

FREQUENTLY ASKED QUESTIONS ABOUT THE PATIENT-CENTERED MEDICAL HOME

What is a Patient-Centered Medical Home (PCMH)?

The PCMH is a medical practice organized to produce higher quality care and improved cost efficiency. In a patient-centered medical home:

- Patients have a **relationship** with a personal physician.
- A practice-based care team takes **collective responsibility** for the patient's ongoing care.
- The Care team is **responsible for providing and arranging all** the patient's health care needs.
- Patients can expect care that is **coordinated** across care settings and disciplines.
- **Quality** is measured and improved as part of daily work flow.
- Patients experience **enhanced access** and communication.
- Practices moves toward use of EHRs, registries, and other **clinical support systems**.

What are the Joint Principles of the Patient-Centered Medical Home?

The **Joint Principles** outline the fundamental concepts of the PCMH. These principles were developed and endorsed by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association in March 2007.

The Joint Principles are attached for reference.

What is the evidence base for the PCMH?

There is extensive evidence in the literature documenting improvements in quality and efficiency when patients have a usual source of care through a primary care practice. The PCMH design builds on that relationship.

<http://www.aafp.org/online/en/home/policy/familymedvalue.html>

<http://www.pcpc.net/content/additional-resources>

http://www.acponline.org/running_practice/pcmh/resources_tools/abstracts.htm

What is the Patient Centered Primary Care Collaborative?

The Patient-Centered Primary Care Collaborative (PCPCC) was created in late 2006, when the ERISA Industry Committee (ERIC) was approached by several large national employers with the objective of reaching out to primary care physician groups in order to facilitate improvements in patient-physician relations and to create a more effective and efficient model of health care delivery.

To achieve these goals, the PCPCC has become one of the major developers and advocates of the Patient-Centered Medical Home (PCMH) model in America. IBM, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics and the American Osteopathic Association were the original founders of the PCPCC. The Collaborative's membership now numbers more than 260 organizations and includes a number of large national employers, the major primary care physician organizations (AAFP, AAP, ACP and AOA), health benefits companies, trade associations, patient advocacy groups, academic centers, and health care quality improvement organizations.

The Collaborative (www.pcpcc.net) believes that, if implemented, the patient centered medical home will improve the health of patients and the viability of the health care delivery system. In order to accomplish our goal of implementing the PCMH, employers, consumers, patients, physicians and payers have agreed that it is essential to support a new and better model of compensating primary care physicians.

What is the NCQA Physician Practice Connection – Patient-Centered Medical Home Designation?

One of the critical issues addressed early in the PCMH development was the need to have an independent, third party entity help determine which practices are delivering care consistent with the patient-centered medical home model. The primary care physician organizations approached the National Committee for Quality Assurance (NCQA) to modify the existing NCQA Physician Practice Connections (PPC) program to align better with the PCMH model, consistent with the Joint Principles. The boards of directors of the AAFP, AAP, ACP and AOA agreed to support pilot testing of this recognition tool – now referred to as the NCQA PPC-PCMH – in demonstration projects. Physician practices may qualify as Level I, Level II or Level III medical homes. This is an important process because the PPC-PCMH will help evaluators of the model determine the capability of individual practices and link the results of the studies to the level attained through the PPC-PCMH tool. In most of the demonstration projects, the cost of the NCQA recognition process is covered by the sponsors of the project and in others it likely will be accounted for in the payment provided for participation. In many of the demonstration projects, the level at which the practice is recognized will also drive the overall payment to the practice. This process provides a clear pathway for practices to determine if they wish to participate in a demonstration and what they would be expected to do and provides purchasers with assurances that the practice has the capabilities needed.

What is the Payment Model for the PCMH?

The framework for payment is a blended payment model that combines fee-for-service with a care management fee (based on the level of medical home designation – Level I, II or III), and performance-based compensation.

The prospective payment, paid on a monthly basis per patient to a designated PCMH, would recognize the investment made by the practice in building the PCMH as well as the additional non-face to face work and added value provided to patients receiving well-coordinated, convenient, patient-centered care. Further, the payment would be risk-adjusted to reflect the complexity of the patient population of the practice. The evidence from several studies indicates that the “savings”

from the model come largely from reduced hospitalizations, reduced emergency department visits, reduced duplicate tests and procedures. It will be important for programs implementing the PCMH to consider the costs of care across the system and not, as Medicare does, segregate physician payment, hospital/ancillary payments and drug costs in Part A, B and D. The savings from Part A, for example, should accrue as appropriate to Part B. Budget neutrality, in the case of Medicare, should be across all segments, not restricted to Part B, and therefore the care management fee should not impact only Part B payments.

Implementing the PCMH model into Medicare may redistribute resources across the entire program. The typical Medicare patient has several chronic conditions and sees multiple physicians. Coordinating these patients' care through the PCMH, with appropriate referrals to subspecialists, may result in fewer visits, tests and procedures as well as reduced hospital admissions and emergency department visits.

Can the PCMH really provide coordinated, comprehensive care?

The PCMH is expected to take responsibility for ensuring that the patient receives all necessary care, providing a large majority of this care within the practice, referring as appropriate, and working with other providers in the health care team both within and without the practice. This expectation is consistent with the residency training of primary care physicians and does not change the scope of practice in any way.

Does the PCMH address the number of uninsured?

The PCMH model has not been proposed as a direct response to the issue of the uninsured – though a robust primary care system, including “healthy” safety net providers, should help disadvantaged populations through improved access to care. Having a usual source of care has been shown to decrease health care disparities. Ideally, the PCMH model will serve as the basis for the redesign of both the delivery and the payment systems. Of course, these changes will likely have their greatest impact when there is health care coverage for all.

Isn't the PCMH simply a return to the “gatekeeper” model that failed in the '90s?

The PCMH model is based on fostering a trusting, long-standing patient-physician relationship in which the patient is encouraged to be an active participant and decision-maker in his/her own care. Based on that relationship and on the preferences of the patient, the personal physician will refer to colleagues in other specialties in order to ensure that the patient receives the most effective and appropriate care. In addition, the PCMH will actively coordinate care for the patient, where ever they are in the health care system be it a hospital, other facility, other specialist, emergency department, etc. The PCMH will facilitate care, not restrict care – it will serve as the patient's ‘gateway’ to the health care system.

Do any other specialties endorse the model?

The following additional organizations support the PCMH joint principles:

- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American College of Cardiology
- American Academy of Chest Physicians
- American College of Osteopathic Family Physicians
- American College of Osteopathic Internists
- American Geriatrics Society
- American Medical Directors Association
- American Society of Addiction Medicine
- American Society of Clinical Oncology
- Association of Professors of Medicine
- Association of Program Directors in Internal Medicine
- Clerkship Directors in Internal Medicine
- Infectious Diseases Society of America
- The Society for Adolescent Medicine
- Society of Critical Care Medicine
- Society of General Internal Medicine

These "Frequently Asked Questions" have been prepared by: AAFP, AAP, ACP and AOA 10/28/08

Joint Principles of the Patient Centered Medical Home

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

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Introduction

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making

- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the “medical home” (AAFP, 2004) or “advanced medical home” (ACP, 2006).

For More Information:

American Academy of Family Physicians

<http://www.futurefamilymed.org> [1]

American Academy of Pediatrics:

http://aappolicy.aappublications.org/policy_statement/index.dtl#M [2]

American College of Physicians:

http://www.acponline.org/running_practice/pcmh/ [3]

American Osteopathic Association

<http://www.osteopathic.org> [4]