# Preparing for the Future with PCMH

## The Shift from Quantity to Quality

Within the last decade, we have seen significant transformation of our healthcare system and practices have had to keep pace, or at least most have attempted. These changes have proven to be frustrating for providers and staff as they are already stretched beyond their limits. Add a public health emergency to the mix and some of these changes seem nearly impossible. Value-based care, also known as accountable care, is ultimately designed to allow opportunities to improve patient satisfaction and outcomes while financially rewarding providers for the quality of care they are providing at a lower cost. The "quadruple aim" we have all heard about. By prioritizing quality over quantity, healthcare can be more effective and efficient.

It appears the year is 2030. According to the CMS Administrator, CMS is working to ensure that all Medicare beneficiaries and a vast majority of Medicaid beneficiaries be in an accountable care relationship. That is just around the corner, but it seems like many are wondering how and where to start. The key is prevention and proactive care utilizing a team-based approach with high level care coordination between transitions, and ensuring patients have access to their primary care team *when they need it.* The key is becoming a Patient-Centered Medical Home! PCMH is what your practice needs to prepare for this inevitable shift to value-based care and providing exceptional care to your rural communities.

"What is a Patient-Centered Medical Home", you might ask? It is a model that RHC's use to deliver on value-based care and allow providers to facilitate wellness at a lower cost which will make the organization more successful when participating in these new and future programs. It puts patients at the forefront and builds better relationships between patients and their care teams. It provides structure and accountability while fostering an environment of quality improvement.

Why do it? As a result of accreditation, you will see improved patient outcomes, improved staff and patient satisfaction, efficiency within the practice and new-found revenue sources. Chronic Care Management is one example. CCM is within reach for all medical practices and is a win for both the patients and the practice. CCM is a program from CMS that provides reimbursement to providers for supporting chronic conditions. Get paid for the work you're doing with Medicare patients! The Compliance Team PCMH standards are the foundation of this program and will ensure success.

Find a PCMH accreditation program that was designed specifically with Rural Health Clinics in mind as you try to navigate through existing and incoming hurdles such as staffing shortages, technology challenges, and staff and provider burnout. Resources and experienced coaches are available to jumpstart your CCM services. Reach out to us anytime for tips and templates to ease your journey.

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