Health Workforce Research Brief
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How Do Nurse Practitioner-led Patient-Centered Medical Homes Differ from Other Patient-Centered Medical Homes?

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BACKGROUND

The patient-centered medical home (PCMH) is an enhanced model of primary care and has grown substantially over time. Although initially established as a physician-centric model, the model has evolved to emphasize team-based care and in some cases, the development of non-physician-led PCMHs (Cassidy, 2010). Currently there are almost 300 nurse practitioner (NP)-led PCMHs recognized by the national accreditation body such as the National Committee for Quality Assurance (NCQA). However, little is known about current status of NP-led PCMHs. The overall goal of this study is to understand whether and the extent to which NP-led PCMHs differ from other PCMHs that are primarily run by physicians.

METHODS

276 NP-led PCMHs and a random sample of 665 physician-, hospital-, or community health center (CHC)-led PCMHs were invited to participate in the online survey. They were all recognized by June 2016 under the NCQA PCMH program. The survey included questions regarding patient population they serve, staff composition as well as services provided by each staff member, and the extent and structure of the innovation they adopted.

FINDINGS

Of the 941 potential participating practices, 21 completed the survey. The respondents included 1 NP-led, 10 physician-led, 4 hospital-led, and 6 CHC-led PCMHs. The number of respondents is not enough to generate any meaningful analysis. This is a preliminary descriptive report, meaning it doesn't draw any conclusions, but rather reports on all the information we collected as of now. The study team is currently making every effort to ensure that the data collected is as complete and accurate as possible through repeated follow-up to non-respondents. The results will be updated once the survey is closed.

Patient Characteristics: The NP-led PCMH was more likely to see patients under both Medicare and Medicaid, but had a similar number of patients with chronic conditions as the other PCMH sites.

KEY FINDINGS

1. The NP-led PCMH had fewer staff and also had fewer patients than other PCMHs.
2. Similar patterns emerged when comparing the services and transformation efforts provided by the NP-led PCMH and those provided by other PCMHs.
3. NPs are key to the design of several emerging models of primary care, and NP-led PCMHs are believed to increase access to primary care by enhancing the ability of NPs to fill gaps in primary care for vulnerable populations in rural and medically underserved areas.
4. It is important for HRSA to track the adoption of PCMHs by NPs as the pace is expected to accelerate.

Staff Composition and Services Provided: The NP-led PCMH reported a total of 5 Full Time Equivalents (FTEs) including 1.5 NPs, 1 registered nurse, 2 medical assistants and 0.5 mental health provider. The NP-led PCMH had fewer staff than other PCMHs (119 FTEs for physician-led PCMH, 16 FTEs for hospital-led PCMH, and 140 FTEs for CHC-led PCMH) and also had fewer patients than other PCMHs. However, similar patterns emerged when we compared the services provided by the NP-led PCMH and those provided by other PCMHs. Core clinical care was provided solely by clinicians such as physicians and NPs. In small practices including the NP-led PCMH, medical assistants played a key role to identify internal processes to improve care delivery with practice staff, coordinate care within/across settings; and link patients with available resources in the community. Larger practices divided themselves into smaller functional teams and included other team members (e.g., care managers, community health workers, pharmacists, etc.) who helped with chronic care management, education, counselling, and community outreach.

PCMH Transformation: As for any transformation efforts during transition, the NP-led PCMH did not hire new staff, but rather provided skills-training to existing staff and integrated behavioural health with primary care. Most other PCMHs reported that they received additional payments including enhanced fee-for-service, care management fees, or pay-for-performance (ranged 30-60%), but the NP-led PCMH did not receive any additional payment in becoming or since becoming a PCMH. In the NP-led PCMH, 100% of patient care revenue came from fee-for-service payments. Most practices including the NP-led PCMH reported that they provided after-hours access, launched or advance electronic health records system, and included patients and caregivers in decision-making and care process. Most PCMHs have been participating in an average of 2.5 other public or private initiatives.

CONCLUSION

Compared to the other PCMHs, the NP-led PCMH had fewer staff and also had fewer patients. However, similar patterns emerged when we compared the services and transformation efforts provided by the NP-led PCMH and those provided by the other PCMHs.

POLICY IMPLICATIONS

With the current and growing shortage of primary care workforce, NPs are key to the design of several emerging models of primary care including PCMHs and the pace is very likely to accelerate. NPs now account for 19% of the primary care workforce and have historically played a vital role in providing primary care in rural and medically underserved areas (AHRQ, October 2011). Evidence so far supports that NPs provide many primary care services as well as physicians do and achieve equal or sometimes better quality at lower cost (Newhouse et al., 2011). NP-led PCMHs are believed to increase access to primary care by enhancing the ability of NPs to fill gaps in primary care for vulnerable populations in rural and medically underserved areas. This project examined the patient and practice profiles in NP-led PCMHs, which will be an important guide as policy makers track the adoption of PCMHs.

References:

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