

Patient-Centered Medical Home-101: Toolkit and Resources for Providers

A toolkit that encompasses an array of resources which will provide an enlightened understanding of the foundations of the PCMH Model and its approach. This toolkit will aid in clarifying the necessary and beneficial steps to establish and follow a PCMH model.



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Introduction:

What is a PCMH? The Ohio Department of Health is leading a statewide expansion of the Patient-Centered Medical Home (PCMH) model of primary care in Ohio in order to: control costs and ensure healthcare in Ohio is affordable, improve health outcomes, and enhance the patient experience. A patient-centered medical home is a primary care practice where one has a team of healthcare workers who care for all of one's health needs; not just one provider, but a whole team. Don't get confused by the word "home." A Patient-Centered Medical Home is not like a nursing home and a care team is not going to one's home. The most important job of a medical home is to take care of the patient and the patient's family, not just one's broken foot, heart condition or diabetes, but all that a patient entails. The care team gets to know the patient and their family personally.

Whatever a patient needs, this team will work with one another to provide the best care.

Why a PCMH approach and implementation? Seven of the 10 leading causes of death in Ohio are lifestyle-oriented – most of which are avoidable – and approximately 75 percent of all health care spending goes to address chronic diseases. Payment systems are based on volume with no expectation of outcomes and the current system of care does not reward doctors for being comprehensive, thorough, or providing good continuity of care to patients. The Patient-Centered Medical Home model of care is one that facilitates partnerships between individual patients and their personal healthcare providers and, when appropriate, the patient's family. Care is managed using modern tools such as registries, information technology, health information exchange and other means to ensure that patients get the appropriate care when and where they need and want in a culturally appropriate manner. By moving to a system where primary care and prevention are the foundations of medical practices and one in which providers are paid for improving the health of their patients and clients through measurable outcomes, is a way to finally get health care spending under control and give patients the quality of care and information they need to increase their level of health at every stage of life.

Patient-Centered Medical Homes in Ohio:

Regional Efforts:

A priority for the Ohio Department of Health (ODH) is to focus on the expansion of the Patient-Centered Medical Home (PCMH) throughout Ohio.

The number of Patient-Centered Medical Homes in Ohio exceeded 500 sites in August 2014. The sites are composed of more than 450 National Committee for Quality Assurance (NCQA)-recognized sites, more than five Accreditation Association for Ambulatory Health Care (AAAHC)-accredited sites, and more than 50 Joint Commission-accredited sites.

Here is what leaders in Ohio's health care transformation movement are saying:

Healthcare Collaborative of Greater Columbus

"PCMHs are a good place for healthcare teams to start demonstrating better ways to manage population health, close care gaps, and reduce wasteful spending. Coupled with payment innovations that reward outcomes instead of volume, PCMHs provide critical building blocks towards value-based healthcare delivery," said Jeff Biehl, president of Healthcare Collaborative of Greater Columbus.

Health Collaborative and Greater Cincinnati Health Council

"The accomplishment of this milestone is a tribute to: 1.) the many primary care offices across the state who did the difficult work in transformation of their practices; 2.) Dr. Wymyslo and the vision he brought to the state in legislation and his foresight in creating OPCPCC to give life to it; 3.) the Governor's Office of Health Transformation which gave credence to the approach and brought the critical mass of payers to the table in the State's Innovation Model and 4.) the Collaboratives in Cleveland, Columbus and Cincinnati for their leadership and support; It is amazing and gratifying to see how this approach to providing true coordination of care for people has struck a chord to bring so many together," said Richard Shonk, MD, PhD, Chief Medical Officer of the Health Collaborative and Greater Cincinnati Health Council.

Better Health Greater Cleveland

"The acceleration in growth of patient-centered primary care in Ohio over the past three years has been truly amazing. We owe this in no small way to the governor's Office of Health Transformation and the Ohio Department of Health, whose leaders are spearheading transformational change in health care delivery and approaches to payment. Better Health Greater Cleveland is proud to be part of these transformative changes in northeast Ohio," said Randall D. Cebul, MD, President of Better Health Greater Cleveland.

Ohio's PCPCC:

The Ohio Patient-Centered Primary Care Collaborative (OPCPCC) is a coalition of primary care providers, insurers, employers, consumer advocates, government officials and public health professionals. They are joining together to create a more effective and efficient model of health care delivery in Ohio. That model of care is the Patient-Centered Medical Home (PCMH).

The OPCPCC is coordinating statewide efforts to implement best practices to advance patient-centered primary care. By providing a forum for health care stakeholders to communicate freely and work together, OPCPCC strives to achieve the following outcomes:

1. Enhanced communication between providers, purchasers, and consumers
2. Identification and dissemination of best practices
3. Increased number of engaged patients, providers, employers and insurers (specific targets and dates to be set)
4. Better care, better health, better satisfaction, better value
5. Become a national leader in terms of collaborative process and sustainable model

In order to receive further information about resources, webinars, conferences, etc., it is recommended that you sign up for a free membership through <http://www.odh.ohio.gov/landing/medicalhomes/Membership.aspx>.

Resources:

I. Comprehending the PCMH Model

Title	Resource
Defining the PCMH- AHRQ	http://pcmh.ahrq.gov/page/defining-pcmh
Introduction to the Patient-Centered Medical Home Video	http://www.emmisolutions.com/medicalhome/transformation/
Defining the Medical Home- PCPCC	https://www.pcpcc.org/about/medical-home
Defining the Patient-Centered Medical Home-Physician Practice	http://www.physicianspractice.com/practice-models/defining-patient-centered-medical-home/page/0/1?GUID=9D86510F-1471-43EA-9AAA-E91A4D8909EA&rememberme=1&ts=08022013
Patient-Centered Medical Homes (PCMH)- Ohio Department of Health	http://www.odh.ohio.gov/landing/medicalhomes/PCMH%20Consumer%20web%20page/PCMHconsumer.aspx

II. Assessing your Practice

Title	Resource
Patient-Centered Medical Home Checklist	http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/PCMHChecklist.pdf
Assessing Practice Readiness for Change	http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod12.html
Assessing Practices	http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod6.html
Joint Commission Primary Care Medical Home Self-Assessment Tool	http://www.jointcommission.org/joint_commission_primary_care_medical_home_self-assessment_tool___/
Online Self-Assessments	http://www.transformed.com/self-assessments.cfm

III. Building a Care Team

Title	Resource
Care Coordination	http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html
Creating Quality Improvement Teams and QI Plans	http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod14.html
Implementing Care Teams	http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod19.html
Science of Improvement: Forming the Team	http://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx
TeamSTEPPS	http://teamstepps.ahrq.gov/about-2cl_3.htm

IV. Coordinated Care, Population Management, Quality Improvement

Title	Resource
Care Coordination Resources	http://www.transformed.com/resources/Care_Coordination.cfm
A Guide to Care Coordination in the Medical Home	https://www.pcpcc.org/guide/core-value-community-connections
Care Delivery Management: Care Coordination	http://www.medicalhomeinfo.org/how/care_delivery/#coordination
Care Coordination Fact Sheet	http://medicalhomes.aap.org/Documents/CareCoordinationFactsheet.pdf
Family-Centered Care Coordination	http://medicalhomes.aap.org/Documents/FamilyCenteredCareCoordination.pdf
Population Health Management in the Medical Neighborhood	https://www.pcpcc.org/resource/managing-populations-maximizing-technology
Population Health Management in an Accountable Care Organization	https://www.pcpcc.org/resource/ehealth-innovation-profile-bon-secours-virginia-medical-group
Improving Patient Health through Medication Management	https://www.pcpcc.org/guide/patient-health-through-medication-management
Basics of Quality Improvement	http://www.aafp.org/practice-management/improvement/basics.html

Approached to Quality Improvement	http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod4.html
Quality and Safety	http://www.transformed.com/resources/Quality and Safety.cfm
Care Coordination	http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

V. Certification, Recognition, Eligibility

Title	Resource
Certification	http://www.ncqa.org/Programs/Certification.aspx
PCMH Recognition	http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
PCMH Specialty Practice Recognition	http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredSpecialtyPracticePCSP.aspx
PCMH/PCSP Multi-site/specialty Eligibility	http://www.ncqa.org/Programs/Recognition/PCMHPCSP/MultisitespecialtyEligibility.aspx
URAC Recognition	https://www.urac.org/
AAAH Accreditation Association	http://www.aaahc.org/
The Joint Commission	http://www.jointcommission.org/

VI. Miscellaneous Resources

Title	Resource
*Medical Home Builder	http://www.practiceadvisor.org/home
PCMH Toolbox	http://toolbox.opcpcc.com/
10 Steps to a Patient-Centered Medical Home	http://www.aafp.org/fpm/2009/1100/p18.html
Vermont Blueprint for Health	https://www.pcpcc.org/initiative/vermont-blueprint-health

PCMH Consumer Website	http://www.odh.ohio.gov/landing/medicalhomes/PCMH%20Consumer%20web%20page/PCMHconsumer.aspx
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* Medical Home Builder is divided into self-paced modules on a variety of operational and clinical areas. Each of the modules contains background information, the ACP Practice Biopsy® (a practice assessment tool), and links to the Resource Library, which includes relevant references and informative guides in a variety of formats including downloadable guides and policy templates. In addition to these components, Medical Home Builder also includes a section called “Practice-to-Practice Pearls” that contains user-submitted best practice videos and a discussion board where questions can be posed to a community of colleagues across the United States working towards similar goals. To support practices applying for recognition or accreditation as a Patient-Centered Medical Home (PCMH), Practice Biopsy questions address the NCQA PCMH 2011, URAC, and draft Joint Commission standards. Free demos are available on the website, but practices **must purchase a license** to use the product.