



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



Pre-Meeting Preparation:

Please read & complete the following enclosures/links:

- **Read** “The Patient-Centered Medical Home” (adapted from AAP PCMH curriculum)
- **Complete the 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?**

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** (<https://carepoint.health.mil>) 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)** (<https://jlv.health.mil/JLV/app/index>)
- 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.) **Make sure you know how to check and complete taskings.**

Links accessible via Chrome on CAC-enabled devices, may need to copy and paste and manually remove menlo security from address

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 (TriCare Online Secure Messaging.) Our medical home also offers **same-day appointments** (often called “24 hour” appointments), weekend hours, 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?**

- **What does TriCare Online Secured Messaging offer the patient?**
- **What does it offer the PCMH?**

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

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?**

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 and/or virtually 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). Daily huddle also allows the PCMH team to evaluate the schedule for the following week, identifying patients who would be better served in a non-traditional or non-face-to-face appointment (t-con or virtual), 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). 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). **Some of these tasks may also be accomplished at team meetings that take place during twice monthly clinic-wide training.**

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?

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 expired 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 most recent survey, followed by TJC PCMH accreditation, was in September 2021. TJC revisits at a minimum of once every 3 years, so we should anticipate the next survey in 2024.

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. Keith 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?**

→ **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?**

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?**

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?**

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?**

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?

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

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?**

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

PCM Change FORM

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?**

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)

- ☐ Ongoing performance improvement occurs hospitalwide for the purpose of demonstrably improving the quality and safety of care, treatment, or services.
- ☐ The interdisciplinary team actively participates in performance improvement activities.
- ☐ Leaders involve patients in performance improvement activities.

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.
- ☐ The PCMH uses clinical decision support tools to guide decision making.
- ☐ 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.
- ☐ 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.
- ☐ The primary care clinician and the interdisciplinary team incorporate the patient's health literacy needs into the patient's education.
- ☐ The PCMH provides patients with access to the following 24 hours a day, 7 days a week:
 - Appointment availability/scheduling
 - Requests for prescription renewal
 - Test results
 - Clinical advice for urgent health needs
- ☐ 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.
- ☐ The PCMH has a process to address patient urgent care needs 24 hours a day, 7 days a week.

- ☐ The PCMH provides disease and chronic care management services to its patients.
- ☐ The PCMH provides population-based care.
- ☐ The PCMH identifies the composition of the interdisciplinary team, based on individual patient needs.
- ☐ The primary care clinician and the interdisciplinary team provide care for a designated group of patients.
- ☐ When a patient is referred internally or externally, the interdisciplinary team reviews and tracks the care provided to the patient.
- ☐ The interdisciplinary team acts on recommendations from internal and external referrals for additional care, treatment, or services.
- ☐ The interdisciplinary team assesses patients for health risk behaviors.

Performance Improvement (PI)

- ☐ The PCMH collects data on the following:
 - Disease management outcomes.
 - Patient access to care within time frames established by the hospital.
 - Patient experience and satisfaction related to access to care, treatment, or services, and communication
 - Patient perception of the comprehensiveness of care, treatment, or services
 - Patient perception of the coordination of care, treatment, or services
 - Patient perception of the continuity of care, treatment, or services
- ☐ 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.

Rights and Responsibilities of the Individual (RI)

- ☐ The PCMH respects the patient's right to make decisions about the management of his/her care.
- ☐ The PCMH allows the patient to select his or her primary care clinician.

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.
- ☐ The medical record includes the patient's self-management goals and the patient's progress toward achieving those goals.