

Frequently Asked Questions: 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 and their staff:

- 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. 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?

The Recognition application process would be through NCQA, which typically includes an on-line tool for an initial assessment done by the practice. When ready, the practice submits a full application with appropriate documentation (and a fee).

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 and Washington, where many elements of the Medical Home model have already been implemented, significant cost-savings have been experienced in those States.

By restructuring physician reimbursement, doctors are compensated by providing comprehensive 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, thereby, incentivizing a broader service base.

Is there a Medical Home we can experience now?

There are several pilot/demonstration projects around the country. Colorado was one of the pilot/ demonstration sites and has 16 NCQA recognized PCMHs. Coming soon- CAFPP will be promoting a “Parade of Medical Homes” highlighting the pilot sites.

How will the CAFPP 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

through AAFP, the Academy must embark on an internal communications campaign to inform its members on the advantages of becoming a designated Medical Home.

The Academy has received a grant and 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.

CAFP and AAFP also have several resources available on the websites to help a practice through the NCQA application process. In addition, CAFP has a PCMH Resource Advisor to guide you to additional resources.

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.

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 Executive VP 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.