NATIONAL RURAL HEALTH RESOURCE CENTER

DRCHSD Quality Improvement Webinar Series

Patient Centered Medical Home (PCMH): The In's and Out's of Implementation

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PCMH: Making it Matter

Quick Overview of PCMH Structure

Learning Objectives

- Understand the key components of a PCMH
- Identify the benefits of a PCMH
- Understand the role of staff members in a PCMH

Patient-Centered Medical Home

A PCMH is organized around the patient and emphasizes the relationship between a patient and their provider

A PCMH improves health care quality and the efficiency of health care delivery by providing a framework for organizing the many components of patient care

Accrediting Bodies

- HRSA Contracts with:
  - NCQA
  - TJC
  - AAAHC
- The Compliance Team
- URAC

Characteristics of a PCMH

- **Personal Physician** – Each patient has an ongoing relationship with their provider
- **Physician directed team-based care** – The provider leads the healthcare team to meet the patient's needs
- **Whole-person orientation** – The provider addresses all the patient's health care needs

Characteristics of PCMH

- **Care Coordination** – The provider ensures that care is efficient and comprehensive
- **Quality and safety** – Care is planned based on what patients need and want, and what has been shown to improve health
- **Enhanced access to care** - Providers value their patients and strive to be accessible

Team-Based Care

- Proactive, planned efficient patient care
- Coordinated delivery processes
- Defined policies, protocols and procedures, staff roles and responsibilities
- Structured communication processes

Care Coordination

- Tracks patient lab tests, notifies patients of normal and abnormal results
- Tracks patient referrals to specialists, following up to receive reports
- Coordinates with Emergency Departments and Hospitals to ensure patient needs are met during their stay and follow-up care provided after discharge

Care Management

- Planned preventative or chronic illness visits
- Individualized patient plan of care
- Patient medication management
- Ongoing patient follow-up

Patient Self-Management

- Problem solving
- Skill building
- Lifestyle modification
- Patient emotional support
- Patient referral to community programs and services

Access to Care

- Patients seen by primary care provider whenever possible
- Flexible scheduling system
- Same day appointments
- Availability of timely clinical advice
- Continuity of clinical information

Population Health Management

- Maintaining the overall health of all patients in the practice
- The practice uses patient information, clinical data and evidenced-based guidelines to identify patients in need of services

Electronic Systems

- Electronic Health Record (EHR) is a tool for systematically documenting patient information
- EHR provides the capability for generating reports summarizing patient information
- E-prescribing, E-mail, and patient portals are other electronic systems utilized by a PCMH

Measuring and Improving Performance

- A PCMH uses an ongoing quality improvement process and monitors the effectiveness of this process over time
- Performance data is used to identify opportunities for improvement in clinical quality, efficiency and patient experience
- A PCMH shares performance data with providers, the practice and publicly

Benefits of PCMH

- Improved compliance with obtaining recommended preventative services
- Better chronic disease management results in fewer ER and hospital visits
- Improved healthcare quality and patient satisfaction

Staff Role for PCMH

- A patient advocate
- Essential member of the PCMH team
- Sharing ideas to improve patient care
- Dedicated to working at your highest level of education and ability

NCQA

- National Committee on Quality Assurance (NCQA)
  - 501(c)(3) dedicated to improving health care quality
  - NCQA offers "recognition" programs for various aspects of clinical care: diabetes, cardiovascular disease, back pain
  - One of the recognition programs is for PCMH
  - 3 Levels of accreditation: Level 1 (lowest), Level 2, and Level 3 (highest); Now just Level 3

PCMH (2022) Overview Comparison

1. Team-Based Care and Practice Organization Knowing and Managing Your Patients
2. Patient-Centered Access and Continuity (AC)
3. Care Management and Support (CM)
4. Care Coordination and Care Transitions (CC)
5. Performance Measurement and Quality Improvement (QI)

1. Team-Based Care and Practice Organization
2. Patient-Centered Health Improvement Plan (PCHIP)
3. Provides patient education and self-management tools to patients and their family/caregiver
4. Provides advanced access to its patients
5. Provides patient follow-up
6. Organization meets the needs of patients when they are closed
7. Takes steps to reduce unnecessary utilization of services
8. Ensures patient health records are complete
9. Must have a quarterly PDSA report

First Steps to PCMH

- Identify a Project Leader and PCMH Team
- Educate the Team on the PCMH
- Perform a Practice Readiness and Policy Assessment
- Develop a Project Implementation Plan
- Develop a Plan for Health Information Technology
- Prepare for and Implement PCMH in the clinic

PCMH Transformation

PCMH transformation requires visible and sustained engagement and tangible support of leaders within the practice

Leaders must provide:

The vision for change

Set the Direction: Mission, Vision, Strategy

Instill confidence and enthusiasm for the PCMH

Provide motivation for continuous improvement and innovation

Identify changes to test

Support staff practice teams redesign themselves and their processes

Build and sustain the will within the practice for transformation

PCMH Implementation Plans

- Plans are comprehensive, focused, actionable and accountable
- Integrate seamlessly into clinic operations
- Incrementally addresses elements of PCMH

PCMH Challenges

- Improving office efficiency, reducing patient wait times and clinic no shows
- Improving care coordination/transitions with specialists and hospitals
- Utilizing nursing staff for care management and patient self-management support
- Fully implementing electronic health records and building quality reports using the EHR

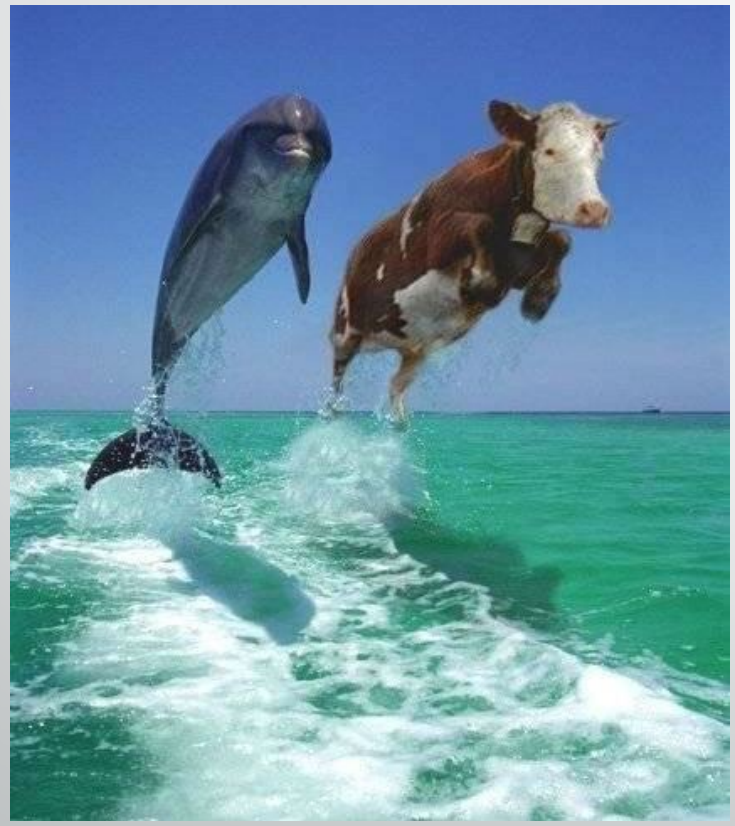
Lessons Learned

- A committed and passionate Leadership Team and Physician Champion are essential
- Physicians/Providers must be on board for PCMH to succeed
- Patient-Centered Medical Home is about building relationships
- Be creative with your resources – start small and build upon what works
- The IT team needs resources and manpower for EHR implementation
- You may need to add staff for care coordination and/or care management
- If you wait for everything to be perfect—you'll never start with PCMH

Lessons Learned (cont.)

- Recognize risks of "change overload" -- need to focus, prioritize, sequence change efforts
- Recognize that successful change happens only through effective teams (make changes with people, *not to* people)
- Change fatigue is serious concern
- Recognize value of external and internal QI coaching

Change is Hard



- Hard to change your shorts while running! (and hard to practice while practicing)
- PCMH requires practice and personal change
- People fear change (loss) – any change

Sustaining Change is Even Harder!

- PCMH requires transformation, not incremental change
- Making many changes is harder than single change
- Sustaining change can be exhausting
- Marathon, not a sprint!

Summing Up: Medical Home is Where…

- Patients feel welcomed
- Staff takes pleasure in working
- Physicians/providers feel energized every day

Resources

- https://www.ahrq.gov/ncepcr/tools/pcmh/index.html
- https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/medical-home.html
- https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/
- https://www.aaahc.org/certification/primary-care/medical-home/
- https://thecomplianceteam.org/our-accreditation-programs/patient-centered-medical-home-pcmh/

Questions