Patient-Centered Medical Home
What You Need To Know

PCMH
Patient-Centered Medical Home

What the PCMH is

- **Advanced, comprehensive primary care**, endorsed as primary care's future by societies of all the relevant clinical professions.
- **A long-term partnership between your team and each patient,** focusing on the whole person: not just care for illness, not just episodic visits, but support and advice for all aspects of health and wellness including prevention, mental health, and health-related behaviors.
- **A team led by the patient's personal clinician**, in which every team member has a role in comprehensive, continuous, and coordinated care.[1] Everyone works to the top of his or her license and everyone works with the patients.
- **A great application of health information technology and data**, to communicate, to manage your patient population, and to measure your results.
- **Finally, payment for value**: insurance plans rewarding good quality care and improved outcomes instead of volume of visits or RBRVUs.[2]

What the PCMH is not

It is <u>not</u> a new set of rules used to limit patients' access to care. The PCMH is designed to break down barriers, not create barriers between patients and clinicians.

Why it's time to transform into a PCMH

"Clear, consistent, compelling"[3] empirical evidence from PCMH initiatives nationwide shows that the investment in being a PCMH benefits patients, clinicians and the healthcare system.[3]

- **Improved outcomes for patients.** Quality care from medical homes is associated with fewer patient deaths, fewer hospital and ER visits that good care would prevent, and better patient satisfaction.[4]
- **Impact on clinicians**. Physicians who practice in medical homes anecdotally report much greater satisfaction with their work than in traditional practice.
- **Better value for the whole system.** Investment in comprehensive, medical home care has produced improvements in quality with less total cost to the system.[4] In other words, higher payments to medical homes yield lower total costs of care, because of better care and coordination.

How to transform

- **Start small and build.** Initially, make changes for a small group of patients. Build from there based upon what your practice learns.
- **Use data to understand your patient population.** Stratifying your patients by age, chronic conditions, and risk levels will help your team identify patients' needs and reach out to patients for care management.
- **Think long term; think partnership**. Develop an ongoing relationship with your patients. Develop care plans with patients who have chronic conditions. Provide two-way communication whenever it's needed by visit, by telephone, and by electronic messaging.
- **Engage patients and families**. Invite patients to be part of your improvement team, and survey patients to help your practice understand how to be more patient-centered.
- **Build a high-value medical neighborhood**. Choose and use the specialists, facilities and community resources that are active partners with you in helping your patients pursue their health goals.
- **Consider seeking recognition as a PCMH.** PCMH recognition is just one step in ongoing practice transformation. Learning the standards for recognition can help provide structure for your transformation process.

What to keep in mind as you transform

- **PCMH is a journey, not a destination.** The more you measure, observe, and improve, the more opportunities you will find to transform the care of your patients and the working life of you and your staff.
- **Others are already on the journey**. You will find primary care clinicians now practicing as medical homes in your state or locality. They can tell you about the investment in continuous quality improvement, and the rewards.

Resources

- **Patient Centered Primary Care Collaborative** www.PCPCC.net A resource center for PCMH practice transformation. Features a resource guide for help in transforming to a PCMH: www.pcpcc.net/guide/practice-transformation
- **American Academy of Family Physicians PCMH Check List** http://www.aafp.org/online/etc/medialib/aafp_org/documents/membership/pcmh/checklist.Par.0001.File.tmp/PCMHChecklist.pdf Offers a framework for how to build a PCMH.
- **American College of Physicians** http://www.acponline.org/advocacy/where_we_stand/medical_home/
- **American Academy of Pediatricians, National Center for Medical Home Implementation** http://www.medicalhomeinfo.org/
- **American Osteopathic Association** http://www.osteopathic.org/inside-aoa/development/practice-mgt/Pages/patient-centered-medical-home.aspx
- **Institute for Patient & Family Centered Care** http://www.ipfcc.org/ A resource center for advancing patient and family-centered care and in particular guidance on how to utilize patients as practice advisors.
- Local medical societies and chapters. Understand what additional assistance and public or private support is available. Learn about what pilots & demonstration projects may exist to help support your journey to becoming a PCMH.
- Websites of the following organizations: NCQA, URAC, NASHP, and The Joint Commission have information about becoming PCMH Recognized or Accredited.

References

1. AAFP. (2007). Joint Principles of the Patient-Centered Medical Home. Retrieved August 23, 2012, from http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf

2. ARHQ. (2012). Defining the PCMH. Retrieved August 12, 2012, from http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_defining_the_pcmh_v2

3. Nielsen, M., Langner, B., Zema C., Hacker, T., and Grundy, P. (2012) Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results. Retrieved August 12, 2012 from http://www.pcpcc.net/files/benefits_of_implementing_the_primary_care_pcmh.pdf

4. Grumbach, K., Grundy, P. Patient-Centered Primary Care Collaborative. (2010) Outcomes of Implementing Patient Centered Medical Home Interventions: A review of the evidence from prospective evaluations studies in the United States. Retrieved August 12, 2012 from http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf

Patient-Centered Primary Care COLLABORATIVE

Boehringer Ingelheim