Are We HOME Yet?

Patient Centered Medical Home

Presented to UNMMG PAC

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Objectives

- Provide background on PCMH
- Clarify and define PCMH
- Update where UNMH is in process
- Answer questions

PCMH Background

- 1967 – American Academy of Pediatrics developed the concept
- 2004 – Future of Family Medicine expanded the concept
- 2006 – ACP introduces “advanced medical home”
- 2007 – Joint Principles by AAFP, ACP, AAP & AOA
- 2008 – AMA adopts the joint principles

Why PCMH? Why Now?

- Decline in Primary Care Physicians
- Dramatic increase in Chronic Care Patients
- Demonstrated effectiveness of Team-Based-Care
- However, little scientific evidence of effectiveness of PCMH!

The 7 Joint Principles

- Ongoing relationship with personal physician (provider)
- Physician directed medical practice
- Whole-person orientation
- Coordinated care across health system
- Quality and safety
- Enhanced access to care
- Payment recognizes the value added

Attributes of PCMH

- Comprehensive – planned visits, registries
- Physician directed – team approach
- Quality & Safety – QI, patient participation
- HIT – patient registries, “robust use of technology”
- Service-oriented culture – patient centered
- Continuous healing relations
- Support & coordination by care team

NCQA Measures

1. Access & Communication
2. Patient Tracking & Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting & Improvement
9. Advanced Electronic Communication

So, What Is A PCMH?

"It's a model of care where individuals use physician practices as the basis for **accessible, continuous, comprehensive and integrated care**."

http://www.familydocs.org/practice-resources/pcmh.php

Today's Care

- My patients are those who make it to see me
- Patients' complaint determines care
- Today's problem dealt with in time available
- Care varies by time available, memory and skill of doctor
- Patients responsible for coordinating their own care.
- I know I deliver high quality care because I'm well trained
- Acute care is delivered in the next available appointment, walk-ins, or by over-booking
- It's up to the patient to tell us what happened to them
- Clinic operations center on meeting the doctor's needs

Medical Home Care

- Our patients are those who are registered in our medical home
- We systematically assess all our patients' health needs to plan care
- Care is determined by a proactive plan to meet patient needs without visits
- Care is standardized according to evidence-based guidelines
- A prepared team of professionals coordinates all patient care
- We measure our quality and make rapid changes to improve it
- Acute care is delivered by open access and non-visit contacts
- We track tests & consultations, and follow-up after ED & hospital
- A multidisciplinary team works at the top of our licenses to serve patients

Chronic Care Model

National Committee for Quality Assurance (NCQA) and the PCMH

- 3-tiered recognition process
  - Based on how the practice is functioning as medical home
- Recognition is offered at three levels:
  - Level 1 – basic
  - Level 2 – intermediate
  - Level 3 – advanced

Overview of NCQA PPC-PCMH Recognition Program

- 9 standards, 7 of which contain “must-pass” elements
- 30 elements, 10 of which are “must-pass”
- Each element contains a series of factors upon which your final score will be based

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	**4**
B. Uses data to show it meets its standards for patient access and communication**	**5**
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	**4**
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	**3**
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

****Must Pass Elements**

NCQA Measuring quality. Improving health care.

Payment Models for PCMH

- Currently - no uniform payment model
- Anticipate 3 parts:
  - Fee For Service
  - Per Member Per Month
  - Performance

Where Is UNMH?

- Application in process
  - Global Application has been processed
- Anticipate Level 1 by end of year
- “Best design” for UNMH in pilot phase

PCMH – A Journey