Enhanced Primary Care

Practice Transformation

Enhanced Primary Care (EPC), an innovative patient-centered medical home (PCMH) program from CDPHP®, offers increased value for members and financial rewards for physicians.

WHY A MEDICAL HOME PROGRAM?

Several years ago, CDPHP recognized a growing shortage of primary care physicians (PCPs) and resolved to make primary care a more attractive career choice for future medical students and practicing physicians. The EPC is an investment in top-quality primary care that is efficient and focuses on disease prevention and chronic care coordination.

Instead of paying PCPs just for episodes of care, the EPC pays them for their efforts to keep their patients well. Higher reimbursements are paid for patients who, based on an analysis of claims data, are sicker and are expected to need more resources.

The savings to be gained by keeping patients healthy are expected to offset the cost of improving payments to the PCPs.

THE TRIPLE AIM

The EPC aligns financial incentives with achievement of the goals of the Triple Aim, an initiative pioneered by the Institute for Healthcare Improvement. The Triple Aim is focused on:

- Enhancing patients' experience with reliable services and access to quality care
- Improving the health of the population served
- Reducing the per capita cost of care

HOW DOES THE EPC WORK?

The EPC rewards care coordination, adoption of electronic medical records, and high-quality member care. All members of the care team are encouraged to work at the top of their licensure, often with mid-level practitioners administering preventive care and handling acute same-day care, to improve practice efficiency and member access.

It is a win-win for patients and physicians, as physicians are no longer forced to see as many patients as possible each day to remain profitable. Improved efficiency within the transformed practices results in easier access to medical appointments for members.

Members who receive their care at an EPC site are encouraged to establish an ongoing relationship with a PCP and take an active role in making decisions about their own care. The practice may also offer access to mid-level practitioners and a range of other health care professionals, all cooperating to support the PCP in caring for his or her patients.

Along with financial support, CDPHP is providing expert consultation to practice sites and helping them achieve medical home certification by the National Committee for Quality Assurance (NCQA). CDPHP staff members from the clinical areas of case and disease management, behavioral health, and pharmacy are sometimes embedded within practices to assist in coordination of care.

"A patient-centered medical home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a **long-term healing relationship**."
—National Committee for Quality Assurance

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PRINCIPLES OF A MEDICAL HOME

1. **Personal physician**
   Each patient has an ongoing relationship with a personal physician trained to provide continuous and comprehensive care.
2. **Physician-directed medical team**
   Personnel in the medical practice work together to coordinate the ongoing care of patients.
3. **Whole person orientation**
   The physician either provides the patient's care or arranges care with other qualified professionals as appropriate.
4. **Care is coordinated**
   Information is shared between the medical home and specialists, hospitals, and other sites of care.
5. **Quality and safety**
   Patients are actively involved in their own care, and practices use information technology and quality initiatives to continually improve.
6. **Enhanced access to care**
   Open scheduling, expanded hours, and new options for communication make it easier to get medical attention when needed.
7. **Provider reimbursements reflect the added value**
   Instead of paying for volume (number of visits), CDPHP is paying for value (the whole scope of patient care).

PRACTICE INSIGHTS

These comments from a CDPHP-participating medical practice illustrate a few of the advantages of the EPC model.

"Our change to a patient-centered medical home has improved our patients' access to care, has improved our efficiency, and has tremendously improved the quality of care."

"Our patients end up in the hospital less often; fewer progress on to end-stage renal failure; we're preventing colon cancer . . . and the list could go on."

"Our nurses and even receptionists and office managers have become involved more with caring for our patients. Nurses use protocols through our electronic health records to help us keep up with health maintenance and disease management."

INTERESTED IN LEARNING MORE?

Physicians interested in applying for EPC status should call (518) 641-3972.

The medical home is structured to meet the specific needs of patients and serves to improve health care value, i.e., improved quality of care, yet with **costs remaining the same or decreasing**.

You can view details on the EPC practices within the CDPHP network by going to Find-A-Doc at www.cdphp.com. Select "Enhanced Primary Care" from the Specialty dropdown menu to locate a list of sites near you.

Call (518) 641-3972 to learn more.

A plan for life.

Capital District Physicians' Health Plan, Inc.
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