Patient Centered Medical Home

MaineHealth Consensus Definition and Joint Principles

Introduction

MaineHealth endorses the consensus definition and joint principles of Patient Centered Medical Home as described by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association. Furthermore, a nationally validated assessment tool such as that from the National Committee Quality Assurance (NCQA) will be utilized to survey MaineHealth entity employed practices.

Definition

"The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family." *(2007; representing approximately 333,000 physicians)* Working in collaboration with the medical neighborhood, the goal is to optimize care through an integrated, coordinated approach across the healthcare system.

Joint Principles

The following joint principles describe the PCMH model, and attributes as outlined by AAP, AAFP, ACP, and AOA.

Personal physician[i] – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician-directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. In some practices the team may be lead by a nurse practitioner or physician assistant.

Whole-person orientation – the personal physician is responsible for providing for a broad array of the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes physical and mental[ii] healthcare for all stages of life; acute care; chronic care; preventive services; and end-of-life care.

Care is coordinated and/or integrated across all elements of the complex health care system or "medical neighborhood" (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

– Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
– Evidence-based medicine and clinical decision-support tools guide decision making.
– Physicians in the practice accept accountability for continuous quality improvement through engagement in performance measurement and improvement that is transparent.
– Patients actively participate in shared decision-making and feedback is sought to ensure patients' expectations are being met.
– Information technology including the electronic health record is adopted and utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
– Practices go through a national recognition process, such as that of the NCQA PCMH, to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

– Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication such as secure e mail between patients, their personal physician, and practice staff.

Payment for care appropriately recognizes the added value provided to patients who have a medical home.

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[i] Patients may opt to have a Nurse Practitioner or Physician Assistant as their primary caregiver and in some instances a specialty practice may serve as a PCMH.

[ii] Given that over half of primary care patients have a mental or behavioral diagnosis or symptoms that are significantly disabling, given that every medical problem has a psychosocial dimension, given that most personal care plans require substantial health behavior change—a PCMH would be incomplete without behavioral healthcare fully incorporated into its fabric. A whole person orientation simply cannot be imagined without including the behavioral together with the physical.