

The Patient-Centered Medical Home Care Model: Implications for Physician Assistant Education

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More is spent per capita on health care in the United States than in any other country; health care spending accounts for close to 16% of our country's gross domestic product. Despite this high rate of spending, there are still significant gaps in access to health care and in the quality of health care in the United States. Moreover, health care costs continue to grow faster than our economy, which adversely affects businesses, the government, and individuals who pay for this care. The health care delivery system in the United States frequently does not meet the needs of those with common chronic illnesses. There are also significant concerns about the primary care workforce, which is decreasing relative to projected need, as the population ages and there are more people with chronic disease.

Several physician professional organizations — including the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, and the American Osteopathic Association — have come together to advocate for a model for primary and principal care called the patient-centered medical home (PCMH). In this model, patients who chose to do so would receive their care from a medical practice that serves as their medical home. This practice would encompass an interdisciplinary health care team designed to meet the needs of the population of patients that

receives care from that practice. Care received outside of the practice would be coordinated by and integrated back into the medical home. The medical home would have systems to support patient-centered care, such as patient registries, evidence-based clinical decision support, open scheduling, secure e-mail access for patients, and ultimately an electronic health record that is interoperable with other sites and providers where the patient receives care. The medical home would be capable of and committed to measuring, reporting, and, where possible, improving quality outcomes.

The PCMH would be supported by a new reimbursement model. It would include the traditional fee-for-service payment for health professional visits within the medical home and for health care professionals seen by the patient outside of the medical home. In addition, the medical home would receive a risk-adjusted monthly care coordination fee for each patient. This fee would support the care given by the team within the medical home practice between patient visits and the systems and technology required to support the medical home. A third payment component would be based on quality outcomes for patients cared for in the medical home.

The Centers for Medicare and Medicaid Services has been directed by legislation to begin a PCMH demonstration project by 2009 at the latest. In the meantime, several

employers and payers are working with the four physician organizations involved, to develop demonstration projects for employees enrolled in their health plans. Some of these were scheduled to get under way before the end of 2007. These will have a health services research component to assess cost and potential savings. It is hoped that care in a PCMH will more consistently control chronic diseases and deliver preventive services. As a result, complications of chronic diseases could be reduced, thus reducing the costs required to treat them.

The PCMH model, if widely implemented, would have many implications for the education of the health professionals being trained to work in such a model. This training would need to include practice in outpatient settings, using information systems, and carrying out quality improvement. Physicians and physician assistants (PAs) practicing in a PCMH would need to be able to measure their performance and use that information for performance improvement. They would need to develop the skills to work in interdisciplinary ambulatory teams, to effectively communicate with those providing care to their patients outside of the medical home, and to coordinate and integrate that care into the medical home.

Thus, just as the care model, especially for chronic disease, needs to be reconfigured into the PCMH, the education model would need to

be reconfigured. Ideally it would promote teamwork and models with shared responsibility and accountability among the professionals on the team.

In training physicians, PAs, and other professionals for the PCMH, more training will need to be devoted to systems-based care, practice-based learning, professionalism, and communication and interpersonal skills. These are the domains of competency that are less likely to be addressed thoroughly in most of our current educational programs. The Competencies for the Physician Assistant Profession explicitly define several of the competencies that will be necessary to practice in a patient-centered medical home.

These include:

- Work effectively with the physician and other health care professionals as a member or leader of a health care team
- Work effectively with physicians and other health care professionals to provide patient-centered care
- Demonstrate professional relationships with physician supervisors and other health care providers
- Demonstrate accountability to patient, society, and the profession
- Analyze practice experience and perform practice-based improvement activities

- Obtain and apply information about their own population of patients
- Apply information technology to manage information, access online medical information, and support self-learning
- Use information technology to support patient care decisions and patient education
- Effectively interact with different types of medical practice and delivery systems
- Partner with supervising physicians, health care managers, and other health care providers to assess, coordinate, and improve the delivery of health care and patient outcomes
- Accept responsibility for promoting a safe environment for patient care and recognizing and correcting systems-based factors that negatively impact patient care
- Apply medical information and clinical data systems to provide more effective, efficient patient care

Institutions that have education and training for multiple health care disciplines could develop, implement, and assess models of interdisciplinary training that would be based on these competencies and would prepare their students and trainees for practice in a PCMH. All of us who edu-

cate health care professionals should work to ensure that students and trainees have access to ambulatory training sites that are multidisciplinary and incorporate information technology, performance measures, and other systems components that facilitate the provision of patient-centered care. Participating in such training is likely to provide good skills no matter what career our students pursue, and even more important, will potentially increase the numbers of practitioners in all of our professions who are willing to enter a career in primary care.

The patient-centered medical home is a care delivery model that may reduce costs and disparities and improve quality in health care, especially for our aging population with an increasing burden of chronic disease. The potential introduction of this care delivery model gives us an opportunity to reflect on the best possible way to train the health professionals for whom we are responsible and to incorporate innovations to improve their training. Whether or not the PCMH model is widely adopted, incorporating into our educational programs the competencies necessary to practice in a PCMH is likely to improve training overall and increase the proportion of health professionals entering careers in primary care. Our overall goal must continue to be to improve our educational programs to train better prepared, more satisfied health professionals who have the knowledge and skills to provide the best possible care to patients.