OHIO ACADEMY OF FAMILY PHYSICIANS

OAFP adopted at its board of directors meeting on March 28, 2010, the Joint Principles of the (PCMH) endorsed by AAFP, AAP, ACP, AOA and AMA as the basis for the Ohio definition, and to add some ***Ohio – specific footnotes*** *to further define the terms 'patient-centered,' 'personal physician,' 'quality and safety,' and 'payment.' The footnotes for PCMH in Ohio appear at the end of this document.*

Joint Principles of the Patient-Centered Medical Home
March 2007

Introduction

The patient-centered[1] 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.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH. The American Medical Association (AMA) endorsed these principles in November, 2008.

Principles

Personal physician[2] – 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.

Whole-person orientation - 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. This includes care 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). 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[3] 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 voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making, and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity 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 between patients, their personal physician, and practice staff.

Payment[4] appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:
- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Ohio Footnotes to the Joint Principles

[1] Patient-centered – This model of care recognizes the central role of patients and – when appropriate – their families, as stewards of their own health. In the PCMH, the team of health professionals guides and supports patients and their families to help them achieve their own health and wellness goals.

[2] A personal physician must be a licensed primary care physician and to be considered a PCMH, the practice must meet all PCMH requirements. It shall be recognized that there may be situations in which the patients' relationship is with a certified nurse practitioner (NP) or physician assistant (PA) who provides the principal or predominant source of care for a patient but the ultimate decision making relative to actions of the clinical team lies with the physician (M.D. or D.O.) with whom the NP or PA collaborates. In those instances when the patients' relationship is with an NP or PA, the NP or PA provider, in a medical home team relationship with their collaborating physician, may perform the responsibilities of first contact, continuous and comprehensive care if he or she is otherwise qualified by education, training, or experience to perform the selected acts, tasks, or functions necessary where the acts, tasks, or functions fall within the certified nurse practitioner's or the physician assistant's scope of practice. It shall be understood and clearly stated that in the context of the current model of PCMH, such collaboration by physicians with NPs and/or PAs requires direct involvement of a physician in the care team who ultimately must be responsible for clinical decisions and policies around components of the team care model. These components include, but are not limited to the following: selection of evidenced-based best practices, clinical outcomes analysis, quality improvement, practice population analysis used to develop clinical policies, and monitoring of collaboration (coordination) relationships with other clinicians and providers of care. These PCMH-collaborating physician responsibilities are unique components of the PCMH model that post-date section 4723.48 of the Revised Code. Because these components require the collaborating physician to set policy, the PCMH-collaborating physician must be an active member of the care team and function as the clinical leader.

[3] Clinical outcomes, safety, resource utilization and clinical and administrative efficiency are consistent with best practices.

[4] Transformational change in health care financial incentives should occur simultaneously with, proportionally to and in alignment PCMH adoption.