Change with Purpose:
Mastering the Patient Centered Medical Home Transition

Because every patient deserves exemplary care!

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Value-Based Care Models

Accountable Care Organizations (ACOs)

- Network of physicians, hospitals, and other providers; providing coordinated, quality care.
- Eliminate unnecessary treatments and diagnostics; focusing on prevention.
- Risk dependent upon agreement ranging from no to high downside.
- Savings created through metric performance.

Bundled Payments

- Collective model of care combines reimbursement for a group of providers in a lump sum.
- Incentivized to deliver and coordinate care efficiently during an episode of care.
- If care isn't sufficient/efficient, larger downside risk for providers.
- Predetermined costs for select services.
- Savings based on reduced cost created by providers.

Patient-Centered Medical Homes

- Team managing patient's primary care to increase quality and coordination.
- Coordinate whole-person care.
- Low level of downside risk for providers with high reward based on performance.
- Graded based on patient access, engagement, and outcomes.

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Summary of Standards

PCMH 1.0 The organization utilizes a team-based approach for patient-centered coordinated care.

PCMH 2.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

PCMH 3.0 The organization provides patient education and self-management tools to patients and their family/caregivers.

PCMH 4.0 The organization provides advanced access to its patients.

PCMH 5.0 The organization provides patient follow-up.

PCMH 6.0 The organization evaluates its quality performance and improvement quarterly.

PCMH 7.0 The organization ensures patient health records are complete.

PCMH 8.0 The organization understands the impact of social determinants of health and health equity.

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The Art of the Huddle

PCHIP™: Patient-Centered Health Improvement Plan

What is a PCHIP?

A plan of Medical Care and support which…

- is unique to each patient and their specific needs
- is culturally and linguistically sensitive
- addresses social determinants of health
- respects the patient's goal for optimal well-being

Helpful Tip

PCHIPs are for patients you identify as high risk. Not all patients require a PCHIP.

Advanced Access

Providing the **right care…** at the **right time…** at the **right place**!

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It is our honor to take care of our patients. So we've designed our healthcare system the way it should be.

LifeSpring Health Systems primary care services serves as a patient centered medical home (PCMH) for our primary care patients.

The PCMH is how we coordinate care. What it means to you is:

- Your primary care provider makes sure you receive medical care when and where you need it.

- We work to make sure you receive seamless services across the healthcare system
- Our team wraps services around you to make sure you appropriate healthcare services, including specialty care, laboratory and radiology care, inpatient services, care coordination, language services, and anything else you may need.
- Our primary care teams are designed around the needs of the patient, so you don't have to be the one doing the difficult work of figuring out how to navigate complicated healthcare systems.

- We work to ensure you understand what is happening with all aspects of the health healthcare– including health conditions, prescriptions, insurance issues, billing issues, etc.
- You can call during normal business hours to address any scheduling or appointment issues.
- We are available 24 hours a day, 7 days a week to assist you with addressing emergent healthcare issues.

To reach your primary care provider after hours, please call [redacted]

https://medx.com/

https://claruscare.com/

https://www.call4health.com/

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Patient Follow-Up

Clinic Policy Includes Follow-Up For:

- Missed appointments
- Medication refill requests
- High-risk medications or new in-home treatments
- Lab and diagnostic results
- Referrals and consultations
- Preventive care and screening reminders
- Care coordination activities
- Frequent ER visits
- Hospital discharges

✅ **Documentation of follow-up is required in the patient health record.**

Quality Improvement

QI consists of actions that lead to **measurable improvement** in services and patient outcomes. **The key is engagement.** Engagement of patients and staff. This will bring great satisfaction to the work they are doing and will result in buy-in.

Examples

1. Lower our NCNS rate from 30% to 18% within 6 months.
2. Collect 30 patient satisfaction surveys each month through EOY.
3. Recheck 90% of BP's that are greater than 140/90 prior to discharge during the 90-day measurement period.
4. Educate 100% of staff on how to assess for and address SDOH by 12/31/25.
5. Complete AWV's on 75% of patients seen between 10/1/25 and 6/30/26.
6. Enroll 30 patients in CCM program during 4th quarter.
7. Follow-up with 85% patients prescribed a new medication within 72 hours during the measurement period of _____ to _____.

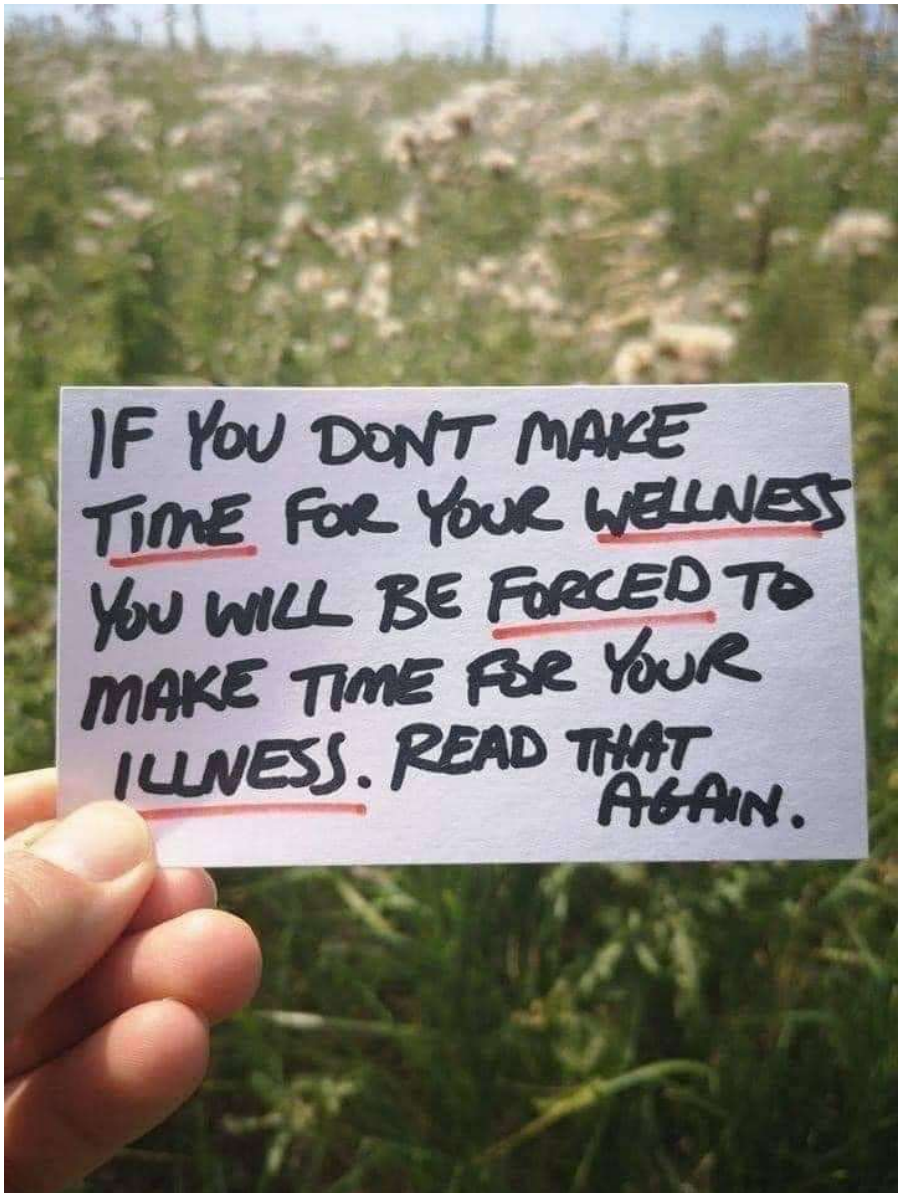
Complete Patient Health Records

- ✓Consent to Treat
- ✓Preferred Language
- ✓Preferred Pharmacy
- ✓Preventive Screenings
- ✓After-Visit Summary
- ✓Patient Healthcare Goals
- ✓Patient Education
- ✓Specialist progress notes
- ✓Follow up communication with patient

Wellness Visits

Why should you do them?

- Wellness visits are an efficient way to capture preventive screenings and close care gaps.
- Not all the work has to be done by the provider.



Social Drivers of Health

Needs Assessment:

- Who gets one?
- How often?
- Is staff trained to assess and address?
- What is your follow-up?

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PCMH Annual Program Evaluation

- Are we meeting our goals?
- Are we improving care quality?
- Are we maintaining compliance for accreditation?

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Path for Practice

Advisor Calls:

1. Orientation Call
2. Review Standards PCMH 1.0 - PCMH 5.0
3. Review Standards PCMH 6.0 - PCMH 8.0 and QI 1.0-2.0
4. Review Universal and Specialty Standards
5. Q & A

- View Clinical Concerns Webinar independently.
- Work PCMH Checklist to identify areas where clarification or increased resources are needed.
- Schedule follow-up calls to evaluate progress.

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Resources

We're here to help!

As part of the accreditation package, TCT has a wide range of tools and resources for the Patient-Centered Medical Home program at no cost, including:

- Webinars
- Templates for Policies and Procedures
- Patient Satisfaction Survey Portal
- Quarterly Improvement Project uidance
- Individual support with an Accreditation Advisor

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Questions

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