The medical home is a model of primary care that is patient-centered, comprehensive, coordinated, accessible and committed to quality and safety.

—Agency for Healthcare Research and Quality

Patient Centered Medical Home Initiative

Challenge

More than 59 million Americans are uninsured or underinsured and lack access to high-quality, affordable health care. Free and charitable clinics help to address this unmet need by providing care at no or low-cost to these patients, many of whom have complex health needs. Despite the critical role of safety net clinics, they are chronically underresourced. They also operate within a health care delivery model that often lacks care coordination and the capacity to manage chronic disease.

Strategy

Americares seeks to improve health outcomes at the population level by championing the safety net sector's transition from a volume-based to a value-based health care delivery model. Our BD Advancing Community Health—Driving Quality Outcomes Program will support the implementation of national, evidence-based standards at the clinic level. Quality improvement experts will help providers integrate behavioral health into primary care services, enabling them to offer holistic care to patients.

Expertise

Americares U.S. Program team has implemented innovative disease management programs and has direct clinic coaching experience. These initiatives have grown out of our long history of successful collaborations with free and charitable clinics, health care organizations and academic institutions. Americares also has access to the tools and resources necessary to implement quality improvement programs in low-income communities.

Patient Centered Medical Home Program

This two-year, evidence-based initiative aims to improve safety net patients' care experiences and outcomes by fostering the delivery of team-based, highly coordinated and integrated care. Two free and charitable clinics will be selected to receive a $100,000 award from the BD Foundation. Americares will support these clinics with direct technical assistance from industry experts, enabling them to develop and implement new policies and procedures to evolve their delivery models. Our goal is for these clinics to obtain recognition from the National Committee of Quality Assurance (NCQA) as a Patient Centered Medical Home (PCMH), a designation that represents their shift towards value-based care delivery. The NCQA-application process also increases provider communication at the clinic level, enabling them to offer coordinated care to patients. Clinics trained on PCMH standards learn to continuously improve patient care. Additionally, PCMH recognition better positions clinics to advocate for funding and community support, as it indicates they are providing patients with high quality, comprehensive health care.

WHAT IS A PCMH?

The Patient Centered Medical Home is an innovative health care delivery model that aims to strengthen the health care system by reorganizing the way clinics provide care. In order to qualify as medical homes, clinics must actively engage patients in care and quality improvement activities. Involving patients allows PCMHs to test strategies to make the health care experience more holistic.

The five pillars of PCMH care emphasize:

1. **A patient-centered orientation that supports self care and involves patients in their care plans.**
2. **Comprehensive, team-based care that addresses most physical and mental health care needs including prevention, wellness, acute care and chronic care.**
3. **Coordinated care across the health care system that connects patients to medical and social resources in their communities.**
4. **Easy access to care that meets patients' individual needs and preferences, including care available after hours, via email and by phone.**
5. **A systems-based approach to quality and safety that includes being responsive to patient experiences and committed to ongoing quality improvement.**

Research shows that PCMHs reduce hospital and emergency department visits, mitigate health disparities and improve patient outcomes, lowering patients' overall health care costs.

LONG-TERM GOAL Once the initial clinics participating in the program receive NCQA recognition as a PCMH, Americares plans to partner with BD to provide technical assistance and grants to more clinics on a rolling basis. Americares will also share the model and tools used to facilitate PCMH implementation, as well as quality improvement webinars, with leaders of these and other clinics interested in taking initial steps towards becoming a PCMH. The overarching goal of this multi-year initiative is to drive quality improvement throughout the sector.

PCMHs in the U.S.

NCQA recognition as a Patient Centered Medical Home (PCMH) correlates with lower care costs and improved health outcomes.

10% **of U.S. primary care facilities are recognized as PCMHs by NCQA**

26 **free and charitable clinics have achieved NCQA recognition as a PCMH**

43% **of clinics in Americares partner network are interested in capacity building initiatives**

4.9%, **or $1,099, lower average annual total Medicare costs for PCMH patients**

83% **of Medicare beneficiaries in PCMHs say their health has improved**