The Patient Centered Medical Home-What Employers Need to Know
By
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In their capacity as payers for their employees' medical services, employers need to be aware of trends that impact the provision and payment of healthcare services. One such trend in primary care healthcare services – specifically, the Patient Centered Medical Home (PCMH) - meets both of these criteria by providing financial incentives to physicians for meeting certain quality criteria. In the following paragraphs, I'll elaborate on the concepts underlying the PCMH, its potential to impact quality and cost of patient care, and some of the barriers to its implementation.

A familiar concept in the medical literature, PCMH now has taken on a "physical form" and, as such, has become the subject of much attention in both medical and lay publications. Patients may look at this term and ask, "Is this just a fancy name for my current doctor's office?" In short, the answer is no. The physical location may be the same as a primary care physician's office, but the designation of PCMH requires a practice to meet specific criteria concerning care processes that are beyond the scope of processes in the average primary care office.

First introduced by the American Academy of Pediatrics in the1960s as a means to improve care for children, the PCMH has recently been resurrected for primary care. In February, 2007, the PCMH model was endorsed by a number of organizations including the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association, all of whom have worked with various aspects of the model for decades. They have jointly defined the medical home as "a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians."*

Conceptually, the PCMH is an idealized vision of primary care (those practices that include family and general practice, internal medicine, pediatrics, and obstetrics and gynecology).A PCMH is a familiar place, with familiar people, that delivers high quality, well-organized, accessible care. It was conceived to address the current issues of fragmentation of care by providing the infrastructure to support care along the full spectrum from wellness and prevention, to chronic care management, to hospitalization and end of life issues.

Research has definitively demonstrated that higher ratios of primary care physicians (compared to specialists) provide higher quality care at a lower cost. However, it is also well recognized that there are inequities in valuing compensation to primary care physicians compared to specialists. As a result, far fewer physicians are choosing careers in primary care. In addition, surveys indicate that many physicians in primary care are disillusioned and considering early retirement or career change. The PCMH approach to care is, in truth, an innovative and promising response to the crisis in primary care.

Throughout the United States, Medicare, Blue Shield plans, and other payers are providing financial incentives for PCMHs while researchers further test the concept in various demonstration programs.

PCMH serves as a means for appropriately compensating primary care providers in a timely manner without major legislative intervention. In theory, the increased costs incurred from direct payments to primary care providers will be offset by savings to the system through higher quality. The peer-reviewed literature documents improved quality, reduced errors, and increased satisfaction when patients identify with a PCMH. Some studies estimate that a primary care-based health care system would cost 30% less than the one in which we currently operate.

What does it mean to qualify as a PCMH? On January 2, 2008, the National Committee for Quality Assurance (NCQA) announced a large, voluntary program to certify physician practices as PCMHs using standardized measurement criteria. Practices seeking recognition complete a Web-based survey and provide documentation to validate their responses. Practices are scored along 9 standards on a 100-point scale and are eligible for three levels of recognition (financial incentives). The nine standards are: (1Access and Communication, (2 Patient Tracking and Registry Functions,. (3 Care Management, (4 Patient Self-Management Support, (5 Electronic Prescribing, (6 Test Tracking, (7 Referral Tracking, (8 Performance Reporting and Improvement, and (9 Advanced Electronic Communications. Optimal scoring on the PCMH scale does not explicitly require the physician to possess an electronic medical record (EMR) system, though having one facilitates many of the requirements.

Essentially, the NCQA certification as a PCMH documents that providers have the infrastructure and capabilities to provide and/or coordinate care for patients along the spectrum of care identified above. In the parlance of the health policy quality world, it involves having the "structure" and "processes" in place to enable optimal "outcomes."

How will this play out in the "real world?" Will the PCMH be a "disruptive innovation" in primary care? As of now, the jury is still out. Admittedly, the initiative is very new. However, despite its advocates' enthusiasm, supportive literature, compelling anecdotes, and the NCQA certification program, the PCMH's adoption outside of large-group, academic, and pilot-program settings remains limited. The reasons for this include the usual suspects of cost and time. Whether or not the rate of adoption increases with further publicity and greater financial incentives, PCMH will remain a trend worth following.

* http://www.ncqa.org/tabid/631/Default.aspx PPC-PCMH Fact Sheet Accessed 2/3/2009

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