

Organizing Care for Complex Patients in the Patient-Centered Medical Home

by Eugene Rich, MD, FACP

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The patient-centered medical home (PCMH) is a model for reorganizing existing primary care practices to provide patient-centered, comprehensive, coordinated, and accessible care. Most PCMH initiatives thus far have focused on improving access to and coordination of traditional medical services. Patients with more complex health care needs require not just better coordination of medical services but also a wide range of social supports to maintain health and functioning. Frail elderly and working-age adults with disabilities have especially complex health and social support needs.

Our team recently published an article and a report supported by Agency for Healthcare Research & Quality on policies and strategies to help typical, smaller primary care practices transform into effective medical homes that appropriately serve patients with complex needs. It draws on the experience of 5 programs around the country that illustrate promising approaches for supporting and collaborating with smaller, independent primary care practices serving these challenging patients. All the programs allow patients with complex needs to maintain existing relationships with their primary care clinicians while giving small practices additional resources to help them overcome barriers to providing excellent care to these patients. The summary in the *Annals of Family Medicine* can be found at <http://www.annfammed.org/content/10/1/60.full>. The detailed analysis can be found in the full white paper at <http://www.pcmh.ahrq.gov>

While patients with complex health care needs represent the greatest challenge to transforming small primary care practices, they also present a great opportunity for medical homes to improve outcomes and care experiences dramatically. We found that to achieve these aims, small practices will require enhanced support and resources—beyond those needed to meet current medical home standards. The most crucial supports appear to be additional practice reimbursement for time spent coordinating care and integration of care coordinators with primary care teams.

A variety of important questions remains to be answered, however. For example, how best to restructure primary care payment to compensate practices for the extra time and resources needed to care for patients with complex health care needs? Are there ways to harmonize practice payment with funding for community resource organizations to promote team-based care? What outcomes should be measured for patients with complex care needs to evaluate efforts to enhance care? Further studies are needed to clarify which models are most effective for practices of varying sizes and patient mixes, as well as those that operate in diverse communities.

Note: For this month's column, colleagues at Creighton posed some questions on this topic that Dr. Rich responds to.

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Question 1: The General Framework of Populations, Services and Outcomes emphasizes the source of disablement as in the person. The International Classification of Functioning, Disability and Health (ICF: <http://www.who.int/classifications/icf/en/>) also includes a list of environmental factors postulated to affect functioning and disability. Please comment on the elements of your model in the context of the ICF.

Dr. Rich's Answer: As this questioner observes, there are a variety of definitions of disability, and various factors determine the degree of functional impairment experienced by any individual with some limitation in capacity. In estimating the burden of disability among adults in the US, our white paper uses data from the American Community Survey which defines disability as "a serious difficulty in one of six capacities: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone."

We also note in our white paper that to accurately understand the resources required to optimize health and functioning of patients with limitation in one of these capacities, a comprehensive needs assessment is required that goes far beyond the issues addressed in a traditional office-based medical assessment. This assessment should note how individuals function in their daily lives and with their family and other social supports. For many complex needs patients, these comprehensive assessments must include direct assessment of the home environment, which can determine the feasibility of care plans and identify adaptations necessary to assist with daily living activities.

Question 2: Government programs addressing disablement are fragmented. For example, resources for medical issues are located in the Medicare and Medicaid programs. Resources for social issues e.g., transportation, employment and education for persons with disabilities are in other federal departments and agencies. Please comment on your perspective about how the organization and integration of services for persons with disabilities is subsequently affected.

Dr. Rich's Answer: In our white paper we note this problem among the challenges that undermine the ability of traditional primary care practices to provide comprehensive and coordinated care to patients with complex health care needs. These patients typically require not only a broad range of medical services provided by diverse clinicians and health care institutions but various social supports as well to overcome functional limitations and maintain independence. These social supports include home and community-based services (HCBS) like personal assistants, home modifications, home care aides, physical therapy, assistive technology, and respite programs supporting in-home family caregivers. Other services can facilitate the patient's social participation in the community, such as accessible transportation and adult day care.

In most communities and practice settings, health and social service systems have separate and distinct financing streams, delivery systems, eligibility rules, and terminology. These divisions further complicate the ability of primary care clinicians to manage the full range of services of benefit to patients with complex care needs. Depending on their income and level of disability, complex needs patients may or may not be eligible for Medicaid and other programs for the aged and disabled which can provide services not covered by Medicare or traditional private insurance. A variety of community-based organizations, such as Area Agencies on Aging (AAAs) and community mental health programs, may provide access to needed resources for some patients with complex needs. Depending on the covered benefits and reimbursement policies of differing State Medicaid programs, other services may be available to some patients. The fact that these support services are "siloes" by payer and agency substantially increases the administrative burden on the primary care clinician who is trying to arrange for needed services. This administrative complexity increases not only the challenge of providing comprehensive and coordinated primary care but also the potential benefits; without robust care coordination, there is great risk of diffused professional responsibility and fragmented care that does not meet patient needs.



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