislation. The U.S. Department of Health and Human Services began a “Healthy People” initiative in 1990, and the leading health indicators in “Healthy People 2020” (physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization and access to health care) represent the country’s major public health concerns for this century.

The indicators reflect the general public health and are measurable and actionable. These indicators are essential to factor in when evaluating the PCMH model. By combining the indicators with performance measures, a system can develop and use standardized and validated evaluation strategies that help to measure outcomes and develop effective incentives.
Health maintenance should have a foundation in wellness. An individual’s health status can transition instantly or over time from wellness to disease, disease back to some level of health, or even a greater level of health as a result of positive physical, social, emotional, psychological and (or) spiritual choices. Currently, the strengths of a PCMH are measured in ER visits and hospitalizations. We believe there are many other opportunities to measure and analyze the PCMH experience and outcomes. For example, payors can take a more active role not only integrating with providers but also influencing patient outcomes through data analytics to further understand how to support the wellness of insured populations. This approach may include creating PCMH-like panels within the payor organizations and resourcing to progressively provide additional support and proactive monitoring of high-risk clients.

Our performance-driven approach

EY is a global leader in working with health care organizations to identify and quantify the drivers that deliver relevant PCMH results. Our PCMH performance management approach is phased and scalable and can be tailored for military treatment facilities (MTFs). We emphasize the importance of data and quantitative modeling to reach performance-driven PCMH outcomes.

Our approach is designed to identify your current performance environment and key PCMH focus areas. We understand that payors, along with patients, have the largest incentive for members to get well and stay well and to use services efficiently. Payment strategies in line with the philosophy of PCMH can include incentives for quality such as patient engagement, increased patient literacy, the efficient use of technology and rewarding care coordination.
Our methodology includes five phases: identify, diagnose, design, deliver and sustain.

- **Identify.** We determine which activities and processes are in scope, and gain or confirm an overall understanding of your organization (e.g., strategic goals, stakeholders, reporting tools, existing initiatives and projects).

- **Diagnose.** We conduct a current-state assessment on how existing PCMH metrics are captured, defined, utilized, reported and acted upon. We analyze information such as existing team structure, facility design, resources and technology available and any in-scope processes. After the current-state assessment, we perform a gap analysis, and using these tools, we help you determine the opportunities on which to focus; for example, an increase in Health Care Effectiveness Data and Information Set guidelines compliance or an increase in patient satisfaction.
Design. We analyze those opportunities further and focus on developing an agreed-upon approach. Opportunities are directly correlated with one another, and it is important to weigh the overall impact, cost and value to stakeholders— with an emphasis on the patient. It is also important to determine if you can define the critical outcome metrics for the opportunities selected and the drivers behind those metrics.

Deliver. During this phase, we will work with you to determine how success will be measured, defined and communicated through the chain of command. We understand how to translate strategy into metrics and actionable plans, and we will work with you to develop and execute a deployment plan that meets your needs and timelines. Our strong finance and performance management credentials give us the experience to help our clients meet their goals and get the greatest return on investment. During this phase, you may need to develop a business case for moving forward. We are experienced in developing business cases for various MTFs to support PCMH.

Sustain. Although this is presented as our final phase, sustaining for the future is considered throughout the other phases. Here we validate that the metrics are accurately captured, used, reported and acted upon. We constantly look for ways to improve processes, and our goal is that leading practices and lessons learned are shared among other departments as well as other MTFs.

Overall, our approach is designed to reduce project risk and create a sustainable performance measurement capability by linking PCMH metrics to performance management processes and decision-making. We work with you to determine the drivers that have a direct influence on your desired end state, helping you improve the decision-making and processes that assist you in providing the best possible patient experience.
Let us help you usher in the future of health care. Contact our Federal Health Advisory group.

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