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Paper Title:

Patient-Centered Medical Home Model: the New View

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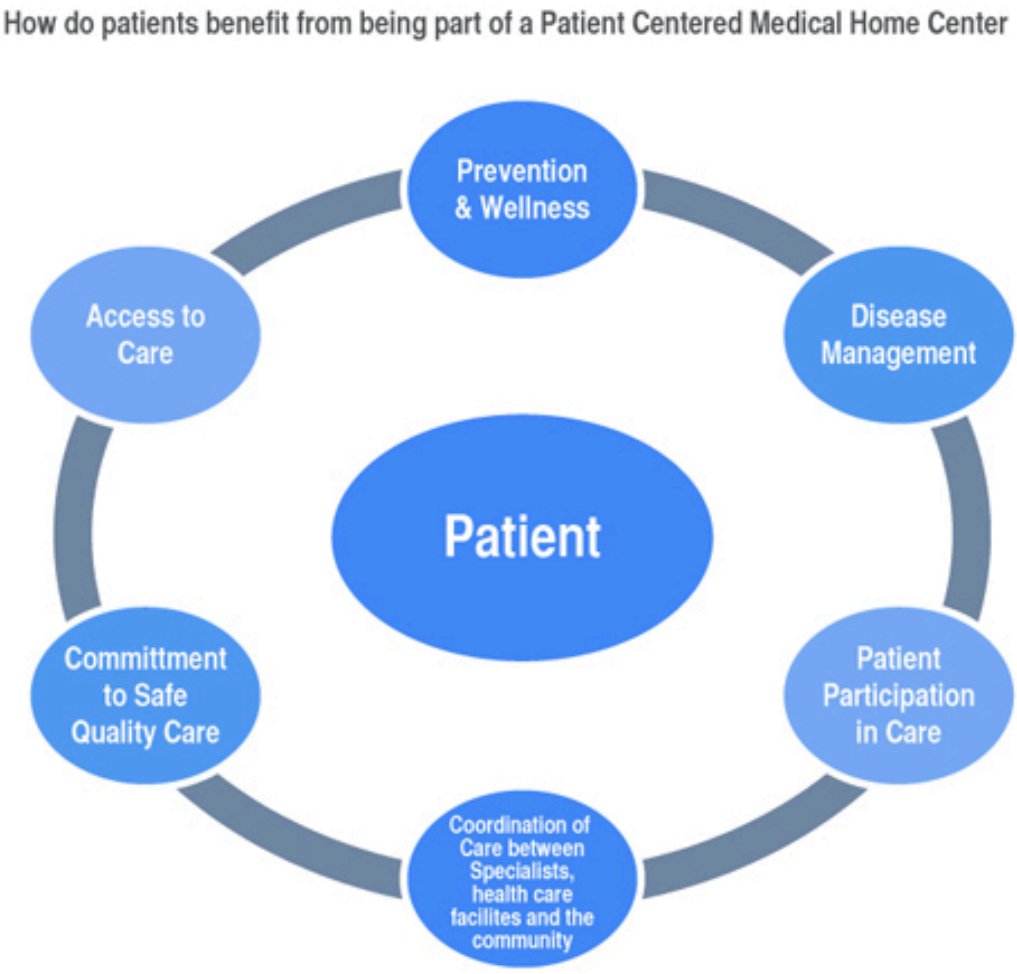
***Note**: Due to the fact I live in the state of Oregon my map and notes are centered on their progressive approach.*

Patient-Centered Medical Home Model: the New View



Why examine Patient-Centered Medical Home options?

As Medicaid spending continues to engulf state budgets, the medical home model of care offers a possibility of renovating the health care administration system. Medical "homes" offer the opportunity to reduce costs while improving quality and efficiency by an innovative approach to delivering comprehensive patient-centered protective; preventative and primary care. The patient-centered medical home (often referred to as PCMH, or medical home) aims to refresh primary care and achieve better quality, improved experience, and attempting to achieve lower costs.

The patient-centered medical home (PCMH) model is designed around patient needs and aims to improve access to care through basic needs like extended office hours and increased communication between providers and patients via email and telephone. The increased care coordination can enhance overall quality while reducing costs.

Patient-Centered Medical Home sounds good, but what does it really do?

The medical home relies on a team of providers to look at overall health instead of individual issues. If a patient had a broken arm they might go to the emergency room for an x-ray, and follow up with their own physician. Yet what if that broken arm led to diminished work hours, financial stress, weight loss or gain from the inability to cook, or even job termination? Then a PCMH model would embrace the broken arm as a need for not just physical support but psychological assistance. It is a 'team" of physicians, nurses, nutritionists, pharmacists, and social workers—to meet varying health care needs. Studies have shown that the medical home model's

attention to the '**whole-person'** and integration offers the potential to improve *physical health* and *behavioral* health.

Although general agreement exists about the basic canons of the medical home, the representative model is still embryonic. Not all medical homes look alike (but this is to their benefit since what they want to create is a place for all to find a safe 'home' that fits their personal needs). Not all medical homes use the same strategies to coordinate care. Accreditation offers formal recognition of licenses and confirmations for operating that include all the usual stamps of approval. It is imperative providers successfully meet specific standards and requirements to ensure the quality care of treatment. Yet facilitating payment from both public and private payers is a complicated canopy to try and reform.

3 Easy ways to understand Patient-Centered Medical Home Care

Comprehensive Care

The PCMH is designed to meet the majority of a patient's physical and mental health care needs through a team-based approach to care.

Patient-Centered Care

The PCMH delivers primary care that is oriented towards the **whole person**. This can be achieved by partnering with patients and families through an understanding of and respect for culture, unique needs, preferences, and values.

Coordinated Care

The PCMH coordinates patient care across all elements of the health care system, such as specialty care, hospitals, home health care, and community services, with an emphasis on efficient care transitions (i.e. from the hospital to moving freely unassisted in ones own home).

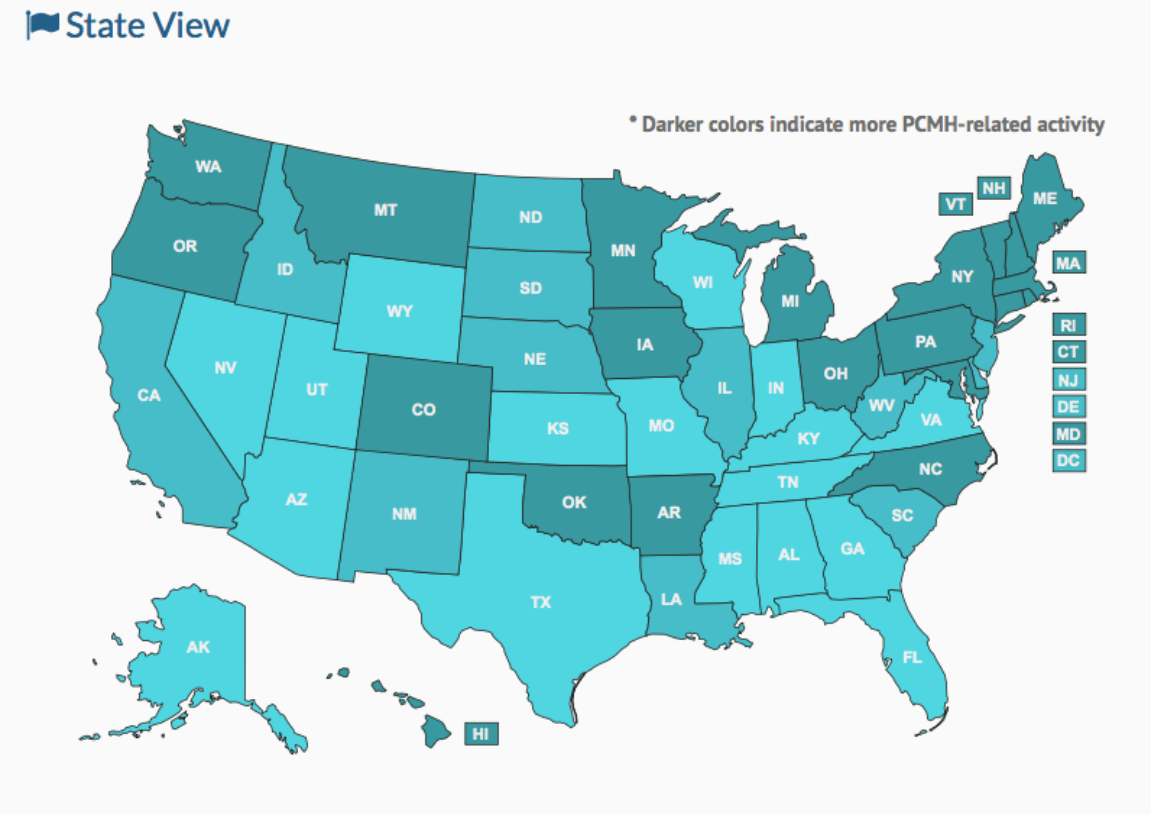
Will PCMH be accepted by my medical insurance?

Medical home accreditation is available from national accreditation organizations; some of the largest insurance carriers (Anthem, Blue Cross/ Blue Shield) are looking toward the model to help reform the burdens of cost between doctors, hospitals, and rehabilitation services. A few states have developed their own standards and are aggressively working toward integrating among the strict elements of insurance carriers. Although certain health care providers (such as community health centers) already embody many criteria of the PCMH, many are seeking formal recognition as patient-centered medical homes.

What is the risk of being part of a PCMH?

Essential to participating in the medical home program is the agreement and understanding that for success that there will need to be conformity to use health information technology (HIT). The medical home can be a physical or a virtual network of providers and services, while the HIT simplifies communication and information sharing among providers. Medical homes use electronic health records, which give providers instant access to patient information (regardless of location). However, HIPPA regulations are the forefront of secured information guarded by three components that represent supporting aspects of policies, record keeping, technology, and safety.

How does Oregon Compare?



Primary care is the front line of Oregon's health system, and the Oregon Health Authority (OHA) is working with public and commercial financiers on payment reform initiatives that move from "volume to value" and away from fee-for-service. In 2015 the Oregon Legislature committed to primary care payment reform by enacting **Senate Bill 231.** This legislation mandated the objective that the general collaborative of all major health care allow participants to share best practices that support innovation and improvement in primary care. A secondary portion requests insurance carriers and providers work together and pursue an

alignment agreement around primary care reimbursement as well as supportive alternative practices.

Exciting New Prospect within PCMH:

The ability to reach outlying communities who struggle for care is one of the innovative aspects of combining the PCMH model. When comparing urban populations in Oregon, rural communities experience higher death rates from heart disease, cancer, and unintentional injury. Rural health disparities contribute to the widening gap in death rates between rural and urban areas each year. The approximately 4.2 million (30%) of Oregonians who live in rural areas are more likely to smoke, be obese, report physical inactivity and have high blood pressure.

Residents in rural counties often face difficulty accessing health care services. Those living in bucolic counties are more likely to be uninsured, live within a health professional shortage area (HPSA) and experience a local hospital closure.

State leaders attempting to bridge the gaps are excited to use the possibility of the PCMH modality to help improve the health status of those living in isolated communities. These include increasing prevention and wellness initiatives, focusing on health care workforce recruitment and retention, improving health coverage through private insurance or Medicaid, and especially expanding **'telehealth'.**

Telehealth is a tool, according to the 2016 United States Congress, that is for "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration." It capitalizes on technology to provide health care in remote areas. *Telehealth* is not a service itself, rather a mechanism for

delivering health care services. With its potential to overcome workforce and access barriers, *Telehealth* can reduce health disparities for aging and underserved populations, reduce patients' costs, burdens associated with lost work time, transportation and child care.

Patient-Centered Medical Home **c**are allows the patient to live under one roof of combined focused care. The patient benefits as the executive of their own personal journey with integrated methods and options that range from traditional to alternative treatment, progressive communication between staff members, cutting edge technological experiences, reduced cost and diminished stress. It is essential to keep in mind that a body with relentless 'dis-ease', *physical* or *mental*, eventually suffers and becomes diseased. The Medical "home" model is a pugnacious new format to undo the intricacies of bureaucracy and unify health care.

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