PATIENT CENTERED MEDICAL HOME (PCMH)

A TEAM APPROACH TO CARE

Primary Care Physicians PC

Excellent support, administrative efficiency & value

PCMH

- **The Joint Principles of the PCMH:**
  - Personal primary care physician
  - Physician directed medical practice team
  - Whole person orientation
  - Care is coordinated and integrated
  - Improved quality and safety
  - Enhanced access to care
  - Payment to support PCMH

TODAY'S CARE		PCMH CARE
My patients are those who make appointments to see me	→	Our patients are those who are registered in our medical home
Patients' chief complaints or reasons for visit determines care	→	We systematically assess all our patients' health needs to plan care
Care is determined by today's problem and time available today	→	Care is determined by a proactive plan to meet patient needs without visits
Care varies by scheduled time and memory or skill of the doctor	→	Care is standardized according to evidence-based guidelines
Patients are responsible for coordinating their own care	→	A prepared team of professionals coordinates all patients' care
I know I deliver high quality care because I'm well trained	→	We measure our quality and make rapid changes to improve it
Acute care is delivered in the next available appointment and walk-ins	→	Acute care is delivered by open access and non-visit contacts
It's up to the patient to tell us what happened to them	→	We track tests & consultations, and follow-up after ED & hospital
Clinic operations center on meeting the doctor's needs	→	A multidisciplinary team works at the top of our licenses to serve patients

Updated 10/17/2012

Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma

PCMH

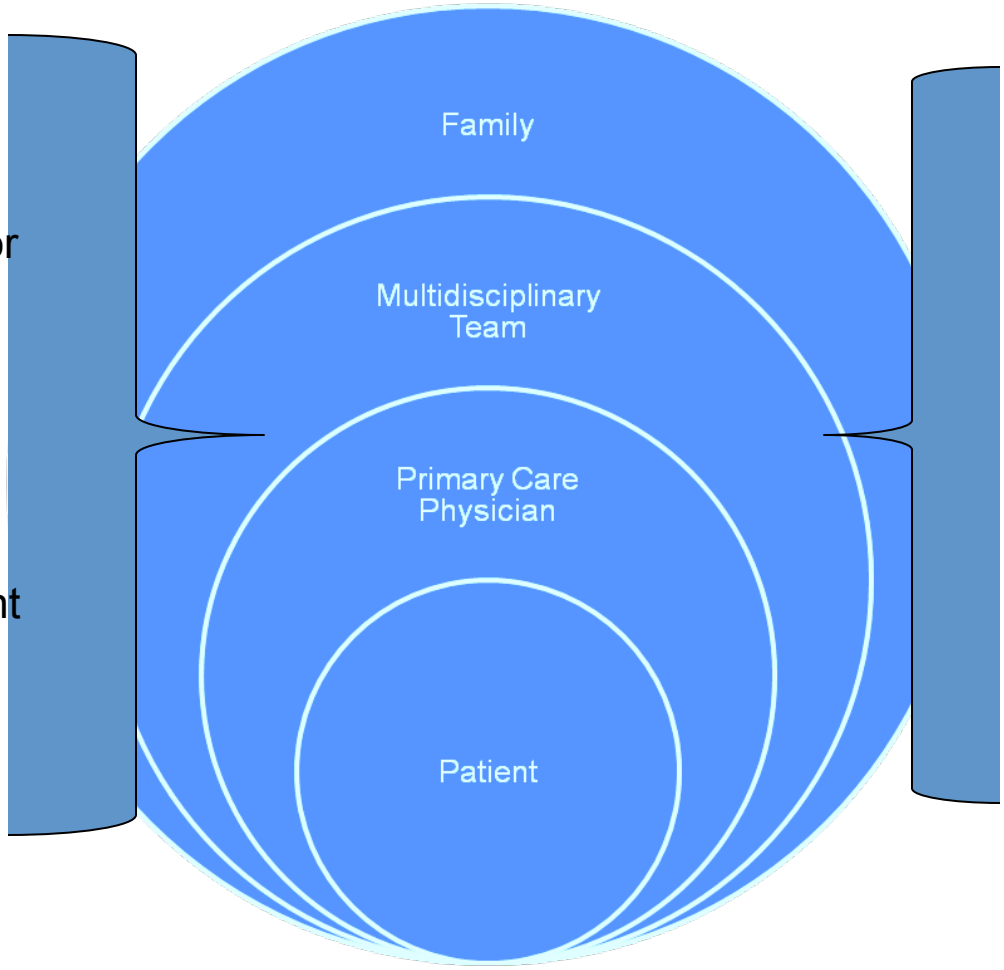
- **PCMH care is:**
  - **Accessible** - to assure that patients get the indicated care when and where they need and want it in a culturally sensitive and linguistically appropriate manner
  - **Coordinated** – care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services
  - **Continuous** - each patient has an ongoing relationship with a primary care physician and team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
  - **Comprehensive** - responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care; chronic care; preventive services; and end of life."

PCMH

- **Interdependent Team**:
  - No significant task can be accomplished without the help of the members within that *TEAM*
  - Within the team, members typically specialize in different tasks
  - The success of every individual is bound to the success of the whole team.

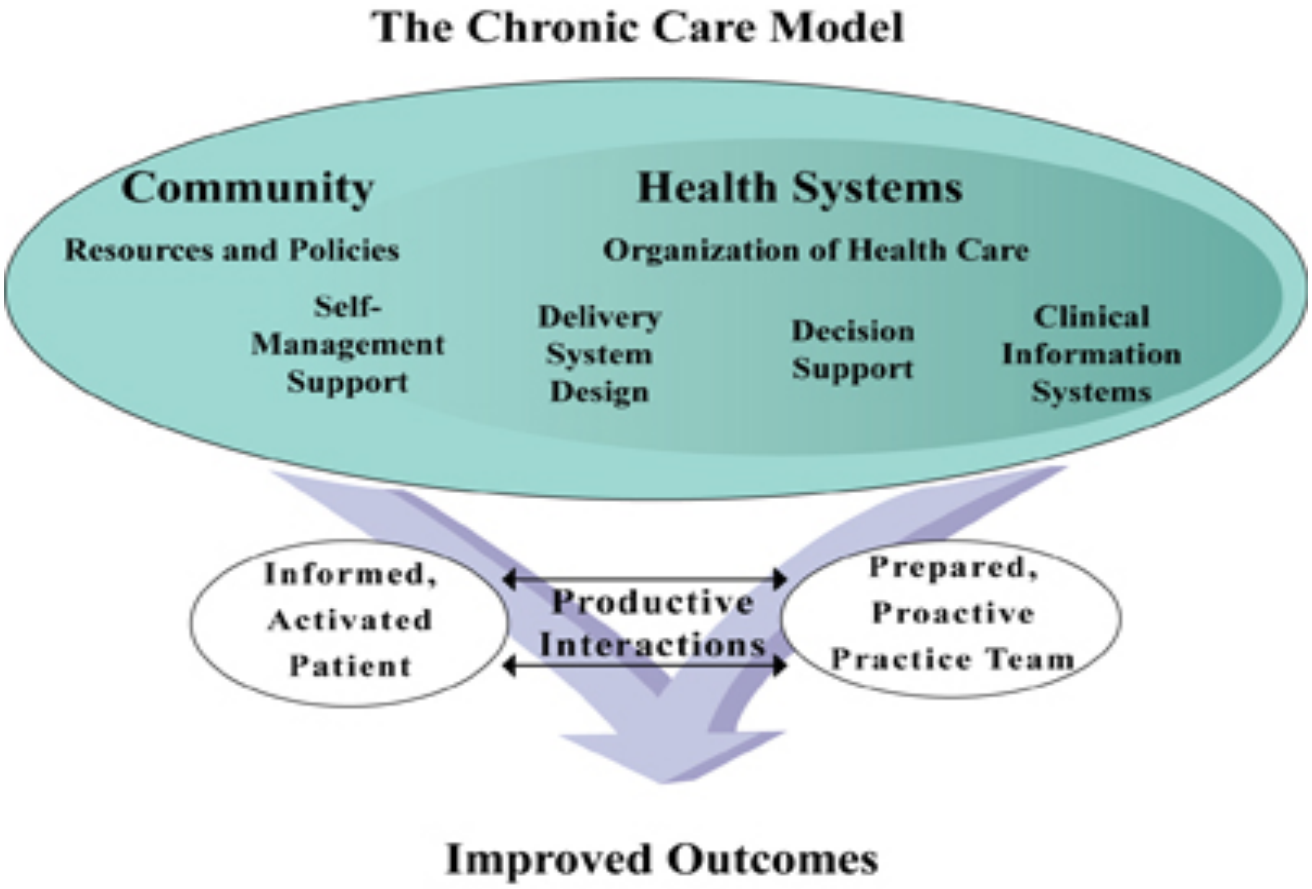
PCMH
CORE OF TEAM-BASED CARE

Administrative Staff
Behavioral Specialist
Care Coordinator
Case Manager
CDE
Clerical Staff
CNS/NP
Dietitian
Health Educator
Medical Assistant
Optometrist
Others
PA
Pharmacist
RN/LPN
Wellness Coach



Immediate Family
Extended Family
Friends
Neighbors

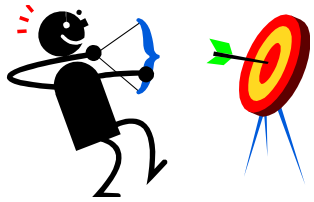
PCMH


The Chronic Care Model
Community
Resources and Policies
Health Systems
Organization of Health Care
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Improved Outcomes
Developed by The MacColl Institute
® ACP-ASIM Journals and Books

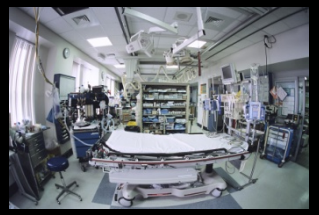
PCMH
Quality Matters

Evidenced-Based Care (EBC) scores are important!

- **Diabetes** - hbA1c, LDL calculated, microalbumin-creatinine ratio, retinal eye exams & foot exams
- **Asthma** – individualized action plan, long acting beta agonist (LABA) and spirometry
- **Chronic Kidney Disease** – blood pressure, BUN, creatinine, flu/pneumonia vaccine, lipid profile, ACE/ARB
- **Congestive Heart Failure** - weight, LDL calculated, ACE/ARB
- **Coronary Artery Disease** – blood pressure, beta blocker, statin, lipid profile
- **Preventative Adult** - mammography, pap smear, colorectal screening, flu/ pneumonia vaccine
- **Preventative Child** - well child visits, adolescent visits and immunizations per age
- **Pediatric Obesity** - lipid profile, BMI, nutritional counseling



PCMH
Utilization & Cost Matter



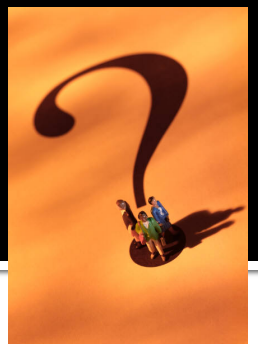
- **Reduce Emergency Department (ED) use for non-emergent conditions**
  - Refer patients to non-hospital based urgent care centers when possible
  - Use the BCBSM/BCN list on our web site www.pcppc.org

PCMH
Utilization & Cost Matter

RADIOLOGY MANAGEMENT

- Reduce Unnecessary X-ray Utilization
  - High and low tech radiology use/cost impacts your financial performance.
  - **Refer patients to free standing radiology facilities**
  - A list of providers is available on www.bcbsm.com or www.mibcn.com. Let your referral providers know this when sending them patients
  - **Use American Imaging Management's (AIM) online prior authorization process to obtain approval for high tech x-ray services for Blue Cross (BC) and BCN patients**.
  - Online authorizations result in additional incentive dollars
  - Points are given for attempting online authorizations with additional credit when the service is approved
  - Authorization criteria can be found on the AIM website.
    - Copy and paste the following link to create your practice's AIM's log on ID and password:
    - https://www.providerportal.com/?utm_source=CorporateSite&utm_medium=Button&utm_content=ProviderPortalLogin

Why PCMH?



- **WHAT MAKES PCMH IMPORTANT?**
  - Patient centered primary care concept is being adopted by:
    - National health care legislation
    - Major payers (Aetna, Blue Cross, Humana, Priority, Medicare and Medicaid)
    - Large employers
    - Labor unions (UAW-VEBA)
    - National quality organizations (NCQA, JCAHO, URAC)
    - Federal and State governments as employers and payers
    - Practitioners and health care systems
- If your practice is ***marginally PCMH*** recognized
  - Insurers/payers may audit your office more often
  - Insurers/payers will examine more carefully your weak and/or non-compliant areas from prior audits
- If you primary care practice ***is not PCMH*** recognized soon:
  - You may be limited to the payers with whom you can contract
  - Patients may be steered to other providers
  - Your quality of care and service may be questioned
  - You will not receive the highest reimbursement