An Innovative Model Utilizing the Interdisciplinary Healthcare Team in the Primary Care Patient Centered Medical Home

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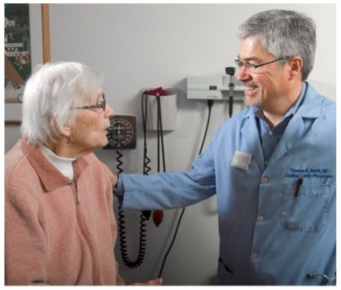

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The Current Healthcare Delivery System is….. Broken

- The costliest 1% of patients consume 1/5 of all health care spending in the U.S.

The Chronically Costly

Trapp, D. (2012) Who are the chronically costly. *American Medical News,* March, 2012

Perhaps now to reframe the issue…..

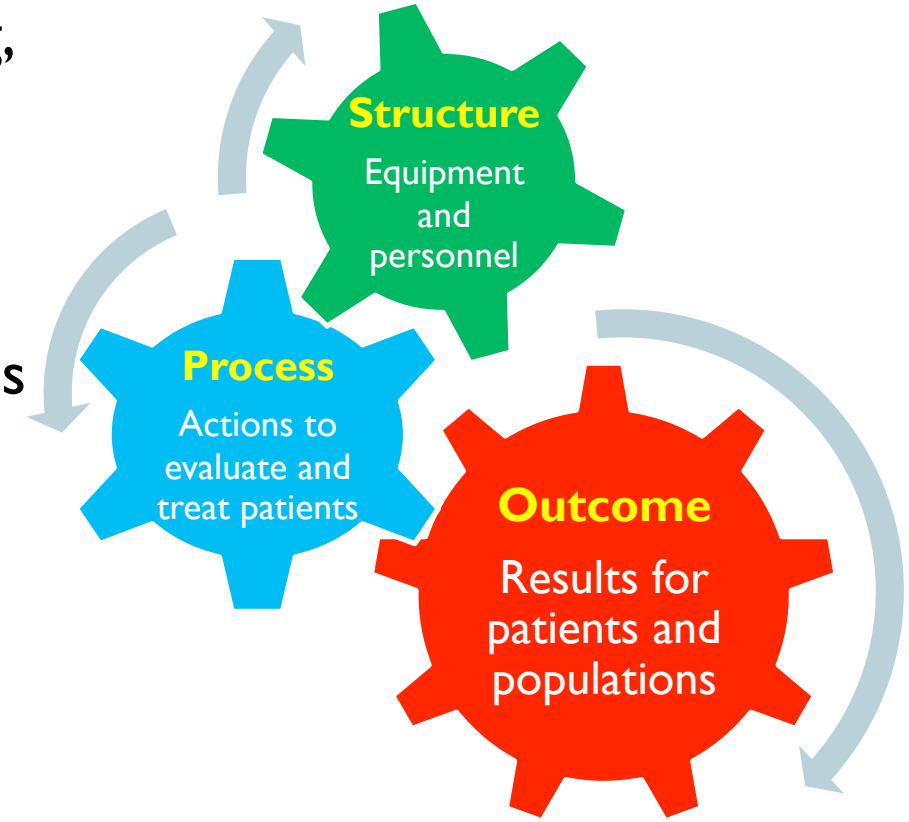
The current healthcare system is…. **Obsolete**

Our world is Changing

Dianne Conrad DNP, RN, FNP-BC

Outcomes--The Donabedian Model

- Structure—how well do we use the tools, setting, providers to deliver care?
- Process—what are the health delivery processes that produce the best care and outcomes?
- Patient Outcomes—ultimately how does structure and process affect the patient and society to improve health?



Donabedian A. (1988). The quality of care: how can it be assessed? *Journal of the American Medical Association, 260*, 1743-1748

NCQA Patient Centered Medical Home Definition: (Process)

- Patient-centered medical home (PCMH) is a model of care where patients have a direct relationship with a provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the care provided to the patient and arranges for appropriate care with other qualified providers as needed.

National Committee for Quality Assurance (NCQA) (2012). PCHM fact sheet. Retrieved from: http://www.ncqa.org/Portals/Public%20Policy/HIMSS_NCQA_PCMH_Factsheet.pdf

Patient-Centered Primary Care COLLABORATIVE

Why the Medical Home Works: A Framework

Feature	Definition	Sample Strategies
Patient-Centered	**Supports patients and families** to manage & organize their care and participate as **fully informed partners** in health system transformation at the **practice, community, & policy** levels	• **Dedicated staff help patients navigate system** and create care plans • **Focus on strong, trusting relationships** with physicians & care team, open communication about decisions and health status, compassionate/culturally sensitive care
Comprehensive	**A team of care providers** is wholly accountable for patient's **physical and mental health** care needs – includes prevention and wellness, acute care, chronic care	• Care team focuses on '**whole person**' and **population health** • Primary care could **co-locate** with behavioral, oral, vision, OB/GYN, pharmacy, etc • Special attention paid to **chronic disease** and complex patients
Coordinated	Ensures care is **organized across all elements** of broader health care system, including specialty care, hospitals, home health care, community services & supports, & public health	• Care is **documented and communicated** effectively across providers and institutions, including patients, primary care, specialists, hospitals, home health, etc. • Communication and connectedness is enhanced by **health information technology**
Accessible	Delivers **consumer-friendly services** with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations	• Implement efficient appointment systems to offer **same-day or 24/7 access** to care team • Use of **e-communications and telemedicine** to provide alternatives for face-to-face visits and allow for after hours care
Committed to quality and safety	Demonstrates commitment to quality improvement through use of **health IT** and other tools to ensure patients and families make informed decisions	• **EHRs, clinical decision support, medication management** to improve treatment & diagnosis. • Establish **quality improvement goals**; use data to monitor & report about patient populations and outcomes

Potential Impacts

Patients are more likely to seek the right care, in the right place, and at the right time

Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated

Providers are less likely to order duplicate tests, labs, or procedures

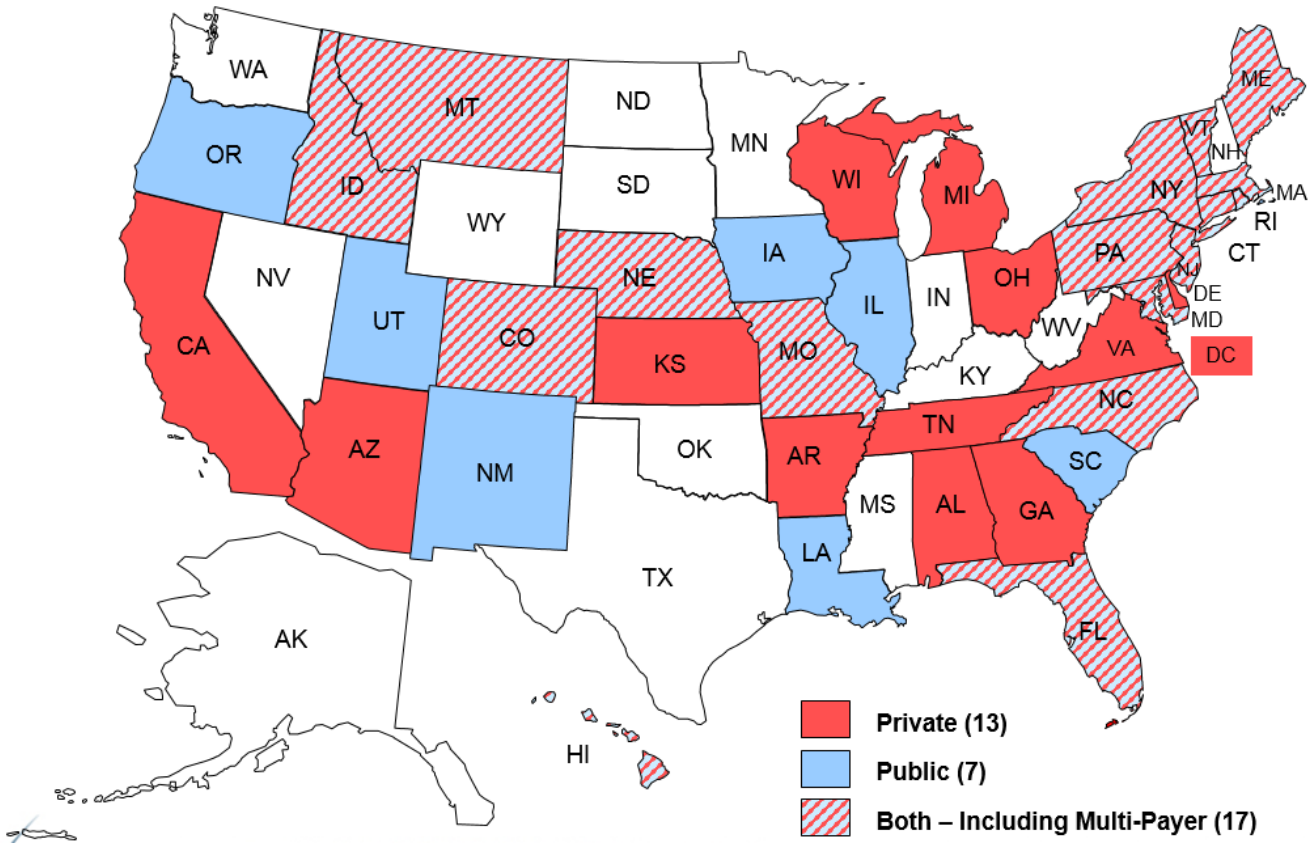
Better management of chronic diseases and other illness improves health outcomes

Focus on wellness and prevention reduces incidence / severity of chronic disease and illness

Lower use of ER & avoidable hospital, tests procedures & appropriate use of medicine = cost savings

Nationwide NCQA PCMH Recognition

37 States* Have Public and Private Patient-Centered Medical Home (PCMH) Initiatives That Use NCQA Recognition



- Over 10 percent of U.S. primary care practices—more than 35,500 clinicians at more than 7,000 practice sites
- Many insurers pay higher reimbursement rates to practices

NCQA (2014). The future of patient-centered-medical homes. Retrieved from: http://www.ncqa.org/Portals/0/Public%20Policy/2014%20Comment%20Letters/The_Future_of_PCMH.pdf

Patient Centered Medical Home: NCQA Key Facets

- Enhanced Access After Hours & On-Line (MU alignment)
- Long-Term Patient and Provider Relationships
- Shared Decision-Making
- Patient Engagement on Health & Healthcare
- Team-Based Care
- Better Quality & Experience of Care (Triple Aim alignment)
- Lower Cost from Reduced Acute Care and ER use (Triple Aim Alignment)

NCQA (2014). The future of patient-centered-medical homes. Retrieved from: http://www.ncqa.org/Portals/0/Public%20Policy/2014%20Comment%20Letters/The_Future_of_PCMH.pdf

NCQA PCMH Levels:

100 Points, 27 Elements, 6 Must-Pass Elements

- Level 1 35-59 points
- Level 2 60-84 points
- Level 3 85-100 points

1. Patient Centered Access
2. Team Based Care
3. Population Health Management
4. Care Management and Support
5. Care Coordination and Care Transitions
6. Performance Measurement and Quality Improvement

National Committee for Quality Assurance (NCQA) (2014). PCHM 2014 Scoring Retrieved from: http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH/PCMH2014ContentandScoringSummary.aspx

Cost of Patient-Centeredness

- Study of 6000 FTE primary care physicians in FQHC (Federally Qualified Health Center) settings
- 10 point increase in PCMH score =

  Increased operating cost of $28,000 per physician
- Conclusion: PCMH concept costs money
- Primary care providers cannot support increased costs unless receive case management reimbursement or benefit from decreased high cost utilization such as ER visits

Nocon, R.S. et al. (2012). Association between patient-centered medical home rating and operating costs at FQHCs. JAMA, e publishes ahead of print. doi.org/10.1001/jama.2012.7048

Blue Cross Patient Centered Medical Homes

- PCMH initiatives across the country in 40 states and the District of Columbia
- More than 5 million members are currently benefitting from care delivered through a BCBS PCMH initiative
- Explore effective means of provider reimbursement with certified B+ PCMH
- Integrate quality improvement, care management and patient educational tools into primary care practices

Blue Cross Blue Shield (2014). PCMH fact sheet. Retrieved from: http://www.bcbs.com/why-bcbs/patient-centered-medical-home/PCMH_FactSheet.pdf

Cost Savings-PCMH in Michigan

Since Blue Cross PCMH designation in 2009

- saved an estimated $155 million in three years, based on prevented claims for care
- averaged about 20 percent lower rates of inpatient admission for patients who had "ambulatory care sensitive conditions." (ie. asthma, high blood pressure, diabetes or children with diarrhea
- higher ratings for care and preventive care services, lower monthly medical cost of $26.37 for adults
- model showed a 12 percent increase in its preventive care rating for pediatric patients

Thoms, S. (2013). Health care cost savings of $155 million estimated for 'patient-centered medical homes,' Blues report. Retrieved from: http://www.mlive.com/business/index.ssf/2013/07/health_care_cost_savings_of_15.html#incart_river_default

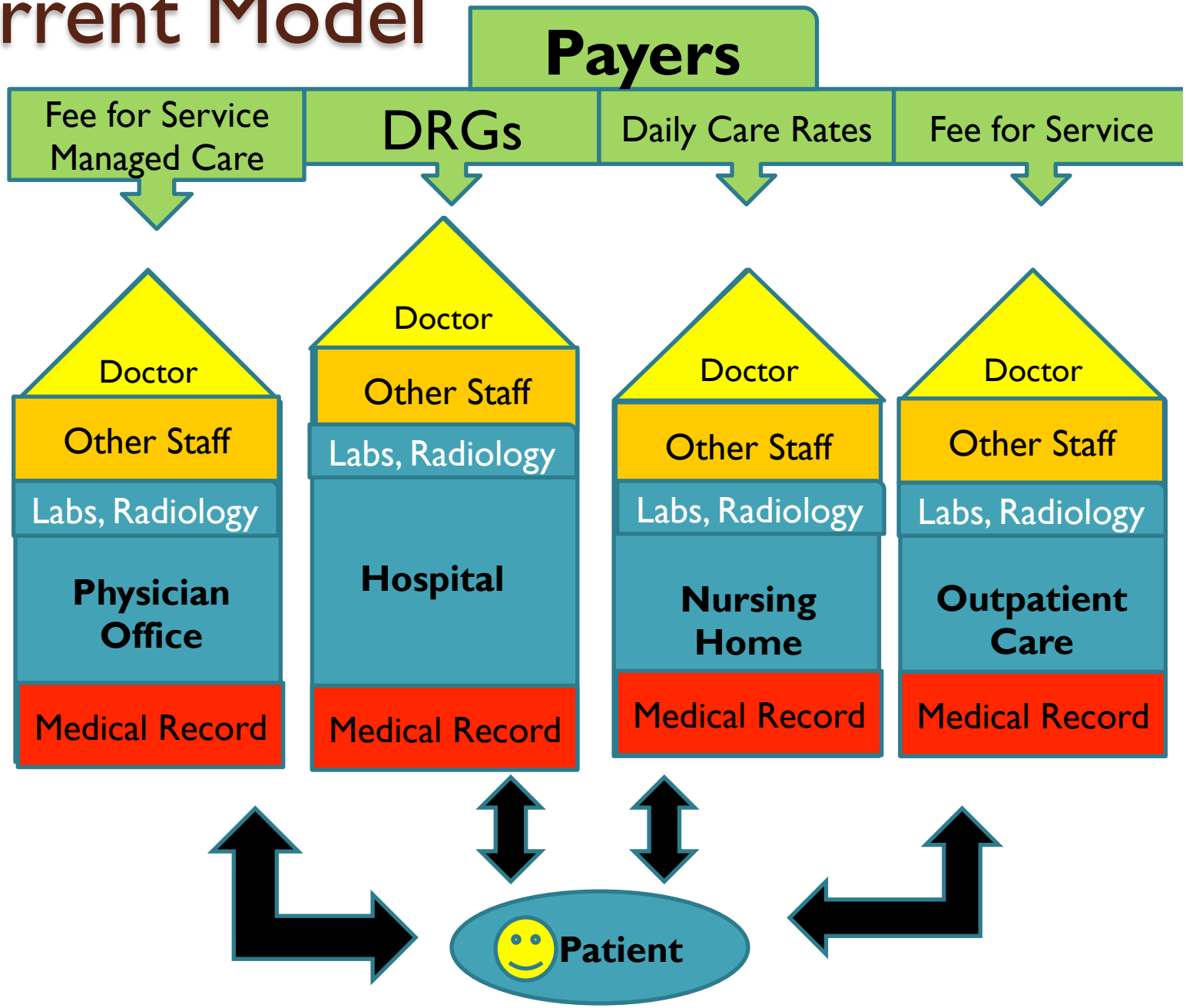
Transition to PCMH for Cadillac Family Physicians, PC

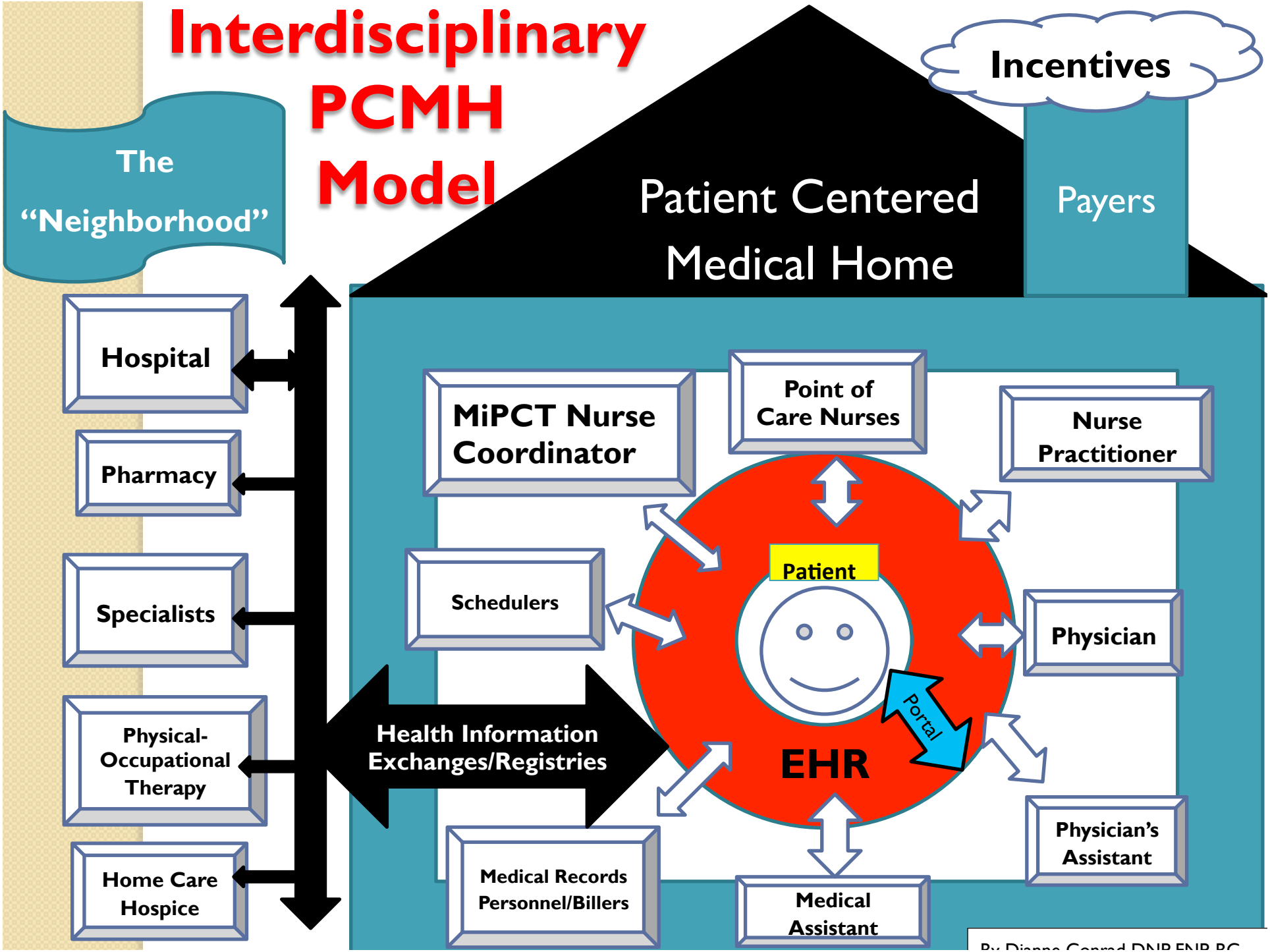
- Pay for Performance began in 2006 with Priority Health.
- Electronic Health Record instituted March, 2005
- Reporting/Alerts in Patient Manager for Point of Care use on Diabetes and other preventative services begun in 2008.
- Evidence Based Care – PGIP with BCBS begun in 2008.
- Wellcentive Patient Registry used in 2008/2009 for PQRI Measures and BCBS designation.
- PCMH Initiatives for BCBS begun in Spring 2009.
- Care Standards for Diabetes set in May 2009.
- PCMH Designation from BCBS for 2009/2010.

Transition to PCMH for Cadillac Family Physicians, PC

- Care Standards for Asthma set in January 2010.
- Huddles begun in Spring 2010.
- Patient Portal begins in Spring 2010.
- AAFP Pilot Quality Improvement Project begun in June 2010.
- NCQA Level 2 Designation in December 2010.
- Care Standards for CHF set in March 2011.
- NCQA Level 3 Recognition in May 2011.
- MU Attestation - Stage 1 - in October 2011.
- MiPCT Partner – January 2012
- MU Attestation- Stage 1, Year 2 & 3 – December 2012 & December, 2013; Stage 2-July, 2014

Current Model




Interdisciplinary PCMH Model
The "Neighborhood"
Patient Centered Medical Home
Incentives
Payers
Hospital
Pharmacy
Specialists
Physical-Occupational Therapy
Home Care Hospice
Health Information Exchanges/Registries
MiPCT Nurse Coordinator
Point of Care Nurses
Nurse Practitioner
Schedulers
Patient
Physician
Portal
EHR
Physician's Assistant
Medical Records Personnel/Billers
Medical Assistant

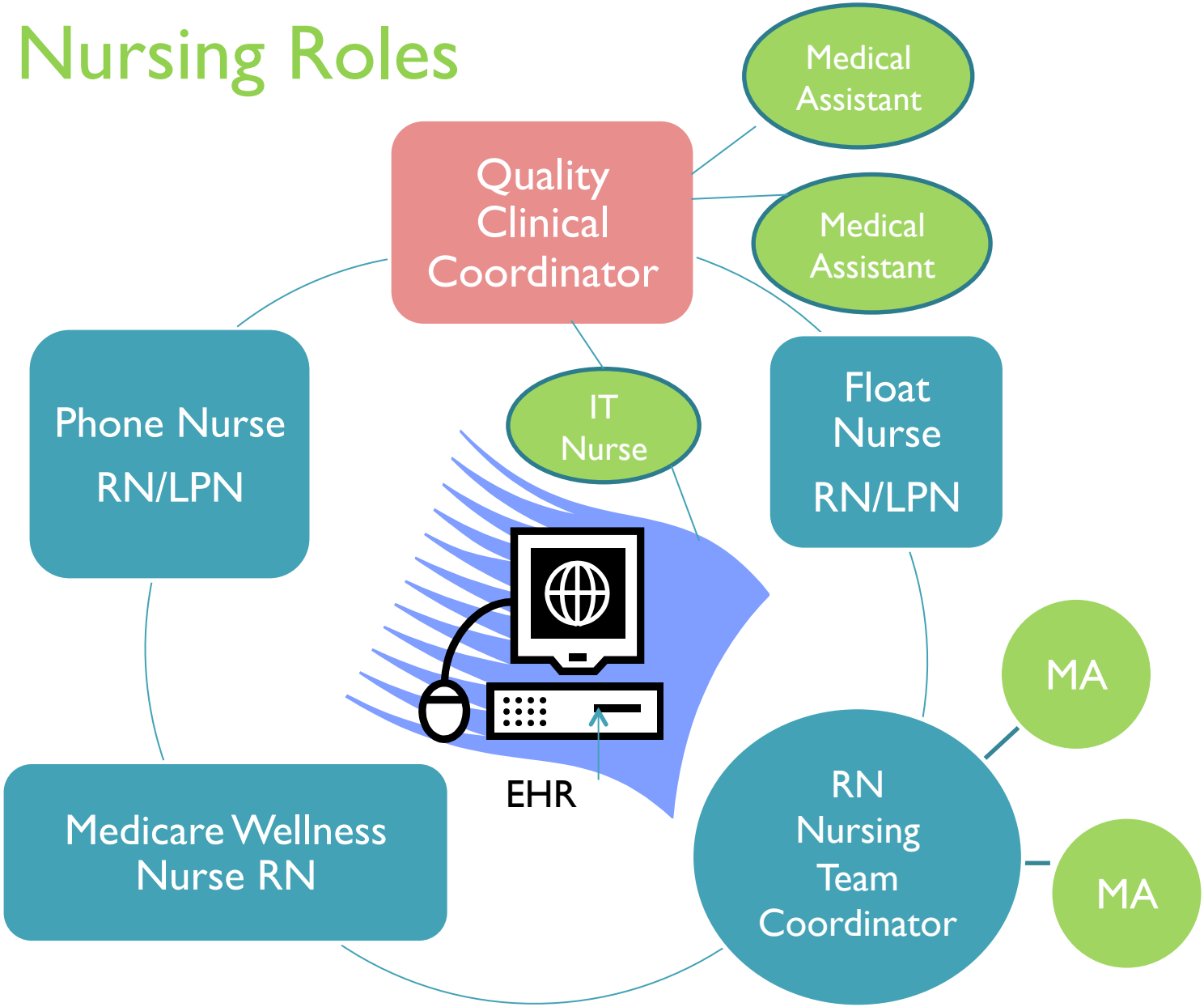
Accountable Care Organizations

Model of Care	Organization	Definition
Accountable Care Organizations (ACO)	Centers for Medicare/ Medicaid (CMS)	A group of providers--potentially including physicians, hospitals, and other post-acute organizations--who are collectively responsible for the total cost and quality of care provided to a panel of patients over a period of time.

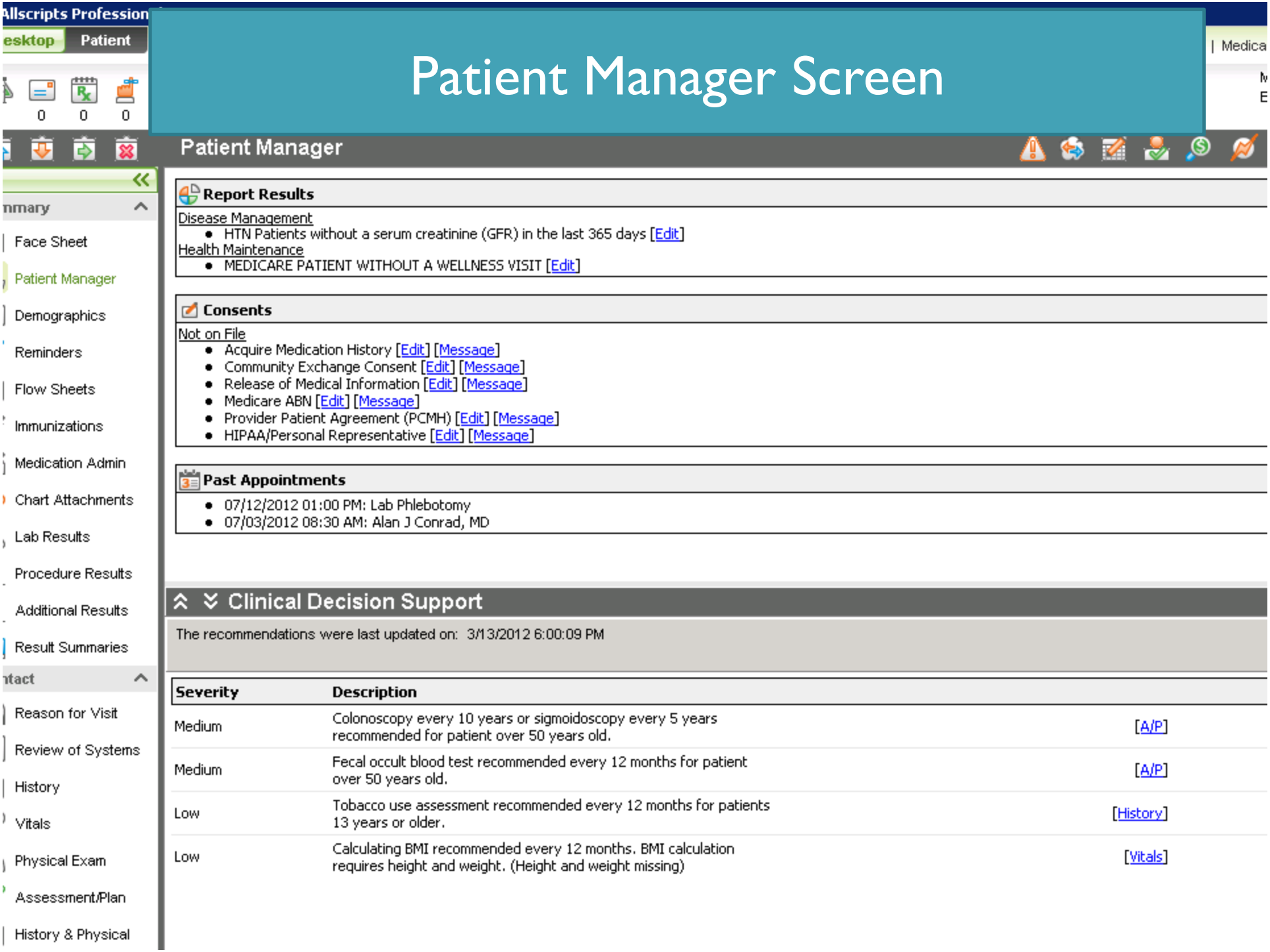
The EHR

- Instituted March, 2005
- Tool for Data Documentation, Data Reporting and Care Coordination
- Linked to scheduling and billing
- Patient Portal
- Linked to outcomes reporting—Registry
- Staff regularly run reports:
  - Care Coordination—Chronic Care Measures outstanding, MCIR, care transitions, same day care (Patient Manager
  - Closing the loop—Procedures, referrals

Nursing Roles



Patient Manager Screen



Point of Care Nurses

- **Initial Medicare Wellness Visit Nurse--RN**

- **Subsequent annual wellness visit now begun**

$106 payment vs
$160 for initial visit

- 650 visits 2011-6/2014
Total Reimbursement =
$106,000

- Provision of Affordable Care Act for Medicare Recipients

- **Cognitive Screening**
- **Depression Screening**
- **Update Immunizations**
- **Risk Factor Identification**
  - Timed Up and Go Test (TUG)
- **Personalized Prevention Plan**—Educational Materials, Council on Aging Info, Advanced Directives

Patient Involvement

- Initial Education and Engagement
  - Brochure explaining PCMH
- Explanation by clinical staff and PROVIDERS understanding PCMH concept
- Contract signed: outlining provider and PATIENT responsibilities in PCMH
- PCMH Standard 5: Support Self-Care and Shared Decision Making

Patient Involvement
Patient Portal

Ability through EHR for patients to:

- Make appointments
- Pay bills
- Email with questions
- Request a refill
- Access lab reports
- Access to Personal Health Record
- Meet requirements for Patient Engagement requirement for Meaningful Use to access provider electronically for clinical information

Cost of EHR Adoption/Maintenance

- Costs of Hardware, Software, IT support, maintenance, staff initial and ongoing training since 2005

= $1.2 million

Incentive Programs-2009-6/2014, = $1.35 Million

MAPCP Demonstration (MIPICT)--Michigan Primary Care Transformation Program . Practice Transformation Payment $2/member/mo (2012-2013)

BCBS PGIP--Physician Group Incentive Program- payment to PHO for participation/ performance improvement in initiatives selected, maximum 4.2% of value of professional reimbursements (E/M codes/Surgical codes)

BCBS PCMH --10% uplift in E/M codes for Level 3 PCHM designation

BCBS Low Cost Provider Uplift

NCQA Priority per member per mo--Incentive program for achieving Level 3 PCMH

PIP **Priority**

Health by Choice Priority--Achieving designated preventative care screening/tx for Priority Health Lifestyle Measures (BMI, B/P, Smoking Status, Lipid/FBS)

Meaningful Use EHR Incentive HiTech Act--Achievement of Stage 1 MU for EHR, now working on Stage 2

Medicare PCIP 10% Incentive, select primary care services (2011-2015)

PQRS Medicare Incentive--Reporting selected quality measures

ERX Medicare Incentive---Ability to transmit as least 10 prescriptions for Medicare recipients in a year (2009-2013)

Medicaid Quality Incentive Performance --selected quality measures for Medicaid recipients

A Nursing Model in the Patient Centered Medical Home: A DNP Project

By: Katie Alfredson

My Degree

- Grand Valley State University, Grand Rapids, MI
- Adult/Older Adult Primary Care
- BSN to DNP

Preparing nurses for practice at the highest levels of our healthcare system

The Question of BSN to DNP

- Lack of experience
- Time for completion
- Cost
- Timely APRN prepared for workforce

BSN to DNP Curriculum

Year 1-2 --Core DNP Courses and 3 Ps (Pathophysiology, Physical Assessment & Pharmacology)

Year 3—Advance Practice Nursing Courses

Year 4—Project and Immersion

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BSN to DNP

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- Rigorous course work
  - Theory
  - Statistics
  - Pharmacology
  - Assessment
  - Pathophysiology
  - Informatics
  - Research
- Clinical requirements
  - 150 clinical hours focused on counseling
  - 100 hours in a specialty setting focusing on transitions of care
  - 500 hours in the primary care setting
  - 400 hours in the DNP role working toward meeting the DNP Essentials

RN-BSN: The experience

- A challenge
- An adjustment
- A new perspective
- Beneficial

Developing the Project

- ID of the phenomenon
- Identifying the site, organizational assessment
- Gathering the committee/other resources
- Developing the project and project plan
- Facilitators/Barriers

DNP Student Approach

- Explore nursing roles in primary care
- Examine the PCMH Nursing Model in action
- Translational Research
- Dissemination of Evidence

Expressed Interest in the Model

- Change from fee for service to quality/ outcomes based reimbursement

- A current lack of resources in the ambulatory setting

Project Deliverables

- An article suitable for publication
- Presenting at a national conference
- Develop a business plan

Last Thoughts

- Healthcare delivery is changing
- Reimbursement will be driven by outcomes
- Understand and constantly update criteria for meeting quality measures.
- Develop workflow processes to identify opportunities and provide quality care
- Use your EHR as a tool to capture and report data and assist in managing care
- Patient involvement occurs throughout process- they are partners in care. There is more emphasis on provider engaging patients electronically.
- Employing nurses and all office staff to help with all these goals…A good investment!
- DNPs to bring best evidence to practice and promote best evidence in practice