

## Assembling Patient-centered Medical Homes—The Promise and Price of the Infrastructure Principles

John C. Rogers, MD, MPH, MEd

The principles of the patient-centered medical home (PCMH) reflect the type of care we provide to patients and the practice infrastructure that supports our work. The care principles are personal physician, physician-directed medical practice, whole-person orientation, and coordinated care, while the infrastructure principles include coordinated care, quality and safety, enhanced access, and payment for added value. I believe that we have been achieving the care principle of the PCMH at a reasonably acceptable level. We can always improve, but that core part of the PCMH is quite well established. The infrastructure principles are the least well developed and offer the greatest promise but also at the greatest price.

The promise that could be realized from enhancing practices to meet the PCMH infrastructure principles is higher reimbursement through a three-part payment structure that as proposed includes (1) per member per month prospective payment component for care coordination, (2) visit-based fee-for-service component, and (3) performance-based component for achievement of quality and efficiency ([www.pcpcc.net/node/14](http://www.pcpcc.net/node/14)).

This reimbursement structure is consistent with the PCMH principle of payment for added value:

*Payment* appropriately recognizes the added value provided to patients who have a PCMH. The payment structure should be based on the following framework:

(1) It should reflect the value of physician and nonphysician staff patient-centered care management work that falls outside of the face-to-face visit.

(2) It should pay for services associated with coordination of care both within a given practice and among consultants, ancillary providers, and community resources.

(3) It should support adoption and use of health information technology for quality improvement.

(4) It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

(5) It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

(6) 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.)

(7) It should recognize case mix differences in the patient population being treated within the practice.

(8) It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

(9) It should allow for additional payments for achieving measurable and continuous quality improvements ([www.pcpcc.net/node/14](http://www.pcpcc.net/node/14)).

The price of the infrastructure principles is the substantial investment of financial and human capital that practices must take to qualify for the added reimbursement. Fulfilling these principles is far from easy, as we are learning from the TransformMED project ([www.transformed.com/](http://www.transformed.com/)):

*Care is coordinated and/or integrated* across all elements of the complex health care system (eg, subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (eg, 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:*

(1) 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 among physicians, patients, and the patients' family.

(2) Evidence-based medicine and clinical decision-support tools guide decision making.

(Fam Med 2008;40(1):11-2.)

(3) Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

(4) Patients actively participate in decision making, and feedback is sought to ensure patients' expectations are being met

(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication

(6) Practices go through a voluntary recognition process by an appropriate nongovernmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.

(7) 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 among patients, their personal physician, and practice staff.

The potential of enhanced reimbursement will not be realized unless practices fulfill criteria for recognition as a PCMH and then receive the care coordination and performance-based components of the payment structure. Given the amount of financial investment and time and effort for practice transformation, there are real risks that practices will choose not to make infrastructure improvements or will make improvements but fail to meet criteria to qualify as PCMHs. While payment reform with the three components is not yet implemented, practices need to begin to make infrastructure improvements now to be ready to qualify as PCMHs when the reimbursement structure does change. TransforMED has taught

us that successful practice change is difficult, should be incremental, and must be actively managed. Waiting to begin the process of practice change until after the new reimbursement system is implemented is too late. Transformation of practices needs to begin now (Report from the CEO: "A House Does Not a Home Make") ([www.transformed.com](http://www.transformed.com)).

The key issue is the voluntary recognition process, especially the criteria that need to be met to qualify as a PCMH to receive the care coordination payment and perhaps performance payment. The likely mechanism for practice certification is the Physician Practice Connections (PPC) process of the National Committee for Quality Assurance (NCQA) ([www.ncqa.org/ppc](http://www.ncqa.org/ppc)). NCQA is adapting its PPC methodology to PCMH certification, with final criteria to be released in the near future. The draft of criteria presented at the Patient-centered Primary Care Collaborative Roundtable held in June 2007 outlined elements that must be passed for PCMH certification:

*(1) Standard 1: Access and Communication*

A. Has written standards for patient access and patient communication

B. Uses data to show it meets its standards for patient access and communication

*(2) Standard 2: Patient Tracking and Registry Functions*

A. Uses paper or electronic-based charting tools to organize clinical information

B. Uses data to identify important diagnoses and conditions in practice

*(3) Standard 3: Care Management*

A. Adopts and implements evidence-based guidelines for three conditions

*(4) Standard 4: Patient Self-management Support*

A. Actively supports patient self-management

*(5) Standard 8: Performance Reporting and Improvement*

A. Measures clinical and/or service performance by physician or across the practice

B. Reports performance across the practice or by physician

These criteria on the surface do not appear too difficult to meet, but there is effort and expense to implement these practice features and to apply for NCQA PPC certification. The final NCQA criteria will provide an explicit roadmap for practices to follow to improve their infrastructures, qualify for PCMH certification, and receive enhanced reimbursement when the new three-component system is in place.

Is the promise worth the price? That is the great question, but do we have any alternative? The status quo is unacceptable, and it appears the PCMH movement is gaining support in many quarters and gaining momentum. Will family medicine practices take the risks to be ready for the opportunity? Will family medicine teachers prepare their students and residents to help practices transform and meet the infrastructure principles? I believe that we will, not simply because doing so will likely increase our financial situation but because building PCMHs that meet the care and infrastructure principles will improve the care we provide to meet our patients' and our communities' needs. We will build our PCMH practices, because it is the right thing to do and it reflects our core values.

*Correspondence:* Address correspondence to Dr Rogers, Baylor College of Medicine, Department of Family and Community Medicine, 3701 Kirby, Suite 600, Houston, TX 77098. 713-798-7744. Fax: 713-798-7789. [president@stfm.org](mailto:president@stfm.org).