Assessing the Knowledge of Jackson-Hinds Providers about Patient Centered Medical Homes

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HISTORY

Revitalizing the U.S. Healthcare System has always been a priority for our nation. Policy makers are aware of the fact that while other developed nations can deliver health care services at the same or higher levels of quality as the United States, they do so at an average of half costs of the U.S. system.[i] This is possible because of the underlying differences between the two systems; the strength of the primary care services. An interest in rebuilding the U.S. primary care capacity has emerged and patient centered medical homes are deemed a means to this end.

It is important to recognize that the current emphasis on the patient-centered medical home concept is largely attributable to the history of its origins in the U.S. The term "medical home" first appeared in the U.S. in 1967 in an AAP published book called "standards of Child Health Care."[ii] The text defined the medical home as one central source of a child's pediatric records, and emphasizes the importance of centralized medical records to Children with Special Health Care Needs (CSHCN) – mainly noting that care for CSHCN is often provided by many different practitioners working in disparate locations independent of each other, was concerned about the duplication and gaps in services that occur as a result of this lack of communication and coordination.[ii]

While Standards of Child Health Care were, at the time it was published, an important guide for pediatric practice, it did not define AAP policy until the 1970s. In 1974, a policy statement titled, "Fragmentation of Health Care Services for Children" was developed.[i, iii] This statement noted that the "delays, gaps, duplications, and diffused responsibilities which characterize fragmented care are expensive, inefficient, and sometimes hazardous to health" and that "implicit in these [the AAP constitution's]

standards is a commitment to the principle that each child deserves a 'Medical Home'."[iii] In its ideal form, this "health care home" was supposed to boast seven key characteristics: (1) commitment to the individual; (2) primary services; (3) full time accessibility; (4) service continuity; (5) comprehensive record keeping; (6) competent medical management; (7) cost effective care.[iii, iv]

The birth of the Medical Home concept as we know it today was first implemented in Hawaii in the 1980's.[ii] The implemented system offered care that was family-centered; community-based (geographically and financially accessible and available), continuous, comprehensive, and coordinated, and utilized the resources of related services in the neighborhood.[ii] The success of medical home programs in Hawaii prompted the AAP to fully endorse the policy and actively propagate the idea across the nation in the late 1980's and 1990's. In 1999 the National Center of Medical Home Initiatives for Children with Special Needs was established, while in 2002, the AAP expanded on the definition of Medical Home described in the original 1992 policy statement.[iii] The 2002 policy statement retains the original 7 components of a Medical Home (accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective), and describes the services that should be provided within this framework. The 2002 statement continued to further explain the Medical Home model of care by providing an operational definition that lists 37 specific activities that should occur within a Medical Home.[v]

As defined today (since 2007) through the joint efforts of the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and American Osteopathic Association (AOA), a patient-

centered medical home (PCMH) is a team based health care delivery model led by a physician, P.A., or N.P. that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes.[iii, v] It is "an approach to providing comprehensive primary care for children, youth and adults".[iv] The provision of medical homes may allow better access to health care, increase satisfaction with care, and improve health.[vi, vii] However, there is still a large debate about how to realize these principles and address the gap that exists between the current state of the primary care system and that envisioned under the medical home model.

At the core of the PCMH model is an ongoing relationship between the patient and the primary care physician.[v] The primary care physician is expected to take responsibility for all of the patient's health care needs and to appropriately arrange care with other qualified professionals. The model elevates the physician's role to leader of the patient's health care team.[iii, v] The physician is expected to ensure that all stages of care—preventive care, acute care, chronic care, and end-of-life care—are coordinated and/or integrated across all elements of the complex health care system.[v, vi]

The PCMH model recognizes that technology plays an increasingly important role in care management and coordination. It encourages the facilitation of care by disease registries, information technology, health information exchange, and other means to ensure that patients get the indicated care when and where they need it.[v]

Proponents insist this is not managed care by another name or a physician acting as a healthcare gatekeeper. In the medical home model, the primary care physician is "not a gatekeeper, but a care facilitator," explains Carole Flamm, M.D., executive medical director at the Blue Cross Blue Shield Association. "Patient choice is very important. The

patient designates ‘my medical home.’ And if patients want to change to a different medical home that provides a better environment or a better value, they can and will do that.”

Presently, there is a lack of coordination between primary care physicians, specialists and hospitals; resultantly, health care providers may be unaware of the other’s treatment plans. Additionally, studies have shown that only 27 percent of U.S. adults can easily contact their primary care physician by telephone; obtain care or advice after hours and schedule timely office visits. This creates an environment in which there is widespread duplication or unnecessary testing and services. This is one of the issues Health Care Reform plans to ameliorate through the implementation of patient centered medical homes.[vi]

NATIONAL COMMITTEE OF QUALITY ASSURANCE

Although there is no single standard definition of a medical home, the agreed upon set of principles are the guiding light behind the movement. The principles are:[v]

- **Enhanced Access:** improve access to healthcare by increasing same day/sick appointments and having 24/7 access to a physician either in the office or via phone after hours[v]
- **Whole Person Orientation**: serve as the patient's main hub for all their care needs, mind, body, and spirit, referring to specialists as appropriate.[v]
- **Coordination of Care:** the physician has active relationships and contacts in the community for patient care (urgent care designation, ER designation, specialists) and has a process in place to receive follow up care regarding their patients[v]
- **Personal Physician:** emphasis on a strong patient-physician relationship[v]
- **Safety and Quality:** focus on evidenced based medical practice, improved chronic disease management, and better communication through technology applications[v]
- **Physician Directed Practice Team:** physician leads staff in creating more efficient office practices[v]
- **Value Based Payment:** Recognizing the importance of quality health care, appropriate payment for medical home activities is imperative.[v]

These principles emphasize access to a personal physician in a trusting, healing relationship, who directs a medical team responsible for the patient's care. Although these principles describe medical homes overall, they do not list specific elements required of a practice to be considered a patient centered medical home. In fact, no one set of criteria exists to identify medical homes. Many state initiatives use state specific definitions or apply the joint principles with modifications. In fact, the lack of specificity allows for a myriad of medical homes to be created. This flexibility is considered important to avoid stifling innovation, but it means it is difficult to generalize about results when different versions of the model are tested. Two organizations, the Joint Commission and the National Committee of Quality Assurance, have developed standards for gauging PCMHs.

To assess the degree to which their practice has transitioned into a patient-

centered medical home, Jackson-Hinds is utilizing the standards developed by the National Committee for Quality Assurance (NCQA).[viii] The NCQA PCMH Program is divided into six (6) standards that align with core components of primary care. The standards, explanations and reporting documentation are located in the Standards and Guidelines for NCQA's Patient Centered Medical Home (PCMH) 2011 Manual.[viii] The PCMH scoring system recognizes practices that have implemented a systematic method to their care processes and can provide documentation of care provided at Level 1, Level 2, or Level 3.[viii] To achieve each level of recognition, each NCQA standard contains twenty-eight (28) individual elements.[viii] Each element contains factors that are worth a percentage of point values that make up the total score for each element. The lowest level requires a practice satisfying all 6 must pass elements at 50% performance level and achieving an overall point value of 35-59.[viii] Level 2 builds on level 1 and is satisfied once a practice achieves a point value of 60-84 points.[viii] The final level, 3, is achieved at a point value of 84-100.[viii] Although the NCQA's standards are widely accepted as the markers for PCMHs, many fear that it won't be enough to fix our healthcare issues. Many fear that if the current tool scores are used to pay providers, the result will be the situation reportedly described by the management consultant Peter Drucker: "What gets measured gets managed." Practices may focus on aspects highlighted by the tool, to the detriment of truly transforming primary care.

While the medical home concept promises to reduce if not eliminate the deficiencies of primary care, there are some challenges that must be overcome. On the forefront of these issues, some physicians have difficulty making the shift to the collaborative work culture required in the medical home setting. This suggests that

changes in medical education may be necessary to help prepare physicians to practice in medical homes. Also, assuming that practitioners, practices and clinics will widely adopt the PCMH model, how will patients be assigned to medical homes and how will assignment changes be handled? Transitioning to a medical home system will require substantial upfront investment. And we are currently unsure of what, exactly, will be necessary, and how long it will take to completely make this transition. Financially speaking, while trial medical home demonstration projects have shown savings, it is unclear what the savings would be and when they would be achieved once the medical home model was established across the U.S. healthcare system; additionally, payment reforms from fee-for-service will have to be in place before the benefits can be captured fully. Before the widespread implementation of PCMHs, the U.S. government will have to keep these issues in mind and seek possible solutions to ensure progress in healthcare reform.

METHODS

This was a cross-sectional study of providers of Jackson-Hinds Comprehensive Health Center regarding their knowledge of Patient-Centered Medical Homes. A total of 62 providers work at all of the Jackson-Hinds Clinics and the survey was disseminated to 50 providers including MDs, DDS and Nurse Practitioners (NPs). 19 providers participated for a response rate of 32%. This survey was based on a survey published in Family Medicine Journal in 2011 by Pablo Joo.[ix]

The survey was handed out to the charge nurses or front desk staff of each clinic or unit in the main clinic. Here, they were given the duty of making the physicians aware of the survey and the timeframe each provider had to complete it. A researcher gave three reminders over the course of 4 days and collected surveys each day from providers and the staff assigned. The survey data was collected anonymously and providers did not receive any incentives for participating.

This was a 3-minute survey asking 10 questions designed to assess general knowledge of patient centered medical homes as well as details in regards to certain aspects of it such as meaningful use. The survey begins by asking what degree the provider taking the survey possesses. It continues by asking to define patient centered medical homes. Providers were judged as having adequate definitions of PCMHs if they referred to it as “coordinated” and/or “comprehensive” primary care; a method of providing primary care that is patient centered and upholds the quality and safety of care. Question 3 continues by asking surveyee to select the 6 MUST PASS elements of PCMHs from a chart of many different elements listed in Standards and Guidelines for NCQA’s Patient Centered Medical Home (PCMH) 2011 Manual.

They were also asked in the two following questions to rate their understanding of each model or principle PCMHs as well as their understanding of the requirements to meet CMS Stage 2 Meaningful Use. Definitions of the principles of PCMHs were provided above the question to be answered. The providers were then asked three knowledge-based questions about PCMHs and Meaningful Use Stage 2 requirements. The last two questions on the survey asked the provider to list the strengths and weaknesses of Jackson Hinds Comprehensive Health Center.

RESULTS

Table 1 summarizes the titles held by the providers. Of those taking the survey, 50% were MD while 42% were NPs. In no more than 3 sentences, 71% of providers have and adequate understanding of PCMHs. Table 1 also assesses the 6 MUST pass elements of PCMHs. Of the 12 elements listed, none of the providers correctly identified all 6 MUST pass elements and 71% of the providers correctly identified at least 3 of them.

Table 2 reviews the self-reported understanding of the principles of PCMHs. The majority of providers claimed to at least have "a great deal" of understanding about the principles of personal physician, a physician directed medical practice, whole person oriented care, coordinated and integrated care, and quality and safety healthcare hallmarks. 44% of providers reported a "somewhat" or "not at all" understanding of the principle of enhanced access to care and 57% of providers reported that they had a "somewhat" or "not at all" understanding of value-based payment.

Table 3 reviews the self-reported understanding of the measures of Meaningful Use Stage 2. The measures are core objectives, menu objectives, and clinical quality measures. The majority of providers, 54%, claim to have a "somewhat" understanding of the core and menu objectives of Meaningful Use while 54% of providers claim to "completely" or have "a great deal" of understanding about the clinical quality measures.

Table 4 represents the three knowledge-based questions about PCMHs and Meaningful Use. Most providers (57%-question 6, 71%-question 7, 92%-question 8) did not answer these questions correctly. All of the individuals who answered question 6 incorrectly also claimed that a primary care physician functioning as a gatekeeper of healthcare is consistent with the principles of PCMHs. The final two questions regarding the strengths and weaknesses of Jackson-Hinds will be explained in the discussion section.

DISCUSSION

Based on the results attained from the provider surveys, Jackson-Hinds providers' have an overall understanding of PCMHs but are not familiar with the standards necessary to achieve the status as set forth by the NCQA. Based on question 2 of the survey, 71% of the providers understood PCMHs in terms of a method of coordinating and delivering primary care. Most noted the need for continuous and longitudinal care. Others noted the need to centralize patient care and records to one physician so as to prevent the duplication of services. Individuals did not, however, have a correct definition of PCMHs if they defined it as primary

providers acting as gatekeepers of medicine. A gatekeeper is defined as a physician forgoing the need of a patient to see a specialist in order to decrease healthcare costs. PCMHs instead, have providers act as care facilitators; ensuring that patients see the appropriate specialist for their needs. As noted in question 6, 57% of the providers incorrectly listed primary care providers as gatekeepers of health care.[ix, x]

Questions 9 and 10 addressed any strengths and weaknesses of Jackson-Hinds. Jackson-Hinds suffers from issues that many community health centers, let alone, other public health institutions, encounter. The biggest issue most providers encounter is the lack of communication or miscommunication. This is a well-known issue and could be ameliorated by centralizing communication to one source, such as phone, email, eClinical Works, etc. Many providers also believe the institution is unorganized in reference to the flow of patients. Providers are often overscheduled, limiting access for walk-in appointments, causing longer wait-times and frustrating patients. This increases the patients' dissatisfaction with services, which inevitably leads to poorer health outcomes or patients seeking services elsewhere. As strengths, many providers believe that the staff and physicians are committed to the organization. The longevity of providers allows for better continuity of care, ensuring that patients who continue to use Hinds' resources continue to see the same providers if they so choose. Hinds' also has extended hours of operation and multiple locations to service the increasing number of patients they see annually.

The purpose of the PCMH Provider Survey was to gauge the knowledge of the providers of Jackson-Hinds, however, it also served to activate them. Many providers worked together to complete the surveys in a "team-based" manner. Some

providers also reviewed online resources so as to gain a better understanding of PCMHs. The administrative staff had not created a method of exposing their providers to PCMHs. This survey served as the first official Hinds' exposure of PCMHs to many of their providers.

LIMITATIONS

The study results are limited by the lack of power. The survey was disseminated to 50 of the 62 providers and 19 were received after 4 collections. Ideally, 30 would have sufficed to conclude that the survey results are representative of the population surveyed. The method of disseminating the survey can also cause bias since some physicians may not have had an adequate understanding of each question. Despite being piloted, some of the questions on the survey were not answered. For instance, Question 6 was not answered by 37% of the providers surveyed. Disseminating the survey to all of the Jackson-Hinds Clinics could have also caused bias since I was not able to in-person explain the survey to the provider or charge nurse and clear up any confusion. Lastly, many providers working together to complete the survey and/or reviewing online information can skew the results of their actual understanding of PCMHs.

CONCLUSION

Based on the surveyed providers, Jackson-Hinds is in need of a method of informing their providers about PCMHs. As my final presentation, I created a tool that can be used to inform providers of the basic knowledge the administrative staff believes their providers should know in reference to the transition. The

presentation documents the results of the survey and questions asked. It continues by delving into the history behind PCMHs, the principles it was founded upon, the 6 MUST PASS elements to be considered a home, how the NCQA gauges how well a clinic/practice is performing as a medical home, and concludes by outlining the aspects of meaningful use and satisfying all of the requirements for CMS Stage 2.

It is also recommended that Jackson-Hinds continue to survey their providers and make improvements based on strengths and weaknesses documented. This can act as a method of incorporating the providers into the transition. As opposed to feeling like changes are implemented and they must adapt, providers will instead be apart of the change.

APPENDIX

Patient Centered Medical Home Provider Survey

JACKSON-HINDS
COMPREHENSIVE HEALTH CENTER

Patient Centered Medical Home Provider Survey

Question - 1 Select the degree/title that applies to you (Check all that apply):

- o M.D.
- o D.D.S.
- o N.P.
- o D.O.
- o M.P.H.
- o Other _____

Question - 2 In no more than three (3) sentences, what is your definition of a Patient Centered Medical Home and its purpose?

_____

_____

_____

Question - 3 Which of the following elements are the 6 MUST PASS components of becoming a patient centered medical home (Check all that apply)?

o Access during office hours	o Report data externally
o After-Hours Access	o Referral tracking and follow up
o Implement continuous quality improvement	o Electronic access
o Comprehensive health assessment	o Care Management
o Use data for population management	o Identify High Risk Patients
o Provide referrals to community resources	o Support Self-Care Process

Question - 4 As of today, how well do you feel you understand this model or principle?

Enhanced Access: improve access to healthcare by increasing same day/sick appointments and having 24/7 access to a physician either in the office or via phone after hours

Whole Person Orientation: serve as the patient's main hub for all their care needs, mind, body, and spirit, referring to specialists as appropriate.

Coordination of Care: the physician has active relationships and contacts in the community for patient care (urgent care, geriatrician, ER, geriatrician, specialists) and has a process in place to receive follow up care regarding their patients

Personal Physician: emphasis on a strong patient-physician relationship

Safety and Quality: focus on evidenced based medical practice, improved chronic disease management, and better communication through technology applications

Physician Directed Practice Team: physician leads staff in creating more efficient office practices

	Not at all	Somewhat	A great deal	Completely
Principle 1: Personal Physician				
Principle 2: Physician-directed Medical Practice				
Principle 3: Whole Person Orientation				
Principle 4: Care Is Coordinated and/or Integrated				
Principle 5: Quality and Safety care Hallmarks				
Principle 6: Enhanced Access to Care				
Principle 7: Value-based Payment				

Question – 5 As of today, how well do you feel you understand the requirements to meet CMS Meaningful Use (MU) Stage 2?

MU = Core Measures (17) + Menu Measures (3) + Clinical Qual. Measures (9)

	Not at all	Somewhat	A great deal	Completely
Core Objective Measures				
Menu Objective Measures				
Clinical Quality Measures				

Question – 6 Which one of the following initiatives is consistent with the principles of the Patient-centered Medical Home (Select one)?

A.	Patients are responsible for communicating information between their health care providers.
B.	Primary care physicians function as gatekeepers regarding patient access to specialist care.
C.	Patients and families participate in quality improvement activities at the practice level.
D.	The appointment of a nurse practitioner to lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Results of Survey in Table Format

Select the degree/title that applies to you:	M.D.	N.P.	D.D.S.	C.N.M.
	50%	42%	0%	8%

In no more than three (3) sentences, what is your definition of a Patient Centered Medical Home and its purpose?	Correct Definition	Incorrect Definition
	71%	29%

Which of the following elements are the 6 MUST PASS components of becoming a patient centered medical home:	At least 3 MUST PASS	All 6 MUST PASS	Less than 3 or None
	71%	0	29%

Which one of the following initiatives is consistent with the principles of the Patient-centered Medical Home:	Answered C (correct)	Incorrect	No Response
	8%	57%	35%

Based on Meaningful Use Stage 2 requirements, what percentage of all permissible prescriptions must be eclinically prescribed by an eligible professional?	Ansered 50% (correct)	Incorrect
	29%	71%

Based on Meaningful Use Stage 2 requirements, what percentage of all clinical lab tests must be incorporated into Certified EHR Technology (CEHRT) as structured data by an EP	Answered 55% (correct)	Incorrect
	8%	92%

As of today, how well do you feel you understand this model or principle:	Not at all	Somewhat	A great deal	Completely
Principle 1: Personal Physician		21%	36%	43%
Principle 2: Physician-directed Medical Practice		36%	43%	21%
Principle 3: Whole Person Orientation		28%	36%	36%

Principle 4: Care Is Coordinated and/or Integrated		28%	57%	15%
Principle 5: Quality and Safety care Hallmarks		36%	43%	21%
Principle 6: Enhanced Access to Care	8%	36%	28%	28%
Principle 7: Value-based Payment	21%	36%	28%	15%

As of today, how well do you feel you understand the requirements to meet CMS Meaningful Use (MU) Stage 2:	Not at all	Somewhat	A great deal	Completely
Core Objective Measures	8%	54%	23%	15%
Menu Objective Measures	8%	54%	23%	15%
Clinical Quality Measures	8%	38%	39%	15%

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