

# THE PATIENT-CENTERED MEDICAL HOME; VISION TO REALITY

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## INTRODUCTION

The most effective, efficient, and comprehensive way to provide medical care is in the context of a close personal relationship between the doctor and the patient and family. The Patient Centered Medical Home is not a new concept, but it takes this idea to a new level, adding medical informatics, an increased emphasis on the team approach to healthcare, and new ways to communicate with patients. It is an answer to our current inefficient, fragmented health care system where costs are rising exponentially while outcomes do not measure up.

## FACTS:

- In 2005, the United States spent 16 percent of its gross domestic product (GDP) on health care. In 2011, almost \$3 trillion was spent on health care. Since GDP is currently just over \$15 trillion (and growing), it is projected that the percentage will reach 20 percent by 2016, if not sooner.
- Although nearly 47 million Americans are uninsured, the United States spends more on health care than other industrialized nations that provide health insurance to all their citizens. Health care spending accounted for 10.9 percent of the GDP in Switzerland, 10.7 percent in Germany, 9.7 percent in Canada and 9.5 percent in France, according to the Organization for Economic Cooperation and Development.
- The annual premium that a health insurer charges an employer for a health plan covering a family of four averaged \$12,100 in 2007. The annual premiums for family coverage significantly eclipsed the gross earnings for a full-time, minimum-wage worker (\$10,712).
- Health insurance expenses are the fastest growing cost component for employers. Unless something changes dramatically, health insurance costs will overtake profits by the end of this year.
- Americans with two or more chronic conditions are twice as likely to experience medical, medication, or lab errors as people in Germany.
- Americans are 38 percent more likely to receive conflicting information from different health care providers than people in Canada.
- Only 30 percent of Americans have access to same-day care. In Germany, 55 percent do. In New Zealand, 53 percent do.
- Minorities face greater risks of complications from heart disease, diabetes, and other common illnesses. Treatable risk factors such as hypertension, low physical activity, tobacco use, infrequent access to care, and obesity are more prevalent among African Americans, American Indians, Alaska Natives, Hispanics, and Native Hawaiians and Pacific Islanders than among white Americans.

The Patient Centered Medical Home model of healthcare delivery is designed to address what is broken in our current system. It replaces a fragmented, illness-focused approach to healthcare with a personal, coordinated wellness-oriented system that encourages partnership between the patient, their family, the physician-led team and the community. It also addresses the issue of accelerated healthcare spending by using care coordination and personal contact to limit overuse and duplication in the system. A study of healthcare costs published in *Annals of Family Medicine* 2004 estimated that if every American had a Medical Home, expenditures would be reduced by 5.6% resulting in a national savings of \$67 Billion each year with an improvement in the quality of care provided.

The idea of a Medical Home is by no means new. The American Academy of Pediatrics (AAP) introduced the term “medical home” in 1967 to describe a partnership approach with patients and families that provides primary health care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective.

In 1978, The World Health Organization International Conference on Primary Care met in Alma Ata, Kazakhstan and outlined the basic components of the medical home and the important role

of primary care in worldwide health. The Alma Ata declaration specifically stated that primary care “is the key to attaining adequate health,” which they further defined as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.” They added that it is “a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal.”

In the 1990’s, these attitudes toward a primary care solution to healthcare delivery were embraced by the Institute of Medicine which specifically mentioned the Medical Home as a construct for healthcare of the future. IOM reports influenced the primary care specialties, and the term Medical Home began to appear in the Family Medicine literature.

The Chronic Care Model was another important contributor to the development of the Patient Centered Medical Home. Ed Wagner, MD, MPH, Director of the MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound, promoted a Medical Home as a model for improving health care of the chronically ill by using a patient-centered approach with coordinated care.

In 2002, The Future of Family Medicine Project of the American Academy of Family Physicians developed a model of care in which every American would have a Personal Medical Home that serves as the focal point through which all individuals— regardless of age, sex, race, or socioeconomic status—would receive their acute, chronic, and preventive medical care services. This Project also contributed to innovative ideas to adapt the medical home to care for patients with more complex and chronic conditions through the creation of medical neighborhoods that include specialty care in a coordinated system.

The American Academy of Family Physicians, The American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association agreed on a structure to define the PCMH. They published seven core facets of a medical home in “Joint Principles of the Patient-Centered Medical Home.”

#### THE SEVEN PRINCIPLES OF THE PATIENT CENTERED MEDICAL HOME

1. *The Personal physician:* each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.

2. *A Physician-directed medical practice:* the personal physician leads a team of individuals at the practice level

who collectively take responsibility for the ongoing care of patients, and work to the top of their capability.

3. *Whole-person orientation for care:* the personal physician is responsible for providing for all of the patient’s health care needs or coordinating care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, and end-of-life care in all venues.

4. *Care is coordinated and integrated* across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by the EMR, registries, health information exchange, and other means to ensure that patients get the indicated care, when and where they need and want it, in a culturally and linguistically sensitive manner.

5. *Quality and safety* define the medical home.

- Practices advocate for their patients to support optimal, patient-centered outcomes. This is achieved by a care planning process driven by a working partnership between physicians, patients, and families.
- Evidence-based medicine and clinical decision-support tools guide decision making. Physicians and the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision making, and feedback is sought to ensure that patients’ expectations are being met.
- Information technology is used to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices achieve voluntary recognition by an appropriate nongovernmental entity. Certification requires that the practice have the capabilities to provide patient-centered services consistent with the medical home model.

6. *Enhanced access to care* is achieved using open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff. Novel methods of care including group visits, virtual visits, telephone visits, asynchronous communication and home-based assessment should be explored and included in the PCMH.

7. *Payment* appropriately recognizes the added value provided of care provided in a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff, patient-centered **care management** work, that falls outside the face-to-face visit.
- It should pay for services associated with **coordination of care** within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of **health information technology** for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with **remote monitoring** of clinical data.
- It should allow for **separate fee-for-service** payments for face-to-face visits (payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should **recognize case mix differences** in the patient population being treated within the practice and cover services based on time and acuity.
- It should allow physicians to **share in savings** from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional **payments for achieving measurable and continuous quality improvements**.

#### PROGRESS AT LGH

Lancaster General Health' Lancaster General Medical Group has been steadily preparing its primary care practices for the PCMH. Under the leadership of Paul Conslato, MD, four practices in the LG system have achieved PCMH certification. Each practice prepared an extensive application demonstrating how it fulfilled the elements of the PCMH. The practices demonstrated effective use of the EMR, data collection and continuous practice improvement based on findings, use of evidence-based best practices, advanced methods of communication to enhance access to the practice, and positive patient outcomes that were a result of practice efforts.

The most recent office to achieve certification is Downtown Family Medicine, the model practice for the Family Medicine Residency Program. Under the leadership of Christian Hermansen, M.D. and his team, DFM scored 97.25 out of a possible 100 points on its application. It joins the Patient-Centered Medical Homes of Lincoln Family Medicine, Strasburg Family Medicine, and Roseville Pediatrics.

This year the LGH Foundation designated its annual giving to the further development of the PCMH in LG primary care practices. Funds will be used to develop and maintain programs to focus on evidence-based best-practice care of diabetes and asthma.

The Institute of Medicine's Envisioning a National Healthcare Quality Report states that "Patient centeredness refers to health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care."

Ongoing efforts of the LG primary Care specialties will provide this kind of care for every patient we serve.

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