Patient Centered Medical Home Lessons Learned in North Carolina

Debra Thompson, DNP, FNP-BC, PCMH CCE

Wilson Gabbard, MBA

Background

- Debra Thompson DNP, FNP-BC, PCMH CCE
  - Vidant Health

- Wilson Gabbard, MBA
  - UNC Health Care System

What is PCMH?

A patient-centered medical home (PCMH) puts patients at the center of the health care system, and provides primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."

(American Academy of Pediatrics)

Introduction to PCMH in 2011

- Vidant Health Strategic Initiative
  - Early Challenges
    - IT resources
    - Provider support
    - Too few resources to do additional work
  - Early questions
    - Why PCMH? Why now?
      - Care delivery paradigm shift

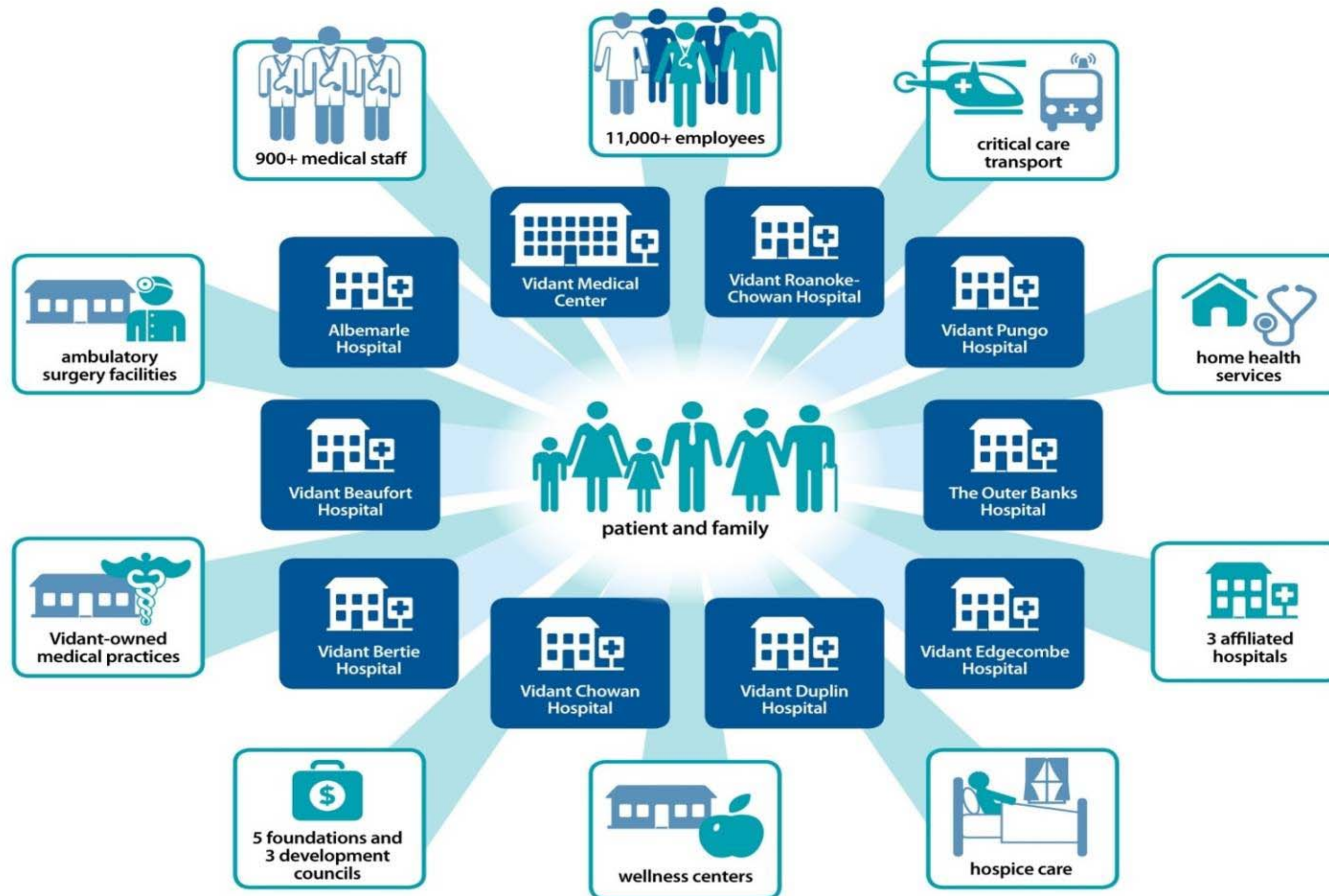
Current state of PCMH

- Vidant PCMH Deployment
  - Began in the fall of 2011
    - 3 NCQA Level 3 PCMH's
    - 5 clinics ~ 60% standards in place- 2015 application
    - 19 clinics "on the journey"
- UNC PCMH Deployment
  - Began PCMH recognition in 2010
    - 3 NCQA Level 3 PCMH practices in UNCFP
    - 2 NCQA Level 3 PCMH practices in Regional Physicians
    - 1 NCQA Level 3 PCMH practices in UNCPN
    - 11 Practices currently seeking recognition

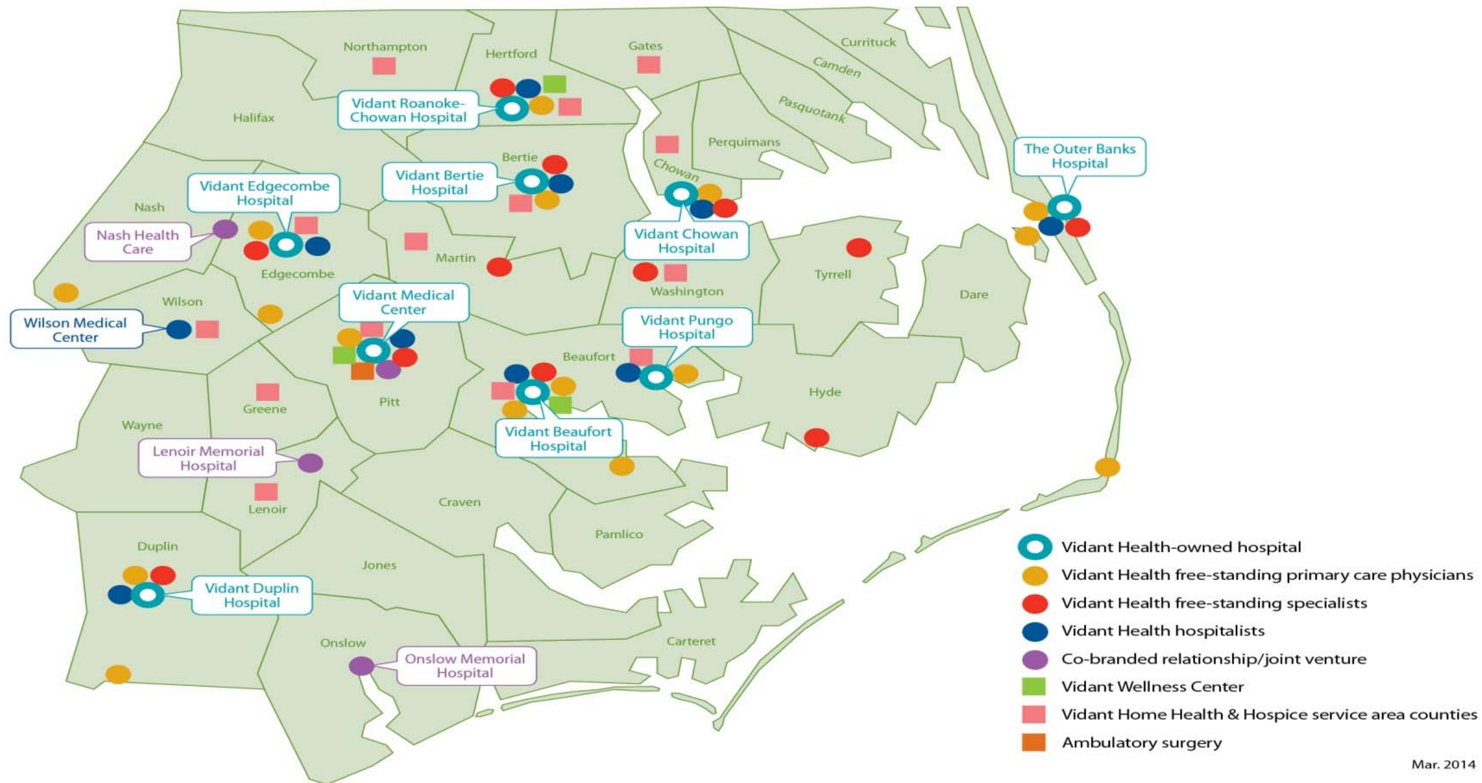
What is driving PCMH at Vidant?

- Vidant Health’s mission, Culture, Quality
- Support for innovative care, future directions toward Population Health
- Patient Centered- most important person on the care team

Vidant Health System of Care



Vidant Health- Who we Serve



What is driving PCMH at UNC?

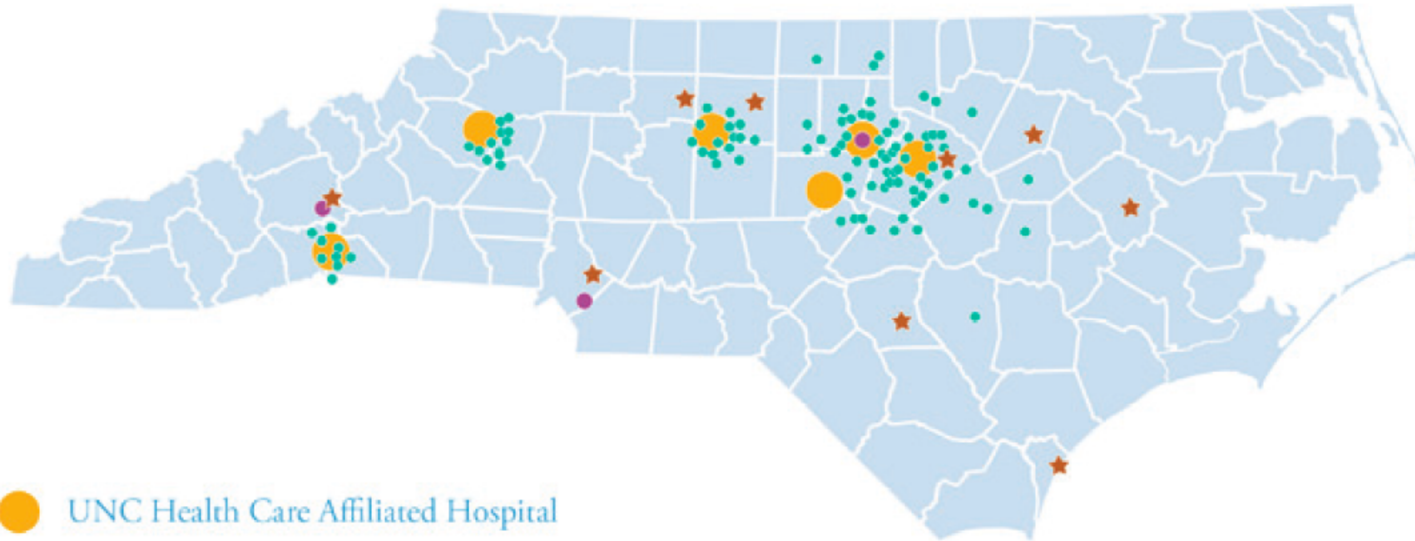
- Better outcomes for patients and families
- Teaching environment and Evidence Based Practice
  - The "lonely throne for the primary care physician"
- Contractual obligation
- Bridging the gap between Fee For Service and Quality Outcomes

Innovation *for* the Future of Health Care

Health care is changing more rapidly than ever. Growth and innovation are essential for health care organizations to effectively meet the challenges that change presents. As we reflect on the past year, it is clear that UNC Health Care is striving toward change that advances our mission.

UNC HCS- Who we Serve

UNC Health Care Across the State



- UNC Health Care Affiliated Hospital
- UNC School of Medicine Campus & Satellite Campuses
- UNC Health Care Owned or Affiliated Physician Practice
- AHEC Practice Site

PCMH Impact

- Vidant outcomes
  - 21% improvement in lipid screening
  - 10% improvement in communication scores
  - 50% improvement in mammography screening
- UNC outcomes (past 12 months)
  - 7% higher CRC screening
  - 9% higher mammography screening
  - 7% higher pneumovax screening

PCMH Impact (Continued)

- Unintended consequences
  - Improved Patient Experience- Patient Advisors:
    - "I think we are going in the perfect direction."
    - "Opportunity to have my voice heard and help make changes"
    - "You become more familiar with your doctor and get a better perspective of your medical condition"
  - Increased Clinical Staff Satisfaction
    - "This is why I went into nursing"
    - "I feel like I am making a real difference"
    - "It is no more than what I was doing before, I am just doing it before the doctors asks me to"

PCMH Challenges

- Provider buy in
- Competing priorities
  - Epic deployment and stabilization, Meaningful Use, Meaningful Use II, ICD-10, Operational targets and increased productivity
- Resources
  - Care managers
  - RD/CDE
- Team based workflows

Vidant Health- It takes a team….

Ten months of activity included:

- 135 factors implemented in 10 months
- ~ 90 chart reviews by clinic staff
- >400 chart reviews by VMG QNS
- 84 PDCAs implemented
- 15 Patient Advisors- 16 meetings
- 42 Hrs education/meetings

UNC Health Care- PCMH is not the goal….

Past 12 months of improvement work included:

- ~1,200 additional colonoscopies
- ~ 900 additional mammograms
- ~1,200 additional pneumovax vaccinations
- >180 onsite meetings with providers and staff

What would you have changed?

- Debra
  - Executive messaging- medical home is our standard of care
  - Education on team based care, workflows, Lean
  - Greater IT integration and support
- Wilson
  - Education with the entire care team on motivational interviewing, care coordination, population health management, etc
  - Better resources to deliver to practices during deployment. (P&P's, logs, screenshots, etc.)

Key skills needed in PCMH

- Patient Engagement
  - Motivational Interviewing
  - Teach back method
  - Patient Activation Measure
- Care coordination
- Population health management
- Tracking referrals, labs, imaging
- Overcoming change fatigue
- Top of license education and team work
- Critical thinking and importance of bringing sharing ideas

Reimbursement reform

- Substantiating population health staff
- Bridging the gap during fee for service reimbursement
- New primary care reimbursement
  - PMPM
  - New CPT codes (TCM, CCCC, etc)
- Setting the stage for ACO’s, shared savings, etc.

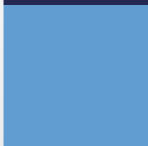
Practices taking the first step

- The best advice we can give is, "DON'T REINVENT THE WHEEL!"
  - AHEC is a great resource for information
  - Peers who have done this in similar settings
  - Patient-Centered Primary Care Collaborative
  - The Advisory Board Company
- Don't be afraid. There is a lot of information and people out there willing an able to support you.
- Include patients/families from the start

PCMH in the next five years

- Vidant Health
  - Goals include:
    - All primary care practices PCMH recognized
    - Medical neighborhood journey
    - System of care: care coordination, population health
- UNC
  - Goals Include:
    - All UNCPN practices PCMH recognized, including specialty practices.
    - Recertify recognition 3 UNCFP practices
    - Deploy recognition and population health programs in acquired entities, including Regional Physicians

Questions?



Patient Centered Medical Home Lessons Learned in North Carolina

Debra Thompson, DNP, FNP-BC, PCMH CCE
dthompso@vidanthealth.com

Wilson Gabbard, MBA
wilson.gabbard@uncpn.com