NCC Pediatrics Continuity Clinic Curriculum: **Medical Home Module 1 – Overview**

Pre-Meeting Preparation:

Please read & complete the following enclosures/links:

- *read* "The Patient-Centered Medical Home" (adapted from AAP PCMH curriculum)
- *complete scoring for* "Joint Commission PCMH Elements of Performance"
- *watch* "The Joint Commission PCMH Option" (9:32 video) available here

Conference Agenda:

- Discuss questions within the module
- Discuss the case
- Discuss the scoring of Joint Commission Elements of Performance

Extra Credit:

- The Medical Home (AAP Policy Statement, 2002)

The Patient-Centered Medical Home

*Adapted from AAP PCMH Resident Modules available here.

Overview

Over the last few decades, there have been numerous attempts by clinicians and policy makers to create a primary care practice model that increases the quality of care patients receive while lowering costs; the Institute for Healthcare Improvement (IHI) calls these goals the "Triple Aim Framework" of patient experience, quality, and cost. (The military health system (MHS) adds "readiness" to this framework and calls it the "Quadruple Aim".) One of the approaches to achieve the Triple Aim—the patient-centered medical home (PCMH)—can provide health care professionals with practical tools needed to accomplish these objectives.

The PCMH is not a physical location, but rather a model for providing patients with comprehensive, family-oriented, around-the-clock care. This approach is not only informed by the best available medical science and supported by peer-reviewed evidence, but builds on a philosophy of care that emphasizes compassion and a deep commitment to the patient and families' well-being.

The definition of PCMH is the following:

> "PCMH is a team-based model, led by a provider, which provides continuous, accessible, patient-centered, comprehensive, compassionate and culturally-sensitive health care in order to achieve the best outcomes."

Key Principles

Several key principles form the building blocks upon which the PCMH rests: **care coordination, access to care, family-centered care, team-based care, and quality improvement**. These principles describe the patient- and family-centered care that is at the heart of a medical home as "healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care."

Care coordination is one of the most important foundational principles upon which a PCMH is built. The American Academy of Pediatrics describes care coordination as "an essential element of a transformed American health care delivery system that emphasizes optimal quality and cost outcomes, addresses family-centered care, and calls for partnership across various settings and communities." This means every patient has access to a personal physician who serves as the patient's primary contact and who makes certain that the patient's journey through the health care system is seamless,

regardless of what physical location she receives actual care in. Coordination is facilitated with the help of patient registries, information technology, health information exchanges, and a variety of other tools.

→ **What is a patient registry, and how are our registries accessed?**

A patient registry is information about patients who share a common diagnosis or medical need. An example of a registry is a list of patients who are due for HPV vaccination. We obtain patient registries from Carepoint.

One focus of care coordination involves transitions of care - how the PCMH receives reports of care received outside the medical home. Here are some of the ways we manage transitions in care in our PCMH:

- Every day at team huddle, the teams search the Carepoint portal for patients seen in the emergency room or admitted or discharged from the hospital. Discharge summaries are available in Essentris or the Joint Legacy Viewer (JLV).
- Select nurses in the PCMH have access to the Nurse Advice Line (NAL) reports, which are also placed into an AHLTA telephone consult and reviewed daily.
- Results of subspecialty consults completed at a military treatment facility are available in AHLTA; results of consults completed at a network provider are available in HAIMS. (The patient administration division (PAD) sends an AHLTA tasking to notify referring providers that the consult report is available for review; referring providers must review the consult report and update the note via the taskings module.)

Enhanced **access to care** is another component in the delivery of high-quality care to patients. In traditional primary care practices, patients often express concern about having to wait weeks or months to see their health care professional. The PCMH addresses this problem by putting in place several mechanisms, including 24/7 nurse triage (our Nurse Advice Line), an electronic patient portal (Tricare Online), and access to the practice by means of telephone and secure messaging (Relay Health). Our medical home also offers same-day appointments (often called “24 hour” appointments), weekend hours (MICC newborn followups), and flexible appointment scheduling or extended hours that allows patients to choose a time slot most convenient to their schedule.

→ **Do we offer “flexible scheduling”? If so, how?**

Yes, we offer appointments starting at 0700 and appointments as late as 1600 to accommodate patient preferences. We also have walk-in clinics for some complaints (staple/suture removal, wart) and group visits for other complaints (asthma, ADHD, lactation support).

→ What does Relay Health offer the patient? What does it offer the PCMH?

RH gives patients the opportunity to message their care team 24/7about appointments, lab results, prescription renewals, and non-urgent health care needs. Patients can submit school paperwork and pictures through RH, and even have a follow-up "visit" for acne through the adolescent clinic! RH also has a robust multi-media education module that patients can use for self-management. RH benefits the PCMH in many ways: it allows us to send mass messages about clinic offerings (e.g. flu shots), send targeted messages to specific populations (e.g. informing patients with asthma about asthma classes), and give lab and rad results without playing phone tag.

→**What does TriCare Online offer the patient? What does it offer the PCMH?**

TOL allows patients to schedule appointments, access immunization records, and view enrollment data online. Patients > 18 years old can also access vital signs, radiology and laboratory results, and encounter notes using TOL. The PCMH benefits when patients use TOL because it is more efficient than contacting us: when patients use TOL to make appointments, this is one fewer telephone call coming through our front desk or the call center. We benefit when patients download immunization records via TOL, as it avoids a phone call or secure message (with its attendant AHLTA telephone consult) and a bunch of legwork to print and send the imms record (receive call, initiate Tcon, access AHLTA record, download/print/scan imms record, fax or email imms record, update Tcon, sign Tcon….whew!).

Emphasis on **patient and family-centered care**, another important component of the PCMH, calls for clinicians and their practice team (the medical home team) to ensure that any decisions made by the team respect not only the patient's needs and preferences but also the family's concerns and preferences. Self-management is an important component of patient-centered care, and a patient's family can help encourage and facilitate self-management if the child is old enough to take on this responsibility. Whether it's encouraging patients to take their medication correctly, helping them adhere to a special diet, or helping them avoid harmful health habits, enlisting the family's support can be incredibly beneficial.

→ Other than providers and nurses, which PCMH team members can help patients adhere to medical guidance? What consults might you place for families that have difficulty with compliance?

Refer to IBHC, social work, or to disease management. IBHC can provide motivational interviewing and brief (4-6 visits) interventional counseling to help the patient manage psychologic stress across a wide variety of medical and psychological conditions. Social workers can connect the patient with community resources, help with special programs (e.g. IEPs, enrollment in WIC and medicare, etc) and provide longer-term behavioral health counseling. Disease management nurses are primarily patient educators, responsible for monitoring/tracking patients

with chronic diseases and providing patients with individualized self-management strategies; DM nurses can follow the patient longitudinally, contacting the patient to help ensure compliance with recommended medical advice.

Family-centered care also means the PCMH staff knows each patient and family they care for well enough to be able to communicate with them in a way they are most comfortable with, whether that be via secure messaging, by telephone, or in person. Similarly, it requires members of the medical home team to be sensitive to issues that concern each family, including, for example, transition to adult systems, discussion of sexually transmitted infections, or any number of other health-related issues.

Team-based care is another important component of family-centered care. The National Center for Medical Home Implementation outlines several key "ingredients" needed to transform a medical staff into a team. It explains that "[t]eamwork involves a set of skilled cross-disciplinary interactions that are learned, practiced, and refined to provide better health care services, promote safety, and enhance outcomes." In practical terms, that means members of an effective team need several skills, including the ability to communicate effectively and respectfully with all other members of the team, and the ability to share ideas freely.

Daily team huddles are one effective strategy used in our PCMH to implement a team-based approach to patient care. Daily huddles improve team efficiency and coordination and are the primary communication method between team members. With a huddle, teams come together physically for 10 minutes at 0850 to plan the day's activities. This technique allows teams to strategize and anticipate needs of patients and their families. Effective huddles require scrubbing of appointments ahead of time per team protocol. Huddles can also occur at any time of day when situations change (e.g. a staff member must unexpectedly leave the clinic, or a very ill patient presents to the clinic who needs treatment significantly more intense than originally anticipated).

The Tuesday weekly huddle allows the PCMH team to evaluate the schedule for the following week, identifying patients who would be better served in a non-traditional appointment (like an appointment with the disease manager) or in a non-face-to-face appointment (like a telephone consult with a nurse), and identify opportunities to increase access by calling patients that may not need an appointment at all (like a patient who had a well checkup 2 months ago with chief complain of "paperwork, or a patient who qualifies for a walk-in clinic like suture removal or wart clinic). Weekly huddles also serve to identify staff absences and coverage and ensure that patients who have preventive health needs are identified (for example, a child with an appointment for "rash" who is overdue for a well child check).

In our clinic, we use TeamSTEPPS and IPASS as communication tools between team members. TeamSTEPPS is an evidence-based teamwork framework proven to reduce errors and improve patient care quality; it focuses on improving information sharing and

clarifying roles and responsibilities to improve patient outcomes. IPASS is a specific tool used to improve transitions of care between team members; it is the hospital standard for handoffs, and is used in both inpatient and outpatient settings. Both written and oral IPASS mechanisms occur when patients are transferred to an inpatient service. (The IPASS form can be found here.)

Team-based care also means including the patient and family in addition to the clinicians and administrators. In fact, patients and their families are the most essential members of the team. Moreover, team members extend beyond confines of the practice. Community partners, specialists, educational partners, and anyone participating in enhancing the life of a child and his family are part of the PCMH team.

→ **Who is a part of our PCMH team?**

Just about everyone!! Within our walls: IBHC, doctors, nurses, admin staff, clinic manager, business manager, specialists, social worker, case manager, disease manager etc etc.

A focus on **quality improvement** is essential for a PCMH to be effective. It requires that clinicians adhere to evidence-based treatment and management protocols and use clinical decision support tools to inform their day-to-day decision making. Concern for quality care also translates into a sense of accountability and a willingness to voluntarily engage in ongoing performance measurement and improvement.

PCMH Certification Programs

There are two main certifying bodies for PCMH practices: National Center for Quality Assurance (NCQA) and The Joint Commission (TJC). In 2016, our medical home received Level II NCQA recognition (Level 1-3 available, 3 being the most functional PCMH), which will expire in 2019. However, the majority of military treatment facilities are moving toward certification by TJC, a non-profit company focused on healthcare safety, quality, and cost. TJC has been accrediting healthcare organizations since 1975 on topics such as infection control, workplace safety, and medication management; it began certifying medical homes in 2011. The TJC PCMH survey occurs *at the same time* as the general hospital safety survey, and our window for the survey is 1 Sep 2017 - 1 Feb 2019.

TJC uses patient tracers to determine compliance with safety and PCMH standards; this means the TJC surveyor (clinical and administrative professionals familiar with health care and trained to survey hospitals and clinics) will follow a patient through the hospital to observe the principles of PCMH in action. They will talk with patients, observe educational materials in the waiting room, perform chart reviews to examine transitions of care, check training records and competencies, and view quality and safety data.

Some of the questions surveyors commonly ask team members during a PCMH survey include:

- Who are the members of your team?
- What PI project are you working on?
- How do you track referrals and lab results?
- How do you communicate with patients? With your team?
- How can patients give feedback about their experience?
- Does your medical home collect data on disease management or population health outcomes?

Case

You see Keith Bauer on your schedule for tomorrow. He is 8 years of age and has moderate persistent asthma. His mother, a single active duty Army Specialist, was expelled from a military training class because she had to bring him to his pediatrician's office during a flare-up not responding to his albuterol inhaler; he was admitted for status asthmaticus and was in the hospital for 5 days. Jonathan has been hospitalized several times in the last year for his asthma.

→ **How does the enhanced access of a PCMH benefit a patient like Keith?**

Patients like Keith and his mother can benefit in numerous ways from experiencing care in a PCMH. Given that SPC Mendez has a busy schedule, offering her access to Tricare Online (which allows her to schedule a visit at her convenience) is valuable. Similarly, offering "flexible scheduling" -- appointments early in the morning or late into the evening -- is also beneficial because they do not interfere with her work and training schedule.

→ **What are some things you might consider doing before this patient even comes into the clinic? What forum would you use to communicate this information to your team?**

Discuss patient at team huddle to communicate patient needs

Check for annual PFTs

Check if the patient has had a flu shot

Check if the patient has picked up his medications

Check for a current asthma action plan

Check to see if this patient has seen any of the PCMH extenders (disease management nurse, behavioral health consultant)

Check to see if this patient has received any group counseling from the disease management nurse

You see Keith for his follow-up, and AHLTA previous encounters does not show a pulmonary encounter in over a year. (You note that the last pulmonary note recommended follow-up every 6 months.) Based on this information, you decide to place a consult.

→ **How will you help the patient comply with your advice to see a pulmonologist?**

There are many ways that a PCMH helps patients navigate our complex medical care system - this is the essence of **care coordination**. Here are a few ways:

(1) Use the discharge sheet in your room to indicate - in writing!! - your recommendation to see pulmonary. You should also indicate any other recommendations/consults/labs on the discharge sheet for the family to take home.
(2) Send the patient to the discharge desk immediately after your visit to make the appointment for pulm. Our discharge desk staff coordinates the next visit for the patient, which is more convenient for the patient (no call to IRMAC!) and, most importantly, increases the chance that the patient will complete the consult.
(3) Check your consult log in AHLTA to ensure that the patient makes the appointment, sees the pulmonologist, and that you are aware of the pulmonologist's recommendations and act on them if needed.
(4) Consider referring the patient to the disease management nurse (DIS MGMT BE) so that she can help track compliance with medications, referrals, etc.

During your visit with Keith, you determine that he isn't compliant with his advair or albuterol use because he feels "different" from other kids when he uses his inhaler. As you get to know him and his mother, you learn that he also hates being admitted to the hospital; you sense that he is frustrated with his chronic disease, and that this frustration is affecting his ability to comply with recommended advice.

→ **How can you help Keith in managing his emotions about his asthma?**

Consider a referral to our behavioral health consultant Dr. Elmore or our Social Worker Ms. Alford - they can discuss these emotions and help Keith work through them.

You also learn that the mother has taken an inhaler in the past (when she had "pneumonia"), but she was not given a spacer with which to use the inhaler. She has since not required Keith to use his spacer - after all, if she didn't have to use one, why should he?

→ **How will you address spacer use with the family?**

No patient should use an inhaler without a spacer (including adults). The medication will be ineffective, and the patient will not benefit from it. This family needs spacer training, which our disease management nurse can provide on-the-spot after your encounter. She has a room assigned to her in the clinic or is available by phone at 240-486-0438. She will also discuss your asthma action plan with the patient, discuss patient self-management goals, and ensure the patient complies with PFTs and consults. The patient will remain on her asthma registry and she will follow-up with the patient at least monthly to see how he is doing.

At the end of your visit, you write a new asthma action plan. As usual, you give the family anticipatory guidance about when they should seek medical care for asthma symptoms.

→ **Who will you tell them to call on weekends and after hours?**

The family should call the Nurse Advice Line (NAL), a 24/7 service which provides medical advice over the phone for TRICARE beneficiaries. The NAL can direct the patient to an emergency room or can book an acute appointment in our clinic. Every morning, our PCMH nurses review the NAL notes (which are in a separate electronic system than AHLTA/CHCS) and copy them into the AHLTA record via Tcon.

→ **What will you tell them to do if they need prescription refills, have an administrative question, or need non-urgent health care advice?**

The family should use Relay Health, also called secure messaging, to contact our clinic for these non-urgent needs. Relay Health is a 24/7 service that allows patients to request results, prescription refills, and appointments on their computer or mobile device. If the family is not connected to us on Relay Health, learn how to invite them (it takes 10 seconds!) or send them to the discharge desk for enrollment.

The patient and mom are thrilled with your knowledge and expertise and thank you profusely for helping them today. They request to see you in clinic for all their future visits.

→ **How do you know if you have room on your panel for this patient?**

Each intern has a patient panel capacity of 55; each senior resident has a patient panel capacity of 99. These panel maximums are based on how often you are in clinic and how many patients you see during your clinics, as well as the expected appointment demand of pediatric patients. You can check your panel in Carepoint to determine if there is an opening for this patient. In reality, it is ok to go over your assigned panel number by a few patients, so if you're very attached to this family, you can move them (using the process below) even if Carepoint indicates that you have no capacity.

→ **How will you help them change their primary care manager to you?**

Fill out the PCM change form in your drawer and give to our clinic lead petty officer (LPO) HM2 Bracey; her office is behind the front desk. Giving the change form to her is important since she changes the patient's affiliation in Relay Health *and* provides a list of panel changes to TRICARE.

The mother wants to know how she can give feedback to the clinic or hospital about the wonderful comprehensive and coordinated care she has received in the clinic.

→ How can the mother provide feedback about her experience?

There are multiple mechanisms available for patient feedback:

(1) JOES (Joint Outpatient Experience Survey) - a survey sent by mail after patients visit our hospital. Patients can return by mail or fill out online. Results are available to anyone with a CAC (patients too!) at JOESReports.com.
(2) ICE (Interactive Customer Evaluation) - an online tool used across the entire military to provide feedback about all kinds of customer service experiences (even stuff like JAG, MWR, the galley, etc).
(3) Comment cards and boxes are available at the front desk and discharge desk.
(4) The patient can always speak with the clinic manager (Mrs. Putney) or service chief (Dr. Richards).

The following are select Joint Commission Elements of Performance (EPs) upon which we will be scored during the TJC PCMH Survey. Select the EPs that we meet by checking the boxes below. Be prepared to defend your answers during continuity clinic.

Leadership (LD)

X Ongoing performance improvement occurs hospitalwide for the purpose of demonstrably improving the quality and safety of care, treatment, or services. (we all participate in PI through the PCMH)

X The interdisciplinary team actively participates in performance improvement activities. (we have a variety of personnel working with their teams on PI projects)

☐ Leaders involve patients in performance improvement activities. (not really; there are no patients either on our PI teams or PI teams at the hospital level)

Provision of Care, Treatment, and Services (PC)

☐ Patient self-management goals are identified, agreed upon with the patient, and incorporated into the patient's treatment plan. (Not consistently)

X The PCMH uses clinical decision support tools to guide decision making. (TSWF has clinical decision support tools, e.g. asthma section, ADHD section)

X Each patient has a designated primary care clinician.

☐ The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient's individual needs. (Not consistently)

☐ The interdisciplinary team identifies the patient's health literacy needs. Note: Typically this is an interactive process. For example, patients may be asked to demonstrate their understanding of information provided by explaining it in their own words. (we ask about preferences for learning, but do not use an interactive process to determine health literacy)

☐ The primary care clinician and the interdisciplinary team incorporate the patient's health literacy needs into the patient's education. (we don't identify the patient's health literacy needs, and therefore do not incorporate these needs into the patient's education)

X The PCMH provides patients with access to the following 24 hours a day, 7 days a week:

- Appointment availability/scheduling (Tricare Online)
- Requests for prescription renewal (Tricare Online, Relay Health)
- Test results (Relay Health)
- Clinical advice for urgent health needs (Nurse Advice Line)

X The PCMH offers flexible scheduling to accommodate patient care needs. Note: This may include open scheduling, same-day appointments, group visits, expanded hours, and arrangements with other organizations.

X The PCMH has a process to address patient urgent care needs 24 hours a day, 7 days a week. (Nurse advice line)

X The PCMH provides disease and chronic care management services to its patients. (Our disease management nurse manages many of our patients with asthma and obesity.)

X The PCMH provides population-based care. (Population-based care = HEDIS; we collect HEDIS data and have completed PI projects to improve these quality numbers)

X The PCMH identifies the composition of the interdisciplinary team, based on individual patient needs. (We include whoever we need, e.g. IBHC, disease management nurse, social work, nutrition)

X The primary care clinician and the interdisciplinary team provide care for a designated group of patients. (PCMs have a patient panel)

☐ When a patient is referred internally or externally, the interdisciplinary team reviews and tracks the care provided to the patient. (We do not track the consults, which would require ensuring that the patient makes the consult appointment (at WR or outside), shows up to the consult appointment, and that the report makes it back to the PCM for action)

☐ The interdisciplinary team acts on recommendations from internal and external referrals for additional care, treatment, or services. (we do not track, thus do no reliably act on recommendations)

X The interdisciplinary team assesses patients for health risk behaviors. (We screen for lead risk, TB risk in young kids, and for depression and smoking in teens)

Performance Improvement (PI)

X The PCMH collects data on the following:

- Disease management outcomes. (disease manager)
- Patient access to care within time frames established by the hospital. (JOES)
- Patient experience and satisfaction related to access to care, treatment, or services, and communication (JOES)
- Patient perception of the comprehensiveness of care, treatment, or services (JOES)
- Patient perception of the coordination of care, treatment, or services (JOES)
- Patient perception of the continuity of care, treatment, or services(JOES)

X The Primary Care Medical Home uses the data it collects on the patient's perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the items listed above. (JOES)

Rights and Responsibilities of the Individual (RI)

X The PCMH respects the patient's right to make decisions about the management of his/her care. (Although subjective, most providers encourage patients to be engaged in their care)

X The PCMH allows the patient to select his or her primary care clinician. (TRICARE assigns a PCM initially, but each patient then receives a call from disease manager to receive orientation to the clinic and to match patient to PCM)

Record of Care, Treatment, and Services (RC)

☐ The medical record contains information about the patient's care, treatment, or services that promotes continuity of care among providers. Note: This requirement refers to care provided by both internal and external providers. (We don't reliably have reports from external consults)

☐ The medical record includes the patient's self-management goals and the patient's progress toward achieving those goals. (We do not reliably document self-management goals, or track the patient's progress toward these goals; disease manager perhaps does)