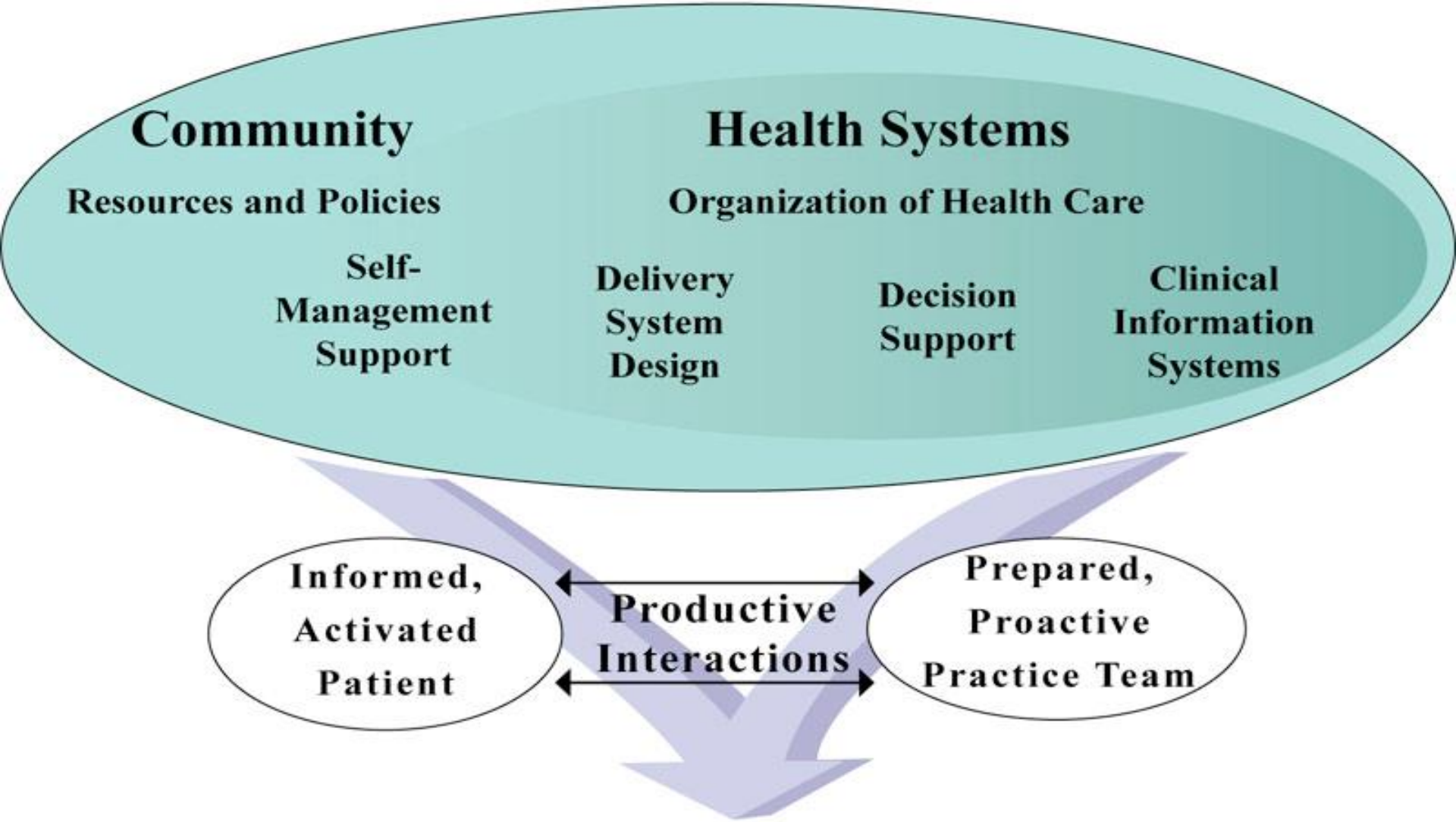
Patient Centered Medical Home

To Be or Not to Be?
This May Not Be the Question

Yali Bair, PhD
Ursa Consulting Group
5/5/15

The Chronic Care Model



Improved Outcomes

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Patient-Centered Primary Care COLLABORATIVE

Defining the Medical Home

Superb Access to Care

- Patients can easily make appointments and select the day and time.
- Waiting times are short.
- eMail and telephone consultations are offered.
- Off-hour service is available.

Patient Engagement in Care

- Patients have the option of being informed and engaged partners in their care.
- Practices provide information on treatment plans, preventative and follow-up care reminders, access to medical records, assistance with self-care, and counseling.

Clinical Information Systems

- These systems support high-quality care, practice-based learning, and quality improvement.
- Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.

Care Coordination

- Specialist care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved.
- Follow-up and support is provided.

Team Care

- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals (including BH specialists).
- Duplication of tests and procedures is avoided.

Patient Feedback

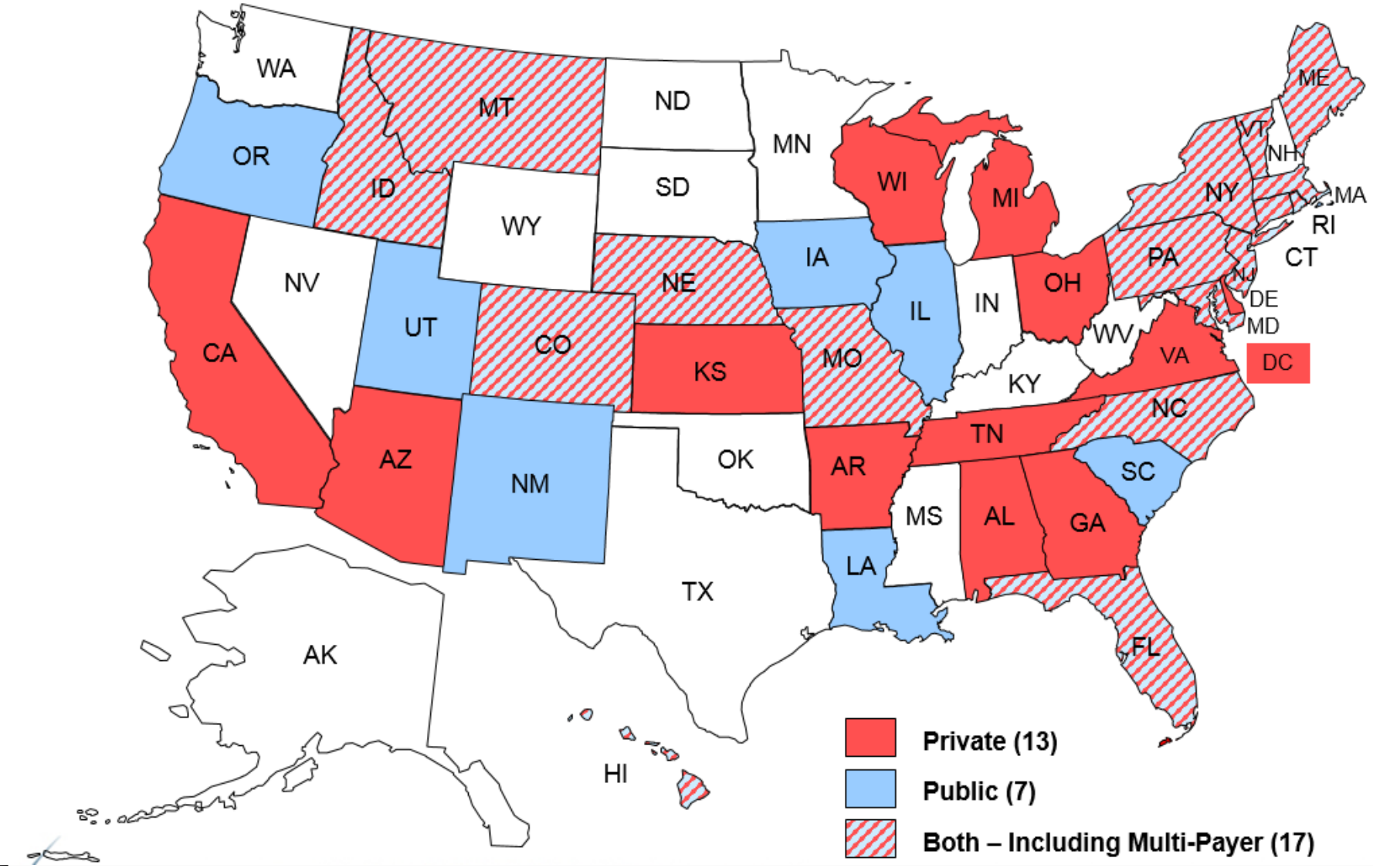
- Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans.

Public information

- Patients have accurate, standardized information on physicians to help them choose a practice that will meet their needs.

Source: Patient Centered Primary Care Collaborative

37 States* Have Public and Private Patient-Centered Medical Home (PCMH) Initiatives That Use NCQA Recognition



http://www.ncqa.org/Portals/0/Public%20Policy/2014%20Comment%20Letters/The_Future_of_PCMH.pdf

PCMH Accreditation Programs

	Program Highlights
NCQA 2011 **www.ncqa.org**	▪ Most widely used recognition ▪ Heavy on IT ▪ Requires solid population management ▪ Practices receive distinction
AAAHC **www.aaahc.org**	▪ Mandatory on-site review ▪ Requires base accreditation
Joint Commission **www.jointcommission.org**	▪ Scoring evenly distributed across content areas ▪ Mandatory on-site review ▪ Requires base accreditation
URAC **www.urac.org**	▪ Based on joint principles ▪ Customizable standards ▪ Mandatory on-site review

http://www.urban.org/uploadedpdf/412338-patient-centered-medical-home-rec-tools.pdf

Does PCMH Work?

The Patient-Centered Medical Home's Impact on Cost and Quality

Neilson, M, et al. **The Medical Home's Impact on Cost & Quality, An Annual Update of the Evidence**, 2012-2013, *January 2014*

Annual Review of Evidence 2013-2014
Patient-Centered Primary Care Collaborative
Milbank Memorial Fund
January 2015

www.pcpcc.org

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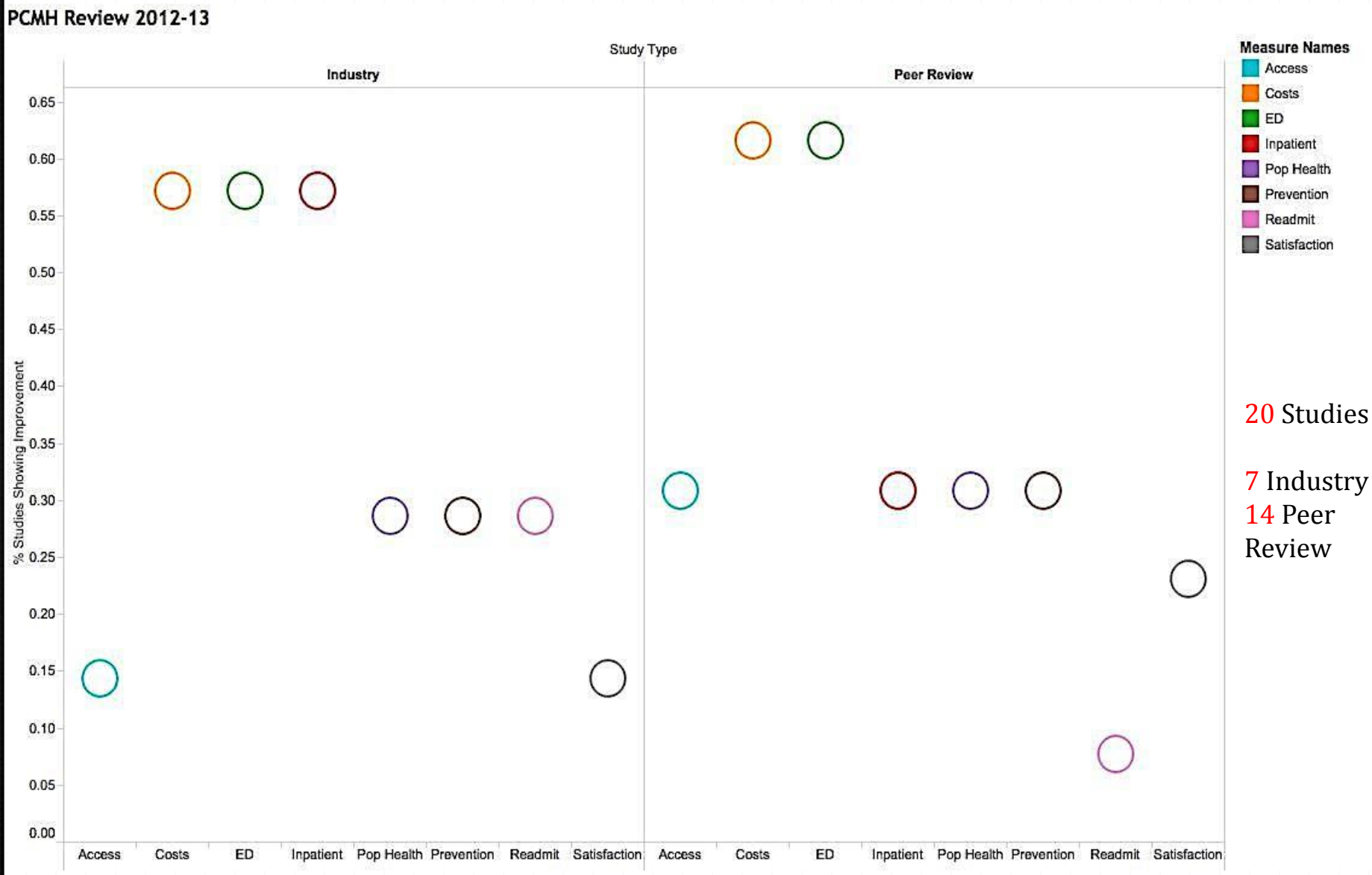

20 Studies

7 Industry
14 Peer Review

Neilson, M, et al. The Medical Home's Impact on Cost & Quality, An Annual Update of the Evidence, 2012-2013, January 2014

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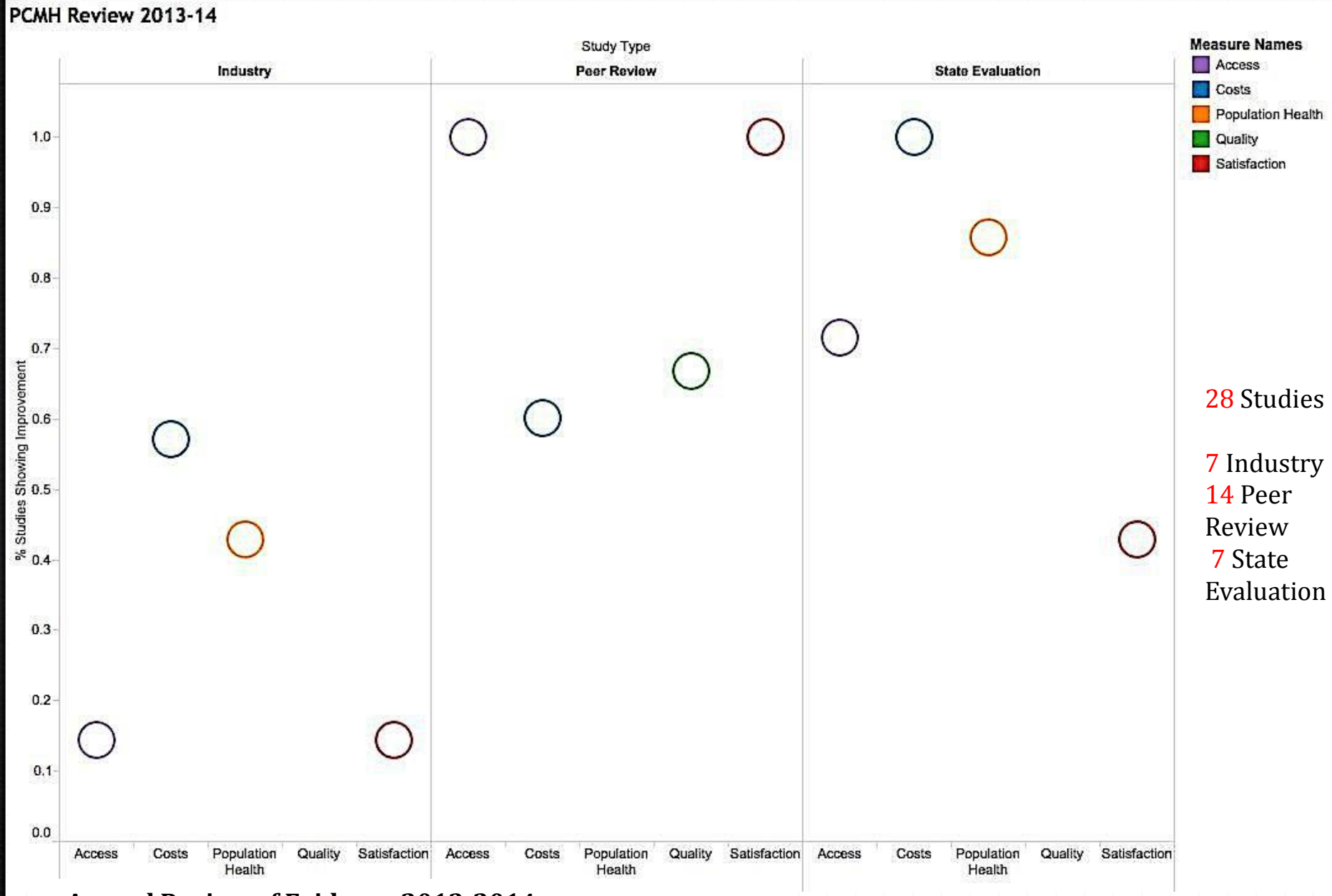

28 Studies

7 Industry
14 Peer Review
7 State Evaluation

Annual Review of Evidence 2013-2014
Patient-Centered Primary Care Collaborative
Milbank Memorial Fund ***January 2015***

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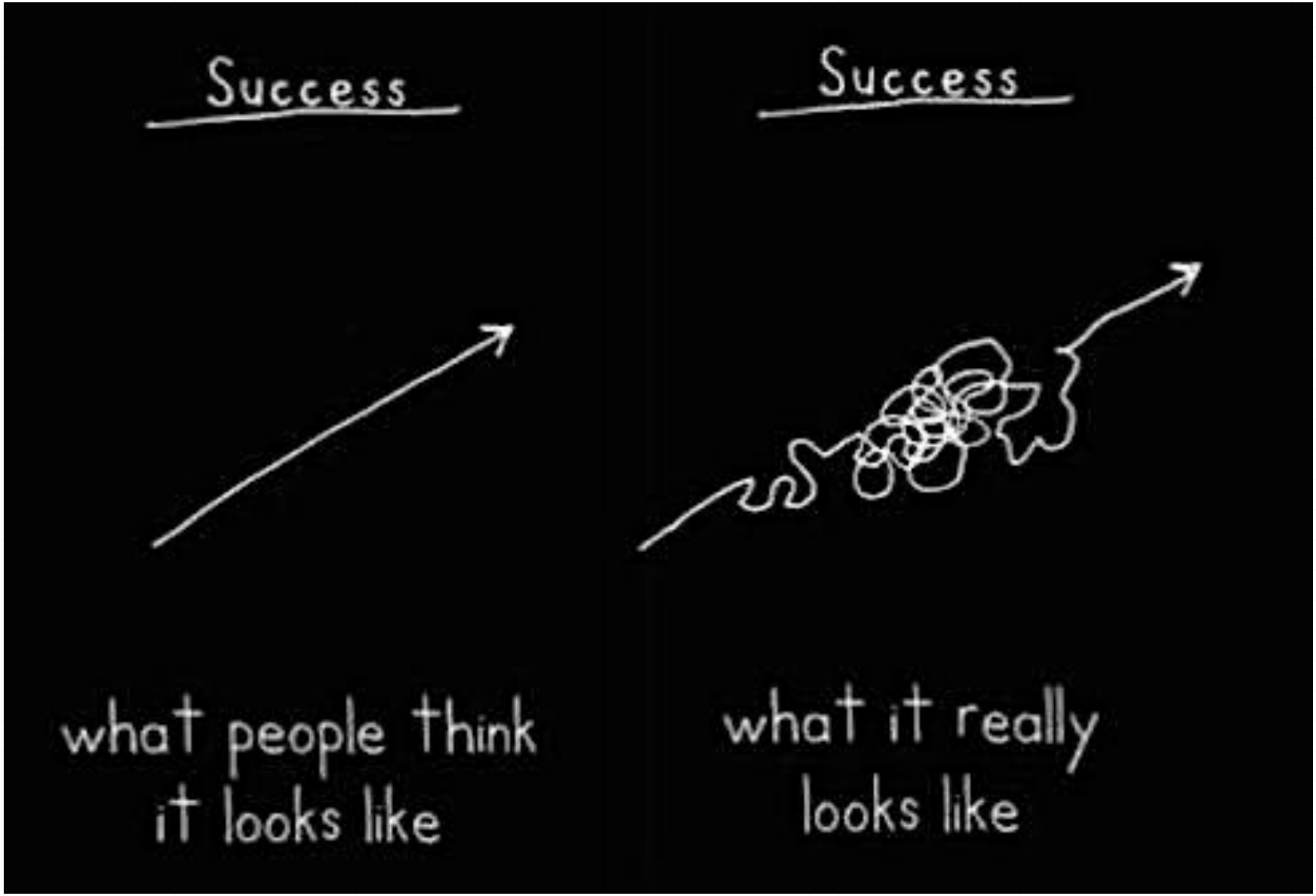
What Does it Take to Be a Successful PCMH Practice?



Most Successful PCMH Practices:

- Have supportive leadership;
- Receive financial or technical assistance, or both, for transformation;
- Use a team-based approach and delegated self-management education to non-physician team members;
- Leverage health information technology;
- Involve patients and families in practice improvement efforts;
- Use a systems approach and standardize when appropriate;
- Have solid quality improvement systems in place.

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Future Directions for PCMH

- The "Medical Neighborhood"
  - Behavioral health integration
  - Specialists
  - Hospital systems
  - Public health
- Providing financial incentives for enhanced primary care
- Developing PCMH-oriented workforce
- Engaging patients, consumers, and the public
- Embracing the potential of technology

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