Patient-Centered Medical Homes (PCMHs)

What is a Patient-Centered Medical Home?

-Patient centered medical homes were first proposed by pediatricians in 1967 primarily for children with special health care needs.[1] However they have received renewed interest as an important health reform innovation to improve the quality of care and patient self-management while reducing health care cost increases.

-The PCMH model is an approach to practicing medicine that offers coordinated, comprehensive primary health care that is accessible, continuous, compassionate, culturally appropriate, and patient-centered.[2]

-In this model, care is personalized for each patient and delivered by a team of professionals that may include a doctor, nurse, medical assistant, health educator and other professionals.

- Goals of a PCMH model include reduction of health care spending, improvement of health status, support of disease management and prevention, improvement of quality of care, reduction of medical errors, and reduction of racial and ethnic health disparities.[3] For example, coordination of care emphasizes the reduction of duplicate tests and prevention of errors in conflicting treatment when patients have several doctors.

- There is growing evidence that PCMHs can reduce health care costs while improving the quality of care, health outcomes and patient satisfaction [14]. There is also considerable potential for PCMHs to remedy health disparities [19].

How can Patient-centered Medical Homes improve our healthcare system?

- Almost three out of four Americans reported difficulty accessing care from their doctor. Half reported poor coordination of care; especially among those who see more than one doctor.[4]

- 4% of CT residents report poor communication with their providers – providers who don't always listen carefully, explain things clearly, respect what they have to say or spend enough time with them [13].

- Only half of CT adults over age 50 get recommended levels of screenings and preventive care [12].[i]

- One in three Americans report getting unnecessary care or duplicate tests. Another 91% believe it is important to have one place or doctor responsible for their primary care and coordinating care.[5]

- A focus on prevention and management of disease in patient-centered medical homes allows movement away from incentives for over-treatment. Patient-centered medical homes are quickly gaining acceptance as a way to reduce health care costs, improve quality, and eliminate disparities in our health care system.[6]

- Patient-centered medical homes require patients to take responsibility for educating themselves about their conditions and managing their care with support from the medical home team. Patients further learn about the best ways to maintain their health, communicate openly with their team of providers, and actively participate in making decisions concerning their care.

- Patients no longer have to keep track of the details of their care, such as test results or medication dosages, across all their providers since their patient-centered medical home coordinates those records. Patients no longer wonder who to call with a problem; they call their medical home for help. The patient-centered medical home staff is already familiar with their family, treatment preferences, and their cultural and language needs.

Does CT have PCMHs?

Yes, there were 732 PCMHs certified by the National Committee for Quality Assurance as of October 2012 [15]. While this is well behind neighboring states, CT is making considerable progress in developing PCMHs.

There are two very large programs supporting PMCHs in CT. The state employee health plan, run by the Office of State Comptroller, has been rewarding practices that achieve PCMH certification with higher reimbursement rates since 2010. The state employee plan covers over 200,000 lives, the largest employer plan in the state [16].

With the shift from capitated managed care plans to self-insurance, CT's Medicaid plan implemented a significant PCMH incentive program that continues to enroll and reward practices that have achieved PCMH certification [18].

What are some of the challenges to implementing a Patient-centered Medical Home model?

- Electronic health records and other structures to share health information among providers are critical to patient-centered medical homes. Currently only 13% of US physicians have even a basic electronic medical record system but the Medicare and Medicaid programs include significant resources for health information technology.[7]

-Care coordination requires the cooperation of providers outside the patient-centered medical home, who are not compensated for those activities. Proposals to increase resources for primary care and patient-centered medical homes at the expense of other providers have met strong lobbying resistance.

- Over 80% of physician practices in Connecticut are small, with five or fewer providers [17]. Smaller practices may face special challenges in transforming to medical homes including smaller staffs and less time for new training.

- Patients also have different responsibilities and rights within a patient-centered medical home including directing all care through their provider team; some may associate this with gate keeping which was not popular in managed care and has largely been abandoned.

- Patient centered medical homes rely heavily on a team approach to care which can be a difficult transition for some providers. Providers must trust that team members will be working at the top of their license.

- Overall, researchers have found that implementing the patient-centered medical home model requires a fundamental transformation of practice, which can be difficult for even willing practices, and is an on-going developmental process rather than a destination.

What is the current support for Patient-centered Medical Homes?

- Patient-centered medical homes have become an important theme of health reform discussions at the federal and state levels.

-States are recognizing the potential of the patient-centered medical home model. Eight states have defined the patient-centered medical home concept in law or regulation and seven states are developing processes and criteria to recognize medical homes.[9] Patient-centered medical home pilots and programs are currently operating across the country.[10]

The American Academy of Family Physicians, the American Academy of Pediatricians, the American College of Physicians, the American Osteopathic Associations and the American Medical Association have signed onto a set of joint principles describing and committing to the patient-centered medical home concept.

-The national Patient-Centered Primary Care Collaborative was created by a group of Fortune 100 companies three years ago and is working to disseminate the patient-centered medical home model.

-The National Committee on Quality Assurance now certifies practices that serve as patient-centered medical homes, drawing higher reimbursement rates from many insurers.

-Medicare is sponsoring patient-centered medical home pilots across the US.

What should policymakers do to support the development of patient-centered medical homes in CT?

- To ensure success, policymakers must assure adequate financial resources, flexibility that respects the wide diversity of successful patient-centered medical homes, support for providers in transforming the way they practice, including training, new tools and other learning, and patience – successful practice transformation takes time.

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May 2010
Updated September 2012

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