Patient-Centered Medical Homes

How Public Health Practitioners Can Support PCMHs

Background

A strong influence on health outcomes are social determinants of health (SDOH), which are factors that are outside of the health care system such as education and income levels.[1, 2, 3] SDOH issues are an important consideration when determining how to best integrate clinical and community strategies to produce better health. The current separate and isolated models of care delivery can be more effective by integrating multiple strategies—clinical, mental health, social, economic, education, and community—within a single population or health care system, using a team-based and whole person approach.[4] Integrated models include Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs).

> "The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."[1]

Many private and public systems have chosen to adopt PCMHs as a health care delivery strategy. PCMHs are led by the primary care provider and coordinate care across the health care community. The patient's full scope of health care needs, including prevention, is the facilitator of all care service. This is irrespective of the number of providers or where the patient receives care.[5] The following overview of PCMHs includes suggestions on how public health practitioners can support PCMH in prevention work and additional resources.

Description of a PCMH

What is a PCMH?

A PCMH is a model of care that strengthens the clinical-patient relationship by replacing episodic care with coordinated, whole person, and long term care. The primary care clinician leads a team of clinical and community health providers who take collective responsibility for patient care. They coordinate care for the patient's health needs and arrange for appropriate care with other qualified health services.[6]

PCMH Defining Principles

The Joint Principles of PCHM include the following:

- **Personal physician** —Every patient has a continuous and consistent relationship with a physician, who is the patient's first contact and coordinates all care.
- **Physician-directed medical practice—**The personal physician leads a team who take collective responsibility for the patient's care.
- **Whole person orientation—**The personal physician takes responsibility for providing and coordinating all acute, chronic, and end-of-life care, as well as preventive services for the patient.
- **Care is coordinated and integrated** —All sectors of the health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services) work synergistically to deliver care in a culturally and linguistically appropriate way.
- **Quality and safety** — Care is evidence-based and health information technology (IT) is strategically used to support optimal patient care. Physician practices complete a PCMH voluntary accreditation process to demonstrate PCMH capability, serve as the patient's advocate within the health care system and

community, and are accountable to coordinate care. Patients and their families are engaged in continuous quality improvement activities and actively participate in decision making.

- **Enhanced access—**Care is available with open scheduling, expanded hours, and options for communication between patients, their personal physician, and team.
- **Payment—**The payment structure should reflect the value that a patient receives from a PCMH. It provides reimbursement for care management and coordination that happens outside of the primary care givers office. Payment also allows for fee-for-service reimbursement for office visits and takes into consideration the varied needs of each patient. Payment should support improved communication through telephone, secure e-mail consultation, and adoption of strategic health IT (e.g., electronic medical records, electronic reminders)for quality improvement, coordination of services, and remote monitoring of clinical data.[7]

How Public Health Practitioners Can Support PCMHs

- **Build strong relationships with physicians and practices:** Public health practitioners can build trusting relationships with the PCMH team to ensure the successful coordination of public health services with clinical services that are both essential to a patient's health and well-being. By collaborating with physicians in a PCMH or similar team effort, public health practitioners can also add a health equity lens to increase awareness of SDOH to improve health outcomes.

- **Serve as a community connector:** Public health practitioners can facilitate PCMH team connections to community-based organizations, services, and community networks that are important to patient care. Practitioners have established relationships with community-based service providers that focus on health education and access to healthy food, physical activity, wellness programs, mental health, and substance abuse services. Practitioners can help patients' access additional resources to compliment clinical care.

- **Engage health care extenders:** Public health practitioners can engage health care extenders, such as community health workers, who have relationships with communities experiencing health disparities, which are "gaps in the quality of health and health care across racial, ethnic, sexual orientation and socioeconomic groups."[8] Health care extenders can provide valuable insight into communities that are linguistically or culturally challenging to the PCMH team and address barriers created by SDOH.

- **Demonstrate the value of population health and prevention strategies:** Public health practitioners can provide information and data to the PCMHs team on public health surveillance or from a community health needs assessment to create a broader understanding by care givers that improving health is more than providing health services to an individual patient. Practitioners can provide information on primary (prevent developing health problem), secondary (at risk for developing health problem), and tertiary (established health problem)[9] prevention activities and programs that focus on preventive screening, healthy eating, physical activity, tobacco cessation, healthy families, child wellness, immunizations, mental health, substance abuse, and safety and other core functions of public health.[3]

Resources

- National Committee on Quality Assurance
- Agency for Healthcare Research and Quality

- Patient entered Primary Care Collaborative
- National Academy for State Health Policy
- Joint Principals of the Patient-Centered Medical Home (March, 2007) (p.2)

References

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