Welcome, Neighbor!

Specialty practices and primary care practices join forces in providing patient centered medical care

We often hear our patients express their frustration as they navigate among their primary care provider (PCP) and specialty practices. For patients, it comes down to "If only they would talk to one another." As healthcare providers, we know that it is not that easy. We all strive to meet our patients' needs and desires within our practices, but sometimes our best efforts are thwarted by antiquated systems and old ways of doing business. In a Patient-Centered Medical Home (PCMH), patients and their families are treated the way they want to be treated in sickness and in health. The care team, PCMHs and specialty practices, knows their patients, cares for and about their patients, and communicates with them and about them. Specialty practices are joining with primary care providers in embracing Patient-Centered Medical Home care model described below to promote coordinated care for our patients on their health journey by creating **PCMH-*N****eighborhoods* (PCMH-N). PCMH-N puts the patient at the center of the health care system, and provides primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective." This work is necessary to ensure our patients receive the benefits of "a hospitable and high-performing medical neighborhood" that aligns specialty group processes with the core competencies of PCMH-N. The goal of a PCMH-N is to promote integrated, coordinated care throughout the health care system, but the ability to reach this goal depends on the cooperation of the specialists and other health care entities (e.g., hospitals, nursing homes) involved in the patient's care.

The National Committee for Quality Assurance (NCQA) is developing a medical home recognition program that is designed for specialty practices based on the neighborhood concept. Being a medical home neighbor (PCMH-N) requires specialty practices to coordinate care and follow up, much like the full PCMH model described below. Specialty practices will be closely linked to primary care practices that provide prevention and other related services and act as the patient's medical home. The environment we work in has changed. Patient expectations are higher. Payment reform rewards practices that achieve high levels of quality and coordination, and insurers are likely to use PCMH recognition as an indicator of a practice's high performance. The rate of change in health care is extraordinary, and

we need to maintain our ability to respond to change with creativity, conviction, and resilience.

What is the definition of a Patient-Centered Medical Home?

You have probably read or heard the term "Patient-Centered Medical Home (PCMH)". You may know that all WellSpan Medical Group (WMG) internal medicine and family practice offices have achieved recognition as Patient-Centered Medical Homes through the National Committee for Quality Assurance (NCQA) under the 2008 standards. You may have also heard that the WMG has a goal of achieving PCMH recognition for ALL of our primary care practices under the newer 2011 standards. But *what* exactly is a Patient-Centered Medical Home?

The PCMH puts the patient at the center of the health care system, and provides primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."

The PCMH treats people and their families the way they want to be treated in sickness and in health. The care team knows their patients, cares for and about their patients and communicates with them and about them. The PCMH provides team-based care that revolves around the patient and family. It takes collective responsibility for its panel of patients, using data to continuously improve. The outcome is a better patient experience and improved health status with a reduction in Emergency Department visits, potentially avoidable hospitalizations, readmissions, and improved evidence-based care.
In addition to becoming recognized by an external agency such as NCQA or the Joint Commission, becoming a PCMH requires transformational change and requires a full commitment by the practice to implement a set of "Core Expectations." Many primary care practices are being transformed into Patient-Centered Medical Homes using the NCQA recognition guidelines as well as an expanded definition put forth by a regional group of providers, payers, and employers sponsored by Aligning Forces for Quality - South Central PA (AF4Q) called PRICE (Payment Reform Incorporating Corporate Engagement).

The core expectations of the PCMH as defined by PRICE are:

Engaged Leadership

- Identify at least one primary care physician or advanced practice provider as

a leader within the practice who visibly champions a commitment to improve care and implement the PCMH model. The primary care leader(s) takes an active role in working with other providers and staff in the practice to build a team-based approach to care, continually examine processes and structures to improve care, and review data on the performance of the practice.

- Establish a quality improvement team, led by the provider leader, that meets regularly and guides the effort.

Patient-centered:

- Assess and respect patient/family values and expressed needs.
- Encourage patients to expand their role in decision-making, health-related behavior change, and self-management.
- Communicate with patients in a culturally appropriate manner, in a language and at a level that the patient understands.
- Provide self-management support at every visit through goal setting and action planning.

Quality Improvement Strategy

- Establish and monitor metrics to evaluate improvement efforts and outcomes and provide feedback.
- Obtain feedback from patients/family about their healthcare experience and use information for quality improvement.
- Committed to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services.
- The practice identifies at least two patients or family members to be part of the practice leadership team.
- Optimize use of health information technology to:
    - Schedule appointments and monitor access to care.
    - Define and understand their patient population, including subpopulations.
    - Define and track care of individual patients and subpopulations, including referrals and abnormal lab/imaging results.
    - Provide patient-specific educational materials.

Coordinated care :

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Provide care management services for high risk patients.

- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.
- Track and support patients when they obtain services outside the practice.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Communicate test results and care plans to patients/families.

Empanelment

- Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, etc.
- Understand practice supply and demand, and balance patient load accordingly.

Organized, Evidence-Based Care

- Enable planned interactions with patients by having available, up-to-date patient information and "standing orders" for the care team before any interaction.
- Use point-of-care reminders and other decision support based on clinical guidelines.

Enhanced Access

- Promote and expand access; ensure that established patients have 24/7 continuous access to their care teams via phone, email, or in-person visits.
- Scheduling options are patient- and family-centered, and accessible to all patients.
- Help patients attain and understand health insurance coverage.
- Patient access to appointments is consistently tracked and improved.

Continuous & Team-Based Healing Relationships

- Clearly link patients to a provider and care team so both patients and provider/care teams recognize each other as partners in care.
- Assure that patients are able to see their provider or care team whenever possible.
- The practice has committed to redesigning primary care practice in a way that utilizes non-physician staff to improve access and efficiency of the practice team in specific ways, such as through greater use of planned visits, integrating care management into clinical practice, delegating some types of patient testing or exams (e.g., ordering of routine screening tests, diabetic

foot exams) to non-physicians; expanding patient education; and providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.
- Cross-train care team members to maximize flexibility and ensure that the needs of patients are met.

The criteria for PCMH certification is very specific and increasingly stringent. In order to achieve recognition as a PCMH, significant design, effort, and documentation need to occur. Many primary care practices are currently engaged in this work and will achieve recognition under the 2011 standards over the next year or two.

The PCMH model reminds us that a patient's needs, safety, and interests must be the foundation of all care delivery. Developing a true care team – where all staff members practice and use their top skill-sets to provide coordinated, comprehensive care to patients when and how they want it – is key to becoming a patient centered medical home.

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