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National Center for Farmworker Health, Inc.

PATIENT CENTERED MEDICAL HOMES:

FREQUENTLY ASKED QUESTIONS

1. WHAT IS PATIENT CENTERED MEDICAL HOME?

The Patient Centered Medical Home (PCMH) is not a location or place; it is a physician-led, team-based approach to providing for a patient's health care needs, or for managing referrals to other qualified professionals. PCMH is an innovative approach to providing improved primary comprehensive primary care by placing the patient at the center of care with an increased emphasis on the doctor-patient relationship through long term care and coordination.

2. WHY PATIENT CENTERED MEDICAL HOME?

As defined by the American Academy of Pediatrics, PCMH is primary care that is "accessible, continuous, comprehensive, family• centered, coordinated, compassionate, and culturally effective." Through this model, a PCMH provides for ongoing care throughout a patient's lifetime including preventative health services, chronic disease management, acute illness treatment and end of life services. Through a model of coordinated care, collaboration and increased communication, the PCMH can provide a higher level of service and safety.

3. WHAT ARE THE PRINCIPLES OF PATIENT CENTERED MEDICAL HOME?

The Joint Principles of the PCMH were published in March 2007 by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA). The following principles are core to the medical home:

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
- Payment

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The American College of Physicians and the Patient Centered Care Collaborative created a video detailing important aspects of the PCMH model.

Video of PCMH model

4. HOW DOES ONE ACHIEVE PATIENT CENTERED MEDICAL HOME RECOGNITION?

The National Center for Quality Assurance (NCQA) is currently the primary organization providing Patient Centered Medical Home (PCMH) recognition. The emphasis on medical homes in the health reform law, and the creation of the demonstration programs, make clear that this will be a major focus for both cost control and care improvement. As of 12/31/10, there were 1,506 sites recognized as a PCMH.

Receiving Patient Centered Medical Home status requires health centers and other providers to meet and document specific criteria. The National Center for Quality Assurance (NCQA) is among the organizations that have developed specific guidelines for patient-centered medical homes. The NQCA has created a brochure which provides an overview of the PCMH recognition process.

Overview brochure of the PCMH recognition process

The NCQA website page provides an overview of the PCMH accreditation process including program information and publications.

Overview of the PCMH accreditation process

5. WHAT ARE HRSA'S VIEWS ON PATIENT CENTERED MEDICAL HOME?

The Health Resources and Service Administration (HRSA) views the accreditation process as beneficial to health centers as it is an indicator of high quality of care, makes health centers more competitive in the marketplace and in that it supports quality improvement and risk management. HRSA established a partnership with the NCQA to implement its Patient-Centered Medical/Health Home (PCMHH) Initiative and released its Program Assistance Letter 2011-01, outlining the processes and requirements for applying for recognition and the technical support available to health centers

Program Assistance Letter 2011-01

HRSA also created a comparison chart that highlights the difference between its National Quality Recognition Initiatives and Patient Centered Medical Home/Home Initiatives.

National Quality Recognition Initiatives and Patient Centered Medical Home/Home Initiatives chart

The Primary Care Development Corporation created, "Obtaining Patient-Centered Medical Home: a How to Manual." This manual was created primarily with Community Health Centers in mind, and provides a set-by-step guide for organizations in applying for and receiving PCMH recognition.

A set-by-step guide for organizations in applying for and receiving PCMH recognition

6. WHAT DOES PATIENT CENTERED MEDICAL HOME OFFER TO COMMUNITY /MIGRANT HEALTH CENTERS?

By definition, all Federally Qualified Health Centers (FQHC) provide comprehensive primary care, provide detailed reporting of services to staff, and have boards which consist of patients; these characteristics of FQHCs are also components of the Patient Centered Medical Home model. The Community/Migrant Health Centers (C/MHC) model, with its emphasis on accessible, culturally appropriate, and community-based, patient centered care, is in close alignment with the PCMH core principles and make them uniquely prepared for recognition as Patient Centered Medical Homes (PCMH). By achieving PCMH recognition, Community/Migrant Health Centers (C/MHC) have the opportunity to engage in an assessment of the health center's strengths and areas for improvement while becoming a model of integrated and up to date care that provides the highest level of patient care.

Although a C/MHC may already provide services as required for PCMH recognition, such as patient accessibility and information exchange, the health center may not have formalized systems or procedures to access services. The PCMH requires health centers to adopt systems and health technologies which maintain patient medical histories to manage a more effective and coordinated level of service. Programs and service provided by C/MHCs can be formalized and digitized through adaptation to the PCMH model.

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