There is a lot of hype about medical practices becoming a medical home, commonly referred to as the Patient-Centered Medical Home (PCMH), and how this might change the landscape in the healthcare industry in the quest for a patient-centered medical practice that improved the quality of care. Primary care physicians are wondering how they can take on the responsibilities involved with the medical-home concept, and specialists are wondering how this will impact their role. Medical suppliers and those serving the industry are paying close attention to all of this and wondering what it means and how it will play out.

The real question is: Why should a physician do it? The answer is: because the physicians taking on this responsibility want to be able to better manage a patient’s care and improve the patient’s outcome. At the same time there are significant financial costs and responsibility involved for coordination of care and managing the patient from across the continuum of care.

The concept of a medical home is a great idea for improving patient care and connecting the dots between the different providers involved in caring for the patient. The goal is to make sure the patient’s care is not compromised. However, in a fragmented system, where much of the information resides within the confidential medical record of each physician [and is not electronic], it is also rather ambitious. I applaud the effort and believe sharing information across the continuum of care will inevitably improve the patient experience, result in earlier detection and earlier intervention with serious illnesses and provide better patient outcomes. But how do we get there from here?

**Guiding principles**

The principles of the PCMH developed by a consortium of the American Academy of Family Physicians (AAFP); American Academy of Pediatrics (AAP); American College of Physicians (ACP); and the American Osteopathic Association (AOA) are:

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

2. 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.

3. Care is coordinated and/or integrated, for example across specialists, hospitals, home health agencies, and nursing homes.

4. Quality and safety are hallmarks of the medical home. Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients...
and the patient’s family. These are just a few. There are even more ambitious expectations to acquire the quality and safety of the medical home.

5. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication.

6. Payment must “appropriately recognize the added value provided to patients who have a patient-centered medical home.” This is a bit of a sticky-wicket as it needs to reflect the value of the PCMH’s work that falls outside of the face-to-face visit, should support adoption and use of health information technology for quality improvement, and should recognize case mix differences in the patient population being treated within the practice.

Implementation

This medical-home concept is a great idea with the goal of improving the healthcare for Americans while reducing the costs of care. But how is this all going to happen – and if it happens, how will it happen without diverting costs for clinical care over to the administrative side of managing patient care?

The PCMH concept moves forward. As of Dec. 31, 2009 there were at least 26 pilot projects, which are being closely evaluated for such factors as clinical quality, cost, patient experience/satisfaction, and provider experience/satisfaction. Some of the projects underway include:

1. A Medicare medical home demonstration [three-year] project involving care management reimbursement and incentive payments to physicians in 400 practices in eight sites. It will evaluate the health and economic benefits of providing targets, accessible, continuous and coordinated, family-centered care to high-need populations.

2. In 2008, CIGNA and Dartmouth-Hitchcock announced they had launched a pilot program in New Hampshire with 391 primary care providers.

3. A UnitedHealth Group medical home pilot in Arizona involving seven medical groups began in 2009 and is scheduled to end in 2011.

4. The state of Maine provided $500,000 in 2009 for a pilot project involving 26 practices.

5. The New Jersey Academy of Family Physicians and Horizon Blue Cross Blue Shield of New Jersey implemented a program in March 2009. It involves 60 primary care practice sites and 165 primary care physicians.

The medical community and healthcare experts around the country are watching closely to see the outcomes of these pilot programs and the impact this has on the future of healthcare providers and their patients.

In reality we all want Americans to be healthier through better education, a desire for healthier lifestyles, prevention, early detection and intervention and continuity of care. The goal is to get patients better, quicker, which inevitably improves the quality of life and reduces the cost of health care.
In light of this, what can medical suppliers and pharmaceutical companies do to support the PCMH model, and is there an opportunity to provide solutions that will help medical practices become more efficient and serve patients better? Physicians are in need of guidance and tools that will improve accuracy in evaluating patients and provide better treatment options. They want to achieve a patient-centered practice that will result in healthier, happier patients and better outcomes. You have their attention! Now what?

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