Patient-Centered Medical Home: An AHA Research Synthesis Report

September 2010

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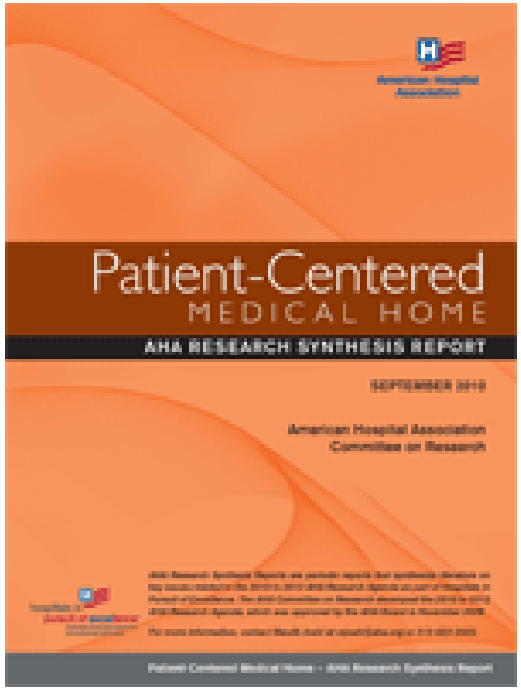

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- Key design features of the Patient Centered Medical Home (PCMH)
- Discussion of federal, state, and private sector medical home models
- Considerations for hospitals interested in developing a PCMH

Patient-Centered Medical Home

- PCMH refers to the provision of comprehensive primary care services that facilitates communication and shared decision-making between the patient, his/her primary care providers, other providers and the patient's family.
- In 2007, four medical societies developed joint PCMH principles which informed the NCQA's Physician Practice Connections – Patient-Centered Medical Home standards.
- The Accreditation Association for Ambulatory Health Care (AAAHC) also offers PCMH accreditation.
- The evidence-base for a PCMH continues to evolve.

Opportunities and Challenges

- Opportunities
  - PCMHs leverage the benefits of primary care (e.g., access to care, established patient-physician relationships, and comprehensiveness of care).
  - Transforming primary care to a PCMH could lead to lower health care costs, improved physician-patient relationships and payment incentives more closely aligned with evidence-based medicine.
  - Could also address racial, ethnic, and socioeconomic disparities in health care outcomes.

Opportunities and Challenges (contd.)

- Challenges
  - Approximately 65 million Americans live in a designated primary care shortage area.
  - Only 27% of U.S. adults can easily reach their primary care physician by telephone, obtain-after hours care or advice and schedule timely office visits.

Health Care Reform

- The Patient Protection and Affordable Care Act (Section 3502) provides grants to "eligible entities" to establish community-based health teams to support primary care providers in the creation of PCMHs.
- Health teams eligible for payments are required to:
  - Submit plans for achieving long-term financial sustainability within three years
  - Submit plans for integrating prevention initiatives, patient education, and care management resources with care delivery
  - Create an interdisciplinary health team (primary care teams eligible for capitated payments include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, doctors of chiropractic medicine, licensed complementary and alternative medicine practitioners and physician assistants)
  - Provide services to eligible patients with chronic conditions

Current Medical Home Programs

Federal	State	Private Sector
Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration	Colorado Children's Healthcare Access Program (CCHAP) •Reductions in ED visits/ hospitalizations	TransforMED National Demonstration Project (NDP) •Important to change roles and identities within the practice
Federally Qualified Health Centers Advanced Primary Care Practice (FQHCAPC)	Michigan Children's Healthcare Access Program (MCHAP) •Resulted in lower ED and inpatient use	Group Health, Seattle •Reduced burnout, improved quality scores, reduced avoidable ED/hospitalization use and costs
Department of Veterans Affairs (VA)	Community Care of North Carolina •$150-$170 million savings in 2006	Geisinger health System •20% reduction in hospital admissions and 7% savings in total medical costs

The Hospital and the PCMH

- Four critical features identified across seven PCMH pilot programs studied
  - All utilized services of dedicated, trained, non-physician care manager to coordinate patient care
  - All provided expanded access to providers, (e.g., access outside of regular office hours)
  - All had analytic tools for real-time data on performance and patient status
  - All used effective incentive payments to encourage physicians to take on care coordination (e.g., additional per member per month payment)
- These four features are areas in which primary care practices are ill-equipped or do not have the required resources and expertise to implement
  - Hospitals likely to assume supportive, complementary role to primary care practices

Potential Role of Hospitals

- Convene physicians to develop strong relationships with specialists
- Offer capital and IT infrastructure to foster seamless communication with hospitals
- Offer staff resources and other functionalities needed to form “health teams” described in health reform
- Serve as a catalyst and offer management expertise to PCMH initiatives
- Serve as an administrator of bundled payments to develop payment allocation for bundled components

PCMH versus ACO in the Patient Protection and Affordable Care Act

	PCMH	ACO
Key Players	Primary care practice teams, including medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, health educators/health system navigators, behavioral and mental health providers, doctors of chiropractic medicine, licensed complementary and alternative medicine practitioners, and physician assistants	Hospitals, physician group practices, networks of individual practices, and partnerships between hospitals and other health care professionals
Delivery Structure	Focus on patient-physician relationship (single practice); physician-led practice; enhanced access to care; coordinated and integrated care; comprehensive, continuous care	Multiple providers; complete and timely information about patients and services they are receiving; resources & support for patient education and self-management support; coordinated relationships of PCP with specialists

PCMH versus ACO in the Patient Protection and Affordable Care Act (contd.)

	PCMH	ACO
Required Resources	interoperable EHR: Resources to provide 24-hour care management and support during transitions in care, including on-site visits, discharge plans, counseling, medication management, referrals for behavioral health as needed; serve as liaison to community prevention and treatment programs	Technology and skills for population management and coordination of care
Accountability	Rests primarily with the primary care practice	Joint accountability for care by all providers involved
Payment Structure	Grants or contracts from HHS to interdisciplinary, interprofessional teams	Traditional fee-for-service, supplemented by annual shared savings for participating ACOs that meet specified quality performance standards at expenditure benchmarks

Level of detail and specificity provided for each program in the Affordable Care Act varies.

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