NURSE-MANAGED AND
A MEDICAL HOME
“IT’S THE RIGHT FIT”
NURSE-LED MEDICAL HOME

1. What is a Nurse-managed health center
2. What is a Patient-Centered Medical Home?
3. Nurse-managed $\rightarrow$ PCMH
4. Why transform into a PCMH?
5. Family Practice & Counseling Network
6. PCMH Process
7. Unanticipated Difficulties
8. Is it worth it?
9. Resources
WHAT IS A NURSE-MANAGED HEALTH CENTER?

Nurse-managed health centers are health centers directed by Nurses in partnership with the communities that they serve. Nurse-managed health centers address health disparities by providing accessible comprehensive primary care and community health programs aimed at health promotion and disease prevention. Care is primarily provided by nurse practitioners, with support from an interdisciplinary team of health professionals, including registered nurses, health educators, community outreach workers, and collaborating physicians.

National Nursing Centers Consortium
WHAT IS A PATIENT CENTERED MEDICAL HOME?

The Patient Centered Medical Home is a health care setting that facilitates **partnerships between individual patients, and their personal providers**, and when appropriate, the patient’s family. Care is facilitated by **registries, information technology, health information exchange** and other means to assure that patients get the indicated care when and where they need and want it in a **culturally and linguistically appropriate manner**.

National Committee for Quality Assurance (NCQA)
**What is PCMH?**

**Dr. Terry McGeeney, MD MBA FAAP**

- Transformed supported by AAFP
- PCMH: A continual relationship with physician
- One visit!

**Why Change?**
- Health care is expensive
- Primary care is unsustainable
- Quality is difficult!

**Currently System is Unsustainable**

**Nationally Relevant!**

**Healthcare is changing**

**Primary care in the driver's seat**

**Synergies**

**Teamwork!**
- Trust
- Communication
- Show value
- Enhanced fee for services

**Reform Isn't Going Away**

**Processes + Culture**

**Urban or rural, we have the same issues**

**Efficiency = Revenue**

**We are here to help!**

**Focus on quality, safety**

**Primary care at the top of your license**

**Primary care is the center of change**

**PCMH is the vehicle for health improvement**

**We will keep you in communication**

**Healthcare is changing**

**Care cost**

12%

**Care transformed supported by AAFP**

**Kansas PCMH Initiative**

**The Family Practice 
Counseling Network**
The transformation to a PCMH is a natural progression for Nurse-Managed Centers

- Comprehensive care
- Interdisciplinary care
- Focus on underserved and vulnerable populations
- Partnership with the communities we serve
- Accessible care
WHY TRANSFORM INTO A PCMH?

1. Belief in Patient-Centered Medical Home model

2. Aligns with vision and mission of Nurse-Managed model

3. Practice transformation leads to better outcomes

4. Changing landscape of healthcare

5. More competitive for funding and grants
## Why the Medical Home Works: A Framework

<table>
<thead>
<tr>
<th>Feature</th>
<th>Definition</th>
<th>Sample Strategies</th>
<th>Potential Impacts</th>
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</table>
| **Patient-Centered**     | Supports patients in learning to manage and organize their own care at the level they choose, and ensures that patients and families are fully informed partners in health system transformation at the practice, community, and policy levels. | • Additional staff positions to help patients navigate the system and fulfill care plans (e.g., care coordinators, patient navigators, social workers)  
• Compassionate and culturally sensitive care  
• Strong, trusting relationships with physicians and care team, and open communication about decisions and health status                                                                 | Patients are more likely to seek the right care, in the right place, and at the right time.                                                                                                                         |
| **Comprehensive**        | A team of care providers is wholly accountable for a patient’s physical and mental health care needs, including prevention and wellness, acute care, and chronic care.                                             | • Care team focuses on ‘whole person’ and population health  
• Primary care is co-located with oral, vision, OB/GYN, pharmacy and other services  
• Special attention paid to chronic disease and complex patients                                                                                                                                         | Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated.                                                                                             |
| **Coordinated**          | Ensures that care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports.                                      | • Care is documented and communicated effectively across providers and institutions, including patients, primary care, specialists, hospitals, home health, etc.  
• Communication and connectedness is enhanced by health information technology                                                                                                                               | Providers are less likely to order duplicate tests, labs, or procedures.                                                                                                                                              |
| **Accessible**           | Delivers consumer-friendly services with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations.                                            | • Implement more efficient appointment systems that offer same-day or 24/7 access to care team  
• Use of e-communications and telemedicine to provide alternatives for face-to-face visits and allow for after hours care.                                                                             | Better management of chronic diseases and other illness improves health outcomes.                                                                                                                                     |
| **Committed to quality and safety** | Demonstrates commitment to quality improvement through the use of health IT and other tools to ensure that patients and families make informed decisions about their health.                                      | • Use electronic health records and clinical decision support to improve medication management, treatment, and diagnosis.  
• Establish quality improvement goals to maximize data and reporting about patient populations and monitor outcomes                                                                                     | Focus on wellness and prevention reduces incidence/severity of chronic disease and illness.                                                                                                                            |
|                          |                                                                                                                                                                                                             |                                                                                                                                                                                                                  | Health care dollars saved from reductions in use of ER, hospital, test, procedure, & prescriptions.                                                                                                                |
FAMILY PRACTICE & COUNSELING NETWORK

- 5 federally-qualified sites
  - 3 comprehensive health centers in Philadelphia, PA
  - 1 comprehensive health center in York, PA
  - 1 behavioral health center for children in Philadelphia, PA
- 19,546 users in 2012
- 85,227 visits in 2012
- EHR – Centricity (implemented in 2006)
- PCMH status – Currently a Level I Patient-Centered Medical Home through NCQA
  - Application submitted to NCQA for re-accreditation on 2/24/13 (Fingers crossed for a Level III!)
SERVICES WE OFFER

☐ Primary care for all ages
☐ Lab services
☐ Pharmacy
☐ Specialty services – Podiatry, Optometry, Cardiology, Physical Therapy
☐ Prenatal
☐ Family Planning
☐ HIV Testing and Treatment
☐ Health Education
☐ Behavioral Health (outpatient and integrated)
☐ Social Work
☐ Care Management
☐ Oral Health
☐ Outreach (and Inreach!)
☐ Peer Support
HOW DO WE TRANSFORM SERVICES OFFERED TO A PATIENT-CENTERED MEDICAL HOME?

One step at a time.

Or in the case of NCQA, one standard at a time...
PCMH PROCESS

1. Construct a Team
   - Who should be on the team?

2. Standards & Elements
   - What are the definitions?

3. Assessment
   - Current status of practice vs. where it could go

4. Communication with Staff
   - Staff buy-in

5. Workplan
   - What does each standard/element need? Who is responsible?

6. Assess Resources
   - Personnel, Financial, system
PCMH PROCESS, CONT.

6. Assess Resources
   - Personnel, Financial, system

7. Make Friends with the staff at NCQA
   - Excellent resource for questions and clarification

8. Use your Community Connections
   - Shared experiences through this project

9. Assemble application
   - Put together the application piece by piece

10. Continue to review application (again and again...)

11. Submit!

12. Maintain your progress
WHAT YOU CAN EXPECT FROM GOING THROUGH THE PROCESS OF BECOMING A PCMH

1. A functional EHR that helps you provide high quality, efficient, comprehensive care
2. Better understanding of current policies and procedures – Are they in line with PCMH?
3. Higher patient satisfaction
4. Comprehensive care team
5. Improvement in clinical outcome measures
6. Increased standardization and efficiency (help manage productivity expectations with high quality, comprehensive care)
7. Where we can improve as a practice
**EHR FUNCTIONALITY**

**Protocol "USPS Ages 25-44 Females"**

Female patients with an age of greater than 25 years, and less than 45 years. Should have the following:

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<th>Schedule</th>
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<th>Last Rslt</th>
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Comment: "Serology testing, documented vaccination history, and routine vaccination against rubella (preferably with MMR) is suggested for females of childbearing age. Height and weight are recommended as part of the periodic health examination. Assessment for problem drinking is recommended."
FPCN’S OPEN ACCESS POLICY

OPEN ACCESS

• Pros
  o Access
  o Fits within our patient’s lives
  o Lower no show rate

• Cons
  o Continuity of care issues
  o Chronic care follow-up is difficult

TRADITIONAL SCHEDULING

• Pros
  o Increased continuity of care
  o Schedule recalls

• Cons
  o Higher no show rates
  o Limited same-day appointments

Outcome: Modified Open Access
CARE TEAM

1. Nurse Practitioner
   ● Provide comprehensive, high quality care

2. Care Manager
   ● Navigation of the system
   ● Coordination of care

3. Medical Assistant
   ● Standing orders
   ● Enhanced functions

4. Registered Nurse
   ● Disease-specific education (ex: medication titration)

5. Behavioral Health Consultants
   ● Integrated behavioral health care
   ● Pediatric assessments

6. Nutritionist/Diabetic Educator
   ● Disease-specific health education

7. Outreach
   ● Inreach – recall system
   ● Health Education

8. Front Desk
   ● Continuity of care
   ● Access
CLINICAL OUTCOMES

Provider Dashboards

a. “Healthy” competition
b. Increased understanding of workflow (where things should be entered)

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<tr>
<td>Grand Total</td>
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<tr>
<td>% Queried about Smoking</td>
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UNANTICIPATED DIFFICULTIES

1. What level should we apply for?
   a. Do we have to do everything?
   b. What level is right for us right now?
   c. What level can we strive for?

2. Do we really understand the standards?
   a. Do not read too much into it
   b. Ask questions

3. Support
   a. Who is the lead person?
   b. How do we ensure equal balance of responsibility?
   c. Do we need to re-invent everything we do?
IS IT WORTH IT?

Absolutely.

Becoming a PCMH is a process every center should go through. It gives you excellent insight into where you are and where you can go.

The results are worth the time and energy you will spend on this process.
RESOURCES

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NCQA
www.ncqa.org

Family Practice & Counseling Network
www.fpcn.us