

Putting the Pieces Together

**Patient Centered
Medical Home**



Objectives

- To provide an introduction and overview to PCMH
- To review PCMH recognition options
- To outline the essential criteria for PCMH recognition



What does “home” mean to you?

- Safe
- Refuge
- Familiar
- Secure
- Comfortable
- Family



Home.....

*“The ache for home lives in all of us,
the safe place where we can go as
we are and not be questioned.”*

Maya Angelou



NIH: National Institute of Health

The patient-centered medical home (PCMH) is four things:

- 1) the fundamental tenets of primary care: first contact access, comprehensiveness, integration/coordination, and relationships involving sustained partnership;
- 2) new ways of organizing practice;
- 3) development of practices' internal capabilities, and
- 4) related health care system and reimbursement changes.

All of these are focused on improving the health of whole people, families, communities and populations, and on increasing the value of healthcare.



AHRQ: Agency for Healthcare Research and Quality: AHRQ

1. Comprehensive Care
 - Team based
2. Patient-Centered
 - Relationship based
3. Coordinated Care
 - Transitions
4. Accessible Services
 - Reduce waits and delays
5. Quality and Safety
 - Organized PI and Leadership



Recognition?

Several national organizations offer patient-centered medical home (PCMH) accreditation, certification, achievement and recognition programs.

1. The Accreditation Association for Ambulatory Health Care (AAAHC): 2011 Medical Home Standards
2. The Joint Commission (JCAHO): Primary Care Medical Home 2011 Standards and Elements of Performance (July 2011)
3. The National Committee for Quality Assurance (NCQA): Patient-Centered Medical Home 2011 Standards
4. Utilization Review Accreditation Commission (URAC): Patient Centered Health Care Home (PCHCH) Practice Achievement Version 1.0 (June 2011)



NCQA definition

- The Patient Centered Medical Home is a health care setting that facilitates *partnerships* between individual patients, and their personal *physicians*, and when appropriate, the patient's family. 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



NCQA Standards

- PCMH 1: Enhance Access and Continuity
- PCMH 2: Identify and Manage Patient Populations
- PCMH 3: Plan and Manage Care
- PCMH 4: Provide Self-Care and Community Support
- PCMH 5: Track and Coordinate Care
- PCMH 6: Measure and Improve Performance



NCQA “Must Pass” Elements

- PCMH 1, Element A: Access During Office Hours
- 2. PCMH 2, Element D: Use Data for Population Management
- 3. PCMH 3, Element C: Care Management
- 4. PCMH 4, Element A: Support Self-Care Process
- 5. PCMH 5, Element B: Track Referrals and Follow-Up
- 6. PCMH 6, Element C: Implement Continuous Quality Improvement



From the recent KGS of IPC3

- American Indians and Alaskan Native people face high rates of illness, disability and death from chronic and preventable diseases. In 2008, the Indian Health Service launched the Improving Patient Care (IPC) program to address these health disparities. With IPC3 concluding in April 2012, the work continues. The Indian Health Service is adopting primary care medical homes to focus on delivery of patient-centered care.



Building a PCMH

- One piece at a time!!!!

