CAROLINA Health & Transition PROGRAM

# CHAT: Fact Sheet on Patient-Centered Medical Home

The term "medical home" emerged in the 1960's through the American Academy of Pediatrics (AAP) promotion of an ideal approach to pediatric care. It urged its members to coordinate medical care for a child from birth through adolescence, with a focus on the child's comprehensive healthcare needs being met in collaboration with parents and family. The "medical home"—typically a general pediatrician—served as the primary care provider, but also as the central repository of the clinical history of each child seen in the practice. This centralized information was intended to go beyond the visit records. The idea was to include documentation of the child's medical care beyond the primary care setting (e.g. hospitalizations, sub-specialty referrals, and allied services such as speech/language or physical therapy).

Today, the term has been more widely adopted and expanded to "*patient-centered* medical home". This term embraces a system-wide model of care that addresses the goals of many institutions, including physician academies, the Institute of Medicine (IOM), and the World Health Organization (WHO), and many others.

One of the core concepts of the **patient-centered medical home (PCMH)** is the enhanced role of primary care providers as the foundation of medical care. In the PCMH structure, the primary care provider (PCP) coordinates the patient's overall health and wellness. In a 2007 report commissioned by the Health Systems Knowledge Network of the WHO, a review of the literature on the rationale for the benefits of such an approach included:

- greater access to needed services,
- better quality of care,
- a greater focus on prevention,
- early management of health problems,
- the cumulative beneficial effect of the above on improved human health,
- a reduction of unnecessary and potentially harmful specialist care.

Moreover, it was reported that where the primary care team functions as a "navigator" through secondary and tertiary care and other sectors, it can be a strategy for achieving cost-effectiveness.[1]

### The Patient Centered Medical Home

***Patient centeredness*** refers to health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care.

Institute of Medicine
*Envisioning a National Healthcare Quality Report*

[1]De Maeseneer J. Primary health care as a strategy for achieving equitable care: a literature review commissioned by the Health Systems Knowledge Network. Geneva. World Health Organization. 2007.

**The Basics of a Primary Care Provider (PCP) Medical Home**

- The patient has a personal physician.
- The practice is physician-directed.
- Patient care is oriented toward health and wellness of the whole person (not the symptom or disease).
- Subspeciality or ancillary services are coordinated by the PCP or the practice integrates these services into the PCP practice.
- Quality and safety drive patient care.
- The medical home provides enhanced access (e.g. evening and weekend hours).

The medical home model complements the goals of the U.S. Surgeon General Office, the American Academy of Pediatrics (AAP), Healthy and Ready to Work (HRTW), and many other state and federal organizations to transition youth with special health care needs from pediatric to adult medical care in a smooth process. In a medical home, the shared responsibility of youth, family and provider in meeting the needs of a youth with a chronic condition or disability creates a pathway of support through adolescence and early adulthood. *(For additional information on the linkage between medical home and transition of youth with special health care needs, see "A Health Care Provider's Guide to Helping Youth Transition from Pediatric to Adult Health Care", Section 2: Transition and the Medical Home.)*

The healthcare reform movement has focused public attention on the importance of high quality primary care services. Those engaged in the effort have been informed of what the physician academies agreed upon in the Joint Principles on the Patient-Centered Medical Home in 2007. One significant feature of the health reform debate is the payment structure for physician services. Among the ideas being discussed is an increase in fees for primary care services provided in a comprehensive medial home model of patient-centered service delivery.

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit 501(c)(3) organization which has focused on improvements in health care quality since its inception in 1990. Under the rubric of Physician Practice Connections®-Patient-Centered Medical Home™ (PPC-PCMH), NCQA has created a set of standards to measure the level to which physician practices are functioning as medical homes. These nine standards, which utilize a scoring system, provide content areas for a clinical practice to focus on in the development of medical home recognition. Among the essential elements, required for recognition, are systems for tracking patient referrals, supportive patient self-management strategies, and measures of physician performance in achieving clinical goals.[7] The Carolina Health and Transition (CHAT) Clinical Toolkit (*Appendix D of the CHAT Medical Practicum*) has been developed to support the documentation goals of PCMH designation.

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[2]The Patient Centered Medical Home, Robert Graham Center , Center for Policy Studies in Family Medicine and Primary Care, 2007. http://www.adfammed.org/documents/grahamcentermedicalhome.pdf Accessed 11/19/09.

[3]Koop, C, Executive Summar: In: McGrap, P, ed. Growing up and Getting Medical Care: Youth with special health care needs. Jeckyll Island, GA; US Public Health Service, 1989

[4]Addressing Transition to Adult health care for adolescents with special health care needs, Scal, P, & Ireland, M, (2005), American Academy of Pediatrics, v. 115, 6, p. 1607-1612, accessed February 28, 2007.

[5]http://www.hrtw.org/healthcare/index.html Accessed 12/03/09.

[6]http://www.medicalhomeinfo.org/Joint%20Statement.pdf Accessed 8/20/08.

[7]http://www.ncqa.org/tabid/631/Default.aspx Accessed 11/20/09.

There are thousands of practices already pursuing this recognition in anticipation of future health reform guidelines, and NCQA provides detailed information at its website. Below is a summary of core elements for NCQA recognition. (See www.ncqa.org for additional information.)

1. Access and Communication (essential element)
   *Example: The practice has the capacity to see patients as they need to be seen.*
2. Patient Tracking and Registry Functions (essential element)
   *Example: Every patient has a problem list.*
3. Care Management
   *Example: The care team does pre-visit planning.*
4. Patient Self-Management Support (essential element)
   *Example: This is an opportunity to teach patients how to call for prescriptions, appointments, carry their own insurance card, educate and provide resources to patients about their disease or condition, etc.*
5. Electronic Prescribing
   *Example: Implement and measure use.*
6. Test Tracking
   *Example: The practice tracks all labs until results available and flags abnormal test results.*
7. Referral Tracking (essential element)
   *Example: The practice uses a system to track referral status.*
8. Performance Reporting (essential element)
   *Example: The practice measures how each physician's HGB A1C testing on their diabetics and reports back how they are doing.*
9. Advanced Electronic Communication
   *Example: The practice has an interactive website.*

Regardless of formal recognition or designation as a PCMH, quality and safety are hallmarks of the medical home model. Appropriate data to support quality and safety efforts are key considerations. Following the chronic care model (*referenced in Appendix B of the CHAT Medical Practicum)*, consideration of the following quality and safety components are recommended[8]:

- 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.

[8]The Patient Centered Medical Home, Robert Graham Center, Center for Policy Studies in Family Medicine and Primary Care, 2007. http://www.adfammed.org/documents/grahamcentermedicalhome.pdf Accessed 12/02/09.

While there are wide variances in resources available to an individual physician or practice group, it is incumbent upon all to agree that the guidelines referenced above can result in improved patient outcomes and greater provider-patient satisfaction. A key principle in "patient-centered medical home" is *home*, a place where the patient feels welcomed and a part of the decision-making process. A key principle in continuous quality improvement (CQI) is the word *continuous*. Tackle small systems improvements first, and as one goal is achieved, look for an opportunity to begin the next improvement.

For more information, see http://www.medicalhomeinfo.org/.

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