



CALIFORNIA ACADEMY OF
FAMILY PHYSICIANS

2009 Congress of Delegates: Patient-Centered Medical Home

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Medical Home

- The goals of this discussion are to:
 - Provide you with background on medical home – history, current status, major activities.
 - Understand resources and perspectives both from a regional and national approach.
 - Have an opportunity to share your feedback and experiences.

Medical Home: Background

- 1967: Concept introduced by American Academy of Pediatrics (AAP)
- 2004: Future of Family Medicine (FFP) expanded the concept
- 2006: ACP introduced its version, the “advanced medical home”
- 2007: AAFP, ACP, AAP & AOA drafted joint principles on the Patient-Centered Medical Home (PCMH)
- Nov. 2008: AMA adopts the joint principles



Medical Home: Background *cont.*

- 7 PCMH Principles include:
 1. Personal physician
 2. Physician directed medical practice
 3. Whole-person orientation
 4. Care is coordinated and/or integrated
 5. Quality and safety
 6. Enhanced access
 7. Payment



Medical Home: Background *cont.*

- Attributes include:
 - Comprehensiveness: planned visits, patient registries
 - Physician-directed: team approach
 - Quality & safety: QI, patient participation
 - HIT: patient registries



Medical Home: Background *cont.*

- Attributes include:
 - Support and coordination by the PCP in forming the care team;
 - Promotion of continuous healing relationships;
 - Robust use of technology; and
 - Service-oriented culture



Medical Home & Subspecialty Care *cont.*

- According to ACP, the following are examples of subspecialists serving as a PCMH:
 - Endocrinology practice treating patients with diabetes on complex insulin regimes or with significant complications.
 - Infectious disease practice caring for an HIV+ patient.
 - Rheumatology practice caring for patients with rheumatoid arthritis.
 - Cardiology practice managing someone with advanced heart failure.
 - Oncology practice coordinating care for a person with a malignancy.

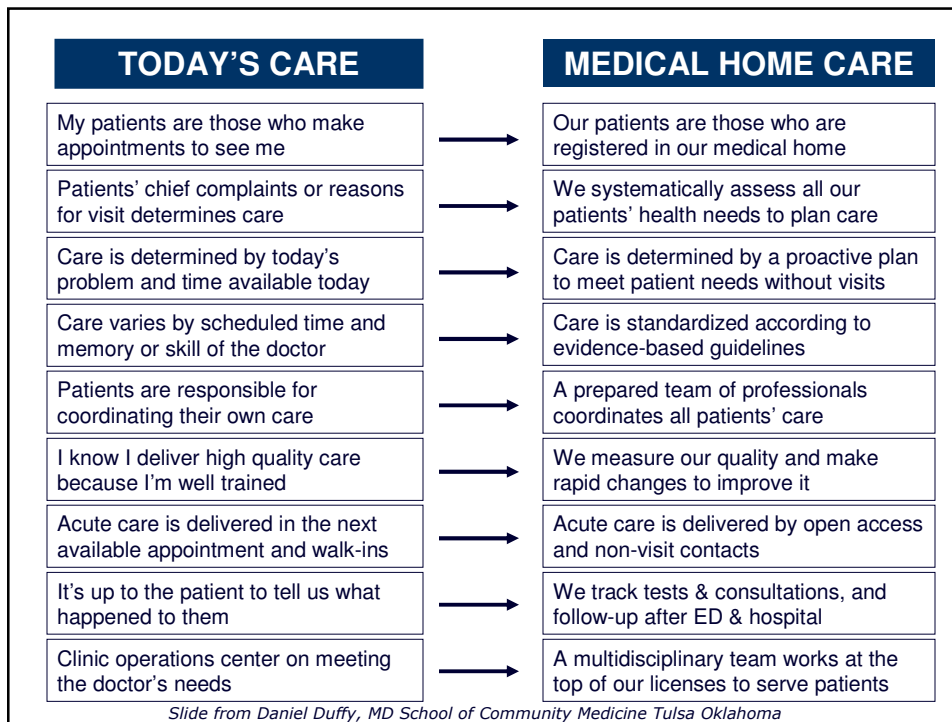


Medical Home & Subspecialty Care *cont.*

When a sub/specialist provides ongoing **principal care** for a patient in the PCMH model:

- This physician would be responsible for routine first contact care (e.g., bronchitis, skin infections, urinary tract infections, routine preventive health measures).
 - or -
- A **principal care** physician hires an NP for primary care.
 - or -
- A **principal care** physician working in a multi-specialist practice can team-up with a primary care colleague.





Medical Home: National Committee on Quality Assurance

- NCQA has developed a certification program
 - Physician Practice Connections Patient-centered medical home (PPC-PCMH)
 - Practice recognition program
 - Objective assessment of practice capability to provide quality care
 - Provides a checklist of office systems and processes to address in your office

Medical Home: NCQA *cont.*

- NCQA definition of a medical home:
 - Each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.
 - The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians



Medical Home: NCQA *cont.*

- PPC-PCMH has 3 levels of recognition and measures:
 - Access/communication
 - Patient tracking/registry functions
 - Care management
 - Patient self-management support
 - E-prescribing
 - Test/referral tracking
 - Performance reporting
 - "Advanced" electronic communication



Medical Home: NCQA *cont.*

- Scoring is done by 3 levels and consists of 10 elements:
 - **Level one:** must pass 5 elements at a 50% scoring level
 - **Level two:** must pass 10 of 10 at a 50% scoring level (50 – 74 points)
 - **Level three:** must pass 10 of 10 at a 50% scoring level (75+ points)



Medical Home: NCQA *cont.*

- Status:
 - In 2008, tested models around the country to determine
 - Associated quality/cost outcomes?
 - Payment associated with recognition?
 - Still waiting for details, but . . .



Medical Home: Tools

- AAFP's TransforMED PCMH assessment tool (free)
- Patient-Centered Primary Care Collaborative
<http://www.pcpcc.net/>
- CAFP Diabetes Resource Center & *Practice Management News* articles www.familydocs.org
- Colorado AFP tools:
www.coloradoafp.org/cafp/pages/medicalhome.asp
www.coloradoaguidelines.org/ipip/rmd.asp
- Family Medicine Digital Resource Library (search "medical home" for tools and templates) www.fmdrl.org
- Your team!



Medical Home Resources

- The Medical Home, Access to Care, and Insurance: A Review of the Evidence (*Pediatrics* 2004; 113; 1493 - 1498)
- The Medical Home: An Idea Whose Time Has Come . . . Again (*Family Practice Management*, Sept. 2007)
- The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change (Robert Graham Center, November 2007)
- Making Medical Homes Work: Moving from Concept to Practice (Center for Studying Health Systems Change, December 2008)





Questions:

1. How do elements of the medical home, such as advanced access and whole-person orientation, create the foundation for the physician-patient relationship?
2. What are the opportunities and barriers to adopting a medical home model in our current dysfunctional payment system? Discuss the financial viability issues related to the medical home model.



Questions *cont.*

3. What are the resources that family physicians can use as they work toward implementing the various elements of the medical home?
4. If and/or when a primary care medical home is available to all patients, what will this look like from both the physician and patient perspective?

