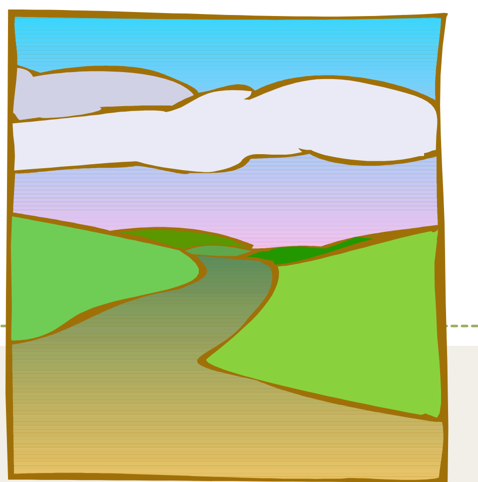


THE TRANSFORMATION JOURNEY AS A MEDICAL HOME

~ A Tale of Two Practices ~

Medical Home Audioconference
December 9, 2009

Objectives

- Recognize process of transforming to PCMH as more than NCQA recognition
- Highlight challenges, successes, & current activities of two practices on journey to more patient centered care

Agenda

1:00(ET)Intro's & overview – Lisa Letourneau

1:15 Journey at New Pueblo Medicine – Mike Cracovaner, CEO

1:40 Journey at Eagle Family Medicine Center – Daniel Orr MD & Susan Orr Esq.

2:05 Panel Q & A

2:30 Adjourn

Defining the Medical Home

"A **medical home** is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective."

- American Academy Pediatrics (1964)

"Change is hard enough; **transformation to PCMH requires epic practice re-imagination and redesign**."

Nutting et al. Annals Fam Med (2009)

But What About NCQA Recognition?...

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	**4**
B. Uses data to show it meets its standards for patient access and communication**	**5**
	9
Standard 2: Patient Tracking and Registry Functions	**Pts**
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21
Standard 3: Care Management	**Pts**
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20
Standard 4: Patient Self-Management Support	**Pts**
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8
Standard 6: Test Tracking	**Pts**
A. Tracks tests and identifies abnormal results systematically**	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13
Standard 7: Referral Tracking	**PT**
A. Tracks referrals using paper-based or electronic system**	**4**
	4
Standard 8: Performance Reporting and Improvement	**Pts**
A. Measures clinical and/or service performance by physician or across the practice**	**3**
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15
Standard 9: Advanced Electronic Communications	**Pts**
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

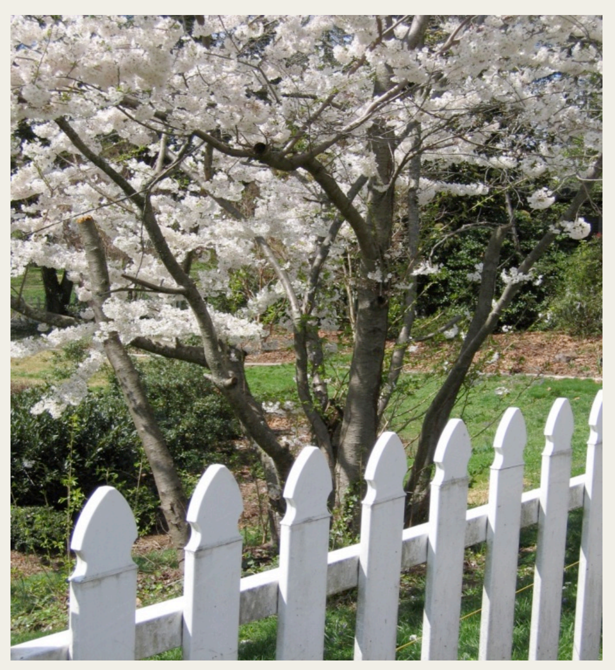
**Must Pass Elements

AAFP-AAP-ACP-AOA PCMH Joint Principles

- Every patient has a personal physician
- Care is provided by a physician-directed team who collectively care for patient
- Personal physician is responsible for providing all patient's needs, or arranging for services to be provided by others
- Care is coordinated and integrated across all aspects of healthcare system
- Quality and safety are hallmarks of PCMH
- Patients are offered enhanced access to care (e.g. expanded hours, enhanced communication options)
- Payment appropriate recognizes added value of

Summing Up: Medical Home Is Where…

- Patients feel welcomed
- Staff takes pleasure in working
- Physicians feel energized every day



Are You There?

What Would Your Patients Say?