The Primary Care Medical Home Certification Journey

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The First Medical Home

- Often considered the “first” medical home, HIV programs (through the federally funded Ryan White Program) offer patient-centered, coordinated care necessary to ensure successful health outcomes for its patients.
- In addition to traditional primary and specialty medical care, these clinics offer support services to ensure access to care and adherence to HIV treatment.
- The care delivery model of HIV practices evolved to medical homes as the disease transitioned from a terminal disease to a chronic illness. ¹

Background

The Vanderbilt Comprehensive Care Clinic (VCCC) is a patient-focused medical home for people living with HIV, located in Nashville, Tennessee.

The VCCC's mission is to provide effective, patient-centered, quality medical care for people living with HIV/AIDS, by combining clinical expertise, secondary services, and collaborating with community agencies.

In September of 2015, the VCCC obtained Primary Care Medical Home (PCMH) certification through The Joint Commission.

Services offered at the VCCC

- Clinical and laboratory evaluation (primary care, colposcopy, obstetrics and HIV)
- Psychiatric care and Mental Health Services
- Clinical Pharmacy Services (Medication Reconciliation and Adherence Counseling)
- Nutrition Services
- Case Management Services & Care Coordination
- New patient navigation
- Coordination of Home Care, Hospice, Infusion Transfusion Services
- Nutrition Assessment and Guidance
- Clinical trials access
VCCC Operations and Staff

• **Operations**
  – Over 8,500 patients enrolled
  – Over 3,200 active patients
  – Over 1,400 visits per month
  – Approximately 300 new patients per year
  – Approximately 30-40 pregnant women per year

• **Staff**
  – Infectious Diseases attending physicians and Psychiatrist
  – Nurse Practitioners (medical & psychiatric)
  – Registered Nurses & Licensed Practical Nurses
  – Social services staff (licensed and non-licensed)
  – Clinical Pharmacist
  – Registered Dietitian

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**Patient Centered Care Model**

- **Care Team**
  - MD/NP
  - LPN/RN
  - Social Worker

- **Support Services**
  - Intake Coordinators
  - Financial Counselors
  - Referral Specialist

- **Psychiatric Services**
  - MD/NP
  - LPN/RN
  - Clinical Social Worker

- **Clinical Pharmacy**
  - RN case managers
  - Patient Assistance Coordinator
  - Pharmacist

- **ART Conference**
  - All patients with HIV medication initiations or changes are reviewed in a case conference by all clinical team
Benefits of a Medical Home

• Better coordinated, more comprehensive and personalized care
• Improved access to medical care and services
• Improved health outcomes, especially for patients who have chronic conditions
• Fewer hospital days, fewer ER visits
• Higher satisfaction levels for patients, providers and staff
• Stronger relationships with patients yield higher treatment plan adherence
• Physicians and staff members who practice at the top of their licenses
• Improved safety and quality of care for the practice
• Opportunities to participate in payment incentives for adopting the functions of a PCMH
• A practice that is better prepared to participate in accountable care organizations

Key Steps in Practice Transformation

• Understand the PCMH Framework
  – History, Core Principles, Patients’ Role
• Communication to Key Stakeholders, including administration, patients and staff
• Determine best certification or recognition option for your organization
• Identify your project team and determine important gaps (self-assessment)

Comparison of NCQA 2014 Medical Home Recognition to 2014 Joint Commission Primary Care Medical Home Certification

<table>
<thead>
<tr>
<th>FEATURE</th>
<th>THE JOINT COMMISSION</th>
<th>NCQA</th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td>Primary Care Medical Home</td>
<td>Patient-Centered Medical Home</td>
</tr>
<tr>
<td>Award Label</td>
<td>Certification</td>
<td>Recognition</td>
</tr>
<tr>
<td>Length of award</td>
<td>3 years</td>
<td>3 years</td>
</tr>
<tr>
<td>Scope of Evaluation</td>
<td>Entire organization/practice</td>
<td>Delivery site specific</td>
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<tr>
<td>Core components/Operational Characteristics</td>
<td>Patient-Centered Care; Comprehensive Care; Coordinated Care; Superb Access to Care; Systems Approach to Quality &amp; Safety</td>
<td>Patient-Centered Access; Team-based Care; Population Health Management; Care Management &amp; Support; Care Coordination &amp; Care Transitions; Performance Measurement &amp; Quality Improvement</td>
</tr>
<tr>
<td>Accreditation of organization also required?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Includes levels of achievement?</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Need to submit documentation of compliance?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>On-site survey conducted to evaluate compliance?</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>On-site consultation on approaches to compliance?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Scoring process</td>
<td>Must comply with all standards, with post-survey opportunity &amp; support to comply</td>
<td>Points-based, with Must Pass elements &amp; critical factors</td>
</tr>
<tr>
<td>Copy of preliminary report available on-site?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Post survey support?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Continued compliance support?</td>
<td>YES</td>
<td>NO</td>
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</tbody>
</table>

2 http://www.jointcommission.org/assets/1/18/PCMH_cross_ncqa.pdf

Foundations of a Medical Home

Patient and provider relationship

Provides information to the patient on the services provided, mission/vision/goals of the organization, patient rights & responsibilities

Continuity of care

Coordinates care across all elements of the broader health care system

Comprehensiveness of care

Primary health care that is relationship-based with an orientation toward the whole person

Accessibility

Delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team

Quality

Using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families; Engaging in performance measurement and improvement; Measuring and responding to patient experiences and patient satisfaction
The VCCC PCMH Model

Choosing the Right Certification Option

- The Joint Commission’s PCMH certification option was selected, in lieu of NCQA’s PCMH Recognition, due to data extraction and reporting limitations with the institution’s EMR system.
- After completing the appropriate assessment tool and identifying gaps essential to obtaining certification, clinic processes were instituted to ensure compliance with certification standards:
  - Restructure the patient intake process and New Patient Information packet
  - Active involvement of patients in CQI processes
  - Revise clinician visit template to ensure patient self-management goals are captured during each encounter
- The application for certification was added to the institution’s triennial reaccreditation survey
Patient Centered

- Intake coordinators and defined intake process
- Review of patient rights and responsibilities
- Assignment to one clinician and ability to request change
- Patient involvement in care: medical team collaboration, clinical pharmacy team, social work and nurse case managers
- Interpreter services
- Electronic prescribing; patient portal
- Adherence, substance abuse, tobacco and safety surveys
- Patient participation in CQI committee, satisfaction surveys

Continuity of Care

- Care provided from age 18 to end of life
- Transition from inpatient to outpatient care
- Access to variety of specialists throughout the medical center
- EMR decision support for clinical care and health maintenance
- Referrals – internal and external – mental health, specialty medical care, oral health, social services
- Close collaboration with home health, hospice
- Integrated EMR system
Comprehensiveness

• HIV, primary care, obstetric care for HIV-infected mothers, mental health, other chronic care, e.g., diabetes, hypertension
• All attending physicians are Internal Medicine/Infectious Diseases trained
• Interdisciplinary care teams – provider, nurse(s), social worker
• Special program care teams – Clinical Pharmacy Services, Social Services, Obstetrics, Adolescent transition

Accessibility

• Patient Portal – over 2,600 patients currently enrolled
• Flexible walk in/work-in visit protocol
• Afterhours call service
• Telephonic Nurse Triage access
Quality

• Health information technology, electronic prescribing, clinical decision support tools
• Performance improvement
  ➢ Data on outcomes, access, patient experiences
  ➢ Utilizing collected data, Continuous Quality Improvement (CQI) Committee with leader, team and patient involvement
• Institutional quality program
• Mandatory compliance with federal oversight-based quality benchmarks

The Joint Commission

Certification Process

PCMH Certification Option
(52 additional requirements)

Ambulatory Care Accreditation
(~900 applicable standards pertaining to medical settings, including 123 applicable to PCMH)

www.jointcommission.org
The Joint Commission

Certification Process

- Applies to an accredited ambulatory care organization (or one seeking accreditation)
- On-site survey process to evaluate compliance with both existing ambulatory care and PCMH requirements
- No special application requirements
- No additional on-site survey time
- No jeopardy to accreditation
- Organization-wide certification for up to 3 years

The Joint Commission

On-Site Survey Process

- On-site survey: No change to ambulatory survey sessions
- Trace patient experience (patient tracers)
  - Observe care provided
- Conduct patient interviews to discuss:
  - Selection of primary care clinician
  - Information offered on how to access the clinic
  - Consideration of language, cultural needs and preferences
- Discussions with organization leaders and staff regarding:
  - Scope of services available—acute, chronic, behavioral health
  - Determining the composition of interdisciplinary teams
- Observe use of infrastructure elements
  - Clinical decision support tools, HIT, e-prescribing, referral tracking
The Joint Commission
On-Site Survey Process (cont.)

• Building Tours

• HR file review
  Ensure primary care clinician is qualified for the role, working within scope of practice, and in accordance with laws and regulation

• Review of performance improvement data
  Patient perception of access and care coordination

• Daily Briefings and Exit Conference
  Written report with both accreditation and PCMH requirements for improvement

After the Survey

• Ensure Evidence of Standards Compliance (“Requirements for Improvement”) for both PCMH and other ambulatory care standards

• The Joint Commission accepts the Evidence of Standards Compliance submitted by the practice

• Recognition awarded for a 3 year Accreditation and Certification period

• Periodical Performance Review by The Joint Commission

• Annual self-assessment of PCMH and ambulatory care standards by the certified practice
Self-Assessment Tools

To help determine your organization’s readiness for certification, complete an assessment tool to identify gaps.

The Joint Commission
http://www.jointcommission.org/assets/1/18/AHC_PCMH_SAT.pdf

NCQA

Other Resources

HRSA National Quality Recognition Initiatives Resources: Comparison Chart

The Joint Commission: Primary Care Medical Home
http://www.jointcommission.org/accreditation/pchi.aspx

NCQA Patient-Centered Medical Home
http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx

Maccoll Center for Healthcare Innovation
http://maccollcenter.org/our-work/patient-centered-medical-home

Patient-Centered Primary Care Collaborative
https://www.pcpcc.org/about/medical-home

HIV Medical Homes Resource Center
https://careacttarget.org/mhrc

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http://www.jointcommission.org/assets/1/18/PCMH_cross_ncqa.pdf
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