

# Patient-Centered Medical Homes

Creating a Culture of Quality Through PCMH

MARHC June 2023



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The Compliance Team

## Learning Objectives

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- | Define Quality
- | Understand the PCMH Model of Care
- | Identify ways to stay current in the healthcare field.

## What is Quality?



The standard of something as measured against other things of a similar kind; the degree of excellence of something.

- Better Results
- Better Care
- Smarter Spending
- Healthier Populations



*Lagniappe (lan-yap): above and beyond measure; a gift given to a customer by a merchant at the time of purchase or service.*

# The Future

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*Vision: A health care system that achieves equitable outcomes through high quality, affordable, person-centered care.*

## Measuring Progress:

- All Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

<https://innovation.cms.gov/strategic-direction>

# Building Your Foundation



- Patient-Centered Medical Home (PCMH) Accreditation
- Chronic Care Management Services
- Participate in payer incentive programs
- Start measuring quality improvement TODAY!
- HUDDLES
- Wellness Visits!



# The Challenges



## Some PCMH Programs can be...

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

## Rethinking PCMH

- Anything taking you away from patient care is heading in the wrong direction!
- Primary focus should be centered around patient care.
- Efficiency in daily operations allows providers to concentrate on “What Matters Most” to the patient!







Things do not get better  
by being left alone.

Winston Churchill

“ quote fancy

## Summary of Standards

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- PCMH 1.0 The organization utilizes a team-based approach for patient-centered coordinated care.
- PCMH 2.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care 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.

## Team Based Coordinated Care

Providers, Nurses, Assistants,  
Clerical, family members,  
Pharmacists, and community  
resources...

Everyone Working Together to  
Improve Overall Care



## Care Coordination

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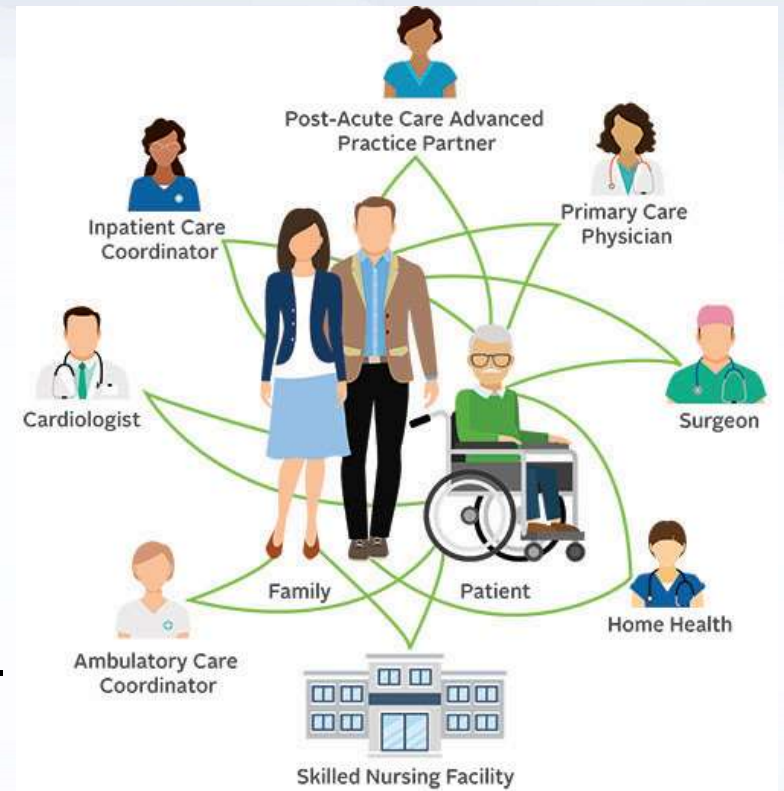
When care is coordinated well, the patient and his or her doctors, nurses, other health care providers, family, and other caregivers communicate with each other so that everyone has the information they need.

Care coordination programs can improve patients' experiences with the health care system and their health outcomes as well as reduce wasteful spending in the long run.



## When Care Needs to be Coordinated

- Follow up after discharge from the Emergency Department
- Care between PCP and specialists
- Transitions between “home” and facilities (SNF, inpatient hospital stays)
- When social services need to be coordinated.
- After labs or diagnostic screenings
- When new or complex medications are prescribed





The Art  
of the  
Huddle

 **The  
ComplianceTeam**

# Huddle Checklist

Team Huddle Checklist	
<i>Use this modifiable checklist to lead your team through efficient, effective huddles at the beginning of the clinic day or session.</i>	
Date:	Start time:
Huddle leader:	
Team members in attendance:	
Check in with the team	
	How is everyone doing?
	Are there any anticipated staffing issues for the day?
	Is anyone on the team out / planning to leave early / have upcoming vacation?
Huddle agenda	
	Review today's schedule
	Identify scheduling opportunities <ul style="list-style-type: none"> <li>• Same-day appointment capacity</li> <li>• Urgent care visits requested</li> <li>• Recent cancellations</li> <li>• Recent hospital discharge follow-ups</li> </ul>
	Determine any special patient needs for clinic day <ul style="list-style-type: none"> <li>• Patients who are having a procedure done and need special exam room setup</li> <li>• Patients who may require a health educator, social work or behavioral health visit while at the practice</li> <li>• Patients who are returning after diagnostic work or other referral(s)</li> </ul>
	Identify patients who need care outside of a scheduled visit
	Determine patient needs and follow up <ul style="list-style-type: none"> <li>• Patients recently discharged from the hospital who require follow up</li> <li>• Patients who are overdue for chronic or preventive care</li> <li>• Patients who recently missed an appointment and need to be rescheduled</li> </ul>
	Share a shout-out and/or patient compliment
	Share important reminders about practice changes, policy implementation or downtimes for the day
	End on a positive, team-oriented note <ul style="list-style-type: none"> <li>• Thank everyone for being present at the huddle</li> </ul>
	Huddle end time:

Source: AMA. Practice transformation series: implementing a daily team huddle. 2015.



- Stand up
- Meet 15 minutes before 1<sup>st</sup> patient arrives
- Be consistent
- Check in and announcements
- Use visuals-Post agenda
- Preview Patients
- Identify potential challenges/concerns
- Keep meeting short
- Be courteous and respectful
- Thank the team
- Close the huddle

# Huddles

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## Did you BRUSH and FLOSS this morning??

**B-** Be on time

**R-** Review schedule (Cancelled appointments, availability, ED or hospital follow-ups)

**U-** Use staff wisely. Roles are reviewed. Who is training? Who is doing call backs? Discharging?

**S-** Special needs (interpreters, service animals, problematic, require extra time, etc.)

**H-** Health Screenings. Who needs PHQ, , mammogram, colorectal cancer screening, labs, etc.

**F-** Feeling. How is staff feeling? Anyone not well?

**L-** Leaving. Is anyone leaving early or coming in late?

**O-** Is anyone out all day? How will we cover?

**S-** Support each other.

**S-** Success depends on how the day begins and how well everyone works together.

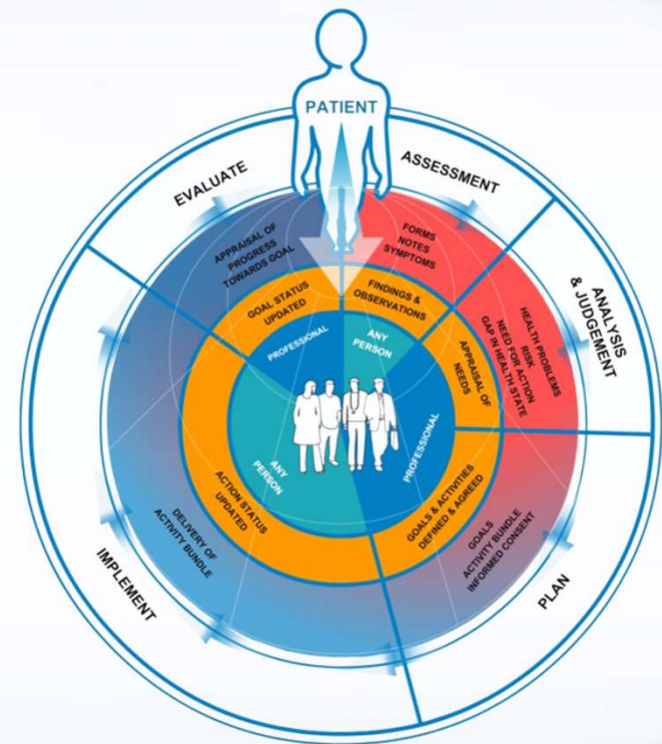


## PCHIP™ Patient Centered Health Improvement Plan™

### What is a PCHIP™?

A plan of Medical Care and support which...

- is unique to each patient and their specific needs
- is culturally and linguistically sensitive
- addresses the social determinants of health
- respects the patient's goal for optimal well-being



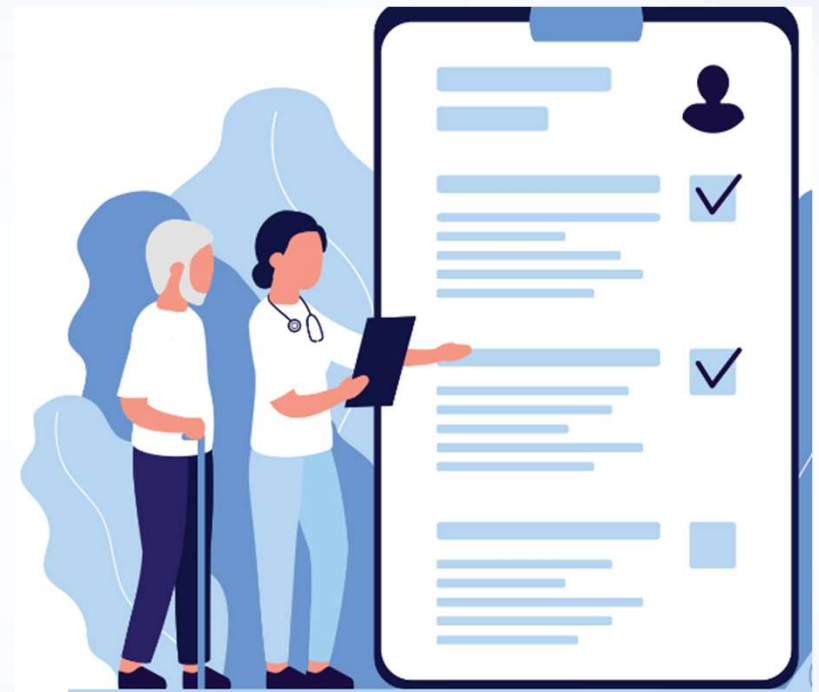
### Helpful Tips

PCHIPs are for patients that you identify as high risk. Not all patients require a PCHIP.

## Components of a PCHIP

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- Patient-Centered Goal that is measurable.
- Barriers to the goal.
- Interventions for those barriers.
- Outline of support system.
- Updated medication list.
- Diagnoses and symptom management.
- Community/social services available.
- Upcoming appointments
- How to contact the clinic during and after business hours.

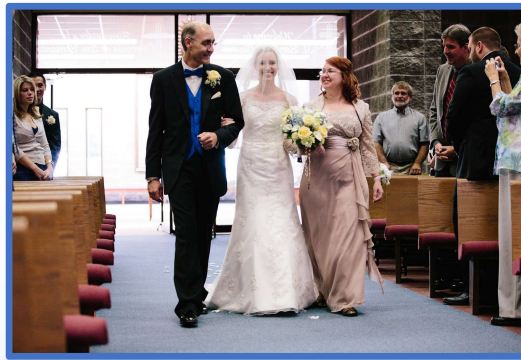


## Example: Patient Centered Goals

Patients' goals aren't always our goals.

What matters most to the patient?

What can be done to help them live their best life now?



# Patient Education and Engagement

**QUIT TOBACCO.  
ONCE AND FOR ALL.**



**HERE'S THE DEAL:**  
Quitting tobacco is one of the best things you can do for yourself. It isn't easy, but you can do it and we're here to help.

**Join us**  
Tuesday evenings 6pm  
Beginning March 29, 2022  
New 4-week series!  
3/29, (skip 4/5), 4/12, 4/19, 4/26

WITH SUPPORT AND EDUCATION, WE'LL HELP YOU TAKE A BIG STEP TOWARD BETTER HEALTH.

Presented by the Kaufman Cancer Center and UM Upper Chesapeake Health Community Outreach  
**CALL 800-515-0044 TO REGISTER**  
Information on how to obtain nicotine replacement products will be shared at our first class.

UNIVERSITY of MARYLAND UPPER CHESAPEAKE HEALTH **UMUCH.ORG**



Build a resource library of Patient Education tools that all providers can access.

FOR CHILDREN AND ADULTS!

**GET CONTROL OF YOUR DIABETES**

YOUR GOAL HBA1C:

HEALTH CARE PROFESSIONAL'S NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

**GREEN ZONE: ALL CLEAR!** *Green Zone Means:*

- ✓ HbA1c under 7
- ✓ Blood sugar under 154
- ✓ Fasting blood sugar usually between 70-130.

- ✓ Your blood sugar is under control.
- ✓ Keep taking your medications as directed by your doctor.
- ✓ Keep checking your blood sugar.
- ✓ Eat a variety of healthy foods.
- ✓ Keep all your medical appointments.

**YELLOW ZONE: CAUTION!** *Yellow Zone Means:*

- ✓ HbA1c between 7 and 8
- ✓ Average blood sugar over 180
- ✓ Fasting blood sugar sometimes over 130

- ✓ Your medications may need to be adjusted.
- ✓ Make sure you're eating the right foods in the right amounts.
- ✓ Be more active. Walk, run, dance, play, work out — just get moving.
- ✓ If your blood sugar does not go down, call your health care professional!

*Work closely with your health care team if you're in the YELLOW zone.*

**RED ZONE: DANGER!** *Red Zone Means: See your health care professional.*

- ✓ HbA1c greater than 8
- ✓ Blood sugar over 212
- ✓ Fasting blood sugar often over 130

IF YOUR BLOOD SUGAR IS HIGHER THAN: \_\_\_\_\_

DO THIS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Call your health care professional if you're in the RED Zone!*

Arkansas Diabetes Control Standards of Medical Care in Diabetes — 2011 Diabetes Care 34(11):1449-1458

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

## Advanced Access

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Providing the right care at the right time and the right place!



## Meeting the Needs

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- ❑ Same day appointments for urgent illness;
- ❑ Evidence of expanded weekday, evening, and/or weekend appointment offerings; and
- ❑ Call coverage or arrangement for after-hours emergencies twenty-four hours a day and seven days a week.

**The U.S. could save \$67 billion (with a B) each year if everyone used a primary care provider as their principal source of care. Every \$1 increase in primary care spending produces \$13 in savings!**

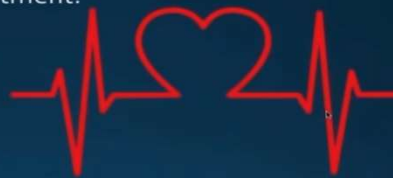
<https://www.medicaleconomics.com/view/delivering-value-healthcare-starts-increased-primary-care-investment>

# Reducing Cost

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## What Happens at the Emergency Department?

- Emergency Department Team's job is to stabilize you and move you to either inpatient or outpatient care.
- Manage Expectations - Not likely to fix/solve a problem in one go.
- Know when to go to the Emergency Department:
  - Heart Attack/Stroke treatment
  - Broken Bones set
  - Dislocations reduced
  - Lacerations stitched
  - Life threatening situation
- Know when to seek care in Primary Care or Urgent Care clinic:
  - Sprains, strains, subluxations
  - Non life threatening situations
  - Fluids



## Helpful Tips

Signage in exam rooms can prompt discussions about calling PCMH before going to the ER

Teach patients about the appropriate use of the ER

## Patient Health Records

- Advanced Directives
- Depression Screenings
- Cognitive Screenings
- Preventive Health measures
- Needs Assessment
- Patient Goals
- Lab/Diagnostic follow-up
- After-visit Summary and Instructions





## Social Determinants of Health

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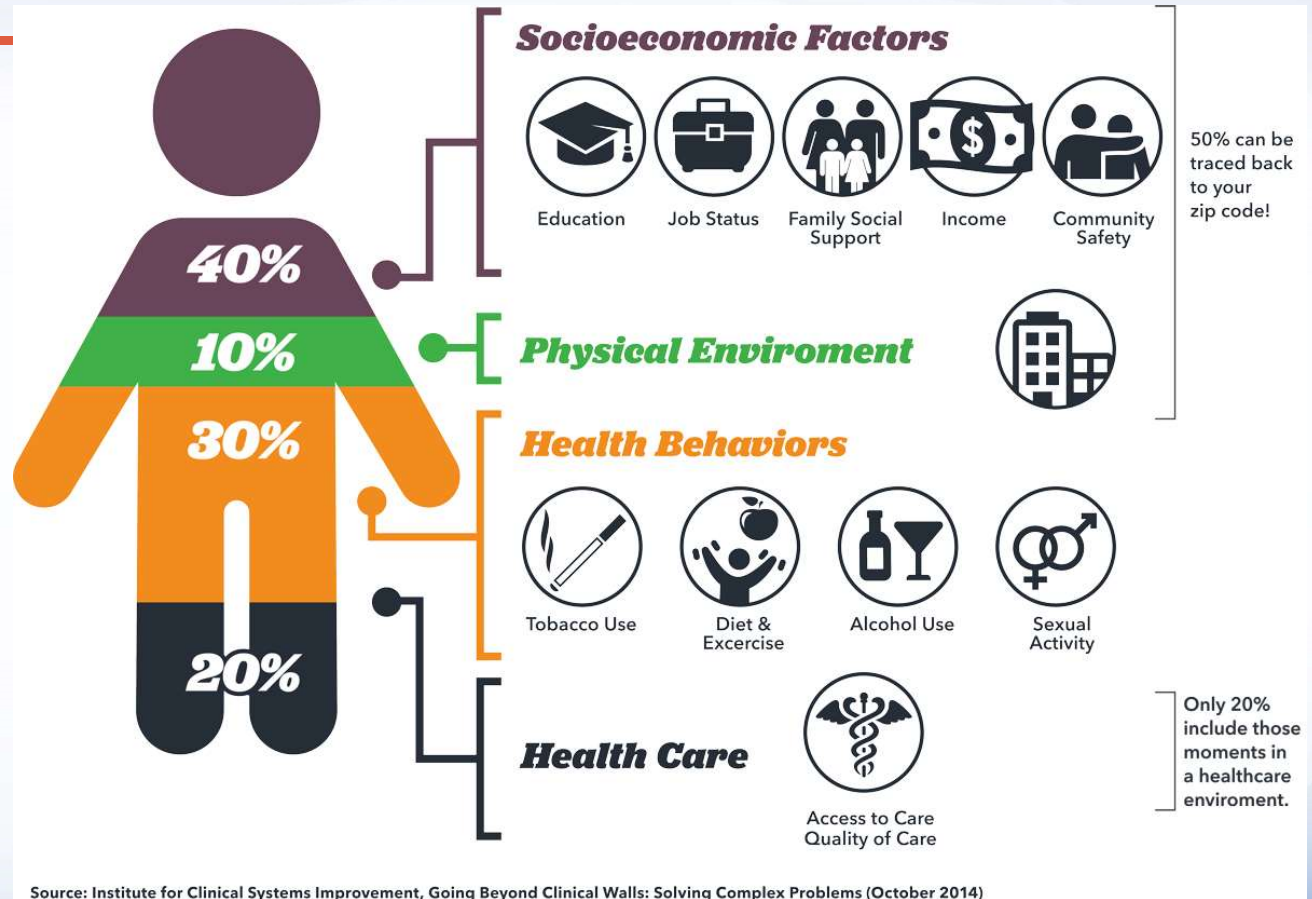
### QUESTION:

What percentage of a person's overall health is determined by what happens in the healthcare setting?



# SDOH

80% of what makes up someone's health is determined by what happens outside of the clinic or hospital.



<https://noahhelps.org/sdoh/>

PHYSICAL HEALTH		
Do you have any health concerns today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain:		
Have you been to the ER or hospitalized in the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain:		
Do you need help managing any of the following:		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Weight	
<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Diet and/or Exercise	
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Quitting Smoking	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pain	
<input type="checkbox"/> COPD	<input type="checkbox"/> Other-	
<input type="checkbox"/> Medications		

MY CONCERNS	
Select any problems or concerns that you are currently facing as you manage your health:	
<input type="checkbox"/> Thinking/memory problems	<input type="checkbox"/> Emotional issues
<input type="checkbox"/> Spiritual support	<input type="checkbox"/> Family Issues
<input type="checkbox"/> Financial Issues	<input type="checkbox"/> Housing
<input type="checkbox"/> Fear for physical safety	<input type="checkbox"/> Find a healthy lifestyle hard/ overwhelming
<input type="checkbox"/> Access to nutritious food	<input type="checkbox"/> Transportation to appointments
<input type="checkbox"/> End of life issues	<input type="checkbox"/> Mobility issues
<input type="checkbox"/> My ability to manage my chronic conditions	<input type="checkbox"/> Other:
<input type="checkbox"/> Social support - friends	

MENTAL HEALTH		
Do you have any mental health concerns today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain:		
Do you need help managing any of the following:		
<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety / Social Anxiety	
<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Alcohol consumption	
<input type="checkbox"/> Drug Use	<input type="checkbox"/> Prescription medication use	
<input type="checkbox"/> Lack of motivation	<input type="checkbox"/> Exhaustion	
<input type="checkbox"/> Thoughts of harming yourself	<input type="checkbox"/> Processing a traumatic event/ PTSD/ Unresolved childhood trauma	
<input type="checkbox"/> Thoughts of harming others	<input type="checkbox"/> Nightmares/ Night terrors	
<input type="checkbox"/> Other:		

GOALS	
Which of the following health goals would improve your quality of life:	
<input type="checkbox"/> Consistent control of blood sugars	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Normal blood pressure	<input type="checkbox"/> Lower cholesterol
<input type="checkbox"/> Heart Health	<input type="checkbox"/> Increased energy
<input type="checkbox"/> Able to manage stress well	<input type="checkbox"/> Minimal symptoms of depression
<input type="checkbox"/> Eliminate anxiety / panic attacks	<input type="checkbox"/> Reach a fitness goal (ex: run a 5K, join a recreational sports team, etc.)
<input type="checkbox"/> Achieve / Maintain sobriety	<input type="checkbox"/> Maintain consistent healthy and clean eating habits
<input type="checkbox"/> Other:	

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

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## Needs Assessment

- Who gets one?
- How often?
- Is staff trained to assess and address?
- What is your follow-up?

## Patient Satisfaction Surveys

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*“Utilizing the patient satisfaction survey and handling complaints has brought awareness to the management team on how to improve and streamline our procedures and workflow.” Brooks Rizzo, FNP-BC, C-RHCP, Sunflower Clinic  
Director MS*

# PCMH Benefits to the Patient



## 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



# PCMH Benefits to 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.

# PCMH Benefits to the Practice

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As a TCT **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!

# Missouri's Model

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MO HealthNet's Primary Care Health Home (PCHH) initiative strives to provide intensive care coordination and care management as well as address social determinants of health for a medically complex population.

One aspect of the program includes the implementation and evaluation of the **Patient Centered Medical Home (PCMH)** model as a means to:

- achieve accessible, high quality primary care;
- demonstrate cost-effectiveness in order to validate and support the sustainability and spread of the model, and
- support primary care practices by increasing available resources and improving care coordination thus improving the quality of clinician work life and patient outcomes.

The MO HealthNet PCHH initiative currently has more than 40 participating organizations with over 160 clinic sites. The PCHH initiative offers comprehensive care management services for Medicaid participants who have two or more chronic health conditions including asthma/COPD, developmental disabilities, diabetes, heart disease, obesity and tobacco use). The program also emphasizes the integration of primary care and behavioral health care in order to achieve improved health outcomes.

**PMPM \$64.68**



# Testimonials

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- *“Since we transitioned from NCQA to accreditation with The Compliance Team in 2021, our staff are able to spend more time on meaningful interactions and less time checking boxes. They are more engaged in providing patient centered care and better able to understand the Importance of PCMH for our patients!” -Sarah Matlock, Director of Care Coordination CMH*
- *“Being an accredited Patient Centered Medical Home has put the patient at the very core of our practices. While seeing our patients, we have improved workflows to look at all aspects of the patient’s health, not just their chief complaint for that visit. We are ensuring that they have established goals, have enhanced after-hours access to their healthcare providers, are closing their open care gap opportunities, and that they are receiving the best quality of care. Since being accredited, we’ve noticed that our quality scores have increased, and patient satisfaction has increased as well.” Dawn Eye, Clinic Exec Assistant OCH*

# Preparation Timeline



What is a Realistic Goal for Survey Readiness?

Each clinic is unique, but 90-120 days is average.

## 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



## What is Chronic Care Management?



The non-face-to-face services provided to Medicare beneficiaries who have multiple (2 or more) chronic conditions.

CMS initially patterned this program specifically for PCMHs because they are uniquely prepared to embrace and succeed with the CCM payment.

**You are doing this work. Get paid for it.**



## Financial Rewards of CCM

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G0511	RHC	Care mgt., RHC/FQHC*	\$77.94 (2023)
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- 25 patients ~ \$1,949 per month
- 50 patients ~ \$3,897 per month
- 100 patients ~\$7,794 per month
- 200 Patients ~ \$15,588 per month

# Pay-For-Performance Initiatives

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A way to improve the quality of patient care and incentivize providers' performance.

The medical home model is associated with a reduction of healthcare costs as evidenced through decreased utilization of unnecessary visits to the ED and in-patient stays. This leads to lower PMPM costs.

[Why is Medical Home Important? \(aap.org\)](http://aap.org)

# Quality Improvement



QI consists of actions that lead to **measurable improvement** in services and patient outcomes. **The key is engagement.** Engagement of patients and staff. This will bring great satisfaction to the work they are doing and will result in buy-in.



- 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.

# Example PDSA

Indicator:		Baseline: _____%
		Goal: _____%
Why is this important?		
<b>PLAN</b>		
We plan to:		
We hope this produces:		
Steps to execute the plan include:	Assigned to:	Date to be completed:
<b>DO</b>		
What happened when we ran the test? What did we observe?		
<b>STUDY</b>		
End Result: _____%		
What did we learn/conclude from this cycle? Why was the test successful/unsuccessful?		
<b>ACT</b>		
		Date:
What are our next steps?		
<ul style="list-style-type: none"> <li>○ We are going to adopt this test and _____.</li> <li>○ We are going to adapt this test and repeat for another cycle.</li> <li>○ We are going to abandon this test and start a new initiative.</li> </ul>		

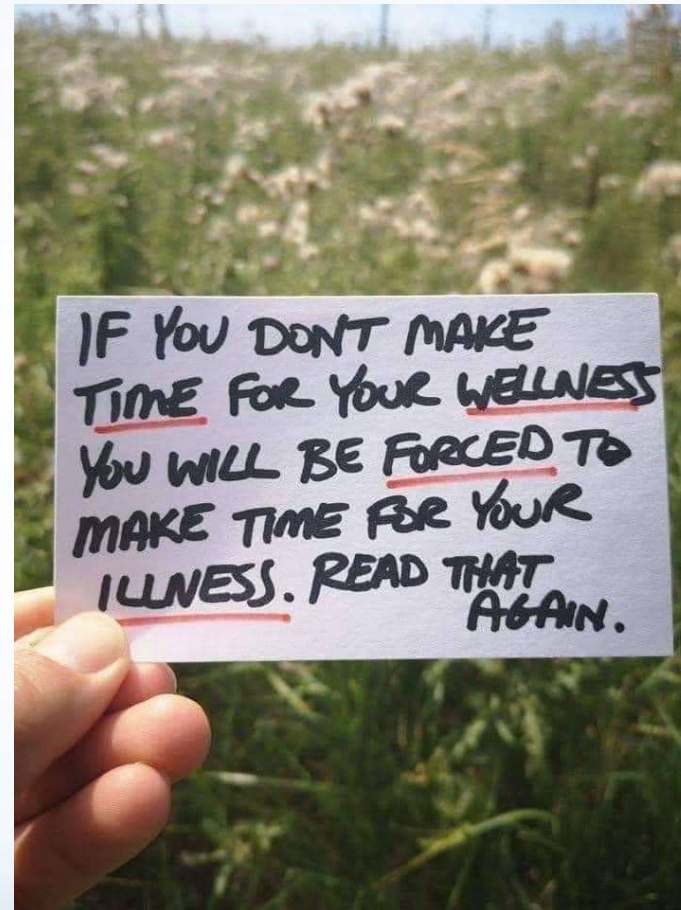
## WELLNESS

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### Why should you do them?

Wellness visits are an efficient way to capture preventive screenings and close care gaps.

Not all of the work has to be done by the provider.





## Who Can Furnish and Bill AWW's

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- Physician
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Medical Professional (including a health educator, registered dietitian or nutrition professional, or other licensed practitioner) or a team of medical professionals working under the direct supervision of a physician.

Non-physicians must legally be authorized and qualified to provide AWW's in the state in which the services are furnished.

# To Recap: Building Your Foundation



- Patient-Centered Medical Home (PCMH) Accreditation
- Chronic Care Management Services
- Participate in payer incentive programs
- Start measuring quality improvement TODAY!
- HUDDLES
- Wellness Visits!



## Resources

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### We are here to help!

Available as part of the accreditation package, TCT has a wide range of tools and 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



# Swing Bed Certification



*Working with TCT, we were able to truly focus on best practices for transitional care. Their outside perspective and in-depth expertise have helped us to develop a comprehensive care program. Swing Bed Certification is essential to validating to the community that we are the best choice for transitional care and right here in their hometown.*

**Kirsten Faessler, MPT**  
COO, Lexington Regional Health Center



**ACCREDITATION.**  
Simplified.

*Swing Bed Certification  
Exclusively from The Compliance Team*

# Accreditation. Simplified.



“Simplification leads to clarity and clarity allows the provider to focus on improving everyday services to their patients and their own bottom lines.”

- Sandra C. Canally, RN, Founder & CEO of The Compliance Team



# QUESTIONS?

Kristen Ogden

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**(417) 631-2942**

The  
ComplianceTeam