Loudoun Medical Group

National Committee for Quality Assurance (NCQA) and the Patient-Centered Medical Home (PCMH)

Objectives:

- Describe the Patient-Centered Medical Home (PCMH) model of care
- Examine the essential characteristics of a Recognized PCMH
- Identify the measurements and documentation criteria for each NCQA requirement
- Understand the collaboration between Family Medicine's role in the development and adoption of the Patient-Centered Medical Home.

Health Care Reform

Priorities for US health care reform…

Quality-WHO (World Health Organization) identifies the US health care system as the "most individually responsive"

- WHO ranks US health care 37th overall (among 191 countries)

Efficiency

- People with acute and chronic medical conditions receive only about two-thirds of the health care that they need.
- Between 20% and 30% of tests and procedures provided to patients are **neither needed nor beneficial**.

*Leatherman and McCarthy, *Quality of Health Care in the United States: A Chartbook,* 2002. The Commonwealth Fund
*Schuster, McGlynn, and Brook.

Health Care Reform

Priorities for US health care reform…

Cost

- The U.S. spends more on health care per capita than any other nation.
- The U.S. spends more on health care as a proportion of GDP (Gross Domestic Product) than any other nation.

Patient-friendly

- Public confidence in hospitals and personal doctors remains relatively high.
- While individuals report generally positive experience with medical care, public confidence and trust in the system at large is eroding.

*Leatherman and McCarthy, *Quality of Health Care in the United States: A Chartbook,* 2002. The Commonwealth

Health Care Reform

Priorities for US health care reform…

Access

- Lack of insurance is a major reason for not obtaining access to needed care.
- The 40 million Americans without insurance coverage are less likely to obtain needed medical care and preventive tests
- Even with insurance, barriers to care still exist:
  - Lack of an established relationship with a doctor
  - Language and Cultural barriers
  - Social Determinants of Health
  - Transportation issues
  - Geography
  - High out-of-pockets costs even for those with insurance ie: high deductibles, underinsured, etc.

Health Care Reform

Priorities for US health care reform…

Automation

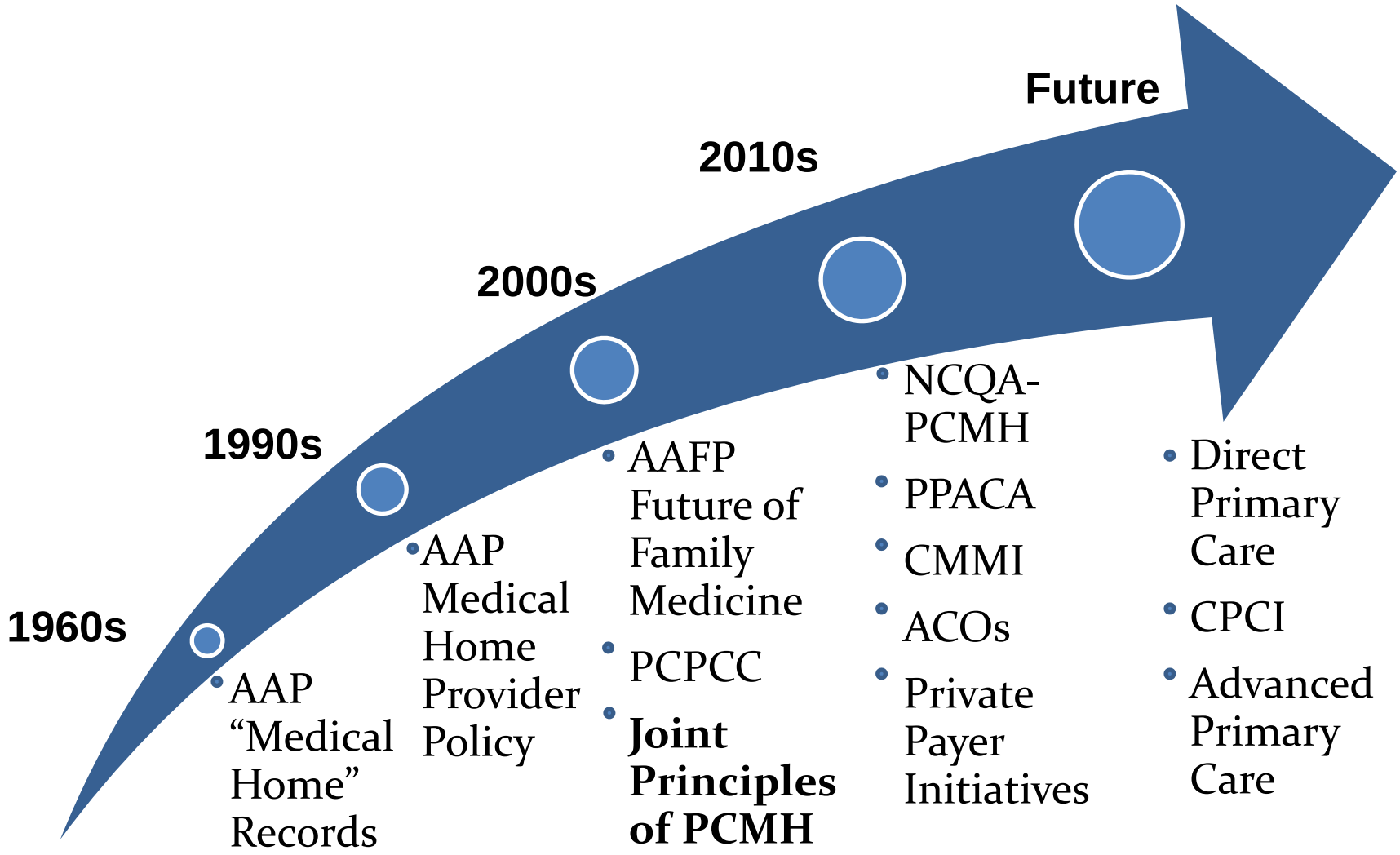
- Infrastructure for health care delivery has not kept pace with the electronic innovations of other industries.
- Many institutions still rely on systems that are not automated and allow opportunities for human error, even though technology exists to minimize errors and improve efficiency.

An effective and efficient health care system is a primary care-based health care system

- Provides access to basic health care services
- Manages health disparities
- Coordinates care
- Controls cost
- Offers sustainability

- www.aafp.org/valueoffamilymedicine

Brief History Of The PCMH



Innovative Solution: History of the PCMH Concept

- Introduced by American Academy of Pediatrics (AAP) in 1967
- Initially referred to a central location for medical records
- The medical home concept was expanded in 2002 to include:
  - Accessible
  - Continuous
  - Comprehensive
  - Family-centered
  - Coordinated
  - Compassionate
  - Culturally sensitive care
- In 2007, the AAP, the American Academy of Family Physicians (AAFP), the American Osteopathic Association (AOA), and the American College of Physicians (ACP) adopted a set of joint principles to describe a new level of primary care.

"Joint Principles" of the Patient-Centered Medical Home

- A personal physician who coordinates all care for patients and leads the team.
- Physician-directed medical practice – a coordinated team of professionals who work together to care for patients.
- Whole person orientation – this approach is key to providing comprehensive care.
- Coordinated care that incorporates all components of the complex health care system.
- Quality and safety – medical practices voluntarily engage in quality improvement activities to ensure patient safety is always being met.
- Enhanced access to care – such as through open-access scheduling and communication mechanisms.
- Payment – a system of reimbursement reflective of the true value of coordinated care and innovation.

Family Medicine is leading the way to make health care more patient-centered.

Will family medicine teachers prepare their students and residents to help practices transform and meet the infrastructure principles? I believe that we will, not simply because doing so will likely increase our financial situation but because building PCMH's that meet the care and infrastructure principles will improve the care we provide to meet our patients' and our communities' needs.

We will build our PCMH practices, because it is the right thing to do and it reflects our core values.

John C. Rogers, MD, MPH, MEd
Past-President,
Society of Teachers of Family Medicine
Fam Med 2008;40(1):11-2.)

PCMH 2011 Overview (6 standards/27 elements)

1. Enhance Access and Continuity
   - A. Access During Office Hours
   - B. Access After Hours
   - C. Electronic Access
   - D. Continuity (with provider)
   - E. Medical Home Responsibilities
   - F. Culturally/Linguistically Appropriate Services
   - G. Practice Organization
2. Identify/Manage Patient Populations
   - A. Patient Information
   - B. Clinical Data
   - C. Comprehensive Health Assessment
   - D. Use Data for Population Management
3. Plan/Manage Care
   - A. Implement Evidence-Based Guidelines
   - B. Identify High-Risk Patients
   - C. Manage Care
   - D. Manage Medications
   - E. Electronic Prescribing
4. Provide Self-Care and Community Resources
   - A. Self-Care Process
   - B. Referrals to Community Resources
5. Track/Coordinate Care
   - A. Test Tracking and Follow-Up
   - B. Referral Tracking and Follow-Up
   - C. Coordinate with Facilities/Care Transitions
6. Measure and Improve Performance
   - A. Measures of Performance
   - B. Patient/Family Feedback
   - C. Implements Continuous Quality Improvement
   - D. Demonstrates Continuous Quality Improvement
   - E. Report Performance
   - F. Report Data Externally

Optional Patient Experiences Survey

Scoring

Total 100 Points

Requires achieving all 6 must pass elements with a ≥50% score

Level	Points	Required Must Pass
1	≥ 35	6 Must Pass
2	≥ 60	6 Must Pass
3	≥ 85	6 Must Pass

Must Pass Elements

Rationale for Must Pass Elements

- Identifies critical concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes “Recognition”

Must Pass Elements

- 1A: Access During Office Hours
- 2D: Use Data for Population Management
- 3C: Manage Care
- 4A: Self-Care Process
- 5B: Referral Tracking and Follow-Up
- 6C: Implement Continuous Quality Improvement

PCMH 1: Enhance Access and Continuity

Standard

- Access
  - During/after office hours
  - Appointments and advice
- Electronic access
- Continuity of care with clinician/care team
- Information to patients about medical home
- Culturally and linguistically appropriate services (CLAS)
- Specific staff roles, responsibilities, training

Meaningful Use Criteria

Patients provided electronic:

- Copy of health information
- Clinical summary of visit
- Access to health information

PCMH 2: Identify and Manage Populations

Standard

- Collects demographic and clinical data
- Searchable data: diagnoses, advance directives, immunizations, screenings, BMI, medications
- Assess/document risks
- Create lists; use for point of care reminders

Meaningful Use Criteria

- Language, gender, race, ethnicity, DOB
- Problem list
- Medication list
- Medication allergy list
- Vital signs
- Growth chart (peds.)
- Smoking status
- Lists of patients with specific conditions for QI, decrease disparities
- Follow-up reminders for care

PCMH 3: Plan and Manage Care

Standard

- Identify patients with specific conditions including high-risk or complex, behavioral health
- Care management
  - Pre-visit planning
  - Progress toward goals
  - Barriers to treatment goals
- Reconcile medications
- E-prescribing

Meaningful Use Criteria

- Clinical decision support
- Medication reconciliation with transitions of care
- E-prescribing
- Drug-drug, drug-allergy checks
- Transmit prescriptions using EHR
- Drug-formulary checks

PCMH 4: Provide Self-Care Support and Community Resources

Standard

- Assess self-management abilities
- Document self-care plan; provide tools and resources
- Counsel on healthy behaviors
- Assess/provide/arrange for mental health/substance abuse treatment
- Provide community resources

Meaningful Use Criteria

Patient-specific education materials

PCMH 5: Track and Coordinate Care

Standard

- Track lab/imaging results; notify patients
- Integrate results into medical record
- Track referrals
- Coordinate with facilities
  - Hospitalized patients and ER
  - Establish information exchange with facilities
  - Follow up with discharged patients

Meaningful Use Criteria

- Incorporate lab/test results
- Exchange patient information with other providers (meds/ allergies, tests)
- Provide summary care record for transitions and referrals

PCMH 6: Measure and Improve Performance

Standard

- Measure performance (preventive/chronic/acute care clinical measures)
- Track utilization measures
- Patient experience survey - identifies vulnerable populations
- Continuous quality Improvement
- Report performance
  - Clinical measures

Meaningful Use Criteria

Report:

- Ambulatory clinical quality measures to CMS/ state
- Immunization data to registries
- Syndromic surveillance data to public health agencies

Emphasize Patient-Centered Care

Increasing patient-centeredness

PCMH 1: Enhance Access and Continuity

- Provide continuity of care with the same provider
- Provide information to the patient about medical home
- Provide access to care during and after office hours
- Provide patient materials and services meeting the language needs of patients

PCMH 4: Provide Self-Care and Community Support

- Provide resources to support patient/family self-management

PCMH 6: Measure and Improve Performance

- Involve patients/families in quality improvement
- Obtain performance data for key vulnerable populations

Focus on Behavioral Health

Incorporating attention to behaviors affecting health, mental health and substance abuse

- PCMH 1: Enhance Access and Continuity
  - Comprehensive assessment includes depression screening, behaviors affecting health and patient and family mental health and substance abuse
- PCMH 3: Plan and Manage Care
  - One of three clinically important conditions identified by the practice must be a condition related to unhealthy behaviors (e.g. obesity) or a mental health or substance abuse condition
  - Practice must plan and manage care for the selected condition
- PCMH 4: Provide Self-Care and Community Resources
  - Self-care support includes educational and community resources and adopting healthy behaviors
- PCMH 5: Track and Coordinate Care
  - Tracks referrals and coordinates care with mental health and substance abuse services
- PCMH 6: Measure and Improve Performance
  - Preventive measures include depression screening

Focus on Pediatrics

- Goal for PCMH 2011 to enhance applicability to pediatric practices
- AAP participated on the PCMH Advisory Committee
- Throughout the Standards
  - "Families" has been incorporated where appropriate
  - "NA for pediatric practices" has been used where appropriate
  - Pediatric examples and explanations have been added
  - References to Bright Futures have been included
- PCMH 1: Enhance Access and Continuity
  - Explanation addresses unique pediatric issues, such as teen privacy and guardianship
- PCMH 2: Identify and Manage Patient Populations
  - Includes pediatric clinical data and age appropriate screenings
- PCMH 3: Plan and Manage Care
  - Explanation specifies relevant pediatric clinical conditions, including well-child care and children/youth with special health care needs
- PCMH 4: Provide Self-Care and Community Support
  - Population specific referrals include parenting and respite care

Focus on Patient Experience

Increasing the emphasis on patient feedback

PCMH 6: Measure and Improve Performance

- Expanded the survey categories (access, communication, coordination, self-management support, whole person orientation, comprehensiveness, shared decision-making) and the requirements for the practice.
- Use of patient survey results for quality improvement
- Involve patients/families in quality improvement
- Optional Recognition for reporting results using a standardized Patient Experiences survey & methodology

Patients today are savvy consumers of health care and have higher expectations.

- Communication
- Access
- Convenience
- Coordination
- Responsiveness

  - Source: Medfusion, an AAFP affinity partner, 2008

Patient Expectations

- 75% want the ability to interact with their physician online (appointments, prescriptions, test results).
- 77% want to ask questions without a visit.
- 75% want email access as part of their overall care.
- 62% of patients say access to these services would influence their choice of physicians.

  – Source: Medfusion, an AAFP affinity partner, 2008

R4

The Patient Centered Medical Home

The Family Medicine Model

Patient-centered | Physician-directed

Slide 27

R4 The picture of the revised house could go here.
Rover, 9/18/2012

Culture of Improvement

- Establish baseline performance measures
- Collect and analyze data
- Discuss best practices and improvement
- Conduct regular clinical team meetings

Risk-stratified Care Management

- Understand ways to identify patient's risk status
- Plan out care for chronic conditions and preventive care
- Identify "high-risk" patients
- Use tools to track populations by risk category

Medical Neighborhood

- Manage care transitions and build linkage to community resources
- Coordinate care with specialists and outside facilities
- Evaluate care transition process

Quality Care

Family Medicine

Convenient Access

- Same-day appointments and extended hours
- E-mail communication with patients (E-visits)
- Web portals for Rx refill and appointments
- Translation and Culturally appropriate services

Shared Decision Making

- Understanding the patient's social barriers, goals and priorities
- Create care plans in collaboration with patient/caregiver
- Monitor progress between visits

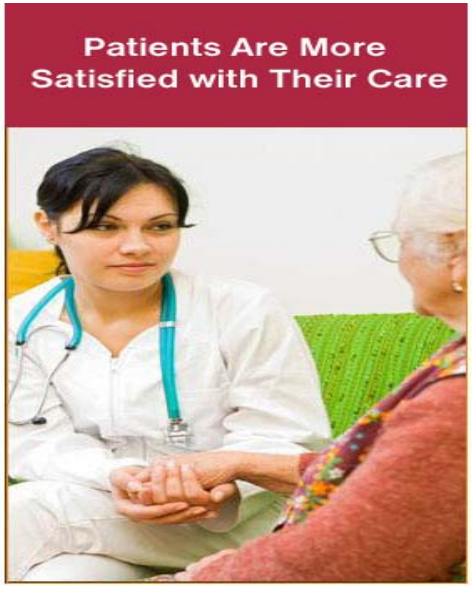
Patient Experience

- Conduct patient satisfaction surveys on a regular basis
- Establish patient advisory panel and QI activities
- Conduct patient focus groups

Quality Care

Patient-centered Care

Family Medicine



Financial Management

- All staff are aware of the most efficient ways to deliver care
- National policies support the investment of resources into primary care practices that are effective and efficient

Culture of Change

- Establish a PCMH leadership team
- Engage all members of the practice in a shared vision
- Provide staff education and training to support patient-centered care

Practice Environment

- Staffing model supports team-base care
- Define roles for team members
- Include health coach and care coordination functions

Practice Organization

Quality Care

Patient-centered Care

Family Medicine

Technology	Digitally Connected	Evidence-Based Medicine	EHR Reporting Tools
• Patient reminders • Patient notification for new information • Reminders for recommended care or health maintenance • Makes patient registries possible	• Enhances care coordination by improving information flow with other physicians, practices, and providers • Improves patient - physician communication	• Point-of-care learning , alerts and reminders • Clinical decision support (e.g., Epocrates)	• Can quickly pull clinical data for quality analysis • Can enhance business processes • Population health management through patient registries

Practice Organization

Health Information Technology

Quality Care

Patient – centered Care

Family Medicine

Information Managed Effectively

Great Outcomes

- Good for patients
  - Patients enjoy better health.
  - Patients share in health care decisions.
- Good for physicians
  - Physicians focus on delivering excellent medical care.
- Good for practices
  - Team works effectively together.
  - Resources support the delivery of excellent patient care.
- Good for payors and employers
  - Ensures quality and efficiency.
  - Avoids unnecessary costs.

PCMH Model and Health Care Reform

- Attempts to fix part of the problem without addressing it comprehensively will **not** lead to viable solutions.
- Advocacy by all stakeholders is necessary.
  - Community projects through local hospitals and resource networks
  - State projects for regional payors and state Medicaid programs
  - National support for changing how care is delivered and for ensuring a prepared workforce to deliver care

Institute for Health Improvement

Triple Aim

The Institute for Healthcare Improvement (IHI) believes that focusing on three critical objectives simultaneously can potentially lead us to better models for providing healthcare.

1. Improve the health of the defined population
2. Enhance the patient care experience (including quality, access and reliability)
3. Reduce, or at least control, the per capita cost of care