November 2007

AAFP Talking Points:
Patient Centered Medical Home

What is a patient centered (or personal) medical home?

The patient centered medical home model is based on the premise that the best health care is not episodic and illness-oriented. Rather, high quality care is patient-centered, physician-guided, on-going and cost-efficient.

A patient centered medical home is a physician practice that has, at its core, an on-going partnership between a patient and his or her physician. The physician, with the assistance of his/her practice team, helps the patient navigate the complex and confusing health care system by coordinating and facilitating services with other qualified medical professionals.

These physician offices:

- use evidence-based guidelines in the treatment of chronic conditions, acute illness and injury, and the provision of preventive care;
- coordinate care across all settings – practices, hospitals, nursing homes, consultants and other components of the complex health care network;
- serve as the patient's "library" of medical records, where the essential elements of a patient's history and health care interactions would be stored, and
- use a team approach, capitalizing on the expertise of mid-level practitioners and medical subspecialists;
- use, or commit to using, health information technology (e.g., registries, electronic prescriptions, electronic health records, personal health records, secure e-mail) to guide and facilitate each patient's care.

Isn't the term "medical home" just another word for gatekeeper or managed care?

No. In fact, the medical home concept is designed to ensure that patients receive the care they need, when they need it. That means a fundamental role for the medical home is to ensure that physician, non-physician health professionals and all other members of the patient's care team communicate with one another about the patient's care, to provide access to subspecialists, and to help the patient understand how their subspecialists' care is related to and affects their overall health care.

How will doctors be approved for Medical Home designation?

DOCTORS will NOT be approved for medical home designation — the PRACTICES will be recognized; this is a practice-level designation and we need to be careful to use that language to differentiate the process from board certification and maintenance of certification. For now, practices would need to be part of a PCMH demonstration project. As soon as NCQA has the criteria posted on their Web site, practices may begin reviewing the criteria and entering the designation process.

How does a physician practice apply to become a Medical Home?

See above. Demonstration projects. The process would be per NCQA, which typically includes an on-line tool for an initial assessment done by the practice to see a preliminary score, followed by a full application with appropriate documentation (and a fee).

How long do you think it will take for every primary care physician in America to qualify to become a Medical Home?

We are not aiming at this point to get every physician practice designated; many will not want to go through the process; for some it may not make sense ... and for now, this recognition process will be limited to those practices participating in NCQA demonstration projects.

Will the Medical Home cost patients more?

No – it is not anticipated that a Medical Home will cost patients more.

The hope is that the Medical home will actually save the health care system money. For example, in North Carolina, where many elements of the Medical Home model have already been implemented, significant cost-savings have been experienced by the State.

By restructuring physician reimbursement, doctors are compensated on the basis of provision of the services inherent in a medical home, such as extended clinic hours, consultation with outside specialists, overall wellness management, etc. Physicians are not simply compensated for face-to-face visits, lessening the expense of a consultation, incentivizing a broader service base.

Is there a Medical Home we can experience now?

There are several pilot/demonstration projects around the country:

- In North Dakota, United has a medical home in operation and has seen some good evidence of success.

- The Veterans Administration has some operational medical homes and can attest to significant emergency room avoidance.

How will the AAFP help its members prepare to become a patient centered Medical Home?

At the same time we are educating health care policy makers, business decision makers and opinion leaders about the benefits of the medical home concept, the Academy must embark on an internal communications campaign to inform its members and chapters on the advantages of becoming a designated medical home.

The Academy will develop materials and information that clearly explain the economic benefits of becoming an official medical home to family physicians and the health benefits to their patients.

A comprehensive set of practice transformation tools is being developed for members, including on-line practice readiness assessments cross-walked with the NCQA PPC PCMH criteria. Many existing Academy and TransforMED resources, and others yet to be identified or developed, will be linked to fill any gaps that are revealed by the on-line assessments. These activities are currently in the planning and development phase within the Practice Support Division and TransforMED. Testing of TransforMED's initial on-line assessment tool will begin in early December 2007.

The AAFP's Commission on Quality is providing active member oversight and content input to this project. How to assist members in meeting level one NCQA PPC PCMH designation is a priority item on the COQ's January 2008 agenda. Integration of these activities with TransforMED is occurring.

Marketing resources will help guide the development of tools to assist members including market research and member feedback as well as developing a campaign to get the message to the members. Promoting the AAFP's support to members and the tools, assessments and resources available to them, is expected to begin the first quarter of 2008.

AAFP Talking Points:
Patient-Centered Primary Care Collaborative

The Patient-Centered Primary Care Collaborative is a coalition of major employers, consumer groups, and other stakeholders who have joined with organizations representing primary care physicians to develop and advance the patient centered medical home.

The Collaborative 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, employers, consumers, patients, physicians and payers have agreed that it is essential to support a better model of compensating physicians.

History of the 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-provider relations, and 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.

The Collaborative's membership contains a number of large national employers, most of the major primary care physician associations (AAFP, ACP, AOA), health benefits companies, trade associations, profession/affinity groups, academic centers, and health care quality improvement associations.

The PCPCC has created an open forum whereby healthcare stakeholders freely communicate and work together to improve the future of the American medical system. The Collaborative also acts as a key source for the continued education of Congressional representatives, the federal and state governments, and individual practices on the patient centered medical home model as a superior form of health care delivery.

AAFP Talking Points:
PCPCC Summit, November 7, 2007

To shine a national spotlight on the need for system reform that will get the nation's health care focused where it belongs — on preventive and primary care, the AAFP was instrumental in facilitating a medical home symposium for policymakers, purchasers and employers in Washington on November 7, 2007 (done in cooperation with the Patient Center Primary Care Collaborative).

The event was attended by more than 240 business leaders, policy analysts, consumer organizations and physician groups, underscoring the growing recognition of primary care and the patient-centered medical home as the most effective means of improving quality and reducing costs.

We believe that the tremendous success of this event will serve a major turning point in our collective efforts to move our nation's health care system to one that is primary care-based.

As part of the Summit, the AAFP's Robert Graham Center produced a white paper entitled, "The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change." The paper is available online at:
http://www.aafp.org/online/etc/medialib/aafp_org/documents/about/pcmh.Par.0001.File.dat/PCMH.pdf

AAFP Talking Points:
NCQA Medical Home Designation Program

The NCQA's voluntary designation program will be used to recognize physician practices as patient-centered medical homes, a development designed to promote comprehensive and coordinated care.

"This (program) is a way of handing a blueprint for the patient-centered medical home to physician practices," said NCQA EVP Greg Pawlson, M.D., M.P.H. "Physician practices can then decide how to implement the criteria."

The NCQA developed the criteria for the recognition program in conjunction with the AAFP, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association.

The NCQA criteria serve as a "roadmap for practices to follow"; program criteria are based on a series of requirements, including patient registries, care management programs, electronic prescribing and follow-ups on tests, among other measures.