A long-recognized means of improving outcomes in chronic disease, the concept of a patient-centered medical home (PCMH) has been embraced by leading physician organizations such as the American Osteopathic Association (AOA), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American College of Physicians (ACP). According to these organizations, representing approximately 330,000 physicians, a PCMH is both:

1) an approach to providing comprehensive primary care for children, youth and adults.
2) a health care setting that facilitates partnerships between individual patients, their personal physicians and, when appropriate, the patient’s family.1

The principles of a PCMH—as agreed upon by the AOA, AAFP, AAP and ACP—are as follows:1

- An ongoing relationship with a personal physician
- Physician-directed medical practice
- Whole-person orientation
- Coordinated care across the health system
- Quality and safety
- Enhanced access to care
- Payment that recognizes the value added

These characteristics comprise the Joint Principles of the Patient-Centered Medical Home, a consensus statement published by the four physician organizations in February 2007.1 The PCMH joint principles have been endorsed by 18 specialty health care organizations since their release, demonstrating the potential worth of the PCMH in improving disease outcomes.

In a PCMH, a physician-led care team is responsible for all the patient’s health care needs and coordinating care across the health care system. Physicians strengthen the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship with the goal of delivering better health care quality, improved involvement of patients in their own care and reduced costs.

Improved quality via the PCMH model is driven by a comprehensive and robust care-planning process that employs evidence-based medicine and clinical decision-support tools to guide decision-making. Patients are integral to the success of this approach to care delivery. Their input on decision-making and feedback on the effectiveness of clinical decisions are actively encouraged.

In applying this comprehensive model of medicine to dyslipidemia, a personal physician directs a team of other health care providers in the care of the patient, just as he or she would in any other disease state treated according to the PCMH approach. This physician-led intervention is crucial in the PCMH-based treatment of the patient with dyslipidemia, since the physician is likely the most knowledgeable care-team member with respect to the myriad of treatment guidelines and recommendations associated with cardiovascular disease.

Likewise, physicians are best equipped to direct the course of treatment to effectively lower low-density lipoprotein cholesterol (LDL-C) levels and reach LDL-C targets such as those set forth in the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (ATP III). Serving in this central role, the physician is responsible for providing for all of the patient’s health care needs or for appropriately arranging care with the other qualified professionals. Due to the multiple comorbidities potentially existing with dyslipidemia, health care professionals working under the direction of the physician may include nurses, physician assistants, endocrinologists, psychiatrists,
The PCMH approach dictates the ongoing, continual care of patients rather than episodic office visits—a clear benefit in the treatment of patients with dyslipidemia who require routine lipid monitoring and robust medication adherence to ensure optimal outcomes. The regular physician-patient interaction and strong physician-patient relationships fostered by the PCMH approach also serve to improve the success of therapeutic lifestyle changes (TLC), the use of which has been supported by clinical trial evidence in patients with dyslipidemia. Furthermore, because the use of two or more lipid-modifying agents may be necessary to achieve guideline-recommended targets, regularly scheduled office visits likewise assist physicians in monitoring, managing, and encouraging medication adherence.

Ongoing, continual intervention on the part of the physician also facilitates the coordination and/or integration of care across all elements of the complex health care system—another component of the PCMH approach. In the treatment of patients with dyslipidemia, this coordination of care may include the routing of individuals through lab-testing protocols, visits to other facilities for various cardiovascular assessments and procedures, and information technology (IT)-facilitated medical record exchange between a number of health care professionals.

Care should likewise be integrated to include the patient’s family and public and private community-based services when appropriate. In the treatment of dyslipidemia, this may be realized by enlisting family members to encourage patient TLC adherence at home or by introducing the patient to community-sponsored programs that promote physical activity.

The PCMH approach also dictates that this care is coordinated and/or integrated in a culturally and linguistically appropriate manner. By taking the cultural and linguistic characteristics of patients with dyslipidemia into consideration, health care providers are better equipped to design effective messaging for improving adherence to medication and TLC.

Two hallmarks of the PCMH approach—quality and safety—are imperative in the treatment of patients with dyslipidemia. Evidence-based medicine and clinical decision-support tools are particularly important for improving quality in the treatment of this complicated disease state, with numerous treatment guidelines and recommendations for cardiovascular disease in existence. These two interventions are particularly useful for assisting physicians as they navigate the multi-

**Evidence-based decision making**

**Culture**

**Communications**

**Access**

**Quality, continuous care**

**Goal setting**

**Integrated care**
tude of disease markers and treatments available for dyslipidemia.

IT-based interventions further serve to support quality and safety in the treatment of dyslipidemia, according to the PCMH approach, by facilitating information exchange and averting potentially dangerous drug interactions or contraindications. Performance measures can promote success in the above, as physicians are assessed by patients on personal satisfaction with care or by an independent quality assurance organization on dyslipidemia disease markers and other treatment outcomes.

As is the case in other disease states, the enhanced access to care promoted by the PCMH approach has tremendous potential for improving outcomes in dyslipidemia. Patients require ongoing and routine medical care to manage their dyslipidemia and reduce their risk for adverse cardiovascular events, demonstrating the immediate advantages of open scheduling, expanded hours and new options for communication between patients and their health care providers. This enhanced access to care can also improve patient adherence to medication and TLC regimens, thus improving outcomes in dyslipidemia by promoting a more comprehensive standard of care that allows patients to take ownership of their treatment success.

To ensure that physicians are adequately compensated for the enhanced level of involvement and time commitment required by the PCMH approach, payment should appropriately recognize the added value provided to patients treated in this manner. Certain inherent costs are associated with the application of the PCMH approach in the treatment of dyslipidemia and other chronic conditions, and these costs tend to be higher than those associated with standard care. As such, payment should reflect the value gained from the added services rendered in the PCMH approach, including the following:

- physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit
- services associated with coordination of care both within a given practice and between consultants, ancillary providers and community resources
- adoption and use of health information technology for quality improvement
- provision of enhanced communication access, such as secure e-mail and telephone consultation
- physician work associated with remote monitoring of clinical data using technology.

Ideally, payment in the PCMH should also allow physicians to share in the savings generated by the reduced adverse outcomes associated with physician-guided care management in the office setting. Furthermore, directly related to the performance measures mentioned previously, payment should include incentives for achieving measurable and continuous quality improvements. In the treatment of dyslipidemia, for example, physicians may be paid incentives when a certain percentage of their patients are prescribed specific lipid-lowering therapies or achieve LDL-C goals.

Since the term was first introduced more than 40 years ago, the PCMH has represented a central location from which a patient’s care can be managed. Now that the concept has been recognized by physicians nationwide as a means of improving outcomes in chronic disease, this definition has been expanded to include coordinated and/or integrated physician-directed care, whole-patient orientation, enhanced access and appropriate payment for added value, with an emphasis on quality and safety. In the treatment of dyslipidemia, these comprehensive principles offer immediate promise in promoting the achievement of evidence-based goals and improved treatment outcomes. These can both be realized through the enhanced physician-patient relationship, ongoing care, and continual health care intervention offered by the PCMH approach.

References

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