

Clinical Watch

FROM CSAC, THE CLINICAL AND SCIENTIFIC AFFAIRS COUNCIL OF THE AAPA

The PCMH: A model for primary care

›WHO SHOULD READ THIS?

All physician assistants who provide primary care.

›WHY IS THIS IMPORTANT?

Health care providers currently operate within a volume-driven system¹ that provides disjointed and high-cost care.^{2,3} There is a continuing call for improvements in payment structure, patient care quality, and patient outcomes. The call for reform is supported by research that shows patients with no usual source of care incur higher health care costs and have poorer health outcomes.⁴

The concept of the patient-centered medical home (PCMH) was developed by primary care physicians and large employers to encourage comprehensive health care, improve patient outcomes, and lower medical costs.⁵ The PCMH approach provides comprehensive care in a setting that facilitates a partnership with the patient, via an interdisciplinary healthcare team and community resources.^{2,6} The current goals of the PCMH include providing high-quality preventive care and effective chronic disease management across the life span and a reimbursement structure that includes coverage for coordination of care and documentation of patient outcomes.²

›WHAT ARE THE CURRENT RECOMMENDATIONS?

The American Academy of Pediatrics, the American College of Physicians, the American Academy of Family Physicians, and the American Osteopathic Association released the Joint Principles

of the Patient-Centered Medical Home in 2007, which were adopted by the AAPA in 2008 as a means to improve the quality of patient care.⁷ AAPA believes these principles can apply to any setting where continuing, longitudinal care is provided.^{8,9} The principles of the PCMH include the following:

Each patient has an ongoing relationship with a personal physician. In some state demonstration projects, the personal physician can be a physician assistant and/or nurse practitioner.

The personal physician leads a team of health care providers who take responsibility for the ongoing care of the patient.

The physician provides for all of the patient's health care needs, at all stages of life, or for coordinating care with other health care providers.

Care of the patient is coordinated across the health care system and the patient's community.

Quality and safety are at the core of the medical home. Patients are partners with the physician. Evidence-based medicine guides decision making, and physician groups participate in performance measurement to assess patient out-

comes. Information technology is used to support patient care, communication, and outcomes assessment.

Access to care is expanded via extended office hours and through alternative methods of communication, such as the Web or e-mail.

The payment structure reflects patient-oriented activities that continue outside the examination room, such as coordination of care, and provides additional reimbursement for providers with measurable improvements in patient care and/or outcomes.⁷

The Centers for Medicare and Medicaid Services developed PCMH pilot projects in 400 practices in 2009, and an additional 22 demonstration projects are under way in 14 states.³ The current model of reimbursement in the PCMH integrates fee-for-service, pay-for-performance, and reimbursement for coordination of patient care. This system provides compensation for services that take place outside the patient examination room with financial recognition that is reflective of patient-case complexity.³

›WHAT'S NEW?

An updated PCMH model emphasizes the multidisciplinary team, with PAs and nurse practitioners as partners and advisors.¹⁰ Recent health care reform legislation introduced to the House of Representatives (HR 2350) and the Senate (S 1174¹¹) would fully integrate and recognize PAs as principle primary care providers for patients within the PCMH model. But more outcomes data are needed to understand the role of PAs in the medical home.¹²

Continued on page 21

TAKE-HOME POINTS

- The concept of the patient-centered medical home (PCMH) was developed by primary care physicians and large employers to encourage comprehensive health care, improved patient outcomes, and lower medical costs.
- Patients in states with a greater number of primary care physicians demonstrate better health outcomes and report better overall health status.
- The updated PCMH model emphasizes the multidisciplinary team, with PAs and nurse practitioners as partners and advisors.
- Evidence that instituting the PCMH will accomplish its stated goals in specific populations is limited, but the most recent data are positive.

This article was written by **Alison C. Essary, MHPE, PA-C**. Contributors included the other members of CSAC: Daniel L. O'Donoghue, PhD, PA-C, Chair; Gilbert A. Boissonneault, PhD, PA-C; Anthony E. Brenneman, MPAS, PA-C; Michelle Lynn Heinan, EdD, PA-C; and Thomas Moreau, PA-C, MS. The manuscript was edited by Sarah Zarbock, PA-C.

Clinical Watch

▶WHAT'S IMPORTANT?

At least 47 million people in the United States have no health insurance, and millions more are underinsured.⁵ In addition, the patient population is aging and there is a marked shortage of primary care physicians.^{5,6} In 1999, 328 primary care internal medicine residency positions were extended and 247 positions were extended in 2009.¹³ PAs are mimicking this trend. AAPA data show that the percentage of PAs practicing in primary care has decreased from 51% in 2000 to 37% in 2008.^{14,15}

However, patients in states with a greater number of primary care physicians demonstrate better health outcomes and report better overall health status.¹² An increase in the number of primary care physicians within an individual state is inversely associated with health care costs, which has been attributed to an increase in health promotion and/or prevention and a decrease in hospitalizations.³ These reports emphasize the need for recruitment into primary care fields and making practice in these fields more attractive.

Stakeholders have issued a variety of proposals to enhance the appeal of primary care for future health care providers. These include promoting primary care practice via Graduate Medical Education (GME) funding of medical residency programs and primary care training for physician assistants and nurse practitioners, increasing the number of GME-funded positions in primary care by 15%, and expanding the GME-funded training sites for primary care to include outpatient settings.¹⁶

▶WHAT ELSE IS IMPORTANT TO KNOW?

The concept of a PCMH shows promise in its ability to enhance the quality of patient care, while potentially reducing health care costs. But as with any project of this scope, there are significant challenges, such as simplifying the concept and enrollment criteria for medical practices, meeting the needs of all primary care patient populations, and providing data that support both

cost-effectiveness and improved patient outcomes.

The PCMH may be a confusing concept, with patients likening it to a nursing home or funeral home.³ It is incumbent on the health care community to provide sufficient education regarding the goals and benefits of the PCMH. A stigma may be associated with a system that encompasses cost-effective health care; patients need to be reassured of the tangible and personal benefits associated with this paradigm shift.³

The enrollment criteria for primary care practices should be inclusive and streamlined. The majority of practices enrolled as PCMHs are large primary care groups. If the PCMH gains momentum, the application and enrollment processes should include small practices with limited resources.^{1,3}

Another challenge for patients and health care providers within a PCMH is accessing and coordinating care in multiple health care settings. For example, a patient moving from a stroke rehabilitation facility to his or her daughter's home may require home health care, transportation services, outpatient rehabilitation, and other services that need to be coordinated by the primary care "home."¹⁰ Patients with chronic illnesses or disability require additional time to manage in and out of the examination room.² Whereas this may be overwhelming for a practice with a large geriatric patient population, a comprehensive care model is ideal for this patient population.

Other challenges to the PCMH model include addressing the health care needs of patients without health insurance and/or inadequate insurance, patients with mental health and/or substance use issues, and patients from diverse backgrounds.^{4,5,17} Although the literature supports a positive correlation between contact with a primary care physician and demonstrated health benefits,⁵ evidence that instituting the PCMH will accomplish its stated goals in specific populations is limited, but recent data are positive. The state of North Carolina saved more than \$200

million per year in health care costs from 2003 to 2006 after implementing a PCMH, which was attributed, in part, to effective coordination of care and preventive health care.¹⁸ The PCMH may need to be assessed in a variety of settings and with a variety of patient populations to demonstrate its impact on patient outcomes.⁹ **JAAPA**

REFERENCES

1. Network for Regional Healthcare Improvement. From volume to value: transforming health care payment and delivery systems to improve quality and reduce costs. Recommendations of the 2008 NHRI Healthcare Payment Reform Summit; July 31, 2008; Pittsburgh, PA. <http://www.nrhi.org/downloads/2008NRHIPaymentReformSummitRecommendations.pdf>. Accessed August 7, 2009.
2. Kirk LM. The patient-centered medical home care model: implications for physician assistant education. *J Physician Assistant Education*. 2007;18(4):7-8.
3. Rittenhouse DR, Shortell SM. The patient-centered medical home: will it stand the test of health reform? *JAMA*. 2009;301(19):2038-2040.
4. Petterson SM, Rabin D, Phillips RL, et al. Having a usual source of care reduces ED visits. *Am Fam Physician*. 2009;79(2):94.
5. Berger E. The patient-centered medical home: a solution to "hamster health care" or a drain on emergency care? *Ann Emerg Med*. 2008;52(6):654-657.
6. Grumbach K, Bodenheimer T. A primary care home for Americans: putting the house in order. *JAMA*. 2002;288(7):889-893.
7. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient-centered medical home March 2007. <http://www.medicalhomeinfo.org/joint%20Statement.pdf>. Accessed August 4, 2009.
8. American Academy of Physician Assistants. HX-4700.5.0 Medical home. AAPA Web site. http://www.aapa.org/images/stories/documents/about_aapa/policymanual/External.pdf. Accessed August 7, 2009.
9. Barr MS. The need to test the patient-centered medical home. *JAMA*. 2008;300(7):834-835.
10. Landers SH. The other Medical Home. *JAMA*. 2009;301(1):97-99.
11. Preserving Patient Access to Primary Care Act of 2009, S 1174, 111th Cong, 1st Sess (2009).
12. Shi L, Macinko J, Starfield B, et al. Primary care, social inequalities, and all-cause, heart disease, and cancer mortality in US counties, 1990. *Am J Public Health*. 2005;95(4):674-680.
13. Steinbrook R. Easing the shortage in adult primary care—is it all about money? *N Engl J Med*. 2009;360(26):2696-2699.
14. American Academy of Physician Assistants. 2000 census highlights and tables. AAPA Web site. <http://www.aapa.org/about-pas/data-and-statistics/846#sectioniii>. Accessed August 7, 2009.
15. American Academy of Physician Assistants. 2008 AAPA physician assistant census report. AAPA Web site. <http://www.aapa.org/images/stories/2008aapacensusnationalreport.pdf>. Accessed August 7, 2009.
16. Iglehart JK. Medicare, graduate medical education, and new policy directions. *N Engl J Med*. 2008;359(6):643-650.
17. Turner EJ, Bazemore AW, Phillips RL Jr, Green LA. Will patients find diversity in the medical home? *Am Fam Physician*. 2008;78(2):183.
18. Wisconsin Academy of Family Physicians. Payment reform. Patient Centered Medical Home Web site. <http://www.wafp.org/pcmh/payment-reform.html>. Accessed August 7, 2009.