



Healthcare Transformation: Meeting Health Care Needs with the Patient Centered Medical Home

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Background

• Current State of Affairs: Nation

- The US, spends more per capita than any other nation, but ranks last among developed countries in health indices. Despite this investment in health care the problems of poor access to care, escalating costs, and erosion of primary care persist. Furthermore, health care is delivered in an episodic uncoordinated manner adding to the cost while fewer than 50% of patients with chronic disease receive the care they need.
- The explosion of chronic disease has further exacerbated the health care crisis. In 2000, 125 million Americans had at least 1 chronic condition, resulting in \$510 billion dollars in direct costs.

• Current State of Affairs: Pennsylvania

- Pennsylvania is confronted with the same issues facing the nation, except the percentage of people who are elderly or who suffer from chronic diseases is higher in Pennsylvania. In 2005, \$1.7 billion in potentially avoidable hospital charges were attributable to suboptimal management of chronic disease. In 2007 the Governor's Chronic Care Management, Reimbursement and Cost Reduction Commission was established and developed a strategic plan for implementation of the Chronic Care Model in Pennsylvania. This initiative is based on the principles of Wagner's Chronic Care Model (CCM) and elements of the Patient Centered Medical Home (PCMH). Demonstration projects have shown that patients cared for in these models are healthier, the providers are more satisfied, and the cost of health care is lowered.

Health Care Delivery	
The Present- Health Care Delivery Today	The Future- The PCMH Model
My patients are the ones I have appointments to see	Our patients are those that are registered in the medical home
Care is based on the presenting problem at the time of the visit	Care is proactive and does not always include a visit to the office
I know I am delivering quality care because I have been well trained	Care is evidenced-based
Patients coordinate their own care	Quality is measured and reported regularly
It is the patient's responsibility to tell me what has happened to them	Tests and consultations are tracked so the team remains informed about the patient
Clinic operates to meet the doctor's needs	A team of health care professionals work together to deliver comprehensive and continuous care

Redesign of Health Care

- Redesign of the health care system is needed to effectively manage chronic diseases, providing care that is coordinated and continuous. Patients want more from the health system and from their physician. Purchasers (individuals, employers, government) are looking for quality and value. The strengthening of primary care is essential to this redesign.
- The Patient Centered Medical Home holds promise as a model of care that can meet the needs of the population, address access, improve quality, enhance patient and provider satisfaction, as well as contain costs.

Joint Principles of the PCMH:

- Personal physician
- Physician lead medical team
- Whole person orientation (comprehensive care for all stages of life, include acute, chronic, preventive and end of life care)
- Care is coordinated and integrated (hospital to home, supported by technology- electronic health records, registries, and is culturally appropriate)
- Quantity and safety (Patient centered, EBM, performance improvement, IT to enhance care and communication-email, websites)
- Enhanced access (open scheduling, expanded hours and new options for communication such as email)
- Payment to support the PCMH (coordination of care, IT system)

