Patient-Centered Medical Home

What is a Patient-centered Medical Home?

-Patient centered medical homes were first proposed by pediatricians in the 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 patient-centered medical home 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 patient-centered medical home 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.

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

- In a recent survey, 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]

- One in four CT residents reports 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.[i]

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

- 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.

What are some of the challenges to implement 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 recent federal stimulus package includes 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.[iii] 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.

- While there is ample evidence on the benefits of access to a usual source of continuous care[7], and patient-centered medical homes are expected to deliver significant savings and improve quality, they have yet to be comprehensively evaluated.

- 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 level. At least four bills this year in the CT General Assembly featured patient-centered medical homes.

- Connecticut has begun a Primary Care Case Management option for HUSKY families that is built on the patient-centered medical home concept. Enrollment in the program has been slow and the administration has limited its reach to only a small part of the state but plans to expand it statewide.[iv]

- As part of re-bidding, CT's state employee health plan is embarking on an extensive patient-centered medical home pilot that will be operational for over 35,000 state employees by early 2011. The state and its carriers, Anthem and United Health, chose ProHealth, CT 's largest primary care practice, for the pilot . ProHealth is transforming all their 74 sites to patient-centered medical homes, seeking certification by the National Committee for Quality Assurance, for all their 350,000 patients or 10% of CT's population.

- As part of planning for SustiNet, CT's health reform initiative, a committee of providers, insurers, payers and advocates has been meeting and collecting information on best practices from other states since November 2009. The committee will be making recommendations July 1, 2010 about what is needed to expand patient-centered medical homes to every CT resident.[9]

-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. To date, no practices in CT have qualified as NCQA certified patient-centered medical homes. Surrounding states have dozens to hundreds of certified practices.[v]

-Medicare is sponsoring patient-centered medical home pilots across eight states this year.

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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[1] C. Sia et al., "History of the MedicalHome Concept," Pediatrics 113, no. 5 Supp. (2004): 1473–1478; and P.W.Newacheck, J.P. Rising, and S.E. Kim, "Children at Risk for SpecialHealth Care Needs," Pediatrics 118, no. 1(2006): 334–342.

[2] AAFP,AmericanAcademy of Pediatrics,American College of Physicians, andAmerican OsteopathicAssociation,"Joint Principles of the Patient-CenteredMedical Home," March 2007, http://www.medicalhomeinfo.org/Joint%20Statement.pdf

[3] Berenson RA, Hammons T, Gans DN, Zuckerman S, Merrell K, Underwood WS, et al. A house is not a home: keeping patients at the center of practice redesign. Health Aff (Millwood). 2008;27:1219-30. [PMID: 18780904]

[4] Felland, Laurie E., and Peter J. Cunningham. Falling Behind: Americans' Access to Medical Care, 2003-2007, Tracking Report No. 19, Center for Studying Health System Change, Washington, D.C. (June 2008)

[5] S. K. H. How, A. Shih, J. Lau, and C. Schoen, Public Views on U.S. Health System Organization: A Call for New Directions, The Commonwealth Fund, August 2008.

[6] AC Beal and MM Doty, "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey - The Commonwealth Fund,"

[7] C DesRoches, et. al., New Engl J Med online, July 3, 2008.

[8] J DeVoe, et. al., Amer J Pub Hlth, 93:786, May 2003

[9] Patient Centered Medical Home Advisory Committee, http://www.ct.gov/sustinet/cwp/view.asp?a=3822&q=450056

[10] Christopher Atchison, presentation at Building a Medical Home: Issues and Decisions for State Policy Makers, NASHP, 10/5/08, Tampa, FL

[11] Patient Centered Medical Home: Building Evidence and Momentum, PCPCC, 2008, National Academy for State Health Policy, November 2008, National Partnership for Women and Families, Sept. 2008

[i] NHQR State Snapshots, US Agency for Health Care Research and Quality, 2008.

[ii] Commonwealth Fund CT State Scorecard, 2009.

[iii] Personal communications, CT State Medical Society.

[iv] CT Health Policy Project, CT Health Notes blog, Medicaid Managed Care Council.

[v] NCQA