The evolution of the PRIMARY CARE MEDICAL HOME

By David Stevens, MD, FAAFM

The primary care medical home (PCMH) has emerged as one of the core building blocks of transforming the nation's health care delivery system. David Stevens, MD, FAAFM, NACHC Associate Medical Officer and Director of NACHC's Quality Center, was asked to talk about the PCMH concept, its impetus under the Affordable Care Act (ACA)and implications for America's Health Centers.

CHForum: *The concept of a PCMH is not new. Yet, it appears we are only at the stage of defining its components. Ultimately, what will be the determinants of a primary medical care home?*

Stevens: Although common principles of the PCMH have long been recognized, such as accessible, comprehensive, coordinated and patient-centered health care, it is true that the definition itself is evolving. For example, the nurse practitioner, not just the physician, is now recognized as a primary care clinician in a medical home.

As a bit of history – the medical home concept was first introduced in the late sixties by the American Academy of Pediatrics (AAP) to improve care for special needs children. In 2007 four groups, including AAP, the American Academy of Family Physicians, the American College of Physicians and the American Osteopathic Association set forth joint principles that today embrace the vision of the primary care medical home. Those principles include:

- A trusting relationship with a regular primary care doctor
- A team-based approach to delivering care and treating the whole person
- Care coordination and integration across all elements of the health care system and the patient's community (family and public and private community-based services)
- Quality and safety including supports that facilitate communication, information sharing and evidenced-based medicine
- Enhanced access to care in terms of expanded hours of operation, communication between physicians and patients
- Payment structures that recognize the value of primary care services

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Of course, health centers are the one place where comprehensive primary care and community health are joined at the hip. I expect a huge leadership role for health centers in future demonstrations.

CHForum: *What do you see as challenges for providers in moving toward the primary care medical home?*

Stevens: We have learned that transformation to the patient-centered medical home is not a simple or easy process. It requires time, leadership, practice redesign, and integration with other parts of the community health system. Some practices have experienced initial drops in productivity or found that the shift to a different work culture was difficult for some clinicians.

It requires total commitment on the part of staff to shift to a team approach that can lead to improved quality of care and better health outcomes. As a recent study conducted by the American Academy of Family Physicians revealed – it is a developmental process that can take as much as five years to achieve. Unfortunately, we don't have five, or even three years to make these changes.

Supporting patient engagement in the new system of care is also important. Patient satisfaction can decline if patients do not understand the medical home concept and their role in it.

Providers need to be aware that there are structural costs in terms of IT infrastructure as well as capacity for care management, enhanced hours of operation, and care coordination. A significant challenge will be in meeting these costs and assuring support in terms of adequate reimbursement needed to function as a medical home. E-mail, telephone consultations, a per member monthly fee for care coordination, and incentive payments based on performance and outcomes are not part of the current visit-based fee-for-service system.

CHForum: *What specific challenges are ahead for health center providers?*

Stevens: First, **health centers must be prepared to work collaboratively in a team environment.** This means closer collaboration, but also reaching beyond their service sites and integrating themselves as part of their community's health system (i.e., hospitals, emergency and local public health departments, nursing homes, specialists, and other providers). As documented in a 2009 health center survey conducted by the Commonwealth Fund, health centers that have these relationships are associated with higher levels of medical home characteristics.

Secondly, **health centers must adapt to the technological world to advance greater effectiveness and efficiency as well as best practices.** All of us must recognize there is a direct connect between meaningful use of EHRs to manage the care of a patient population and to participate in the exchange of health information across providers and care settings. Obviously, it will entail changes in our operations. Nonetheless, we must recognize that HIT is a vitally needed tool for the future medical home to keep pace and excel in continuous, quality improvement.

CHForum: *What is your advice for community health center leaders?*

Stevens: Health centers must continue to be leaders in this transition into a new era of health care. Over the years, they have defined the basics of a primary care medical home. We must maintain that leadership. We must not only meet but also exceed medical home standards and set the highest benchmarks for quality, cost and patient experience outcomes.

Taking advantage of additional HRSA support, all health centers should begin the process for formal recognition or accreditation as medical homes – leading to 100% recognized medical homes by 2015. As an outcome measurement set is being defined for medical homes, we should be on the cutting edge of testing these measures and documenting outstanding performance. We've done this before with the Health Disparities Collaboratives and we can do it again!