Defining the Medical Home: The Oregon Experience

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Objective: **The patient-centered medical home (PCMH) is emerging as a key strategy to improve health outcomes, reduce total costs, and strengthen primary care, but a myriad of operational measures of the PCMH have emerged. In 2009, the state of Oregon convened a public, legislatively mandated committee charged with developing PCMH measures. We report on the process of, outcomes of, and lessons learned by this committee.**

Methods: **The Oregon PCMH advisory committee was appointed by the director of the Oregon Department of Human Services and held 7 public meetings between October 2009 and February 2010. The committee engaged a diverse group of Oregon stakeholders, including a variety of practicing primary care physicians.**

Results: **The committee developed a PCMH measurement framework, including 6 core attributes, 15 standards, and 27 individual measures. Key successes of the committee's work were to describe PCMH core attributes and functions in patient-centered language and to achieve consensus among a diverse group of stakeholders.**

Conclusions: **Oregon's PCMH advisory committee engaged local stakeholders in a process that resulted in a shared PCMH measurement framework and addressed stakeholders' concerns. The state of Oregon now has implemented a PCMH program using the framework developed by the PCMH advisory committee. The Oregon experience demonstrates that a brief public process can be successful in producing meaningful consensus on PCMH roles and functions and advancing PCMH policy. (J Am Board Fam Med 2012;25:869–877.)**

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The patient-centered medical home (PCMH) is a promising strategy to achieve the triple aim of improved health outcomes, better patient experiences, and reduced per-capita costs by strengthening primary care.[1–4] Professional organizations representing US primary care physicians have developed 7 principles that outline the core elements of the PCMH: a personal physician, physician-directed medical practice, whole-person orientation, coordination and integration of care, attention to quality and safety, enhanced access to care, and payment that appropriately recognizes the value of the PCMH.[5] Coalitions of insurers, employers, professional organizations, and others have endorsed these principles, leading to broad agreement about general concepts underlying the PCMH.[6] As the PCMH moves from concept to reality, many entities have developed detailed operational PCMH definitions and measurement strategies based on the needs of their particular stakeholders.[7–11] This diversity of operational definitions has led to a range of projects all bearing the same generic name "medical home."[2,4,12]

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The most widely used tools to measure attributes of a medical home are the PCMH recognition programs developed by the National Committee for Quality Assurance (NCQA).[3,8] The 2008 version of the NCQA criteria has been criticized for a variety of reasons: the administrative burden and expense required to achieve recognition, a failure to emphasize practice characteristics associated with short-term improvement in outcomes, an absence of cost or quality measures, an insufficient emphasis on core primary care functions such as continuity and comprehensiveness of care, an absence of a patient-centered focus, and a lack of emphasis on practice improvement over time.[2,7,10,13–19]

States and insurers have approached perceived shortcomings of the NCQA and other recognition criteria in a variety of ways to create operational PCMH measures that meet the unique needs of their local environments. Strategies have included creating "wrap around" outcome measures for medical homes in addition to NCQA recognition,[20–22] requiring recertification or paying improved rates for higher levels of NCQA recognition,[20–22] or creating independent medical home measures.[9,23,24]

Oregon has a history of producing innovative, community-based solutions to health policy challenges through public engagement of its citizens. In the late 1980s, Oregon developed the Oregon Health Plan (OHP). [25,26] A centerpiece of the OHP was development of a prioritized list of health services[27] to guide coverage decisions under Oregon's Medicaid program. During the process of implementing the OHP, and continuing over the last 2 decades, the state has held hundreds of public meetings and developed deep experience in engaging its citizens to develop new health policies.

In 2009, the Oregon Legislature passed comprehensive health reform legislation.[28] This law established a single agency, the Oregon Health Authority, to oversee all public health care programs within the state, with the goal of consolidating state and local government purchasing power (approximately one third of the insured population in Oregon younger than age 65) to align quality and payment standards and drive delivery system change. The law paid particular attention to primary care, directing the state to develop a program to promote the development of PCMHs, which Oregon's law termed *patient-centered primary care homes* (PCPCHs).

While many articles comment on PCMH policy and payment reform,[3,4,29–31] little has been written about how operational PCMH measures are developed in a policymaking context. Few existing medical home measures were developed in a public forum with input from a broad set of community stakeholders. This article reports on the process and lessons learned during the development of PCPCH standards and measures for the state of Oregon.

Methods

Oregon House Bill 2009 created a 15-member public advisory committee to guide PCPCH policy development. The law delegated 3 specific tasks to the Oregon Office for Health Policy and Research and the PCPCH Advisory Committee[32]:

1. Define core attributes of the PCPCH.
2. Establish a simple and uniform process to identify PCPCHs.
3. Develop uniform quality measures for PCPCH performance.

The selection and meetings of the PCPCH Advisory Committee were conducted in accordance with Oregon's Public Meetings Law.[33]

Committee Selection

The director of the Oregon Department of Human Services appointed the PCPCH Advisory Committee in October 2009. Committee members were identified through service on prior state committees and a public call for nominations. Committee members included individuals with a diverse range of experience, including several practicing primary care physicians (Table 1).

Committee Meetings and Staff Support

The committee held seven 2-hour meetings over a period of 3 months. Meetings were public, time was allotted for public comment, and all meeting materials were posted online. Committee members communicated frequently and reviewed committee work with professional colleagues and patient advisory groups. Staff for the committee included individuals experienced in leading public meetings and familiar with PCMH concepts and the overall direction of health reform in Oregon.

Materials Development and Decision Making

Oregon Office for Health Policy and Research staff conducted extensive background research on meth-

Table 1. Members of Oregon's Patient-Centered Primary Care Home (PCPCH) Advisory Committee

	Committee Member Background
Chair	Former President: Regence Blue Cross and Blue Shield of Oregon, Internist
Vice-Chair	County Health Department Director with experience integrating mental and physical health services
Members	Medical Director: rural Medicaid MCO, family physician
	Benefits manager for a large employer
	Executive Director: Oregon Primary Care Association
	Vice-President: Oregon Pediatric Society, pediatrician
	Executive Director: Oregon Nurses Association, RN
	Community advocate, rural Oregon
	Medical Director: urban Medicaid MCO, lead sponsor of an ongoing medical home demonstration project, internist
	Rural family physician
	Quality Improvement Director: Peace Health Medical Group, faculty at Institute for Patient- and Family-Centered Care
	Senior Medical Director for Primary Care: Legacy Health, participant in an ongoing medical home demonstration project, internist
	President: Oregon Academy of Family Physicians, family physician
	Director of Community Partnerships at an urban safety net clinic, RN
	Clinical Quality Representative: Kaiser Permanente, family physician
Ex-Officio Members	Content expert in care coordination, advanced primary care models, informatics and research, internist
	Content expert in practice transformation, internist
	Content expert in mental health and health policy, psychiatrist
	Content expert in primary care, continuity of care and research, family physician
	Director of Health Care Purchasing: Oregon Health Authority
	Staff: Addictions and Mental Health Division, Oregon Department of Human Services
Staff	Administrator: OHPR, family physician
	Health Policy Development Director: OHPR
	Health Policy Fellow: OHPR, family physician

MCO, managed care organization; OHPR, Oregon Health Policy and Research; RN, registered nurse.

ods for measuring primary care and PCMH functions. Initial committee discussions focused on identifying PCPCH core attributes based on the PCMH joint principles[5] and core primary care principles.[34] After the committee agreed on language for core attributes, discussions focused on defining categories of measurement (standards) within each core attribute and proposed measures within each standard. Committee staff relied on a number of sources to develop draft standards and measures, including measures developed by the NCQA, other organizations, primary care researchers, and other states.[8,9,11,23,24,35–42]

Results

Initial committee discussions focused on whether to adopt an existing PCMH measure set for use in Oregon. In general, the committee felt that the PCMH measures available in late 2009 did not adequately address the needs of Oregon stakeholders. Committee members echoed many concerns about extant PCMH measures that have been cited in the literature (see the introduction of this article). Furthermore, committee members felt that local buy-in from both health care professionals and the public would be essential for Oregon's PCPCH criteria to be accepted and used. Given these concerns, the committee decided the best approach for PCMH measurement was to engage Oregonians in the development of PCPCH measures for use in our state, rather than importing a set of measures developed elsewhere. A by-product of this decision was a series of public meetings and discussions about the PCMH that helped build consensus and provided visibility to the committee's work.

The committee developed a total of 6 PCPCH core attributes, which comprise 15 standards and 29 measures of PCPCH processes and outcomes. An overview of Oregon's PCPCH core attributes, standards, and measures is shown in Table 2. Rec-

Table 2. Overview of Core Attributes, Standards and Measures of Oregon's Patient-Centered Primary Care Home Model

Core Attributes	Standards	Measures
Access to care: *be there when we need you*	In-person access	1. Appointment access 2. After-hours appointments
	Telephone and electronic access	3. Telephone advice 4. Electronic access
	Administrative access	5. Prescription refills
Accountability: *take responsibility for making sure we receive the best possible health care*	Performance improvement	1. Performance improvement 2. Clinical quality improvement 3. Public reporting
	Cost and utilization	4. Ambulatory sensitive utilization
Comprehensive whole person care: *provide or help us get the health care, information, and services we need*	Scope of services	1. Preventive services 2. Medical services 3. Mental health and substance abuse services 4. Health risk behavior assessment and intervention
Continuity: *be our partner over time in caring for us*	Provider continuity	1. Personal clinician assignment 2. Personal clinician continuity
	Information continuity	3. Organization of clinical information 4. Clinical information exchange
	Geographic continuity	5. Specialized care settings (hospital)
Coordination and integration: *help us navigate the health care system to get the care we need in a safe and timely way*	Data management	1. Population data management 2. Electronic health record
	Care coordination	3. Care coordination 4. Test and result tracking 5. Referral and specialty care coordination
	Care planning	6. Comprehensive care planning 7. End of life planning
Person and family centered care: *recognize that we are the most important part of the care team and that we are ultimately responsible for our overall health and wellness*	Communication	1. Communication of roles and responsibilities 2. Interpreter services
	Education and self-management support	3. Education and self-management support
	Experience of care	4. Patient experience survey

ognizing the importance of patient-centeredness as a core concept, the committee described PCPCH core attributes and functions in patient-centered language that would be accessible to policymakers and the general public. For example, "Access to Care" became "Be there when we need you."

Tables 3 and 4 provide examples of detailed language for 2 of the 6 core attributes, Access and Accountability, including specific standards and measures. The full committee report containing specific measures for all 6 core attributes can be found online.[43]

The committee developed a 3-tiered framework of basic, intermediate, and advanced measures. Within this framework, basic measures describe functions that are foundational to the PCPCH care model and that most primary care clinics could meet without additional resources. Intermediate measures describe functions requiring additional investment or infrastructure, and advanced measures describe the optimal performance of a high-functioning PCPCH clinic. The goal of the 3-tiered measurement framework was to engage the broadest possible number of primary care clinics at the entry level and create incentives for improving a limited number of PCPCH processes and outcomes over time.

When developing measures, the committee was guided by a desire to give clinics some flexibility in how they demonstrate PCPCH processes and improved outcomes. For example, the committee did not endorse a specific measure for Appointment Access (eg, the third next available appointment), but developed a framework that focused first on measuring access, then on setting goals for improvement, and ultimately on demonstrating high performance through excellent access scores on a patient survey (Table 3). Similarly, measures for

Table 3. Sample Patient-Centered Primary Care Home (PCPCH) Measures: Access to Care (Be There When We Need You)

● Make it easy for us to get care and advice for us and our family members.			
● Provide flexible, responsive options for us to get care in a timely way.			
Standard	Description	Measure	Description
In-person access	Make sure we can quickly and easily get an appointment with someone who knows us and our family. Ensure that office visits are well-organized and run on time.	1. In-person access	PCPCH tracks and improves in-person access to care and patient satisfaction with in-person access to care. *Basic*: PCPCH tracks and reports a standard measure of in-person access to care. *Intermediate*: PCPCH sets a specific goal for improving an in-person access measure and demonstrates improvement. *Advanced*: PCPCH meets a benchmark or demonstrates improvement in the percentage of patients reporting high satisfaction with access to in-person care on a patient experience survey.
		2. After-hours access	PCPCH offers access to in-person care outside of traditional business hours. *Basic:* PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours. *Additional measure:* PCPCH offers access to in-person care ≥8 hours weekly outside traditional business hours.

Performance Improvement (Table 4) require a clinic to first choose performance measures and set improvement goals appropriate to its patient population, then to demonstrate improvement toward performance goals, and finally to meet benchmarks for national clinical quality indicators.

For some PCPCH functions, a basic standard was established without a requirement for performance improvement. For example, under the Telephone and Electronic Access standard, continuous telephone access to a clinician is a basic PCPCH function. Likewise, under the Comprehensive Whole Person Care attribute, availability of comprehensive medical and preventive care services is a basic function. Finally, in addition to the required measures, the committee identified a number of additional measures that describe "value-added" PCPCH functions (eg, offering extended office hours [Table 3]), for which PCPCH clinics could earn additional recognition and payment.

Discussion

A number of states and payers are working to promote medical homes and develop new payment mechanisms for primary care. In many states, developing a shared operational definition for a "medical home" has been a stumbling block in this process. With little evidence to define empirically the "right" way to measure and pay for medical homes, the Oregon PCPCH Advisory Committee sought to develop a set of measures that reflected the values of Oregon stakeholders. We do not think that our standards are better than anyone else's, but the process of public conversation created a shared vocabulary and ownership of the PCPCH in Oregon that helped to move medical home policy forward. The following lessons learned during our process may be valuable to others seeking to develop community-based strategies to promote medical homes.

Patient-Centeredness as a Strategy for Building Consensus

The decision to describe PCPCH core attributes and standards in the patient voice (Table 2) was a prominent success of the committee's work. This approach helped crystallize key concepts in succinct, understandable language without debates over terms, such as "integration" and "team-based care" that have taken on specific meanings among certain stakeholders. The patient-centered focus also facilitated conversations about the scope of

Table 4. Sample Patient-Centered Primary Care Home (PCPCH) Measures: Accountability (Take Responsibility for Making Sure We Receive the Best Possible Health Care)

Standard	Description	Measure	Description
Performance improvement	Work to improve the care and services you provide and ask us for feedback and ideas about what to improve.	1. Performance improvement	PCPCH measures its own performance, with an emphasis on preventive services, sets goals, and improves its care over time.
	Publically report information about the safety, quality and cost of the care you provide.		*Basic:* PCPCH tracks at least 3 performance indicators, one of which is an indicator of a preventive service, and reports goals for improvement.
	Show us what you are doing to ensure we will get the right care while avoiding unnecessary care.		*Intermediate:* PCPCH demonstrates improvement towards its reported goals on at least 3 performance indicators, one of which is an indicator of a preventive service.
	Involve us in helping to decide areas for improvement.	2. Clinical quality improvement	PCPCH improves clinical quality indicators,* with an emphasis on indicators of preventive services, in its patient population.
			Advanced: PCPCH demonstrates improvement in a certain number of clinical quality indicators. PCPCHs achieving a benchmark level of performance on a given indicator would be required to maintain excellent performance, but not demonstrate continued improvement.
		3. Public reporting	PCPCH participates in a program of voluntary public reporting of practice-level clinical quality (eg, reporting of performance indicators to a health plan, Medicare or Medicaid, the state, or the Oregon Quality Corporation).
			Intermediate: PCPCH publically reports practice-level clinical quality indicators to an external entity.

*PCPCHs should have the ability to select clinical quality indicators most relevant to their patient population from a preestablished statewide set of nationally accepted quality measures.

services that should be available to patients without engendering interprofessional conflicts (eg, between nurse practitioners and physicians or primary care clinicians and specialists) that have bogged down PCMH discussions in other states.

Breadth of Representation

The opportunity for a facilitated dialogue among a diverse group of Oregon stakeholders (patients, clinicians, and payers) helped the committee balance a number of tensions inherent in developing PCPCH policy. As committee members shared their unique perspectives, the group was able to achieve consensus on a range of PCPCH measures that addressed the primary care needs of specific patient populations (eg, children and individuals with mental illness) and the policy needs of specific stakeholder groups (eg, payers and small, rural primary care practices). Examples of challenging areas where the group was able to achieve consensus include integration of mental health, developmental screening and addictions assessment, and treatment capacity in PCPCHs, describing care coordination in terms of key functions rather than specific job titles or practice staffing arrangements and including cost and utilization outcomes in PCPCH measures.

Time-Limited Tasks, Experienced Committee Members, and Knowledgeable Staff

The committee was able to accomplish a significant amount of work in a short time frame. The time-limited nature of the committee assignment helped keep the group moving forward and allowed the participation of practicing clinicians. Committee members entered the process with experience working together, and veterans of prior public committees helped maintain an aspirational but pragmatic focus to group discussions. Finally, the presence of dedicated committee staff and selected content experts helped drive the work of the committee while still allowing an open and public process.

Moving from Policy Development to Implementation

The work of the committee described in this article was limited to creating a definition and measurement framework for the PCPCH in Oregon and did not extend to implementing PCPCH measurement or developing payment methodologies to support the PCPCH care model. After the development of the PCPCH measures, the Oregon Health Authority convened a number of additional committees and public meetings to develop administrative rules and an operational plan for its PCPCH program.

In November 2011, the Oregon Health Authority launched a PCPCH program based on the standards reported here.[44] The PCPCH recognition process is free of charge to primary care clinics and requires clinics to attest to meeting PCPCH criteria and submit performance data for key measures. Clinics recognized as PCPCHs will earn enhanced payment for enrollees in Oregon's Medicaid Program. Future expansion of the PCPCH program to other public and private payers is anticipated.

Conclusions

The criteria used to define and measure the performance and outcomes of the PCMH likely will continue evolving for years to come. In the time since the Oregon PCPCH Advisory Committee completed its work, NCQA has updated its PCMH measures and a number of other national organizations have announced their own "medical home" recognition programs.[45–47]

We believe that others can learn from the process and results produced by the Oregon PCPCH Advisory Committee, but significant differences in primary care systems and stakeholder preferences across the country will lead to different policies to promote medical homes. Although some states might face a greater challenge reaching public consensus on medical home policy, we feel the process of identifying and improving medical homes cannot simply be built by a partnership between health plans and provider groups at the national level.

As has been the experience in a number of states, strong state leadership is important in promoting uniform measurement of medical homes and tying payment reform to standard measures of success. The process used to develop PCPCH standards and measures in Oregon suggests that public engagement of key stakeholders can quickly create the shared policy framework necessary to strengthen the primary care delivery system on the basis of accountability for key outcomes. As federal health reform is implemented, there must be flexibility for states to implement meaningful and unique delivery system reforms supported by multiple payers and guided by the input of local stakeholders.

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