The Road to Becoming a Recognized Patient Centered Medical Home: A Quality Improvement Journey

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Purpose and Scope

- **Purpose**
  - To improve patient outcomes and healthcare delivery at Palma Ceia Family Care
- **Scope**
  - Phase II: development of PCMH infrastructure, systems, and processes
  - Complete Interactive Survey System assessment & documentation
  - Submit application to NCQA
  - Selected work/activities associated with project Phase III: Project Evaluation

Background

- **Current U.S. healthcare system concerns**
  - Described as a mosaic, fragmented, disintegrated network of constituents
  - Ranked number one for healthcare expenditures.
    - $2.9 trillion is spent on healthcare;
    - 17.4% of Gross Domestic Product
  - Ranked lowest in overall healthcare standing for quality, access, efficiency, equity, and indicators of health
- **Impact/ Result**
  - Waste of resources
  - Loss of information
  - High cost
  - Low quality care

Proposed Solution

- **Patient Centered Medical Home (PCMH) Model Objective**
  - Revitalize the joy of practice by increasing patient and provider satisfaction
- **Principles**
  - Coordination of care
  - Effective communication
  - Transformation of primary care into what patients desire
  - Higher quality of care, lower costs, and improved patient and provider satisfaction
- **NCQA PCMH Recognition Program**

Scoring
Level 3=85-100
Level 2=60-84
Level 1=35-59

→ 6 Standards
27 Elements
178 Factors

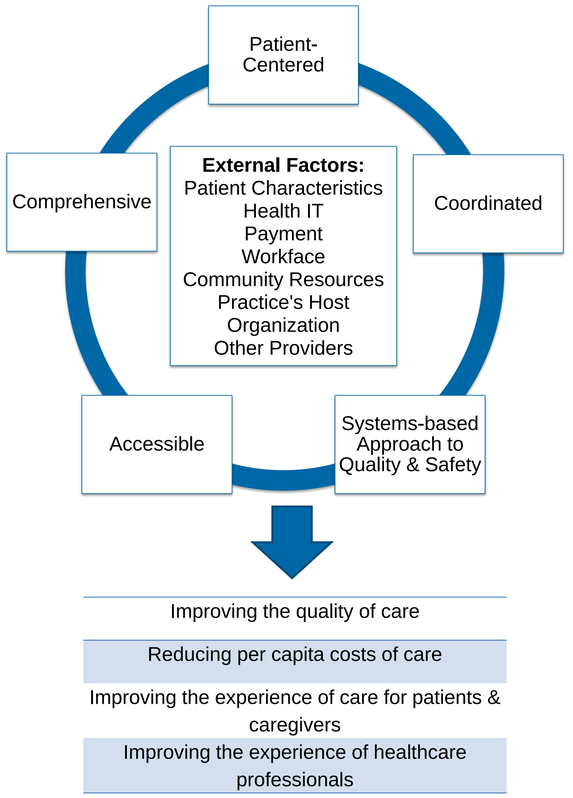
Setting

- **Palma Ceia Family Care**
  - Physician owned solo practitioner family practice
  - Patient panel = 3,000 patients
  - Volume = 15-20 patients/ day

Methods

- **Project Design**
  - Evidence translation practice improvement
  - Multi-phase Doctor of Nursing Practice project

PCMH Implementation Model



Adapted From: https://pcmh.ahrq.gov/sites/default/files/Figure1.png

Lessons Learned

- Establish clear project goals and measurable outcomes
- Understand and assume accountability to lead a team
- Expand scope and depth of knowledge related to healthcare delivery
- Develop understanding of continual tracking and monitoring to improve patient outcomes
- All practices (irrespective of size) can make prompt and sustained transitions to a PCMH if provided with external support

Phase II Implementation

- Established target submission date
- Developed registries and reports via *eClinicalWorks*
- Created clinical and administrative practice policies, procedures, protocols, and educational materials
- Developed care pathways and procedures
- Facilitated staff involvement and oriented PCFC personnel to NCQA PCMH guidelines
- Assisted staff with changes in workflow, responsibilities, and implementation of new practice policies and procedures
- Attended regularly scheduled team meeting with physician team champion to ensure progress updates, strategic planning, and alignment of goals/survey submission timeline
- Uploaded and linked data and supporting documentation into the ISS tool
- Completed ISS survey review and submitted to NCQA

Summary of Infrastructure Enhancements

DNP Consultant Tangible Products	Volume Generated
Written Policies	23
Example Materials/ Patient Education	132
Reports	87

Results

Patient-Centered Medical Home	Points Received	Possible Points
PCMH 1: Patient-centered access	9.50	10.00
PCMH 2: Team-based care	9.37	12.00
PCMH 3: Population health management	16.00	20.00
PCMH 4: Care management and support	19.00	20.00
PCMH5: Care coordination and care transitions	12.00	18.00
PCMH6 : Performance measurement and quality improvement	15.00	20.00
Category total:	80.87	100.00

80.87 total points = Level II NCQA PCMH Recognition

DNP Essentials Alignment

DNP Competencies	Key DNP Project Activities
Scientific Underpinnings for Practice	Application of model of care based on comprehensive scientific theories and concepts through implementing evidence-based care guidelines
Organizational and Systems Leadership…	Implementation of innovative model of care to improve healthcare delivery and care outcomes
Clinical Scholarship and Analytical Methods…	Completion of comprehensive literature review and application of Donabedian framework
Information Systems/ Technology and Patient Care Technology…	Integration and application of EHR and patient registries to achieve project outcomes
Health Care Policy…	Application of NCQA guidelines and standards
Interprofessional Collaboration…	Collaboration with PCFC interprofessional team to achieve project goals
Clinical Prevention and Population Health…	Utilization of patient registries to monitor, track and improve population outcomes for PCFC patient panel
Advanced Nursing Practice	Integration of clinical knowledge and DNP competencies to achieve project outcomes

Acknowledgments

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References

See available handout for references.