Nebraska Hospital Association

# Patient-Centered Medical Home

# Objectives

- What is Patient Centered Medical Home
- PCMH Concepts
- Benefits of PCMH

# What is PCMH

- A model for strengthening primary care through the reorganization of existing practices to provide patient-centered, comprehensive, coordinated, and accessible care that is continuously improved through a systems-based approach to quality and safety.
- Team Based Care

# NCQA PCMH

- National Committee Quality Assurance (NCQA)
- Patient Centered Medical Home
- 2008 NCQA launched the first recognition program
- 2011/2014 NCQA updated the recognition program
- 2017 Redesigned the recognition program

# Six PCMH Concepts

- Team based Care and Practice Organization
- Knowing and Managing Your Patients
- Patient-Centered Access and Continuity
- Care Management and Support
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvment

# Team Based Care

- The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs. Includes:
  - Prevention and wellness
  - Acute care
  - Mental health treatment
  - Rehabilitation
  - Chronic care (Population Health)

Referenced AHRQ

# Knowing and Managing your patients

- Proactive Reminders
- Closing loops
- Depression screenings
  - Follow up if needed

# Patient Centered Access and Continuity

- Access needs and preferences
- Access for patients outside of business hours
- Technology Supported Alternative appointments

# Care Management and Support

- Identify patients from comprehensive assessment
- Monitor patients for care management
- Care plans for care managed patients
- Keep chronic conditions under control

# Care Coordination and Care Transitions

- Referral management process
- Coordinate with other clinicians improve continuity and close gaps
- Care coordination with other facilities
- Follow up calls after transitions and documentation

# Performance Measurement and Quality Improvement

- Clinical quality measures, example(A1C > 9 inverted number)
- Patient experience measures
- Value based payments (contract with insurance company)

# Benefits of PCMH

- Reduce fragmentation
- Align with payers
- Improve staff satisfaction
- Improve patient experience
- Better manage chronic conditions
- Align with state/federal initiatives
- Lower health care costs
- Improve patient-centered access
- Loop closure

# Care Coordination

- In a PCMH, the level of care coordination depends largely on the complexity of needs of each patient.
  - Must start with a comprehensive assessment of each individual's needs for health and social support. This involves much more than a standard medical history.

# PCMH & Plan of Care

- The patient, their family and the care team should jointly create this plan
- Updates should be made to this plan based on patient needs
- Regularly monitoring and communication is the most important piece to effective care coordination with the patient, copy given to patient

# How to support Complex Populations

- EHRs, HIEs, IT (notifications of discharges)
- Quality Measurement and Improvement
- Care coordination team
- Population care teams ie diabetes team, hypertension, obesity, CHF, COPD

# Billable Items

- TCM-Transition of Care Management
  - Phone call 2 days after discharge and not readmitted in 30 days
- CCM-Chronic Care Management
  - Documentation and care plan

# Annual Reporting Requirements

- Annual Reporting Requirements for PCMH
- Annual Reporting Guideline Book reviews the concepts ( Process Step by Step, Crosswalk table)
- www.ncqa.org for additional resources

# Example of a concept

| TC 06 (Core) Individual Patient Care Meetings/Communication: Has regular patient care-team meetings or a structured communication process focused on individual patient care. | |
|---|---|
| **GUIDANCE** | **EVIDENCE** |
| The practice has a structured communication process or holds regular care-team meetings (such as huddles) for sharing patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow.<br><br>A structured communication process is focused on individual patient care and may include tasks or messages in the medical record, regular email exchanges or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process.<br><br>Consistent care-team meetings allow staff to anticipate the needs of all patients and provide a forum for staff to communicate about daily patient care needs. | • **Documented process**<br>***AND***<br>• **Evidence of implementation**<br><br>  ***Documented Process Only*** |

# Reference Websites:

- NCQA National Committee for Quality Assurance

  https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/
- NCQA National Committee for Quality Assurance (2021). NCQA Patient-Centered Medical Home ( PCMH) Standards and Guidelines. Version 6.1 (Effective January 15, 2021).
- AHRQ PCMH Resource Center

  https://pcmh.ahrq.gov