Blueprint For Success: The Patient Centered Medical Home

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Objectives

The participant will be able to

- Describe a Patient Centered Medical Home
- Discuss the evolution of the PCMH
- Identify the essential principles within the PCMH concept
- Identify the importance of the NCQA to the PMCH
- Apply the role of the DNP prepared APRN within the PCMH

Present Day Primary Care

- 65 million Americans live in designated primary care shortage areas (HPSA)
- Only27% of U.S. adults can easily contact their primary care physician by telephone, obtain care or advice after hours, and schedule timely office visits

(HPSA. Retrieved from http://bhpr.hrsa.gov/shortage/hpsas/)

Present Day Primary Care

- 50% of all patients do not understand primary care physician instructions because most visits are too short to address concerns

- Adequate coordination between primary care providers, specialists, and hospitals is lacking

(Patient-Centered Medical Homes. Health Policy Brief (Sept.14, 2010)
http://www.rwjf.org/files/research/68929.pdf

Primary Care

"Primary care is the key to attaining adequate health"

World Health Organization

(1978)

International Conference on Primary Health Care. Declaration of ALmaoAta. (1978) *WHO Chronicles. 32(11*) 428-430.

One Definition of PCMH

An approach to providing comprehensive primary care for children, youth and adults.

The PCMH is a health care setting that facilitates partnerships between individual patients, and their healthcare providers, and when appropriate, the patient's family.

(Patient-Centered Primary Care Collaborative)

NCQA PCMH Definition

A model of care that strengthens the provider-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship

AAP Definition

A medical home is not a building, house or hospital, but rather an APPROACH to providing comprehensive primary care.

A medical home is defined as:
primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective

(http://www.medicalhomeinfo.org/)

Patients are at the center of A Patient Centered Medical Home

Patient's Perspective of a PCMH

"They give me exactly the help I need and want, exactly when and how I need and want it."

Joint Principles

- Personal physician/clinician
- Clinician directed medical practice
- Whole person orientation
- Coordinated care
- Quality and safety
- Enhanced access
- Value added payment

http://www.pcpcc.net/joint-principles

Background of the Medical Home

1967: AAP called for a central location for archiving a child's medical record

1996: IOM advocated for medical homes

1999: IOM report *"To Err is Human"*

2002: Future of Family Medicine Project called for a "personal medical home" for all Americans

Background of the Medical Home

2005: American College of Physicians called for "advanced medical homes"

2009: American Recovery and Reinvestment Act (ARRA)

2010: Patient Protection and Affordable Care Act (PPACA)

Definition of "Clinician"

"an individual who uses a recognized scientific knowledge base and has the authority to direct the delivery of personal health care services to patients"

. . . . "may be a physician, nurse practitioner, or physician assistant."

IOM (1999): *To Err is Human*

- Health care in the US is not as safe as it should be
- Preventable medical errors cost human lives, lost income, lost household productivity and disability
- Errors result in loss of trust in the healthcare system and diminished satisfaction by patients and health professionals

Institute of Medicine (1999). To err is human: Building a safer health care system. Washington, D.C.: *National Academy Press.* Washington, D.C. Retrieved from http://www.iom.edu

Contributing Factors to Errors

- Decentralized and fragmented healthcare system (or "nonsystem")
- Patients may see multiple providers, but there is limited sharing of information or coordination of care
- Until recently, there was little financial incentive for healthcare organizations and providers to improve safety and quality

Why PCMH?

- Creates a **framework** for change
- Creates a **common language** for change
- Creates an **opportunity** for change

Essentials of a PCMH

"TLC"

- Teamwork
- Leadership
- Communication

Becoming a PCMH

MISSION

To improve the quality of health care

VISION

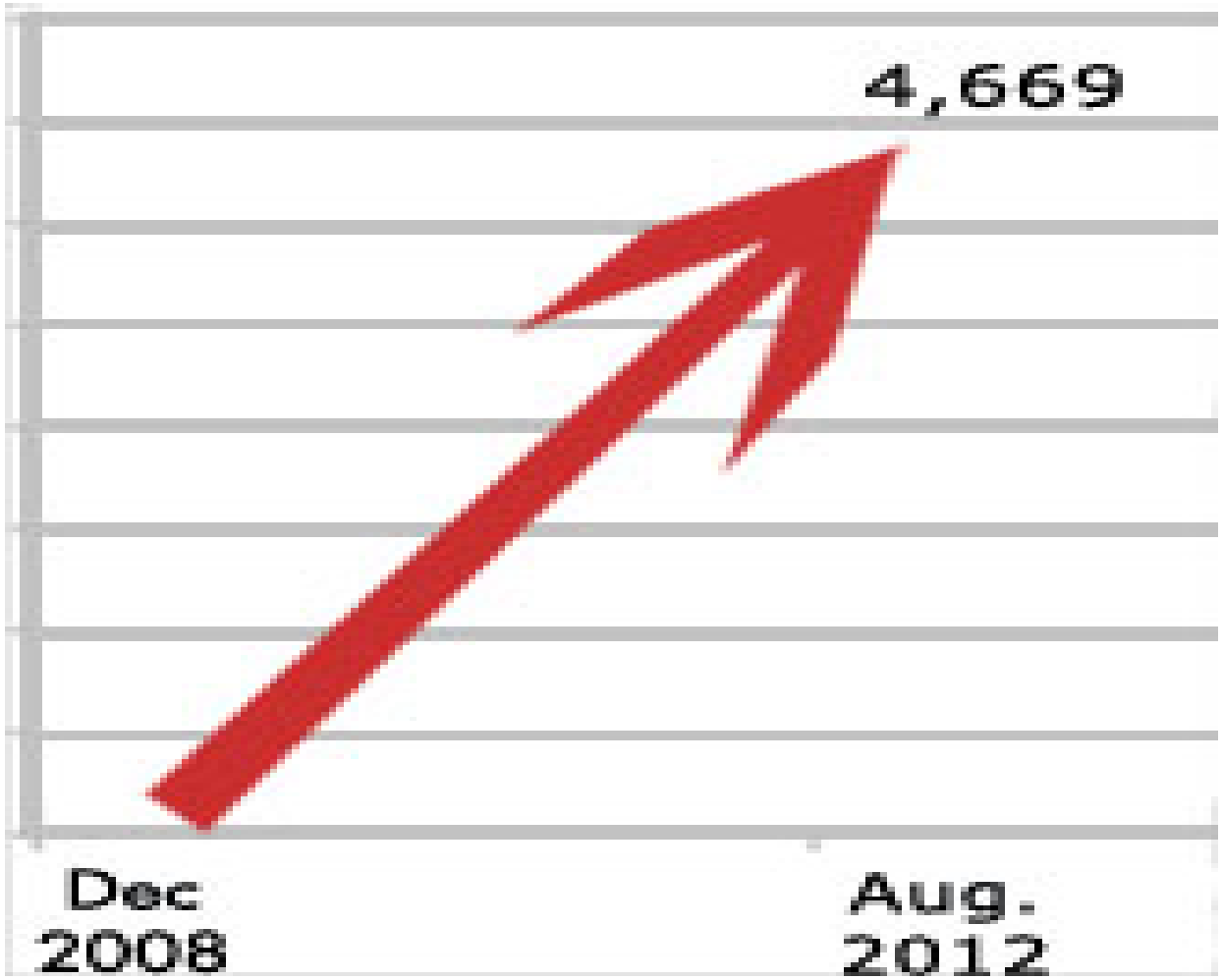
To transform health care through quality measurement, transparency and accountability

- NCQA is a private, independent non-profit health care quality oversight organization founded in 1990
- NCQA is committed to measurement, transparency, and accountability
- NCQA unites diverse groups around the goal of improving health care quality

"[Better] performance is not simply—it is not even mainly—a matter of effort; it is a matter of design"

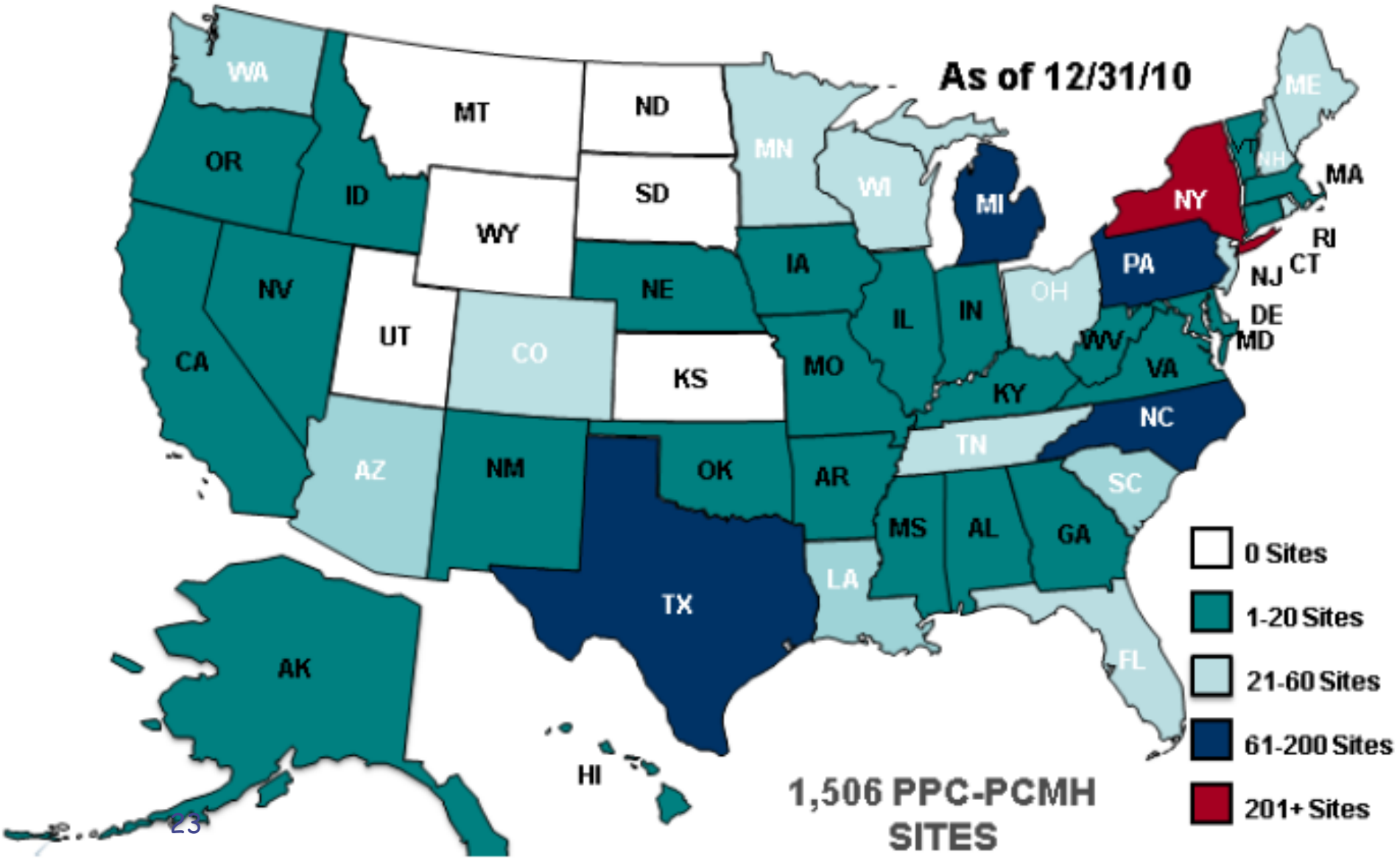
-Don Berwick
Administrator of CMS

NCQA Recognized PCMH Practices



Source: http://www.ncqa.org/

NCQA Recognized PPC-PCMH Sites



NCQA PCMH 2011 Guidelines

- Patient centered
- Emphasis on planning, managing and coordinating care for patients
- Use of continuous quality improvement process
- Align with federal initiatives for meaningful use

Meaningful Use

- An incentive program for deployment of EHRs and their effective use for patient benefit
- A new national infrastructure to support deployment and beneficial use of EHRs
- A vision for the evolving, dynamic and optimal uses of information to support health and health care improvement

Blumenthal, D. (2011). A quick look at meaningful use. *The Stat bulletin, 80*(5), 1-3.

Goals for the Redesigned PCMH

- Improve the patient experience
- Recognize clinicians for their efforts
- Provide confidence for purchasers that their dollars are spent on quality care

Why NCQA Recognition Process?

- The PCMH is an expanded role for primary care, in comprehensiveness, in follow-through, and in population management
- Doing more work must translate to getting more pay
- Payers want an external validation that they are getting VALUE when the pay more for PCMH

NCQA Overview of PCMH

- Recognition—not a certification
- Achieve Level 1, Level 2, Level 3 based upon scoring of points (100 points maximum)
- Divided into 6 standards, which are subdivided into elements and factors with assigned point values; some are "must-pass"
- Partial points for degree of success

Level of Recognition

Level	Points Earned out of 100	Must Pass Elements
Level 1	35-59 Points	Score ≥50% on all 6 Must Pass Elements
Level 2	60-84 Points	Score ≥50% on all 6 Must Pass Elements
Level 3	85-100 Points	Score ≥50% on all 6 Must Pass Elements

Getting Started

Go to the NCQA website at http://www.ncqa.org/tabid/629/Default.aspx

- 2011 PCMH Survey Tool ($80)
- Application for Patient-Centered Medical Home (Free)
- 2011 PCMH Standards and Guidelines (Free) (available in E-Pub, eReader, and Kindle)
- HEDIS 2012 CAHPS PCMH Survey (Free)

Getting Started

- IT requirements: computer, internet access, Microsoft Word, Microsoft Excel, Adobe Acrobat Reader
- The designated computer should have access to the practice's clinical and administrative systems
- Survey system is done only in Internet Explorer

Must Pass Elements

- PCMH 1A: Access during office hours
- PCMH 2D: Use of data for population management
- PCMH 3C: Care management
- PCMH 4A: Support self-care process
- PCMH 5B: Referral tracking & follow-up
- PCMH 6C: Implement continuous quality improvement

◇Standards ◇Elements ◇Factors

BUILDING THE MEDICAL HOME

PAYMENT FOR ADDED VALUE


Enhanced Access
PAYMENT FOR ADDED VALUE

1. Enhance Access and Continuity

A. Access During Office Hours*
B. Access After Hours
C. Electronic Access
D. Continuity
E. Medical Home Responsibilities
F. Culturally and Linguistically Appropriate Services (CLAS)
G. Practice Organization

*Must Pass

Identify and Manage Patient Populations

Enhanced Access

PAYMENT FOR ADDED VALUE

2. Identify and Manage Patient Populations

A. Patient Information

B. Clinical Data

C. Comprehensive Health Assessment

D. Using Data for Population Management*

*Must Pass


Identify and Manage Patient Populations
Enhanced Access
Plan and Manage Care
PAYMENT FOR ADDED VALUE

3. Plan and Manage Care

A. Implement Evidence-Based Guidelines

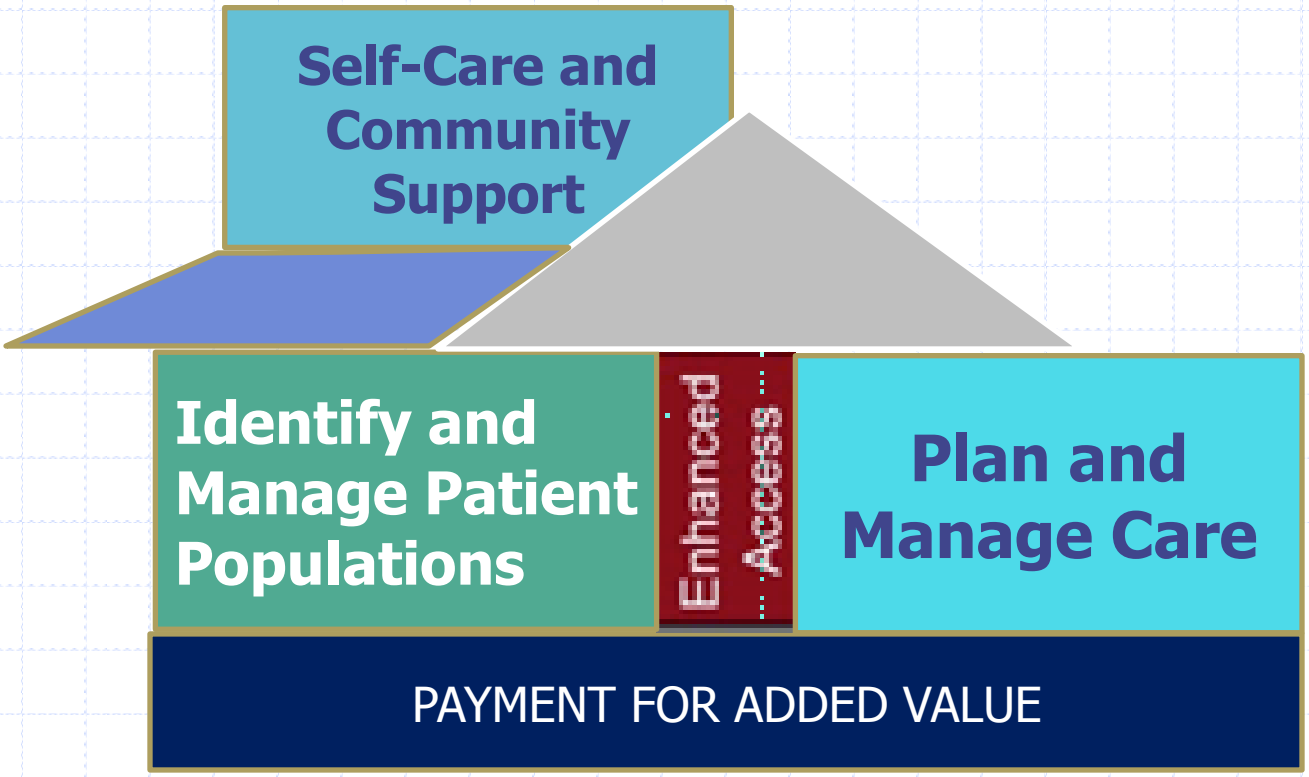
B. Identify High-Risk Patients

C. Manage Care*

D. Manage Medications

E. Electronic Prescribing

*Must Pass

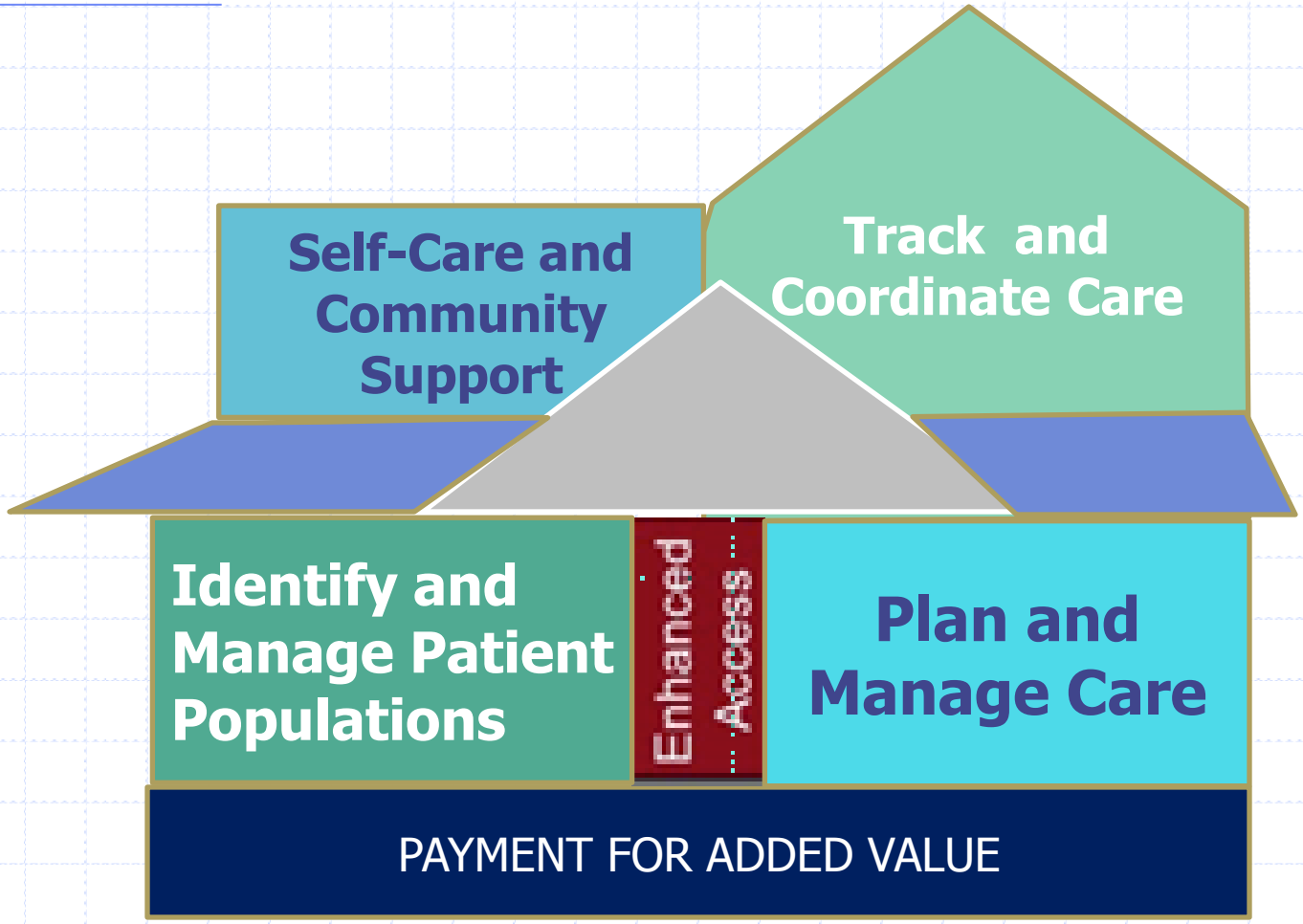

Self-Care and Community Support
Identify and Manage Patient Populations
Enhanced Access
Plan and Manage Care
PAYMENT FOR ADDED VALUE

4. Provide Self-Care and Community Support

A. Self-Care Process*

B. Referrals to Community Resources

*Must Pass


Self-Care and Community Support
Track and Coordinate Care
Identify and Manage Patient Populations
Enhanced Access
Plan and Manage Care
PAYMENT FOR ADDED VALUE

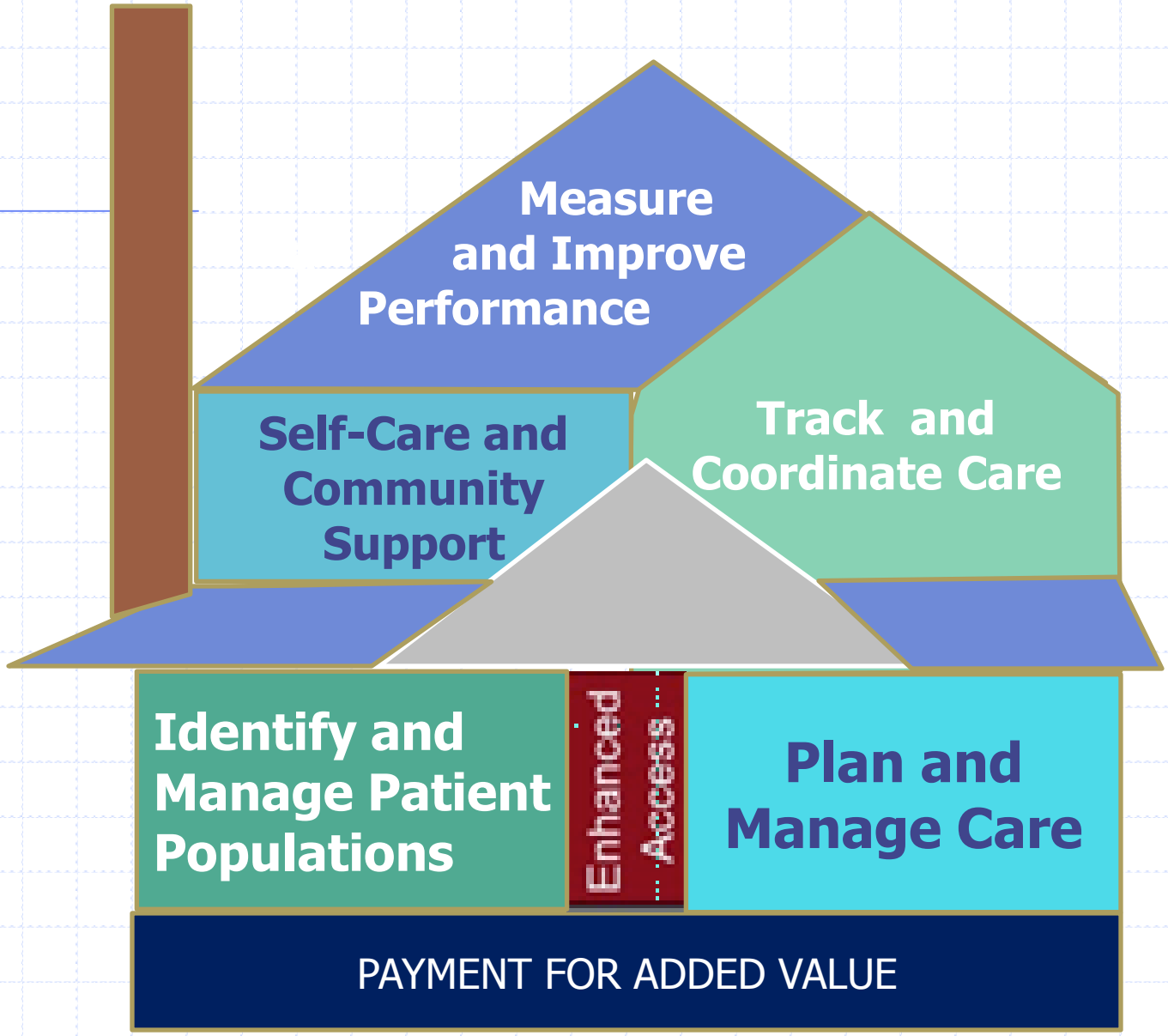
5. Track and Coordinate Care

A. Test Tracking and Follow-Up

B. Referral Tracking and Follow-up*

C. Coordinate with Facilities/Care Transitions

*Must Pass


Measure and Improve Performance
Self-Care and Community Support
Track and Coordinate Care
Identify and Manage Patient Populations
Enhanced Access
Plan and Manage Care
PAYMENT FOR ADDED VALUE

6. Measure and Improve Performance

A. Measures of Performance
B. Patient/Family Feedback
C. Implements Continuous QI*
D. Demonstrates Continuous QI
E. Performance Reporting
F. Report Data Externally
G. Use of Certified EHR Technology

*Must Pass

THE DNP PREPARED APRN AND THE PATIENT CENTERED MEDICAL HOME

October, 2010:
NCQA recognizes "nurse-led" primary care practices as patient centered medical homes.

"Solving the crisis in primary care: The role of nurse practitioners, certified nurse-midwives, and certified midwives. *ANA Issue Brief (2010)* Retrieved from http://nursingworld.org/

Patient Centered Care

"Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs."

QSEN: Quality and Safety Education for Nurses

http://www.qsen.org/definition.php?id=1

DNP Essentials

I. Scientific underpinnings for practice
II. Organizational and systems leadership for quality improvement and systems thinking
III. Clinical scholarship and analytical methods for evidence-based practice
IV. Information systems/technology and patient care technology for the improvement and transformation of health care

AACN (2009). Essentials of doctoral education for advanced nursing practice. Retrieved from http://www.aacn.nche.edu/publications/position/DNPEssentials.pdf

DNP Essentials

V. Health care policy for advocacy in health care

VI. Interprofessional collaboration for improving patient and population health outcomes

VII. Clinical prevention and population health for improving the nation's health

VIII. Advanced nursing practice

AACN (2009). Essentials of doctoral education for advanced nursing practice. Retrieved from http://www.aacn.nche.edu/publications/position/DNPEssentials.pdf

Blueprint for Success

- Provider buy-in
- Lay the foundation
  - Culture, Mission, Vision
- Build the framework
  - Standards, Elements, Factors of PCMH
- Home ownership
  - Providers, staff, patients take responsibility
- Home maintenance
  - Continuous Quality Improvement

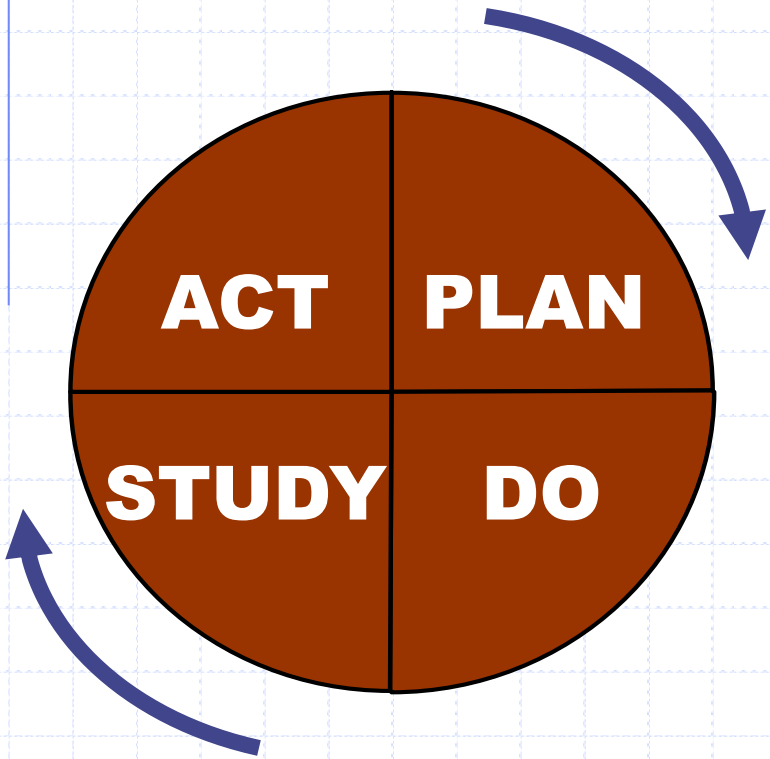
Change doesn't just happen, change is *led*

Teamwork Competencies

- Trust
- Conflict management
- Commitment to one's own job and the larger mission
- Recognize everyone is a leader in their own area
- Follow through

Workflow Process Change

Plan-Do-Study-Act



PLAN

- Identify change needed & Set goals

DO

- Implement

STUDY

- Analyze what happened

ACT

- Make sure improvement is permanent

PCMH 1: Enhance Access and Continuity

1A: Access During Office Hours ***Must Pass***	The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for: 1. Providing same-day appointments ***(critical factor)*** 2. Providing timely clinical advice by telephone during office hours 3. Providing timely clinical advice by secure electronic messages during office hours 4. Documenting clinical advice in the patient medical record.
1B: After-Hours Access	The practice has a written process and defined standards and demonstrates that it monitors performance against the standards for: 1. Providing access to routine and urgent-care appointments outside regular business hours 2. Providing continuity of medical record information for care and advice when office is not open 3. Providing timely clinical advice by telephone when the office is not open ***(critical factor)*** 4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open

PCMH 1: Enhance Access and Continuity

1C: Electronic Access

The practice provides the following information and services to the patient and families through a secure electronic system.

1. More than 50% of patients who request an electronic copy of their health information (e.g. problem lists, diagnoses, diagnostic test results, medication lists and allergies) receive it within 3 business days
2. At least 10% of patients have electronic access to their current health information within 4 business days of when the information is available to the practice
3. Clinical summaries are provided to patients for more than 50% of office visits within 3 business days
4. Two-way communication between patients/families and the practice
5. Request for appointments or prescription refills
6. Request for referrals or test results

PCMH 1: Enhance Access and Continuity

1D: Continuity

The practice provides continuity of care for patients/families by:

1. Expecting patients/families to select a personal clinician
2. Documenting the patient's/family's choice of clinician
3. Monitoring the percentage of patient visits with selected clinician or team

1E: Medical Home Responsibilities

The practice has a process and materials that it provides to patients/families on the role of the medical home, which include the following:

1. The practice is responsible for coordinating patient care across multiple settings
2. Instructions on obtaining care and clinical advice during office hours and when the office is closed.
3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside of the practice
4. The care team provides the patient/family with access to evidence-based care and self-management support

PCMH 1: Enhance Access and Continuity

1F: Culturally and Linguistically Appropriate Services (CLAS)	The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families 1. Assesses the racial and ethnic diversity of its population 2. Assesses the language needs of its population 3. Provides interpretation or bilingual services to meet the language needs of its population 4. Provides printed materials in the languages of its population

PCMH 1: Enhance Access and Continuity

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1G: The Practice Team	The Practice provides a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. holding regular team meetings and communication processes (critical factor) 3. Using standing orders for services 4. Training and assigning care teams to coordinate care for individual patients 5. Training and assigning care teams to support patients

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