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## Turning an office into a home



Remember your family doctor? The person who knew your whole history? Who would see you outside of office hours and on weekends? IBM and healthcare advocates want to bring the family doctor back... in the form of a new model for primary care: the Medical Home. And in this new world, he or she will even make house calls—albeit virtually.

“It started about three years ago,” remembers Dr. Paul Grundy, IBM’s director of healthcare transformation. “We were talking about all the things that large employers in the U.S. like IBM had done to reduce costs and improve quality and we realized we were failing to address a fundamental issue: primary care.”

Shortly afterwards, he helped found the Patient-Centered Primary Care Collaborative (PCPCC), a coalition of large employers, consumer organizations and medical providers. They developed a healthcare model based on the premise that more holistic primary care could save money by reducing the incidence of major health problems later in life.

### From episodic care to holistic care

In the Medical Home model, the primary care physician acts as healthcare “coach”, leading the team that manages a patient’s wellness, preventative and chronic care needs. He or she spends more time with each patient in person, is available via email and phone for consultation; offers expanded hours and coordinates care across the individual’s entire care team.

For example, a diabetic in the Medical Home model could give daily blood test readings by phone, email or even a state-of-the-art remote monitoring device and get medical instructions the moment he needs them, rather than wait for an appointment. The care team would have a holistic health plan in place focusing on diet and exercise as well as monitoring glucose levels.

### Minding bedside manners

Transitioning to a Medical Home model will require a variety of behavioral and process changes in any practice—both large and small. For example: how to input data into a tablet or laptop while maintaining a conversation with the patient.

Patients of several practices reported that they were concerned that their doctors no longer looked them in the eye. It takes time and experience to adapt to new technology.

As doctors grew more proficient with the technology, complaints diminished. “It’s better now—I think he finally knows how to use that thing,” said one patient.

Countries outside of the U.S. are also taking new approaches to primary care. In the U.K., they have adopted a similar “family doctor” model that provides better accessibility to one’s general practitioner and continuity of care for patients, which leads to better patient satisfaction.

### Going digital creates a smarter doctor’s office

Health information systems are central to the Medical Home model. An electronic health record (EHR) serves as the single source of information that can be shared across a network of providers and specialists. In a 2008 Commonwealth Fund survey of 7,500 chronically ill participants, Americans fared worse than their counterparts in seven other countries. They were most likely to report wasting time because their care was so poorly organized. About a third reported that medical records and test results were not available when needed or that tests were duplicated unnecessarily. A third experienced a medical error, such as being given the wrong medication or test results.<sup>1</sup> An EHR can help to reduce such errors, eliminate duplicate tests, highlight drug interactions, improve overall quality of care and reduce costs.

Other IT tools can reduce errors and enhance collaboration. These include:

- a Web portal for patients to make appointments and look up lab results
- computerized physician order entry
- e-prescribing
- patient registries.

Work flow tools can help automate tasks such as sending patient reminders and ease coordination across a variety of providers.

Health analytics and decision support tools offer the ability to look across a patient registry for trends that can provide clinical insight into the treatment of disease.

Moving to an EHR system may also prompt a change in support roles. Since less time is required to maintain paper records, staff can take on more strategic tasks. A practice may need to add roles such as a case manager or benefits specialist to manage the ongoing care of a roster of patients.

## Early pilots, promising results

### How does MORE care cost LESS money?

In the short run, the amount of money doesn’t change—the way it is distributed does. For this model to be implemented on any significant basis, health insurance reimbursement practices need to change. Currently, primary care physicians are reimbursed by patient encounter, which encourages one doctor to see as many patients per day as possible. The result is often exhausted doctors, jammed waiting rooms, and fragmented care with the patient doing much of the coordination himself.

Under the new Medical Home model, physicians are paid a per-patient monthly fee and reimbursed for e-mail and phone consultations, to encourage ongoing communications and build relationships.

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## Two trends building momentum around Medical Home model:

1. *shortage of primary care physicians due to adverse practice conditions*
  2. *increasing prevalence of chronic disease in the U.S.*
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Practices may be paid additional monies to defray the costs of implementing electronic health records and other technologies. They may also add specialists to their staffs. There may be pay-for-performance incentives to recognize improved quality of care.

In general, costs for a medical home transformation range from \$23,000-\$100,000 per physician.<sup>2</sup>

Critical to the success of the model is buy-in from Medicare (Federal Government insurance coverage to people who are aged 65 and over) and Medicaid (Federal Government insurance program for people with low incomes and resources) since they are such significant payers. State governments may also step in to defray the costs of implementation in the short term to gain longer-term savings. IBM has been working with agencies at both the State and Federal level to set up pilot programs and has developed solutions to support the model.

### Early results show promise

Over time, with the team-based holistic approach, quality of care and outcomes can improve and costs go down. This can be as short as a year for some populations of patients.

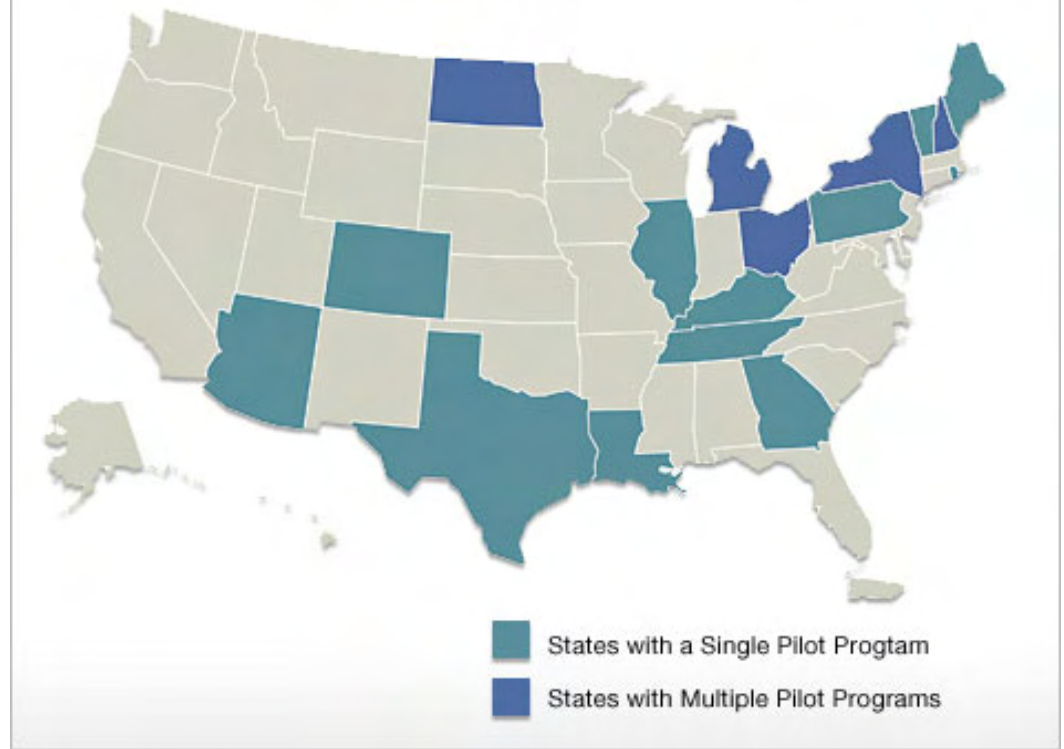
- The Geisinger Health System in Pennsylvania reports cutting costs by 7% using the Medical Home model for 80,000 visits.<sup>3</sup>
- A Medicaid experiment in North Carolina saved the Government \$162 million in 2006, 11% less than the state would have paid under the old form of reimbursement.

### Is there a doctor in the house?

Advocates are hoping the Medical Home model will solve another problem: the shrinking numbers of medical students choosing primary care as a specialty. Last year, only 7% of medical school graduates chose family practice.<sup>4</sup> Many parts of the country do not meet the minimum of one primary care doctor per 1,000 patients. It's not surprising. Specialists such as gastroenterologists can earn \$406,000 compared to a median income of \$150,000 for general practitioners.

While many doctors, insurers and employers are intrigued by the Medical Home, the biggest obstacle is lack of deployment: it is estimated that the Medical Home has been adopted by less than 1% of U.S. practices to date (based on the fact that less than 15%

## Patient-Centered Medical Home pilot map



of practices actually have an EHR system and most of those don't meet the criteria of a medical home).<sup>5</sup> It takes two to five years for a typical practice to fully convert to the model. "It's more than deploying technology and hiring specialists, it's a change in roles, attitudes and skills," says Grundy, "It's a real change in the way you practice medicine."

Under the new Obama administration, with its platform of improved and universal healthcare, advocates are hopeful that this new primary care model may finally find a home.

1 Health Affairs Journal, The Commonwealth Fund, NY, Fall 2008

2 Task Force Report 6. Report on Financing the New Model of Family Medicine, [http://www.annfammed.org/cgi/reprint/2/suppl\\_3/s1](http://www.annfammed.org/cgi/reprint/2/suppl_3/s1)

3 Health Affairs, "Continuous Innovation in Healthcare: Implications of Geisinger Experience", 2008

4 New York Times, "Trying to Save by Increasing Doctor's Fees", August 22, 2008

5 Medical Groups' Adoption Of Electronic Health Records And Information Systems, <http://content.healthaffairs.org/cgi/reprint/24/5/1323.pdf>



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New Orchard Road, Armonk, New York 10504, USA