2022

PCMH

A Value Based Quality Improvement Model

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Enhancing Your Practice with Patient Centered Medical Home

Meet the PCMH Presenters

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Learning Objectives

- What is a Patient Centered Medical Home?
- What is the value of a PCMH
- Process for becoming a PCMH

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What is a Patient-Centered Medical Home?

Patient-Centered Medical Home: What is a PCMH? | Primary Care Collaborative (pcpcc.org)

- The patient-centered medical home (PCMH) is a model of care in which patients are engaged in a direct relationship with a chosen provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and advocates and arranges appropriate care with other qualified providers and community resources as needed.

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Basic Elements of a Patient Centered Medical Home?

Adapted from the AHRQ definition, TCT describes the medical home as an approach to the delivery of primary care that is:

- Patient-centered: A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- Comprehensive: A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- Coordinated: Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.
- Accessible: Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT innovations.
- Committed to quality and safety: Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health.

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A journey, not a Destination!

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Why Become a Patient Centered Medical Home?

- CMS is moving to change how it structures payment from a quantity to a quality approach. It will provide incentives for better processes and outcomes. The prediction is 2030.
- Medicaid programs have made enhanced payments to providers who achieved certain distinctions or process measures.
- PCMH is the fundamental framework for the future of Value-based Care and Chronic Care Management.

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9 Compelling Reasons to become a TCT PCMH

1. Patient Engagement
2. Improved Outcomes
3. Decreased Emergency Department Use
4. Increase in Revenue
5. Decrease in Hospital Readmissions
6. Increase in Market Share
7. Increase in Staff Satisfaction
8. Increase in Patient Satisfaction
9. It's the Right Thing to Do

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Decrease Cost

Primary Care
Community Resource $s

Ambulatory Care
Home Services $$

ED Utilization
Hospitalization $$$

Differences between Traditional Care Models and PCMH

Traditional Method	PCMH
• Paper records with minimal use of technology	• EMR • Population Health Management • E-Prescribing • Patient Portals
• Top-down delegation	• Provider-staff meetings/huddles regularly
• Focus on sickness • Reactive care	• Focus on Health, wellness, and prevention as well as treating illness. • Proactively monitor and prevent.
• Patients call for appointments after ED or hospital discharge	• Practice works closely with hospitals and patients are called post-discharge.
• Provider is the primary or sole source for care	• Multidisciplinary team surrounds patient
• Occasional satisfaction surveys collected	• Consistent QI measures and methods in place.
• Patient comes to the clinic for care only	• Telehealth • Meet the patient where they are at. • Community Resources

Let’s Talk Quality Data Submission!

We recognize that clinics are doing great work so why not show it off. QI consists of actions that lead to measurable improvement in services and patient outcomes. These can be very small and simple improvements or large and complex depending on what you feel matters most to your clinic and the population you serve. The key is engagement. Engagement of patients and specifically staff. This will bring great satisfaction to the work they are doing and will result in buy-in. The format TCT prefers is the PDSA model:

- Plan: Develop the initiative and tasks.
- Do: Implement your plan.
- Study: Analyze the results.
- Act: Adjust or adopt the process based on the results found in the study phase.

Barriers to Becoming a Patient Centered Medical Home

- Resistance to change
- Inadequate financial resources
- Low workforce
- Low adaptive reserve
- Your EHR
- Staff/provider buy-in
- Motivation

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Dealing with Resistance

No one can whistle a symphony. It takes a whole orchestra to play it

HE Luccock

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Some PCMH Programs can be…

- Rigid
- Burdensome
- Labor Intensive
- Expensive
- Overwhelming
- Data Centered

Robs time devoted to patient care.

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Rethinking PCMH

- Anything taking you away from patient care is heading in the wrong direction!
- We believe the primary focus should be centered around patient care.
- Efficiency in daily operations allows providers to concentrate on “What Matters Most”, the patient!
- Its a Winning Approach for both Clinics and Patients.

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How Does PCMH Benefit My Clinic?

As an Exemplary Provider, you demonstrate to Federal and State regulatory agencies, payors, and the community at large that you deliver exceptional, safe, and quality care. Recognition is key to reimbursement and payors respond. What are payors looking for?

Lower cost and improved outcomes

PCMH is the foundation for our value-based payment future!

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How does PCMH Benefit My Patients?

Examples of PCMH patient care improvements:

- Same day appointments for urgent illness and expanded appointment hours
- A specific plan to handle all types of patient communication
- After-hours triage service and phone access to an on-call provider
- Implementation of a team-based approach to coordinated care
- Assigned care coordinator who develops relationships with patients and provides direct access to the care team

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Are There Any Benefits for Staff?

Staff Satisfaction:

PCMH provides rewards not just to the patients but also to your providers and staff when everyone is engaged and truly understands the ‘why’ behind the model. In talking with clinics currently designated as patient centered medical homes, staff engagement was often cited as the hardest hurdle to accomplish.

However once PCMH was fully implemented, most clinics report a much higher level of provider/staff satisfaction along with higher patient satisfaction ratings.

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Preparation Timeline

What is a Realistic Goal for Survey Readiness?

- Each clinic has a unique timeline.
- 90-120 days is average.

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Path for Primary Care Practices

Advisor Calls:

1. Orientation Call
2. Review Standards PCMH 1.0 – PCMH 5.0
3. Review Standards PCMH 6.0 – PCMH 8.0 and QI 1-0-2.0
4. Review Universal and Specialty Standards
5. Q & A

View Clinical Concerns Webinar Independently

Work PCMH Checklist to Identify Areas Where Clarification or Increased Resources are Needed

Schedule Follow-Up Calls to Evaluate Progress

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PCMH Standards

PCMH 1.0	The organization utilizes a team-based approach for patient-centered coordinated care.
PCMH 2.0 care	The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose needs to be managed and coordinated.
PCMH 3.0	The organization provides patient education and self-management tools to patients and their family/caregivers.
PCMH 4.0	The organization provides advanced access to its patients.
PCMH 5.0	The organization provides patient follow-up.
PCMH 6.0	The organization evaluates its quality performance and improvement quarterly.
PCMH 7.0	The organization ensures patient health records are complete.
PCMH 8.0	The organization understands the impact of social determinants of health and health equity.
QI 1.0	The organization collects data for patient satisfaction, dissatisfaction, and complaints.
QI 2.0	The organization performs an annual evaluation of its written policies and procedures for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home Model.

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Who Should Be On The PCMH Implementation Team ?

At a Minimum:

Clinic/Practice Manager and Care Coordinator

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Successful Implementation Teams…

- Read the Standards before Training
- Attend Training Calls
- Develop an Implementation Plan and Timeline
- Find Provider Champion(s)
- Invite Other Staff to Participate
- Delegate Duties and Set Deadlines
- Utilize TCT Web Templates and Webinars
- Read About PCMH Innovation
- Reach Out to other Practices

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Resources

Available as part of the accreditation package, TCT has a wide range of resources for the Patient Centered Medical Home program at no cost including:

- Webinars
- Templates for Policies and Procedures
- Patient Satisfaction Survey Portal
- Quarterly Improvement project guidance
- Individual support with an Accreditation Advisor

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Utilizing the Standards and Checklist to develop a preparation and implementation plan

The next step is survey. The survey is an open book test. Use the standards and checklist to develop a plan to prepare the clinic to become a PCMH and to implement the process.

Important areas to pay close attention are:

- EMR
- Expanded Hours
- Care Coordinator
- Patient Care Teams
- Patient Care Plans and Education
- Community Resources

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EMR and HIPAA Compliance

- Is your EMR system PCMH compatible?
- Pharmacy information and care coordination notes?
- Does EMR have HIPAA compliant functions?
- Time out to protect PHI?
- Will your EMR produce after-visit summaries?
- Will your EMR generate care plans?

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Expanded Hours:

Do you currently provide expanded hours to fit the needs of your patients?

How will you expand hours of operation?

How will you implement for provider/staff coverage?

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Care Coordination

Do you currently have a Care Coordinator/Navigator?

If not, who will be responsible?

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Patient Care Teams:

Do you currently identify patient care teams?

Do you conduct daily team **huddles**?

Do you utilize Behavioral Health professionals?

Do you communicate with pharmacists about medication compliance?

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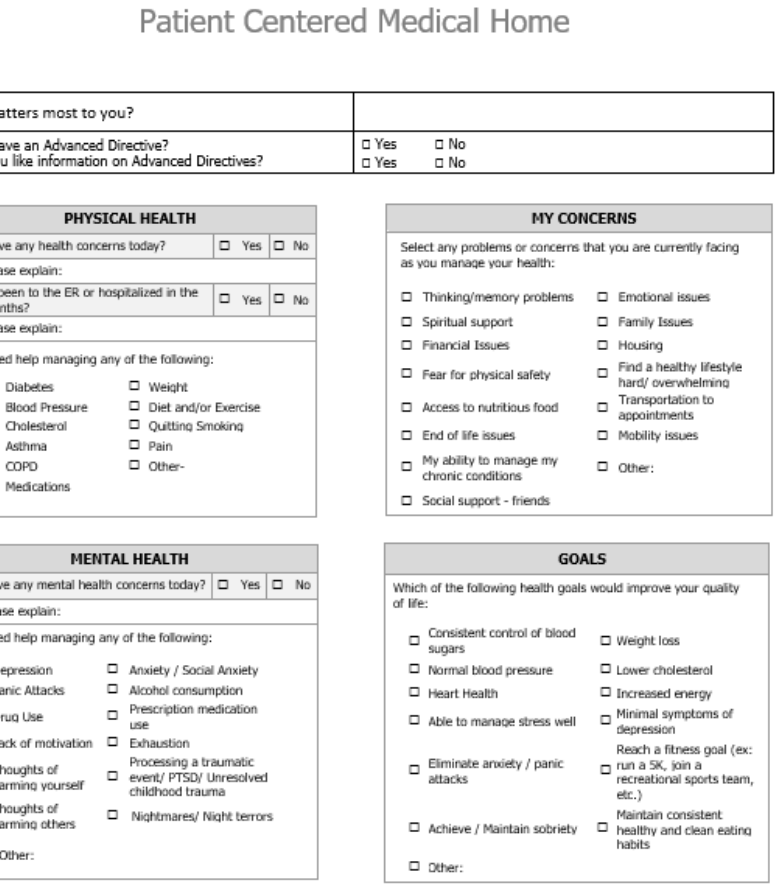
Patient Care Plans and Education



Patient Centered Medical Home

What matters most to you?	
Do you have an Advanced Directive? Would you like information on Advanced Directives?	☐ Yes ☐ No ☐ Yes ☐ No

PHYSICAL HEALTH

Do you have any health concerns today?	☐ Yes	☐ No
If yes, please explain:		
Have you been to the ER or hospitalized in the last 12 months?	☐ Yes	☐ No
If yes, please explain:		

Do you need help managing any of the following:

- ☐ Diabetes
- ☐ Blood Pressure
- ☐ Cholesterol
- ☐ Asthma
- ☐ COPD
- ☐ Medications
- ☐ Weight
- ☐ Diet and/or Exercise
- ☐ Quitting Smoking
- ☐ Pain
- ☐ Other-

MY CONCERNS

Select any problems or concerns that you are currently facing as you manage your health:

- ☐ Thinking/memory problems
- ☐ Spiritual support
- ☐ Financial Issues
- ☐ Fear for physical safety
- ☐ Access to nutritious food
- ☐ End of life issues
- ☐ My ability to manage my chronic conditions
- ☐ Social support - friends
- ☐ Emotional issues
- ☐ Family Issues
- ☐ Housing
- ☐ Find a healthy lifestyle hard/ overwhelming
- ☐ Transportation to appointments
- ☐ Mobility issues
- ☐ Other:

MENTAL HEALTH

Do you have any mental health concerns today?	☐ Yes	☐ No
If yes, please explain:		

Do you need help managing any of the following:

- ☐ Depression
- ☐ Panic Attacks
- ☐ Drug Use
- ☐ Lack of motivation
- ☐ Thoughts of harming yourself
- ☐ Thoughts of harming others
- ☐ Other:
- ☐ Anxiety / Social Anxiety
- ☐ Alcohol consumption
- ☐ Prescription medication use
- ☐ Exhaustion
- ☐ Processing a traumatic event/ PTSD/ Unresolved childhood trauma
- ☐ Nightmares/ Night terrors

GOALS

Which of the following health goals would improve your quality of life:

- ☐ Consistent control of blood sugars
- ☐ Normal blood pressure
- ☐ Heart Health
- ☐ Able to manage stress well
- ☐ Eliminate anxiety / panic attacks
- ☐ Achieve / Maintain sobriety
- ☐ Other:
- ☐ Weight loss
- ☐ Lower cholesterol
- ☐ Increased energy
- ☐ Minimal symptoms of depression
- ☐ Reach a fitness goal (ex: run a 5K, join a recreational sports team, etc.)
- ☐ Maintain consistent healthy and clean eating habits

Identify a life goal or reason that motivates you to work towards better health.

The Patient-Centered Medical Home is an approach to primary care that is built around YOU! You are the most important member of your healthcare team! We want to meet your goals and needs. We know that health is not achieved in a clinic; but rather built in our homes, schools, workplaces and communities. Help us get to know you and your healthcare needs by completing the form below.

- Do you discuss “What Matters Most” with the patient and set health goals?
- Do you develop a Patient Care Plan? We call them PCHIPs!
- Do you provide education regarding diagnosis and treatment?

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Community Resources

Do you discuss socio-economic determinants with your patients that may impact their health?

Do you provide information to your patients regarding community resources available to them?

Do you have a list of community resources available for patients in need?

https://www.findhelp.org/

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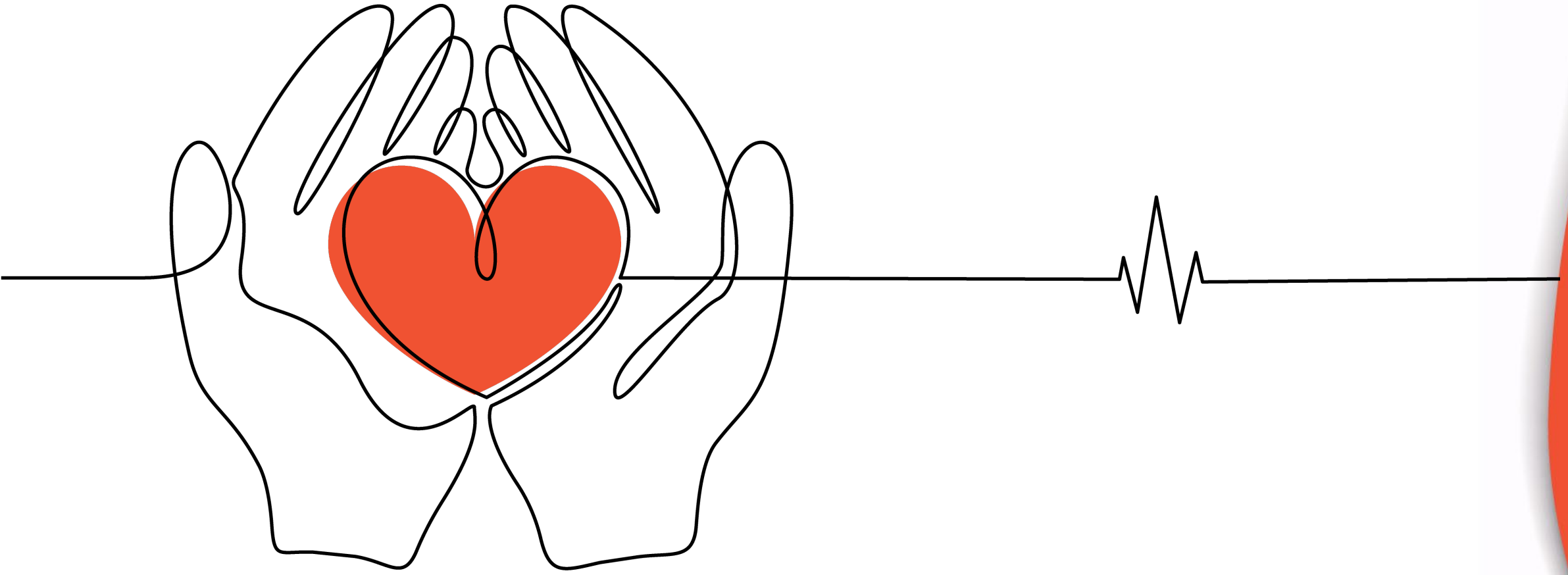
Thank You For All You Do!



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