

Health Policy Forums

Implications of the Patient-Centered Medical Home Concept for Health Professional Training Programs

Michael S. Barr, MD, MBA, FACP

Senior Vice President

*Division of Medical Practice, Professionalism, and Quality
American College of Physicians*

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Dr. Michael Barr, Senior Vice President of the Division of Medical Practice, Professionalism, and Quality at the American College of Physicians (ACOP) presented on the impetus behind the Patient-Centered Medical Home (PCMH), the future of coordinated care, and training health care professionals.

Dr. Barr first discussed the history of the PCMH, which dates back to 1967 as a concept developed by the American Academy of Pediatrics (AAP). Over the years it has evolved and been recognized and adapted by many medical societies. Though never quite executed, the Tax Relief and Health Care Act in 2006 included a Medicare Medical Home Demonstration project. By February 2007 joint principles of the PCMH were outlined and included some of the following components: personal physician, physician- directed medical practice, whole person orientation, coordinated/integrated care, quality and safety, enhanced access to care, and payment to support the PCMH.¹

During this time, the Patient-Centered Primary Care Collaborative (PCPCC) was formed; it included six collaborative centers and over

500 stakeholders. It was started to facilitate improvements in physician-patient relations and create a more effective model of healthcare delivery.² Today, the primary focus of the collaborative is to develop and advance the PCMH.

Dr. Barr explained two key historical markers and their impact on the PCMH. The Affordable Care Act encourages the development of new patient models and emphasizes the establishment of community support teams to support PCMH. The Comprehensive Primary Care Initiative, a program of the Center for Medicare and Medicaid Innovation, was designed to foster collaboration and strengthen primary care in the US. According to Dr. Barr, it is a “game changer.”

Dr. Barr went on to describe the Patient-Centered Medical Home Neighbor (PCMH-N) which takes into account the fact that care is often needed outside of a PCMH. The model emphasizes integration and coordination of services by specialty providers with the PCMH.

Barr also provided an overview of traditional and competency-based education models and

explained the characteristics of Entrustable Professional Activities (EPAs) which focus on the demonstration of the necessary knowledge, skill, and attitudes to be “trusted” to perform the activity independently. Some of the top EPAs identified at a recent summit include: assess and create customized care for patients with language/and or cultural barriers; provide care in non-traditional ways; understand and engage the patient’s care team; and continuity over other sites of care.

The context for teaching to prepare health care professionals should include: whole person orientation; care coordination; quality and safety; and knowledge of enhanced access and payment models.

It is important to note that Jefferson Family Medicine Associates (JFMA) achieved NCQA recognition as a Level 3 PCMH a few years ago, and continues to actively adopt and implement many components of the PCMH.

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REFERENCES

1. Patient Centered Primary Care Collaborative. Joint Principles of the Patient Centered Medical Home. February 2007. <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>. Accessed December 27, 2011
2. Patient Centered Primary Care Collaborative. History of the Collaborative. <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>. Accessed December 27, 2011.