



Patient-centered, Physician-directed Medical Home

The Patient-centered Medical Home—the Next Step in the Evolution of America’s Healthcare System?

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Healthcare Yesterday and Today

National polls have demonstrated significant levels of public dissatisfaction with the United States health care experience.¹ Americans have many reasons to be disappointed. The United States spends over \$2.1 trillion dollars on healthcare per year,² despite 47 million (15.8 percent) uninsured Americans (including 8.6 million children)³ and an additional 16 million underinsured.⁴ As a result, mortality rates for some of our nation’s most vulnerable populations, including poor women, have stagnated or even deteriorated in the past decade.⁵ Without adequate support for paying catastrophic medical costs, some 1.9-2.2 million Americans face medical bankruptcy annually.⁶

By many accounts, the U.S. healthcare system is approaching a crisis point. As a percentage of gross domestic product (GDP), healthcare spending is projected to rise from 16 percent to 20 percent by 2015.⁴ Across the country, physicians are limiting or refusing to see new Medicare patients.⁷ This past July, physicians groups were barely able to muster enough votes in the U.S. Senate to prevent a 10.6 percent cut in Medicare reimbursement rates. Rather than fixing the Medicare payment formula, Congress passed legislation that puts Medicare cuts on hold for the next 18 months. Should such cuts in reimbursement ever go into effect they would have a devastating impact on the ability of seniors to receive care. In addition, there are enormous financial disincentives for primary care practices as the gap in earnings between primary care and specialist physicians continues to widen.⁸ These disincentives are projected to cause a shortage of 35,000-44,000 adult generalists by 2025.⁹

Over the past 50 years, the American healthcare system has evolved in a seemingly uncoordinated and irrational fashion. There has been increasing consolidation of hospitals into large hospital networks, physicians into physician groups and small insurers into mega-insurers as each entity vies to improve its bargaining power.¹⁰ We have seen the rise of health maintenance organizations designed to control cost inflation through aggressive management of physician practice. We have also seen the rise of the gatekeeper model and its subsequent rejection by patients and providers in the late 90s.

The next steps in the healthcare evolutionary process are beginning to take shape. Pay-for-performance formulas are

being worked into physician reimbursement schedules. Rising prescription drug costs have been eating up a greater proportion of the healthcare pie and are now causing physicians and patients to review the ethical implications of certain industry-physician interactions. Consumer-based healthcare principles are being employed in the form of health savings accounts, increased co-pays and deductibles, and a general shifting of costs and risk from employers onto employees. Despite the many changes taking place, American healthcare can still be characterized as being highly fragmented, unaffordable, error-prone and inaccessible for many.

A New Course for Healthcare Tomorrow

Confronted with a declining interest in generalist practice in 2002, the leadership of seven national family medicine organizations commissioned the Future of Family Medicine (FFM) project to design a strategy for the renewal of family medicine. FFM project leaders recommended against simply reinforcing our nation’s primary care infrastructure. Instead they wanted to restructure it entirely through a New Model of Care.¹¹ The New Model of Care came to be known as the Patient-centered Medical Home (PCMH).

From the start, the PCMH concept received strong support from other primary care groups. In 2007, American Academy of Family Physicians (AAFP), American Academy of Pediatricians (AAP), American College of Physicians (ACP) and American Osteopathic Association (AOA) published a joint statement outlining the seven core principles of a PCMH: (1) personal physician, (2) physician-directed medical practice, (3) whole person orientation, (4) coordination and integration of care, (5) quality and safety, (6) enhanced access, and (7) appropriate payment.¹²

Most Americans today experience frustration as they attempt to navigate the complicated health system and are forced to wait weeks or months before seeing their physician. Many patients receive inappropriate testing and procedures, while others go years without obtaining preventive health screens or having their chronic diseases addressed. These problems are the result of inadequate science, poor coordination of care, and a flawed payment system that rewards overuse of health resources. The

medical home concept aims to address these problems by fundamentally altering the way we deliver primary care services.

A PCMH model practice is made up of an interdisciplinary team led by a personal physician. The team may include social workers, clinical pharmacists, nurse practitioners, physician assistants and others depending on specific community needs. The team is collectively responsible for providing comprehensive care for all stages of life and for coordination of care between specialists. When possible, ancillary services, procedures and diagnostic testing are performed onsite within the medical home. Practice efficiency is maximized through the utilization of health information technology (HIT) in the form of e-lab, e-prescribing, e-visits, electronic records and disease registries. Patients are sent reminders about when they need to attend follow-up appointments for chronic disease management or obtain preventive health screens. The model practice is continuously tailored to meet the community needs through proactive patient satisfaction surveys. High quality care is obtained through evidence-based best practices and regulatory compliance with national standards. Enhanced access is delivered through same day appointments, after hours and weekend coverage, online services, and culturally sensitive care. Group visits are offered to educate patients with certain health needs such as diabetes management and smoking cessation. Lastly, the practice is appropriately reimbursed for providing

care coordination, innovative chronic and preventive care programs, HIT installation and maintenance, and other infrastructure needs.

Evidence Supporting the PCMH Model

There is much evidence available to demonstrate how PCMH principles result in decreased healthcare costs and improved patient outcomes. Researchers have shown in other developed countries that a strong primary care infrastructure involving practice characteristics such as care coordination, continuity, community orientation and disease registries is associated with improved population health.¹³ It has also been demonstrated that an increased supply of primary care physicians—central to the PCMH concept—is associated with improved health outcomes and decreased total costs.¹⁴ A national study by the Commonwealth Fund showed that medical home characteristics such as regular source of care, enhanced access, and efficient practice are associated with reduction or elimination of healthcare disparities among racial and ethnic minorities.¹⁵ In North Carolina, a reformed payment system that incorporates a care management fee to incentivize PCMH-like practice saved the state Medicaid program an estimated \$124 million dollars in 2006.¹³ Research from The Lewin Group estimated that converting Medicare to a system based upon the medical home would save the program \$15.5 billion dollars annually while improving the health of Medicare beneficiaries.¹⁶

In 2006, TransforMED

(see pp. 30-31) launched the National Demonstration Project to study the incorporation of the medical home model in 36 family medicine practices across the United States.¹⁷ In 2007, the Preparing the Personal Physician for Practice (P4) initiative began as a second major pilot project to test the incorporation of the medical home model into 14 family medicine residencies. In addition, National Committee for Quality Assurance (NCQA) is developing standards that practices will have to meet to be considered medical homes.¹⁸ It is the expectation that in the future public and private payers will reimburse practices with a care management fee relative to how well they meet NCQA standards.

Moving Forward with the PCMH

The PCMH movement is just beginning to stretch its legs. Already it has been embraced by business leaders, consumer groups and the wider medical community through the Patient-centered Primary Care Collaborative (PCPCC).¹⁹ In response to this collaborative effort, PCMH pilot projects are being implemented in many states across the country. In addition, PCPCC leaders are holding discussions with representatives from Medicaid programs regarding potential future pilot projects involving Medicaid and SCHIP beneficiaries.

In 2007, the AAFP put forth its “Healthcare for Everyone” proposal for covering the uninsured.²⁰ The core idea in the proposal was to provide all Americans with a PCMH. While this proposal does not

address all of the challenges facing our health system in crisis, it does offer a bold strategy for reconstructing our broken system from the ground up. PCMH may very well be the critical building block for a U.S. health system infrastructure in which medical care for everyone is accessible, well-coordinated, affordable and of high quality.

References

References available upon request.