PATIENT CENTERED MEDICAL HOME AS AN EFFICIENT MODEL OF CARE DELIVERY
Inefficiencies in Health Care in the US...

- While cost of care in the US is high, the quality of outcomes is lower than expected...
Two Areas of Potential Cost Control…

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Health Policy Issues Regarding PCMH

- The Patient Centered Medical Home (PCMH) model has the potential to improve quality of care.

- Initially, PCMH models cost more to start up and evaluate... However, long term cost savings may create a more efficient health care system (decreased downstream utilization)...

- Demonstration projects prompted by the PPACA are showing cost savings in hospital care; however, inherent cost increases occur in the outpatient setting.
Fractionated Medical Care

- Disconnect between the patient and the medical providers leads to fractionated medical care:
  - Duplicated care
  - Increased expenses
  - Lack of expected quality
  - Decreased patient and physician satisfaction
Fractionated Medical Care

- Seen frequently in patients with chronic diseases
  - Lack of coordination between physicians
  - Lack of communication at hospital discharge

- Only 3-20% of discharges from hospitals were communicated to an outside physician
  - In those cases pertinent results were communicated only 65% of the time.

One goal of the PCMH is to decrease this fractionated, duplicative care...
Medical Home Model

- First published as a care system for children with disabilities in 1967 by the American Academy of Pediatrics
- The generalist physician was to be a ‘repository’ of the patient’s medical information
Development of HMO’s

- Currently, HMOs insure 21% of the US population under the age of 65.
- Due to the business model, patient and physician dissatisfaction occurred.
Medical Home ≠ HMO

- **Medical home model**
  - Coordinates care through a primary physician
  - **Goal** is to reach quality outcomes for the patient
  - Physicians are incentivized to help the patient **realize** those quality outcomes
Common Tenets of a Medical Home

- Improved communication
- Use of data system to improve safety
- Care management/coordination
- Patient self-care
- Performance reporting
Funding of the Model

- Pay-for-performance
- Capitated systems
- Fee-for-service

- New York Hudson Valley P4P/Medical Home Project
  - Upfront costs were covered by insurance company and tech ‘grants’
Workforce - Difficulties

- *Health Affairs* in 2008 projected a workforce shortage of 35,000-44,000 generalist physicians by 2025.

- Group Health Cooperative found that primary care physicians decrease their patient volume from 2,300 to 1,800 in the first year of a medical home.
Workforce – Possibilities

- Outcomes from Geisinger Medical Home Model project exhibited decreased rates of readmission to the ER by 18%.
- Initial decrease in outpatient capacity may be offset by shifting medical providers from costly inpatient settings to efficient outpatient settings.
Non-traditional Medical Homes

- U.S. Department of Health and Human Services in 2010 described a model in which mental health specialists would serve as the medical home for patients with mental disorders.

- Demonstration projects are under evaluation in settings where ‘long term physician-patient relationships are expected.’
  - Oncology
  - Cardiology
American Academy of Family Physicians
American Academy of Pediatrics
American College of Physicians
American Osteopathic Association

National organizations representing NPs, especially in rural areas urged congress to allow NPs to serve as leaders of medical homes...In April 2009, the ACP/AAFP/AAP/AOA released a statement acknowledging this request and need, but supported the team-based approach to be led by a physician.

Combined, these organizations represent over 330,000 physicians.
National Committee for Quality Assurance (NCQA)

- Leading accreditation agency for a medical practices to become qualified a PCMH.

- Evaluates standards for insurance companies and medical practices, covering 70.5% of the insured

- As of July 2011, Over 2800 practices were certified
Unintended Consequences

- Concerns about access
  - Fully implemented PCMH models showed decreased capacity for annual number of patient visits per provider.
  - Forecasted workforce shortages may exacerbate difficulties for patients to access care in timely manner.
  - Potential delays in care and patient resistance may offset improved satisfaction overall.
Recommendations

- Demonstration models have shown that the medical home model leads to
  - Improved quality
  - Cost savings
  - Improved satisfaction
  - Decreased duplicative care
- Funding for medical home models should continue to support this model of care.
Recommendations

- Alternative medical home models proposed to improve access need to be evaluated further to examine their efficiency.
  - Specialists organized in long-term chronic disease
  - NP led medical homes in rural areas

- Collaborative projects with ACOs should be continued as a method to maintain quality of care in that system of care.