Module 1: Laying the Foundation for a Patient- and Family-Centered Medical Home
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Learning Objectives

- Discuss key characteristics and benefits of the patient- and family-centered medical home (PFCMH) to a practice, patients, and their families, including the role of residents, families, and clinical and community partners.
- Describe the value of establishing a collaborative partnership with patients and families.
- Elicit and incorporate patient and family feedback during a child’s medical visit or encounter with the practice.

Pretest

1. How would you describe a patient- and family-centered medical home (PFCMH)?

2. Which practice characteristic best describes a PFCMH?
   a. It offers patients and families more robust coordinated care during their entire journey through the health care process.
   b. It provides 24/7 access to clinicians.
   c. It makes use of health information technology to improve clinical outcomes, lower the cost of care, and favorably affect patient and family satisfaction.
   d. All of the above.

3. Which of the following features can help distinguish a PFCMH from a traditional pediatric practice?
   a. It offers variable appointment options so that a patient/family can best choose a time that is convenient.
   b. It creates patient registries to better monitor and track patients’ needs.
   c. It ensures a smooth transition of care from hospital to home by arranging to receive hospital discharge summaries within 14 days of discharge.
   d. A and B.

4. Clinicians in a PFCMH should not violate parents’ or patients’ privacy by inquiring about how their social lives affect their ability to adhere to a treatment/care plan regimen. True or false?

Overview

Over the last few decades, there have been numerous attempts by clinicians and policy makers to create a primary care practice model that increases the quality of care patients receive while lowering costs. One of the approaches—the patient- and family-centered medical home (PFCMH)—can provide health care professionals with practical tools needed to accomplish these objectives.
While the term patient- and family-centered medical home is often shortened to patient-centered medical home, it is important to include the word family in any discussion of medical homes because families are key to promoting health and wellness, managing chronic and complex conditions, and assisting with transitions and ongoing care for children and youths of all ages.¹

The PFCMH is not a physical location, but rather a model for providing patients with comprehensive, family-oriented, around-the-clock care. This approach is not only informed by the best available medical science and supported by peer-reviewed evidence, but builds on a philosophy of care that emphasizes compassion and a deep commitment to the patient and families’ wellbeing.

Several key principles form the building blocks upon which the PFCMH rests. The American Academy of Pediatrics has collaborated with the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association to draft a series of core PFCMH concepts. These principles describe the patient- and family-centered care that is at the heart of a medical home as “healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.”²

The concept of the PFCMH was introduced by the American Academy of Pediatrics in 1967.³ Since its inception, it has evolved into a set of foundational principles and an approach that clinicians can incorporate into their everyday routine. Several of these principles are outlined below. The case study that follows is not designed to provide residents with the full clinical picture of a patient but to illustrate how PFCMH concepts can be put into action in everyday medical practice.

Care coordination is one of the most important foundational principles upon which a PFCMH is built. The American Academy of Pediatrics describes care coordination as “an essential element of a transformed American health care delivery system that emphasizes optimal quality and cost outcomes, addresses family-centered care, and calls for partnership across various settings and communities.”⁴ This means every patient has access to a personal physician who serves as the patient’s primary contact and who makes certain that the patient’s journey through the health care system is seamless, regardless of what physical location she receives actual care in. Coordination is facilitated with the help of patient registries, information technology, health information exchanges, and a variety of other tools.

Enhanced access to care is another component in the delivery of high-quality care to patients. In traditional primary care practices, patients often express concern about having to wait weeks or months to see their health care professional. The PFCMH addresses this problem by putting in place several mechanisms, including 24/7 nurse triage, an electronic patient portal for access
to educational materials and laboratory results, and access to the practice by means of telephone, secure e-mail, or secure text messaging (or a combination of those). Some medical homes also offer same-day appointments, weekend hours, and flexible appointment scheduling that allows patients to choose a time slot most convenient to their schedule.

Emphasis on family-centered care, another important component of the PFCMH, calls for clinicians and their practice team (the medical home team) to ensure that any decisions made by the team respect not only the patient’s needs and preferences but also the family’s concerns and preferences. Self-management is an important component of patient- and family-centered care, and a patient’s family can help encourage and facilitate self-management if the child is old enough to take on this responsibility. Whether it’s encouraging patients to take their medication correctly, helping them adhere to a special diet, or helping them avoid harmful health habits, enlisting the family’s support can be incredibly beneficial.

Family-centered care also means the PFCMH staff knows each patient and family they care for well enough to be able to communicate with them in a way they are most comfortable with, whether that be via secure text-messaging, by telephone, or in person. Similarly, it requires members of the medical home team to be sensitive to issues that concern each family, including, for example, transition to adult systems, discussion of sexually transmitted infections, or any number of other health-related issues.

Team-based care is another important component of family-centered care. The National Center for Medical Home Implementation outlines several key “ingredients” needed to transform a medical staff into a team. It explains that “[t]eamwork involves a set of skilled cross-disciplinary interactions that are learned, practiced, and refined to provide better health care services, promote safety, and enhance outcomes.” In practical terms, that means members of an effective team need several skills, including the ability to communicate effectively and respectfully with all other members of the team, and the ability to share ideas freely.

A team huddle is one effective strategy used within the PFCMH to implement a team-based approach to patient care. It can improve team efficiency, communication, and coordination. With a huddle, typically teams come together physically for 5 to 10 minutes at the beginning of each work day or clinical session to plan the day’s activities. This technique allows teams to strategize and anticipate needs of patients and their families.

Team-based care also means including the patient and family in addition to the clinicians and administrators. In fact, patients and their families are the most essential members of the team. Moreover, team members extend beyond confines of the practice. Community partners, specialists,
educational partners, and anyone participating in enhancing the life of a child and his family are part of the PFCMH team.

*Focus on quality improvement* is essential for a PFCMH to be effective. It requires that clinicians adhere to evidence-based treatment and management protocols and use clinical decision support tools to inform their day-to-day decision making. Concern for quality care also translates into a sense of accountability and a willingness to voluntarily engage in ongoing performance measurement and improvement.

**Case Study**

The following case study highlights both an approach to take and the items that need to be explored if a practice wants to truly provide holistic, comprehensive care—the cornerstones of a PFCMH.

Jonathan Mendez, 8 years of age, has moderate persistent asthma. His mother, a single working parent, had to lose a day’s pay in order to bring him to his pediatrician’s office because of a flare-up not responding to his albuterol inhaler. Jonathan has been hospitalized several times in the last year for his asthma. In a follow-up visit after his last hospital stay, he presents with a low-grade fever. Physical examination reveals wheezing, increased work of breathing, and tachypnea. The medical history reveals no comorbidities.

Patients like Jonathan and his mother can benefit in numerous ways from experiencing care in a PFCMH. Given that Ms Mendez has a busy schedule, offering her an online portal that allows her to schedule a visit at her convenience is valuable. The Web-based portal is also useful because it is hard for her to take time during her workday to call the office for an appointment. Similarly, offering appointments late into the evening and on weekends is also beneficial because they do not interfere with her work schedule.

A PFCMH can also help prevent many problems among patients with asthma. Through use of a patient registry, for instance, the medical home staff has a mechanism to make sure Jonathan’s family is notified to schedule and receive flu vaccination. Similarly, a PFCMH can provide a way to coordinate care with the child’s school so that he receives the correct medications on time and has them available in school if needed. A medication portal will also allow Jonathan’s mother to request a refill for his prescribed preventive and rescue medication, ensuring the prescriptions get filled on time.

Equally important for patients like Jonathan is a coordinated care plan for his asthma, including a working or action plan, providing a smooth transition from one treatment setting to another. Jonathan was released from the community hospital a week before this office visit. Fortunately, because communication between the hospital and medical home is good, the office was informed of hospital discharge recommendations and received a copy of the discharge and hospitalization summary within 24 hours of his release. Had that not been the case, important information to be included in the coordinated care plan may have been missed.
Ideally, an information technology–enabled health information exchange would exist that automatically sends a copy of the patient’s discharge summary to the child’s pediatrician. Once the medical home has that in hand, the team can meet to decide on the best course of action and schedule a follow-up visit in the office for the patient, ensuring adherence, understanding, and incorporation of patient and family feedback into the action plan. When a health information exchange is not in place, other arrangements can be made between the hospital and medical home, ensuring receipt of discharge recommendations. That can include secure faxes, secure e-mails, and phone calls.

During the follow-up visit, a member of the medical home team (in this case, a nurse educator), meets with Ms Mendez to evaluate the family situation and determine any obstacle that would hinder her full involvement in Jonathan’s care. The conversation reveals she needs to frequently leave her son with the maternal grandparents, one of whom is a heavy smoker. That will necessitate a discussion with the mother about ways to mitigate the effects of secondhand smoke on his condition, ensure his grandparents understand the implications of their smoking on his asthma, and review how to use a spacer for his inhalers.

The conversation between the nurse or care coordinator and Ms Mendez is also a good time to assess her educational level, language and literacy skills (if English is her second language), and ability to comprehend educational materials on asthma so that the medical home team can make necessary adjustments to working with Ms Mendez to ensure she is a full partner in her son’s care.

A medical home looks beyond usual medical issues that affect a patient’s health. It attempts to delve into psychosocial and other issues that may make it difficult for patients to adhere to a treatment protocol. For instance, during the office visit, someone on the team will want to inquire about Jonathan’s ability to manage his condition at school and in other social situations.

- Is he embarrassed about having to use an inhaler in class?
- Are his classmates harassing him because he can’t participate in sports because of his asthma?
- Is the school aware that he has an asthma action plan and if so, do they understand how to use it?
- Does Jonathan recognize his symptoms indicating when he needs to use his rescue inhaler?

Similarly, the medical home is in a position to identify possible mental health problems in the child or his family, including the stress of caring for a child with a chronic disease. Turchi and Mann explain that “[p]articularly for low-income families whose only point of access to the health care system may be the child’s medical home, screening for social needs during the child’s visits provides opportunities to evaluate and link the families to appropriate resources. This may lead to improved outcomes for low-income children’s health and development.”

Any office visit with a patient with asthma would be incomplete without a detailed conversation about the asthma action plan. Because Jonathan has been a patient in this practice for several months, he already has a current asthma action plan. The visit described in this case study affords clinicians an opportunity to review the action plan to determine if it needs to be adjusted.

A PFCMH thrives on family feedback and their involvement as partners in the decision-making process. Respect for a patient’s and family’s preferences and culture must play a vital role in creating and adjusting the treatment protocol, including the aforementioned action plan. For instance, when reviewing the long-term control and quick-relief medications listed in the action plan, this is a good time to solicit Ms Mendez’s input.
• Is she struggling to pay for Jonathan’s medications?
• Do the cultural beliefs of the Mendez family interfere with adherence to the regimen?
• Does she believe, for instance, that herbal remedies are more effective and less likely to cause adverse effects?

Clinicians in a PFCMH will also want to reach out to specialists that Jonathan’s family are seeing to get details on their visits and solicit information about the family’s interactions with specialists. Since Jonathan has also been seeing an allergist and pulmonologist, the medical home team needs to coordinate these patient encounters with the specialists and obtain the family’s feedback on those visits. Questions worth asking the family include:

• Did the specialist explain why she performed additional testing not done during the family’s visit to the pediatrician?
• Do they understand the treatment plan prescribed by the specialist, or did she use too many technical terms?
• Do they know if the specialist is communicating with the medical home team and if the care plans or treatment plans will be combined?
• Do they have concerns about paying for these tests and treatments?
• Do they know when follow-up with the specialist team is needed?

If English is not the preferred language by which the family communicates or they lack the necessary literacy, professionals may also want to arrange interpretation services when they visit the practice or the specialists’ practices.

Fortunately, applying the PFCMH principles outlined above help Jonathan and his mother bring his symptoms under control. Coordination and integration of care; care planning, along with some adjustments to his medications; better communication with his specialists; and linkages with community resources stabilize his condition and give Jonathan and Ms Mendez the tools and self-confidence to address any medical and psychosocial challenges ahead.

Summary

The PFCMH is a model of care for providing patients with comprehensive, family-oriented, 24/7 access to care. The model emphasizes better care coordination and integration, expanded access to clinicians, a team-based approach, more focus on the family’s needs and preferences, and a concerted effort to improve the quality of care patients receive. As the case of Jonathan Mendez illustrates, this model of care relies on open, respectful communication with patients and their families and an appreciation for the psychosocial issues that affect their lives outside the health care setting.

Posttest

1. How would you describe a patient- and family-centered medical home (PFCMH)?

2. Which practice characteristic best describes a PFCMH?
   a. It offers patients and families more robust coordinated care during their entire journey through the health care process.
   b. It provides 24/7 access to clinicians.
   c. It makes use of health information technology to improve clinical outcomes, lower the cost of care, and favorably affect patient and family satisfaction.
d. All of the above.

Explanation:
Care coordination is one of the most important foundational principles of a PFCMH. It ensures that patient care is organized across all elements of a broader health care system, including specialty care, hospitals, home health care, community services and support, and public health. It requires every patient and family to have a personal physician who serves as the patient’s primary contact and who makes certain that the patient’s journey through the health care system is seamless, regardless of where she receives actual care. Coordination of care is facilitated with the help of tools such as: patient registries, care planning, information technology, health information exchanges, secure text messaging, and secure e-mails. Enhanced access to care is another key PFCMH principle. In traditional primary care practices, patients often express concern about having to wait weeks or months to see their health care professional. A PFCMH attempts to deliver 24/7 nurse triage, an electronic patient portal for access to educational materials and laboratory results, and quick access to practice services as methods to enhance access to care.

3. Which of the following features can help distinguish a PFCMH from a traditional pediatric practice?
   a. It offers appointments at a time that is convenient for the patient and family.
   b. It creates patient registries to better monitor patients’ needs.
   c. It ensures a smooth transition of care from hospital to home by arranging to receive hospital discharge summaries within 14 days of discharge.
   d. A and B.

Explanation:
A medical home arranges with local hospitals to receive patients’ discharge summaries within 24 hours of their release. Ideally, an information technology–enabled health information exchange or work flow would exist that automatically sends a copy of the patient’s discharge summary to the child’s physician, but, when this is not feasible, secure faxes, secure e-mails, and phone calls are acceptable ways to exchange information about the patient’s discharge. Electronic health records are valuable tools for a medical home, but all too often, it is not possible for one record to communicate with another, making it impossible to share discharge summaries in this way.

4. Clinicians in a PFCMH should not violate parents’ or patients’ privacy by inquiring about how their social lives affect their ability to adhere to a treatment regimen. True or false?

Explanation:
One advantage of a PFCMH is that it seeks to help patients address obstacles to care that occur outside the 4 walls of a medical practice. In the case study above, for instance, it was appropriate for the medical home team to inquire about Jonathan’s ability to manage his condition at school and in other social situations. While still respecting the patient’s privacy, one can ask a child, or his parent or family member, whether psychosocial issues will prevent him from adhering to the treatment regimen, for instance.

Reflections to Consider
The following questions are meant to prompt thought and discussion either individually or in a small group. There are no right or wrong answers.
• How would enhancing and/or adopting PFCMH improve the health of your patient population?
• What aspects of the PFCMH would most improve your ability to care for children and families?
• What aspects of PFCMH are you currently employing in your practice?
• What are the barriers to the PFCMH in your current practice? What can you do to address these barriers?

References


Resources

American Academy of Pediatrics
• “AAP Medical Home Resources” Web page (http://aap.org/medicalhome)
• “The Medical Home” policy statement (http://pediatrics.aappublications.org/content/110/1/184.full.html)

National Center for Medical Home Implementation Web site (www.medicalhomeinfo.org) Patient Centered Primary Care Collaborative Transforming Patient Engagement: Health IT in the Patient Centered Medical Home handout (www.pcpcc.org/sites/default/files/media/pep-report.pdf)