Patient Centered Medical Home

What, Why, and Assistance

A patient centered medical home (PCMH) addresses how a primary health care professional works in partnership with the patient/family to assure that all of the medical and non-medical needs of the patient are met.

Receiving care through a medical home can improve the health outcomes of patients by promoting timely use of health care services, increasing continuity of care, and raising satisfaction of care by families and providers.

When patients have a stable and continuous source of care they are more likely to receive appropriate preventive care, early diagnosis and better maintenance of chronic care conditions, and less likely to be hospitalized for preventable conditions. According to the National Association of Community Health Centers (NACHC), when patients have an established health care home, they have improved odds of being in good health. This ultimately results in fewer hospitalizations and visits to the ER. And reduces the need for specialty care services.

However in addition to improving patient care and quality of life for patients, patient centered medical homes have the potential for reducing health care costs that result from uncoordinated care creating duplication of health care services, misuses of diagnostic and specialty care services, and costly emergency room (ER) visits that can be prevented by timely and stable patient-focused preventive and primary care.

PCMH and the Triple AIM

PCMH is connected to the Institute for Healthcare Improvement (IHI) Triple AIM. The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

A January 2014 report, PCMH Project Evaluations Report Positive Results for Metrics Related to 'Triple Aim' provides useful information.

Quick Facts about PCMH

Transforming Primary Care in Nevada

NVPCA is engaged in supporting their members and educating the entire safety net medical home community in Nevada regarding practice transformation. We are committed to supporting our members to obtain national recognition as a PCMH.

NVPCA provides technical assistance and training, working to improve the health status and quality of health care provided to patients. Specifically, NVPCA is interested in working to inform, educate and provide varying forms of technical assistance to CHCs and other organizations who are interested in seeking recognition as a PCMH. Through population health and primary care improvements we know that more people in Nevada can maintain a higher quality of life.

Our quality improvement programs support our mission to increase health equity and access to comprehensive health care for low-income and vulnerable people in Nevada.

Supporting your Practice as a PCMH in Nevada

NVPCA, as funded by the Health Resources and Service Administration Bureau of Primary Health Care (HRSA BPHC), is obligated to provide training and technical assistance to community health centers so that ALL become recognized as a PCMH.

NVPCA's practice transformation, PCMH and QI consultant is supporting all CHCs in Nevada and other members upon request. She is a PCMH certified content expert (CCE) through National Commission for Quality Assurance (NCQA) with experience as a practice transformation coach regarding quality improvement and PCMH.

Other Questions

To obtain technical assistance, training or general support for PCMH recognition and practice transformation, contact PCMH Consultant Dawn Gentsch at dgentsch@nvpca.org.