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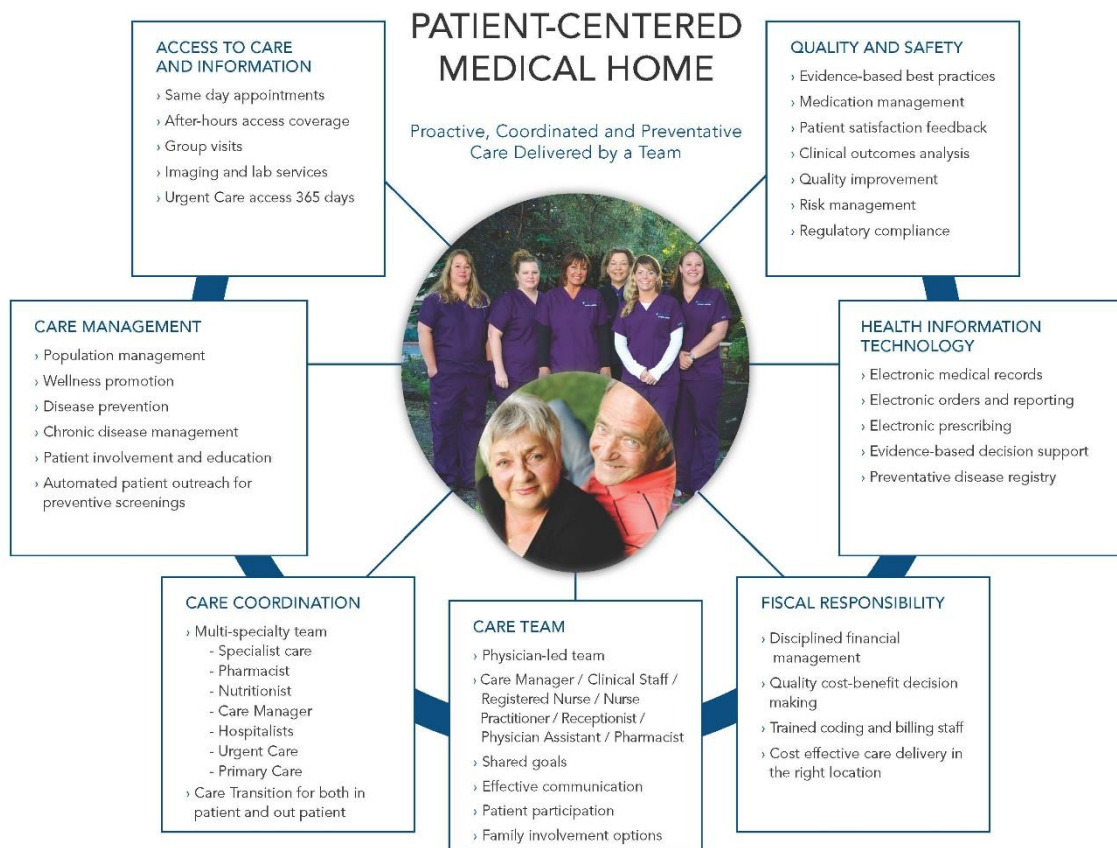Dr. Donald Jurivich
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INTRODUCTION

The patient centered medical home (PCMH) defines a model of primary health care that is different than the traditional clinic concept of a single physician practice. Usual clinical practice revolved around patient symptoms and patients arriving at the doctor's office only when they had a problem (REACTIVE). By contrast, PCMH is team – based healthcare that is both PROACTIVE (regularly scheduled encounters for chronic disease management, wellness and prevention) and REACTIVE (evaluating patients when problems arise).

PATIENT-CENTERED MEDICAL HOME

Proactive, Coordinated and Preventative Care Delivered by a Team

ACCESS TO CARE AND INFORMATION
› Same day appointments
› After-hours access coverage
› Group visits
› Imaging and lab services
› Urgent Care access 365 days

QUALITY AND SAFETY
› Evidence-based best practices
› Medication management
› Patient satisfaction feedback
› Clinical outcomes analysis
› Quality improvement
› Risk management
› Regulatory compliance

CARE MANAGEMENT
› Population management
› Wellness promotion
› Disease prevention
› Chronic disease management
› Patient involvement and education
› Automated patient outreach for preventive screenings

HEALTH INFORMATION TECHNOLOGY
› Electronic medical records
› Electronic orders and reporting
› Electronic prescribing
› Evidence-based decision support
› Preventative disease registry

CARE COORDINATION
› Multi-specialty team
  - Specialist care
  - Pharmacist
  - Nutritionist
  - Care Manager
  - Hospitalists
  - Urgent Care
  - Primary Care
› Care Transition for both in patient and out patient

CARE TEAM
› Physician-led team
› Care Manager / Clinical Staff / Registered Nurse / Nurse Practitioner / Receptionist / Physician Assistant / Pharmacist
› Shared goals
› Effective communication
› Patient participation
› Family involvement options

FISCAL RESPONSIBILITY
› Disciplined financial management
› Quality cost-benefit decision making
› Trained coding and billing staff
› Cost effective care delivery in the right location

From a historical perspective, the medical home was first introduced by the American Academy of Pediatrics in 1967. Since then, the PCMH concept has evolved in adult and Geriatric Medicine, merging chronic disease management with continuous quality improvement and other innovations commonly referred to as health care re-design. PCMH has become increasingly important as both the government (Medicare, Medicaid) and commercial insurances seek to improve the quality of care they purchase and to control costs. The primary mantra for PCMH is evidenced – based medicine to improve quality while lowering costs. In terms of fellowship competencies, both Patient Based Learning (PBL) and Health Systems competencies are deeply embedded in the PCMH model.

Sanford Health is one of the early adopters of PCMH. The Patient-Centered Primary Care Collaborative (PCPCC) indicates nearly 500 public and private medical home initiatives across the United States (PCPCC, 2014). Payers and others are working to gather evidence of the effects of different approaches to implementing the medical home model, so the model can be refined and adapted to the varied needs of patients, practices, and regions.

Several major programs offer PCMH recognition or accreditation for medical practices. The most commonly used recognition program is that of the National Committee for Quality Assurance (NCQA). NCQA has recognized roughly 5,700 practice sites (which include about 28,000 clinicians) as medical homes. Other recognition entities include the Joint Commission, URAC (formerly the Utilization Review Accreditation Commission) and the Accreditation Association for Ambulatory Health Care. Some states and payers have their own medical home recognition programs.   This process is referred to as "accreditation" or "certification."   As a Geriatrician leader, you can play a key role in practice transformation and evolution of a PCMH. During this process, you'll need to access what works and what does not work so well towards improving quality and reducing costs (e.g., avoid hospitalizations or improving advance directives).

PRINCIPLES AND CONCEPTS OF THE PCMH
According to the Agency for Healthcare Research and Quality (AHRQ) the PCMH is built around five core principles and functions:

1. **Comprehensive care.** The PCMH is oriented toward the "whole person" and is responsible for addressing all the patient's physical and mental acute, chronic, and preventive health care needs. This involves the direct provision of the appropriate care when possible or arranging for other qualified professionals (such as specialists) to provide care when necessary. Care within the primary care setting is delivered by a team rather than a single clinician, so professionals with different skill sets are available to meet the patient's needs.
2. **Patient-centered approach.** The PCMH provides care that is relationship based and tailored to best meet each patient's needs, values, culture, and preferences. Each patient has the opportunity to build ongoing, trusting relationships with a team of health care professionals. Clinicians seek to engage patients in their health care; provide the support, education, and information they need to make informed health care decisions; and recognize them as important members of the care team. PCMH clinicians and health care professionals use their cultural competence to treat patients with dignity, respect, and compassion, and they seek to meet patients where they are so that care is delivered in the way that best suits the patient's needs.
3. **Coordinated care.** All of a patient's health care is coordinated by the PCMH, including care received in hospitals, from specialists (including mental and behavioral health specialists), and through community or home-based services and supports. Coordination of care may be facilitated by patient registries, use of health information technology (such as electronic health records), and other methods. To ensure that care is properly coordinated, the PCMH strives to build strong communication with patients and among all members of a patient's care team. The goal of coordination is greater efficiency through avoidance of duplication of services, synchronization of services so that they have a maximum impact, and ensuring connection of patients to needed services.
4. **Accessibility of services.** To ensure that patients are able to access care when they need it, the PCMH offers short wait times for urgent care, enhanced hours, and around-the-clock access to the care team via telephone or electronic methods (email, patient portal, etc.). Care teams also seek out and respond to patient preferences regarding access and communication (e.g., whether patients prefer to communicate via email or telephone, and what language they prefer to use when getting care).
5. **Quality and safety.** To achieve optimal patient health outcomes and the highest quality of care, the PCMH is committed to quality improvement (QI), performance improvement, patient satisfaction, and population health management. Practices use evidence-based medicine and decision support tools to guide shared decision making and use patient registries to track the health status of their entire patient panel. Practices use data-driven QI methodologies to continuously monitor performance in a variety of care areas. Patients are engaged in QI processes and involved in practice decision making to ensure that care is provided in accordance with patient wants and needs. (Module 8 has information on and resources for supporting QI work.)

These principles closely align with the core values of primary care as defined by the Institute of Medicine: provision of integrated, accessible health care services to meet the majority of personal health care needs in a sustained partnership with patients in the context of family, community, and cultural considerations.

PCMH Recognition Programs
Currently, at least four major programs offer practices the opportunity to document the ways they provide care aligned with the principles of the medical home, thereby achieving PCMH or medical home recognition. In addition, some payers and states offer their own recognition programs. If a practice you are working with is interested in PCMH recognition, one way that you can help is by encouraging practice leaders to think carefully about which recognition program is most appropriate for the practice.

Table 25.1 outlines four major PCMH recognition programs, along with links to resources that provide more information on each. The practices you are working with may be participating in a program through a state or payer that is not on this list. Nonetheless, since the PCMH principles are common across many programs, the resources available from these organizations will likely be helpful to you and the practices you work with. Program requirements and other details change regularly, however, so you should regularly consult the links provided here to gather the most up-to-date information on various programs

Table 25.1. Four patient centered medical home recognition programs Selected Patient Centered Medical Home Recognition Programs

Accrediting Body	Program	Program Elements	Resources
The National Committee for Quality Assurance	Patient Centered Medical Home 2014 Standards	☐ Patient-centered access ☐ Team-based care ☐ Population health management ☐ Care management and support ☐ Care coordination and care transitions ☐ Performance measurement and quality improvement	http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
URAC (formerly the Utilization Review Accreditation Commission)	Patient Centered Medical Home Accreditation Version 2.0	☐ Quality care management ☐ Patient-centered operations management ☐ Access and communications ☐ Testing and referrals ☐ Care management and coordination ☐ Electronic capabilities ☐ Quality performance reporting and improvement	https://www.urac.org/accreditation-and-measurement/accreditation-programs/all-programs/patient-centered-medical-home/
Accreditation Association for Ambulatory Health Care	2013 Medical Home Standards	*Not publicly available.*	http://www.aaahc.org/en/accreditation/primary-care-medical-home/
The Joint Commission	Primary Care Medical Home 2014 Standards and Elements of Performance	*Not publicly available.*	http://www.jointcommission.org/accreditation/pchi.aspx

PCMH Initiatives and Payment Models

Many payers across the country are implementing new payment systems that incentivize practices to achieve full PCMH recognition or implement certain aspects of medical home (such as care management or the use of care teams). These payers include private health plans and state Medicaid programs (about half of which had implemented new payment structures that reward practices for performing the functions of a PCMH as of 2012). For example, the Federally Qualified Health Centers, supported by the US government to provide health care for

un-insured patients, are increasingly being incentivized (more payment) to reorganize into a PCMH. To learn more about these incentive programs, please look at:

☐ The National Academy for State Health Policy provides a detailed list of medical home initiatives in each state: available at http://www.nashp.org/med-home-strategies/initiative-overview

☐ The Patient-Centered Primary Care Collaborative provides a primary care innovations and PCMH map, http://www.pcpcc.org/initiatives/list

☐ The National Center for Medical Home Implementation provides a list of national demonstration projects and state initiatives http://www.medicalhomeinfo.org/national/projects_and_initiatives.aspx

Understanding payment models of PCMH initiatives. Payers use a variety of financial incentives and payment models to encourage primary care practices to become medical homes. The Safety Net Medical Home Initiative has outlined five potential payment models that public and private payers might consider to incentivize PCMH activity (Bailit et al., 2010)

PCMH payment models

Model Type	Description
Fee-for-service (FFS) with adjustments	FFS with specialized codes for PCMH services or higher FFS rates.
FFS Plus	This model includes several possible approaches, such as: ☐ FFS models with lump-sum payments to cover the work necessary to obtain PCMH recognition. ☐ FFS with a per-member per-month (PMPM) payment, sometimes called a monthly care coordination or care management payment. ☐ FFS with a PMPM payment and pay for performance based on predetermined performance measures.
Shared savings	This model includes all approaches with a shared savings component (for example, FFS with some share of savings distributed to practices that reduce costs compared to a benchmark – these programs usually include quality of care standards to ensure that reductions in cost do not reduce care quality).
Comprehensive payment	Similar to a capitated (per-person) payment model but includes enhanced payments to support PCMH activities.
Grant-based payment	Grant-based payments are awarded to cover PCMH transformation costs.
Other models	☐ Administrative support to help practices transform. ☐ Central utility models that allow practices to share important PCMH resources (for example, care coordination services, QI programs).

Summary and Conclusions

Given the growing use of PCMH recognition programs and new payment models to improve the quality of primary care, you will likely encounter many practices in various stages of the medical home recognition process. As a PF, you can help practice staff stay focused on the overall goals and objectives of the PCMH embodied in the principles and concepts described here as they make their way through the recognition process. After a practice achieves PCMH recognition, you can play a key role in helping the practice maintain a QI infrastructure and continually refine and improve its approach to delivering patient care.

OBJECTIVES

Medical Knowledge
1. Describe the five core principles and functions of the PCMH.
2. Describe the main PCMH recognition programs
3. Locate resources available for ongoing PCMH initiatives.
4. Describe the major PCMH payment models currently in use.
5. Locate sources to stay apprised of new developments related to the PCMH

Communication
1. Apply spoken and written communication skills to accommodate the neurosensory – impaired older adult
2. Apply "meaningful use" techniques in patient communication such as the written plan for the patient and caregiver at the end of a clinical encounter.
3. Demonstrate motivational interviewing
4. Use graphic / diagrammatic tools of communication to identify patient goals (e.g., Target)
5. Access health literacy
6. Engage team communications
7. Report how to use non – verbal and verbal communication with the cognitively impaired older adult.
8. Communicate consultant findings to PCP

Professionalism
1. Demonstrate punctuality
2. Show good patient follow –up (actions on laboratory results, notify patients)

Patient care
1. Provide high quality, patient – centered, culturally sensitive health care
2. Apply different elements of PCMH such as home visits, telehealth, group visits, wellness visits, presurgical clearance.
3. Guide and collaborate team care, including RN health coaches. \
4. Demonstrate evidence – based health care.

Patient-Based Learning and Improvement
1. Design and execute a quality improvement project

Systems-Based Practice
1. Describe the different models of geriatric care and how the PCMH matches and differs from these models.
2. Report on the different Medicare initiatives to improve quality of care while reducing costs
3. Understand the Institute for health care improvement initiatives, especially the Age – Friendly Hospital program.

METHODS OF EVALUATION

Evaluations will be based on core competencies:

COMPETENCIES	PATIENT CARE	MEDICAL KNOWLEDGE	PRACTICE BASED LEARNING	INTERPERSONAL COMMUNICATION SKILLS	PROFESSIONALISM	SYSTEMS BASED PRACTICE
EVALUATOR						
ATTENDING	X	X	X	X	X	X
PEER	X			X	X	
PROGRAM DIRECTOR*						
SELF**						
PATIENT/FEMILY MEMBER				X	X	
ALIED HEALTH PROFESSIONAL				X	X	X
PARTICIPATION IN DIDACTICS		X				

*Milestones based quarterly evaluations *Evaluations performed semi-annually and annually

RESOURCES

I.   Definitions and joint principles of the PCMH

http://pcmh.ahrq.gov/page/defining-pcmh

http://www.pcpcc.org/about/medical-home

http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf

The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change

II.   Payment Approaches

http://www.pcpcc.org/sites/default/files/media/payment_brief_2011.pdf

http://www.safetynetmedicalhome.org/sites/default/files/Policy-Brief-1.pdf

Jerry Cromwell and Leslie Greenwald: Costs and Productivity in Patient-Centered Medical Homes: A Simulation.

     III.   <u>Toolkits</u>

http://www.pediatricmedhome.org/

http://www.medicalhomeimprovement.org/

http://www.aafp.org/practice-management/transformation/pcmh/recognition.html

GERIATRIC MILESTONES

Complete list of UND Geriatric Medicine Fellowship Curricular Milestones can be found in the handbook/website.

ROTATION SPECIFIC MILESTONES

Communication

1   Practice culturally sensitive shared decision-making with patients and families/caregivers in the context of their health literacy, desired level of participation, preferences, and goals of care
3   Use strategies to enhance clinician–patient oral and written communication in patients with hearing, vision, or cognitive impairment
4   Skillfully discuss and document goals of care and advance care planning with elderly individuals and/or their families/caregivers across the spectrum of health and illness
5   Assess patients for capacity to make a specific medical decision and, if lack of capacity is determined, identify strategies and resources for decision-making, including guardianship
6   Provide compassionate care while establishing personal and professional boundaries with patients and families/caregivers
7   Effectively lead a family/caregiver meeting
Complex illness(es) and frailty in older adults
22   Demonstrate the ability to manage the care of patients with multimorbidities by integrating the evidence, patient's goals, life expectancy, and functional trajectory. Document clinical reasoning when management differs from standard treatment recommendations
23   Demonstrate the ability to manage psychosocial aspects of the care of older adults including interpersonal and family relationships, living situations, adjustment disorders, bereavement, and anxiety
25   Provide geriatric consultation in all settings with attention to multimorbidity, age-related changes in physiology, function, treatment efficacy and response, medication management, and psychosocial issues

Systems-Based Care for Elder Patients
General
29   Reduce iatrogenic events among elders in all settings through implementation of patient-specific and system-wide strategies to prevent falls*, immobility, delirium*, pressure ulcers*, incontinence*, malnutrition*, indwelling catheter use, nosocomial infections, deep vein thrombi, restraints, depression*, functional decline*. (NB: asterisk indicates additional competencies in syndromes or functional impairment section)
32   Demonstrate knowledge of commonly accepted geriatric quality indicators
33   Participate in quality improvement efforts to enhance the quality of care of older adults
35   Identify patient and family/caregiver needs and refer to appropriate local community resources
36   Recognize and document signs of elder abuse and/or neglect and refer to community resources and adult protective services when appropriate
37   Recognize the complexity of geriatric care and demonstrate the ability to prioritize care, in a time-efficient manner, during encounters with geriatric patients
41   Describe models of care that have been shown to improve outcomes for older adults, e.g., ACE Units, PACE, multifactorial interventions to prevent falls, delirium prevention
Hospital care
43   Recognize common and subtle presentations of delirium and manage appropriately
        Ambulatory care
45   Perform and interpret an outpatient geriatric assessment, and develop a management plan that includes appropriate consultation with and referrals to other disciplines and community based resources
46   Recognize patients who are at risk for hazardous driving, identify strategies to reduce risk, and integrate state and local laws into the management plan
Long-term care and nursing home care
49   Individualize long-term care patient management considering prognosis, comorbidity, patient and caregiver goals, and available resources especially in the following situations: (a) consideration for transfer to the acute care hospital; (b) weight loss, dehydration, swallowing disorders; (c) agitation and problem behaviors
50   Describe the role of a long-term care medical director and demonstrate an understanding of nursing home and long-term care regulations and requirements, including the Minimum Data Set
51   Manage acute problems in long-term care via telephone call
Geriatric Syndromes
Falls and dizziness
52   Perform and interpret common gait and balance assessments, recognizing abnormal gaits associated with specific conditions
53   Conduct an appropriate evaluation of patients who fall or are at risk for falling, implement strategies to reduce future falls, fear of falling, injuries, and fractures, and follow up on referrals
54   Evaluate, manage, and refer (when appropriate) patients with symptoms of dizziness or lightheadedness, differentiating among those with single or serious causes and those that are multifactorial

Pressure ulcers

63   Recognize patient risk factors for pressure ulcers, and in high-risk patients work with an interprofessional team to develop a prevention plan

64   Stage pressure ulcers and demonstrate proficiency in describing their clinical characteristics (e.g., size, color, exudate)

65   Develop a treatment plan for pressure ulcers with an interprofessional team, incorporating the indications for surgical and nonsurgical treatments for ulcers (e.g., debridement, classes of wound care products and treatments, pressure relieving devices, etc.)

Hearing and vision disorders

67   Screen for hearing loss and recognize when referral is appropriate

68   Recognize common ophthalmologic conditions associated with aging, including changes of normal aging, cataract, glaucoma, age-related macular degeneration, and refer when appropriate to ophthalmology, optometry, and/or low-vision services

Urinary incontinence

69   Identify, evaluate, and treat the most common forms of both reversible and chronic urinary incontinence using nonpharmacological interventions where possible

70   Refer when appropriate for urologic or gynecologic evaluation including urodynamic testing, pessary evaluations, pelvic floor muscle training

71   Identify, evaluate, and manage urinary retention and incomplete bladder emptying including the appropriate use of intermittent catheterization or indwelling bladder catheters

Weight loss and nutritional issues

72   Identify and appropriately evaluate and manage involuntary weight loss

73   Discuss with patients and families/caregivers the risks and benefits of appetite stimulants, nutritional supplementation, enteral tube feeding, and parenteral nutrition, particularly in patients with advanced dementia or near end of life

74   Identify swallowing disorders in patients with involuntary weight loss or recurrent pneumonias, and work with an interprofessional team to evaluate, manage, and educate patient and caregiver(s) based on goals of care

Constipation and fecal incontinence

75   Identify, evaluate, and manage constipation and fecal impaction using nonpharmacological and pharmacological modalities

76   Identify and provide initial evaluation and management of fecal incontinence