

# Patient-Centered Medical Homes in 2016

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There is much information in the medical literature concerning the medical home concept. Each medical practice must utilize that literature to devise a system of care—a patient-centered medical home—that best meets the needs of patients, families, and practice staff. This article is Goldsboro Pediatrics' attempt to describe its system of care, its patient-centered medical home.

In 1967, the American Academy of Pediatrics (AAP), under the leadership of Dr. Calvin Sia of Hawaii, began using the term *medical home* to describe an approach to taking good care of children with special health care needs [1]. In 2002, the AAP published a policy statement that explained the value of the medical home concept [2]. In 2007, primary care organizations published the Joint Principles for the Patient-Centered Medical Home [3, 4]. The National Committee for Quality Assurance (NCQA) also developed a recognition program through which physicians can demonstrate to payers their efforts to build effective patient-centered medical homes [5, 6]. The Patient-Centered Primary Care Collaborative was developed in 2006 and continues to provide a forum where health care professionals, administrators, and policy experts can share experiences and ideas in an effort to improve patients' access to high-quality care within a cost-effective system [7].

Much has been published about the medical home and the essence of good primary care. The AAP, the American Academy of Family Physicians, and the American College of Physicians all have policies outlining the essence of the patient-centered medical home. Can we boil all those guidelines down to a simple formula for primary care physicians? There have been many attempts to do this; one states that there are "five components of medical homes: usual source of care; personal doctor or nurse; family-centered care; coordinated care; and obtaining needed referrals" [8].

In our pediatric practice, our goal is to give all patients access to a pediatrician who can see their medical record 24 hours a day/7 days a week and can assist them in achieving optimal health outcomes by providing necessary acute care and comprehensive preventive services. For patients with special needs, the patient-centered medical home should coordinate services to meet patients' chronic health care needs and help them achieve optimal outcomes through evidence-based, high-quality, cost-effective care.

At Goldsboro Pediatrics, there are 10 key components of the patient-centered medical home.

## #1: Visionary Leadership With an Outcomes-Based Approach to Health Care

As our practice has grown from a 1-pediatrician rental office to a 29-provider, 4-office, integrated network, we have embraced a commitment to outcomes-based care. The managing partner is a pediatrician who is extremely talented in the areas of information technology and practice management. Our practice administrator has a Master's in Business Administration degree and is gifted in the areas of human resources, information technology, and business. One of our partners is very involved in community, state, and national health care politics, such that our practice is always working closely to mold the child health programs of Medicaid, the Child Health Insurance Program (CHIP), and Blue Cross and Blue Shield of North Carolina (BCBSNC). We also have mental health professionals on our staff, along with a full-time lactation consultant.

We focus on multiple adverse outcomes in our patient population: uncontrolled asthma, school failure, poor parent-infant attachment and bonding, obesity, adolescent pregnancy, inadequate school readiness of kindergarten students, immunization refusal, foster care, and behavioral health conditions. We have become adept at managing the use of psychotropic medications. Our quality improvement efforts have resulted in a patient- and family-centered system of care for children at risk of experiencing poor outcomes.

## #2: A Team of Providers Who Are Able to Provide State-of-the-Art Care

Our team consists of 16 pediatricians, 8 nurse practitioners, 2 physician assistants, 2 mental health professionals, 1 lactation consultant, many nurses, numerous clerical staff, a practice administrator, and an office manager. For the past 32 years, we have conducted 3-4 educational

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seminars per month for pediatricians, nurse practitioners, physician assistants, school-based health center staff, pediatric providers who work at a nearby military base, mental health professionals, and lactation consultants. Community partners are invited to these sessions. Today, this program is jointly sponsored by the Brody School of Medicine at

East Carolina University, which allows participants to receive up to 36 hours of Category I continuing medical education credit each year. Our practice also provides a generous budget for all providers to access appropriate out-of-town, online, and print educational resources. We are committed to being on the cutting edge in our specialty.

### **#3: Minimization of Unnecessary Emergency Department and Hospital Care**

All 4 of our offices have routine hours from 8:00 AM until 5:00 PM Monday through Friday. We conduct a walk-in hour in all offices every weekday from 8:00 AM to 9:00 AM. The main office is open until 8:30 PM Monday through Friday and until 5:00 PM on Saturday, Sunday, and most official holidays. After hours, patients can call the main office and talk to a nurse. The nurse does not send patients to the emergency department without allowing families to speak with an on-call pediatrician. We also supervise 6 school-based health centers that use our electronic medical record (EMR) system and are open every minute that schools are in session. Center enrollees are advised to call our main office when schools are closed. When Medicaid administrators look at emergency department utilization, patients at our practice are well below the state average [9].

### **#4: Integration of Hospital Care and Office Care**

A pediatrician is always on call for our community hospital, where we oversee a pediatric ward and a Level II neonatal unit. The census on the pediatric floor ranges from 0 to 15 patients. The hospital delivers approximately 1,500 babies per year. Our pediatricians function as neonatologists for the hospital. The on-call pediatrician provides consultation services for emergency department staff, non-pediatric hospital physicians, and community-based physicians who need help taking care of pediatric patients. We cannot justify the expense of having a pediatrician in the hospital at all times, but a pediatrician is always readily available for hospital issues. The on-call pediatrician can access the EMR system of the practice to assure continuity of care for our hospital patients.

### **#5: Business Savvy Physicians and Staff**

Our practice administrator and managing partner work with our office manager to assure that we file all third-party insurance claims accurately and that we receive payment efficiently. Because we serve over 20,000 children covered by Medicaid and never refuse to treat a sick child, we have to be very efficient in the way we schedule appointments. Our providers must help each other when some providers have packed schedules or very time-consuming patients, while other providers have excessive numbers of patients who do not show up for appointments. Our nurses are allowed, with the permission of patients, to move patients to providers who have unfilled openings in their schedules. We also participate in third-party payer programs that allow us to earn extra payment for providing quality care and satisfying acceptable practice parameters. This requires us to monitor practice patterns such as generic prescription rates, appropriate referrals, and avoidance of unnecessary hospitalizations. Finally, we know that our cash flow depends upon our volume of business, and we constantly encourage staff

to bend over backwards to assure we take advantage of all opportunities to provide onsite care for patients. We allow patients to walk in almost any time Monday through Friday for immunization updates and flu vaccines, provided they are up to date according to the health supervision guidelines of the AAP.

### **#6: User-Friendly EMR System**

We were early adopters of EMRs, bringing our system online on January 1, 2000. We pay for in-office, full-time information technology support, and we contract with consultants to manage database issues and portal development. We invest heavily in providing in-service activities for all staff, and they are very comfortable navigating the EMR system. The practice helped school-based health centers incorporate our EMR system so that patient care is seamless between the centers and the practice. Any provider can access the EMR system off site. We are able to document achievement of quality measures for third-party payers and the federal government through the current EMR system.

### **#7: Physicians and Staff Skilled at Implementing Quality Improvement Projects**

Quality improvement projects have allowed our practice to qualify for optimal payment by Medicaid, CHIP, private health insurance plans, and the federal government. The most rigorous quality improvement programs have been the meaningful use initiative of the federal government and NCQA's patient-centered medical home recognition program. The practice qualified for Stage 1 meaningful use payments and is considering applying for Stage 2. The practice has also achieved the highest NCQA medical home recognition status on 3 occasions. These quality improvement programs have stimulated the practice to improve efficiency and to address certain pediatric conditions that lead to poor outcomes (obesity, asthma, and attention deficit hyperactivity disorder). There is overlap between these quality improvement projects and Part IV of the Maintenance of Certification (MOC) program of the American Board of Pediatrics (ABP). Therefore, when our practice completes all the quality improvement activities required by NCQA, our pediatricians have met all the Part IV MOC requirements of the ABP.

### **#8: Community-Based Care Coordination Staff**

Since 1991, our practice has partnered with the North Carolina Medicaid program to develop Community Care of North Carolina (CCNC). Through CCNC, our practice qualifies for community-based care coordination staff. Since our practice has over 20,000 Medicaid enrollees, we qualify for up to 4 care coordinators. These people live in our community and understand the local system of care, which includes the resources of multiple agencies: the health department, housing authority, public schools, Head Start, Smart Start, Child Development Services Agency, Department of Social

Services, vocational rehabilitation, and mental health services. When our providers encounter patients with complex medical and/or psychosocial needs, they enlist the help of care coordinators in assuring that these patients receive the care and services they need to achieve good outcomes. Care coordinators in the tertiary hospitals work with our community-based care coordinators to provide seamless care for patients with especially complex conditions and/or situations.

### **#9: Supportive Private and Public Third-Party Payers**

Over the years, our practice has worked closely with Medicaid, CHIP, and BCBSNC to assure that cash flow to the practice is sufficient to support the mission of the practice. The North Carolina Pediatric Society/North Carolina Chapter of the AAP has been instrumental in helping pediatricians develop Medicaid and CHIP programs that are user-friendly for families, children, and pediatricians. Representatives of the society meet regularly with BCBSNC administrators to discuss practice and payment issues. A pediatrician in our practice has been seriously involved with the North Carolina Pediatric Society since 1983, assuring that state government and private insurance plan leaders understand how Medicaid, CHIP, and BCBSNC infrastructure and payment affect access, quality, and cost effectiveness in the community setting.

### **#10: Providers Who Have Their Fingers on the Pulse of the Community**

Goldsboro Pediatrics is the only pediatric practice in Wayne County, so the leaders of the practice strive to ensure that all children in the county have access to the services and supports they need to achieve optimal outcomes. We have worked with the hospital and other organizations to establish 6 school-based health centers in schools where there are large numbers of children from low-income families who, for a variety of reasons, do not have access to care in a primary care practice or the health department. Our physicians have realized that many children need mental health services, so we have brought mental health professionals into the practice, linked community-based mental health profes-

sionals with the school-based health centers, and developed a telemedicine program to give high-risk patients access to a child psychiatrist at the Brody School of Medicine at East Carolina University. Our practice has also led community efforts to address psychosocial issues such as obesity, adolescent pregnancy, child abuse or neglect, and school readiness.

As we enter the era of value-based payment, we know that our model may change. If we can continue to build our system of care on the 10 key elements above, our children and families will continue to benefit from our rich experience as a patient-centered medical home. **NCMJ**

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