Patient Centered Medical Home

The next generation in patient care

Provider Training
Module I
OBJECTIVE

To explain...

What Patient Centered Medical Home is
How it works
Why it’s important
Where to begin
Overview

AmeriHealth Caritas Family of Companies (ACFC) has built a culture of deep commitment to improving the health outcomes of our members. The Patient Centered Medical Home aligns with our mission and focuses on the needs of the population to:

✓ Enhance access
✓ Improve clinical outcomes
✓ Promote accountable care
✓ Reduce care cost
✓ Reduce avoidable ER visits, admissions and re-admissions
What is Patient Centered Medical Home
Patient Centered Medical Home (PCMH) is best described as a care delivery model or philosophy of primary care that is patient-centered, comprehensive, team-based and coordinated, with a strong focus on patient safety, quality and accessibility.

*It’s a model for achieving primary care excellence to ensure a patient receives the necessary care that meets his/her needs through a whole person approach and in a manner he/she can understand.*
The objective of the PCMH is to offer a centralized setting that facilitates the partnerships between the patient, physicians and when appropriate, the patient’s family or care-giver.

The PCMH model is designed to:

✓ *Improve access to high-quality care*
✓ *Enhance patient-provider relationships*
✓ *Reduce unnecessary utilization and related cost*
The American Academy of Pediatrics introduced the medical home concept in 1967, originally designed to centralize the archives for children’s medical records, in 2002 the concept was expanded.

The concept of the PCMH is intertwined into the Patient Protection and Affordable Care Act
There are 7 joint principles established by the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and American Osteopathic Association (AOA) to describe the characteristics of PCMH.
Joint Principles

- **Coordinated/Integrated Care:** care is coordinated and integrated across all elements of the complex health care system. Care is managed by registries, information, exchange and other means, assuring suitable care in a culturally and linguistically appropriate manner and a process for follow up care is established.

- **Enhanced Access:** improve access to healthcare by increasing same day/sick appointments, open scheduling and expanded hours.

- **Personal Physician:** emphasis on a strong patient-physician relationship, to provide continuous comprehensive care

- **Physician Directed Practice Team:** physician leads staff in creating more collaborative and efficient office practices

- **Payment System:** innovative and appropriate payment options

- **Safety and Quality:** emphasis on evidenced based medical practice, improved chronic disease management, and better communication through technology applications

- **Whole Person Orientation:** serve as the patient's main advocate for the patient’s ongoing needs, referring to specialists as appropriate
Examples of PCMH

- **Care Coordination**
  - Track patient care across multiple settings (hospital & ER follow-up)
  - Coordinate with specialists
  - Track and follow-up on labs and imaging tests
  - Pro-active care reminders

- **Care Management and Planning**
  - Use registries to organize care
  - Implement evidence-based guidelines
  - Utilize daily huddles to plan visits
  - Develop standing orders to maximize team-based approach to patient care

- **Self-Management Support**
  - Educate patients on their condition
  - Involve patients in setting care plans
  - Engage patients in their own care
  - Provide tools to patients for self-management and condition tracking

- **Continuous Quality Improvement**
  - Set improvement goals and use data to monitor and track performance
  - Utilize national guidelines for benchmarking
  - Optimize EMR function with structured, searchable data

- **Enhanced Access**
  - Offer same-day appointments for patients who need to be seen
  - Provide clinical advice and care options for patients when they get sick after hours

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**Improved Patient Outcomes for**
- Diabetes,
- Hypertension,
- Congestive Heart Failure and Asthma

**Improved Screening Rates for Preventable Conditions**
Transitioning to the PCMH Model of Care

To become a nationally recognized PCMH, practices may achieve NCQA Patient Centered Medical Home recognition by meeting standards to:

- Improve patient access and communication
- Provide self-management support
- Track and coordinate care.
- Provide comprehensive care

Other recommended accrediting bodies that offer recognition include:

Accreditation Association for Ambulatory Health Care
The Joint Commission
URAC
Transforming your practice

Becoming an effective PCMH requires transformation of the way primary care services are delivered. Practices must demonstrate that they meet specific standards for NCQA recognition. NCQA published updated standards in 2014. Although many of the measures remain the same, the 2014 standards include some modifications to the existing measures, as well as some additional measures that will be explained further in this presentation.

Note:

Practices that have already purchased an application through the NCQA website have until March 31st of 2015 to be recognized under the 2011 standards.

The PCMH program aligns closely with the federal program that rewards clinicians for using health information technology to improve quality (CMS’s Meaningful Use Requirements).

This presentation is informational only, please visit www.ncqa.org/pcmh for additional guidelines and information.
Overview of NCQA Required Elements: 2011 vs 2014

Transforming your practice begins with meeting specific standards/elements. Each standard/element has assigned points. For more information please visit www.ncqa.org/pcmh

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Providers must meet specific criteria in each of the categories (The bolded items represent the MUST pass elements for 2011):

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*

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 & 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

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Providers must meet specific criteria in each of the categories. There are 6 Standards/27 elements/100 points

1) **Patient-Centered Access (10)**
   - A. Patient–Centered appointment access *
   - B. 24/7 Access to clinical advice
   - C. Electronic Access

2) **Team Based Care (12)**
   - A. Continuity
   - B. Medical Home Responsibilities
   - C. Culturally and Linguistic Appropriate Services
   - D. Practice Team*

3) **Population Health Management (20)**
   - A. Patient Information
   - B. Clinical Data
   - C. Comprehensive Health Assessment
   - D. Use of Data for Population Management*
   - E. Implement Evidence –Based Decision Support
   - **Must Pass***

4) **Care Management & Support (20)**
   - A. Identify Patients for Care Management
   - B. Care Planning and Self care Support *
   - C. Medication Management
   - D. Use Electronic Prescribing
   - E. Support Self care & Shared Decision Making

5) **Care Coordination & Transition (18)**
   - A. Test Tracking and Follow Up
   - B. Referral Tracking and Follow Up*
   - C. Coordinate Care Transitions

6) **Performance Measurement and Quality Improvement (20)**
   - A. Measure Clinical Quality Performance
   - B. Measure Resources Use and Care Coordination
   - C. Measure Patient Family Experience
   - D. Implement Continuous Quality Improvement*
   - E. Demonstrate Continuous Quality improvement
   - F. Report Performance
   - G. Use Certified HER Technology

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Access During Office Hours

Practices may receive credit for this factor as long as they can demonstrate to NCQA they reserve an adequate number of same-day appointments to accommodate their patients who need same-day care. Same-day appointments must be reserved within the schedule and held open for same-day use – adding ad hoc or unscheduled sick-care appointments to an already overbooked schedule (sometimes called “work-in” appointments) does not meet NCQA requirements.

Some PCMH practices reserve same-day appointments for sick care only, and others include same-day access for routine/chronic care as well. The practice written scheduling policy must outline criteria for the types of visits that warrant same-day access (triage requirements) and a policy for scheduling routine care.

Documentation:
Show office policies: Submit copies of office policies and indicate the date they were implemented (must be in effect at least 90 days prior to submitting application, but not older than one year – make sure all policies are dated).

Please refer to www.ncqa.org/pcmh for more information.
NCQA 2011 Example Use of Data (2D)

Use Data for Population Management

Practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients and clinicians of services needed for the following (at least 2 to obtain the minimum 50% score needed for must-pass elements):

Factor 1: At least three different preventive care services
Examples: mammograms, colonoscopies, immunizations, well-child visits, fasting blood sugar, stress tests, etc.

Factor 2: At least three different chronic care services
Examples: diabetes care (A1C, micro-albumin, foot & eye exams, etc.), coronary artery disease care, lab values outside normal range, asthma care, ADHD, obesity, depression, etc.

Factor 3: Patients not recently seen by the practice
Examples: care management follow-up visits, overdue periodic physical exams, etc.

Factor 4: Patients on specific medications
Examples: harmful side effects, generic options, recall notice.

Documentation:
Demonstrate ability to generate lists of patients that need services and show examples of outreach to remind patients of needed services - sample letters, secure emails, phone scripts, etc.

Please refer to www.ncqa.org/pcmh for more information
Manage Care

- Provide the following for at least 75% of patients with “important conditions”:
  
  ✓ Factor 1: Pre-visit preparations
  ✓ Factor 2: Individual care plans
  ✓ Factor 3: Written care plans to patients
  ✓ Factor 4: Address barriers
  ✓ Factor 5: Provide clinical summary to patients
  ✓ Factor 6: Identify needs for additional care mgmt support
  ✓ Factor 6: Missed appointment follow-up

- The first conditions you may select from must be chronic/recurring conditions.
  
  - Select at least 1 from this category (most practices select 2).
  - Examples: DM, HTN, COPD, CHF, Asthma, Hyperlipidemia, HIV/AIDS, etc.

- Practice is required to select one condition that is related to unhealthy behavior, substance abuse or mental health.
  
  - Examples: Smoking*, Obesity, Depression, Substance Abuse, ADHD, etc.
  
  *Most practices find Smoking easier to document

**Documentation**

Provide a written plan of care to patients, provide patients with a written copy of their care plan that is tailored for the patient’s use at home.

Please refer to [www.ncqa.org/pcmh](http://www.ncqa.org/pcmh) for more information
Self Care Process

The practice conducts activities to support patients with the “important conditions” selected in 3A (and 3B if you selected high-risk)

Factor 1: Provide educational resources to at least 50% of patients
Factor 2: Use EHR to identify educational resources to at least 10% of patients
Factor 3: Develop individualized self-management plans for at least 50% of patients
Factor 4: Document self-management abilities of at least 50% of patients
Factor 5: Provide self-management tools to patients for at least 50% of patients
Factor 6: Provide healthy lifestyle counseling for at least 50% of patients

Documentation

Factors 1-3: Reports or logs demonstrating data collected in the tracking system used by the practice (an Excel report or a report from practice EHR system meets the requirement). The report must cover at least a one-week period of time. All PHI must be blocked!
Factors 4-5: Practice must be able to show a documented process, evidenced by at least 3 examples.

Please refer to www.ncqa.org/pcmh for more information
Implements Continuous Quality Improvement

Practice will access data and measure performance on at least 2 of the following factors:

Factor 1: At least three preventive care measures
For example: mammograms, colonoscopies, vaccines, bone density exams, smoking, depression screenings, alcohol use, etc.

Factor 2: At least three chronic or acute care clinical measures
For example: Hemoglobin A1C, LDL, blood pressure, diabetic foot and eye exams, etc.

Factor 3: At least two utilization measures affecting health care costs
For example: ER visits, hospital admissions, use of brand-name drugs when generics are available, etc.

Factor 4: Performance data stratified for vulnerable populations (to assess disparities in care)
For example: diabetic smokers, elderly, language barriers, low-income, disability, co-morbid conditions, frailty, etc.

**Documentation:**

Practice must be able to provide reports showing performance on the measures selected above.

Please refer to [www.ncqa.org/pcmh](http://www.ncqa.org/pcmh) for more information

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NCQA : 2011 MUST PASS ELEMENTS

2011 must pass -minimum of 29 points.

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

2011 must pass -minimum of 29 points.
NEW - 2014 Must Pass Elements

2014 must pass - minimum of **29.5 points**

- 1A: Patient Centered Appointment Access (4.5 pts)
- 2D: Practice Team (4 pts)
- 3D: Use of Data for Population Management (5 pts)
- 4B: Care Planning and Self care Support (6 pts)
- 5B: Referral Tracking and Follow Up (6 pts)
- 6D: Implement Continuous Quality Improvement (4 pts)
How can ACFC help?
ACFC’s role is to help provide and support practices by offering effective integrated programs and tools to help with transitioning your office:

- **Assist practices with NCQA Recognition and PCMH transformation:**
  - Introduction to NCQA Must-Pass Elements
  - Share best practices and documentation examples from other PCMH practices
  - Organize learning opportunities

- **Provide education on PCMH Program operations and requirements:**
  - PCMH quality measures
  - Automated tracking and reporting

- **Provide continued support to practices after NCQA recognition:**
  - Share examples of best practices
  - Organize learning opportunities
  - Provide feedback on provider performance
Data & Technology
We offer several tools to help practices becoming PCMH through our free online portal Navinet or Availity:

- Patient Registry
- Care Gaps Stratification
- Authorization, medical and pharmacy claims data
Transformation Support

- Transformation roadmap and tools
- Sample Transformation guide
- Sample Practice checklist
- Transformation staff support
- Facilitate practice to practice information sharing
Coordinated Care Management

- Care manager staff
- Care plan
- Regional support
- Integrated behavioral health management
- Community resources

Diabetes Self Care Goal Sheet

Choose one goal at a time.

What will I do? ________________________________

Where will I do it? ________________________________

How often will I do it? ________________________________

What might get in the way of my plan? ________________________________

What could I do to make sure my plan works? ________________________________
Ongoing Performance Management

- Performance reports
- Provider dashboard
**Patient Care Before & After**

**Typical care**
- “My patients are those who make appointments to see me.”
- Patients are responsible for coordinating their own care.
- “It’s up to the patient to tell us what happened to them.”
- Care is determined by today’s problem & time available.
- Care varies by provider.
- “I know I deliver high-quality care because I’m well trained.”
- Clinic operations focus on meeting doctors’ needs.

**PCMH care**
- “Our patients are those on our team’s panel, whether they make appointments or not.”
- A prepared team of professionals coordinates all patient care.
- “We track tests & consultations and follow up after ED & hospital visits.”
- Care is determined by a proactive plan to meet health needs, with or without visits.
- Care is standardized by evidence-based guidelines.
- “We measure our quality and make rapid changes to improve it.”
- An inter-disciplinary team focuses on meeting patients’ needs.
How to get started

1. Become familiar with PCMH standards and Accreditation requirements
2. Review must pass elements
3. Explore EMR capabilities, tracking mechanisms in place to “close loop”
4. Create a tracking log for after hours care
5. Identify resources for patient education
6. Ensure staff is collecting necessary data from patients and update active patient list

Are you ready?
Why be PCMH?

What are the benefits?
PCMH Practice Benefits

- Assist practices in preparing for value based reimbursement strategies (government and commercial payers)
- Effective use of EMR and available data/information
- Improved patient outcomes
- Improves practice performance for incentive programs for all payers
- Improved patient satisfaction and adherence to care plans
- In an era of transparency and consumer engagement, national recognition as a “best practice”
- Prepare practice for transparency and sharing of quality/outcomes data
- Overall more effective practice workflow and seamless continuous quality improvement
PCMH Patient Benefits

- Assist with identifying and removing barriers to accessing care in the correct setting
- Assist with navigating a complex health care delivery system
- Improved clinical outcomes
- Improved patient understanding of/and adherence to care plans
- Improved communication between care team and patient (and family) “whole person”
- Overall better experience of care and satisfaction with primary care physician and support team
Helpful PCMH Resources


http://www.safetynetmedicalhome.org/

http://medicalhomeinfo.org/

http://bizmedsolutions.com
(free logon to view available materials)

www.pcpcc.org

http://www.ncqa.org/Home/PatientCenteredMedicalHome.aspx

http://pcmh.ahrq.gov/

http://www.valuepartnerships.com/patient-centered-medical-home/

http://www.pcpci.org/resources/browse
QUESTIONS

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AmeriHealth
Caritas
Care is the heart of our work