GE-NMF PRIMARY CARE LEADERSHIP PROGRAM

PCLP

Patient Centered Medical Home

Nancy Chang, Adelante, Phoenix

Introduction

- US healthcare system is broken
- Medical care is very expensive, but poor in quality and delivery
- Patient Centered Medical Home (PCMH) was proposed in 1967 by the American Academy of Pediatrics
- Purpose of PCMH is to establish a central place for patients to receive care and to improve care coordination

PCMH Definition

- 1) Patient Centered- partnership among practitioners, patients and their families
- 2) Comprehensive- team to care for patient's physical and mental health, including preventative care, chronic care, and acute care
- 3) Coordinated care- organize elements of all health care, ex: specialty care, home health, hospital
- 4) Accessible: electronic and telephone access
- 5) Quality: use IT tools to assist in providing care (ex: reminders)

Table 1. National Committee for Quality Assurance patient-centered medical home standards

Standard	Must pass element (to achieve NCQA physician recognition)[a]
Enhance access continuity	Access during office hours
Identify and manage patient populations	Use data for population management
Plan and manage care	Manage care
Provide self-care support and community support	Support self-care process
Track and coordinate care	Track referrals and follow up
Measure and improve performance	Implement continuous quality improvement

NCQA, National Committee for Quality Assurance. Adapted with permission [7].
[a]These refer to areas of quality that must be passed to get the desired NCQA Physician Recognition. In order to get the highest level of recognition, all 10 elements must be passed.

Examples

- Hudson River Health Care
  - Patient Care Partners (community health workers)
    - Coordinate care, make referrals, respond to patient needs, f/u phone calls to patients, check to ensure referral appointment was completed
  - Nurses (RN)
    - Bilingual nurse to manage those at highest risk, provide education
  - Electronic Health Records (EHR)
    - Prompts preventive care and DM specific interventions
- Washington State Dept. of Health
  - Medical Assistants (MA)- improve care flow, handle group visits, care coordination
  - RN's- Dedicated to managing high risk patients
  - Group sessions to provide support and learn about cholesterol, blood sugar, etc.
  - Use EHR to identify high risk patients

Examples cont…

- Thomas Jefferson University
  - “Super” Licensed Practical Nurse (LPN) and “Super” MAs
    - Use data to monitor, coordinate care, identify DM patients, identify patients not meeting targets, make f/u phone calls to patients, streamline referrals to dietician, podiatrist, and preventive care
  - Pharmacist
    - Visits site to discuss HbA1c, cholesterol, meds, etc.
- Weslaco Medical Clinic
  - Shared medical appointments: 90 minutes DM class, patients pulled individually to see provider over this time period, class covers insulin, BP, DM related topics
  - EHR- Used to keep track of screenings and other tasks (ex: labs)

Examples cont…

- Children with Special Health Care Needs (CSHCN)
  - Randomized controlled intervention
  - Care coordinator/family support specialist is a paid parent with experience caring for CSHCN, provides emotional support, home visits, info, advocacy, monthly follow up
  - Lead nurse practitioner provides core intervention, education
  - Study results: improved outcomes, suggests financial savings but does not elaborate

- Autism Primary Care Medical Home Intervention
  - General pediatrician
  - Nurse care coordinator
  - Scheduling coordinator
  - Specific care plan, monitoring log, coordination with outside sources

IMPROVING PATIENT CARE | REVIEW

The Patient-Centered Medical Home

A Systematic Review

George L. Jackson, PhD, MHA; Benjamin J. Powers, MD, MHS; Ranee Chatterjee, MD, MPH; Janet Prvu Bettger, ScD; Alex R. Kemper, MD, MPH, MS; Vic Hasselblad, PhD; Rowena J. Dolor, MD, MHS; R. Julian Irvine, MCM; Brooke L. Heidenfelder, PhD; Amy S. Kendrick, RN, MSN; Rebecca Gray, DPhil; and John W. Williams Jr., MD, MHS

- 31 peer reviewed studies rated as good or fair
- No single strategy used in most studies
- Improvement in preventive services and patient experience
- Suggests possible reduction in ER visits
- Insufficient evidence to evaluate efficacy for chronic illness
- Insufficient evidence to determine efficacy of PCMH on clinical outcomes and costs

Challenges to studying PCMH

- Studies vary widely in range of outcome
- Lack of consistency in studies
- Inconsistent use definitions for PCMH
- Quality of studies
- Measuring outcomes

Conclusions

- Not enough long term data available to evaluate costs and clinical outcomes
- Need models that are adaptable to other chronic illnesses and high risk populations
- No standard way to deliver PCMH care
- Opportunity to create new standards
- Best strategy to establish PCMH is to target the specific patient population with the resources available

References

- *Defining the Medical Home | Patient-Centered Primary Care Collaborative*. (n.d.). Retrieved July 22, 2013, from http://www.pcpcc.org/about/medical-home
- Farmer, J. E., Clark, M. J., Drewel, E. H., Swenson, T. M., & Ge, B. (2011). Consultative care coordination through the medical home for CSHCN: a randomized controlled trial. *Maternal and child health journal*, *15*(7), 1110–8. doi:10.1007/s10995-010-0658-8
- Golnik, A., Scal, P., Wey, A., & Gaillard, P. (2012). Autism-specific primary care medical home intervention. *Journal of autism and developmental disorders*, *42*(6), 1087–93. doi:10.1007/s10803-011-1351-5
- Helfgott, A. W. (2012). The patient-centered medical home and accountable care organizations: an overview. *Current opinion in obstetrics & gynecology*, *24*(6), 458–64. doi:10.1097/GCO.0b013e32835998ae
- Jackson, G. L., Powers, B. J., Chatterjee, R., Bettger, J. P., Kemper, A. R., Hasselblad, V., Dolor, R. J., & Williams, J. W. (2012). The Patient-Centered Medical Home: A Systematic Review. *Ann Intern Med*, *158*(3), 169-178.
- Longworth, D. L. (2011). Accountable care organizations, the patient-centered medical home, and health care reform: what does it all mean? *Cleveland Clinic journal of medicine*, *78*(9), 571–82. doi:10.3949/ccjm.78gr.11003
- Patient-Centered Primary Care Collaborative (2011). Practices in the Spotlight: The medical home and diabetes care. www.pcpcc.net