The Patient Centered Medical Home (PCMH)

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Council of Community Clinics
May 23, 2012
Via Webinar August 2, 2012

One Definition

California Primary Care Association:

A Patient-Centered Health Home is an approach that uses a "whole person" orientation to provide comprehensive health care by facilitating an active partnership between patients, their family, and their primary care provider team to provide high quality, timely care in a coordinated and consistent way.

Other Ways to Define PCMH

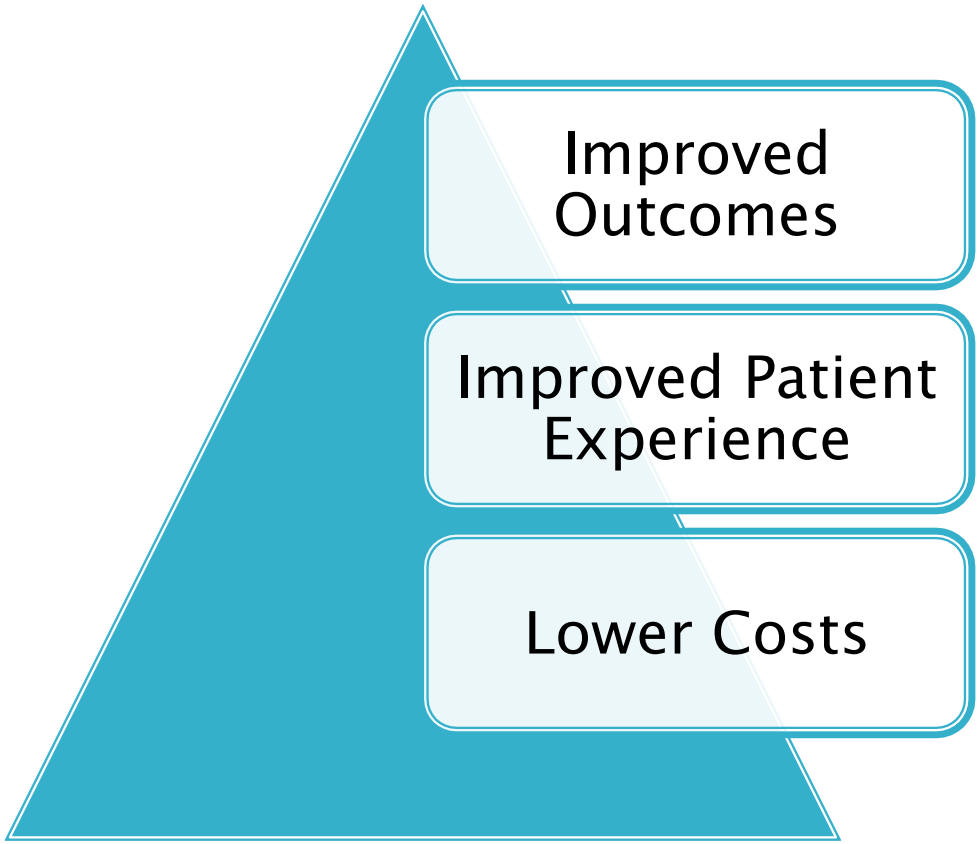
Recognition Agencies

- NCQA
- The Joint Commission
- AAAHC

Funders

- CMS
- Medicaid Programs
- Health Plans
- County LIHP

Institute for Healthcare Improvement's Triple Aim



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PCMH Common Elements

Use Care Teams	Empanelment – Identify and manage patient populations	Enhance Access and Communication
Coordinate Care	Educate Patients and Family Members	Improve Quality/ Track Outcomes

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Care Teams

- Paradigm shift:
  Practicing alone → practicing on a team
- Team may include: physician, nurse, care manager, MA, behavioral health specialist, health coach, front desk staff
- Daily huddles
- Staff members functioning at their highest level according to skill and competencies
- Major reorganization of staff roles and responsibilities
  - Medical Assistant role is enhanced
  - New positions added
  - Re-evaluate workflow in the patient visit cycle

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Empanelment

- **Shift from acute responsive care to proactive and planned care**
- Patients assigned to a care team
- System for evaluating and evenly distributing the workload
- Provides for continuity of care
- Care team responsible for all patients whether or not they have come into the clinic
- Care Team better understands the needs of their patients
- Trusting relationship established with provider and care team.
- Use of data for management of assigned population

Access

- Increased access during office hours
- Electronic access
- After hours access
- Continuity of care
- Culturally and linguistically appropriate services
- The Practice Team

Care Management

- Planned visits and telephone follow-up
  - Patient self assessment
  - Medication reconciliation
  - Order lab tests/results
  - Update or review self management goals
- Care Coordination
  - Test tracking
  - Referral tracking
  - Transition of care
- Chronic illness and self management support

QI/Track Outcomes

- Measure performance
- Measure patient/family experience
- Implement and demonstrate continuous quality improvement
- Report performance
- Need certified EHR in order seek recognition beyond Level 1 (NCQA has 3 levels)

Activate Patients and Educate/Engage Family members

- Educate patients about this new model of care and introduce patient to care team
- Engage patient and families in care
- Identify what patient would like to accomplish with the visit
- Involve patient/family members in the treatment decision making process
- Assess patient's readiness to learn
- Identify what patients is willing to work on

Pathways to PCMH

- Monthly Peer Group Meeting
- CCC in conjunction with Qualis has provided training on several PCMH elements; Additional training required
- Set up on-line forum for posting/sharing of documents and best practices among our health centers
- Modified patient satisfaction survey to meet PCMH
- 91% of LIHP clinics have completed the PCMH self assessment
- Clinics are still preparing. No submissions for recognition yet.
- Several clinics preparing to submit by end of calendar year

The Central San Diego Health Home Collaborative Partners

CSDHHC

Selected Objectives

1. Designate a care coordinator and develop P&P to implement a care team model for adult/family med.
2. Empanel and manage patients for adult/family medicine.
3. Implement strategies to reduce the number of unnecessary emergency room visits and hospital readmissions within 30 days.
4. Strengthen transitions of care between partners through increased relationship building and coordinated communication.

1. Clinics have identified a coordinator who has in turn developed Care Teams and the policies and procedures
2. All clinics have empanelled their project target populations, and are refining their provider panels
3. CHG and hospital partners have signed BAAs with clinics to identify the highest utilizers of care. Coordinating data review meetings to identify clinic-specific strategies to reduce unnecessary ER visits and readmissions.
4. Scripps Mercy Hospital will be hosting a first ever Central Region Care Transitions Partners Meet and Greet in June 2012. A similar event will be coordinated with UCSD's Emergency Room and Clinical Practice Access Teams.

HOW WE MEASURE SUCCESS

Preventive Care Measures

Example: Adult BMI Assessment – % of patients 18+ years of age who had an outpatient visit and who had their BMI documented in the measurement year or the year prior.

Chronic Disease Measures

Example: Controlling High Blood Pressure – The percentage of patients ages 18+ years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement period.

PCMH Patient and Staff Satisfaction

- Patient focus groups
- Patient satisfaction survey
- Staff interviews and written surveys
- Staff huddle observations

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Lack of Payment for PCMH

- Case management
- Care coordination
- Panel management
- Population health
- Encounters with health educators, care coordinators, or health navigators
- Telephone and online communication
- Generating and reviewing reports

Additional funding is needed to…

Care Teams

- Provide training to enhance care team functions and address challenges
- Develop the workforce, such as increasing MA scope or adding mental health to team
- Support HR in revising job descriptions
- Increase involvement of physicians in hiring and evaluating new team members

Empanelment

- Hire panel manager
- Train call center or reception staff on scripting to direct patients to PCP
- Develop process to reach out to panel for preventive care, needed medication refills, and follow-up visits

Quality

- Put enhanced infrastructure into place to run regular reports
- Develop data collection and reporting process, as well as regular reporting templates
- Develop system to extract data to support grant applications

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Additional funding is needed to…

Access

- Customize scheduling templates to assure same day access for urgent visits and other visits needed within 1-2 days.
- Put system into place for patient communication, i.e. phone, email, text
- Create a patient web portal to access health information, history and test results

Coordination

- Hire care coordinator(s) to track and follow up on specialty referrals
- Train care coordinators on how to follow up on care transitions such as hospital or emergency department care follow-up
- Contact patients discharged from hospital to assure necessary follow-up

Patient Ed

- Develop materials to educate patients about their care team and contacts between visits; create and distribute team identification cards.
- Train health educators on motivational interviewing; activate patient to take a role!

Lessons Learned

- Much time, resources, funding, and expertise is needed for CCHCs to transform into PCMHs.
- Individualized clinic TA is needed in addition to multi-clinic group trainings.
- Pulling providers and staff away from clinic for training is expensive and unreimbursed.
- Clinics need to be strong in quality data collection and reporting in order to be successful.
- Physician buy-in is critical for success.
- Many PCMH functions are unreimbursed and cannot be sustained without some form of funding.