HealthARCH
ADVANCING RESOURCES TO CHANGE HEALTHCARE

A Division of the UCF College of Medicine

Taking Healthcare to the Next Level

THE PATIENT CENTERED MEDICAL HOME

Where Coordinated Quality Care Lives

What is a Patient Centered Medical Home?

THE PATIENT CENTERED MEDICAL HOME (PCMH) IS A MODEL OF CARE THAT STRENGTHENS THE PHYSICIAN-PATIENT RELATIONSHIP BY REPLACING EPISODIC CARE WITH COORDINATED CARE AND A LONG-TERM COLLABORATIVE RELATIONSHIP.

Led by a physician, the PCMH uses a team-based approach, providing continuous and comprehensive care throughout a patient's lifetime to maximize health outcomes. The PCMH will improve and transform how care is organized and delivered on a national level.

WHAT ARE THE BENEFITS OF BECOMING PCMH RECOGNIZED?

- Aligns with emerging payment models based on quality and value rather than patient volume.
- Improves health outcomes.
- Enhances the patient and provider experience through personal interaction with doctors and care teams.
- Reduces expensive, unnecessary emergency department usage.
- Increases doctors' ability to stay better connected with the medical community and manage care more efficiently.
- Improves access to care through easier scheduling of appointments and extended office hours.

Better Health Better Care and Lower Costs

1 IN 2 AMERICANS HAVE A CHRONIC CONDITION

75% OF HEALTHCARE COSTS ARE DUE TO CHRONIC CONDITIONS

A coordinated approach to care can help prevent and manage chronic conditions like heart failure, diabetes and hypertension. The PCMH can help reduce costs and improve patient outcomes, and it aligns with payment models where care is incentivized through quality and value rather than volume.

THE IMPACT OF THE PCMH

PENNSYLVANIA CHRONIC CARE INITIATIVE[1]

- Lower rate for hospitalizations (-1.7)*
- Lower rate for ED vists (-4.7)*
- Increase in primary care visits (+77.5)*

* (per 1000 patients per month vs. comparison)

CAPITAL HEALTH PLAN, FLORIDA[2]

- 40% fewer inpatient hospital days
- 18% reduction in healthcare claims costs
- 250% increase in primary care visits

BLUE CROSS BLUE SHIELD OF MICHIGAN[3]

- 13.5% fewer child ED visits
- 10% fewer adult ED visits
- $26.37 healthcare cost savings per member per month

[1]Source: RAND, Pennsylvania Chronic Care Initiative (PACCI), Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care, JAMA, June 2015

[2]Source: Patient-Centered Primary Care Collaborative (PCPCC), Benefits of Implementing the Primary Care Medical Home A Review of Cost & Quality Results, September 2012

[3]Source: CareFirst Blue Cross Blue Shield, CareFirst's Patient-Centered Medical Home (PCMH), 2012

Contact HealthARCH for a FREE initial consultation to begin your PCMH transformation journey.

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HOW WE CAN HELP

HealthARCH is at the forefront of Health IT and the latest developments in Healthcare Reform. Our NCQA Patient-Centered Medical Home Certified Content Experts (PCMH CCE) will support your practice through the PCMH process from initial assessment to transformation and recognition.

OUR SERVICES:

- **PCMH Readiness Assessment** – gap analysis of existing processes and documented policies for preparation of technical assistance plan
- **Project Plan** – customized for each practice
- **PCMH Transformation** – consultation and technical assistance to support improving healthcare delivery, administrative practices and systems of care, cost and quality
- **PCMH Education and Coaching** – customized training focusing on PCMH methodology and best practices
- **Workflow Redesign** – analysis and improvement of required processes
- **Documentation Audit** – audit of all reports, documents, processes and policies
- **Submission Support** – submission of all required documentation

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