

Patient-centered Medical Homes: The fix for our health care system?

Health care costs are out of control, care is inefficient and fragmented, and Americans receive only 55% of recommended care on average.¹ There is no shortage of proposals to reform the health care system and no shortage of controversy over which reforms to implement. But one option that enjoys great support across interest groups is the patient-centered medical home concept. Proponents argue that medical homes can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities. Medical homes have become an important theme of health reform discussions at the federal and state levels. At least four bills this year in the General Assembly featured medical homes. Connecticut has begun a Primary Care Case Management program for HUSKY families that is built on the medical home concept.²

Medical homes are not buildings or hospitals, but a different way of practicing medicine. Medical homes offer coordinated, comprehensive primary health care that is accessible, continuous, compassionate, culturally appropriate, and patient-centered. Coordination of care can reduce duplicate tests and prevent errors in conflicting treatment when patients have several doctors. Care is personalized for each patient and delivered by a team of professionals who put the patient and their needs at the center of care. The team may include a doctor, nurse, medical assistant, health educator and other professionals. Medical homes can make primary care practice more appealing to graduating physicians who are predicted to be in short supply as the US population ages.

Medical home patients do have to take responsibility for educating themselves and managing their care, with help from the medical home team. They must learn about the best ways to maintain their health, communicate openly with their team of providers, and actively participate in decision making about their care. Treatment in medical homes focuses on prevention and management of disease. Patients are not responsible for keeping track of the details of their care across all their providers such as test results or medication dosages; their medical home coordinates those records. Patients don't have to wonder who they should call with a problem – they call their medical home for help. The medical home staff know them and their family, know their preferences, know which treatments are most likely to help, and understand their cultural and language needs.

Originally envisioned by pediatricians to serve medically complex children, the medical home concept has been extended to all consumers. 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 all signed onto a set

¹ McGlynn, et. al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, 348: 2635-2645, 6/26/03.

² PCCM: A New Option for HUSKY, CT Health Policy Project, www.cthealthpolicy.org/pccm

of joint principles describing and committing to the patient-centered medical home concept. Recognizing the benefit to payers, the Patient-Centered Primary Care Collaborative was created by a group of Fortune 100 companies three years ago and is working to disseminate the medical home model. The National Committee on Quality Assurance now certifies practices that serve as medical homes, drawing higher reimbursement rates from many insurers. Medicare is sponsoring medical home pilots across eight states this year.

States are recognizing the potential of the medical home model. Eight states have defined the medical home concept in law or regulation and seven states are developing processes and criteria to recognize medical homes.³ Medical home pilots and programs are operating across the country in at least 37 states including Connecticut.⁴ In 2005 Ontario implemented the first wave of Family Health Teams, very similar to medical homes, to reduce ER use and expand access to preventive care. There are now 150 Family Health Teams across the province in areas of need, with 50 more in planning.⁵

Despite the momentum, medical home implementation faces some significant barriers. Coordinating care among providers, a cornerstone of the concept, is very difficult without electronic health records and structures to share health information among providers. Only 13% of US physicians have even a basic electronic medical record system⁶ but the federal stimulus package includes significant resources for health information technology. Care coordination also requires the cooperation of providers outside the medical home, who would not be compensated for those activities. Patients have different responsibilities and rights within a medical home including directing all care through their provider team; some may associate this with gatekeeping which was not popular in managed care and has largely been abandoned. Proposals to increase resources for primary care and medical homes at the expense of other providers have met strong lobbying resistance. And while there is ample evidence on the benefits of access to a usual source of continuous care⁷, and medical homes are expected to deliver significant savings and improve quality, they have yet to be evaluated.

Preliminary research is promising, but also offers caution and guidance for success including patience, flexibility and support.⁸ Researchers have found that implementing the medical home concept 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.

³ Christopher Atchison, presentation at Building a Medical Home: Issues and Decisions for State Policy Makers, NASHP, 10/5/08, Tampa, FL

⁴ 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

⁵ C Hull, The Medical Home Model and Family Health Teams, Research and Education Services, Legislative Assembly of Ontario, 5/11/09.

⁶ C DesRoches, et. al., New Engl J Med online, July 3, 2008.

<http://content.nejm.org/cgi/content/full/359/1/50>

⁷ J DeVoe, et. al., Amer J Pub Hlth, 93:786, May 2003

⁸ P Nutting, et. al., Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home, Annals of Family Medicine, 7:254-260, May/June 2009.

Recommendations for policymakers include:

- Assuring 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
- Patience – successful practice transformation takes time

So what can CT policymakers do, specifically, to support medical homes in our state?

- As a purchaser – CT purchases health coverage for over 700,000 people, that is more than one in five state residents
 - The state can support and expand the PCCM program for HUSKY families that is built on patient-centered medical homes
 - The state can promote and support development of medical homes for other coverage groups including state employees, retirees and dependents, SAGA, and Medicaid
- As a regulator – every provider of care needs a license from the state
 - The state can define and provide recognition to patient-centered medical homes
 - The state can provide technical assistance for practice transformation
- As a protector of the public's health –
 - The state can develop pilot medical home projects to further our understanding of barriers and identify solutions that work in CT
- As a market leader
 - The state can use its considerable clout to convene other payers and providers to develop collaborations supporting medical homes

The patient-centered medical home has great potential to re-orient our health care system toward prevention and management of disease and away from incentives for over-treatment. Medical homes are gaining acceptance as a way to reduce health care costs, improve quality, and eliminate inequities in our health care system.

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