PCMH-N: Implications for Allergists

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Recent years have seen physicians assaulted with a whole new alphabet soup of plans for reorganizing medical care in the U.S. and new organizations popping up promoting this or that scheme overnight, like mushrooms. PCMH (Patient-Centered Medical Home), ACO (Accountable Care Organizations), PCPCC (Patient Centered Primary Care Collaborative), etc.

So what is this about, why is it happening and, most important of all, what does it mean for us and our practice of allergy?

It all starts with the ever rising, unsustainable increasing costs of health care in the United States which have co-existed with poor health quality outcomes and inadequate access to care for its citizens. Thus, by many measures, we are failing at three fundamental goals of any health care system: to provide high-quality health care to all our citizens at an affordable cost.

Numerous studies to diagnose the causes of these problems indicate that the system has a serious problem of lack of coordination between the various components, compounded by a shortage of primary care physicians who can act as first line provides and coordinators of care. All too often, this does not happen now because of a lack of proper infrastructure and incentives, financial and otherwise, for primary care physicians.

Four primary care organizations met in 2007 to address this issue (American Academy of Pediatrics, American College of Physicians, American Academy of Family Practice, American Osteopathic Association). They determined that patients needed a "medical home" where they could get most of the regular care they needed, a place where they could reliably count on getting the help they needed and where all their care could be coordinated so that care would not be fragmented, as it so often is now. They defined the Patient Centered Medical Home as:

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

Specifically, they enunciated seven principles:

1. Each person has an ongoing relationship with a personal PCP.
2. The physician leads a team which is collectively responsible for care.
3. The physician is responsible for caring for the whole person at all stages of life and for providing preventive services.

4. Care is integrated across entire health system, facilitated by information technology. Information is exchanged with patients and their families in culturally and linguistically appropriate manner.
5. A premium is set on quality and safety, based on evidence, with accountability for continuous quality improvement through performance measurement. Care planning is done collaboratively with the patient, family, and other relevant parties. All this is supported by information technology, which also supports patient education and improved communication.
6. There is enhanced access to care using open scheduling, expanded hours, and new communications options.
7. Payment recognizes the added value of the PCMH. For example, payment is based on: value of non-face time work, pay for care within practice and between consultants, community resources, and ancillary providers. Payment supports: adoption of IT for quality improvement; enhanced patient communication via email and phone consultation; recognizes value of work associated with remote monitoring of clinical data; recognizes case mix differences in the population being served; allows shared savings for reduced hospitalizations; provides for added pay for measured and continued quality improvement.

A number of payment models have been proposed but the most widely used is one which has three components: a visit based fee for service, a monthly per patient care coordination fee to cover the cost of services not provided by the fee for service charge and to cover the additional cost of infrastructure and, finally, a performance based payment. It is hoped, but not yet proven, that the additional costs of starting and running a PCMH would be covered by savings from better, more coordinated care and the use of electronic records.

For allergists, as specialists, the glaring question is where do we fit into this scheme? How does a specialist relate to such a primary care-driven model of care? Doesn't this sound like just another gatekeeper model? If we want in, how do we get in? Is staying out viable?

The issue of the place of the specialist in the PCMH model was addressed in 2007 when the ACP Council of Specialty Societies formed a work group to define the relationship between the PCMH and the PCMH-Neighbor. Dr. Richard Honsiger has been one of the co-chairs of the group and Dr. Daniel Ein is a member of the group.

The workgroup has published a position paper, which outlines several possible interactions between the PCMH and the PCMH-N and sets out principles behind care coordination agreements (aspirational, not legally binding) that guide those interactions. In parallel with the PCMH model itself, it acknowledges that incentives will be required to encourage meaningful participation; and introduces the issue of a recognition process for the PCMH-N.

The paper outlines four different types of interactions between the PCMH and its neighbors:

1. Pre-consultation exchange clarifying the need for a consultation and prioritizing the care;
2. The formal consultation;
3. Co-management (with various degrees of shared responsibility); and
4. Complete transfer of care to the PCMH-Neighbor.

The underlying requisites of the interactions are for communication and coordination in order to avoid the errors and costs of our current fragmented system of care. These interactions should be governed by care coordination agreements that set out the relative responsibilities of the PCMH and the PCMH-N and address issues including co-management protocols, content and frequency of information exchange, in-patient processes, handling of secondary referrals, self-referrals of patients to the PCMH-N and management of emergencies if the PCMH cannot be contacted.

There are a number of incentives for a specialty practice to participate in the Neighbor program. The specialist might expect a higher volume of referrals from the PCMH and those referrals are likely to be of higher quality because of coordination and shared information.

Financial incentives would also have to be built into the model. One proposed such compensation model parallels that proposed for the PCMH. There would be a fee-for-service component, a monthly base payment to cover the cost of infrastructure requirements of the PCMH-N and a performance, quality-based payment. Other financial incentives could include a gain-sharing provision. Various payment proposals for PCMHs are being studied in pilot projects around the country.

Certification of a practice as a PCMH-N would require a formal recognition process by an independent agency. This already exists for the PCMH through the NCQA (other organizations are also proposing recognition processes of their own). A similar program for PCMH-N is under study by the NCQA.

Allergists, like other specialists, could elect not to participate in any PCMH-N program. They could also reconfigure their practices to qualify as a PCMH-N and seek the official validation that comes with completing the recognition process noted above. Finally, they could serve as a PCMH itself, providing principle care to some or all of their patients. In fact, many allergists do provide some general medical care to some part of their practice, often on an ad hoc basis. Whether or not they would choose to re-tool their practices to qualify as a PCMH, with all the requirements and costs involved, is questionable. Informal polling of colleagues, suggests that most allergists would not seek such a role because they became specialists, in part, in order not to practice general medicine.

Our three national allergy organizations (AAAAI, ACAAI and JCAAI) have examined the issue of endorsing the PCMH concept. A number of reservations have been expressed about the concept, such as: it is another gatekeeper model, it is too bureaucratic, cumbersome and expensive to form, it will decrease referrals to allergists. Despite these

concerns, the organizations have agreed that the concept merits further study and they support that ongoing effort.

It is hoped that the merits and pitfalls of this important new model for organizing medical care in the United States will emerge from the numerous pilot projects that are ongoing across the nation. Stayed tuned for periodic updates.

We wish to thank Dr. Lawrence S Weisberg for allowing us to refer to his paper, **"The Patient-Centered Medical Home and the Nephrologist"** *and to the CSS Workgroup for all their hard work and excellent ideas in defining the PCMH-N model.*