Patient Centered Medical Homes

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Presentation Overview
1. Medical home basics
2. What do you need to know?
3. What does it take?
4. Where do you start?

Patient-Centered Primary Care Collaborative (PCPCC)

• “A model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs.”
Based on the AHRQ definition, the PCPCC describes the medical home as an approach:

- Patient-centered
- Comprehensive
- Coordinated
- Accessible
- Committed to quality and safety

Potential Barriers:

- EMR Investments
- Resources for Staff Training
- Resistance to Change

Overcoming barriers:

- EMR Investments
  - Plan for those possible increases in the return on investments.
  - Efficiencies
  - Higher more accurate coding
  - Less need for transcription
  - Identifying patients who need to come in for appointments

- Resources for Staff Training
  - Facilitate learning
  - Join a learning collaborative
  - Develop a QI structure within your clinic
Overcoming Barriers Cont.

• Resistance to Change
  – Responsibility for creating a culture that both accepts change embraces change is with management and executives of the organization
  – Change must involve the people, not imposed on them
    • Understand Change management principals
    • Use John Kotter’s “Eight Steps to Successful Change”

Change Concepts

Change concepts form the Safety Net Medical Home Initiative

Engaged Leadership
QI Strategy
Empanelment
Continuous and Team-Based Healing Relationships
Organized Evidenced-Based Care
Patient-Centered Interactions
Enhanced Access
Care Coordination

http://www.safetynetmedicalhome.org/change-concepts