The Board's Role to Support Patient-Centered Medical Homes

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What is patient-centered medical home (PCMH)? PCMH is a concept for providing primary care that is emerging as a model for improving the delivery of care.

What are characteristics of patient-centered medical homes? The current medical home concept is represented in **Joint Principles** put forth in 2007 by the four primary care physician professional organizations -- American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association.

- **Personal physician** -- Primary care physicians have a personal ongoing relationship with their patients;
- **Physician directed team** – Team works to collectively provide ongoing care;
- **Whole person** -- The personal physician assumes responsibility for providing or making arrangements for all health care needs of their patient.
- **Coordinated and integrated care –** Services are linked across the health care system (health center, hospital, specialty care) and with the patient's community (family, public, community-based services).
- **Quality and safety** – Delivery supports are incorporated such as evidence-based medicine and decision support tools, and information technology to measure performance, educate patients, and enhance communication among providers.
- **Enhanced access** to care including expanded hours of operation and communication between physicians and patients.
- **Payment structures** that recognize the added value of primary care services.

What changes do organizations face when transforming to a patient-centered medical home?
Becoming a patient centered medical home requires a commitment to system-wide transformation. Such transformation requires visible and sustained support from leadership, including the board of directors, executive management, and clinic leadership. Potential areas of change include:

- Embedding PCMH in the organization's vision.
- Developing the business plan that includes PCMH, including budget, staffing, expected results.
- Identifying a team to guide the transformation process.
- Establishing a communication strategy that informs staff, board, providers.
- Scheduling provider time beyond direct patient care.
- Building PCMH into staff hiring and training.
- Capturing data related to PCMH and including clinical leaders involved PCMH in the design/interface of information technology and the electronic medical record.
- Identifying level of involvement of staff, patients, and families in planning, implementing, assessing, and improving changes related to PCMH.

How will the medical home benefit patients at health centers?

- The Medical Home team is familiar with their patients and helps them navigate through the system.
- Patients participate with their health care team and provider as an informed and engaged partner.
- Improved communication with the health care team ensures a holistic, integrated, and coordinated whole person approach to care.

How will the Medical Home benefit the Health Center?

- Ongoing quality assurance reviews and surveys will be used to regularly assess quality services.
- Feedback about patient experience will be solicited and used to generate improvement in service delivery.
- Some State Medicaid Agencies and third party payers provide financial incentives for medical home recognition.
- The Health Resources and Services Administration (HRSA) is collaborating with the National Committee for Quality Assurance (NCQA) to support planning and preparation for NCQA medical home recognition.

What roles are health centers playing?

Health centers are already engaged in medical home initiatives.

- Sixty-eight health centers are involved in the ***Safety Net Medical Home Initiative*** supported by the Commonwealth Fund and others. The Initiative assists health centers transform their practices to medical homes. Four of the five regional coordinators are primary care associations.
- The HRSA ***Patient Centered-Medical/Health Home Initiative*** supports health centers to earn **NCQA** medical home recognition as mentioned above.
- The Accreditation Association for Ambulatory Health Care (AAAHC) offers recognition or accreditation programs for the patient-centered medical home. The Joint Commission is developing a program.

For information and resources:

Joint Principles of Patient Centered Medical Home: http://pcpcc.net/content/joint-principles-patient-centered-medical-home

HRSA Patient-Centered Medical Home Initiative: http://bphc.hrsa.gov/policy/pal1101/

The Safety Net Medical Home Initiative published a series of implementation guides on transforming a practice to PCMH. *See Change Concepts for Practice Transformation:* http://www.ghmedicalhome.org/safety-net/index.cfm

The Accreditation Association for Ambulatory Health Care has a Medical Home Accreditation
http://www.aaahc.org/eweb/dynamicpage.aspx?webcode=mha

National Committee for Quality Assurance: http://www.ncqa.org/tabid/631/Default.aspx

The Agency for Healthcare Quality and Research (AHRQ) Patient Centered Medical Home (PCMH) Resource Center for resources and tools related to the patient-centered medical home concept.
http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483

The Commonwealth Fund for comprehensive information on related research. http://www.commonwealthfund.org/

The National Academy for State Health Policy(NASHP) provides information on state Medicaid and CHIP programs' implementation of policies that advance the medical home http://www.nashp.org