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Review

Expanding the primary care patient-centered medical home through new roles for registered nurses

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ABSTRACT

New models of health care delivery such as the patient-centered medical home have emerged to address the Triple Aim of improving the health and the care of patients with the benefit of reducing the cost of quality primary care. The Donabedian approach of addressing structure and process to produce quality outcomes is used to introduce an innovative model of the patient-centered medical home that includes nurses as part of the interdisciplinary team of care providers. New nursing roles and processes are described that optimally utilize electronic health record technology to improve care coordination and care delivery. Economic outcomes have been realized in the form of incentives to a primary care practice and reimbursement for quality, cost-effective care. Recognition of outstanding quality care in this new model demonstrates how an effective care system is evolving to meet the changing health care needs of the population.

The concept of the patient-centered medical home (PCMH) has been promoted by the Institute of Medicine (IOM)[1] as a model of health care delivery to address the issues of providing care that is safe, effective, timely, efficient and equitable. Patient-centeredness is also a key concept of the Triple Aim, with goals to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care.[2] In recent years, the PCMH has been highlighted as a means of achieving the Triple Aim as it has shown promise in reducing the cost burden of care from the "chronically costly," the costliest 1% of patients that consume 1/5 of all health care spending in the U.S.[3] Through the PCMH and pursuit of the Triple Aim, a care delivery system is developing that focuses on the patient and providing appropriate care at the right place, the right time, and from the right provider. Ultimately, the needs of those with chronic disease can be addressed while the health of all patients in the primary care setting is promoted.

To achieve this, a paradigm shift from provider-centered care to patient-centered care delivery is required. A comprehensive approach to address structure, process and outcomes of care delivery can help guide this process. The Donabedian Model[4] is a framework to address the complexities of this paradigm shift. To address this shift in health care delivery, the following will need to be considered:

- Structure—how well do we use the tools, setting, and providers to deliver care?
- Process—what are the health delivery processes that produce the best care and outcomes?
- Patient outcomes—ultimately how does structure and process affect the patient and society to improve health?

Despite the development of the PCMH approach to address current health care issues and incentives to promote sustainability of the PCMH, there is not a standardized method for operationalizing these concepts. Innovative structural elements such as new roles for qualified staff and optimal use of electronic health records (EHRs) are needed to implement new care processes in the primary care setting, to ultimately realize improved quality care outcomes.

Purpose

The purpose of this article to describe an innovative approach to deliver primary care: the Interdisciplinary Patient-Centered Medical Home Model. This model includes adding qualified personnel such as registered nurses at the point of care delivery in the primary

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care setting, as a means of delivering the quality care processes needed in the evolving concept of the PCMH. Traditionally, the staff in primary care settings consists of physicians, advanced practice nurses, physician assistants, medical assistants and other clerical staff to provide care. In this innovative model, nurses assume various new roles and care processes are designed to coordinate and deliver care. This model provides a twofold opportunity for the nursing workforce to (1) provide cost effective care in primary care, and (2) to realize nurses practicing to the full extent of their education as advocated by the Institute of Medicine in the *Future of Nursing*.[5]

In addition to adding nurses as team members, other aspects of the Interdisciplinary PCMH Model include using information technology and improved processes to deliver timely, coordinated care to impact the health of all patients in a primary care practice. The use of the electronic health record will be explored as a tool to document and coordinate patient care, including population health, to enhance care delivery in the primary care setting.

Through the use of this model, economic outcomes, in the form of incentives to the practice and reimbursement for quality, cost-effective care have been realized and demonstrate how an effective care system is evolving to meet the changing health care needs of the population. As payment systems change from fee-for-service to value-based reimbursement in the ambulatory care setting, an interdisciplinary team that includes nurses and effective care processes will be needed to capture incentives and new codes for care coordination.[6]

Current model of health care delivery

Our current care delivery system focuses on disease management rather than prevention. In addition, each care institution is a silo of care. Episodic care occurs within these silos with little communication between systems during care transitions. This leads to costly care that is provider-centered rather than patient-centered (see Fig. 1).

A patient may access these silos at a given time, depending on the specialty services of providers in that institution. The payment structure for care delivered is particular to the care setting. Each care episode is directed by physician orders that flow through various health care professionals, laboratories, radiology and other services. Each care institution maintains its own medical record, which has limited ability to interface with other institutions. Consequently, the current health system has many opportunities for breakdown, leading to the issues of compromised safety and quality, lack of coordination, excessive spending, limited access and equity in care delivery.[2,7,8] Ultimately, this results in costly care where the patient's needs and satisfaction are not adequately addressed.

The patient centered medical home

The patient-centered medical home concept is evolving as a strategy to address the complexities of today's health care delivery. The National Committee for Quality Assurance (NCQA) formally recognizes primary care practices as PCMHs for meeting objective quality criteria.[9] The NCQA describes the patient-centered medical home as a model of care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.” (p.2).[10] Only practices that have successfully utilized systemic processes and information technology (IT) in ways that enhance patient care quality are given this recognition, making the PCMH a prestigious designation.

Designation as a PCMH is associated with cost savings. A national study compared cost and utilization outcomes for beneficiaries of Medicare fee-for-service receiving care in practices recognized by the NCQA as PCMHs and outcomes for those receiving care in practices lacking this recognition.[11] The study

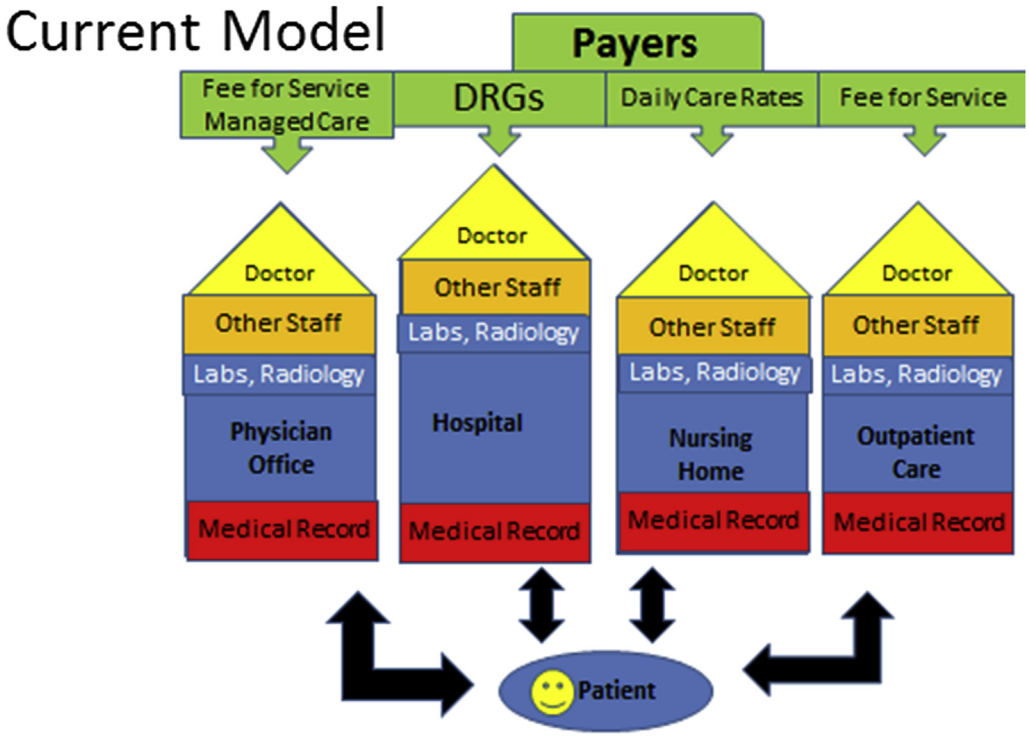

Fig. 1. Current model.