

THE PATIENT-CENTERED MEDICAL HOME

The Patient-Centered Medical Home (PCMH) is a model of care based on the relationship between a patient and his/her personal primary care physician. The primary care physicians (pediatricians, internists, family physicians) lead a proactive health care team to provide long-term coordination and management of their patients' health care across all settings. Patients receive the right care in the right setting, and physicians are compensated for the additional time and effort required to manage their patients' care.

The concept of a "medical home" was initially introduced by the American Academy of Pediatrics (AAP) in 1967. In March 2007, the AAP, the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), and the American Osteopathic Association (AOA) issued the "Joint Principles of the Patient-Centered Medical Home" in response to several large national employers seeking to create a more effective and efficient model of health care delivery.

Health care industry experts expect the PCMH model to form the basis for upcoming federal health care reform. In addition, the PCMH model of primary care is the solution chosen by big payers like Blue Cross Blue Shield of Michigan, Medicare and Medicaid, as well as big employers like Ford and IBM, to solve our healthcare system's most pressing problems:

- shrinking Primary Care work force just when the research is clearly showing that Primary Care saves money and improves quality
- unrelenting cost increases currently consuming 17% of GDP
- quality of care lower than other western countries that are paying half what we pay

Principles of Patient-Centered Medical Home

1. Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
2. The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients, using a planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
3. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
4. The goal of the physician and the team is to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
5. The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals, 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 (e.g.,

subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).

6. Evidence-based medicine and clinical decision-support tools guide decision-making.
7. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physicians, and practice staff.
8. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
9. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

How to become a Patient-Centered Medical Home

Becoming a patient-centered medical home (PCMH) means providing the care that you want for your patients. It means:

- implementing some basic and focused information technology solutions,
- formalizing and enhancing some office procedures that you probably already follow, and
- Coordinating the efforts of your staff in caring for your patients with chronic disease, especially diabetes the first year.

It will also mean an increase in the reimbursement you receive from Blue Cross Blue Shield of Michigan (BCBSM) for office visits, an increase of at least 10%. Sparrow Physicians Health Network will help you. Our staff will visit your office, help you plan and help you implement technologies like electronic prescribing and a patient registry.

The BCBSM Patient-Centered Medical Home Designation Program consists of three parts.

1. Calculation of quality/use scores, based on several metrics:

- **Evidence-based care score**
 - Overall rate: Diabetes, CAD, CHF, Low Back Pain, COPD, Antibiotic usage, Medication Management.
 - Pediatric rate: Antibiotic usage, Asthma.
- **Preventive services score**
 - Adult rate: Breast Cancer Screening, Cervical Cancer Screening.
 - Pediatric rate: Adolescent Well Care Visit, Adolescent Immunization Status, Childhood Immunization Status-Combo 3, Well Child Visits in the First 15 Months of Life, Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life.
- **Generic Dispensing Rate**
 - Use rate.
 - Rate of improvement.
- **Emergency Department Use for Primary Care Sensitive Conditions**
 - Separate rates for pediatric-only population.
- **High-Tech and Low-Tech Imaging**
 - Separate pediatric rate for low-tech imaging.

2. Calculation of Patient Centered-Medical Home score, based on accomplishing designated PCMH Capabilities/Tasks that are based on 7 Initiatives:

- **Patient Provider Partnership Initiative**
- **Patient Registry Initiative**
- **Performance Reporting Initiative**
- **Individual Care Management Initiative**
- **Extended Access Initiative**

- Test Results Tracking & Follow-Up Initiative
- Electronic Prescribing Initiative

3. Blue Cross Blue Shield Office site visit:

- A representative from Blue Cross Blue Shield will visit office to review transformation of office to PCMH before designation is given.

The following chart demonstrates how scoring for the 2009 PCMH designation was achieved.

Metric	<i>Weights for Practices w/ Both Adults & Peds Metrics</i>	<i>Weights for Practices w/ only Adult Metrics</i>	<i>Weights for Practices w/ only Peds Metrics</i>
TOTAL	100.0%	100.0%	100.0%
PCMH Initiatives	50.0%	50.0%	50.0%
EBCR	16.7%	16.7%	17.4%
Adult Preventive	2.1%	4.2%	
Peds Preventive	2.1%		4.9%
Adult ED Use	2.1%	4.2%	
Peds ED Use	2.1%		4.9%
GDR Rate	8.3%	8.3%	9.0%
GDR Improvement	8.3%	8.3%	9.0%
Low-Tech	4.2%	4.2%	4.9%
High-Tech	4.2%	4.2%	

How Sparrow Physicians Health Network Will Help You Become a Patient-Centered Medical Home

SPHN will initially visit your office to give a brief overview of the PCMH program and go over the 7 initiatives. Once it is determined that your office wishes to move forward we ask that the office designate an individual who will take ownership of the project and devote time helping to transform the office into a Patient-Centered Medical Home. This person should be comfortable with the day to day operations of the office and have a good working relationship with both physicians and staff.

SPHN will then set up a patient registry and electronic prescribing demonstration if needed. Ariphron patient registry and Dr. First e-prescribing are both free to offices for the first two years. Technical support for set up and operational training is also provided.

Once the office has started using the patient registry and e-prescribing SPHN will help the office work on the other 5 initiatives. SPHN will begin meeting with the office PCMH manager on a regular basis, usually twice a month to start. There will also be contact by phone and e-mail. We will base our contact on how much help you need. Most offices already do many of the tasks that are involved with the 7 initiatives but need help formalizing policies and standardizing processes. SPHN is willing to help wherever your office needs help.

For more information please contact SPHN at (517) 364-8150.