Patient Centered Medical Home Model Concept Paper

Patient Centered Primary Care Implementation Work Group

Introduction

The Patient Centered Medical Home (PCMH) Model is a patient-driven, team-based approach that delivers efficient, comprehensive and continuous care through active communication and coordination of healthcare services. PCMH is based on a set of seven principles (1) and depends on a core and expanded team of healthcare personnel who work with the Veteran patient to plan for their overall health.

Background

The medical home concept originated during the 1960's in pediatrics as a way to coordinate care for children with special health care needs. (2) The pediatrician, along with their practice, became the central coordinator for the child's medical care and records. However, this did not translate into adult general practice; in 1983, 36% of patient visits were to a primary care provider. The American Academy of Family Physicians (AAFP) released a position statement in 2004 that responded to the lack of patient centeredness in primary care, which was endorsed by the American College of Physicians (ACP). (2) In 2007, the ACP and AAFP, along with the American Academy of Pediatrics (AAP), and American Osteopathic Academy (AOA) published a joint statement on the principles of the 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. (1)

VHA desires to remain at the forefront of health care delivery. Over the past ten years, we created arguably the best primary care system in the world, built on many of the key components of PCMH. However, we recognize that there needs to be a transformational integration of these key elements into a cohesive, highly functional team that is primarily focused on the Veteran patient's goals and needs. PCMH engages patients in a more active role to manage their health care rather than being advised what to do through a provider-centered system. It is expected that PCMH will demonstrate quality improvement, greater Veteran satisfaction, and cost savings from decreased hospital visits and fewer readmissions through patient focused care. (3) While the incorporation of Primary Care within VHA has been associated with improvements in Veteran satisfaction and important quality measures, our health care system still remains largely focused around the provider and health care team, rather than the Veteran patient. Therefore, we are initiating the implementation of a PCMH Model in all VHA health care facilities. The objective of VHA PCMH is to improve patient satisfaction, clinical quality, safety and efficiencies by becoming a national leader in the delivery of primary care services through transformation to a medical home model of health care deliver. This model is meant to focus on all patients receiving VA primary care, which is known to be 80 to 90% of the enrolled Veteran patient population.

Principles of Patient Centered Medical Home

Patient-driven. Patient-driven care focuses on the person rather than the condition/disease. (4) It establishes a partnership among the primary care team, Veteran patients, and their families and/or caregivers ensuring that Veteran patient's wants, needs,

and preferences are respected and at the hub of decision-making. These preferences and goals are easily retrievable, modifiable and reviewed/discussed regularly with the Veteran patient. Also Veteran patients will have the knowledge and support required to make decisions and fully participate in the management of their health care. (5) This includes improving access for both face-to-face medical encounters and remote/virtual encounters.

Team-based. An interdisciplinary team is formed that includes the Veteran patient, their primary care provider, RN care manager, clinical and administrative staff, as well as other clinical services necessary to meet the health goals and needs of the Veteran patient including specialists. While the primary care provider's relationship with the Veteran patient will remain key, that bond will be augmented and strengthened by involving other health care staff as part of an integrated team. Together the team takes responsibility for the Veteran patient's ongoing care through a cooperative effort among all members. As a member of the team, the Veteran patient is an active participant in decisions while being provided information and encouraged to exercise ownership of his/her health. (4) The Veteran patient, with support from other members of the team, becomes engaged in his or her health care, ensuring the health care system best serves their individual needs. (6)

Efficient. Technology is utilized to support optimal patient care, performance measurement, systems redesign, patient education, and enhanced communication. (4) This allows Veteran patients to receive appropriate responsive care at the moment they need it, and for all team members to work at the top of their competency in an accountable manner toward meeting the goals of care. Interdisciplinary team specialists collaboratively provide focused recommendations when consulted and episodic direct patient care when needed, while core functions are handled by primary care team members who are better situated to meet these needs. (4)

Comprehensive. The primary care team uses education, preventive care services, lifestyle coaching, appropriate consultation, and early detection screenings to deliver whole person oriented care. Comprehensive care addresses all medical, behavioral, psychosocial, and functional status issues. All issues are first addressed by primary care as they are able to manage most of these needs both acutely and on an ongoing basis. (4) In cases where additional expertise is necessary, primary care continues to serve as an important and trusted resource for the Veteran patient. The PCMH team also looks to the community as a resource, understanding the importance of where people live, their exposures, experiences, and special risks inherent in a population contribute to a patient's overall health and wellbeing. The team uses this greater understanding of individual differences within population-based trends to deliver effective care. The PCMH team also looks to community providers to provide care when the necessary medical resources are not available within VA, thereby securing a full spectrum of care for the Veteran patient.

Continuous. Continuity is a key component of primary care, and development of a continuous, longitudinal relationship between the Veteran patient and provider is of utmost importance. The primary care provider directs the team in its responsibility for delivering all of the Veteran patient's health care needs and for appropriately arranging care with other qualified professionals when necessary. These health care needs include acute, chronic, preventive, and end of life care. (4) The development of a continuous relationship with both the primary care provider and the team carries beyond episodic

visits, using frequent communication throughout the Veteran patient's life and changing needs. For this reason, the team is able to adjust over time depending on the complexity of the needed care, maintaining the personal relationship. (4)

Communication. The communication between the Veteran patient and other team members is honest, respectful, reliable and culturally sensitive. Providers and staff encourage the Veteran patient to offer truthful communication without the fear of judgment or repercussions. This type of communication allows for all team members to make informed decisions and recommendations. As care continues, information sharing among the team maintains a focus on the Veteran patient as the locus of control. (4) Communication as guided by the Veteran patient will include providers in all care settings.

Coordination. The primary care team, in partnership with the Veteran patient, develops an evolving plan for care that is implemented through coordination across all elements of the health care system. (6) Coordination is achieved through active interdisciplinary collaboration that is facilitated by registries, information technology, health information exchange and other means to assure that patients make informed choices and get the agreed upon care when and where they need and want it in the appropriate manner. (4) Information from multiple diverse sources is pulled together into a single system supporting the information needs on which PCMH depends.

VHA PCMH Team Design

The primary care team consists of the Veteran patient along with all the staff, clinical and administrative, necessary to promote the wellbeing of the veteran patient. The team can be described as two parts: the core team and the expanded team. The core team of the Veteran patient, his/her provider, a RN care manager, a clinical staff assistant, and an administrative staff member are responsible for the central functions of a medical home model. The RN care manager, clinical staff assistant, and administrative staff member serve the provider's entire panel of Veteran patients. To coordinate seamless care, all members of the core team will collaborate with other medical and support staff, including nonVA health care providers, to meet the needs of the Veteran patient. Expanded team members will be on site seeing patients episodically, while consultants may work remotely from the core team and provide consults as deemed necessary. The core team will manage these consultations in order to provide coordinated care and thus smooth transitions between the many facets of the health care system.

Coordination of Care and Care Management

Coordination of Care ensures that high risk transitions, or "hand-offs", are managed appropriately providing a continuous link with the core team even when the care is provided at a facility away from the location of primary care. Coordination of care is a responsibility of all team members involved in the care of the Veteran patient, and it occurs with full engagement of the Veteran patient. Two care integration roles, RN care manager and RN/SW case manager, serve to smooth hand-offs between all care settings including those involving VA and non-VA providers. Although care management functions reside within the core team, specialized services are provided on an episodic basis when the Veteran patient can benefit from additional expertise such as that of mental health providers, medical/surgical specialties, pharmacists, dieticians, chaplains, etc. The PCMH system insures that the burden of transferring information

between providers, including between VA and community providers, is not solely placed on the Veteran patient.

Evaluation

Effective evaluation and measurement is essential to PCMH implementation. There are currently 23 medical home demonstration projects that have either been completed, in progress, or are proposed across the US Healthcare industry. (1) During one such project by the Group Health Cooperative in Seattle, the practice saw a 29% decrease in emergency room visits, 11% decrease in hospitalizations, and 6% reduction in inpatient visits among a sample of 9,200 patients after one year of medical home implementation. (3) It is expected that PCMH implementation among the 5 million Veterans served by VHA would show substantial improvements to Veteran patient health and satisfaction along with cost savings in the aforementioned areas.

The anticipated outcomes expected to be associated with the medical home implementation include improved patient and staff satisfaction, improved health outcomes, reduced mortality, fewer preventable hospital admissions for patients with chronic diseases, reduced ER visits, and improved patient engagement and share decision-making with recommended care. Indicators will be developed as quantitative, longitudinal means of evaluating these outcomes including demographic changes, attitudes, and clinical and administrative quality improvements. A number of Demonstration Laboratories will be created to provide a platform for critical evaluation and innovation techniques.

Conclusion

While most VHA Primary Care practices have already adopted many of the features of patient centered care and the medical home, complete achievement will involve strategic assessment and redeployment of resources, realignment of priorities, and a major cultural change – an effort that will be truly transformative. It will help align VA with national health care reform initiatives and enable VHA to continue to provide leadership in health care delivery while assuring that our Veterans' health is managed with the utmost quality, safety and effectiveness. With the Patient Centered Medical Home Model, our Veteran patient population will have superb access to high quality primary care that affords them a healthier lifestyle.

References

1. American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). Joint principles of the patient-centered medical home. February 2007 [cited 4 Sept 2009]. Available from: http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf.
2. Carrier E, Gourevitch MN, Shah NR. Medical homes: challenges in translating theory into practice. Medical Care. 2009;47(7):714-722.
3. Reid RJ, et al. Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. Am J Managed Care. 2009;15(9):e71-87.
4. The patient centered medical home: history, seven core features, evidence and transformational change [monograph on the internet]. The Robert Graham Center. Nov

2007 [cited 4 Sept 2009]. Available from: http://www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2007/rgcmo-medical-home.Par.0001.File.tmp/rgcmo-medical-home.pdf
5. Hurtado MP, Swift EK, Corrigan J eds. Envisioning a national health care quality report (US). Institute of Medicine. Washington, DC. National Academy Press. 2001 [cited 4 Sep 2009]. Available from: http://www.nap.edu/catalog.php?record_id=10073#toc
6. The advanced medical home: a patient-centered, physician-guided model of health care [monograph on the Internet]. American College of Physicians. 22 Jan 2006 [cited 4 Sep 2009]. Available from: http://www.acponline.org/advocacy/events/state_of_healthcare/statehc06_5.pdf