The Patient-Centered Medical Home: What is the PCMH?

What is the Patient-Centered Medical Home?

- ...a vision of health care as it should be
- ...a framework for organizing systems of care at both the micro (practice) and macro (society) level
- ...a model to test, improve, and validate
- ...a part of the health care reform agenda
Attributes of Patient-Centered Primary Care

- Superb access to care
- Patient engagement in care
- Clinical information systems that support high-quality care, practice-based learning, and quality improvement
- Care coordination
- Integrated, comprehensive care; smooth information transfer across a fixed or virtual team of providers
- Ongoing, routine patient feedback to a practice
- Publicly available information on practices
The Joint Principles of the PCMH

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access to care
- Payment to support the PCMH

Team-based care:
- NP/PA
- RN/LPN
- Medical Assistant
- Office Staff
- Care Coordinator
- Nutritionist/Educator
- Pharmacist
- Behavioral Health
- Case Manager
- Community resources
- DM companies
- Others…

---

Patient-Centered, Physician-Guided Care

Adapted from:
Defining Primary Care: An Interim Report, Institute of Medicine 1994
Professional Societies Endorsing Joint Principles

- American Academy of Hospice & Palliative Medicine
- American Academy of Neurology
- American Academy of Pediatrics
- American Academy of Family Physicians
- American College of Cardiology
- American College of Chest Physicians
- American College of Osteopathic Family Physicians
- American College of Osteopathic Internists
- American College of Physicians
- American Geriatrics Society
- American Medical Directors Association
- American Osteopathic Association
- American Society of Clinical Oncology
- American Society of Addiction Medicine
- Infectious Diseases Society of America
- Society for Adolescent Medicine
- Society of Critical Care Medicine
- Society of General Internal Medicine

Gaps in Care Coordination

- Primary care and specialists:
  - No information sent to Peds specialist 49% of time; no feedback to primary care 55% of time
  - Dissatisfaction with quality of referrals (28% of primary care; 43% of specialists rating information from the other)

- Emergency Department
  - 30% of adults indicated regular physician not informed about visit

- Hospital
  - 33% of adults with chronic condition did not have follow-up plans post hospital discharge
  - 3% of primary care physicians discussed discharge plans with hospital physicians
  - 66% of time primary care follow-up post discharge was done without a hospital discharge summary

Bodenheimer, T: Coordinating Care – A Perilous Journey through the Health Care System. NEJM 2008;358:10
Specialty Care Connections

- PCMH is NOT a gatekeeper system
- Jointly develop/identify referral guidelines
- Emphasis on transitions in care & continuity
  - Referral agreements
  - Care transitions programs
- Some subspecialists may want to qualify as PCMH
- ACP in discussions with several groups regarding the PCMH model and primary care/specialty care interface (sharing care)

Summary

- The PCMH is based on the Chronic Care Model and concepts about patient-centered care
- The PCMH is a team model of health care – and that team includes the patient
- It will take all members of the health profession to address the current challenges to our health system