

Patient Centered Medical Home

“An Overview of This New Care Model”

JACKSON PHYSICIANS ALLIANCE



PCMH- Patient Centered Medical Home

- The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care.
- The PCMH represents a comprehensive health care model that facilitates partnerships between individual patients, their provider teams, and the patient's family.
- PCMH is patient care delivery that is holistic and coordinated.



PCMH- Patient Centered Medical Home

Key Elements Include:

- Patient-centered care
- Team approach to care
- Use of advanced information systems
- Whole person orientation
- Care provided in a community context
- Redesigned primary care offices
- Personal medical home designation
- Elimination of access barriers
- Focus on quality and safety



Patient Centered Medical Home

- ❖ PCMH is not a new concept. It has been evolving since the late 1960s.
 - **1967** – American Academy of Pediatrics
 - **1990** – Included elements of the Chronic Care Model developed by Ed Wagner at the MacColl Institute for Healthcare Innovation in Washington State.
 - **2007** – Extended the model beyond care for chronic health problems and raise the standard of practice by adding measurement of quality indicators and enhanced technology for service and documentation.
 - **2008** – National Committee for Quality Assurance PCMH Recognition Program.



Development of PPC-PCMH

- American Academy of Pediatrics (AAP)
- American College of Physicians (ACP)
- American Academy of Family Physicians (AAFP)
- American Osteopathic Association (ACA)



Patient Centered Medical Home

- **2009 -2010**

BCBSM Designated PCMH Practices in the PGIP program - This designation occurs annually.

Two PCMH Assessments throughout the calendar year.

Priority Health accepts NCQA accreditation



The Chronic Care Model

The Chronic Care Model



Developed by The MacColl Institute
© ACP-ASIM Journals and Books



Proven Benefits Of A PCMH

- Increased patient and family/care-giver satisfaction
- More efficient use of limited resources
- Improved quality
- Reduced health disparities among patient treatment
- Improved professional satisfaction



Popular PCMH Approaches

- ❖ Presently, there are two popular approaches to obtaining PCMH designation:
 1. BCBSM's PGIP Program
 2. NCQA PPC-PCMH™ Accreditation
- ❖ Still no national “recipe” for PCMH. Rather a number of multi-year demonstration programs are underway throughout the country.



BCBSM Initiatives for PCMH

- Patient-provider partnership
- Extended access
- Patient tracking and registry
- Performance reporting and improvement
- Test results tracking and follow-up
- Individual care management
- E-prescribing



BCBSM Initiatives for PCMH

- Preventive Services
- Linkage to Community Services
- Self – Management Support
- Patient Web Portal
- Coordination of Care
- Specialist Referral Process

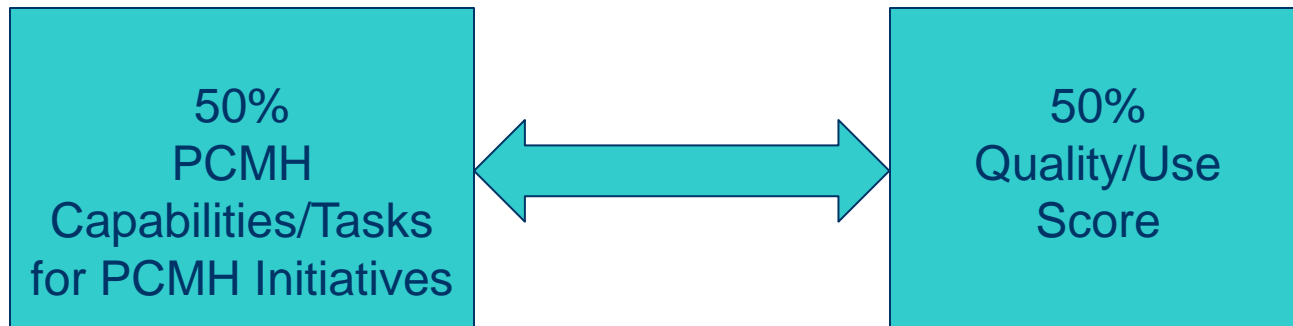


BCBSM Quality/Use Score

- Generic Use
- ED Visit Rate
- Low Tech and High Tech radiology use
- Evidence Based Care Report
- Preventive measures – Adult mammogram and pap; peds immunizations for 2 months & 13 months, and well visit 15 months & 36 months



BCBSM PCMH Designation



PCMH

NCQA PPC[®]-PCMH[™]

**National Committee for Quality Assurance
Physician Practice Connection –
Patient Centered Medical Home**



PPC – PCMH NCQA 2008 Standards

1. Access and Communication*
 2. Patient Tracking and Registry Functions*
 3. Care Management*
 4. Patient Self-Management and Support*
 5. Electronic Prescribing
 6. Test Tracking*
 7. Referral Tracking*
 8. Performance Reporting and Improvement*
 9. Advanced Electronic communication
- * - Notates Standard with “Must Meet” element(s)



PPC-PCMH NCQA Must Pass Elements

1. PPC 1A: written standards for patient access and patient communication
2. PPC 1B: Use of data to show meeting standards
3. PPC 2D: Use of paper or electronic-based charting tools to organize clinical information
4. PPC 2E: Use of data to identify important diagnoses and conditions in practice
5. PPC 3A: Adoption and implementation of evidence-based guidelines for these conditions
6. PPC 4B: Active support of patient self-management
7. PPC 6A: Test tracking and follow-up
8. PPC 7A: Tracking referrals with paper-based or electronic systems
9. PPC 8A: Measurement of clinical and/or service performance
10. PPC 8C: Performance reporting by physician or across the practice



PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass elements at 50% Performance Level
Level 3	75 – 100	10 of 10
Level 2	50 - 74	10 of 10
Level 1	25 – 49	5 of 10
Not Recognized	0 – 24	< 5

Levels: If there is a difference in Level achieved between the number of points and “Must Pass”, the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 “Must Pass” Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 – 24 points or less than 5 “Must Pass Elements are not Recognized.



Data Sources

- **Documented process** – written statements describing practice’s procedures, protocols, process, workflow forms
- **Reports** – aggregate data showing evidence of action
- **Records or files** – actual patient files or registry entries documenting action taken
- **Materials** – prepared materials for patients or clinicians, e.g. clinical guidelines, self management and educational resources



Time Periods for Documentation

- Materials, documented processes, records, files and examples should show implementation and use for **at least 3 months prior to submission**
- Reports and data (including Record Review Workbook) should show current performance **not older than 12 months**



Next Steps – Assessing what's required of the practice

1. Computer with:
 - ❖ Email
 - ❖ Internet access
 - ❖ Microsoft word
 - ❖ Microsoft excel
 - ❖ Adobe Acrobat Reader (available free online)
2. Desire to develop and cultivate your office team and develop a team approach
3. Commitment to develop/enhance policies and procedures
4. Commitment to develop/enhance job/position descriptions



Next Steps Continued

5. Invest in staff training and development
6. Make personal commitment to patients and processes
7. Improvement in Quality Measures
8. Celebrate successes in your journey to becoming a PPC-PCMH accredited or PGIP PCMH designated practice.
9. Share your experiences and successes with your colleagues.
10. Continuous Improvement – transformation of processes and patient care.
11. Others.....



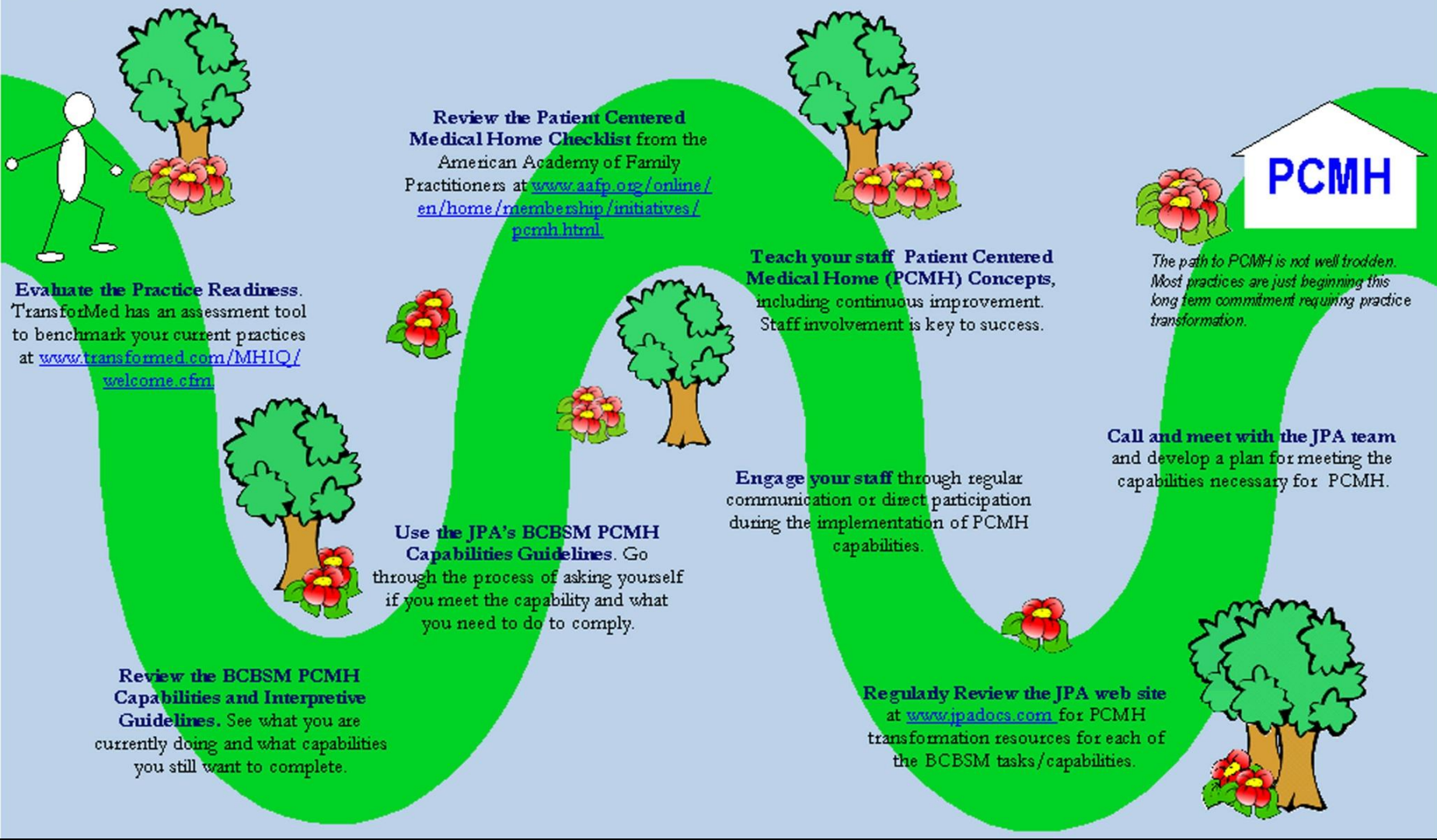
Why Now?

Patient Centered Medical Home?

- It's the right thing to do for your patients
- Patients expect it
- Employers demand it
- Insurers are paying more for it
- The current healthcare delivery system of care is not working. The United States is re-tooling both its healthcare financing as well as healthcare delivery reform so things are quite confusing.



Highlights of the Path to Patient Centered Medical Home (PCMH)



Evaluate the Practice Readiness. TransformMed has an assessment tool to benchmark your current practices at www.transformed.com/MHIQ/welcome.cfm

Review the Patient Centered Medical Home Checklist from the American Academy of Family Practitioners at www.aafp.org/online/en/home/membership/initiatives/pcmh.html

Teach your staff Patient Centered Medical Home (PCMH) Concepts, including continuous improvement. Staff involvement is key to success.

The path to PCMH is not well trodden. Most practices are just beginning this long term commitment requiring practice transformation.

Call and meet with the JPA team and develop a plan for meeting the capabilities necessary for PCMH.

Use the JPA's BCBSM PCMH Capabilities Guidelines. Go through the process of asking yourself if you meet the capability and what you need to do to comply.

Engage your staff through regular communication or direct participation during the implementation of PCMH capabilities.

Review the BCBSM PCMH Capabilities and Interpretive Guidelines. See what you are currently doing and what capabilities you still want to complete.

Regularly Review the JPA web site at www.jpadoes.com for PCMH transformation resources for each of the BCBSM tasks/capabilities.

PCMH

PCMH Contacts

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NCQA – Susan Maxsween

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Next Education Webinar

Patient – Provider Agreement

August 11, 2010

12:00 PM – 1:00 PM

Presenter: Erika Byrum

