Patient Centered Medical Home (PCMH)

The PCMH is a model of practice in which a
Team of health professionals,
guided by a personal physician,
provides
    continuous,
    comprehensive, and
    coordinated care in a
    culturally and linguistically
sensitive manner to patients.

Patient Centered Medical Home (PCMH)

The PCMH provides for
all of a patient's health care needs,
or
Collaborates with other qualified professionals to meet those needs.

In addition, PCMH provides patient centered care through:

- evidence-based medicine
- expanded access and communication
- care coordination and integration
- care quality and safety.

How the AAFP sees the PCMH

Acronym Police

AAFP

** AAFP American Academy of Family Physicians
*

** AAFP American Association of Feline Practitioners (Hillsborough, NJ))
*

** AAFP American Association of Family Physicians

** AAFP American Academy of Forensic Psychology

** AAFP American Academy of Fixed Prosthodontics
*

** AAFP Alabama Academy of Family Physicians
*

** AAFP Association of Austrian Film Producers (Vienna, Austria)

** AAFP Azalia Analog Front Panel

* AAFP American Association of Football Prognosticators (est. 1969)

Acronym Police

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Acronym Police

PCMH

** PCMH Patient-Centered Medical Home (American Academy of Family Physicians)
*

** PCMH Pitt County Memorial Hospital (Greenville, NC, USA)
*

** PCMH Plea and Case Management Hearing (English criminal law)
*

** PCMH Postgraduate Center for Mental Health
*

** PCMH Professional Certified in Materials Handling (job title)
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* PCMH Placer County Mental Health (Auburn, CA

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Health information technology

Are you taking advantage of these e-prescribing technologies:

- ❑Medication interaction checking
- ❑Allergy checking
- ❑Dosing alerts by age, weight, or kidney function
- ❑Formulary information

Do you have these evidence-based medicine supports in place:

- ❑Templates to guide evidenced-based treatment recommendations
- ❑Condition-specific templates to collect clinical data
- ❑Alerts when parameters are out of goal range

Health Information Technology

Does your practice use a registry to facilitate:
Population health management
❑Individual health management
❑Proactive care
❑Planned care visits

Do you have the access you need to these clinical decision support tools?
Point-of-care answers to clinical questions
❑Medication information
❑Clinical practice guidelines

Is your practice connected to the health care community in these important ways?
❑Internet access
❑Quality reporting tools

Patient Experience

Which of the following are you using to improve your patients' access to care?

- ❑Same day appointments
- ❑Email
- ❑Web portal for Rx, appointments, or information
- ❑Referral to online resources
- ❑Non-visit based care and support

Does your practice support patient self-management through:

- ❑Motivational interviewing
- ❑Shared goal-setting
- ❑Home monitoring (when appropriate)
- ❑Group visits and support groups
- ❑Family and caregiver engagement

Patient Experience

Clear communication requires:

- ❑Patient language preference
- ❑Cultural sensitivity
- ❑Active listening
- ❑Plain language, no jargon
- ❑Patient satisfaction surveys

Do you and your patients share in the decision-making process by:

- ❑Discussing treatment options in an unbiased way
- ❑Considering the patient's priorities
- ❑Creating and revisiting follow-up plan

Quality Measures

Are you using these clinical information systems:

- ❑Registries
- ❑Referral tracking
- ❑Lab result tracking
- ❑Medication interaction alerts
- ❑Allergy alerts

Your practice is a culture of improvement if you and your staff:

- ❑Establish core performance measures
- ❑Collect data for better clinical management
- ❑Analyze the data for quality improvement
- ❑Map processes to identify efficiencies
- ❑Discuss best practice

Quality Measures

Does your practice use these checklists and reminders?

- ❑Evidence-based reminders
- ❑Preventive medicine reminders
- ❑Decision support

Do your care plans reflect:

- ❑An updated problem list?
- ❑A current medication list?
- ❑Patient-oriented goals and expectations

Practice Organization

Rigorous financial management is essential. Are you:

- ❑Budgeting for forecasting and management decisions
- ❑Contracting with health plans from a selective and informed position
- ❑Managing the practice's cash flow
- ❑Staying on top of accounts receivable

Does your practice offer individuals and teams opportunities for development through:

- ❑Ongoing education
- ❑Leadership training
- ❑Team meeting

Practice Organization

Does your practice offer individuals and teams opportunities for development through:

- ❑Roles and responsibilities that are stimulating and rewarding
- ❑Shared vision and responsibility for quality of care
- ❑Value for the contributions of all individuals

Does the practice rely on data to drive decisions to:

- ❑Continuously improve quality and efficiency
- ❑Monitor supply and demand
- ❑Ensure adequate and fair distribution of work

The Maryland Multi-payer Pilot (MMPP)

Practices that join the pilot will test a new care delivery and reimbursement model.

Reimbursement will be based on

- fee-for-service,
- care coordination payments, and
- performance bonuses derived from savings generated by the practice.

Over time, the pilot is expected to:

- improve quality of access and care coordination for patients
- increase physicians satisfaction with their practices' work style
- decrease costs of care by eliminating unnecessary emergency department visits and reducing avoidable hospital stays and readmissions.

- **Appendix C**
- **Care Manager Roles and Responsibilities**
- For a specific, identified population of participating patients, the Care Manager is expected to fulfill the following functions:
- 1. Population Management:
- a. In conjunction with the Practice team, identify participating patients at risk for poor outcomes, those in transition from hospital to home or from skilled nursing home to home, and those experiencing poor coordination of services who would benefit from more intensive follow-up.
- b. Provide proactive outreach, including telephonic and face-to-face encounters in the home or clinical setting.
- c. Identify participating patients in need of disease management intervention.
- d. Prioritize patient follow-up based on care management assessment and risk stratification.

- 2. Care Review and Planning:
- a. Complete a structured assessment of medical, biopsychosocial support and self-management support needs.
- b. Work collaboratively with the primary care provider and other staff at the Practice Site to develop an individualized plan of care that identifies goals and targeted interventions for all patients in care management.

- 3. Care Coordination:
- a. Provide transition of care management and act as liaison to hospital, long-term care, specialty, home health services and other community-based services for high-risk care managed participating patients.
- b. Maintain ongoing appropriate documentation on care coordination to promote Practice team awareness and ensure patient safety and follow through on the care plan.
- c. Assist participating patients in problem-solving potential issues related to the health care system, financial, and psychological barriers.
- d. Function as the system navigator and point-of-contact for high-risk participating patients and family, with the patient and family having direct access for asking questions and raising concerns.
- e. Ensure open communication regarding patient interactions with physicians and office staff.
- f. Help participating patients with problems in arranging referrals, screenings, and test procedures.
- g. Screen and refer as appropriate for depression and other psychological treatments.

h. Assume an advocacy role on the participating patient's behalf with the Carrier to coordinate benefit management for appropriate supplies and services for the patient in a timely fashion.
i. Identify and utilize cultural and community resources; establish and maintain relationships with identified service providers.
j. If a patient is assigned to a case manager at a Carrier, coordinate patient care with the Carrier's case manager.

4. Follow Up:
a. Provide medication management, including medication reconciliation and making recommendations to primary care providers for medication changes based on evidence-based protocols.
b. Collaborate with the Participating Practice's clinicians to establish and update a shared care plan.
c. Provide support for improving health behaviors and self-management skills - Goal Setting, Action Planning, and Problem Solving.
d. Provide more intensive follow-up during care transitions and other high-risk periods.
e. Provide information and education regarding screenings and diagnostic test results.

5. System Development:
a. Care Managers play an important role in supporting quality improvement for chronic care, such as participating in and supporting planned individual and group visits, and development of new forms and procedures.
b. Care Managers play a key role in providing clinical and self-management support training to non-RN and other Practice staff, as needed.

NCQA

Acronym Police

- PCP
- PCMH
- NCQA
- MMPP
- AAFP

Acronym Police

NCQA

- National Committee for Quality Assurances
- North Carolina Quality Award
- National Council on Quality Assessment
- National Committee on Quality Accreditations
- National Commission on Quality Assessment
- National Committee for Quality Assurance
- National Council on Quality Assurance
- National Center for Quality Assistance

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Acronym Police

MMPP

- Markov-Modulated Poisson Process
- Magnesium Monoperoxyphthalate
- Moscow Machine-Building Production Association (Russia aero engine manufacturer)
- Multi-Mode Pipe Projector
- Maryland Multi-Payer Pilot
- Multiple-Message-Per-Process

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MHCC

- Maryland Health Care Commission
- Mount Hood Community College
- Mental Health Coordinating Council
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- Memorial Hospital of Converse County
- Mental Health Consumer Concerns
- Maryland Heights Chamber of Commerce

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NCQA

Mission

- To improve the quality of health care

Vision

- To transform health care through quality measurement, transparency, and accountability

NCQA

- Standard 1: Access and Communication
- Standard 2: Patient Tracking and Registry Functions
- Standard 3: Care Management
- Standard 4: Patient Self-Management Support
- Standard 5: Electronic Prescribing
- Standard 6: Test Tracking
- Standard 7: Referral Tracking
- Standard 8: Performance Reporting and Improvement
- Standard 9: Advanced Electronic Communications

NCQA

Development Goals for Physician Practice Connections (PPC)

- Evaluate systematic approach to delivering preventive and chronic care (Wagner Chronic Care Model)
- Build on IOM's recommendation to shift from "blaming" individual clinicians to improving systems
- Create measures that are actionable for physician practices
- Validate measures by relating them to clinical performance and patient experience result

NCQA's New Medical Home Standards

- Emphasis on patient-centeredness and patient experience of care
- Reinforces incentives for meaningful use (HIT)
- Focuses attention on aspects of primary care that improve quality and reduce cost
- Based on advances in evidence and changes in practice capability

NCQA PCMH 2011

6 Standards, 27 Elements, 149 Factors

Points	Standard and Element	No. Factors	Must Pass 50% score
20	**1 Enhance Access and Continuity**	34	
4	A Access During Office Hours	4	X
4	B Access After Hours	5	
2	C Electronic Access	6	
2	D Continuity	3	
2	E Medical Home Responsibilities	4	
2	F Culturally and Linguistically Appropriate Services (CLAS)	4	
4	G Practice Organization	8	
17	**2 Identify and Manage Patient Populations**	35	
3	A Patient Information	12	
4	B Clinical Data	9	
4	C Comprehensive Health Assessment	10	
5	D Using Data for Population Management	4	X
17	**3 Plan and Manage Care**	23	
4	A Implement Evidence-Based Guidelines	3	
3	B Identify High-Risk Patients	2	
4	C Manage Care	7	X
3	D Manage Medications	5	
3	E Electronic Prescribing	6	
9	**4 Provide Self-Care and Community Support**	10	
6	A Self-Care Process	6	X
3	B Referrals to Community Resources	4	
18	**5 Track and Coordinate Care**	25	
6	A Test Tracking and Follow-up	10	
6	B Referral Tracking and Follow-up	7	X
6	C Coordinate with Facilities/Care Transitions	8	
20	**6 Measure and Improve Performance**	22	
4	A Measures of Performance	4	
4	B Patient/Family Feedback	4	
4	C Implements Continuous Quality Improvement	4	X
3	D Demonstrates Continuous Quality Improvement	4	
3	E Performance Reporting	3	
2	F Report Data Externally	3	
100 Points		**149 Factors**	**6 MP Elements**