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Medical Home NEWS

Medical Home Demo For FQHCs Really Didn't Move Needle On Care

In order to create a medical home that creates an impact, how much money is enough?

By Ron Shinkman

Federally Qualified Health Centers (FQHCs) that converted to patient-centered medical homes under a recent Medicaid demonstration project showed some small improvements in care delivery, but were unable to quantify whether the overall cost of care was reduced significantly, if at all.

That's the conclusion of new research from the California-based RAND Corp., which examined the results from the FQHC Advanced Primary Care Practice Demonstration. It ran from 2011 to 2014 and helped convert more than 500 of the safety net clinics, which receive supplemental federal funds, into medical homes.

Altogether, the FQHCs received an additional $6 per Medicare patient per month for creating a NCQA Level 3 medical home, according to Katherine Kahn, M.D., an adjunct physician policy researcher at RAND and co-author of the study, which will be published this month in the *New England Journal of Medicine.*

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In This Issue

Can Hypertension Be Better Managed Through The Medical Home?

What are the key factors involved?

By Alison J. O'Donnell, D.O., Hillary R. Bogner, M.D. et al.

Hypertension is a modifiable risk factor for cardiovascular and kidney disease, yet the proportion of adults whose hypertension is controlled is approximately 44%. Leading primary care organizations introduced the patient-centered medical home (PCMH) to address high costs and poor health outcomes, particularly those related to chronic medical conditions such as hypertension. The objective of the PCMH model of care is to have a centralized setting that facilitates partnerships between patients and their personal physicians and, when appropriate, the patient's family.

Several studies demonstrated associations between use of the PCMH model and improvements in the proportion of patients achieving hypertension control. Findings from qualitative studies described electronic health records (EHRs), patient-centered care, the use of protocols or guidelines, and commitment from leadership, providers, and staff as facilitators of improving hypertension control. Conversely, participants felt that concerns about the accuracy of blood pressure measurement, a lack of time and resources, a lack of protocols, and patient-level factors were barriers to improving hypertension control.

In this study, in contrast to previous work, we examined hypertension management in the context of the PCMH, a model becoming widely adopted in primary care settings. We also explored perceptions of a range of stakeholders identified by participating sites, including nurses, clinicians, administrators, and social workers.

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