

09-08

STATEMENT OF POLICY

Patient-Centered Medical Homes

Policy

The National Association of County and City Health Officials (NACCHO) is cognizant of the need to restructure the delivery of healthcare in the United States. A patient-centered medical home is among the first steps to improve the health of patients and the healthcare delivery system.

NACCHO supports the following:

- A patient-centered medical home approach that provides comprehensive primary care, including prevention and wellness services, in a setting that facilitates partnerships between individual patients, their providers, and, when appropriate, the patient's family. This may occur in a traditional clinical setting or in a local health department (LHD) that is serving in a safety net capacity.
- A whole person orientation to healthcare, including integration of mental, behavioral, and oral health services. This means ensuring that a patient's primary provider takes responsibility for appropriately arranging care with other qualified professionals to provide acute care, chronic care, preventive and wellness services, and end of life care. If the patient does not have a primary provider and is receiving safety net services, every attempt should be made to coordinate appropriate care.
- Coordinated and/or integrated care that reaches across all elements of the complex healthcare and public health system and the patient's community, ensuring that patients receive the indicated prevention and care when and where they need and want it in a culturally and linguistically appropriate manner.
- Clinical practices, prevention and wellness services, and safety net services that advocate for the patients to support the attainment of optimal, patient-centered outcomes.
- Enhanced access to care through systems such as open scheduling and expanded hours.

NACCHO encourages LHDs to do the following:

- Engage in dialogue with community health centers and other clinical practices (both private and public), and specialty organizations in their communities about how to ensure the application of this model.
- Use this topic to open discussion and share resources with providers in their community, particularly related to medical safety nets.
- Participate in community activities and engage with community groups supporting patient-centered medical homes.

NACCHO also encourages private medical providers and community health centers to work with LHDs.



Justification

Research from countries where patient-provider relationships focus on primary care consistently shows that people live longer, populations are healthier, and patients are more satisfied with their care. These primary care providers do more preventive health counseling, perform more screenings and immunizations, and provide care advocacy and coordination that lead to lower rates of death for heart disease, cancer, and stroke and lower rates of hospitalizations for ambulatory care for sensitive diagnoses like pneumonia. Chronic condition management and medical errors and omissions are significantly reduced with this patient-centered primary care.¹

In a demonstration of the patient-centered medical home model in Wisconsin, a facility in Milwaukee is seeing improved outcomes among its diabetic patients:

- An absolute reduction of 1 percent (from 8.7 to 7.7) in hemoglobin A1C.
- Immunization rates increased from 50 percent to 80 percent for Pneumovax[®].
- An increase in the number of patients obtaining eye exams.

In Menomonie, Wisconsin, a family practice provider is including nurses and other members of the staff in the management of patient education and documentation, freeing him to concentrate on what he does best. This has resulted in the following:

- Patient wait times are down.
- Nurses are more satisfied.
- Physicians are more satisfied.²

The Commonwealth Fund 2006 Health Care Quality Survey found that when adults have a medical home, in addition to health insurance coverage, racial and ethnic disparities in access and quality are reduced or even eliminated. The survey found that when adults have a medical home, their access to care and rates of preventive screenings improve substantially. Practice systems in the form of patient reminders also improve the quality of care for vulnerable patients by promoting higher rates of routine preventive screening. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders and that when minority patients have medical homes, they are just as likely as whites to receive these reminders. The results suggest that all providers should take steps to create medical homes for patients.³

Record of Action

*Approved by NACCHO Board of Directors
November 2009*

References

1. A Revolution in Health Care in the US. Downloaded September 11, 2009 from <http://www.pcpcc.net/content/patient-centered-medical-home>.
2. Wisconsin Patient Centered Medical Home. Downloaded September 11, 2009 from <http://www.wafp.org/pcmh/wisconsin-pcmh.html>.
3. Beal A., Doty M., Hernandez S., Shea K., and Davis, K. Closing The Divide: How Medical Homes Promote Equity In Health Care (Results From The Commonwealth Fund 2006 Health Care Quality Survey). June 2007. Downloaded June 8, 2009 from http://www.commonwealthfund.org/~media/Files/Surveys/2006/The%20Commonwealth%20Fund%202006%20%20Health%20Care%20Quality%20Survey/Closing_divide%20pdf.pdf.