



Quality-driven, evidence-based, patient-centered:

Hudson Valley's medical home transformation offers a glimpse of what's possible

Issue Brief

Everyone—patients, physicians and their staff, hospitals, health plans and employers—has a vested interest in making health care more efficient, accessible and cost-effective. Few, however, have the resources, processes or will to make that happen.

Hudson Valley physicians *did* make it happen. With strong support from three local organizations and assistance from payers, they embraced the patient-centered medical home (PCMH), powerfully transforming how they practice medicine. The PCMH represents a quality-driven restructuring of how health care is delivered, characterized by patient engagement; care coordination; better access to care; a focus on preventive care; meaningful use of health information technology such as electronic health records and e-prescribing; and a team approach to care.

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At the heart of the PCMH is the patient, who has a trusting relationship with a primary care physician. "I think of the patient-centered medical home model—as a patient—as the ideal version of primary care that I myself would like to access for my own care and for the care of my family members," said Susan Stuard, executive director of Taconic Health Information Network and Community (THINC).

Quick huddles build teamwork, enhance communications

A simple and effective element of the patient-centered medical home is the team "huddle," a short, all-team daily planning session to discuss that day's schedules and patients. Huddles allow the practice to plan for changes in the daily workflow, manage potential crises and make adjustments. Done consistently, they can improve efficiency and patient satisfaction. A quick huddle can ensure everyone is on the same page. It should be at a consistent time, a central location—and should last seven minutes or less. In large practices, a representative from each area can attend. In smaller practices, huddles can help prevent the problems that can arise when one person assumes everyone else knows what's going on.²

Properly designed and executed, a medical home can enhance outcomes, improve satisfaction and reduce unnecessary hospitalizations and emergency department visits.¹ Through research and evaluation, Hudson Valley leaders are working to ensure that their medical homes are indeed properly designed and executed.

Under Stuard's guidance, THINC has championed the pay-for-performance medical home transformation project which rewards practices that achieve National Committee on Quality Assurance (NCQA) PCMH certification. The program pays physician bonuses for achieving community-defined clinical and operational goals, such as care coordination.

The Hudson Valley experience

Through their participation in the project, 11 primary care practices—representing 236 doctors at 51 sites—recently achieved NCQA Level 3 medical home recognition—the highest level achievable. The patient panels at the practices represent nearly half a million residents; each benefits from the PCMH, regardless of who pays for their health care.

Three federally qualified community health centers (FQHCs)—safety net providers—were among those in the Hudson Valley to achieve NCQA Level 3 certification. As in other PCMH projects around the country, the health

centers' historical focus on population health provided some unique insights. The implications of an expanded community strategy are significant. The project demonstrated that the medical home model can ensure that “uninsured, the Medicaid and the undocumented patients receive the same personalized quality of care as anyone else,” said Paul Kaye, MD, vice president for practice transformation at Hudson River HealthCare (one of the 11 practices), medical director of Taconic IPA (TIPA) and THINC treasurer.

The Hudson Valley Initiative (HVI) is an idea incubated in and nurtured by three Hudson Valley organizations: THINC, TIPA and MedAllies. The three organizations provide support to physicians as they transform their practices to new care models, engage insurance plans to support change and evaluate the effectiveness of new care models through research.

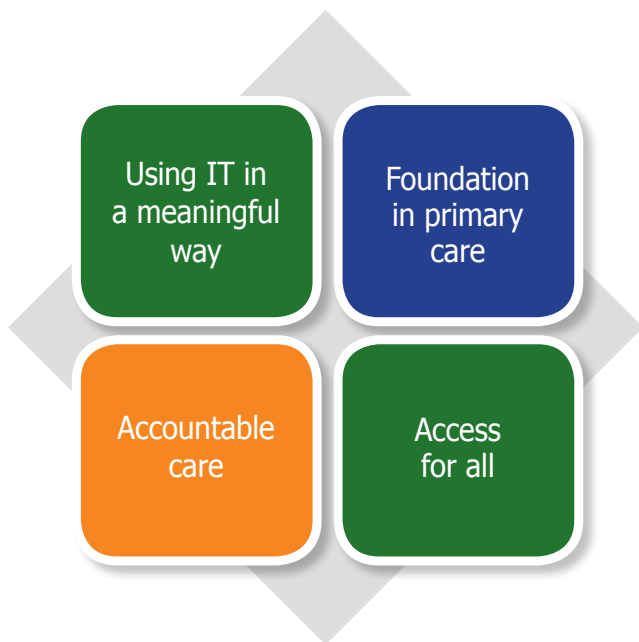
Their goal is both simple and profound: Improve quality, safety and efficiency of health care in the Hudson Valley through better care delivery models enabled by health information technology. The work is based on three principles:

- Health care should be patient-centered, coordinated and accessible
- Financial models used to pay for health care should result in lower cost and increased quality
- Health information technology (HIT) should be used as a tool to improve patient care and community health

The PCMH transformation project is a giant step in that direction. Hudson Valley primary care practices not only embraced the concept of the PCMH, they became trailblazers; their experience provides a model of what can be done to advance the PCMH across the country.

Thorough preparation, careful execution, national evaluation

Planning for the pay-for-performance PCMH project began in 2006 and took two and a half years. THINC managed the overall project, beginning with coordinating the payers and providing a community framework for consensus building and decision making. MedAllies provided the essential health IT infrastructure. TIPA funded consulting services from TransforMED and Masspro to assist the



Building blocks for improved care delivery

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—PAUL KAYE, MD, VICE PRESIDENT FOR PRACTICE TRANSFORMATION AT HUDSON RIVER HEALTHCARE, MEDICAL DIRECTOR OF TACONIC IPA (TIPA) AND THINC TREASURER

practices as they worked to adopt more efficient, effective care delivery practices.

The payers—six health plans (Aetna, CDPHP, Hudson Health Plan, MVP, United HealthCare, and WellPoint)—and IBM, the region’s largest employer, supported the project with incentive payments to help practices offset the transformation’s startup costs. The practices themselves provided the necessary staff and resources for transformation.

Participating practices were recruited based on both their commitment to quality improvement and their robust use of HIT. The criteria were “tough,” said A. John Blair III, MD, FACS, CEO, MedAllies, and president of TIPA. The project deliberately united solo practitioners and several small practices with large practices with dozens of physicians.

The transformation occurred over an intensive 10-month period in 2009. Completing the health plan data contracts and acquiring the data began in 2009, taking 19 months. Incentive payments were distributed in 2010.

A work plan was created for each practice, and medical home coaches and practice leads met every two to three weeks. The leadership of the selected practices formed the TIPA Medical Council and met monthly to collaborate, share best practices and facilitate solutions. The practices then submitted their data for NCQA approval.

Leadership, commitment, stability

The project showed that physician practices of all sizes and types *can* become PCMHs. But, warned Blair and Kaye, it is hard work, particularly for smaller practices with limited resources. Regardless of size, the commitment to transformation *must* be practice-wide: It demands

substantial, intense work, both in reconceiving the practice and in completing the NCQA requirements. Larger practices need senior management, including the administrator and financial executive, to be 100 percent behind this as well. “This is a test of leadership,” Kaye cautioned.

It also demands fiscal stability. The payer incentives were essential, but a practice should be fiscally sound *before* embarking on the medical home process, Stuard and Kaye explained. Practices incur significant upfront costs and incentive payments often arrive much later.

And transformation requires sweat equity. Many providers were surprised by just how much work was involved, Kaye said. Practices not only needed to meet NCQA PCMH goals regarding population health, managing referrals, working as a team, creating access for patients and other elements; they also had to negotiate the NCQA application process.

Collaboration among competitors

The TIPA Medical Council assisted practices with all the aspects of the transformation. It provided a powerful opportunity for competing physicians to work in partnership towards a common end, said Kaye and Blair. Private practices learned from safety net providers, and the large practices learned from the small.

“This is what we think of as a multidisciplinary patient-centered medical home project,” said Stuard. Small, solo, large, FQHCs, multi-specialty settings were all included. “Everyone had something to offer. Each practice really has its own set of strengths.”

This team approach also gave the Hudson Valley practices an edge, said Kaye. “Not that many projects have seen so much collaboration. We’re very proud of that.”

That team spirit characterized not only the TIPA Medical Council, but operations within each practice. Working as a team is a change for physicians, Kaye observed. Each made changes to become more “team-like,” Kaye said. For example, most did morning huddles to prepare for patient visits in advance. “That five to 10 minutes was a big help.”

The power of IT: A foundation for transformation

Hudson Valley physicians had one additional advantage: previous investments made in advanced health IT. The 236

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providers were already experienced health IT users; their learning curve was not as steep as it has proven to be for many other practices.

The PCMH National Demonstration Project, a large-scale pilot, revealed just how difficult it is for practices to implement sophisticated HIT systems while transitioning into a medical home. Few practices could simultaneously transition to sophisticated EHRs and maintain high patient satisfaction ratings.³

In contrast, HIT has been part of the Hudson Valley story for more than six years. A critical component of the success is the existing physician EHR install base, which boasts a 38 percent adoption rate (46 percent among primary care providers). As of August 2010, MedAllies had helped more than 600 physicians implement EHRs, and the number continues to grow. And MedAllies provides ongoing support to these practices, allowing them to continue their transformation into patient-centered medical homes.

Meaningful use of health information technology lies at the foundation of the medical home. In the PCMH, HIT can be used by clinicians in all settings in a meaningful way to support, measure, evaluate and improve patient care.

NCQA recognition and beyond

“Health information technology is a starting point, but we are focused on the bigger picture: real transformation for improved quality, safety and efficiency of health care in our community,” Stuard said.

That larger vision is yet another reason for Hudson Valley’s success.

While originally targeting NCQA Level 2 recognition, all 11 practices exceeded expectations, attaining Level 3 status. As of August 2010, these Hudson Valley providers represent 44 percent of Level 3 providers in New York, and nearly 10 percent of all Level 3 practices in the U.S.

The process involved far more than meeting external criteria, Kaye emphasized. “It may seem like that initially, but after a while you realize that you are going to have to transform the way you think about your practice.” It’s revelatory, he said. “Until you study what you are doing, you don’t realize what your practice *isn’t* doing and where it needs improvement. It provides the motivation to do even better.” That was the experience with Hudson Valley physicians, he said. “They *wanted* to make these improvements. That’s why they participated.”

NCQA recognition is not a destination, but rather a beginning, because PCMH transformation is an ongoing process. “NCQA recognition is an excellent start on the journey to being a real patient-centered medical home, but it’s just that: the first key phase. Being a PCMH and achieving true care coordination in a community really builds on things that type of recognition program looks for,” Stuard said.

The medical home is the foundation for a larger vision. The Hudson Valley Initiative embraces the vision of the Ideal Community:

- Care will be coordinated and managed by a primary care team along a continuum that includes specialty, acute and long-term care.
- Care will be patient-centered and focused on the needs of the patient and family regardless of payment source.
- Consumers, providers, employers and health plans will have timely access to information about patient satisfaction, cost, quality and appropriateness of care delivered.
- Health information technology will be used by clinicians in all settings in a meaningful way to support, measure, evaluate and improve patient care.
- Health care financing will be restructured to sustain care delivery models that maximize value.

Stuard and Kaye identified several key trends to watch as new primary care models evolve and mature.

A strong emphasis on clinical quality data: The medical home must deliver improved health outcomes, not simply improved processes, Kaye said. It takes time to make the changes and evaluate how well they worked. Policymakers and payers need to allow for such efforts, and they need to be patient, he said. Changes in health outcomes and utilization take two, three or even four years to materialize. “Give it time, don’t judge too quickly,” Kaye said. The expenses are upfront, but the payoffs come down the line. Payers must not “keep ratcheting up the bar” to demonstrate early results, either, he warned. When practices are making massive changes, payers need to allow them to come to fruition.

Increased physician accountability for patient engagement: Good primary care from a trusted source can change patient behavior. Accordingly, Kaye said, physicians need to take responsibility for outcomes and better understand self-management support. Too often, patient education consists of handing the patient a pamphlet.

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“The parking lots of physicians everywhere are littered with pamphlets,” he said. Practices should engage patients in a supportive dialogue regarding their goals and then help them meet those goals. “‘Non-compliant’ is the wrong word: We just haven’t figured out a way to help them reach their goals. Part of being a medical home is doing just that,” Kaye said.

Value-based purchasing and enhanced care coordination: Stuard sees a tremendous opportunity to build on PCMH efforts and share information about clinical outcomes, care quality and appropriate utilization. That data can provide the bases for value-based purchasing and enhanced care coordination initiatives. “You are going to hear consumers say: ‘This is a really terrific practice,’ and see health plans willing to provide excellent or at least reasonable compensation to these practices for doing a great job,” she said.

Improved primary care reimbursement: “We all hope this will lead to an increase in primary care reimbursement

and in the primary care workforce so we have enough doctors,” Kaye said. “The primary care shortage is tied directly to reimbursement. That needs to be stated up front and clearly; sometimes we talk around it.” The way to increase the supply of primary care physicians, he said, is to reduce the reimbursement and compensation disparity between primary care physicians and their specialty colleagues.

A stronger patient voice: A fair criticism of the medical home designation process is that patients’ voices have not been heard that much, Kaye said. “It should be the patients who say that you are a medical home.” Preliminary results from the PCMH National Demonstration Project bear this out: Patient satisfaction actually dipped as practices in the project became medical homes. Researchers noted that PCMH models must be careful not to evolve at the expense of personal relationships with patients.⁴ Kaye said the patient’s voice *will* be a large part of how the Hudson Valley medical homes move forward.

Sustainable change and a model for the future

The Hudson Valley made a significant investment in transforming primary care, and it’s paying dividends. Physicians have changed—and continue to change—the way they practice medicine. Moving forward, practices will continue to measure their success quantitatively and qualitatively, and adjust and expand their initiatives accordingly. And of course, they will continue meaningful use of health information technology.

Such effort requires transformation not only of how care is delivered, but also how providers are reimbursed. To create *sustainable* long-term change, reimbursement models must appreciate the added value this new model of care offers.

“We know that health information technology—electronic health records, e-prescribing and other applications—are important tools for improving health care delivery. But payment design changes are also necessary to speed their adoption and to ensure they’re used to improve the quality, safety and efficiency of health care delivery,” Kaye said.

That change is beginning to happen. “It makes me really hopeful that we can pair structural changes in provision of care with the appropriate structural changes in reimbursement,” Stuard said. She is optimistic: “We are an example of what is possible.”

Build and measure: Research and evaluation demonstrate success, yield valuable insights

BUILDING A MEDICAL HOME, even to NCQA specifications, is only part of the process. Research and evaluation are essential to its long-term success.

Bringing the evaluative and data support elements of the pay-for-performance medical home project together posed an early challenge, because each insurance company independently structured its data collection and incentive payment processes. Under Stuard's guidance, THINC coordinated the effort.

Taconic IPA recruited Jill Quaresimo, R.N., J.D., to serve as research nurse for TIPA. She uses her knowledge of clinical processes to manage a number of research projects, and works closely with researchers from Weill Cornell Medical College organizing physician office practice training

meetings designed to assist transformation to the patient-centered medical home model. She also collects quality data and oversees practice data collection for quality reporting and research.

To solidify the research and evaluation efforts, Hudson Valley leaders maintain an aggressive research agenda in partnership with Weill Cornell Medical College. Researchers are evaluating the Hudson Valley medical home experience, measuring care outcomes, patient and provider satisfaction, quality and outcome measures, the impact of health IT on quality and performance, and cost savings through efficiency and reduced utilization.

Medical home pilots abound, but the scope of this one particularly intrigued researchers: The Hudson Valley experience should produce robust quality and cost estimates that are generalizable to other practices. The results can inform policy debate as well as health plans' decisions about the value of medical homes.

NCQA Standards

The NCQA's Physician Practice Connections—Patient-Centered Medical Home features nine standards:

1. Access and communication
2. Patient tracking and registry functions
3. Care management
4. Self-management support
5. Electronic prescribing
6. Test tracking
7. Referral tracking
8. Performance reporting and improvement
9. Advanced electronic communication

Standalone e-prescribing can reduce errors—up to seven-fold. This study of the benefits of e-prescribing—using standalone software with clinical decision support—in primary care practices was published in June 2010 in the print version of the *Journal of General Internal Medicine*. (Quaresimo was a co-investigator.) The study looked at the number and severity of prescribing errors in 12 community-based medical practices in the Hudson Valley, comparing the number of prescription errors between those using e-prescribing and those who stuck with paper-based prescriptions between September 2005 and June 2007. The study found an almost seven-fold decrease in prescribing errors after one year, and illegibility errors were eliminated by e-prescribing.⁵

Patient, physician satisfaction increases, but coordination a concern Recently completed baseline surveys found high levels of patient and provider satisfaction, but noted both groups surveyed had issues about coordination of care.⁶ In particular, investigators looked at the impact of medical home redesign on clinical quality, health care costs and patient experience. Overall patient satisfaction was high, and it was fairly consistent across survey items. There was room for improvement, however: Patients were least satisfied with access to care and coordination of care.

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Likewise, overall provider satisfaction was high (although not quite as high as patient satisfaction). Areas of provider dissatisfaction varied widely. Findings are being prepared for submission to a peer-reviewed journal. Subsequent satisfaction surveys will gauge changes, either positive or negative, compared to the baseline.

Ongoing work from Cornell includes a collaboration with the Institute of Family Health (IFH) for a novel EHR-based quality reporting evaluation; an IRB protocol will detail both methodology and a data collection tool for the chart-review component that is under review. ■

ENDNOTES

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**Susan Stuard, MBA,
executive director, THINC**

Stuard leads the not-for-profit convening organization that establishes research-based criteria to enhance health care quality and value in the Hudson Valley.

Prior to THINC, Stuard was the director for technology policy development at the New York-Presbyterian Hospital. She was also the vice president of regulatory affairs for the Greater New York Hospital Association (GNYHA) where she led GNYHA's efforts with respect to clinical information technology and the HIPAA privacy and security rules. She holds a Master's of Business Administration from the Yale School of Management and a bachelor's degree from Hamilton College.



**Paul Kaye, MD, medical director,
TIPA; vice president, practice
transformation for Hudson River
HealthCare; and treasurer of THINC**

Kaye has been a pediatrician for 30 years. He serves as part-time medical director for Taconic IPA and has provided medical

leadership to a community health center network that serves over 45,000 patients at 14 sites. He also serves on the

Technical Advisory Panel for the Commonwealth Fund's Transforming Safety Net Clinics into Medical Homes project. Kaye is a graduate of SUNY Upstate Medical Center and did his pediatric residency at University of Wisconsin Hospital in Madison.



**A. John Blair III, MD,
CEO of MedAllies, Inc. and
President of Taconic IPA**

Blair is a board-certified general surgeon who spent 15 years in academic medicine and private practice before becoming president of TIPA, and then CEO of

MedAllies. He serves on the Privacy and Security Workgroup and the NHIN Workgroup of the Policy Committee of the Office of the National Coordinator and is co-chair for the HIE Workgroup for the Certification Commission for Health Information Technology (CCHIT). He is a member of the National Committee on Quality Assurance (NCQA) Committee on Performance Measurement, and serves on the Health Information Technology Advisory Committee (HITAC) for the National Quality Forum.

About the Hudson Valley Initiative



The **Hudson Valley Initiative** is an effort among three organizations—Taconic IPA, Taconic Health Information Network and Community and MedAllies—to revolutionize health care delivery through a shared vision to improve the quality,

safety and efficiency of health care in the community. We leverage health information technology, physician practice transformation and value-based purchasing in pursuit of care delivery that is patient-centered, coordinated, accessible, high quality, and efficiently delivered through sustainable financial models. For more information go to www.hudsonvalleyinitiative.com.



Taconic IPA is the nearly 4,000-member strong physician leadership organization focused on innovative initiatives to transform medical practices and improve health care quality. For more information go to www.taconicipa.com.



THINC is the not-for profit convening organization that defines and sponsors research to advance improved patient care delivery models using health information technology; structures and implements pay-for-performance criteria associated with physician practice quality initiatives; and governs the region's secure health information exchange network. For information go to www.thinc.org.



MedAllies is the health information services provider that facilitates physician practice redesign to improve efficiency and effectiveness of health care through health information technology, and operates the technical backbone for health information exchange. For more information go to www.medallies.com.