

Family Medicine Updates



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ACHIEVING A PATIENT-CENTERED MEDICAL HOME AS DETERMINED BY THE NCQA—AT WHAT COST, AND TO WHAT PURPOSE?

In 2007, multiple primary care organizations (American College of Physicians [ACP], American Academy of Family Physicians [AAFP], American Academy of Pediatrics [AAP], and American Osteopathic Association [AOA]) agreed upon the basic elements of a patient-centered medical home (PCMH). In an effort to promote the adoption of these elements, the National Center for Quality Assurance (NCQA) has, in consultation with the same primary care organizations, established a set of standards for achieving a PCMH, divided into 3 levels of achievement, organized along 9 areas, and comprising 30 discrete elements, 10 of which are mandatory “must passes.” Level I recognition requires meeting 5 of these must pass elements; level II or III recognition requires the applicant meet all 10 of the must pass elements and corresponding prescribed point levels.

It occurred to us that it might be useful to contemplate these standards in light of what the Institute for Healthcare Improvement is now calling the “triple aim” for improving care—managing (reducing) overall costs, ensuring a great patient experience of care, and achieving both process and outcome measures of care quality. The recent national demonstration project of the American Academy of Family Physicians—TransforMED—has shed light on both the apparent obstacles to achieving these goals and standards, as well as the kinds of resources that will be needed to overcome

the barriers. We offer, as a stimulus to discussion and perhaps as a guide to empirical investigation, the following matrix in which we portray the NCQA elements along one side and the several kinds of benefits and costs along the other side. Based on our experience as practitioners and investigators, and with some support from existing literature, we suggest that there may be real differences in the relative intensity of both benefits and costs for each of the 30 NCQA elements, and indicate that by showing 1, 2, or 3 pluses in a cell to signify the relative intensities of costs and benefits:

We have chosen to simply add the numbers of pluses in the 3 benefits columns and divide them by the sum of the pluses in the costs columns to derive a crude estimate of the benefit/cost ratio for each of the NCQA elements. There are obvious shortcomings to this—different constituencies would necessarily assign different utilities to each of the elements portrayed across the top, and we have not shown the reader a systematic review that would support our personal assignment of values to each cell. Think of the table below as more of an illustration or example to communicate a way of thinking about this issue. Nonetheless, it is intriguing that our personal assessment of benefit vs cost ratio bears little relationship to the points that the current NCQA rubric assigns to each of the elements of a PCMH.

In creating this table, we imagined “starting from scratch,” and we recognize that the costs, in particular, might be different for some established practices, and would certainly be different for a practice to maintain the elements. We are also cognizant that both the NCQA elements and the table do not explicitly attend to a key finding of the TransforMED project: it’s all about relationships: doctor-patient, doctor-nurse-staff, and practice-community. Practices that are mindful of all of these relationships and that are relatively good at

NCQA PCMH Standard	NCQA Pts	Benefits			Costs			Benefit/ Cost
		Reduce Cost	Care Experience	Quality	Leadership	Team Resources	Capital	
1. Access and communication	9	++	+++	+++	++	++	+	1.6
2. Patient tracking	21	++	++	+++	+++	++	+++	0.87
3. Care management	20	++	+++	+++	+++	+++	+++	0.89
4. Patient self-mgmt support	6	++	+++	+++	+	++	+	2.00
5. Electronic prescribing	8	++	++	+++	+	+	++	1.75
6. Test tracking	13	+	+	++	+	+	++	1.0
7. Referral tracking	4	+	+	++	+	+	++	1.0
8. Performance improvement	15	+	+++	+++	+++	+++	+	1.0
9. Advanced electronic comm	4	+	++	++	+	+	++	1.25

keeping them healthy are more likely to achieve and sustain the technical elements portrayed in the first column. Perhaps the columns that portray the need for leadership and for team investment are a reasonable proxy. In any case, the point of the exercise is to suggest that it may be worth thinking about what kinds of benefits accrue when one adopts each of the standards, what kinds of resources (people, time, and money) are necessary to establish the standards, and how the relative value assigned to each resource expense or benefit would depend upon what constituency is making that judgment. It also suggests that empirical research that takes into account all of these costs, benefits, and stakeholder perspectives would be more helpful than that which only examines a portion of the costs or a portion of the benefits for a single constituency.

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AMA DELEGATES ADOPT AAFP'S JOINT PRINCIPLES OF PATIENT-CENTERED MEDICAL HOME

After several years of effort, the AAFP and other primary care specialty groups scored a huge win at the 2008 interim meeting of the AMA House of Delegates when the delegates agreed to support the Academy's vision of the patient-centered medical home, or PCMH.

During the meeting, AMA delegates adopted, intact, the "Joint Principles of the Patient-Centered Medical Home," a document that was developed by the AAFP, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association.

The 7 joint principles describe characteristics of the PCMH, including the following:

- Coordination of care to enhance the patient-physician relationship
- A focus on quality and safety
- Enhanced access to care
- A payment structure that recognizes the value of and pays physicians appropriately for coordinated services and care management

According to AAFP President Ted Epperly, MD, of Boise, Idaho, the adoption of the principles is "his-

toric" for the Academy because it "brings on board the AMA's support of the joint principles as a health care delivery system that's rooted deeply in primary care for the people of America."

During testimony at a reference committee hearing, Epperly said that the principles exemplify "comprehensive patient-centered health care with deep trusting relationships with a patient's personal physician and his or her practice in which care is integrated, coordinated and focused on the whole person."

"Multiple state, national and international studies have demonstrated that this care will increase the value of health care by increasing quality and lowering cost," Epperly noted.

Dale Moquist, MD, of Houston, Texas, chair of the Academy's delegation to the AMA, said that the delegates' action indicates "where the house of medicine is going to be" on this issue. "When we're testifying about health system reform and the benefits of the PCMH, the AMA can be right beside us," he said.

In all, the delegates acted on several resolutions related to the medical home. One amendment the delegates added was referred to the Board of Trustees for further study. That amendment calls on the AMA, working with all interested specialty societies, to continue to study the PCMH concept, with particular emphasis on ensuring the following:

- The value-added services of the medical home are fully funded by financing mechanisms outside the Medicare Part B physician payment pool, including from private insurance, Medicare Parts A and D, and Medicaid
- Patient access to necessary quality specialty care without a gatekeeper is preserved
- Patients can select any qualified physician practice as their medical home
- The house of medicine is unified on this issue

Primary Care Training

The AMA House of Delegates also voted to support several measures designed to encourage physicians and physicians-in-training to choose careers in primary care. The measures included calls to enhance payment for primary care physician services and decrease debt loads.

The AMA agreed to advocate creation of various programs to encourage physicians to practice in underserved areas, including the permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program.

"We feel we won a trifecta," said Moquist. "We got the adoption of the patient-centered medical home. We got the adoption of the (AMA Council on Medical Education report recommendations on) primary care as a medical career choice. And we got the actions to