Development of a Patient-Centered Medical Home and its impact on Physician Practices

Exploratory Paper

Maliha Gillani, MHA, FACMPE
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This paper is being submitted in partial fulfillment of the requirements for election to Fellow with the American College of Medical Practice Executives.
INTRODUCTION

The concept of a patient-centered medical home (PCMH) is based on a set of principles and depends on a team of healthcare personnel who work together to plan for the overall health of the patient.\(^1\) The “medical home” concept originated during the 1960s in pediatrics as a way to coordinate care for children with special healthcare needs.\(^2\) The term “medical home” was published by American Academy of Pediatrics (AAP) in 1967. The AAP emphasized the importance of centralized medical records for children and defined a medical home as a single central source of a child’s pediatric records.\(^3\) The pediatricians, along with their practices, became the central coordinators for the children’s medical care and records. However, this did not translate into adult general practice until the mid-1990s. The Institute of Medicine (IOM) defined the concept of a medical home in the 1990s as a means of fostering “continuous healing relationships” where patient’s needs and values are central to the practice mission. All through the 1990s, this idea was only discussed until the American Academy of Family Physicians (AAFP) released a position statement in 2004 responding to the lack of a patient-centric approach in primary care. Until this point, most practices were all about volumes and generating revenues and less accountable for quality. This position was also endorsed by the American College of Physicians (ACP).\(^4\) In the same publication, AAFP promoted the chronic care model which includes self-management, decision support, delivery system design, clinical information system, and community resources. These discussions shaped the emergence of a patient-centered medical home where the
provision of healthcare revolves around the patient. The patient-centered medical home (PCMH) model of care delivery for primary care practices holds the promise of higher-quality care, improved self-management by patients and reduced costs.

This paper will discuss the evolution of a PCMH and how it impacts physician practices, in particular the primary care practices. Utilizing a literature review, the current healthcare system and demographics, the major components of the PCMH model, things to consider during the transformation from a traditional practice to a PCMH model, current nationwide trends in PCMH certification, and advantages and disadvantages of a PCMH will be discussed.

CURRENT HEALTHCARE SYSTEM AND DEMOGRAPHICS

The emergence of a patient-centered medical home cannot be understood without a thorough comprehension of the healthcare system in United States and its demographic changes. Several studies illustrate that healthcare costs have raised dramatically over the last fifty years. Healthcare costs represented only 5.2 percent of the U.S. gross domestic product (GDP) in 1960, soared to 16 percent of GDP in 2005 and are projected to grow to nearly 20 percent of GDP by 2018.\(^5\) (Graph #1) Physician practices are no different than other healthcare entities in this cost trend. The median overhead for primary care practices is 49 percent, according to the 2014 MGMA cost-survey report based upon 2013 data. Other than staff salaries and benefits, which take the largest portion, it is estimated that medical practices spend up to 37 percent of their revenue on administrative
costs. Although medical practices decreased operating expenses 2.2 percent in 2010, general operating costs since 2001 have increased almost 53 percent to $252,629, far above any gains in revenue over the ten year period.

Historically, general practitioners provided first-contact care in the United States. Today, however, only 42 percent of the 354 million annual visits for acute care treatment for newly arising health problems are made to patients’ personal physicians. More than 50 percent of primary care is now being provided in emergency rooms and urgent care centers. Two major factors contribute to the high usage of emergency rooms by patients and the rising healthcare costs. These include an aging population with chronic conditions and restricted access to care including no health insurance.

Aging population is causing a demographic shift in the United States. The overall US populations that are 45 to 64 years old, are growing rapidly and people in this age group typically have higher healthcare costs than those incurred by younger individuals. Fifty percent of Americans in this age group live with one or more chronic conditions and only 54 percent of chronically ill adult patients receive recommended care. The increasingly sedentary lifestyle of most Americans and the tendency to consume more calories are greatly exacerbating the effects of aging on their health leading to obesity. There are several chronic conditions associated with obesity such as diabetes, hypertension and high cholesterol that degrade quality of life, diminish longevity, and raise health care costs. Studies show that over 60 percent of patients are non-compliant with the care for the chronic conditions. Some experts estimate that as much as three-fourths of total healthcare expenditures are directly or indirectly attributable to obesity and related chronic diseases.
Research has also shown that the current primary care practices do not have enough proper resources to provide quality care to patients. A study published in the Journal of Health Affairs showed that the primary care providers who practice with a panel of two thousand or more patients per full time provider are unable to provide accessible, high-quality care to their patients.\textsuperscript{11} The growing population has also resulted in limited access by the increasing average number of patients per practice. Everyone cannot be accommodated in an 8 hour day, and sometimes the providers are booked a month in advance. Even when the patients are able to secure an appointment, a majority of the office visit is spent in the waiting room because the physician is running behind. This is due to double booking and over booking errors, since physicians look at the increasing patient volume to cover the overhead charges. Furthermore, the proportion of physicians practicing part time has increased from 13 to 19 percent since 2006, thus contributing to the limited access for the patients.\textsuperscript{12}

There is a perception among many Americans that despite coverage, cost and other problems in the healthcare system, the quality of healthcare in the United States is better than it is anywhere else in the world. In fact, 55 percent of Americans surveyed in 2007 said U.S. patients receive better quality of care than patients in other nations, even though only 45 percent said they thought the United States had the world’s best health care system.\textsuperscript{13} Moreover, while Americans overwhelmingly support government action to increase coverage and reduce the costs of health care, a poll found that 63 percent worry that the quality of their own care would get worse if the government ensured health care for all.\textsuperscript{14}
These issues of aging population, chronic conditions, lack of proper care and limited access to the physicians are all addressed by a patient-centered medical home.

CONSTITUENTS OF A PCMH

Efforts by Dr. Sia Calvin, a Honolulu-based pediatrician, to pursue new approaches to improve early childhood development in Hawaii in the 1980s laid the groundwork for an AAP statement in 1992 that defined a medical home largely the way Sia conceived it:

“The AAP believes that the medical care of infants, children, and adolescent ideally should be accessible, continuous, comprehensive, family-oriented, coordinated and compassionate.”

In 2007, ACP, AAFP, AAP, and the American Osteopathic Academy (AOA) published a joint statement to establish the principles of a medical home. These principles emphasize personal relationships, team delivery of holistic care, coordination across specialties and settings of care, quality and safety improvements, open access and affordable care.

The National Committee of Quality Assurance (NCQA), a major certifying agency states:

“A patient-centered medical home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, and health information exchange.
and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.17

Even though there are various definitions and certification criteria, there are common elements which together define the principles of a PCMH. These include; having a personal physician, having a whole-person focus, providing coordinated care, a focus on quality and safety, integrated care through the healthcare system and providing enhanced access.

Courtesy: Parkway Medical Group18
1. Personal Physician Requirement

One of the prime requirements for a PCMH is that a personal physician must be assigned to each patient. The physician will lead a team of individuals who would collectively take the responsibility for the ongoing care of the patients. Primary care physicians will need to warmly accept and build trusting relations with all their patients. Therefore, instead of care being rendered by nurses, each patient will be seen by the same physician every time to provide whole-person care. The personal physician will either provide all the healthcare needs of the patient or take the responsibility for arranging care with other qualified healthcare professionals. Hence, the physician will have to spend more time in clinical care instead of administrative work and managing the practice.

2. Whole-person care

Whole-person care emphasizes: pre-visit planning, assessing patient progress toward treatment goals, and addressing patient barriers to treatment goals. This requires a plan for every patient visit and having all the records available to discuss care with the patient. Care coordination plays a vital role in identifying high risk patients and patients with chronic conditions as well as in managing their care. If the practice understands its patient population, then it can put systems and work flows in place to provide quality care. The collection of demographic and clinical data for population management is
another standard of PCMH which includes assessment and documentation of patient risk factors and point-of-care reminders.\textsuperscript{20} Therefore, the patient is treated as a whole.

3. \textbf{Electronic Health Records (EHR)}

The implementation of electronic health records is an essential step for a PCMH. The utilization of registries and health information technology is necessary to ensure that patients receive appropriate and continual care. An EHR is needed because physicians need a longitudinal patient record of health information, emergency room visits and inpatient stays. Patients can request referrals, test results and communication. Performance measures, patient education and enhanced physician-patient communication are also some key elements for a medical home. A PCMH model also requires the practice to track utilization measures such as rates of hospitalizations and emergency room visits. All of these tasks can be achieved through the use of an EHR which has the capability to track the hospitalizations, monitor the visits and produce reports for quality indicators needed to maintain PCMH certification.

4. \textbf{Increased Access}

PCMH offers better access to care through open scheduling, extended hours and convenient appointment setup options for patients via patient portal and emails. A primary care practice is no longer limited to a nine-to-five schedule. Expanded hours for the practice are a way to increase access for patients through weekend hours or after-
hours availability of physicians. In addition, the practice must be able to provide same-day appointments, timely clinical advice via telephone during and after office hours. This can be challenging for the practice because it requires the physician to be available even after the practice closes. It also requires the practice to be open at least one Saturday a month with full staff. This improved access is important for the patients who work five days a week and cannot come to the physician office during business hours.

5. ** Provision of Self-care and Community Support **

Another feature of a PCMH is to provide self-care and community support to its patient population. The practice must assess patient/family self-management abilities. After that it must work with patient/family to develop a self-care plan and provide tools and resources to execute that plan. This measure is especially important for patients with chronic conditions and can provide them with support groups, community resources and self-help measures. In order to have this system set up, the practice must have the knowledge of its patient population and their needs. The practice can provide brochures about various chronic conditions and provide self-measure tools to the patients which they can use at home.

6. ** Tracking and Coordination of Care **

Coordination and integration of complex healthcare systems, not only with the specialists, hospitals, home health agencies, and nursing homes but also with the patient’s
loved ones and community-based services, are essential to a PCMH. There are several ways to ensure the continuity of care such as informational, longitudinal and interpersonal methods. Informational continuity means a centralized collection of patient information that is accessible to all providers caring for the patient and to which all providers can contribute. Longitudinal continuity entails a physical site where a patient receives the proper care by an individual or a team that coordinates diverse services. The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals). Lastly, the interpersonal continuity includes among other things, the practice following up with discharged patients. This component also includes medications reconciliation at each visit and post-hospitalization. The use of e-prescribing is a key feature of the care management as well.

CERTIFICATION AND TRANSFORMATION INTO PCMH

PCMH certification is currently provided by four agencies:

a. Accredited Association for Ambulatory Healthcare (AAAHC)

b. Joint Commission (JC)

c. Utilization Review Accreditation Commission (URAC)

d. National Committee for Quality Assurance (NCQA).22

The AAAHC developed standards to advance and promote patient safety, education, and research and quality ambulatory healthcare through peer-based
accreditation processes. The practice is notified in advance to have specific documents available for the surveyor to review on a set date. The survey is conducted by professionals who are experienced in ambulatory healthcare. These professionals observe the elements of high-quality care consistent with AAAHC standards and interview the team members and patients at the hospital.

The Joint Commission utilizes a similar process consisting of on-site surveyor who assesses the practice’s performance and its compliance with the primary care medical home standards. The survey team provides feedback on corrective actions, improvements to workflow and staff education at the practice. Furthermore, the practices are required to annually assess their compliance and submit documentation through an electronic process called Periodic Performance Review. This is a quality control measure for the practices to retain their accreditation. A consultant or advisor is available to the practice for guidance through this process.²³

URAC has a similar process where each practice is evaluated on site by a reviewer or a PCMH certified auditor. In order to become certified, the practice must submit the application and required documents through a web-based portal. The practice then receives a summary report that identifies a compliance score and a designation category.²⁴ Practices can earn one of four designations: achievement, achievement with electronic records, certification, and certification with electronic records. Achievement is the lower recognition which shows that the practice is utilizing the measures related to PCMH elements and certification means that the practice is certified as a PCMH.

NCQA’s PCMH tool is a practice self-report measure and has become the de facto standard for PCMH recognition. The practice is assessed for nine standards: access
and communication, patient tracking and registries, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communications. Compared to the other three agencies, NCQA recognition requires more data collection, analysis and documentation which can take anywhere from 3 to 12 months.  

The transformation of a practice into a PCMH is more than just a tangible process of implementing the electronic health records, reorganizing staff and having patient education material in place. The process involves a psychological change in the attitude of the providers, the staff and the overall management. The physician and the staff members have to think and act like a team for proper care coordination. They have to treat the patient as a whole and ensure that all team members communicate with each other.

The PCMH transformation is not complete without the active participation of patients in their own care. Each patient needs to have an ongoing relationship with the personal physician trained to provide first-contact, continuous and comprehensive care. In a lot of the primary care practices, patients see a different practitioner every time, and therefore, no personal rapport is built with the patient.

Another major transformation is the implementation of steps needed to increase access to care for patients and to improve communication, which entail after-hours care, counselling and medication management. It is important for the practice to have a system in place to provide after-hours care either by having a clinician who is on-call or by developing a triage system. Medication management is important because the patients should not have to wait for the next business day in order to obtain refills. The practice
needs to develop protocols for medication refills especially for after-hours. Lastly, patient engagement and relationship building are fundamental for a successful PCMH start up. This is a gradual process that continues beyond the transitional stage and involves patient education and counselling.

CURRENT CERTIFIED PRACTICES AND THEIR RESULTS

Once the primary components of a PCMH were identified, several states piloted PCMH programs. One such program is the Colorado Children’s Healthcare Access Program (CCHAP). CCHAP began in 2006 as an 18-month pilot project to help private pediatric and family practices serve Medicaid patients by providing a medical home setting for low-income children. The pilot included seven pediatric practices serving 7,000 children in the Denver metro area. CCHAP worked with private practices to receive enhanced Medicaid payments in exchange for providing preventive services and also provided support services like care coordination, a resource hotline, and Medicaid billing assistance to the providers. This pilot increased immunization rates and preventive care visits, reduced emergency department use, and reduced Medicaid costs in affiliated practices. CCHAP launched a second pilot in 2007 that led to improvements in preventive care and reductions in emergency department visits and hospitalizations. As of January 2010, the program includes 116 practices and 405 providers, representing 93 percent of private pediatric practices and pediatricians in Colorado.26
The Michigan Children’s Healthcare Access Program (MCHAP) is another successful PCMH program. It was launched in 2008 to provide access to medical homes for low-income children in Grand Rapids and surrounding Kent County, Michigan. MCHAP provided enhanced Medicaid payments to pediatric providers while helping organize community-based care coordination, supportive services, and family provider education. A one-year pilot program reported lower usage of emergency room and inpatient services among MCHAP patients along with increased immunization rates. The results showed that when the overall care was well managed, the costs for the emergency room visits as well as the overall healthcare costs decreased for the patients.

North Carolina also has a certified PCMH program. Community Care of North Carolina, an enhanced medical home supported by the state’s Medicaid program since 1998. The program builds community health networks organized collaboratively by hospitals, physicians, health departments, and social service organizations to manage care. Each enrollee is assigned to a specific primary care provider, while network case managers work with physicians and hospitals to identify and manage care for high-cost patients. A study by the University of North Carolina found the program saved roughly $3.3 million in the treatment of asthma patients and $2.1 million in the treatment of diabetes patients between 2000 and 2002 while reducing hospitalizations for both patient groups. In 2006, the same program saved the state roughly $150 to $170 million.

In private sector, Group Health, which provides insurance and care to 500,000 residents in the Pacific Northwest, piloted the PCMH redesign at one of the Seattle-area clinics in 2006. As part of the pilot, Group Health decreased the number of patients, for whom each primary care doctor was responsible from 2300 to 1800; thereby allowing
physicians to spend more time with the patient and coordinate his/her care.\textsuperscript{29} Group Health also invested $16 more per patient per year to staff the medical home pilot clinic. An evaluation conducted at the end of a two-year period found that the model reduced physician and care team burnout, improved quality scores, and reduced emergency, specialty, and avoidable hospitalization use and costs. In addition, the model resulted in increased patient involvement in decision making and improved patient-physician interactions (Graph# 2). The success of this program prompted Group Health to spread the medical home model to all of its medical centers in early 2010.

Goppert-Trinity Family Care, part of Hospital Corporation of America (HCA) Midwest Physicians, uses a PCMH model that focuses on increased access for patients, improved electronic documentation, chronic disease management and quality outcome measurement. The practice has achieved recognition from the NCQA as a Level 3 PCMH.\textsuperscript{30} Level 3 certification is the highest attainable level of recognition from the NCQA, and Goppert-Trinity’s certification is valid through 2015. As a result of this two-year pilot project in collaboration with Blue Cross/Blue Shield of Kansas City, the practice has improved the overall level of care, which includes pediatric, adult care, and elderly care.

In 2011, HCA also ran pilot programs for its practices in Florida. This model focused on patient experience and provider satisfaction in addition to access for patients. While still piloting the practices, Blue Cross Blue Shield of Florida contacted HCA executives and promised a 16 percent increase in the contracted fee schedule, once the practices become PCMH certified.\textsuperscript{31} On a larger scale, these millions of dollar gave the senior executives the motivation to pilot practices in other states as well and look more
seriously into this certification. Since HCA implemented PCMH in two states, some other commercial payers came forward and promised better contracted rates for the Virginia practices as well. As a result, for HCA practices in Virginia, it will be beneficial to go for the certification both from a patient and provider perspective.

Children’s of Alabama has provided specialized medical care for ill and injured children across the state and throughout the southeastern U.S. since 1911. It is the only medical center in Alabama dedicated solely to the care and treatment of children. It is a private, not-for-profit medical center that serves as the primary site of the University of Alabama at Birmingham (UAB) pediatric medicine, surgery, research and residency programs. Pediatric East is a branch of Children’s of Alabama with offices located in Trussville and Pinson achieved the top-ranking Level-3 PCMH certification from the NCQA in March 2013. Greenvale Pediatrics also part of Children’s of Alabama, with offices in Hoover, Alabaster and Brook Highland, also recently received Level-1 PCMH certification. Greenvale Pediatrics will install a patient portal system where patients can view their lab work, request appointments and phone calls, and chat live with the doctor’s office. This will help qualify Greenvale for a higher-level certification in three years.

Pushing for evidenced-based medicine, PCMH certification requires physicians and staff to monitor and record every aspect of the patient’s care, including referrals, medication pick-ups, emergency room visits, diagnostic tests, shots and other services performed both within and outside of the practice. The goal is a team-based approach that provides comprehensive care for the patient.

Tufts Medical Center’s hospital-based primary care practice, General Medical Associates (GMA), was recognized as a level-3 PCMH in December 2013. This
recognition proved that Tufts Medical Center’s primary care practice had the tools, 
systems and resources to provide their patients with the right care at the right time. To 
qualify for level-3 PCMH status, Tufts Medical Center was required to show evidence 
that they provided and maintained a high level of patient engagement and outreach, and 
effectively removed barriers to care. NCQA conducted a rigorous review of the primary 
care practice’s operations, processes and procedures, requiring evidence that it provided 
same-day appointments, offered extended office hours, called high-risk patients to ensure 
they understood their discharge summary after hospital admissions, returned patient 
phone calls in a timely manner and had a representative available by phone to answer 
emergency questions at all times. Some of GMA’s PCMH initiatives included:

a) Calling patients who may need extra support two weeks in advance of their 
   appointment to ensure they are well prepared for their visit.

b) Sending a letter to patients who were due for preventive screenings and procedures 
   during their birthday month.

c) Stressing pre-visit preparation among staff, so the care team already knows, 
   understands and anticipates each patient’s individual needs when they arrived for 
   their appointment.

d) Instituting a team-based approach in caring for patients, including a dedicated social 
   worker, a depression and substance abuse coordinator, many nurse practitioners, 
   administrative coordinators, a pharmacist and medical assistants - in addition to 
   doctors and nurses.34
e) Saving at least 25 appointment slots daily for patients who need to be seen urgently. This kept patients from needing to seek care in the emergency department.

f) Catering to the local Chinatown community by prioritizing the hiring of clinical and support staff who can interact with local patients in their native languages. GMA recently hired two new full-time, Mandarin-speaking physicians and provides clinic handouts and materials translated into Chinese and Spanish.35

g) Reaching out to new local residents by mail with a “welcome” postcard, describing the ease of seeing a GMA doctor in their neighborhood.

**PROS AND CONS OF THE PCMH CERTIFICATION**

There are several advantages and disadvantages to a PCMH implementation and they are discussed below.

a) **Pros**

Studies show that a PCMH improves patient-physician relationship by making communication easy and access convenient. Patients are satisfied when they feel they have access to their physicians in a manner they want and at a time suitable for them. Health Partners Medical Group implemented a PCMH model in 2004 as part of their delivery system redesign. A five-year study showed that there was a 350 percent reduction in appointment wait time after the implementation, which resulted in happier
patients. The increased access and after-hours appointment availability is to provide ease to the patients in their busy schedule such that they can visit the practices and take care of their health.

A PCMH model results in better management of chronic conditions. A unique statewide multi-payer initiative in Pennsylvania was undertaken to implement the PCMH guided by the Chronic Care Model (CCM), with diabetes as an initial target disease. Results showed that there was significant improvement among the patients who had evidence-based complications screening and who were on therapies to reduce morbidity and mortality. In addition, there were statistically significant improvements in key clinical parameters for blood pressure and cholesterol levels, with the greatest absolute improvement in the highest-risk patients for diabetes. The practice tracks the chronic conditions, symptoms and provides education to the patients. In return, the patients also actively participate in the management of their condition which improves the results.

A major advantage of a PCMH is that patients do not have to worry about carrying their medical records, and the overall care is managed at the practice level in conjunction with other specialists and providers. This results in improved quality of care and higher patient satisfaction. The “Guided Care PCMH model” was used by Johns Hopkins Hospital system to coordinate care, monitor patients and teach them about self-management. After eight months of implementation, the program reported that the guided care patients were more than twice as likely as usual care patients to rate the quality of their care highly.

A PCMH model results in fewer hospital admissions and emergency room visits for the patients because the patients themselves are actively involved in the care process.
and treatment plan. The PCMH model used by Johns Hopkins showed that there was a 24 percent reduction in hospital admissions, 15 percent fewer emergency room visits, and an annual saving of $75,000 per practice.\textsuperscript{40} The patients also saved on healthcare costs due to decreased emergency room visits. The decreased emergency room visits are a result of patients using their primary care physicians for their needs.

\textbf{b) Cons}

Setting up a PCMH is costly for a small practice requiring cash, resources, training and staffing. The cost for a practice to implement these services will vary based on several factors, such as practice size, existing practice capabilities, ramp up costs required to be a qualified PCMH, and characteristics of the practice’s patient population. The research, published online in the Journal of the American Medical Association (JAMA) in 2010 was the first national study to put a price on these additional costs. The study found that mean operating cost per patient per month (PPPM) for the clinics was $51.23.\textsuperscript{41} The cost of improving the quality of care which will make a difference could be an additional $2.26 PPPM for an average health center. For the average patient population per clinic of 18,753 patients, that translates to more than $500,000 in additional costs annually.\textsuperscript{42} These costs could really impact the bottom line of the practices.

There is a huge learning curve to acclimatize the patients and the staff with the PCMH model and its work flow. Patients have to own their share of the responsibilities such as making appointments, follow-up visits, prescriptions refills, communicating
frankly about health concerns, and actively participating in their healthcare decisions. Notably, many will fall short, and disparities will put specific patient groups at a disadvantage. For example, elderly patients who do not have electronic communications such as email or internet will have trouble getting used to the new system. One such example is not having access to internet or computers to receive electronic results or notifications. Studies have shown that low income, culturally diverse and other special populations will likely require support to meet their patient responsibilities in the PCMH.43

The model requires either an increased time for patient appointments or hiring other clinical personnel to provide patient education, which can impact the bottom line. Patient education especially for chronic conditions is important and requires a dedicated staff member. The practices can no longer just write a prescription and let the patient go and manage their condition on their own. There has to be a proper follow-up to the practice visit such as reminder calls for medication. A designated person from the practice will need to call patients and ensure they understood everything during their visit and have no further questions. This person can also ensure that patients have the necessary information to better manage their chronic condition.

Since a PCMH requires interdepartmental coordination with precision, there is a possibility of a catastrophe for the physician practices if the proper systems and people are not in place. Integrated care delivered by interdisciplinary teams is a core concept, but who leads and who is included on the team can vary considerably. While the PCMH opens the door to bring new players and professional disciplines to the patient care team, the division of labor and responsibility has been a source of considerable angst, often
pitting professional groups at odds over who is in charge. Physicians may assume dominion as primary care team leaders, but nurse leaders in particular have been quick to question this role. Sometimes physicians will lead, but not always. New roles and identities that require new competencies and emphasize collaborative practice styles are emerging for physicians and other health professionals. Other health professionals are also queued up to lead these interdisciplinary, interprofessional teams.44

RELEVANCE OF A PCMH TO THE PHYSICIAN PRACTICES

The PCMH is a model of care in which patients are engaged in a direct relationship with a chosen provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and advocates and arranges appropriate care with other qualified providers and community resources as needed. By becoming a recognized PCMH, practices can improve care delivery and take advantage of private or public incentive payments that reward patient-centered medical homes. The Patient Protection and Affordable Care Act (ACA) offers enhanced federal funding to states for health homes serving Medicaid beneficiaries. Delivery system reform and the potential for shared savings available through programs promoted by the Center for Medicare & Medicaid Innovation (The Comprehensive Primary Care initiative, The Advanced Primary Care Practice Demonstration and the Advance Payment ACO Model) hold promise to further expand access to PCMHs for patients, specifically elderly, chronically ill and low income populations across United States. Because the PCMH is foundational to Accountable
Care Organizations (ACOs) also known as “medical neighborhoods,” the PCMH is likely to gain greater prominence as ACOs continue to develop in the marketplace.

The practices can greatly benefit in terms of reduced cost, clinical relevance, patient satisfaction and retention and lastly provider satisfaction. Patients associated with a PCMH report greater overall satisfaction for their care. This will eventually become important in the era of health reform where payments will be incentivized based upon quality of care and patient satisfaction. A PCMH implementation helps the physicians to develop a chronic disease management plan for patients on an individual level. This helps build rapport with the patients and the physicians are more satisfied when they see improved clinical outcomes. It eventually helps the practice administrators to market their practice as providers of better quality care.

The implementation of a PCMH is a great deal of work for a practice administrator due to staffing, training, physician buy-in and transitioning to a comprehensive EHR. However, it gives a chance for the practice administrators to redefine patient relationships with more comprehensive coordinated care. It helps the practice to establish comprehensive preventative and wellness care programs which ultimately improves quality of care and patient satisfaction. The value of primary care accrues at the level of the patient and the population, whereas the costs are at the level of the practice and the enabling systems. Lastly, the practices and the practice administrators should understand that some outcomes will be seen immediately while others can take anywhere between 5–10 years to see the full health and economic effects of the PCMH.
CONCLUSION

Despite some of its weaknesses, the PCMH is one of the most widely discussed primary care models for delivery system reform. This is because it emphasizes the creation of a strong primary care foundation and higher quality care at a lower cost. The basis of this model is to provide continuous, comprehensive, and coordinated patient care with 21st-century practice innovations, like the use of electronic information systems, population-based management of chronic illness, and continuous quality improvement. Such a healthcare model would foster a strong relationship between the patient and the provider, which would lead to mutual satisfaction. Since 2008, when the NCQA began recognizing practices as a PCMH, more than 26,000 clinicians at more than 5000 practice sites have received the NCQA designation, and the numbers are rising steadily in United States. After the success of the state-run pilot programs, various private sector practices are looking into this certification because it will soon become a gold standard of care for the primary care practices. In particular, large practices have higher stakes in PCMH certification.

The practices should understand that investment is needed to enable functional relationships within the PCMH, between patients and their PCMH, and among the PCMH, its healthcare system and the community partners. A PCMH brings new measures that reflect the higher order primary care functions such as the integration, prioritization and personalization of care, and measures that assess the effect of the PCMH and primary care across multiple levels of health care, health and society.
Future PCMH recognition and certification processes should focus more on patient-centered attributes and the proven, valuable key features of primary care than on the features of disease management and information technology. It will be interesting to see the impact of new health reform on a PCMH as more people have health insurance coverage. It is expected that due to increased healthcare coverage these patients will obtain primary care from the physicians rather than in the emergency room. Researchers should study, if the primary care practices are able to meet the demands of the increased volumes and still achieve better clinical outcomes.

Nevertheless, the PCMH model is still evolving and will need adequate capital funding from a combination of federal, state, local, insurance industry, and health system sources. Expecting practices to front the cost of transformation with the hope of more appropriate reimbursement in the future is unlikely to succeed. Ultimately, for the PCMH to spread and become the norm, the delivery system must be reformed to support this approach to care.
APPENDIX

Graph #1

Projections of National Health Expenditures and Their Share of Gross Domestic Product, 2012-2021

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<td></td>
<td>17.9%</td>
<td>17.8%</td>
<td>18.2%</td>
<td>18.2%</td>
<td>18.3%</td>
<td>18.4%</td>
<td>18.6%</td>
<td>18.9%</td>
<td>19.2%</td>
<td>19.6%</td>
</tr>
</tbody>
</table>


Courtesy: Kaiser Health Foundation
APPENDIX (Continued)

Graph # 2

Table 4. Comparison of Patient Experience at the PCMH and 2 Control Clinics at Baseline and 12-Month Follow-up

<table>
<thead>
<tr>
<th>Patient Experience Subscales</th>
<th>PCMH Clinic (n = 1024)</th>
<th>Control Clinics (n = 1662)</th>
<th>Adjusted Mean Difference in 12-Month Scores Between Clinics&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline Mean</td>
<td>12-Month Mean</td>
<td>Mean Difference (12-Month vs Baseline)&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Ambulatory Care Experiences Survey (ACES) Short Form&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of doctor-patient interactions</td>
<td>86.1</td>
<td>88.0</td>
<td>1.52&lt;sup&gt;*&lt;/sup&gt;</td>
</tr>
<tr>
<td>Shared decision making</td>
<td>85.6</td>
<td>87.9</td>
<td>0.96</td>
</tr>
<tr>
<td>Coordination of care</td>
<td>81.3</td>
<td>84.4</td>
<td>2.82&lt;sup&gt;**&lt;/sup&gt;</td>
</tr>
<tr>
<td>Access</td>
<td>87.3</td>
<td>88.4</td>
<td>0.54</td>
</tr>
<tr>
<td>Helpfulness of office staff</td>
<td>92.1</td>
<td>92.5</td>
<td>0.07</td>
</tr>
<tr>
<td>Patient Assessment of Chronic Illness Care Survey (PACIC)&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient activation/involvement</td>
<td>77.4</td>
<td>82.0</td>
<td>4.06&lt;sup&gt;***&lt;/sup&gt;</td>
</tr>
<tr>
<td>Goal setting/tailoring</td>
<td>69.1</td>
<td>71.7</td>
<td>4.71&lt;sup&gt;***&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

PCMH indicates patient-centered medical home.

<sup>a</sup>P value from paired t test for the average difference in scores between 12-month and baseline scores across all patients in the clinic.

<sup>b</sup>Adjusted mean difference and P value from linear regression comparing average 12-month score adjusting for age, educational attainment, self-reported health status at baseline, and baseline patient experience between the PCMH and control clinics.

<sup>c</sup>The ACES Short Form and PACIC questions (scored on 6-point and 5-point Likert scales, respectively) were totaled within the subscales and then transformed to 100-point summary scores.

Courtesy: Group Health<sup>47</sup>
End Notes

1 Advance Medical Home, 2006


3 Calvin, Sia, Tonniges Thomas, Osterhus Elizabeth, Taba, Sharon (May 2004). "History of the medical home concept." *Pediatrics*, 1474


6 2014 MGMA cost Survey


12 Bodenheimer et al. (2010). Primary Care: Current Problem and proposed solution. *Health Affairs*, 803
http://www.urban.org/uploadedpdf/411947_ushealthcare_quality.pdf


17 NCQA- Patient Centered Medical Homes, 2011 Primary Care Collaborative


19 Bodenheimer, et al. (2012). Transforming Primary Care: From Past Practice to the practice of the future. Health Affairs, 782

20 NCQA- Patient Centered Medical Homes, 2011


30 HCA Midwest, 2012

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