Quality Health Care, PACE and The Medical Home Model

Over the past several years there has been increased pressure from many health care advocates to begin transitioning our national health care system to a patient centered medical home model. As the health care reform debate has continued, the concept of the medical home has been cited by many as an achievable goal, and the model of care to which our health care system should aspire. But just what is the medical home? Does it really provide higher quality care and better outcomes than existing models of care? And finally, does it currently exist?

Defining the Medical Home

To understand this concept and its potential for the future of health care in our nation, it’s important to first know what is meant by the term “medical home.” While specific definitions may vary, at the heart of the medical home is a commitment to coordinated, patient-centered care. According to the Robert Graham Center, the policy arm of the American Academy of Family Physicians, there are seven core features that define the medical home, as summarized below:

1. **Personal Physician** – Each patient has an ongoing relationship with a personal physician who provides first contact, continuous and comprehensive care;
2. **Physician-directed Medical Practice** – The personal physician leads a team of individuals who collectively take responsibility for the ongoing care of patients;
3. **Whole Person Orientation** – The personal physician is responsible for providing all the patients’ health care needs or taking responsibility for appropriately arranging care with other qualified professionals. Includes care for all life stages - acute, chronic, preventive, and end of life care;
4. **Care is Coordinated** – The health care system (hospitals, home health agencies, nursing homes) and the patient’s community (family, public/private community based services) are fully integrated;
5. **Quality and Safety** – Focus is on optimal patient-centered outcomes - evidence-based medicine guides decision-making, physicians are accountable, and patients actively participate in decision-making;
6. **Enhanced Access** – Physicians and staff facilitate greater access to care;
7. **Payment Reform** – New payment structures are recognized and include the following framework – reflect value of the physician/staff; pay for services associated with coordination of care; support adoption and use of health IT; recognize value of physician work with remote monitoring; allow for separate fee-for-service payments and more.

“The patient-centered medical home concept brings together the preventive and primary services that are the foundation of efficient, high quality health care. People who have a medical home receive whole-person care that is integrated and coordinated by a health care team.”

Ted Epperly, M.D., President of the American Academy of Family Physicians
Higher Quality Care = Better Outcomes

Those advocating for the medical home concept routinely point to higher quality of care and better health care outcomes as major benefits of the model. Although no wide-scale research has yet been conducted on medical homes, there are studies that demonstrate significantly improved outcomes. For example, a study (1) published in the July 2009 issue of Pediatrics, the Journal of the American Association of Pediatrics, found that among health care facilities employing practices associated with the medical home concept, those with higher scores in organizational capacity, care coordination and chronic condition management were associated with significantly fewer hospitalizations; and higher chronic condition management scores were associated with lower emergency department use.

PACE as a Medical Home

The concept of the medical home is nothing new to the more than 70 Programs of All Inclusive Care for the Elderly (PACE) now operating across the nation. In fact, the medical home is an integral part of the PACE model where primary care providers (PCPs) have a crucial, and predominant, role in the delivery of medical care. PACE staff PCPs are key members of the PACE interdisciplinary team and coordinate all of their patients’ medical care regardless of where it is delivered or by whom – including medical care provided by one or more medical specialists, and care provided to PACE participants in the hospital. PACE PCPs, who are knowledgeable about their patients’ multiple medical conditions and their health care goals and preferences, follow their patients over time and across settings. The PACE interdisciplinary team—the essence of the PACE program—integrates care provided by multiple, individual providers into a single, comprehensive, individualized care plan.

In contrast to the payment methods employed in traditional health care plans, PACE organizations receive monthly payments to provide all Medicare and Medicaid covered benefits as well as additional services necessary to maintain participants’ health and wellbeing. In this bundled payment approach, funds are pooled so that services are provided without regard to payer source. PACE payments are fixed and as a result, incentives are strong to eliminate duplicative or unnecessary services, prevent avoidable hospitalizations, and to develop community-based alternatives to institutional care. In fact, since becoming permanent Medicare providers in 1997, PACE programs around the country have a proven record of success using medical homes, bundled payments, and exemplary quality to achieve fewer hospital stays among participants, reduced re-hospitalizations and reduced need for nursing home care.

If you are interested in finding out about the PACE Model of Care or if there is a Program of All-inclusive Care for the Elderly (PACE) near you or a loved one, please visit www.PACE4You.org

(1) Improved Outcomes Associated With Medical Home Implementation in Pediatric Primary Care; W. Carl Cooley, MD et. al.; PEDIATRICS Vol. 124 No. 1 July 2009, pp. 358-364 (doi:10.1542/peds.2008-2600)