AMERICAN COLLEGE OF RHEUMATOLOGY
POSITION STATEMENT

SUBJECT: The Patient Centered Medical Home Concept

PRESENTED BY: Committee on Rheumatologic Care

FOR DISTRIBUTION TO: Members of the American College of Rheumatology
Medical Societies
Medicare Carriers/Private Insurers
Members of Congress

BACKGROUND:

The patient centered medical home has been proposed as a potential solution to control costs and improve quality in healthcare. PCMH is comprised of six principles: 1) that each patient have an individual doctor or medical home where the care is physician directed; 2) that care reflects a “whole person orientation;” 3) that care is coordinated and integrated across all elements of the complex health system; 4) that quality and safety are hallmarks, and that EHR, evidence based medicine and quality measurement and improvement programs are utilized to ensure quality; 5) that enhanced access to care is provided through open scheduling and expanded hours; and 6) that payment adequately supports the infrastructure, time and staffing needed.

The ACR realizes this is a laudable goal, but concerns exist as to whether expected gains can be achieved. Chronic care currently consumes approximately 70% of the health care dollar. In chronic musculoskeletal conditions, a rheumatology led integrated multidisciplinary team may have better outcomes at lower cost.

The ACR has multiple concerns about this health care model including:

- Will the rheumatologist lose autonomy in providing proper subspecialty care for patients with rheumatoid arthritis and other rheumatologic disorders?
- Will there be any financial disincentives for primary care providers to refer to rheumatologists?
- Will other specialists such as orthopedists be permitted to refer to rheumatologists, and vice versa?
- With the ever expanding knowledge base of medicine, can every primary care physician have a good enough grasp on all aspects of medicine to know when to refer and to whom?
- How will the increased administrative workload of the PCMH affect the primary provider’s time to see patients?
- How has the program been tested? Pilot testing thus far has not been able to demonstrate workable PCMH in small or medium sized practices, the practice size that provides the vast majority of primary healthcare in the US today.
- How will the program be financed? Many of the considered finance models would pay for PCMH implementation by taking money away from specialists. Such models would have catastrophic consequences for non-procedural specialties such as rheumatology, as these specialties are already suffering from the same inequitable reimbursement issues that threaten primary care.

What rheumatologists do know is that early treatment of rheumatoid arthritis has been found to be essential in controlling disease and preventing further damage. If treatment is delayed even for a few months patient quality of life and health outcomes are adversely affected. It is difficult to embrace any

program that does not reduce inefficiencies and not improve care. The extensive documentation and requirements may slow work flow and increase frustrations.

It is important that this concept be fully tested in pilot programs before implementation. The requirements of the PCMH will need adequate funding for EHR, nurse coordinators and management teams. It is essential that this be adequately funded to be achievable.

It is also unacceptable to reimbursement payments to other specialists, especially nonprocedural specialists, to fund this program. The AMA has a policy that supports the concept of PCMH but that extra reimbursement provided to primary care physicians should not be at the expense of specialists. Nonprocedural specialists are already in short supply and reducing reimbursement will worsen shortages. ”Enhanced access to care is provided through open scheduling and expanded hours” will not be possible if reduced payments lead to fewer rheumatologists.

Position:

The ACR does not endorse the PCMH model at this time because of the numerous unanswered questions that will likely affect the quality of patient care, and because of the inadequately tested and as yet unproven administrative assumptions that may increase inefficiencies in health care delivery. Access to rheumatologic care may be strongly negatively impacted by this model.

Approved by the Committee on Rheumatologic Care: 01/2010
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