



## Patient-Centered Medical Home Discussion Digital Healthcare Conference 2009

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The medical home: What is it? What isn't it?

**Patient-Centered Medical Home (PCMH) is an approach to deliver comprehensive care, coordinated by a PCP-led extended care team**

Personal Relationship with a  
PCP and Care Team

+

Proactive Focus on Health,  
Care Intervention and Chronic  
Disease Management

+

Technology, Services &  
Applications to Support the  
New Collaborative Care Model

### Principles of PCMH

Patient Centric/Personal PCP  
PCP-directed medical "team"  
Whole person orientation  
Care is coordinated and/or integrated  
Emphasis on quality and safety  
Enhanced access  
Appropriate reimbursement



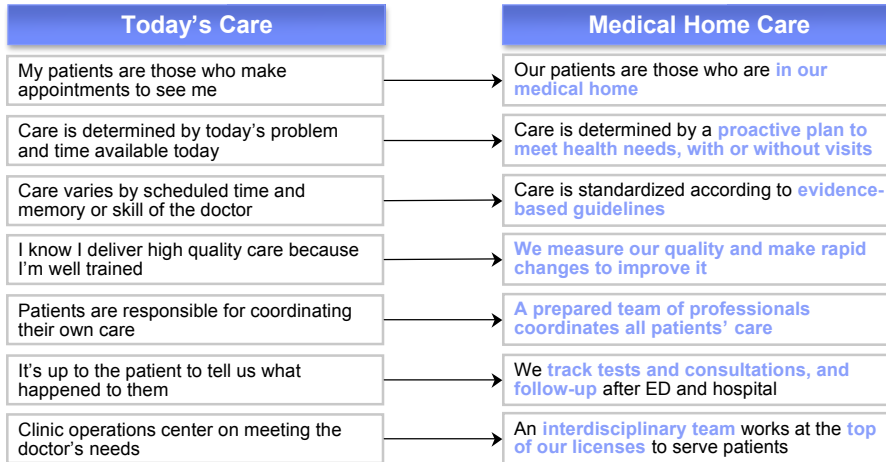
❖ *"The Patient-Centered Medical Home (PCMH) provides care that is "accessible, continuous, comprehensive and coordinated and delivered in the context of family and community."<sup>1</sup>*

Source: 1) [www.medicalhomeinfo.org/join%20statementpdf](http://www.medicalhomeinfo.org/join%20statementpdf)



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**The PCMH concept advocates enhanced access to comprehensive, coordinated, evidence-based, interdisciplinary care**



Source: Adapted with permission by IBM from Daniel F. Duffy, M.D.



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**While other approaches have addressed some PCMH Principles, none have addressed them all**

Factor/Principle	PCMH	Managed care	Pay for performance	Disease management	Chronic care model
<b>Purpose/focus</b>	Facilitate partnership between PCP and patient	Ideally: cost, quality; Actually: control utilization	Meet operational goals with financial incentives	Meet specific management targets for chronic disease	Org. framework for chronic care mgt and practice improvement
<b>Patient centric/ personal PCP</b>	Yes	No	No	Maybe, often led by actors independent of primary care	Yes, for chronic illness
<b>PCP-directed medical "team"</b>	Yes	No	No	No	Yes
<b>Whole person orientation</b>	Yes	No	No	No	Yes
<b>Care is coordinated and/or integrated</b>	Yes	No incentive for coordination	No incentive for coordination	Maybe	Yes
<b>Emphasis on quality and safety</b>	Yes, evidence-based and best practice; improved outcomes rewarded	No, reduced utilization rewarded	Indirectly; process targets rather than outcome ones	Yes, particularly for diseases	Yes, for chronic illnesses
<b>Enhanced access</b>	Yes	No, reduced access	No	Maybe	Yes, for chronic care patients
<b>Appropriate reimbursement</b>	Yes for PCPs, unclear for others	Potential conflict in motivation	No, still volume driven	Partially, if evidence-base used	Yes, for chronic illnesses

Alignment with PCMH Principle: ■ Aligned ■ Mixed alignment ■ Not aligned

Source: IBM Healthcare and Life Sciences, IBM Institute for Business Value

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**Nevertheless, the PCMH model needs additional support**

• **Better clinical content**

- Evidence-based or personalized health and care
- Tools to help with correct and complete diagnosis

• **Changes with and support from other stakeholders** since the PCMH model cannot be dropped into the current system for optimal results; examples include:

- Consumer responsibility
- Alignment, coordination or integration with care delivered by others outside the medical home
- Payment system reform
- Coverage decisions
- Changes in education and training for clinicians
- Policy reform

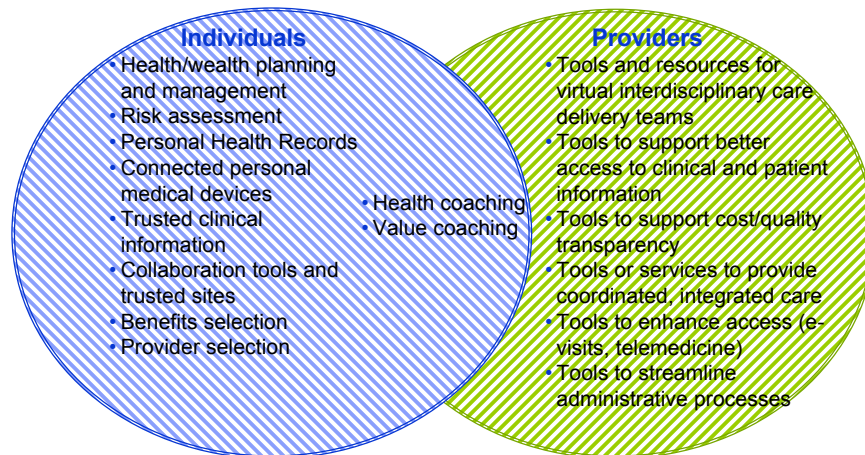
• **Infrastructure to support PCMH model (IT and other services) targeting the consumer/patient and the clinicians**

Source: IBM Healthcare and Life Sciences, IBM Institute for Business Value

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**For example, health insurers, CDOs or other entities could offer a variety of services or tools both to individuals and to providers**

**Examples of Tools and Services**



Source: IBM Healthcare and Life Sciences, IBM Institute for Business Value

## Discussion

- Is primary care transformation essential to healthcare reform?
- Is the PCMH the best way to transform primary care?
- Is the PCMH real, hype or just “over-hyped”?
- What impact could or should it have on specialty practices and hospitals?