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The Patient Centered Medical Home: Federal, State and Local Initiatives to Transform Primary Care

The First of an Occasional Series in Interprofessional Education and Care in the Patient-Centered Medical Home

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The Patient Centered Medical Home (PCMH) is rapidly emerging as one prototype for redesigning health care delivery, restructuring reimbursement, and reestablishing the critical value of primary care. The actual term “medical home” was introduced by the American Academy of Pediatrics, (AAP) in 1967, initially referring to a central location for archiving a child’s medical record. In 2002, the AAP expanded the medical home concept to include care characterized as accessible, continuous, comprehensive, patient-centered, coordinated, compassionate, and culturally effective. In 2004, the American Academy of Family Physicians (AAFP) embraced the model in its Future of Family Medicine project report, and in 2006, the American College of Physicians (ACP) similarly issued a report endorsing the primary care medical home. Soon thereafter in 2007, the AAP, the AAFP, the ACP, and the American Osteopathic Association (AOA) wrote a document entitled the Joint Principles of the Patient-Centered Medical Home. The Principles of the PCMH include the following:

- **Personal clinician**: Each patient has an ongoing relationship with a personal primary clinician trained to provide continuous and comprehensive care.
- **Clinician leads a team**: A team of individuals, led by the primary clinician, provides care and collectively takes responsibility for the ongoing care of patients.
- **Whole-person orientation**: All needs of the patient are addressed including the provision of acute, chronic, preventive, and end-of-life care. Care is provided in a culturally and linguistically appropriate manner.
- **Care is coordinated and integrated**: Care is coordinated across all elements of the complex health care system and the patient’s community, and is facilitated by registries and information technology.
- **Quality and safety**: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes. Evidence-based medicine and clinical decision-support tools guide decision-making. Clinicians accept accountability for measurement and improvement projects.
- **Enhanced access**: Access is facilitated through expanded hours, advanced-access scheduling systems, and new forms of communication.
- **Payment**: A business model in partnership with payers is developed that provides enhanced payment that appropriately recognizes the added value of the PCMH and supports the development of new systems of care that emphasize the aforementioned principles.

Currently, the concept of the medical home is receiving increased attention as a strategy to improve access to quality health care for more Americans at lower costs. Emphasis on primary care as the foundation of health care delivery reform emerges from evidence demonstrating that systems of care based on primary care provide better health outcomes, greater cost savings, and greater reductions in health care disparities. While more research is needed to evaluate the individual aspects and collective impact of the PCMH, preliminary data support the ability of medical homes to advance societal health. An essential step in the transformation to a PCMH involves a move from physician-centered care to an interprofessional team approach in which care is shared among several professionals, each bringing their particular expertise to support a person-centered plan of care which promotes health and optimizes prevention.

In 2007, Pennsylvania Governor Edward Rendell created the Office of Health Care Reform (OHCR) to improve health care for all Pennsylvanians. By executive order, he also established the Pennsylvania Chronic Care Management Reimbursement and Cost Reduction Commission to develop a strategic plan to improve quality and reduce cost in the area of chronic care. In 2008, this Commission initiated a three-year project to transform health care and improve chronic care management by supporting the development of PCMHs throughout the state. Jefferson Family Medicine Associates (JFMA) was one of 32 primary care practices, and one of two academic teaching practices, selected to participate to pilot this initiative in Southeast Pennsylvania.

Through its participation in Pennsylvania’s Chronic Care Initiative and related work, JFMA has developed the major components and characteristics of the PCMH including but not limited to: an advanced open access system; clinician directed interdisciplinary clinical teams involving clinical pharmacists, health educators, nurses, medical assistants, occupational therapists, and patients themselves, as key members of clinical teams; embedded mental health, fitness, pain management, and chronic disease self-management programs; a fully functioning group visit program for patients.
with diabetes; patient registries; electronic medical records with electronic prescribing; quality and safety programs with a new Quality Improvement Coordinator including public reporting of quality outcomes; case management, using insurance databases to identify and manage high risk and high utilizing patients; a network of community-based resources and partners to support patient education, diet, exercise, and disease management; and payment reform, including participation in multiple pay-for-performance programs. In 2009, JFMA received recognition as a Level 3 (highest level) NQCA PCMH. However, despite such recognition, there is still much more work to be done. Indeed, our experience in the Chronic Care Initiative has shown us that practice transformation is a constant, ongoing process. We look forward to sharing details of the JFMA experience and other medical home models in future installments of this series.

REFERENCES