What is a Patient-Centered-Medical Home (PCMH)? and Web Resources

A PCMH is a primary care medical clinic or office where physicians and staff create a holistic focus on the individual patient's needs. This focus includes educating a patient on their health care needs and shared decision making between the physician and patient. It also includes a focus on preventive care, patient self care and gaining family support when needed. PCMH includes a nurse that focuses on care coordination and using technology to identify patients with specific needs. Examples can be reminders for vaccinations, follow up after a hospitalization or getting the patient to a diabetes education class that teach a patient to check their own blood sugar levels and what foods are healthy or detrimental to their condition. It can also include mental, dental or specialty health care needs that result in referrals or cultural or social needs of a patient that effect physical health.

PCMH is also a process a physician's office will go through to make their office procedures more efficient and to enable all medical staff to work to the "top" ability of their license. Similar to a manufacturing plant going through a quality improvement process, a clinic can make changes that better enable an office to run more efficiently and patients to get better care with less duplication of medical procedures.

Why a PCMH works?

Less duplication of medical tests. Fewer emergency room visits. Fewer hospital re-admissions for the same condition. Better, more informed patient self care. More compliance with preventive care and testing. Less delay in getting an appointment. Less wait time in the office. More comprehensive and predictable care procedures in the office with a team of professionals. Higher staff, physician and patient satisfaction. Less costly care when conditions are caught in early stages. Better health outcomes for patients with multiple or chronic conditions. Better coordination and continuity of care from one medical facility to another.

All these items can be achieved through a transformation to PCMH. That's why is works. Long term health care cost savings, better health outcomes, more satisfied staff and patients can all be realized.

Here are some related statistics:

- In 2011, BCBS of NE collaborated with clinics in nine cities to launch the medical home pilot program. Doctors managed the care of 1,243 patients with diabetes, using tests to help improve the patient's blood sugar, blood pressure and cholesterol levels. Results showed that patients who participated in the program had 10 percent fewer hospital admissions and 27 percent fewer emergency room visits compared to patients not in the program. Cost savings of $1,059 per patient realized.
- Nebraska Medicaid Pilot Program report recommends continuation of the PCMH model. Findings from the pilot showed distinct improvement in patient health outcomes through targeted care coordination.

Why do we need to have a statewide multi-payer medical home process?

Transforming a clinic into a patient-centered-medical home takes time and money up front. The pay off in better health outcomes may be a year, two or even three down the road. Today's traditional "fee for service" reimbursement scheduled does not pay for many of the tasks necessary to be efficient and patient centered. Therefore, the payment structure needs to change to enable such transformation. Also,

all patients need to be treated equally. Therefore, all payers need to reimburse similarly. It is impossible for a clinic to treat patients in a stratified manner because of different reimbursement schedules. It's similar to setting up a railroad. We're not asking the State to run the railroad or set prices, just to pick a common width of track to lower everyone's cost and allow interoperability.

You can find more information at many web resources including:

http://www.nebrafp.org/ Nebraska Academy of Family Physicians

http://www.pcpcc.org/ Patient Centered Primary Care Collaborative

www.nashp.org/ National Academy of State Health Policy

http://transformed.com/ TransforMed

http://pcmh.ahrq.gov/ US Dept of HHS, Agency for Healthcare Research and Quality

http://www.aafp.org/practice-management/pcmh/overview.html American Academy of Family Physicians

http://dhhs.ne.gov/medicaid/Pages/med_pilot_resource.aspx NE Dept of HHS, PCMH Pilot Program