REVIEW ARTICLE

An Introduction to the Patient-Centered Medical Home

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The Patient-Centered Medical Home is a redesign of office practice that maintains the core values of traditional family medicine, creates health care teams that track and improve patient care, improves access, satisfaction and patient-centeredness, and is supported by reformed reimbursement. The Affordable Care Act has acknowledged the role of the Patient-Centered Medical Home and contains many components that support the study and expansion of the model. This first offering in a series of articles on the Patient-Centered Medical Home will provide an introduction to the principles of the Patient-Centered Medical Home, its place in national delivery demonstration projects and accountable care organizations, and a description of some of the changes practices can begin to make in the transition to a medical home.

The Patient-Centered Medical Home is a name used to describe a new model of primary care practice. This medical home is not just a specific office location, it is a redesigned way of providing traditional family medicine. The basic core principles of family medicine are maintained, but care is delivered by a physician-led team, with new roles and new tools. New forms of technology facilitate access, communication, coordination, and evidence-based management. Outcomes are measured and improved and ultimately, payment supports the increased value of the care that is given.

This first article in a series of articles on the Patient-Centered Medical Home will provide an introduction to the principles of the Patient-Centered Medical Home, its place in national delivery demonstration projects and accountable care organizations, and a description of some of the changes practices can begin to make in the transition to a medical home.

Three indisputable realities for primary care emerged at the beginning of the 21st century. The first was that primary care was in trouble — physicians were overwhelmed with the burden of paperwork and non-reimbursed services, income inequalities with specialists were growing each year and fewer students were choosing family medicine or general internal medicine for a career.[1,2] The second reality was that demographic changes in the US predicted an aging population with an increased burden of chronic disease and a high demand for services. Taken together, these predictions suggested that health care payment systems, primarily Medicare — would be bankrupt in a short time. A third reality was more favorable; a growing and consistent body of evidence suggested that robust primary care could produce improved outcomes at lower cost.[3]

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In 2004 the American Academy of Family Physicians presented its "Future of Family Medicine" findings and laid out the critical need for change in the structure and delivery of primary care within 10 years, or "family medicine would cease to exist as we know it".[4] This report presented the concept of the *Personal Medical Home*. The idea of a "medical home" had been introduced and developed by pediatricians, who, in 1967, first described the need for more proactive primary care responsibility for the lives of children with disabilities. In 2006 the American College of Physicians introduced the *Advanced Medical Home*, outlining a similar model for general internists.[5] In 2012, with over 100 demonstration projects across the country showing a variety of improvements in primary care delivery, physician satisfaction and/or cost effectiveness, the Patient-Centered Medical Home (or PCMH) has become a shorthand code for fixing whatever is wrong with both primary care and the American Health Care System.

The breakthrough for the Patient-Centered Medical Home came in 2007 when the American Osteopathic Association, the American Academy of Pediatrics, the American Academy of Family Physicians and the American College of Physicians agreed on the **Joint Principles of the Patient-Centered Medical Home**.[6] This document, endorsed at the time, by organizations representing 333,000 physicians, has served as a most reliable description of the content of the PCMH.

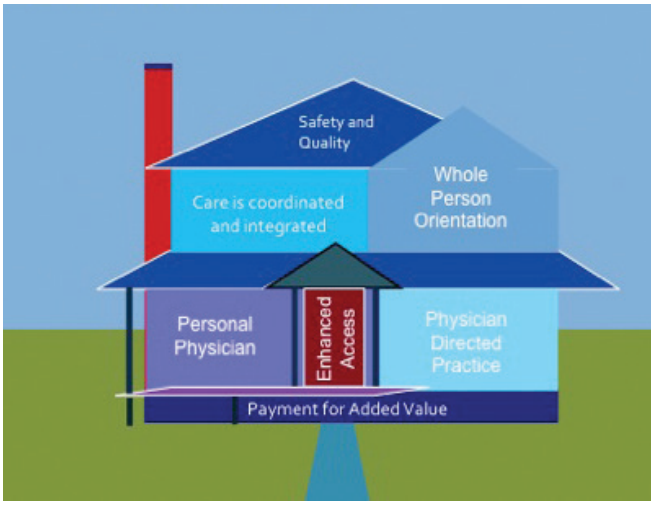
After hearing the joint principles of the medical home, most established primary care physicians fall into one of two groups; we either exclaim, "we already do that! I've been doing that for 10 years" or we say, "no one could ever do that — we don't get paid to do it and it will not happen unless we do". In truth, the reality of the medical home probably falls somewhere in between. Most smoothly running family medicine practices incorporate many of the components of the PCMH and don't see the need to change. Some are so busy that they don't

have time to change, or feel the need to change, especially if promises of better reimbursement are vague and theoretical. However, the savings achieved by medical homes have been shown to increase over time; with more savings generated by more patients using medical homes over a longer period.[7]

The Joint Principles describe seven aspects of the PCMH;

1. A Personal Physician
2. A Physician-Directed Medical Practice Team
3. Whole Person Orientation
4. Care that is Coordinated and/or Integrated
5. Quality and Safety are Hallmarks
6. Enhanced Access to Care is Available
7. Payment Appropriately Recognizes Value

The Joint Principles Medical Home



A PERSONAL PHYSICIAN

The personal physician is a core principle of the medical home. Each patient should have a doctor who "knows me and knows my family". Knowledge of the patient, their family, their community and culture are cornerstones of high-quality family medicine. Continuity with a patient's own doctor produces better outcomes and higher satisfaction for patients and doctors. All recognition systems for a medical home ask a practice to verify that patients have an identified personal physician and can get in to see their own physician when they need him/her.

A PHYSICIAN DIRECTED MEDICAL PRACTICE TEAM

"The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients". This team can be of variable sizes and composition. One large practice might have a registered nurse, nutritionist and social worker as part of the team. Another practice might have only the physician and one or two medical assistants as the full team. Broad concepts of the team include medical ancillary services such as home health, hospice or physical therapy. In the North Carolina Network, small practices had a regional case manager that was part of the team for multiple small practices.[8] Team members do not necessarily have to be under the same roof or even supported by the practice income. But no matter the size, the PCMH team takes responsibility to provide comprehensive care to the patient.

Learning to practice in teams requires a reorganization of the roles and responsibilities of traditional members of the practice "staff". Team members are encouraged to practice at the highest level of their license and training. Doctors can "hand-off" multiple tasks that were traditionally reserved for them; the giving of immunizations, the discussion of over-the-counter recommendations for simple problems, the callbacks for normal or mildly abnormal labs. New roles and responsibilities for team members can be developed through the establishment of new office workflows and protocols for commonly encountered issues or problems.

In a medical home with a great team, the care becomes proactive instead of reactive. Team members meet to plan for the patients visit with short team "huddles" or a formal "pre-visit," or even group visits for chronic disease. Patients that are known to have chronic problems are contacted and/or coached by the medical staff, not just the physicians. Patients who do not come in for a visit are encouraged to return, not forgotten till the next visit. As a result, care is planned and more productive interaction can take place.

WHOLE-PERSON ORIENTATION

Care for the whole person is also a core principle of family medicine. PCMH Practices attempt to provide as many services for the patient as possible and are fairly reimbursed for the value they bring. Osteopathic family medicine, with an emphasis on whole-person care and the enhanced services of Osteopathic Manipulative Medicine (OMM) provide additional value to patients and families. General internal medicine, general pediatrics, family medicine, or a combined primary care practice can be a medical home. One medical home may not need to provide all services for all patients, but a PCMH should provide the coordination of services that contribute to comprehensive care.

CARE THAT IS COORDINATED AND/OR INTEGRATED

A medical home is "home base" for a patient — an entrée into the daunting world of the U.S. healthcare system. Patients with multiple chronic problems or life threatening acute problems need coordinated care on many levels. The referred patient is

not just wished "good luck and good bye" once a serious, acute or chronic problem is diagnosed. The PCMH team tracks a patient through multiple consultant visits, hospitalizations and testing. This type of follow-up may not be new to a practice, but the PCMH consciously tracks patients in and out of the hospital and/or consultant's offices. The PCMH practice should become a partner with the larger health care system or organization. Proactive tracking and coordination saves money and provides value to the system as a whole. Value, eventually, in this redesign of care, is, or will be rewarded.

Care coordination is facilitated by people and information technology. The PCMH health care team will have a "care coordinator" or "care advocate"; a nurse or a medical assistant, who will be trained to ensure that care transitions are appropriate, timely and effective within and between practices. Ensuring appropriate care may seem like an impossible task for nurses or medical assistants, but new tools and technology will assist them. Tracking patients, especially within one health care organization gets easier. Patients can be reminded to show up for appointments and tests with texts, automated calls, personal phone, email or the internet. Even patients within "safety net" practices have shown increased response rates to phone calls or text messages. The PCMH will start to "own" care management, because with the help of their own electronic health record (EHR) the practice knows who needs to be seen and who has come into be seen.

QUALITY AND SAFETY ARE HALLMARKS

Evidence-based guidelines and care plans support protocol-driven outcomes and processes for PCMH team members. This is provided by point-of-care access mobile applications, internet sites or the practices' electronic health records. In order to support improved decisions making, many of our own medical societies, foundations and neutral coalitions of medical providers have worked to create and support evidence-based guidelines.

TABLE 1: Evidence-Based Guidelines and Recommendations for PCMHs

Health Team Works	http://www.healthteamworks.org/guidelines
Institute for Clinical Systems Improvement	https://www.icsi.org/guidelines__more/
United States Preventive Services Task Force	http://www.uspreventiveservicestaskforce.org/recommendations.htm
Choosing Wisely	http://www.choosingwisely.org/doctor-patient-lists/

In the last year the American Board of Internal Medicine Foundation initiated the "Choosing Wisely" initiative, which provides materials to physicians and patients to "begin conversations to reduce overuse of test and procedures, and support physician efforts to help patients make smart and effective care choices".[9] The early research on changing physician practices in regard to overused and ineffective testing suggests savings of as much as five billion dollars per year.[10]

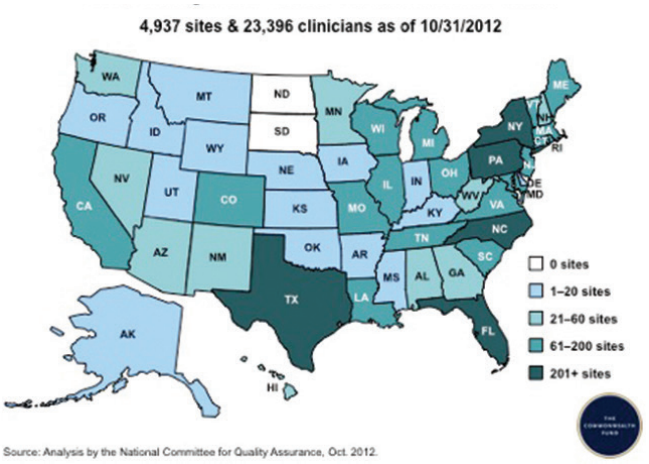


FIGURE 1: NCQA-Recognized Practices Across the United States

In the medical home, "quality" is measured and improved. The biggest change in the concept of the medical home, besides the idea of patient-centeredness, is that a medical home tries to improve itself for its patients. It measures and re-measures. The PCMH knows how it is doing with standard measures of good patient care, and tries to do better.

The PCMH practice will be paid for improved performance through pay-for-performance and/or the shared savings of a bundled payment process. These payment processes are not in place everywhere but should be coming soon. The Joint Principles of the Patient-Centered Medical Home also advocate a voluntary recognition program for medical homes. Improved payment may not necessarily be tied to recognition, but many insurance payers now provide higher payment for recognized practices. The most broadly accepted program is the National Committee on Quality Assurance.

ENHANCED ACCESS TO CARE IS AVAILABLE

Access to a patient's personal physician in a timely manner is also a primary goal of the patient-centered medical home model. Enhanced access is often a good starting point for a practice as it enters into the transformation to a medical home. "Open Access", sometimes known as "advance access", is a scheduling process in that allows same or next day visits for a significant number of patients. Instead of a schedule that

is absolutely full, each physician leaves a substantial number of visits open. In true open access, as many as 100% of the visits are unscheduled, but most practices keep 35-50% of their slots to be scheduled in the traditional way. Traditional appointments are sometimes kept for patients that have to arrange transportation or need a physical exam.

In addition to open access appointments, enhanced access means multiple ways to interactively communicate with patients, including; email, social media, websites, "e-visits", a patient portal, and group visits. Texting and email are obvious, easy ways to communicate to the tech-savvy younger generation, but if you check with your patients, most are emailing, texting and using the internet almost daily. Text and email have the advantage of working day or night and an immediate response is not necessary. Although most email is not secure and HIPAA (Health Insurance Portability and Accountability Act) compliant, text and email have been used by physicians for years, adding warnings and disclaimers. The medical home incorporates text and email more fully into patient care. Emails can report blood sugars and await a response from the physicians. Texting can confirm appointments or consults. Detailed email and responses can amount to an "e-visit" and may be reimbursable.

Practice websites can be reasonably priced and simple information sources for patients; listing your hours, you accepted insurances and your biography. Websites can also be interactive self-management medical resources; the equivalent to a 30 page "welcome to the practice" pamphlet. Every piece of paper, form or handout that you currently use in your office can be uploaded to a website for patient download. Every practice policy can be displayed. Your patients can get their referrals, sign up for refills, learn what a low potassium means and what they should do about it, and they can even take a questionnaire to explore whether they might have depression or erectile dysfunction. The more interactive the website, the more it might cost. Websites can hold large amounts of information about your practice and be available to your patient for about $15.00 dollars a month.

A patient portal can be added to a website for an additional fee, or can be supplied or purchased through your electronic health records. A portal website means that you need a user name and a password to enter and that it is protected by a higher level of security than regular email. Patient portals can be used to release lab results or imaging results to patients. Some practices will routinely release all lab results – even abnormal results – in an effort to be transparent and timely. Portals are often used for scheduling appointments, requesting refills, or even more sophisticated "e-visits." Your patient can also pay for a service with a credit card through a patient portal.

PAYMENT APPROPRIATELY RECOGNIZES VALUE

All the enhanced services, gizmos, and emails required of the Patient-Centered Medical Home have a cost. The nurses and MAs need time for training and meetings. Data must be pulled out the EHR, analyzed and reported. Protocols and patient support materials must be developed and disseminated.

Therefore, the significant question in PCMH transformation has been, "where do we find the time and money to do this"? The answer to this question depends on where you practice, what insurers you work with, and what medical partners you have.

The Joint Principles of the PCMH state that payment should appropriately recognize value. Payment reform would consist of a combined three-part reimbursement structure: 1.) face-to-face communication with fee-for-service 2.) a monthly fee to practices for care management, and 3.) a "pay-for-performance" fee that recognizes outcome targets and cost effectiveness. The Principles clearly endorse a fee-for-service rate that is not lowered in order to pay for the other components of reimbursement, "services that fall outside the face-to-face visit…should not result in a reduction in the payments for the face-to-face visit."[11] Physicians should also receive additional payments "to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting". This is a fundamental principle of the bundled payment or shared savings of an Accountable Care Organization. Case mix difference should also be recognized, and indeed many of the pilot programs provide information about the most high-risk, "sickest" patients in their practice.

Unfortunately the Joint Principles of the PCMH, while endorsed by primary care, were not legislated into law or accepted as regulation by the major health insurance companies in this country. They were, however, endorsed by the Primary Care Patient-Centered Collaborative (PCPCC).[12] The PCPCC is a collaborative of medical organizations, pharmaceutical corporations and large employers. The PCPCC supports the medical home with advocacy directed at consumers, legislators, but most importantly – employers. They urge large purchasers of health insurance to advocate for the PCMH and improved reimbursement for it.[13]

Recently, major commercial insurance payers such as Wellpoint, United Health Care, Blue Cross Blue Shield and Aetna have begun pilot programs to support better reimbursement for high quality primary care offices and the Medicare Payment Advisory Commission (MedPAC) has recommended a 10-year program to increase payments to primary care providers at the expense of specialty providers.[14] These efforts to improve reimbursement for primary care physicians providing medical

homes underscore the recognition that the income gap for high quality primary care physicians needs to be reduced.

ACCOUNTABLE CARE ORGANIZATIONS AND THE PCMH

Accountable Care Organizations (ACOs) are proposed as the organizational structure that will help deliver the triple aim in health care: improved patient experience, better health and lower cost. One PCMH practice or even a hospital can't do this by itself. Accountable Care Organizations are designed to create an integrated health care delivery system covering the continuum of health care services for a population of patients within a defined geographic area. Because they include primary care, specialists, hospitals, urgent care and home care, they ideally can coordinate care, prevent unnecessary care and limit hospital admissions and re-admissions. The design, organization and leadership of the ACO will ultimately dictate how much of the shavings are shared with the primary care doctor, but in general, an ACO will support the combined payments describe above.

In most designs, the ACO must attribute its members from an agreement with their primary care doctor. A Medicare ACO, for example, will sign patients only through an agreement with their primary care physician. The more patients and primary care doctors on board, the larger the ACO. But the ACO will want to choose those practices and primary care doctors that can coordinate care and hold down unnecessary costs. This is the connection with the PCMH. The ACOs want to sign up functioning medical homes.

HOW TO GET STARTED

Your practices may be well on their way to status of a medical home, or you may just be starting. There is general agreement that the PCMH is a work in progress, no matter where you begin. Taking on the transformation to a PCMH seems less daunting if you start with your strengths. If you have electronic health records and have applied for meaningful use (MU) dollars you are well positioned to explore the overlap between MU and recognition for PCMH. If you have strong patient communication, you might see how small enhancements get you to the level expected for a PCMH.

There are multiple checklists that are freely available to help you do a baseline assessment. The simplest is the Medical Home Index. It gives a basic assessment of what your practices strengths and weaknesses might be. The MHIQ® (Medical Home Implementation Quotient) is a longer more detailed checklist – but may help your implementation team decide where to start (Table 2).

This series of articles for the *Osteopathic Family Physician* will provide information and resources to start or continue the transformation of your offices and will include:

- Open Access and Improved Communication in the PCMH
- Population health and Care Coordination in the PCMH
- Team Meetings, and Team Care in the PCMH
- Getting Ready for Medical Home Recognition
- PCMH and the ACO; the financial models and outcomes so far.

TRANSFORMATION BASICS

The transformation to PCMH requires engaged leadership within the practice. The leader and/or the leadership team must be a champion for the process and must embody enough power and influence to continue this it over time. Giving this process time, persistence and resources is critical. It usually takes longer than is planned and "change fatigue" has been repeatedly reported.[15] The leader should not try to do this without an implementation team that represents all members of the practice. There should be strong communication: between the implementation team and the rest of the office, within the office itself, and especially to patients. Lastly, give the right people the right responsibility to get you moving.

TABLE 2: Practice Self-Assessment Tools for the Patient Centered Medical Home

Name	Sponsoring Organization	Web URL	Details
Medical Home Index	Center for Medical Home Improvement	http://www.medicalhomeimprovement.org/pdf/CMHI-MHI-Adult-Primary-Care_Full-Version.pdf	They ask the results are shared with the CMHI
Medical Home Implementation Quotient - MHIQ	American Academy of Family Physicians	http://www.transformed.com/MHIQ/welcome.cfm	Registration is required but membership in the AAFP is not required
The Joint Commission's Primary Care Medical Home Option: Self-assessment Tool	The Joint Commission	http://www.jointcommission.org/assets/1/18/PCMH_SAT_1.4.13.pdf	Used in preparation for Joint Commission PCMH accreditation

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