# The Patient Centered Medical/Health Home & Health Centers The Future is Here!

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# Primary Health Care's Mission

Improve the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services

# Health Centers and their Primary Care Journey

- 40+ years of providing primary health care to America's Underserved
- Health Center Growth Initiative, 2001
- Federal Grant - ~20%
- >16 Million Patients – Medicaid or Uninsured
- The Health Center Primary Care Model
  - Rooted in Community Oriented Primary Care

# Health Centers and their Quality Journey

- Evaluating Care Delivered
  - Clinical Indicators
  - Life Cycle Approach

- Health Disparities Collaboratives —*Diabetes, Asthma, Depression, Cardiovascular, Prevention, Access, etc.*
- Accreditation
- National, State, and local partners provide essential technical assistance
- HRSA Core Measures – pap testing; appropriate immunizations, HbA1c control, BP control

# HRSA's HIT Investment at HCs

- HRSA provides funds to Health Center Controlled Networks (HCCNs) to support the creation, development, and operation of networks of safety net providers for the enhancement of health center

| | |
|---|---|
| FY '07 | $31.0 million |
| FY '08 | $25.8 million |
| FY '07 | 70 grants to 400 HCs towards HIT;<br>35 grants to serve ~ 4m patients |

# Patient-Centered Medical Home
## Definition and Goal

- A primary care delivery model that is patient-focused, well organized, easily accessible, comprehensive, continuous, safe, accommodating, equitable, culturally appropriate, and evidence-based

- To provide patients with a broad spectrum of care across all life stages that results in improved health and healthcare delivery

Source: The Robert Graham Center and the Center for Policy Studies in Family Medicine and Primary Care. The Patient Centered Medical Home. History, Seven Core Features, Evidence and Transformational Change. November 2007

# Patient-Centered Medical Home (PCMH) Core Elements

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Coordinated and integrated care
- Quality and safety
- Enhanced access
- Payment reform

Source: The Robert Graham Center and the Center for Policy Studies in Family Medicine and Primary Care. The Patient Centered Medical Home. History, Seven Core Features, Evidence and Transformational Change. November 2007

# NCQA Standards

1. Access and communication
2. Patient tracking and registry functions
3. Care management
4. Patient self-management support
5. Electronic prescribing
6. Test tracking
7. Referral tracking
8. Performance reporting and improvement
9. Advance electronic communications

Source: Hudson Scholle, S. NCQA. Defining the Patient-Centered Medical Home. Presentation to NACHC, March 14, 2008

# Health Centers & Medical Home

| Health Home Core Elements | Health Center Primary Care Model |
|---|---|
| Personal Physician | √ **(Maximize Continuity of Care)**<br>▫ **Admitting Privileges**<br>▫ **Established Arrangements for Hospitalization, Discharge Planning** |
| Physician Directed Medical Practice | √ and Other Independent Practitioners<br>▫ Adoption of Team-Based Models, esp. Care Models |
| Whole Person Orientation | √<br>▫ **Comprehensive** package of primary and preventive services<br>▫ Patient Preferences, Values, and Culture, incl. Language |

# Health Centers & Medical Home - 2

| Health Home Core Elements | Health Center Primary Care Model |
|---|---|
| Whole Person Orientation (cont'd) | √<br>▫ Behavioral and Oral Health<br>▫ **Translation, Transportation, Outreach**<br>▫ **Education** and Self-Management Goals |
| Care Coordinated/ Integrated | √ (Developing)<br>▫ **Admitting Privileges**<br>▫ **Arrangements for Hospitalization, Discharge**<br>▫ **Collaborative Relationships**<br>▫ Growing Need for Specialty Care<br>▫ Developing Technology Infrastructure |

# Health Centers & Medical Home - 3

| Health Home Core Elements | Health Center Primary Care Model |
|---|---|
| Quality and Safety | √ (Accelerating)<br>▫ Widespread Knowledge and Adoption of Care Models (Evidence-Based)<br>▫ Standardized HRSA Quality Reporting<br>▫ Growing Adoption of EHRs & Registries<br>▫ Patient Safety and Pharmacy Collaborative |
| Enhanced Access | √ (Developing)<br>▫ **Accessible Hrs Operation/Location**<br>▫ **After-Hours Telephone Coverage**<br>▫ Open Access<br>▫ Advanced Electronic Communication |

# Health Centers & Medical Home - 4

| Health Home Core Elements | Health Center Primary Care Model |
|---|---|
| Community Focused | √<br>▫ **Demonstrate, Document, and Respond to Community Need**<br>▫ **Governed by Patient Majority Board**<br>▫ **Established Collaborative Relationships** |
| Equitable Care Delivery | √<br>▫ **Sliding Fee Discounts**<br>▫ **Reports on Disparities in Outcomes**<br>▫ Application of Cultural Competence |
| Payment Reform | Growing Evidence of health center cost effectiveness |

# Steps Towards Acceleration PCM/HH Elements

- Workforce Partnerships
- Team based care models
- Continued Expansion in Service - Behavioral & Oral
- Technology Infrastructure development
- Technical Assistance focused on Access and Patient Experience
- PCM/HH Initiatives

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