The Road to Becoming a Recognized Patient Centered Medical Home: A Quality Improvement Journey
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Purpose and Scope
- **Purpose**: To improve patient outcomes and healthcare delivery at Palma Ceia Family Care
- **Scope**: Phase II: development of PCMH infrastructure, systems, and processes
- Complete Interactive Survey System assessment & documentation
- Submit application to NCQA
- Selected work/activities associated with project Phase III: Project Evaluation

Background
- **Current U.S. healthcare system concerns**
  - Described as a mosaic, fragmented, disintegrated network of constituents
  - Ranked number one for healthcare expenditures. $2.9 trillion is spent on healthcare; 17.4% of Gross Domestics Product
  - Ranked lowest in overall healthcare standing for quality, access, efficiency, equity, and indicators of health
- **Impact/Result**
  - Waste of resources
  - Loss of information
  - High cost
  - Low quality care

Proposed Solution
- **Patient Centered Medical Home (PCMH) Model Objective**
  - Revitalize the joy of practice by increasing patient and provider satisfaction
- **Principles**
  - Coordination of care
  - Effective communication
  - Transformation of primary care into what patients desire
  - Higher quality of care, lower costs, and improved patient and provider satisfaction
- **NCQA PCMH Recognition Program**

PCMH Implementation Model

Method
- **Project Design**
  - Evidence translation practice improvement
  - Multi-phase Doctor of Nursing Practice project

Results
- **Patient-Centered Medical Home**
  - Establishment of clear project goals and measurable outcomes
  - Understand and assume accountability to lead a team
  - Expand scope and depth of knowledge related to healthcare delivery
  - Develop understanding of continual tracking and monitoring to improve patient outcomes
  - All practices (irrespective of size) can make prompt and sustained transitions to a PCMH if provided with external support

Scoring System
- **Scoring**
  - Level 3: 85-100
  - Level 2: 60-84
  - Level 1: 35-59

<table>
<thead>
<tr>
<th>Standards</th>
<th>Elements</th>
<th>Factors</th>
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<tbody>
<tr>
<td>6</td>
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<td>178</td>
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| 178 Factors |

**PCMH Consultant Tangible Products Volume Generated**

- Written Policies
  - 23
- Example Materials/Patient Education
  - 132
- Reports
  - 87

**Summary of Infrastructure Enhancements**

**DNP Consultant Tangible Products Volume Generated**

| PCMH 1: Patient-centered access | 9.50 | 10.00 |
| PCMH 2: Team-based care         | 9.37 | 12.00 |
| PCMH 3: Population health management | 16.00 | 20.00 |
| PCMH 4: Care management and support | 19.00 | 20.00 |
| PCMH5: Care coordination and care transitions | 12.00 | 18.00 |
| PCMH6: Performance measurement and quality improvement | 15.00 | 20.00 |

**Category Total**: 80.87/100.00

**80.87 total points = Level II NCQA PCMH Recognition**

**DNP Essentials Alignment**

<table>
<thead>
<tr>
<th>Scientific Underpinnings for Practice</th>
<th>Key DNP Project Activities</th>
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<tr>
<td>Application of model of care based on comprehensive scientific theories and concepts through implementing evidence-based care guidelines</td>
<td><strong>Organizational and Systems Leadership</strong>...</td>
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<tr>
<td>Implementation of innovative model of care to improve healthcare delivery and care outcomes</td>
<td><strong>Clinical Scholarship and Analytical Methods</strong>...</td>
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<td>Completion of comprehensive literature review and application of Donabedian framework</td>
<td><strong>Information Systems/Technology and Patient Care Technology</strong>...</td>
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<td>Integration and application of EHR and patient registries to achieve project outcomes</td>
<td><strong>Health Care Policy...</strong></td>
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<tr>
<td>Application of NCQA guidelines and standards</td>
<td><strong>Interprofessional Collaboration...</strong></td>
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<tr>
<td>Collaboration with PCFC interprofessional team to achieve project goals</td>
<td><strong>Clinical Prevention and Population Health...</strong></td>
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<tr>
<td>Utilization of patient registries to monitor, track, and improve population outcomes for PCFC patient panel</td>
<td><strong>Advanced Nursing Practice</strong>...</td>
</tr>
<tr>
<td>Integration of clinical knowledge and DNP competencies to achieve project outcomes</td>
<td><strong>Acknowledgments</strong></td>
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**Acknowledgments**

We would like to thank our Project Supervisory Committee Chair, Dr. Michael, for her continual support and commitment to student success. We would also like to thank our Project Committee Member, Dr. Malone, for her project involvement.

**References**

See available handout for references.