Achieving Medical Home Recognition at a Community Practice

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HAVERSTRAW PEDIATRICS, HAVERSTRAW , NEW YORK

Introduction

Community Practice serving predominantly immigrant Hispanic population located in Rockland County, approximately 31 miles north of New York City

POPULATION:

VILLAGE OF HAVERSTRAW:
Population 2010: 11,910. 7.8% < 5 years, 26.5% < 18 years old
Racial distribution: 67.1% Hispanic, 19.3% Whites, 9.7% Blacks
Median Household income: $ 43,009

ROCKLAND COUNTY:
Population 2010: 311, 687. 7.7% < 5 years old; 27.7% < 18 years old
Racial distribution: 65% Whites, 12% Blacks, 16% Hispanic
Median household income: $78,218. 11.6% below poverty line.

Population served is often 1st generation immigrants who congregate with extended families on arrival. When established, move to various parts of the county and neighboring counties and continue to follow at the office.
Often first few visits rendered gratis.

PRACTICE:

Patients served: approximately 6000.
80% Public Health Insurance, 15% Private Health Insurance, 5% Others/Uninsured.

4 Physicians – 2 males, 2 females. Full-time.
Age range: 36 years – 69 years, Years in practice :1-32 years
Hours: Mon-Fri: 9 am – 8 pm, Sat: 9-3 pm
Staff members: 12.
1 Nurse (also works as Care Coordinator), 3 Medical Assistants, 1 Manager, 1 Referral specialist, 1-1/2 Biller, 5 Front Office
Work at the practice : Median 8 years
Electronic Medical Record System: iPatientCare/Medical Communication System
Duration in use: 5 years

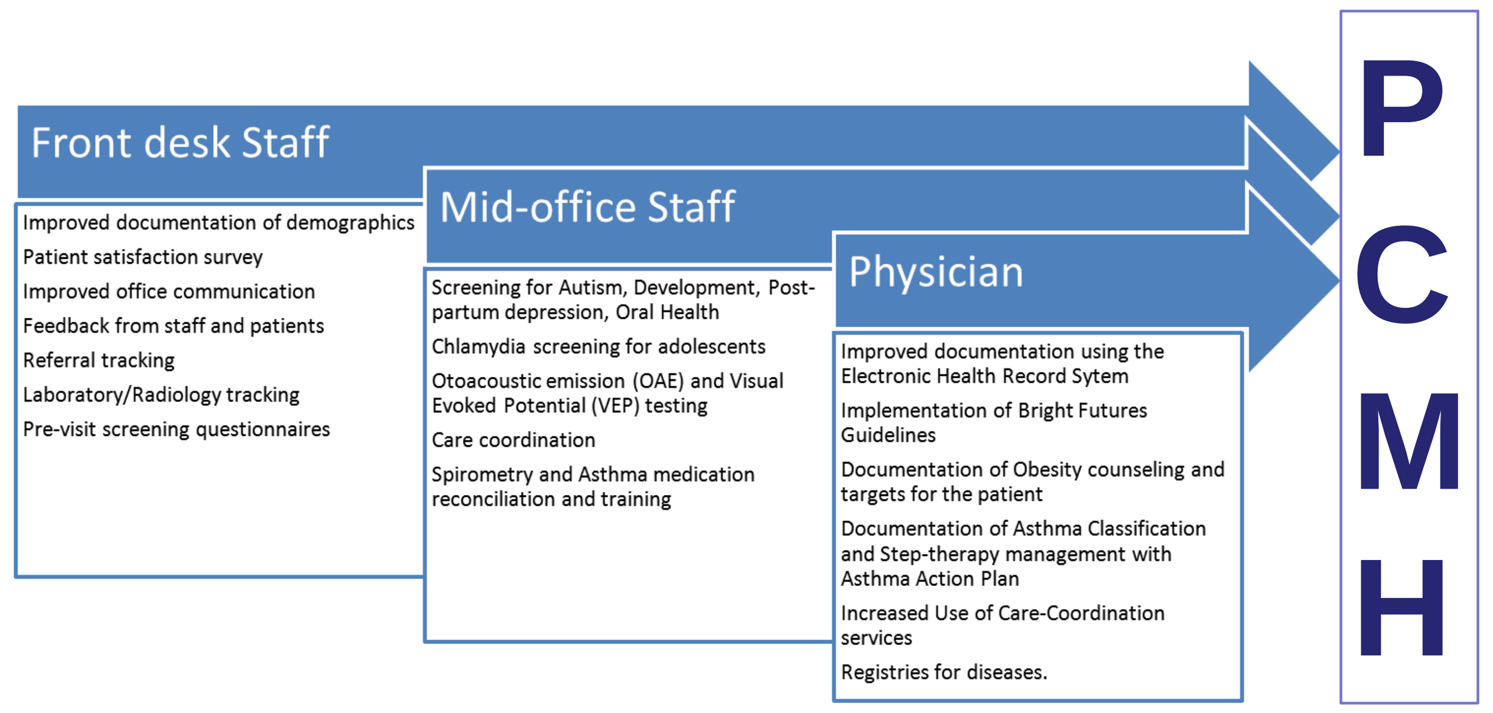
GOAL:

NCQA Patient Centered Medical Home (PCMH) Recognition.
Challenges:
1) Absence of systematic Quality Improvement tracking, only used Quality Improvement enforced by Insurance plan audits
2) Office staff not accustomed to systematic patient input data
3) Partial adherence to current Bright Futures priorities
4) Electronic Record System not configured to generate reports
5) Electronic Record System planning for a major upgrade – new system
6) Busy practice with little/no time for planning and executing changes
7) No dedicated Information technology staff at the practice
8) Minimal/no budget

Advantages:
1) Motivated and dedicated people at the practice
2) Electronic Record System leadership willing to work with us
3) Patients receptive and ready to help.

Methods

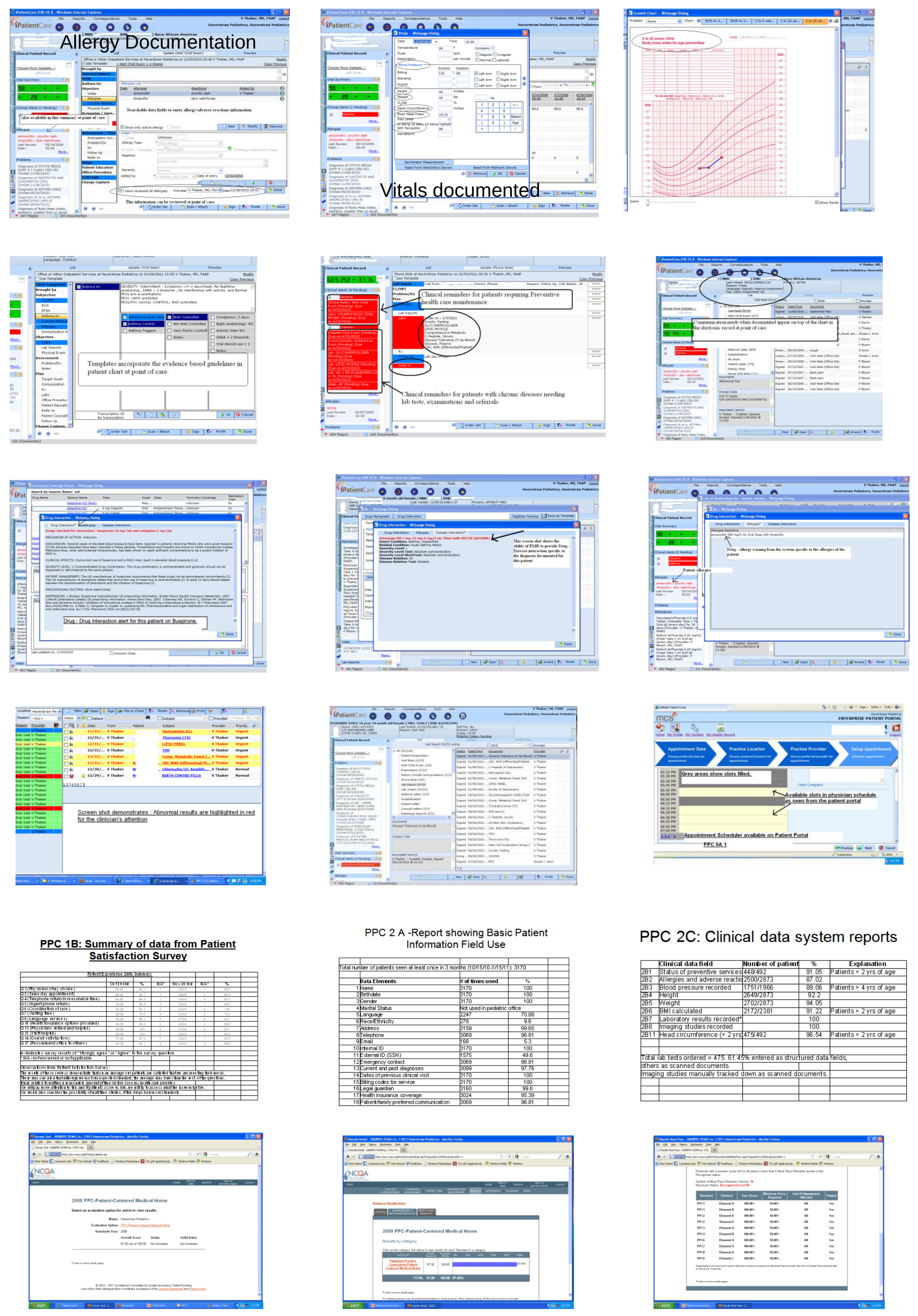
1) Responsibility of PCMH Recognition process assigned to one physician (VT) with leadership buy-in.
2) Lead physician assigned time for the process.
3) On-line training of the process using NCQA website resources and on-line workshops : PPC-PCMH 2008 standards.
4) Consultation with New York State consultants – IPRO.
5) Readiness evaluation from NCQA Interactive Survey Tool to understand the position of the practice in the process and identification of gaps.
6) EMR vendor agrees to have dedicated staff who alongside the physician works on identifying requirements for data collection and report generation. Several templates generated and refined over the course of 3-5 months.
7) Periodic patient satisfaction surveys implemented.
8) Bright Futures Course training performed on EQIPP course.
9) New process implementation: Post-partum depression screening, Developmental screening (PEDS screen), Autism screening (MCHAT), Oral Health Screening, Fluoride varnish, Use of Bright Futures questionnaires.
10) Routine Chlamydia screening for adolescents 15 years and older.
11) Documentation of NHLBI Classification for Asthma and clear documentation of step-therapy approach.
12) Identification of Obesity, Oral Health and Mental Health Resources in the local area. Documentation of counseling facilitated by making one-click options in the EMR.
13) Modification of well visit and sick visit templates to improve documentation of delivery of care according to the state-of-the art standards.
14) Streamlining of tracking of laboratory and radiology studies by obtaining on-line access to the various HIPAA compliant websites.
15) Conferences with specialty care providers to implement referral tracking
16) Conference with Hospital administration to get data on hospital visits. Hospital implements new information system.
17) Systematic documentation of coordination of care by creating dummy codes which can run reports, if needed. Viz. CSHCN (Children with Special Health Care Needs)
18) Creation of Disease specific registries – Asthma, CSHCN, Premature babies.



Results

PCMH Initiative at Haverstraw Pediatrics: August 2010 – March 2011.
Interactive Survey Tool Submitted in March 2011.

Results:
- Medical Home Recognition Achieved on 4/20/2011. Score 97/100
- Patient Satisfaction Rates substantially increased
- Staff Satisfaction Rates improved.
- Physicians happier to be working at the current standards of care.
- Work-flow systems at the office improved. Tracking systems from the new report generator used to track monthly performance.
- Implementation of indigenous Quality Improvement programs.
- Medical home incentive from New York State – managed care and fee for service Medicaid.



Conclusions

Patient centered Medical Home (PCMH) has been identified as a roadmap in practice transformation to provide quality, accessibility and satisfaction. Transforming existing primary care practices into PCMH does present significant challenges. Several states and health care organizations including academic medical centers have undertaken large collaborative to enhance the implementation of these principles in practice. These collaborative may or may not be available for small community practice like ours. We lacked the technology and financial resources required to hire an external consultant who could guide us through the process. Even for primary care physicians who are technically apt to undertake this data driven process, time constraints add an additional burden. Across the nation, primary care physicians today juggle the responsibility of providing best care while accommodating increasing numbers of patients to maintain cash flow.

To our knowledge, we are the first pediatric primary care practice sharing our experience in implementation without being part of a large group effort. We do have the advantage of being small, where the involvement of staff, feedback and workflow changes are on a small scale. But, we lack the resources of group initiatives, academic experience with Quality Improvement and availability of "experts". Our experience suggests that it is important to have a transformation coach who can serve to keep the initiative focused, motivate and follow-up. The presence of electronic records, a good relationship with providers of the software and identification of mutual interest in the process makes the task at hand much easier. Sharing of information with the staff and physicians at regular intervals and making smaller benchmarks while working towards the higher goal made the systemic changes easier for the practice as a whole.
New York State does offer financial incentives for PCMH certification. However, over the 8-month process of certification, this became a smaller objective in view of the higher patient satisfaction rate and growth of the practice. Additionally, the staff and physicians are proud to be part of a primary care model that emphasizes team-based medicine, a partnership between patients and providers, and expanded access and communication. We predict patient centered care as the next phase of health care as recognized by the Affordable Care Act of 2010.

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