Becoming a Patient Centered Medical Home

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Deciding on Certification

- Why Get Certified?
- Which Certification and With Whom?
- Perform A Self Assessment
  - PCDC PCMH Assessment
    - http://www.pcdc.org/resources/patient-centered-medical-home/pcdc-pcmh/pcdc-pcmh-resources/PCDC-PCMH/ncqa-2011-medical-home.html

PCMH Scoring

6 standards = 100 points
6 Must Pass elements

NOTE: Must Pass elements require a ≥ 50% performance level to pass

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	85 - 100	6 of 6
Level 2	60 - 84	6 of 6
Level 1	35 - 59	6 of 6
Not Recognized	0 - 34	< 6

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 “Must Pass” Elements are not Recognized.

Developing a Team

- PCMH Coordinator/Project Manager
- Medical Directors
- Senior Director of Clinic Operations
- Senior Director of Strategy
- Director of Development
- Director of Nursing
- EMR Manager
- Empanelment/Scheduling Manager

Choosing Areas of Focus

- Review PCMH Guidelines
- Analyze Impact on Organization
- Develop Timeline for Implementation

NCQA PCMH 2011 Content and Scoring

PCMH 1: Enhance Access and Continuity	Pts
A. Access During Office Hours**	**4**
B. Access After Hours	4
C. Electronic Access	2
D. Continuity (with provider)	2
E. Medical Home Responsibilities	2
F. Culturally/Linguistically Appropriate Services	2
G. Practice Organization	4
	20

PCMH 2: Identify and Manage Patient Populations	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. Use Data for Population Management**	**5**
	16

PCMH 3: Plan and Manage Care	Pts
A. Implement Evidence-Based Guidelines	4
B. Identify High-Risk Patients	3
C. Manage Care**	**4**
D. Manage Medications	3
E. Use Electronic Prescribing	3
	17

PCMH 4: Provide Self-Care and Community Resources	Pts
A. Support Self-Care Process**	**6**
B. Provide Referrals to Community Resources	3
	9

PCMH 5: Track and Coordinate Care	Pts
A. Track Tests	6
B. Track Referrals**	**6**
C. Coordinate with Facilities/Care Transitions	6
	18

PCMH 6: Measure and Improve Performance	Pts
A. Measure Performance	4
B. Measure Patient/Family Feedback	4
C. Implement Continuous Quality Improvement**	**4**
D. Demonstrate Continuous Quality Improvement	3
E. Report Performance	3
F. Report Data Externally	2
	20

Optional Patient Experiences Survey	

** Must Pass Elements

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Implementation Timeline

February	March	April	May	June	July	September	December	February	March
Quality Dashboard developed	Monthly Care Team Meetings start	Proactive Outreach report DM/Asthma/HTN ready	E-Prescribing live	Proactive Outreach process for DM/Asthma/HTN starts	Self-Management Training for nurses and educators	Patient Portal live	Ambulatory Clinical Quality Measures reported to CMS	Self Management and Care Manager Training for MA staff	Lab Tracking in place?
Start using CAHPS survey	Patient Check out form pilot		Clinical Summary reports to providers weekly	Training on Secure Messaging & new CCC forms	Self-Management overview for providers (with EMR update on forms)			Referral Tracking in place	Patient Orientation Video
Behavioral Health Handoff Workflow documented	Implement call routing and phone note procedure		Patient Checkout Form in use	New Patient Brochure ready	PCP clean up with individual providers			Site Directors and Site Managers develop site based QI plans	
Staff Training on call routing and phone note procedure	Same Day Appt Scheduling Protocol in place		New Patient Orientation Video Script Done	Patient Portal Working Group Starts meeting	Reports on call response times (nurses & ans serv)			Care Manager Implemented	
	Community Referral list on Spine		Care Team monthly "Business Meeting" starts	Schedule for reports to providers on QI Measures	Proactive outreach for Mammograms in place				
	Interpreters Role document completed								
Reporting	Training	Documentation	Pilot	Implementation: Providers & Support Staff		Implementation: Support Staff		Patient Process	

LCHC Focus Areas

- Patient Experience
  - Brochure, Video, Surveys, Empanelment
- Electronic Communication
  - E-Prescribing, Patient Portal, Secure Messaging
- Quality Improvement
  - Reports, Self Management, Patient Outreach, Result Tracking
- Workflow Documentation

Sustaining Change

- Plans for Future
- Continuing to Improve
- Keeping the Patient at the Center