

Primary Care Practice Facilitation Curriculum

Module 25: The Patient-Centered Medical Home:
Principles and Recognition Processes



Agency for Healthcare Research and Quality

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Primary Care Practice Facilitation Curriculum

Module 25. The Patient Centered Medical Home: Principles and Recognition Processes

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Module 25. The Patient Centered Medical Home: Principles and Recognition Processes

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge in the principles of the patient centered medical home (PCMH)

Time

- Pre-session preparation for learners: 60 minutes
- Session: 75 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the five core principles and functions of the PCMH.
2. Describe the main PCMH recognition programs, as well as the factors that should be considered when a practice selects a recognition program.
3. Locate resources available for ongoing PCMH initiatives.
4. Describe the major PCMH payment models currently in use.
5. Locate sources to stay apprised of new developments related to the PCMH.

Exercises and Activities To Complete Before, During, and After the Session

Pre-session preparation. Ask the learners to review the following information. (60 minutes)

1. The content of the module.
2. Agency for Healthcare Research and Quality. Patient Centered Medical Home Resource Center: Defining the PCMH. Available at <https://www.ahrq.gov/ncepcr/tools/pcmh/defining/index.html>.
3. National Academy for State Health Policy. States with medical home activity for Medicaid/CHIP. Available at <https://www.nashp.org/state-delivery-system-payment-reform-map/>.
4. Information under the “Medical Home” tab of the Patient-Centered Primary Care Collaborative website. Available at <https://www.pcpcc.org/about/medical-home>.

Preparation (1 hour)

1. Prepare a presentation that introduces the principles of PCMH, provides the basics of PCMH recognition programs, and describes the ways in which the PF will work with practices on PCMH-related activities.

During the session. Presentation (15 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (60 minutes)

1. What are the core principles of the PCMH? Why is it important for a primary care practice to align the care it provides with these principles?
2. What are the major PCMH recognition programs? How can a practice facilitator help practices determine which recognition program is most suitable?
3. What are some of the resources a practice facilitator can use to identify ongoing PCMH initiatives that might be relevant to a particular practice?
4. What are some of the payment models that payers are currently using to incentivize practices to obtain PCMH recognition or adopt various elements of the PCMH?

After the session

1. Ask learners to review the additional resources provided at end of the module.

Module 25.

The patient centered medical home (PCMH) model has become a cornerstone of primary care redesign. While the concept of the medical home was first introduced for pediatric settings by the American Academy of Pediatrics in 1967, the major primary care physician associations developed and endorsed the joint principles of the PCMH in 2007. Since then, the PCMH concept has become increasingly important as Medicare, Medicaid agencies, health plans, and other payers seek to improve the quality of care they purchase and to control costs. Based on recent information collected by the Patient-Centered Primary Care Collaborative (PCPCC), there are nearly 500 public and private medical home initiatives across the United States (PCPCC, 2014). Payers and others are working to gather evidence of the effects of different approaches to implementing the medical home model, so the model can be refined and adapted to the varied needs of patients, practices, and regions.

Several major programs offer PCMH recognition or accreditation for medical practices. The most commonly used recognition program is that of the National Committee for Quality Assurance (NCQA). NCQA has recognized roughly 5,700 practice sites (which include about 28,000 clinicians) as medical homes. Other recognition entities include the Joint Commission, URAC (formerly the Utilization Review Accreditation Commission) and the Accreditation Association for Ambulatory Health Care. In addition, some states and payers have their own medical home recognition programs.

This module is designed to:

- increase your knowledge of and familiarity with the principles and concepts of the PCMH,
- provide you with an introduction to some of the PCMH recognition programs in which practices may be participating, and
- familiarize you with a range of models that some private and public payers use to incentivize practices to adopt the PCMH model of care (including examples of ways these models are being implemented in different states).

This module will provide information and resources for working with practices as they seek and attain PCMH recognition, which is the process through which a practice achieves its status as a medical home. This process is also sometimes referred to as “accreditation” or “certification.” Understanding the principles of the PCMH will help you support practices through the recognition process, which can be challenging, while ensuring that the objectives of true practice transformation to a PCMH do not get lost as practices document processes to achieve PCMH status.

Principles and Concepts of the PCMH

According to the Agency for Healthcare Research and Quality (AHRQ) and the Patient-Centered Primary Care Collaborative (which based their definition on AHRQ’s), the PCMH is built

around five core principles and functions: comprehensive care, a patient-centered approach, coordinated care, accessibility of services, and quality and safety.

- **Comprehensive care.** The PCMH is oriented toward the “whole person” and is responsible for addressing all the patient’s physical and mental acute, chronic, and preventive health care needs. This involves the direct provision of the appropriate care when possible or arranging for other qualified professionals (such as specialists) to provide care when necessary. Care within the primary care setting is delivered by a team rather than a single clinician, so professionals with different skill sets are available to meet the patient’s needs. ([Module 28](#) has more information on team-based care and working with practice teams.)
- **Patient-centered approach.** The PCMH provides care that is relationship based and tailored to best meet each patient’s needs, values, culture, and preferences. Each patient has the opportunity to build ongoing, trusting relationships with a team of health care professionals. Clinicians seek to engage patients in their health care; provide the support, education, and information they need to make informed health care decisions; and recognize them as important members of the care team. PCMH clinicians and health care professionals use their cultural competence to treat patients with dignity, respect, and compassion, and they seek to meet patients where they are so that care is delivered in the way that best suits the patient’s needs.
- **Coordinated care.** All of a patient’s health care is coordinated by the PCMH, including care received in hospitals, from specialists (including mental and behavioral health specialists), and through community or home-based services and supports. Coordination of care may be facilitated by patient registries, use of health information technology (such as electronic health records), and other methods. To ensure that care is properly coordinated, the PCMH strives to build strong communication with patients and among all members of a patient’s care team. The goal of coordination is greater efficiency through avoidance of duplication of services, synchronization of services so that they have a maximum impact, and ensuring connection of patients to needed services.
- **Accessibility of services.** To ensure that patients are able to access care when they need it, the PCMH offers short wait times for urgent care, enhanced hours, and around-the-clock access to the care team via telephone or electronic methods (email, patient portal, etc.). Care teams also seek out and respond to patient preferences regarding access and communication (e.g., whether patients prefer to communicate via email or telephone, and what language they prefer to use when getting care).
- **Quality and safety.** To achieve optimal patient health outcomes and the highest quality of care, the PCMH is committed to quality improvement (QI), performance improvement, patient satisfaction, and population health management. Practices use evidence-based medicine and decision support tools to guide shared decisionmaking and use patient registries to track the health status of their entire patient panel. Practices use data-driven QI methodologies to continuously monitor performance in a variety of care areas. Patients are engaged in QI processes and involved in practice decisionmaking to ensure

that care is provided in accordance with patient wants and needs. ([Module 8](#) has information on and resources for supporting QI work.)

These principles closely align with the core values of primary care, which are defined by the Institute of Medicine as providing integrated, accessible health care services to meet the majority of personal health care needs in a sustained partnership with patients in the context of family and community (see [Module 3](#), Primary Care Landscape and Context, for more details).

Key sources of information on the PCMH

- <https://www.ahrq.gov/ncepcr/tools/pcmh/index.html>
- <https://www.pcpcc.org/>
- <https://medicalhomeinfo.aap.org/Pages/default.aspx>

PCMH Recognition Programs

Currently, at least four major programs offer practices the opportunity to document the ways they provide care aligned with the principles of the medical home, thereby achieving PCMH or medical home recognition. In addition, some payers and states offer their own recognition programs. If a practice you are working with is interested in PCMH recognition, one way that you can help is by encouraging practice leaders to think carefully about which recognition program is most appropriate for the practice.

Table 25.1 outlines four major PCMH recognition programs, along with links to resources that provide more information on each. The practices you are working with may be participating in a program through a state or payer that is not on this list. Nonetheless, since the PCMH principles are common across many programs, the resources available from these organizations will likely be helpful to you and the practices you work with. Program requirements and other details change regularly, however, so you should regularly consult the links provided here to gather the most up-to-date information on various programs.

Table 25.1. Four patient centered medical home recognition programs

Selected Patient Centered Medical Home Recognition Programs			
Accrediting Body	Recognition Program	Program Elements	Resources
The National Committee for Quality Assurance	Patient Centered Medical Home Standards	<ul style="list-style-type: none"> • Patient-centered access • Team-based care • Population health management • Care management and support • Care coordination and care transitions • Performance measurement and quality improvement 	https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/
URAC (formerly the Utilization Review Accreditation Commission)	Patient Centered Medical Home Accreditation	<ul style="list-style-type: none"> • Quality care management • Patient-centered operations management • Access and communications • Testing and referrals • Care management and coordination • Electronic capabilities • Quality performance reporting and improvement 	https://www.urac.org/accreditation-cert/patient-centered-medical-home-certification/
Accreditation Association for Ambulatory Health Care	Medical Home Standards	<i>Not publicly available.</i>	https://www.aaahc.org/accreditation/primary-care/medical-home/
The Joint Commission	Primary Care Medical Home Certification	<i>Not publicly available.</i>	https://www.jointcommission.org/accreditation-and-certification/certification/certifications-by-setting/hospital-certifications/primary-care-medical-home-certification/

To determine which recognition program is most appropriate or suitable for a given practice, the American Academy of Family Physicians recommends that practices take the following three steps:

1. **Determine whether any initiatives are underway in the state or region to help practices become certified as a PCMH.** See the section below on “PCMH Initiatives and Payment Models” for more information on this topic.
2. **Learn whether the practice is required to become recognized as a PCMH by an outside group or entity.** For example, a practice may be asked to become a PCMH by an accountable care organization or may be required or incentivized to do so by a government agency, such as the Health Resources and Services Administration (HRSA) or the Centers for Medicare & Medicaid Services (CMS). Often such programs and initiatives require that participating practices achieve PCMH recognition with a *specific* program (that is, practices cannot necessarily choose which PCMH program to pursue).
3. **Assess what PCMH recognition programs are preferred or incentivized by the major payers with whom a practice contracts,** such as Medicaid, private health plans, Medicare, or other payers.

A practice will likely also want to consider the costs of attaining PCMH recognition. Some recognition programs charge fees, which may or may not be covered by a payer or other entity. However, in addition to recognition program fees, the overall cost also includes staff resources dedicated to achieving recognition, which can be extensive. In addition, some recognition programs require that practices have electronic health records that meet meaningful use standards. As a practice facilitator, it will be important for you to help practices understand that the recognition process will require a great deal of staff time, effort, and resources.

Once the practice has selected the recognition program that it will use and obtained the set of standards for the chosen program, the practice can start the work of documenting its current performance and making any necessary changes to practice processes and care delivery to achieve PCMH recognition.

Most PCMH recognition processes have many components, requiring input and cooperation from almost all members of the practice. Having an established QI or practice transformation team in the practice is an important part of successfully completing the process. (See [Module 8](#) on QI and [Module 28](#) on teams, which offer information on how to support this step.)

In the past, the Urban Institute (<https://www.urban.org/>) and the Medical Group Management Association (<https://www.mgma.com/>) compiled documents that compare and contrast medical home recognition programs. The information in these documents may not be current, but these organizations may offer updated comparisons in the future, so it is helpful to become familiar with their Web sites and perhaps join any mailing lists that would provide updated information.

PCMH Initiatives and Payment Models

Many payers across the country are implementing new payment systems that incentivize practices to achieve full PCMH recognition or implement certain aspects of medical home (such as care management or the use of care teams). These payers include private health plans and state Medicaid programs (about half of which had implemented new payment structures that reward practices for performing the functions of a PCMH as of 2012) (National Academy for State Health Policy, 2015; Takach, 2012). Some states have also implemented multipayer initiatives that provide enhanced payment to PCMHs (Edwards et al., 2014).

Identifying PCMH initiatives. Several resources are available to help practice facilitators identify PCMH initiatives in their state or region:

- The National Academy for State Health Policy provides a detailed list of medical home initiatives in each state: available at <https://www.nashp.org/state-delivery-system-payment-reform-map/#toggle-id-2>
- The Patient-Centered Primary Care Collaborative provides a list of primary care innovations and PCMH programs, which is searchable by location or program name: available at <https://www.pcpcc.org/initiatives/list>
- The National Resource Center for Patient/Family-Centered Medical Home provides a list of national demonstration projects and state initiatives: available at <https://medicalhomeinfo.aap.org/national-state-initiatives/Pages/default.aspx>

Understanding payment models of PCMH initiatives. Payers use a variety of financial incentives and payment models to encourage primary care practices to become medical homes.

The Safety Net Medical Home Initiative has outlined five potential payment models that public and private payers might consider to incentivize PCMH activity (Bailit et al., 2010). Table 25.2 describes these models and provides examples of each model.

Table 25.2. PCMH payment models

Model Type	Description
Fee-for-service (FFS) with adjustments	FFS with specialized codes for PCMH services or higher FFS rates.
FFS Plus	This model includes several possible approaches, such as: <ul style="list-style-type: none">• FFS models with lump-sum payments to cover the work necessary to obtain PCMH recognition.• FFS with a per-member per-month (PMPM) payment, sometimes called a monthly care coordination or care management payment.• FFS with a PMPM payment and pay for performance based on predetermined performance measures.

Model Type	Description
Shared savings	This model includes all approaches with a shared savings component (for example, FFS with some share of savings distributed to practices that reduce costs compared to a benchmark – these programs usually include quality of care standards to ensure that reductions in cost do not reduce care quality).
Comprehensive payment	Similar to a capitated (per-person) payment model but includes enhanced payments to support PCMH activities.
Grant-based payment	Grant-based payments are awarded to cover PCMH transformation costs.
Other models	<ul style="list-style-type: none"> • Administrative support to help practices transform. • Central utility models that allow practices to share important PCMH resources (for example, care coordination services, QI programs).

Note: This table was adapted from one available at <https://www.safetynetmedicalhome.org/sites/default/files/Policy-Brief-1.pdf>.

Understanding the growing role of multipayer initiatives. Multipayer initiatives align incentives across payers and provide guidance to primary care practices on how to redesign and improve care. For example, the Center for Medicare and Medicaid Innovation (CMMI), part of CMS, launched the Comprehensive Primary Care (CPC) initiative in 2012. CPC was a 4-year initiative designed to test practice redesign models and a multipayer payment model (For more information, see <https://innovation.cms.gov/innovation-models/comprehensive-primary-care-initiative>). In this initiative, Medicare worked with commercial payers and Medicaid agencies to provide enhanced payments that are not based on visits and shared savings, performance feedback, and shared learning activities to primary care practices that take on the task of providing their patients with comprehensive primary care. A number of states (such as New York and Oregon) have also pursued multipayer initiatives focused on the PCMH or related transformation activities.

Summary and Conclusions

Given the growing use of PCMH recognition programs and new payment models to improve the quality of primary care, you will likely encounter many practices in various stages of the medical home recognition process. As a PF, you can help practice staff stay focused on the overall goals and objectives of the PCMH embodied in the principles and concepts described here as they make their way through the recognition process. After a practice achieves PCMH recognition, you can play a key role in helping the practice maintain a QI infrastructure and continually refine and improve its approach to delivering patient care.

Resources

- Definitions and joint principles of the PCMH
 - <https://www.ahrq.gov/ncepctr/tools/pcmh/defining/index.html>
 - <https://www.pcpcc.org/about/medical-home>
- Payment Approaches
 - https://www.pcpcc.org/sites/default/files/media/payment_brief_2011.pdf
 - <https://www.safetynetmedicalhome.org/sites/default/files/Policy-Brief-1.pdf>
- Toolkits
 - <https://medicalhomeinfo.aap.org/tools-resources/Pages/Building%20Your%20Medical%20Home%20Guide.aspx>
 - <https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/medical-home/recognition.html>

References

Bailit M, Phillips K, Long A. Paying for the medical home: payment models to support patient-centered medical home transformation in the safety net. Seattle: Bailit Health Purchasing and Qualis Health; October 2010. Available at <https://www.safetynetmedicalhome.org/sites/default/files/Policy-Brief-1.pdf>

Edwards S, Button A, Hong J, et al. Patient centered medical home initiatives expanded in 2009-12: providers, patients, and payment incentives increased. *Health Aff* 2014;33(10):1823-1831.

Patient-Centered Primary Care Collaborative. “Mapping the medical home movement: PCPCC launches map highlighting enhanced primary care programs and patient-centered medical homes.” June 9, 2014. Available at <https://www.pcpcc.org/2014/06/06/mapping-medical-home-movement>

Takach M. About half of the states are implementing patient-centered medical homes for their Medicaid populations. *Health Aff* 2012;31(11):2432-2440.