

Maine Multi-Payer Pilot of the Patient Centered Medical Home

DRAFT

Guiding Principles for Maine Patient Centered Medical Home

The stakeholders of the Maine Multi-Payer Pilot of the Patient Centered Medical Home (PCMH) model endorse the “Joint Principles of the Patient-Centered Medical Home” as outlined by the American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American College of Pediatrics (AAP), and American Osteopathic Association (AOA) in defining the medical home model – see attached.¹

In addition to the AAFP-ACP-AAP-AOA Joint Principles, the stakeholders of the Maine Multi-Payer PCMH Pilot also identify the following additional principles that define implementation of the PCMH model in Maine:

- Given the unique geographic and demographic characteristics of the state and the need to take an inclusive approach to primary care practice, we envision a patient-centered medical home model that is delivered by practice teams that may be broad and varied in their composition but are held to a common set of expectations and consistent standard of care.
- We recognize that nurse practitioners and physician assistants are an integral part of the primary care system, and are important members of the primary care practice team.
- We consider references in the AAFP-ACP-AAP-AOA Joint Principles to “the personal physician” to be too narrow, and use the broader definition of the “personal primary care provider”. Similarly, we more broadly define references to the “Physician directed medical practice” to include “primary care practice”.
- We expand the description of “whole person orientation” in the Joint Principles to include a responsibility of the primary care team to recognize and integrate the patient’s entire healthcare needs, including integration of behavioral and physical health needs.
- We recognize that payment for the medical home must appropriately recognize the added value provided to patients, but also must be balanced by savings from improved efficiencies and decreased costs achieved by reducing inappropriate utilization (e.g. avoidable Emergency Department use and hospitalizations, diagnostic testing not supported by evidence based guidelines) and decreasing unwarranted variations in care.

We further recognize that some stakeholders believe the definition of the Patient-Centered Medical Home as defined by the Joint Principles, and as further defined by the NCQA Physician-Practice Connection-PCMH (PPC-PCMH) standards, are limited, and/or in need of further refinement. As with any relatively new process, we are committed to continually reviewing the Joint Principles and standards, and consider them subject to potential future revision. Today, however, we recognize that they stand as the current national consensus definitions of a Patient-Centered Medical Home and endorse them as the core principles for the PCMH model when considered together with those noted above.

¹ Joint Principles of the Patient Centered Medical Home, AAFP, AAP, ACP, AOA – March 2007

**American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)**

**Joint Principles of the Patient-Centered Medical Home
March 2007**

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth, and adults. The PC-MH 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 PC-MH.

Principles

Personal physician - 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 medical 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; end of life care.

Care is coordinated and/or integrated across all domains of the 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 are hallmarks of the medical home:

- Practice advocates 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 through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

Payment 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 work that falls outside of the face-to-face visit associated with patient-centered care management.
- 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.