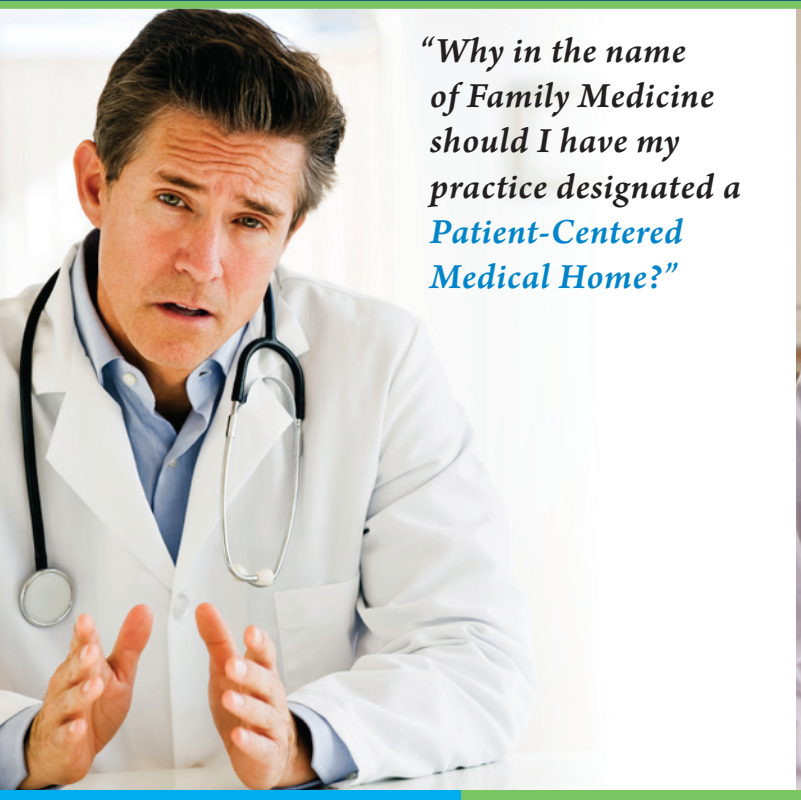
PENNSYLVANIA ACADEMY OF
FAMILY PHYSICIANS FOUNDATION

The Patient-Centered Medical Home Initiative



"Why in the name of Family Medicine should I have my practice designated a Patient-Centered Medical Home?"

"Because PCMH increases satisfaction for both patients and physicians. Throughout the country, PCMH is helping to reduce cost and improve treatment outcomes.

In short: It's the right thing to do!"

Visit pafp.com

Our Patient-Center Medical Home Initiative:

- Helps you determine which of the national reviewing bodies would be the best one for you to approach to seek PCMH recognition.
- Provides you with tools to help assemble and manage a PCMH team.
- Is here when you need advice on how to complete the assessment process.

"We saw (the PCMH process) as a way to improve care and deliver better value to patients … PAFP was very helpful. They provided resources and people to help us prepare the application and guide us through the process."

– Joseph Cincotta, MD, Chief Medical Officer, Heritage Medical Group

Are you considering the PCMH model for your Family Medicine practice?

More and more family physician practices are adopting PCMH as an effective, coordinated approach to providing patient care.

A recent survey found that almost 70 percent of respondents were already in the process of transforming into or interested in becoming a PCMH.

PCMH reduces health care costs and improves overall quality of care.

What is the PCMH model?

The PCMH model is based on the premise that the best health care is not episodic and illness-oriented. It assumes that high-quality care is patient-centered, physician-guided, ongoing, and cost efficient.

PCMH is defined by the nation's four largest primary care physician associations* by seven principles (on page 4).

NOTE: *American Academy of Family Physicians (AAFP); American Academy of Pediatrics (AAP); American College of Physicians (ACP); American Osteopathic Association (AOA)

The seven principles of the Patient-Centered Medical Home

1. **Personal physician** – Each patient has an ongoing relationship with a personal physician, trained in first contact, continuous and comprehensive care.
2. **Physician-directed medical practice** – The personal physician leads a team that collectively takes responsibility for the patient's ongoing care.
3. **Whole-person orientation** – All of the patient's health care needs are provided by the personal physician or arranged to be provided by other qualified professionals.
4. **Coordinated Care Care** – Coordinated Care - Care is coordinated across all elements of the healthcare system and the patient's community. Care is facilitated by registries, information technology, health information exchange and other means to assure care is received when and where needed.
5. **Quality and safety** – Hallmarks of the medical home.
6. **Enhanced Access** – Access is enhanced through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.
7. **Payment** – Appropriately recognizes the added value PCMH brings to the patient.

How can a practice become qualified or recognized as a PCMH?

There are four national organizations recognizing physician practices for implementation of PCMH standards:

- National Committee for Quality Assurance (NCQA) – the first to recognize PCMH practices.
- The Accreditation Association for Ambulatory Health Care (AAAHC) – accredits ambulatory health care organizations and managed care organizations.
- The Joint Commission (TJC) – will accredit and certify ambulatory care centers nationally, beginning in 2012.
- URAC (originally Utilization Review Accreditation Commission) – an independent, non-profit accrediting organization that released new standards in 2011 for a two-year practice achievement award.

Like other review processes in health care, many of the standards developed by the accrediting organizations overlap. Yet, each of the four programs is distinct and has different "moving parts."

Comparing four sets of standards, deciding which set best fits your practice and determining where to begin the review process can be daunting, if not discouraging. BUT…

The PAFP's Patient-Centered Medical Home Initiative program is your solution.

Experienced help for PCMH transformation

Clearly there are benefits – both to patients and to the bottom line – when a practice demonstrates that it has adopted the PCMH model. The most important benefits are:

- Improved quality of health care and greater patient satisfaction.
- Stronger position for seeking enhanced payments from insurance companies and for future payment reforms based on PCMH compliance.

The PCMH Initiative understands that medical practices are businesses. Our staff knows that treating patients and maintaining patients' health takes first priority in the business of Family Medicine.

PAFP will help your practice become a PCMH

The PAFP Patient-Centered Medical Home Initiative is a service available exclusively to practices in Family Medicine. It can reduce administrative time as your staff begins the process of achieving PCMH status.

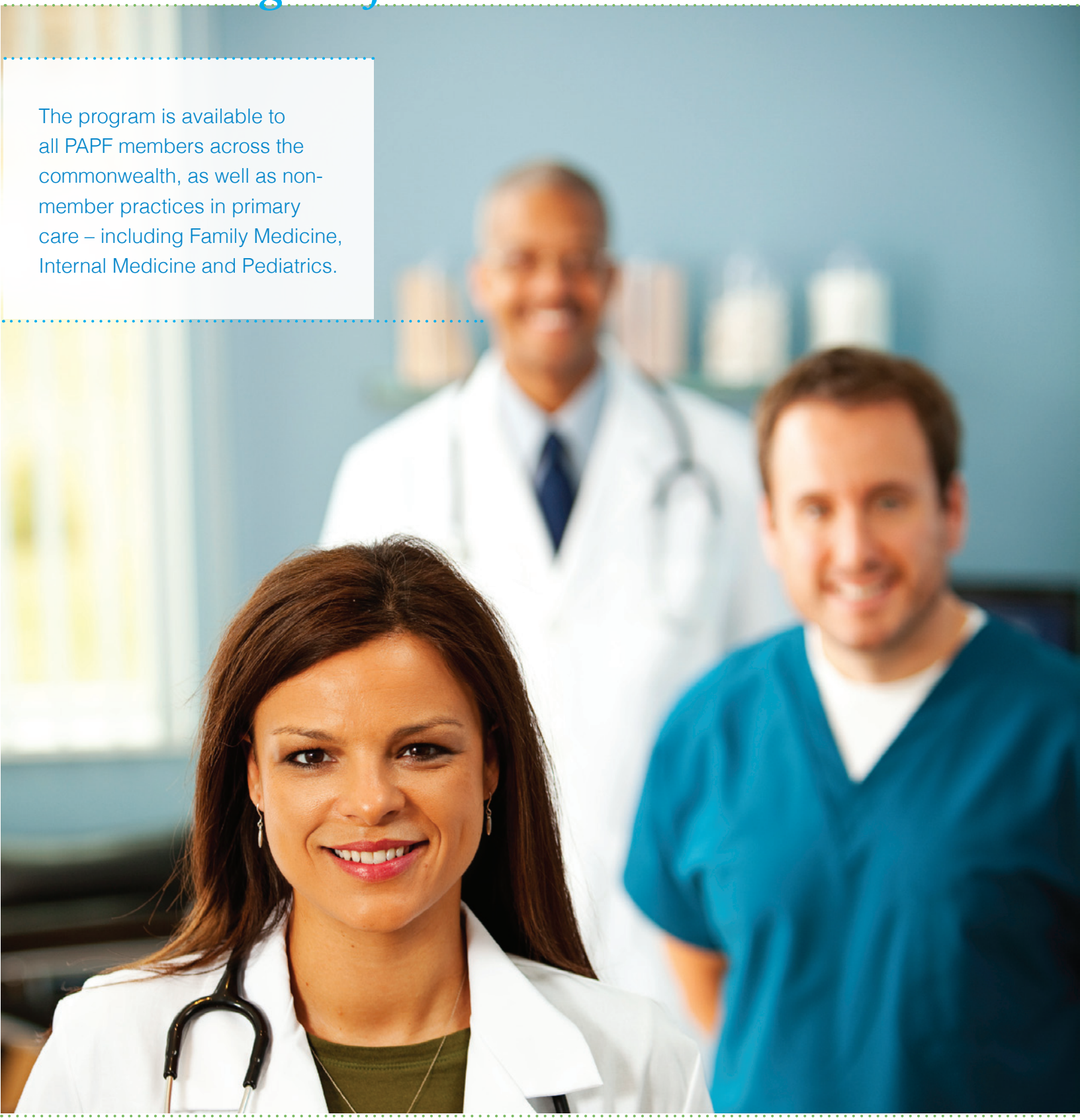
PCMH Initiative advisers are very familiar with all four of the current recognition programs, and they monitor each program's revisions and updates. They have several years of solid experience guiding practices through the review process.

Our PCMH advisers will:

- **Help you do an assessment** to determine which PCMH governing body review process best fits your practice.
- **Provide you with tools to do a "gap analysis"** to see how your practice compares to PCMH standards. You'll know what your weaknesses are and what work needs to be completed.
- **Advise you on building a PCHM team**, including how to decide who should be on the team, how it should be managed, and how to ensure accountability to the team and the practice.
- **Offer tips on effective team meetings.** Strong leadership is needed to shape the challenging process of establishing and managing regular meetings, creating effective minutes, maintaining accountability and building an effective action plan.
- **Assist you with setting up a tracking system.** You'll learn how to your team as it documents practice compliance with each PCMH standard. You'll receive effective tools for tracking team members' responsibilities, due dates and progress updates as they work through the process.

Who's eligible for PCMH Initiative assistance?

The program is available to all PAPF members across the commonwealth, as well as non-member practices in primary care – including Family Medicine, Internal Medicine and Pediatrics.



Why should you take advantage of this unique program?

Pennsylvania is at the forefront of the PCMH movement nationally. Evidence is mounting that practices built around the patient-centered model are more effective, more efficient and more productive.

For example: the Pennsylvania Chronic Care Initiative (PCCI), established in 2008 in southeastern Pa., reports that practices managing chronic diseases in the PCMH model show significant improvement in the percentage of diabetes patients who received screenings for complications and who, as a result, were placed on therapies to treat them. There were also statistically significant improvements in blood pressure and cholesterol levels, especially in the highest-risk patients.

It's early. But PCMH proponents believe the model will prove to be everything it promised – including encouraging payers to reward practices that adopt the seven principles of the Patient-Centered Medical Home.

"NCQA PCMH recognition is an essential mark of quality, both in patient processes and patient outcomes. With the insurer payment mechanism shifting to 'quality over quantity,' the PCMH recognition ensures that you will be paid for the care you provide as a Medical Home."

– Bill Warning, MD, Program Director, Crozer-Keystone Family Medicine Residency Program

Endorsements

The joint principles of the Patient-Centered Medical Home (PCMH) are at the very soul of a Family Medicine practice. It is a new model of health care delivery, changing the way health care is delivered in America.

The Pennsylvania Academy of Family Physicians wholeheartedly supports the PCMH model. All physician practices are encouraged to embrace its patient-centered focus.

The PCMH Initiative was created by PAFP at the behest of its Board of Directors and has flourished through the dedication of its staff. It is due to this commitment by PAFP's physician leadership and the daily efforts of expert administrators that this program is offered to Pennsylvania's primary care practices.

Pennsylvania's leadership in the PCMH movement is highly regarded. PAFP was selected to present a major session at the Institute for Healthcare Improvement (IHI) International Symposium in Washington, D.C., in spring 2012.

Contact PAFP for more information

The PCMH Initiative is a service of the Pennsylvania Academy of Family Physicians, based in Harrisburg. More information is available online the PAFP website by clicking here.

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