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A Program Evaluation to Assess Readiness for the National Committee for Quality Assurance's Patient Centered Medical Home Model Application

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Abstract

The Patient Centered Medical Home Model is associated with enhanced patient experience and quality improvement outcomes. The Model has the capacity to guide primary care practices to enhance quality, provide more comprehensive, patient centered care, and increase practice revenue. An urban, nurse managed community health center that has recently implemented the nurse care manager role (a Model requirement) desires to apply for recognition. A program evaluation was conducted to assess current practice, policies, and procedures in place at a Community Health Center through the lens of the National Committee for Quality Assurance's forty Patient Centered Medical Home Model core competencies. Evidence of core competency completion was verified through reports generated from the electronic health record. As a product of this evaluation, a business plan was created to guide the Community Health Center to attain the core competencies using a method that can be adapted for any primary care setting.

Introduction

The Institute for Healthcare Improvement created the Triple Aim in 2007.[1] The Triple Aim called to light the importance of improving population health, improving the quality of healthcare delivered, and the necessity to do so at a lower cost.[1] Although the Triple Aim since expanded to the Quadruple Aim, encompassing provider satisfaction, the original three components remain the same.[2] Despite this call to action, healthcare costs in the United States remain disproportionately high compared to nations with similar income levels over a decade later.[3] Recent payment reforms have incentivized providers to place more emphasis on the value of services performed and less emphasis on volume.[4] This shift in payment is increasing in significance as many primary care practices lost revenue due to the COVID-19 pandemic in

2020.[5] To increase value, primary care practices are turning to the Patient Centered Medical Home (PCMH) Model to guide transformation.[6] Although the concept of PCMH has been around since the 1960s, the Model has increased in popularity in recent years.[6] The National Committee for Quality Assurance (NCQA) is now the most common program utilized for attaining PCMH recognition in the United States.[7]

National Committee for Quality Assurance's Patient Centered Medical Home Model

To achieve NCQA-PCMH recognition, primary care practices submit evidence of the completion of 40 core competencies and of 25 elective credits outlined in the organizations standards and guidelines.[8] The core competencies and elective credits, are grouped in six key concepts that aim to increase quality, patient centered care, and teamwork within an organization.[9] These concepts are Team-Based Care, Knowing and Managing Your Patients, Patient Centered Access and Continuity, Care Management and Support, Care Coordination and Care Transitions, and Performance Measurement and Quality Improvement.[9]

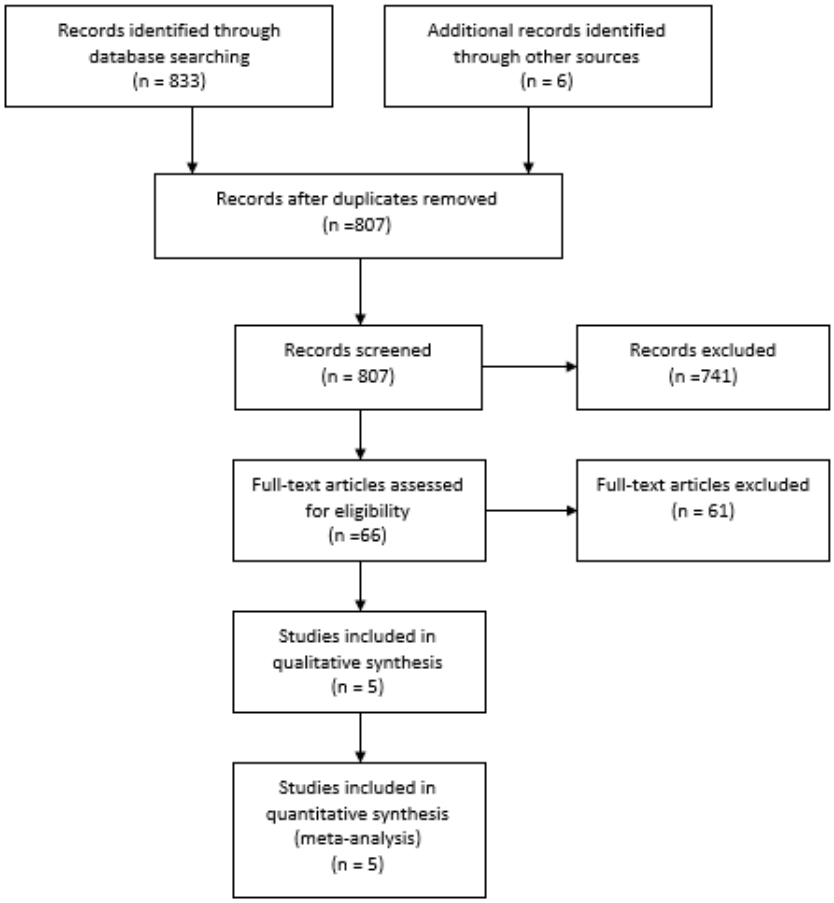
PCMH and Primary Care Practices

A literature review was conducted on achievement of NCQA-PCMH recognition by primary care practices to identify benefits of and barriers and facilitators to obtaining recognition. A preferred reporting items for systematic reviews and meta-analyses (PRISMA) diagram was used to guide the literature review.[10] A comprehensive electronic search using the databases CINAHL, PubMed, and Medline was conducted. The search was limited to full text articles published in English, published in 2017 or later due to recent changes in NCQA recognition standards.[11] The keywords searched were "patient centered medical home or PCMH" and "care coordination" and "primary care." Included were articles that focused on primary care practices or care management services. Articles were excluded if they did not take place in a

primary care practice and if other team members were the sole focus of the study, such as community health workers or psychologists. Information was also obtained from the NCQA website which had detailed information on the standards, requirements, and guidelines for NCQA-PCMH recognition.

The initial search generated 833 articles and an additional six articles were found on the NCQA website. After excluding duplicates, 807 articles were screened using the inclusion and exclusion criteria. After review of titles and abstracts, 66 articles appeared to meet inclusion criteria. An in-depth review of the article content led to the elimination of an additional 60 articles. The remaining six articles were used for this project (see Figure 1).

Figure 1. PRISMA Diagram[10]



Literature Review Results

While there are many forms of PCMH recognition, a key finding from the literature was that PCMH recognition is beneficial to primary care practices. PCMH recognition was associated with enhanced patient experience, most notably in high-risk populations[12] and quality improvement outcomes.[13] Multiple articles mentioned that electronic medical records were essential for implementing the NCQA-PCMH Model.[13, 14] Thus, making PCMH implementation more feasible in practices with electronic medical records in place.[14] Larger organizations and primary care practices were noted to potentially have more resources which could make PCMH recognition easier to attain.[14] Despite this, many smaller organizations were able to gain PCMH recognition, with some smaller practices outperforming larger practices in a number of key PCMH areas. [12]

The results of the literature review found care managers were essential for PCMH recognition.[15] In the literature, nurse care coordinators were cited by surveyed providers as the single most important aspect of a payer-based PCMH program.[15] Providers further attested that nurse care coordinators improved not only their experiences with PCMH but also patient experiences.[15] Although the article that highlighted nurse care managers referred to them as care coordinators, the functions of these personnel included tasks which the nurse care manager traditionally completes such as making follow-up calls to patients, increasing self-management skills, and initiating/managing patient care plans.[15] The results of this literature review supported primary care practices striving towards NCQA-PCMH recognition.

Project Purpose

The purpose of this project was to conduct a program evaluation of a small, urban, nurse managed Community Health Center (CHC) through the lens of the 40 core competencies for

NCQA-PCMH recognition. Core competencies were identified as complete, partially complete, or incomplete. The goal was for the CHC to determine if NCQA-PCMH recognition could be attained with the current practice model.

Guiding Theoretical Frameworks

The Chronic Care Model[16] and the Logic Model[17] guided this program evaluation. The Chronic Care Model emphasizes the importance of care managers in the primary care setting to support vulnerable patients with multiple chronic illnesses.[16] CHC has many patients who could benefit from care management and this is a key concept for NCQA-PCMH recognition. The Logic Model identifies a goal and or situation and the inputs necessary to achieve this goal.[17] Outputs support achieving the short and long-term outcomes.[17]

Methods

Setting

CHC was established nearly 20 years ago and is a small, nurse managed health center that cares for an underserved population in an urban Midwest area. CHC clinical staff consists of three primary care providers, one registered nurse, and two medical assistants. The CHC recently received a grant to integrate behavioral health into the primary care setting which will bring the addition of a psychiatric mental health nurse practitioner, social worker, and community health worker. The staff at the CHC support the goal of NCQA-PCMH recognition and view this as a Model to improve the quality of patient care while promoting practice sustainability.

Design and Analysis

Current practice, policies, and procedures at the CHC were reviewed through the lens of the NCQA-PCMH core competencies.[9] The level to which current practice, policies, and procedures adhered to the NCQA-PCMH core competencies were evaluated and tracked using

the PCMH self-assessment tool provided by the NCQA. Stakeholders within the organization including the practice manager, quality improvement specialist nurse practitioner, and the patient services manager/biller were key informants and explained current practice to the program evaluator. Additionally, aggregate level data was extracted from the electronic health record (EHR). Using the data collected, the 40 NCQA-PCMH core competencies level of completeness was documented. Core competencies were identified as complete if no further action was required to meet NCQA-PCMH requirements. Competencies were labeled partially complete if some, but not all aspects of the core competency criteria were met. Finally, competencies were identified as incomplete if no elements of the core competency requirements were in place at the CHC. Partially complete and incomplete core competencies were further analyzed to identify the gap between current practice and NCQA-PCMH requirements.

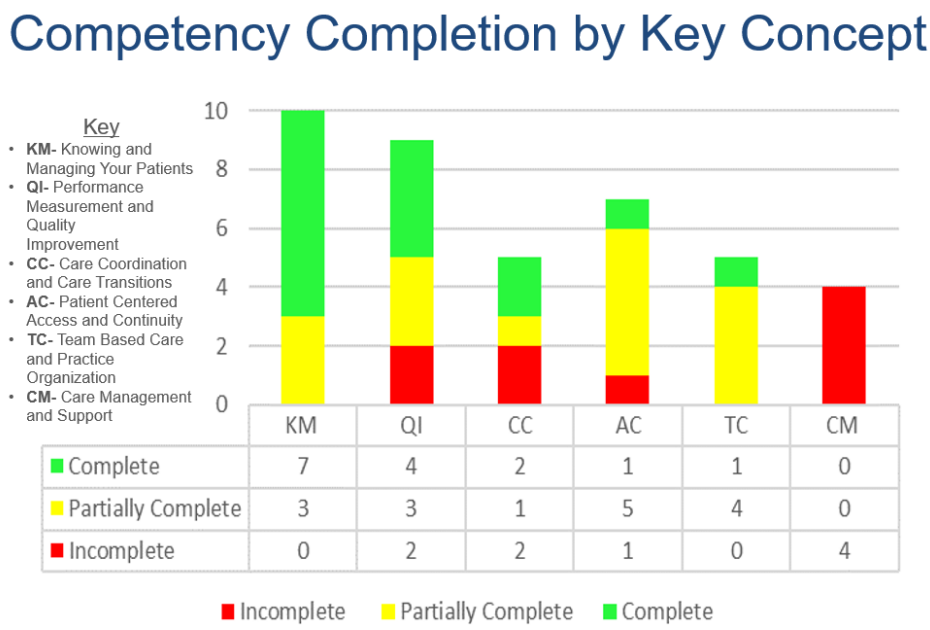
Results

The program evaluation revealed 37% (15 of 40) of the core competencies were complete and aligned with NCQA-PCMH standards. Forty percent (16 of 40) of the core competencies were partially complete. Finally, 23% (9 of 25) of the core competencies were incomplete (see Figure 2).

Each of the six Key Concepts are composed of a unique number of core competencies.[9] "Knowing and Managing Your Patients" has 10 competencies, 70% (7 of 10) were complete and 30% (3 of 10) here partially complete. "Performance Measurement and Quality Improvement" has nine competencies, 44% (4 of 9) were complete, 33% (3 of 9) were partially complete, and 22% (2 of 9) were incomplete. "Care Coordination and Care Transitions" is made up of five core competencies, 40% (2 of 5) were complete, 10% (1 of 5) were partially complete, and 40% (2 of 5) were incomplete. "Patient Centered Access and Continuity" has seven core

competencies, 14.5% (1 of 7) were complete, 71% (5 of 7) were partially complete, and 14.5% (1 of 7) were incomplete. “Team Based Care” is composed of five core competencies, 20% (1 of 5) were complete and 80% (4 of 5) were partially complete. Lastly, 100% (4 of 4) of the core competencies in “Care Management and Support” were incomplete.

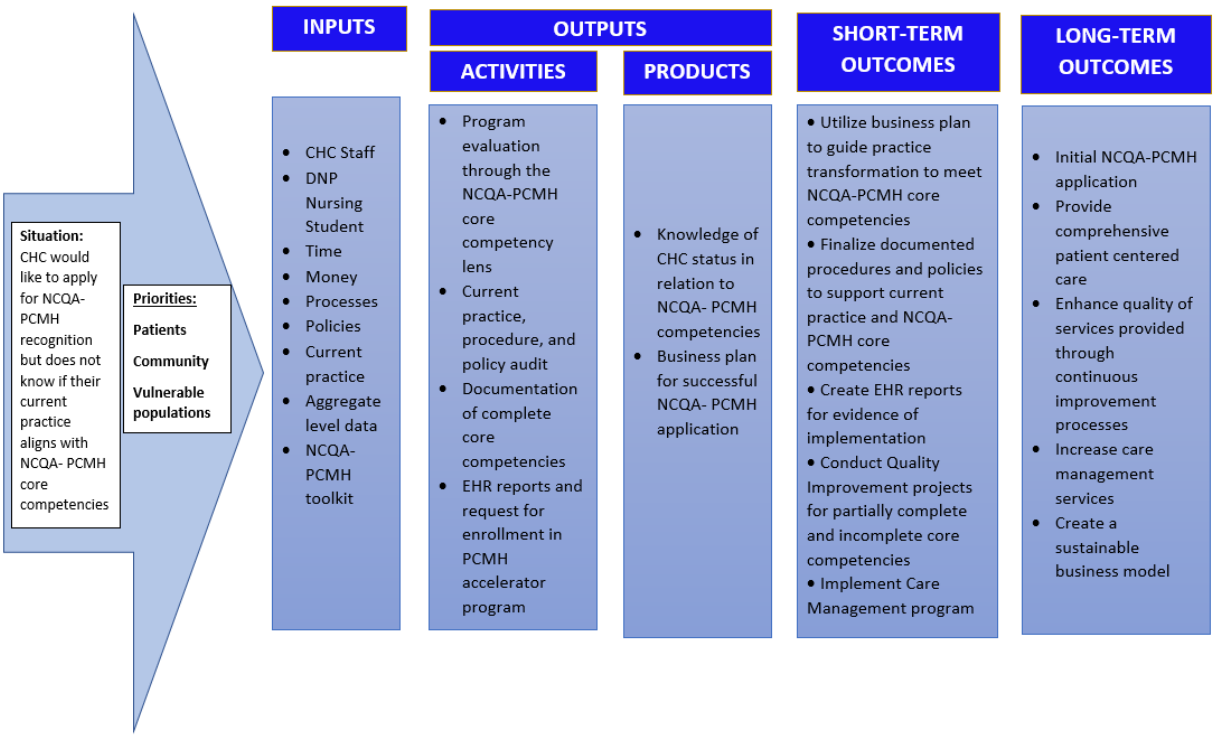
Figure 2. Core Competency Completion by Key Concept



Discussion

The findings of this evaluation, identified a gap between current practice at CHC and the NCQA-PCMH core competencies. Thus, a detailed business plan was designed to guide CHC in modifying practice prior to applying for NCQA-PCMH recognition. CHC intends to follow the short-term outcomes, illustrated in the application of the Logic Model, as shown in Figure 3, to achieve NCQA-PCMH recognition in the future.

Figure 3. Application of the Logic Model[17]



Documentation of Procedures and Policies

When conducting the program evaluation, CHC staff thought many core competencies were complete within the practice. However, in many instances, there was no written procedure or evidence of documentation to support this belief, thus making the measures partially complete or incomplete. Overall, 14 NCQA-PCMH core competencies were partially complete due to a lack of a written policy or procedure, seven in the key concepts of Team-Based Care and Practice Organization and Patient-Centered Access and Continuity. Draft procedures and policies were created as part of the program evaluation and included in the CHC business plan. The draft procedures and policies will be finalized and implemented by the CHC practice manager and staff to complete the competencies in the future. Primary care practices seeking to achieve

NCQA-PCMH recognition must be diligent in documenting procedures and policies that reflect current practice. The gap between the CHC's current practice and NCQA-PCMH core competencies for documented procedures and policies validates to perform a self-assessment prior to applying for NCQA-PCMH recognition.

Tracking quality measures and data

Another barrier to applying for NCQA-PCMH recognition was the lack of ability to measure or produce reports to track findings. The core competencies for NCQA-PCMH recognition often require primary care practices to supply a report as proof of core competency completion. The majority of these reports can be generated from the EHR or from community-level data. Two reports require manual data entry and tracking. CHC program evaluation found nine NCQA-PCMH required reports were currently accessible through the EHR or community-level data, while 12 reports would need to be created in order to complete core competencies. To enhance readiness for NCQA-PCMH recognition, practices must closely appraise current data and reports through the lens of the NCQA-PCMH core competencies. Having a quality improvement specialist, or a team member that specializes in information technology would be a valuable asset.

Quality Improvement Projects

In addition to measures that required documentation and the creation of reports, the program evaluation brought forth the need for quality improvement projects to drive partially complete and incomplete competencies to be complete. Some core competencies that would benefit from a quality improvement project would require a written process to meet NCQA-PCMH standards. An example of this is in a core competency from Team-Based Care and Practice Organization, which outlines care team meetings and communication requirements.[8]

This competency requires primary care practices have "structured communication processes."[8(p36)] Although the CHC had a care team huddle, there was no written procedure and no structure to guide the huddles. A huddle structure worksheet was created and inserted into the business plan for NCQA-PCMH core competency completion. Once approved, CHC could conduct a quality improvement project to implement the huddle structure. Primary care practices need to commit to quality improvement projects if they wish to achieve NCQA-PCMH recognition.

Care Management and Care Coordination

The two key concepts with the highest percentages of incomplete competencies were Care Coordination and Care Transitions and Care Management and Support. Ironically, CHC became interested in PCMH recognition when a nurse became a certified care manager, a position supported by the Chronic Care Model to improve care for the vulnerable population CHC serves.[16] The program evaluation, identified that although the nurse was a care manager, the practice was not in alignment with the standards that NCQA-PCMH required for a care management and care coordination program. This illustrates the difference between having a certified care manager onsite and providing a care management and care coordination program. Primary care practices wishing to apply for NCQA-PCMH recognition need to critically evaluate current practice against NCQA-PCMH core competencies. Simply having a staff member with a care management certification does not complete the core competency requirements.

Limitations

The primary limitation for this project was that staffing changes occurred throughout the program evaluation and the practice lost multiple staff members. Many of the positions were intentionally changed to support a staffing model that integrates Medical Assistants;

nevertheless, the turnover affected day-to-day operations as new staff were onboarded and trained.

Implications

The program evaluation conducted at CHC revealed unforeseen barriers to NCQA-PCMH recognition. Although recognition remains an attainable goal for CHC, the timeline is longer than initially anticipated. Before applying for NCQA-PCMH recognition, primary care practices should perform a similar gap analysis, using the NCQA-PCMH standards and guidelines[8] to determine how closely current practice aligns with the NCQA-PCMH core competencies.

The business plan created from this evaluation documented the level NCQA-PCMH complete, partially complete and incomplete core competencies. For competencies that were partially complete or incomplete, steps that CHC must take to complete each competency was outlined. As CHC completes additional competencies, evidence will be updated in the business plan. When CHC applies for NCQA-PCMH recognition, the business plan will be utilized as evidence of core competency completion. Other primary care practices that conduct a gap analysis for NCQA-PCMH recognition could use a similar approach to guide practice transformation.

Conclusion

This program evaluation highlighted some of the difficulties primary care practices face when seeking NCQA-PCMH recognition. The evaluation further provided CHC with a roadmap for successful NCQA-PCMH recognition through the development of a business plan paired with an adaptation of the Logic Model.[17] Primary care practices seeking to achieve NCQA-PCMH

recognition can utilize this project approach as a foundation to conducting their own self-assessment prior to pursuing recognition.

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A Program Evaluation to Assess Readiness for NCQA-PCMH Application

Alida Semrinec

DNP Project Defense

April 20, 2021

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- Advisor:
  - Dr. Marie VanderKooi DNP, MSN, RN-BC
- Advisory Team:
  - Dr. Sandra Spoelstra PhD, RN, FGSA, FAAN
  - Dr. Tamara Van Kampen DNP, RN

Objectives for Presentation

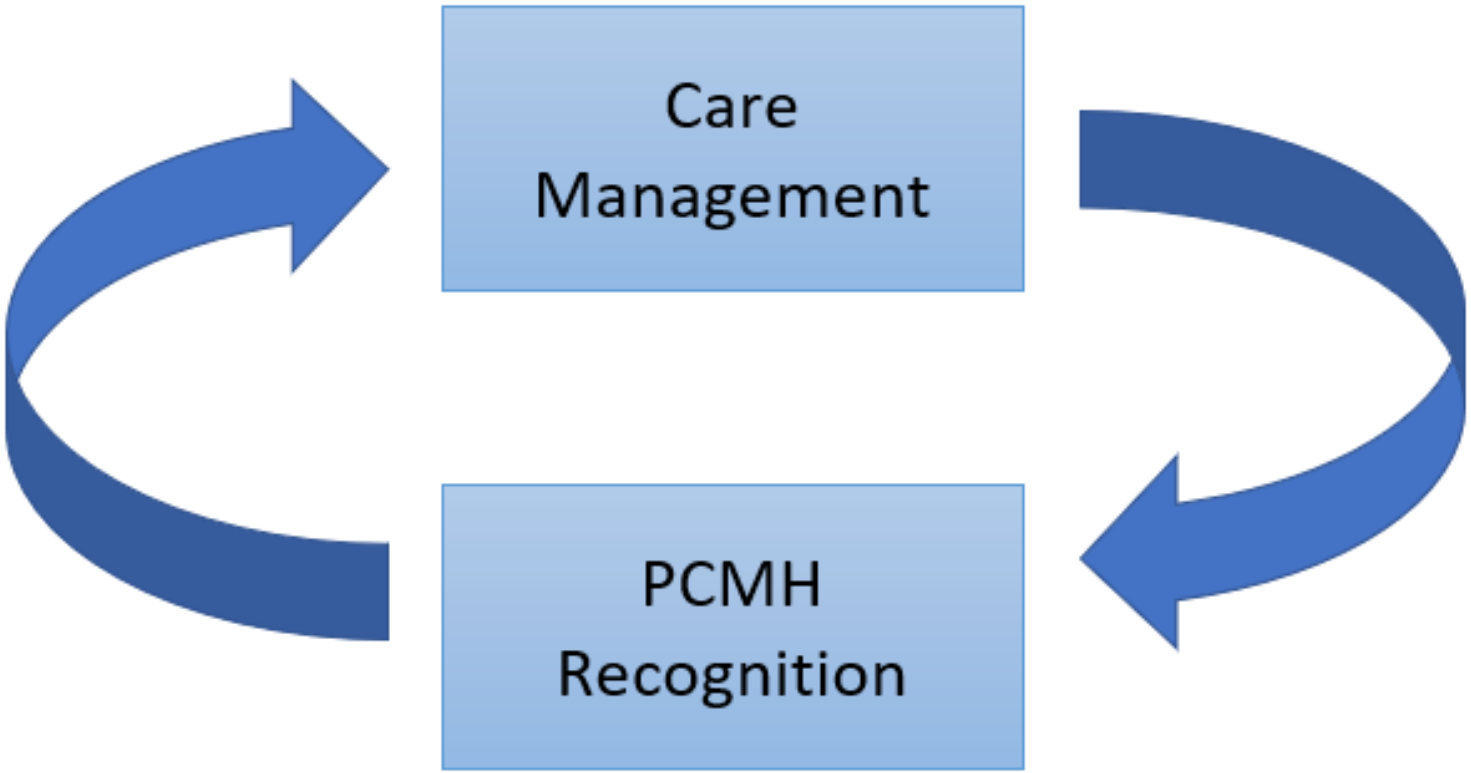
1. Present background information to support the need for the project.
2. Present findings of the organizational assessment and the literature review.
3. Explain the clinical practice question and the project purpose.
4. Present the project plan, results, and key takeaways.
5. Discuss plan for dissemination.
6. Apply project work to the DNP.

INTRODUCTION

Introduction

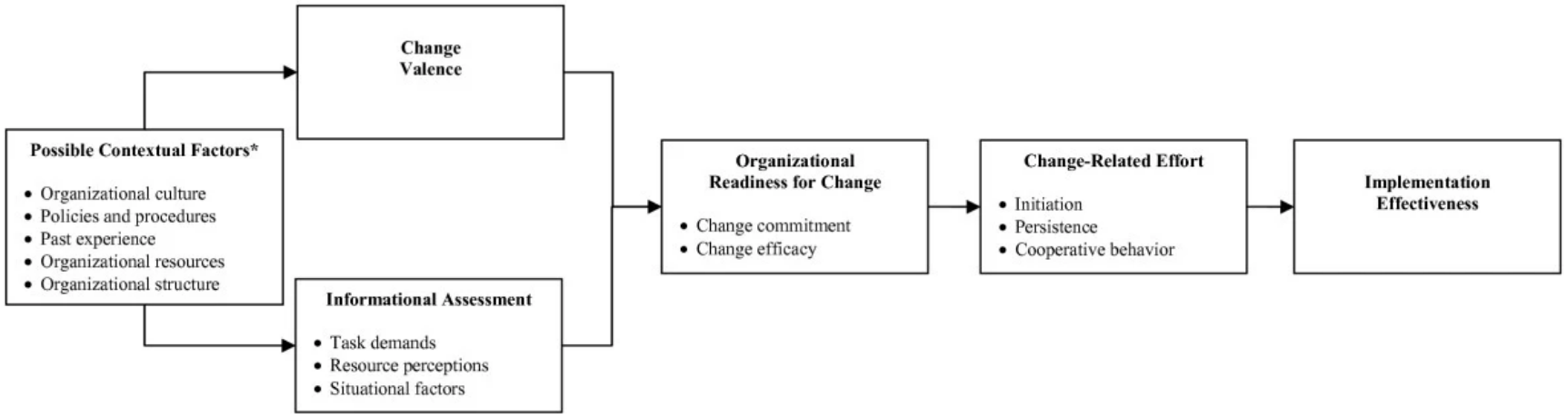
- The Patient Centered Medical Home Model (PCMH) is associated with enhanced patient experience (Sarinopoulos et al., 2017) and quality improvement outcomes (Mahmud et al., 2018).
- This Model has the capacity to guide primary care practices to enhance quality, provide more comprehensive, patient centered care, and increase practice revenue (Philip et al., 2019).
- Following the recent implementation of the nurse care manager role, a PCMH requirement, a small, urban, nurse managed community health center (CHC) was interested in applying for PCMH recognition.

Introduction



ORGANIZATIONAL ASSESSMENT

Organizational Readiness for Change Model



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SWOT Analysis

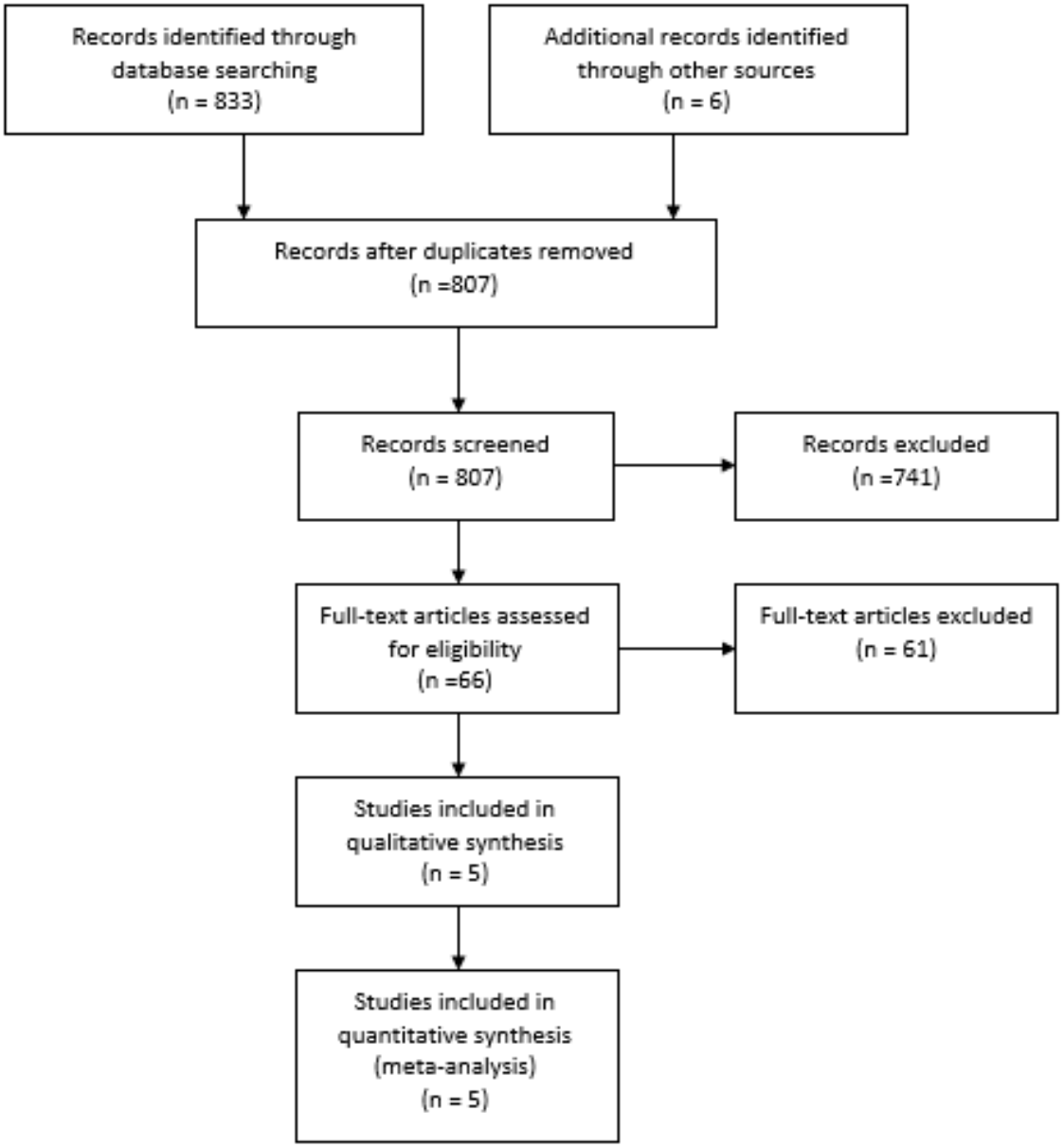
Strengths	Weaknesses
• Nurse managed • Engaged employees • PCMH model supports mission statement • **RN care manager** • **Positive results from patients who have received care management services** • Partnership with local university • Students	• Small practice • Lack of time • Fee for application (NCQA, 2020d) • **Staffing model – RN currently responsible for bringing patients to rooms, collecting labs, and checking vital signs**
Opportunities	**Threats**
• **Improve patient experience/ quality of life for current care management patients and expand this program to impact additional patients.** • Decrease number of unused prescription medications in the community • Increased health equity(Purnell et al., 2016) • Increase revenue (NCQA, 2020c)	• Cost of application (NCQA, 2020d) • Cost/ time needed to implement quality improvement measures necessary to receive PCMH designation. • **Covid-19 decreasing revenue and decreasing patients / providers in office**.

LITERATURE REVIEW

Literature Review

- Purpose: To identify the benefits of NCQA-PCMH recognition and barriers and facilitators to successfully apply for recognition.
- Methods: PRISMA flow diagram paired with a comprehensive electronic search using CINAHL, PubMed & Medline.
- Inclusion criteria: Primary care practices and care management services focused, English language, published in 2017 or later, full text items.
- Keywords: “Patient Centered Medical Home or PCMH,” “care coordination,” and “ primary care.”

PRISMA Figure

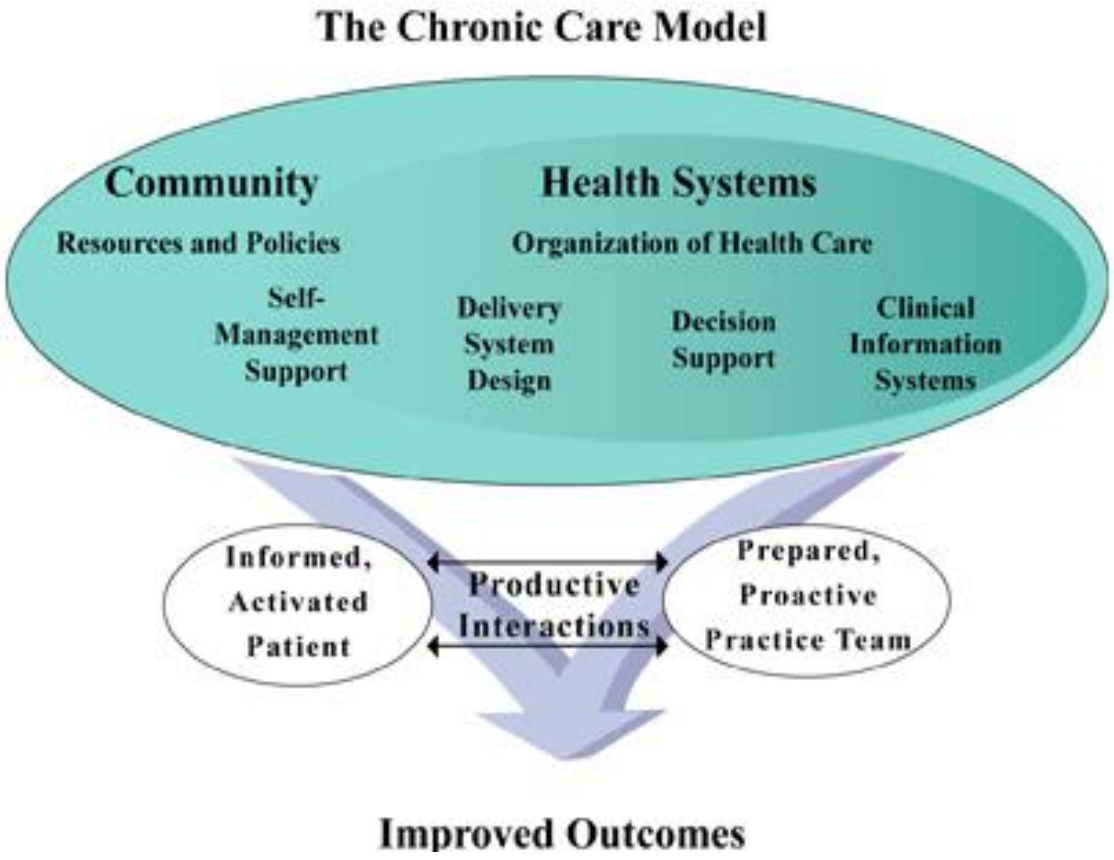


(Adapted from Moher et al., 2009)

Synthesis of Review Results

- NCQA-PCMH recognition was associated with greater numbers of improved outcomes when assessed in Federally Qualified Health Centers (Mahmud et al., 2018).
- PCMH was associated with enhanced patient experience, most notably in high-risk populations (Sarinopoulos et al., 2017) and quality improvement outcomes (Mahmud et al., 2018).
- Electronic health records (EHR) and nurse care managers were essential for PCMH (Gimm et al., 2019; Mahmud et al., 2018; Pereira et al., 2019).
- Standards and guidelines guided practice transformation (NCQA, 2020a).

Conceptual Model for Phenomenon



(Wagner, 1998)

Clinical Practice Question

What core competencies of the NCQA-PCMH recognition program is this small, urban, midwestern, nurse managed community health center currently meeting, and is NCQA-PCMH recognition an attenable goal for this practice in 2021?

PROJECT PLAN

Purpose and Project Type

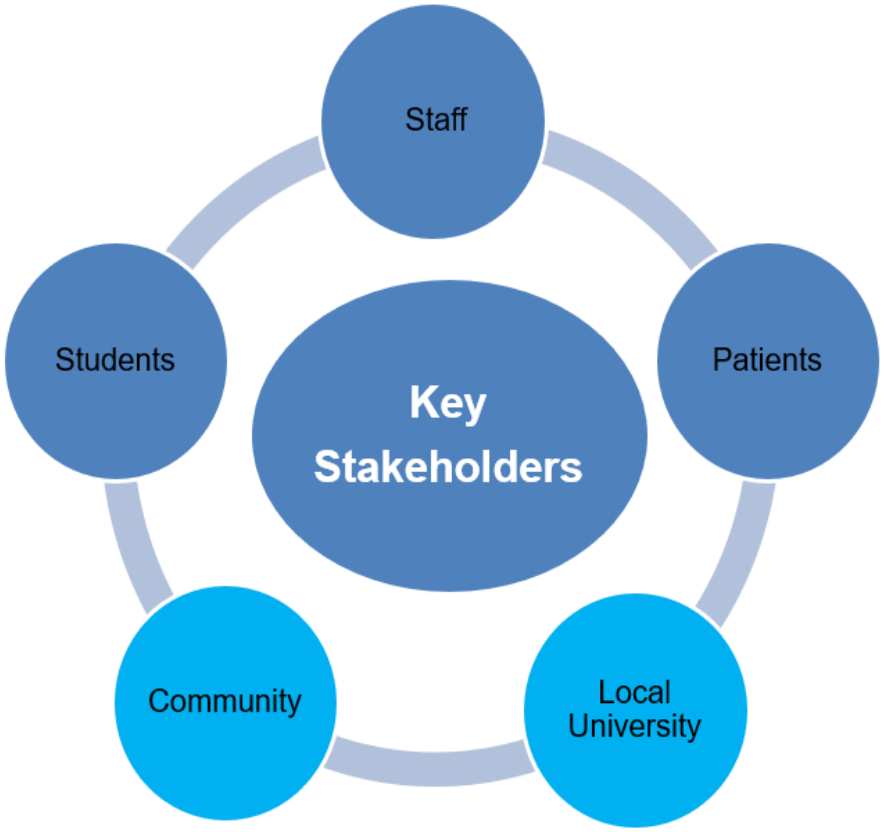
- **Project Purpose:** To conduct a program evaluation of the CHC and the implementation of the nurse care manager role. Specific objectives were to identify gaps and other areas of preparation readiness for NCQA-PCMH application and evaluate if the prior implementation of the nurse care manager role at the CHC adhered to NCQA-PCMH standards.
- **Project Type:** Program evaluation

Project Design

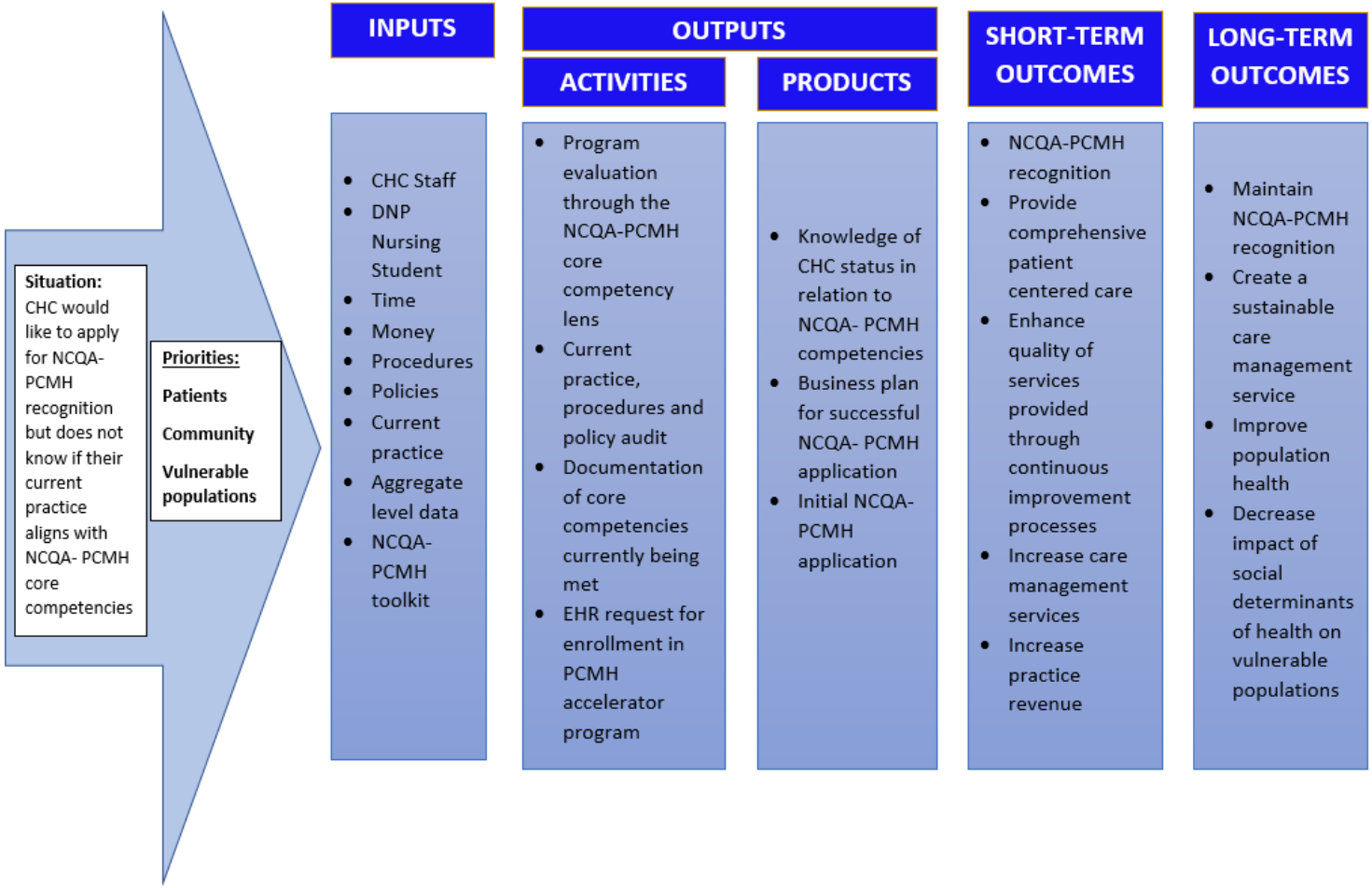
- Program Evaluation: This project evaluated the current practice, policies, and procedures in place at the CHC through the lens of the NCQA-PCMH core competencies. Additional evidence of core competency completion was verified through reports generated from the electronic health record.

Setting & Stakeholders

- Setting: Small, urban, nurse managed, community health center.
- Internal stakeholders
- External stakeholders



Evaluation Model: The Logic Model



(Adapted from Millar et al., 2001)

Proposed Budget: Year One

A Program Evaluation to Assess Readiness for NCQA-PCMH Application	Dollar Value	Hours spent on project/Notes
Revenue (year 1)		
Project Manager Time (in-kind donation)	$13,480.00	67.4/hr (mean wage of Practice Manager and NP who would have otherwise worked on this project) x200 hours
Social Determinants of Health Incentive from Prority Health	$7,482.00	([607 (number of medicaid members] x $1.00) + (33[number of medicare members] x $0.50) x12 = $7,482 * if 5% of Priority Health Patients are Screened*
Care Management Incentive from Priority Health	$25,543.08	$2.01 x1059 (number of PH Members) x 12 (from having two "touches" with at least 3% of PH members)
Care Management Visits goal: 50	$5,100.00	($81.00 x50) + ($23x150) = $7500 Charge for 1st "touch" + Charge for "touches 2-4"- (current number of patients with "four touches" ($81.00 x16) + ($23x48) = $2,400 = $5,100
Care Management Risk Adjusted Model Incentive from Priority Health	$13,978.80	1059 (number of PH Memebers) x12(number of months in a year) x $1.10 (Standard PMPM Payout for risk quartile 1)
Total Revenue (year 1):	$40,040.80	
Expenses		
Project Manager Time (in-kind donation)	$13,480.00	67.4/hr x 200
PCMH Standards and Guidelines for 2021	$0.00	
Team Member Time:		
Practice Manager	$2,696.00	67.4/hr x40
Nurse Practitioner/Quality Improvement Specalist	$2,696.00	67.4/hr x40
Customer Service/Billing Specalist	$272.70	27.27/hr x10
Nurse Care Manager	$18,116.00	51.76/hr x7x50 (one day/week for 7 hours x 50 weeks)
Application Fee	$2,075.00	800 x2 + 475 x1
Total Expenses(year 1):	$39,335.70	
Tota Revenue - Total Expenses:	$705.10	

All the hourly wages include fringe benefits and were found on the United States Labor Bureau Website (United States Bureau of Labor Statistics, 2019).

Proposed Budget: Year Two

Budget NCQA, PCMH Year 2		
Revenue		
Social Determinants of Health Incentive from Priority Health	$7,482.00	([607 (number of medicaid members] x $1.00) + (33[number of medicare members] x $0.50) x12 = $7,482
Care Management Visits goal: 100	$10,200.00	($81.00 x50) + ($23x150) Charge for 1st "touch" + Charge for "touches 2-4"- current number of patients with "four touches" ($81.00 x16) + ($23x48) = $5100) x2 = 10,200
Care Management Risk Adjusted Model Incentive from Priority Health	$13,978.80	1059 (number of PH Memebers) x12(number of months in a year) x $1.10 (Standard PMPM Payout for risk quartile 1)
Total Revenue:	$31,661.00	
Expenses		
Practice Manager	$2,696.00	67.40/hr x40 (time spent on renewal)
Nurse Care Manager	$18,659.48	51.76/hr x7x50 (one day/week for 7 hours x 50 weeks) x1.03
Renewal Fee	$465.00	$155X3
Total Expenses:	$21,820.48	
Total Year 2 Revenue-Expenses:	$9,840.32	

All the hourly wages include fringe benefits and were found on the United States Labor Bureau Website (United States Bureau of Labor Statistics, 2019).

IMPLEMENTATION STRATEGIES & ELEMENTS

Implementation Strategies & Elements

Powell et al., 2015 Evaluation Strategy	Action Item
Assess for readiness and identify barriers and facilitators	Conducted an organizational assessment utilizing the Organizational Readiness for Change Model
Capture and share local knowledge	Analyzed current practice, policies, procedures, and aggregate level practice data through the lens of the NCQA-PCMH core competencies and created a dissemination plan
Audit and Provide Feedback	Collected aggregate level data on current practice, and how to meet the NCQA-PCMH core competencies

Implementation Strategies & Elements

Powell et al., 2015 Evaluation Strategy	Action Item
Develop and organize quality monitoring systems	Identified techniques to monitor progress on partially complete and incomplete core competencies
Facilitation	Utilized problem solving skills to identify a “plan” for core competencies that are partially complete and incomplete
Develop a formal implementation blueprint	Created a timeline and a business plan to address partially complete and incomplete core competencies

Implementation Strategies & Elements

Powell et al., 2015 Evaluation Strategy	Action Item
Promote adaptability	Modified current policies and procedures to reflect NCQA-PCMH core competencies, created draft policies and procedures when no baseline data existed
Use data experts	Collaborated with Quality Improvement Specialist, Practice Manager, and Patient Services Manager/Medical Biller

Measures to Evaluate & Data Collection

Topic	Concept	How Measured	When Measured	Who Measures
Evaluation Strategies	Assess for change readiness	Discussion, observation	Pre evaluation	Student
	Engage Stakeholders	Discussion	Pre evaluation	Student
	Identify change champion; Practice manager and nurse practitioner	Discussion	Pre evaluation (September 2020)	Student, Practice Manager, Nurse Practitioner
	Analyze current practice, policies, procedures and current aggregate level practice data through the lens of the NCQA-PCMH core competencies	EHR reports, documented policies, protocols and procedures	During evaluation	Student
System Outcomes	Number of NCQA-PCMH core competencies complete	EHR reports, documented policies, protocols and procedures	Post evaluation	Student
	Number of NCQA-PCMH core competencies that were partially complete	EHR reports, documented policies, protocols and procedures	Post evaluation	Student
	Number of NCQA-PCMH core competencies that were incomplete	EHR reports, current practice, procedures and documented policies	During evaluation	Student
	Readiness for NCQA-PCMH Q-Pass application	EHR reports, current practice, procedures and documented policies	Post evaluation	Student
Policy Outcome	New or modified policies and procedures to reflect NCQA-PCMH core competencies	Policies and procedures	During / Post evaluation	Student, Practice Manager, Nurse Practitioner

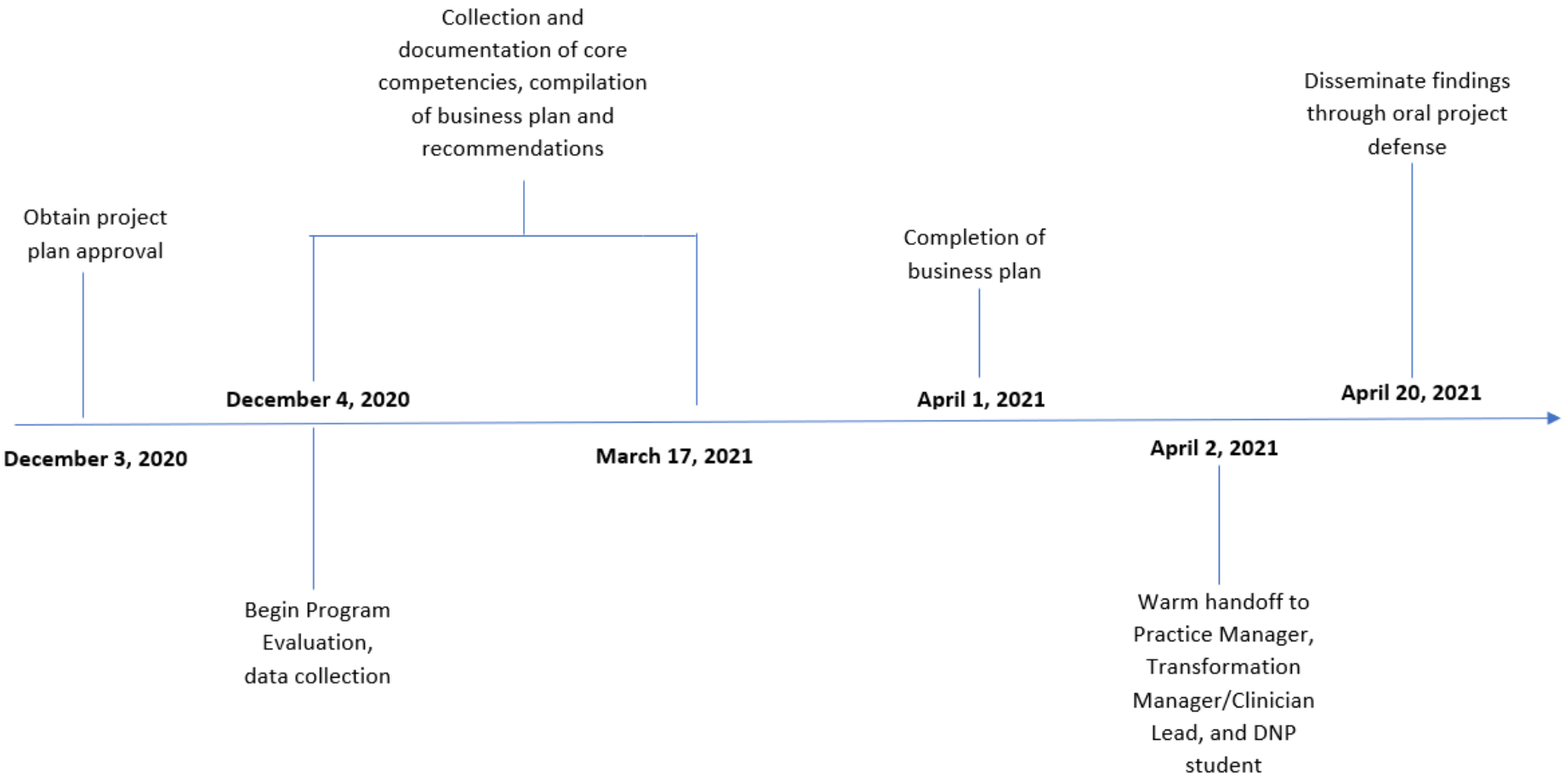
Evaluation Toolkit

- The NCQA- PCMH Standards and Guidelines were used as the program evaluation tool kit. The emphasis of this program evaluation was placed on the core competencies within this toolkit.
- NCQA is the most commonly used PCMH accrediting body with over 13,000 practice recognized nationally (NCQA, 2020c).
- NCQA recognition has been associated with improved outcomes, more so than other accrediting organizations (Mahmud et al., 2018).

Data Collection Methods & Analysis Plan

- Review of current practice, policies, procedures.
- Review of EHR aggregate level data.
- Documentation of core competencies completion status.
- Analysis of partially complete and incomplete competencies.
- Process improvement plan for partially complete and incomplete competencies in the format of a business plan.

Timeline

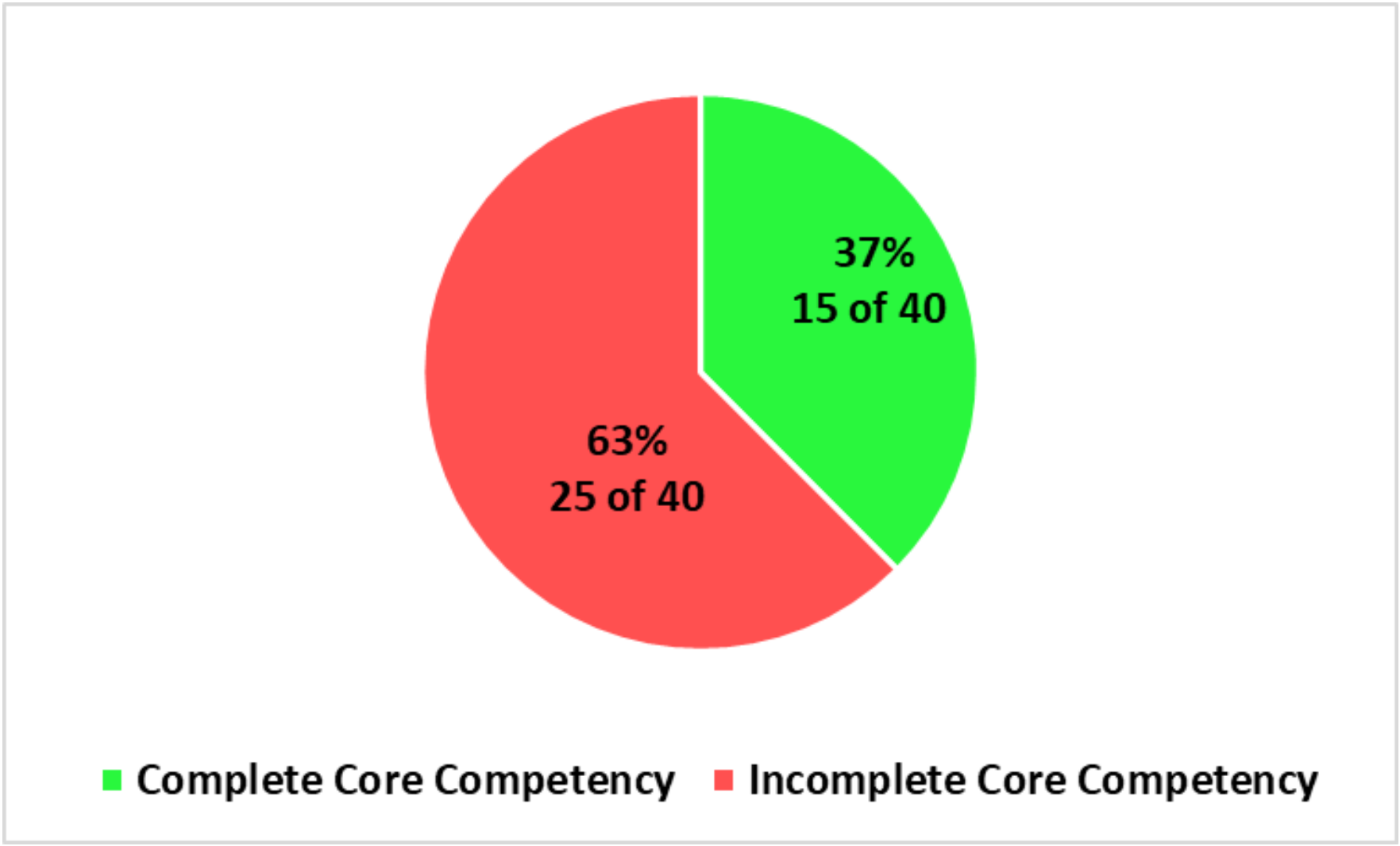

Collection and documentation of core competencies, compilation of business plan and recommendations
Disseminate findings through oral project defense
Obtain project plan approval
Completion of business plan
December 4, 2020
April 1, 2021
April 20, 2021
December 3, 2020
March 17, 2021
April 2, 2021
Begin Program Evaluation, data collection
Warm handoff to Practice Manager, Transformation Manager/Clinician Lead, and DNP student

Ethical Considerations

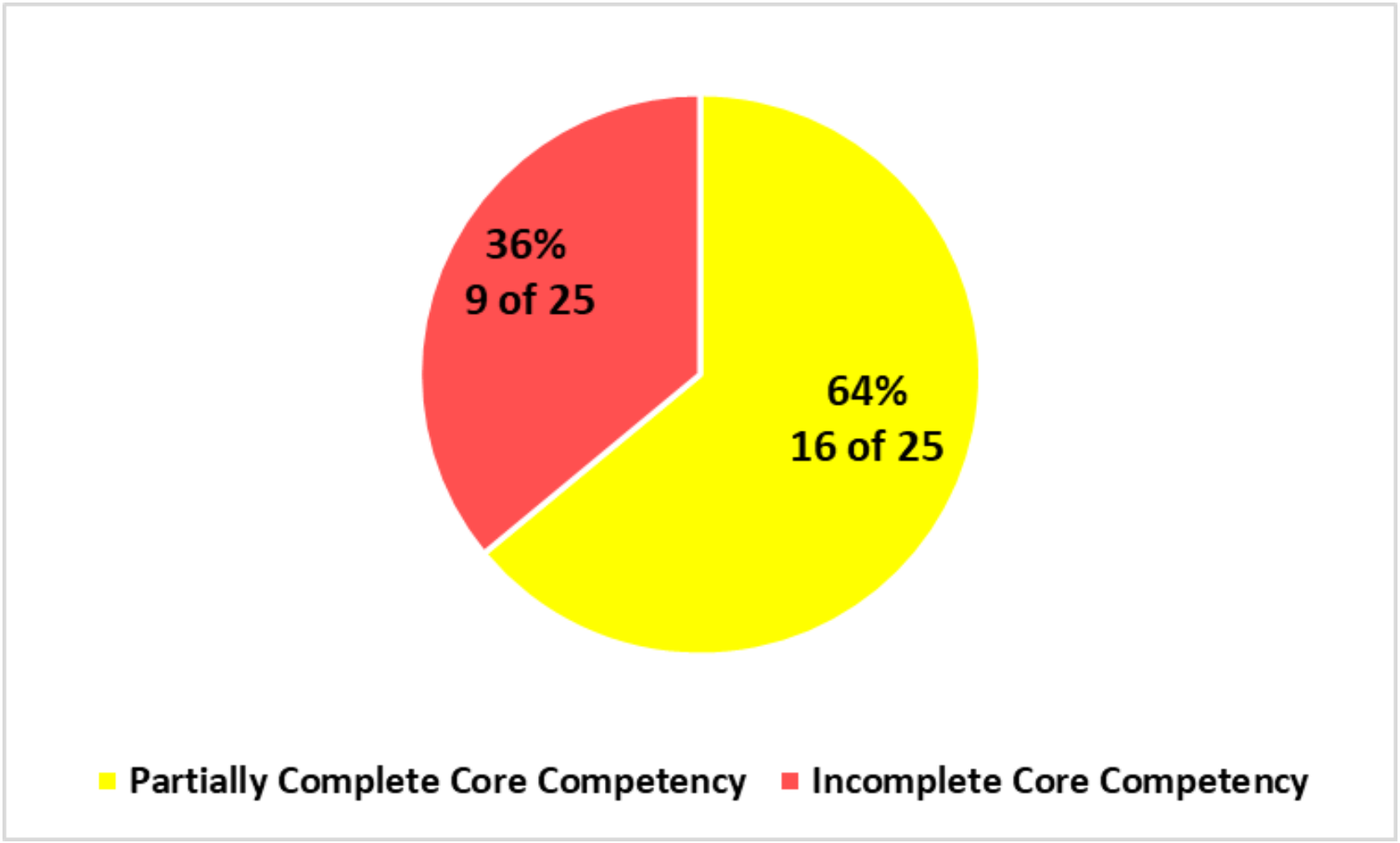
- Project was deemed exempt by the University IRB.
  - Letter available on request.
- All data was collected at the aggregate level.
- Due to the small practice size no surveys or 1:1 observations were conducted as it would have been difficult for participants to remain de-identified.

RESULTS

NCQA-PCMH Core Competency Evaluation



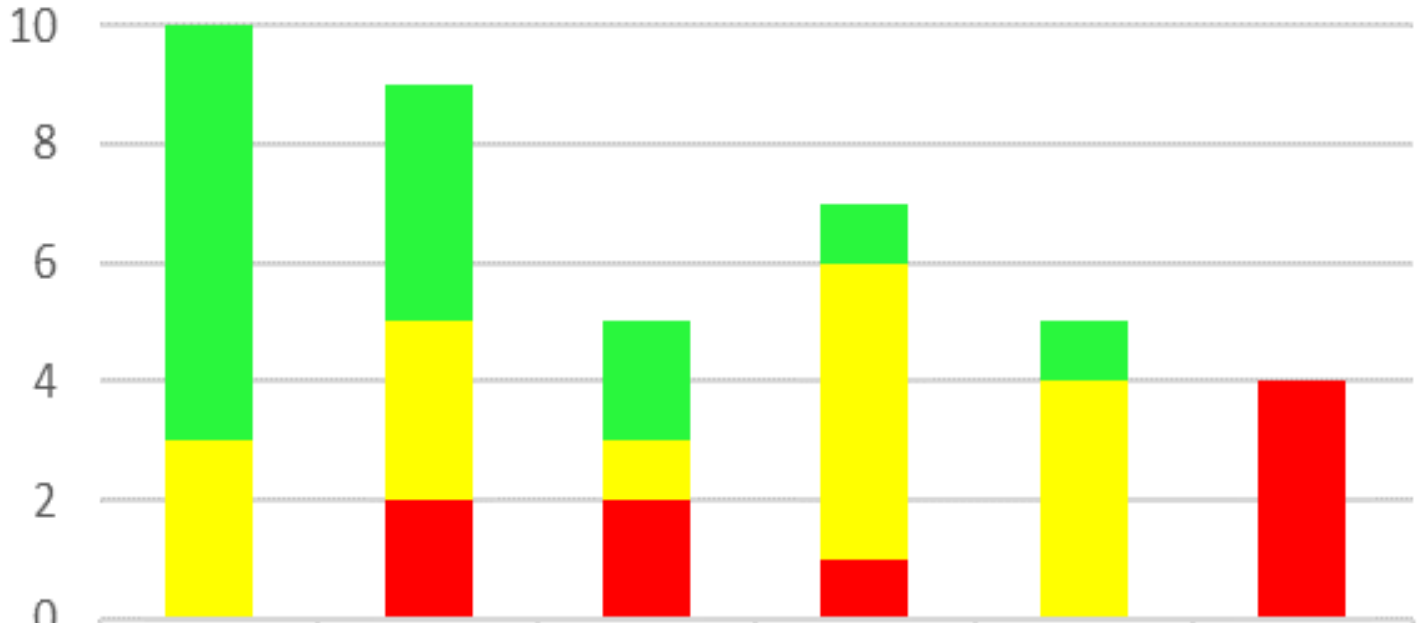
Analysis of Incomplete Competencies



Competency Completion by Key Concept

Key

- **KM-** Knowing and Managing Your Patients
- **QI-** Performance Measurement and Quality Improvement
- **CC-** Care Coordination and Care Transitions
- **AC-** Patient Centered Access and Continuity
- **TC-** Team Based Care and Practice Organization
- **CM-** Care Management and Support



	KM	QI	CC	AC	TC	CM
Complete	7	4	2	1	1	0
Partially Complete	3	3	1	5	4	0
Incomplete	0	2	2	1	0	4

Incomplete Partially Complete Complete

Business Plan Excerpt

- Competency Team Based Care and Practice Organization 06: Individual Patient Care Meetings and Communication.
- This competency is partially complete.

TC 06 (Core) Individual Patient Care Meetings/Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care.

GUIDANCE	EVIDENCE
The practice has a structured communication process or holds regular care-team meetings (such as huddles) for sharing patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow. A structured communication process is focused on individual patient care and may include tasks or messages in the medical record, regular email exchanges or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process. Consistent care-team meetings allow staff to anticipate the needs of all patients and provide a forum for staff to communicate about daily patient care needs.	• Documented process *AND* • Evidence of implementation *Documented Process Only*

(NCQA, 2020a)

Current state: Team huddles take place on Tuesday and Wednesday mornings. The huddles follow a similar structure each day, but are not formally documented. There are no documented processes to support the huddle structure. After huddle, team members use the EHR secure chat function when patient needs or questions arise throughout the day to communicate with the rest of the care team.

In order to satisfy this measure: Implement team huddles on a daily basis, update the date this began in the huddle description below. Draft processes created by the DNP student, following the FHC policy and procedure template, for Huddle and the use of Athena Secure Chat are located on pages 25 and 26. These processes must be finalized, compiled in a process manual, and implemented. The practice must also implement a structured huddle worksheet (proposed worksheet p.23) and provide evidence of secure chat use. A deidentified snip of a conversation on Athena secure chat could act as evidence for this competency.

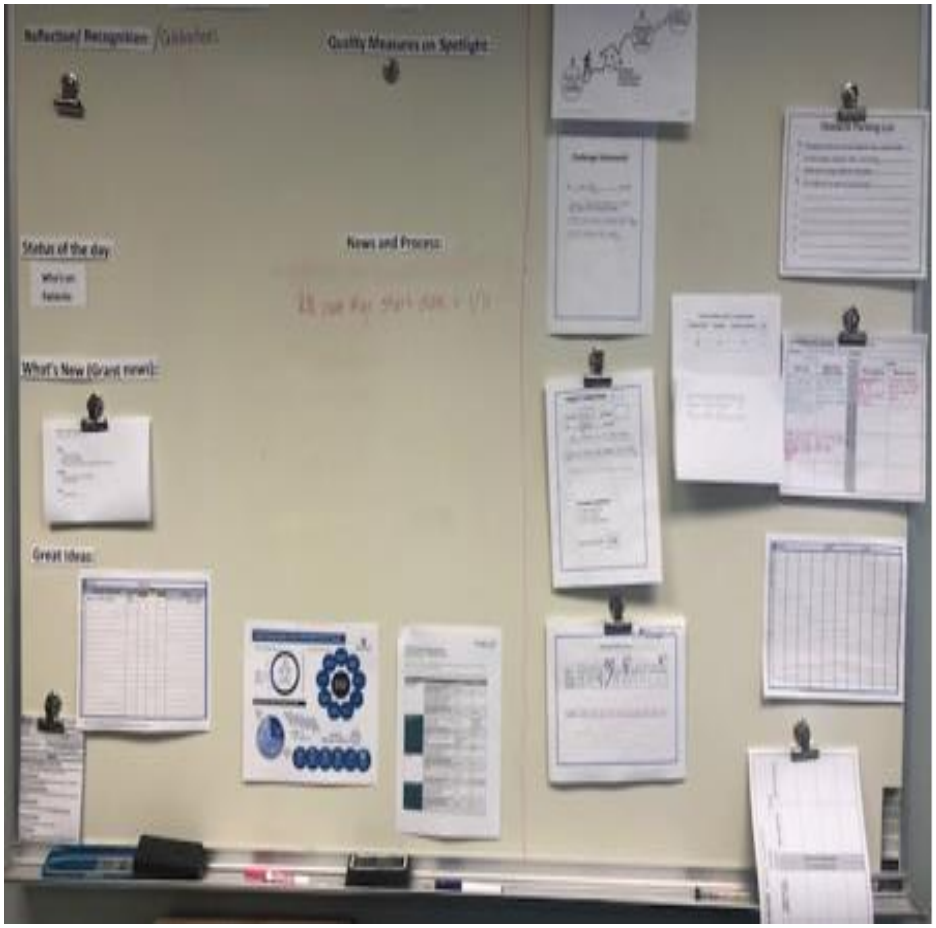
Huddle description:
Weekly huddles began in October 2020. These huddles were led by the grant project manager who is a green belt in LEAN Sigma Process Improvement.

Daily huddles focusing on patient care and daily staffing/concerns started _____2021. A structured huddle worksheet must document each day and maintained directly under the huddle board. The grant project manager continues to lead daily huddles, if she is not available to do a morning huddle, the practice manager leads the huddle for that day.

Business Plan Excerpt

Date:	Start time:
Huddle Leader:	
Team Members in Attendance:	
Daily Quote & Announcements	
Team Check In: ▯ How is everyone doing? ▯ Follow up on previous day concerns. ▯ Any staffing or scheduling concerns for the day? ▯ Any specific patient care needs or concerns for the day? Notes:	
Huddle end time:	

Standardized Huddle Form



Huddle Board at CHC

Business Plan Excerpt

Proposed Procedure Manual

Topic: Daily Huddle

Effective Date: To be determined

Authorization: Practice Manager

Review/Revision(s):

Employee Accountability: All employees

Purpose: The purpose of this procedure is to ensure that structured communication between care-team members is completed on a regular basis.

Process:

1. A team meeting, referred to as a "huddle" is to be completed each morning.
2. All team members are expected to attend huddle, including students.
3. Huddle is to start 15 minutes before the first appointment of each day and will last no longer than 10 minutes.
4. Huddle will follow a structured format (see p. 28) and will address daily concerns that affect practice work-flow as well as patient care.
5. If an item cannot be fully addressed within the time constraints of a daily huddle, key stakeholders will work collaboratively to address the concern outside of huddle, updating the team during huddle when progress is made. As the key stakeholders can change with each item, team members responsible for addressing the concern will be identified and documented during huddle.
6. Huddle will be documented utilizing a standardized outline.
7. Huddle documentation will be kept in a folder under the huddle board and documents will be scanned into the computer and filed in a designated folder at the end of each week by a student worker.

Proposed Procedure Manual

Topic: Athena Secure Chat

Effective Date: To be determined

Authorization: Practice Manager

Review/Revision(s):

Employee Accountability: All employees

Purpose: The purpose of this procedure is to ensure that structured communication between care-team members is completed on a regular basis during business hours when huddle is not in session.

Process:

1. Providers and support staff will utilize the secure chat feature in the EHR, Athena, to communicate patient care questions, concerns, and needs that arise throughout the business day when in person communication is not available.
2. Professionalism will be maintained during messaging exchanges. Messages will be free of abbreviations or slang and will be appropriate and polite.

Business Plan Excerpt:

- Competency Knowing and Managing Your Patients 14: Medication Reconciliation.
- This competency is complete.

KM 14 (Core) Medication Reconciliation: Reviews and reconciles medications for more than 80 percent of patients received from care transitions.	
GUIDANCE	**EVIDENCE**
The practice reviews all prescribed medications a patient is taking and documents this in the medical record. Conflicts or potential discrepancies in medications are identified and addressed by clinical staff. Medication review and reconciliation occurs at transitions of care, or at least annually. Maintaining an accurate list of a patient's medications reduces the possibility of duplicate medications, medication errors and adverse drug events. Medication reconciliation is an important safety net for patients received from care transitions, because they are more likely to be elderly, use multiple pharmacies, multiple providers and have co-morbid conditions. **Medication reconciliation** is the process of obtaining and maintaining an accurate list of all medications a patient is taking and addresses any potential conflicts including name, dosage, frequency and drug-drug interactions.	• Report

(NCQA, 2020b)

Current state: This measure is complete. The image below is a report found in Athena, in the NCQA-PCMH program accelerator. While this measure is currently complete, this status could change as new providers start at the FHC.

In order to satisfy this measure: Update data to represent most recent data collected at time of NCQA-PCMH application.

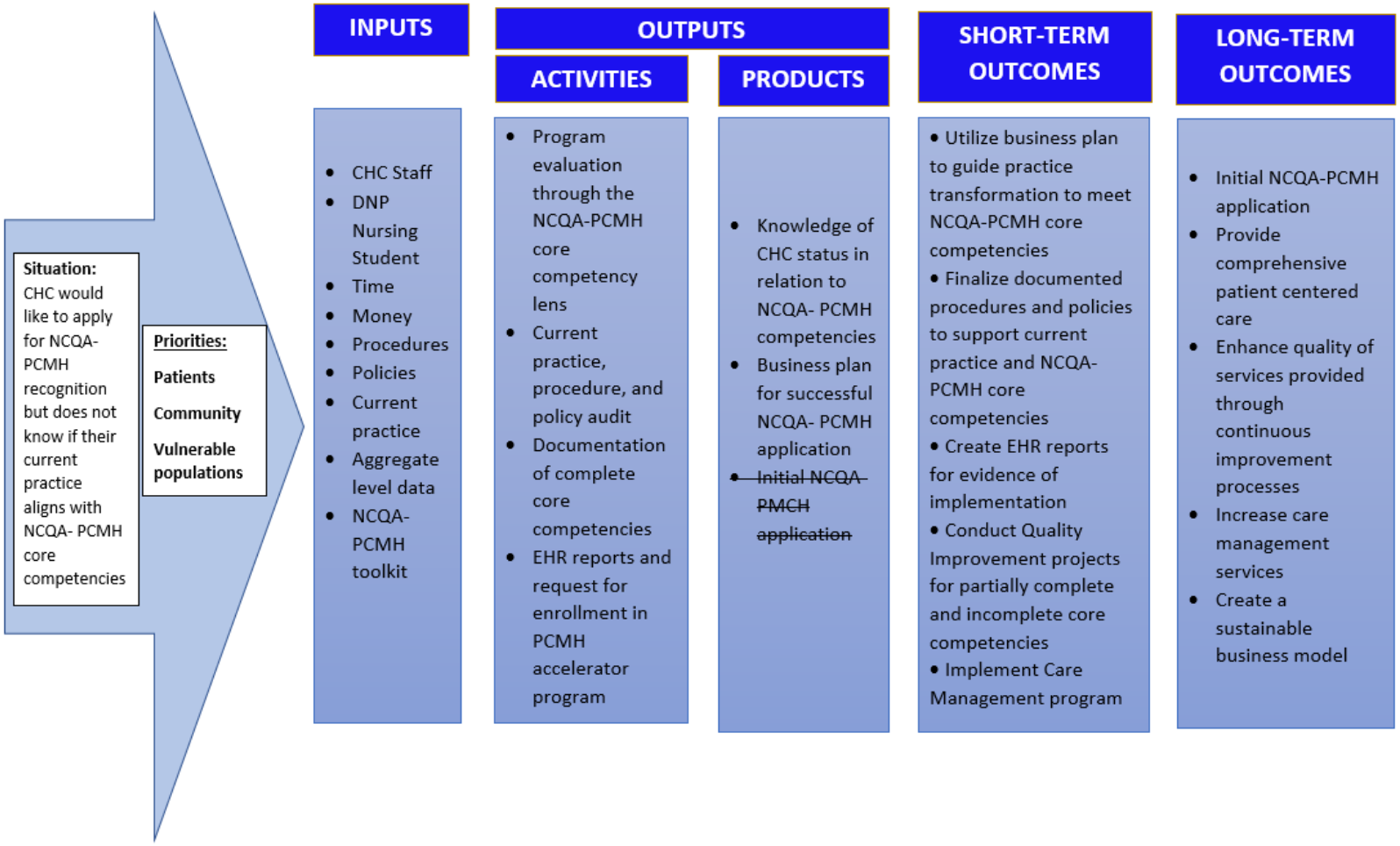
Above: Evidence report pulled from Athena, PCMH program accelerator data.

DISCUSSION & CONCLUSION

Discussion

- Documentation of procedures and policies:
  - Competencies only partially complete due to lack of documentation to support current practice.
- Tracking Quality Measures and Data:
  - Core competencies require EHR or community level reports for evidence of completion.
- Quality Improvement Projects:
  - Needed to drive partially complete and incomplete core competencies to completion.
- Care Management and Care Coordination:
  - Chronic Care Model.
  - Requires the most time to complete.

Discussion: The Logic Model



(Adapted from Millar et al., 2001)

Implications for Practice

Successes	Limitations
1. Leadership support 2. Team culture 3. Current practices	1. Staffing model changes 2. Hiring and onboarding 3. Changes in incentives

Conclusions & Recommendations

- NCQA-PCMH recognition is not an attainable goal for the CHC in 2021, but may be in 2022.
  - Logic Model revised short and long-term goals.
- Assessment of progress should be evaluated quarterly, with updates made to the business plan.
- When no core competencies are projected to take longer than nine months to complete, NCQA-PCMH application should be submitted.

Project Budget

Total Revenue	$0.00	
Expenses		
PCMH Standards and Guidelines for 2021	$0.00	
Team Member Time:		
DNP Student (in kind donation)		
Practice Manager	$2,696.00	67.4/hr x40
Nurse Practitioner/Quality Improvement Specalist	$2,696.00	67.4/hr x40
Customer Service/Billing Specalist	$272.70	27.27/hr x10
Total Expenses	$5,664.70	

All the hourly wages include fringe benefits and were found on the United States Labor Bureau Website (United States Bureau of Labor Statistics, 2019).

Sustainability Plan

- Warm handoff to Transformation Manager/ Clinician Lead and DNP student
  - Utilize business plan to guide transformation.
  - Begin with incomplete core competencies, specifically care management and care coordination.
  - When no core competencies are incomplete, apply for NCQA-PCMH recognition.

Dissemination

- Business plan, written and verbal.
- Student Scholars Day.
- GVSU ScholarWorks.
- Journal of Primary Care and Community Health.

SCHOLARWORKS@GVSU

REFLECTION ON DNP ESSENTIALS

DNP Essentials Reflection

- Essential I: Scientific Underpinnings for Practice.
  - Analysis of current practice in comparison to NCQA-PCMH core competencies.
- Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking.
  - Creation of NCQA-PCMH budget.
  - Care Delivery Approach Evaluation.

DNP Essentials Refection

- Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice.
  - Conducted a literature review.
- Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care.
  - Data collection from EHR.

DNP Essentials Reflection

- Essential V: Health Care Policy for Advocacy in Health Care.
  - Creation and evaluation of procedures and policies.
- Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes.
  - Collaborated with interdisciplinary team.

DNP Essentials Reflection

- Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health.
  - Vulnerable, underserved patient population care delivery model evaluation.
- Essential VIII: Advanced Nursing Practice.
  - Use of analytical skills to evaluate current practice compared to core competencies.

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