

How do NP-led PCMHs differ from physician-led PCMHs?

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Background

- Patient-Centered Medical Homes (PCMHs), were initially established as a physician-centric model, but have evolved to develop team-based care to best serve population health needs
- Since 2010, National Committee for Quality Assurance (NCQA) officially recognized PCMHs led by nurse practitioners (NPs)

Aim

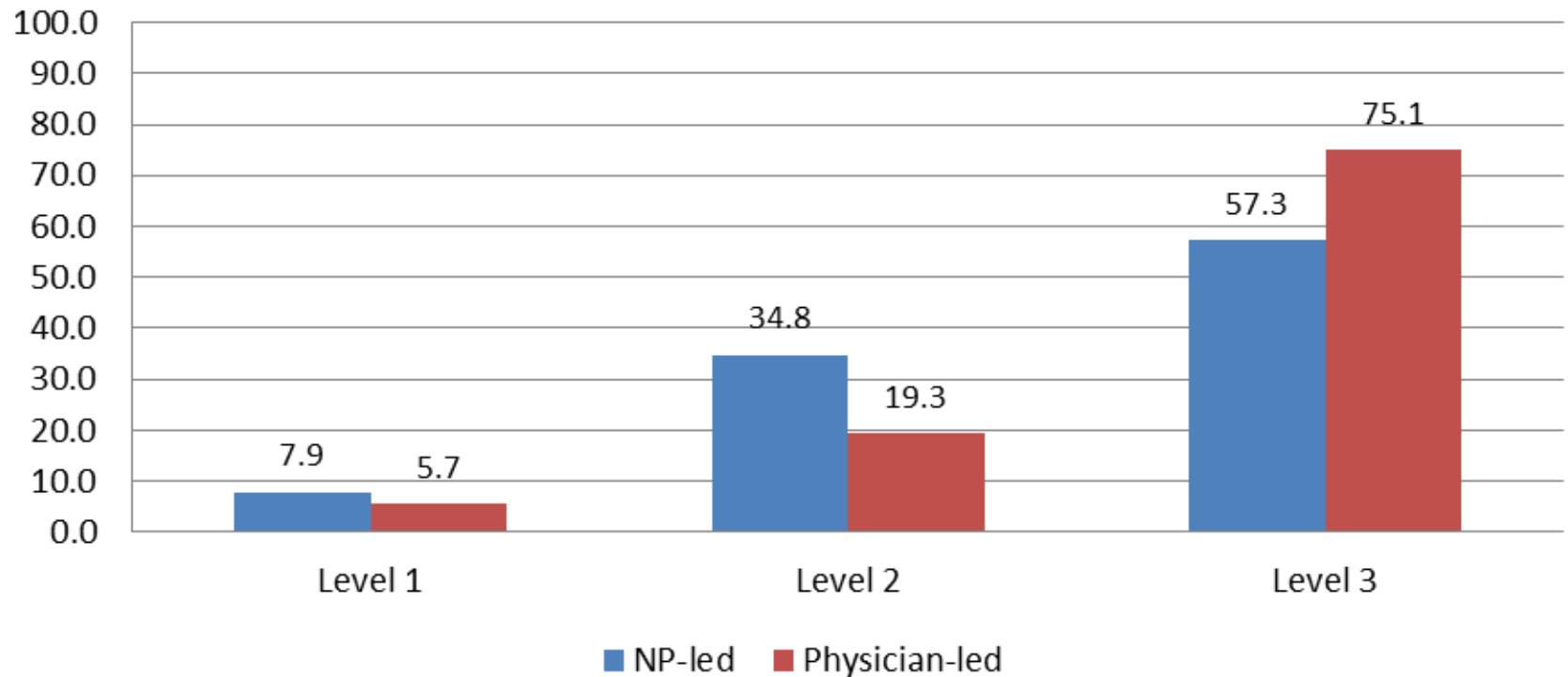
- To examine whether and to what extent NP-led PCMHs differ from physician-led PCMHs, in terms of
 - Level of PCMH achievement
 - Composition of primary care clinicians
 - Geographic and population characteristics of PCMH location

Data and Study Population

- Data from 11,870 practices recognized under the NCQA PCMH program as of May 2016, linked to the Area Health Resource Files
- NP-led PCMH
 - If no physician(s) practiced at the same physical location/practice site
 - 391 NP-led vs. 11,479 physician-led

PCMH Achievement, %

Among 391 NP-led PCMHs, 57.3% achieved Level 3, the highest recognition, whereas the majority of physician-led PCMHs (75.1%) achieved Level 3 ($p < 0.001$).

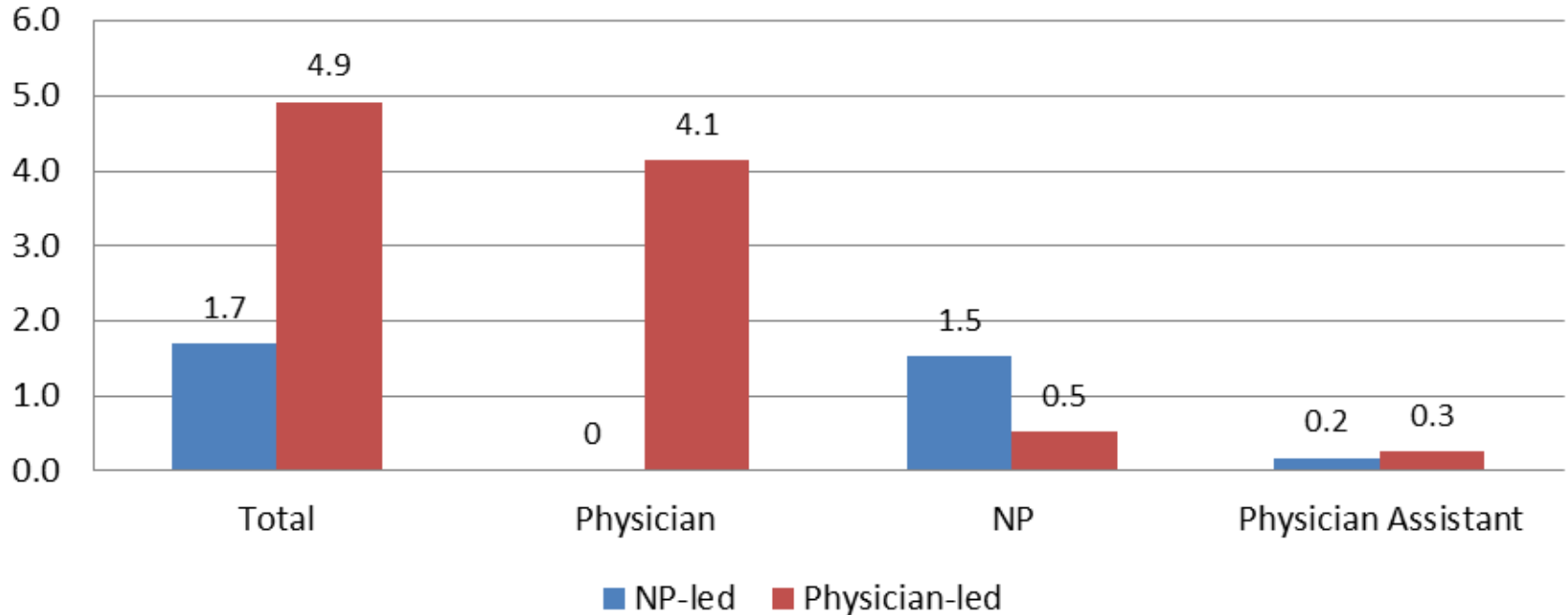


NCQA PCMH 2011
6 Standards, 27 Elements, 149 Factors

Points	Standard and Element	No. Factors	Must Pass
20	1 Enhance Access and Continuity	34	
4	A Access During Office Hours	4	X
4	B Access After Hours	5	
2	C Electronic Access	6	
2	D Continuity	3	
2	E Medical Home Responsibilities	4	
2	F Culturally and Linguistically Appropriate Services (CLAS)	4	
4	G Practice Organization	8	
17	2 Identify and Manage Patient Populations	35	
3	A Patient Information	12	
4	B Clinical Data	9	
4	C Comprehensive Health Assessment	10	
5	D Using Data for Population Management	4	X
17	3 Plan and Manage Care	23	
4	A Implement Evidence-Based Guidelines	3	
3	B Identify High-Risk Patients	2	
4	C Manage Care	7	X
3	D Manage Medications	5	
3	E Electronic Prescribing	6	
9	4 Provide Self-Care and Community Support	10	
6	A Self-Care Process	6	X
3	B Referrals to Community Resources	4	
18	5 Track and Coordinate Care	25	
6	A Test Tracking and Follow-up	10	
6	B Referral Tracking and Follow-up	7	X
6	C Coordinate with Facilities/Care Transitions	8	
20	6 Measure and Improve Performance	22	
4	A Measures of Performance	4	
4	B Patient/Family Feedback	4	
4	C Implements Continuous Quality Improvement	4	X
3	D Demonstrates Continuous Quality Improvement	4	
3	E Performance Reporting	3	
2	F Report Data Externally	3	
100 Points	Level 1: 35–59 points and all 6 MP elements Level 2: 60–84 points and all 6 MP elements Level 3: 85–100 points and all 6 MP elements	149 Factors	6 MP Elements

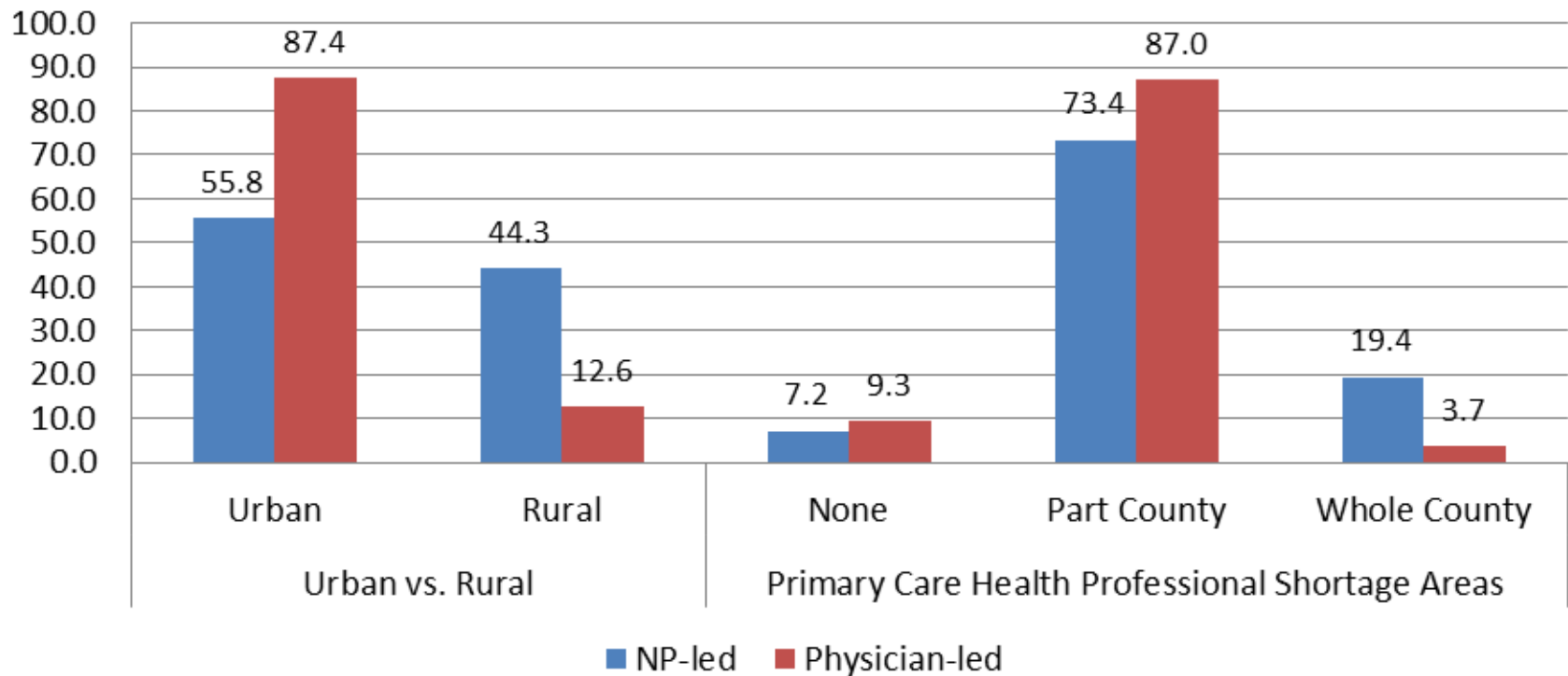
Primary Care Clinicians

Physician-led PCMHs have a larger number of total clinicians than NP-led PCMHs (4.9 vs. 1.7) ($p < 0.001$), whereas the mean number of NPs at NP-led PCMHs was nearly three times the number at physician-led PCMHs (1.5 vs. 0.5) ($p < 0.001$).



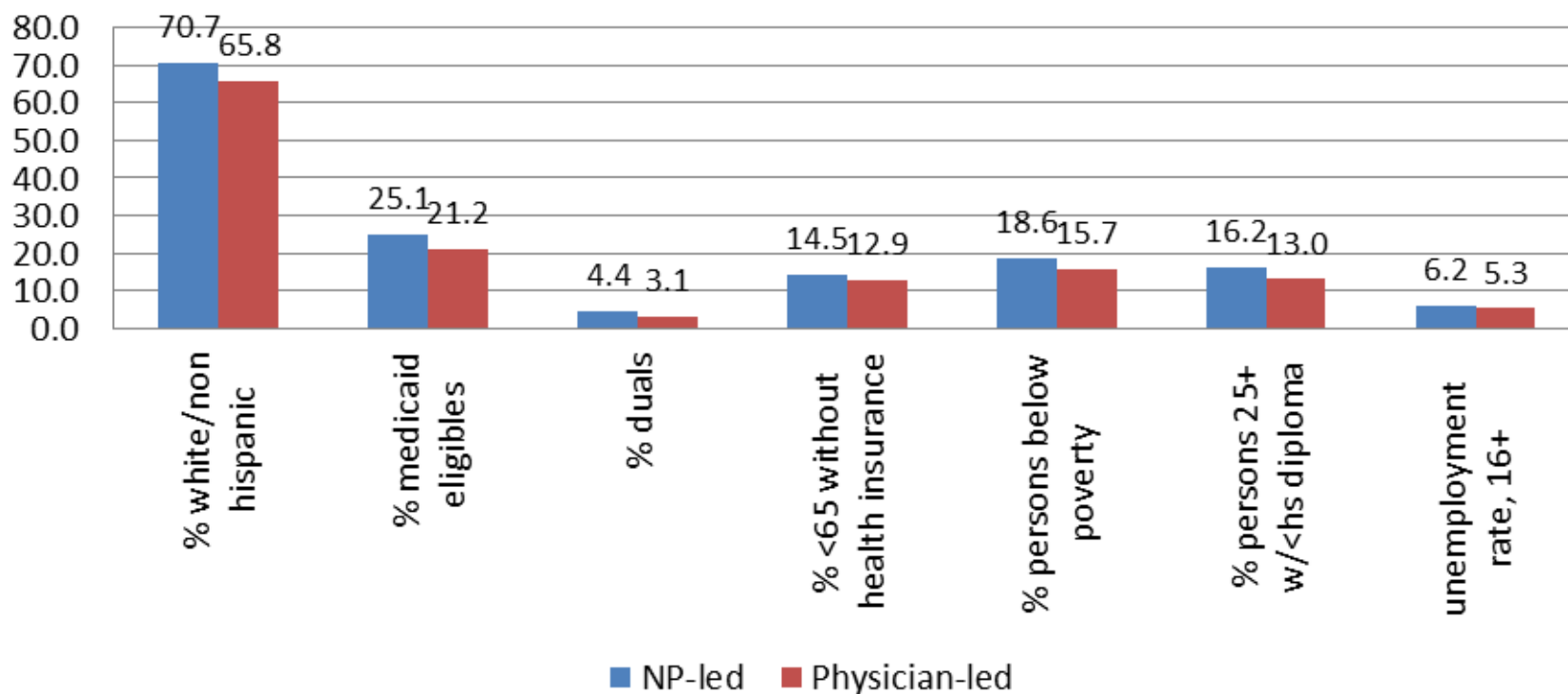
Geographic Location, %

NP-led PCMHs were over three times as likely to be located in rural areas ($p < 0.001$), and over five times more likely to be located in areas designated as a whole county shortage areas than physician-led PCMHs ($p < 0.001$).



Population Characteristics, %

NP-led PCMHs were slightly more likely to be located in areas with more people eligible for Medicaid, without health insurance, with high unemployment rate ($p < 0.001$).



Implications

- NP-led PCMHs are believed to meet growing demand for primary care, in particular, for rural and underserved population
- A clear understanding of differences in capabilities, values, priorities and needs of the population served is essential as speeding the spread of this innovation

Limitations

- Limited to descriptive patterns
- Unable to examine
 - Staff composition other than primary care clinicians, as well as roles and responsibilities of each team member
 - Services provided
 - Transformation made in (or since) becoming a PCMH

Supplemental Survey (In Progress)

- Selected 941 practices with valid recognition status as of Jan 2017
 - 276 NP-led vs. 665 (randomly selected) physician-led
- Successfully verified 321 practices having valid contact information
 - 119 NP-led vs. 202 physician-led
- 61 practices responded (19%)
 - 9 NP-led vs. 52 physician-led

Preliminary Findings: Staffing FTEs

	NP-led (n=9)		Physician-led (n=52)	
	Mean	Std. Dev.	Mean	Std. Dev.
Primary Care Physician	0	0	7.34	12.69
Specialty Care Physician	0	0	2.18	8.95
Nurse Practitioner	2.11	0.70	4.18	7.21
Physician Assistant	0	0	1.53	4.58
Certified Nurse Midwife	0	0	0.37	1.20
RN	0.61	1.05	3.73	5.47
LPN/LVN	0.83	1.37	4.74	11.36
Certified Nursing Assistant	0.11	0.33	0.70	2.31
Medical Assistant	1.22	1.09	19.01	49.56
Case Manager, not an RN	0.44	1.33	1.01	2.12
Mental Health Provider	0.17	0.35	0.87	1.76
Certified Social Worker	0	0	0.75	3.39
Community Health Worker	0	0	0.63	2.07
Dietitian/Nutritionist	0	0	0.40	1.23
Health Educator/Counselor	0	0	0.12	0.50
Pharmacist	0	0	0.75	1.83
Physical Therapist	0	0	0.43	2.77
Laboratory Technician	0.11	0.33	1.17	3.29
Radiology Technician	0.11	0.33	0.94	2.82
IT Staff	0.22	0.44	1.56	3.26
Receptionist	1.22	0.97	10.72	29.64
Other	0.78	0.71	11.29	32.39
Total	7.94	4.29	74.43	143.86

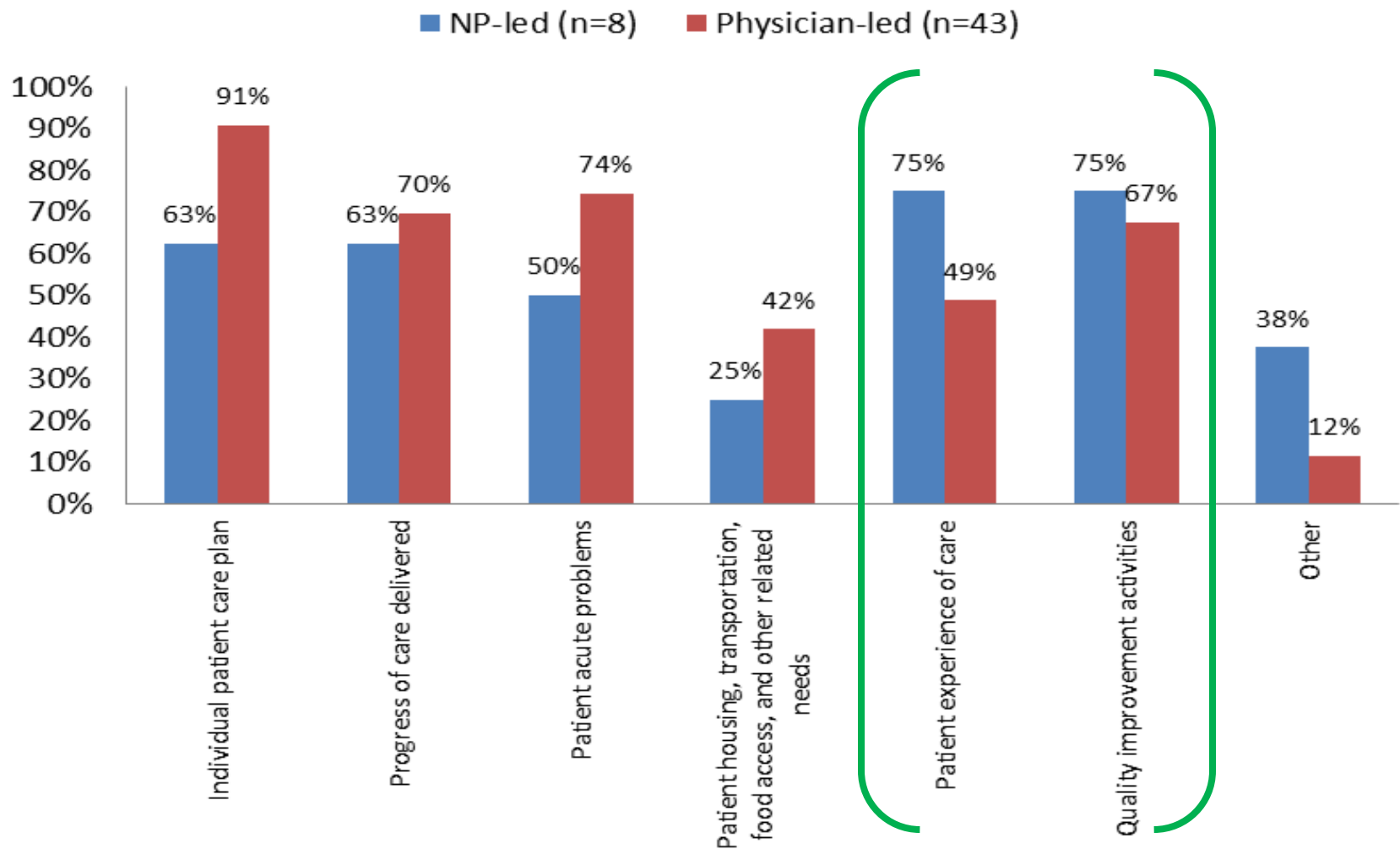
Preliminary Findings: Service Provided

- Physician-led PCMHs with more allied staff and resources are well functioned providing
 - Whole-person
 - Comprehensive, and
 - Coordinated care
- NPs at NP-led PCMHs are key/only clinicians who provide medical services overlap with those of physicians at physician-led PCMHs

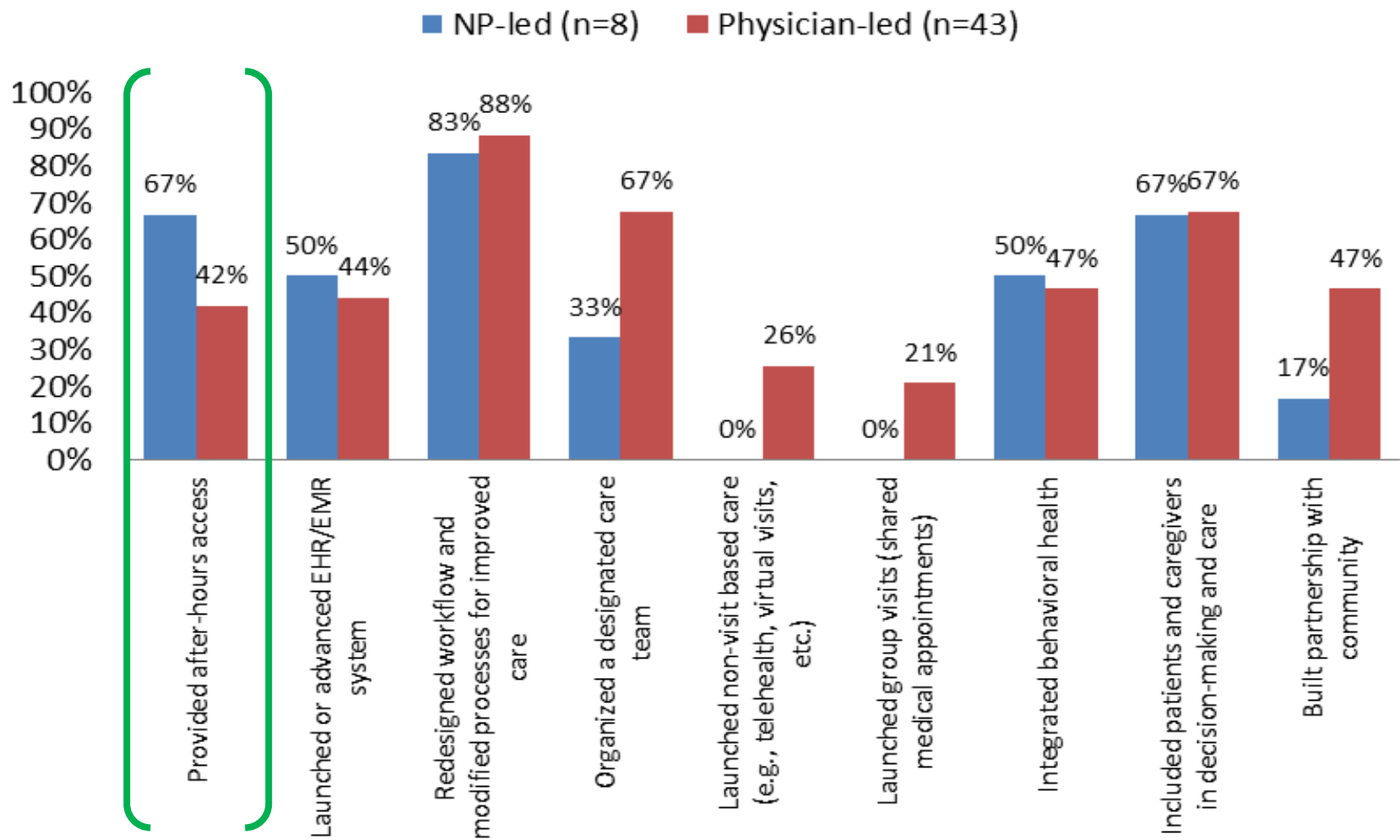
13 Questions to Assess Service Provided

1	Develops care plans with patient and caregiver
2	Provides prevention and wellness
3	Provides behavioral health care
4	Provides disease management programs for patients with chronic conditions
5	Manages patients at high risk for poor outcomes or extraordinary resource use
6	Holds planned education sessions (e.g., diet/nutrition, exercise, tobacco cessation, stress management, taking medications, symptom recognition)
7	Provides population management (e.g., prospective management of patients who need services and screenings)
8	Identifies internal processes to improve care delivery with practice staff and coordinates care within the practice
9	Coordinates patient care with other health care providers across different settings, including specialty care, hospitals, home health care, and long-term care supports
10	Links patients with available services and resources in the community (e.g., education, housing, labor, justice, transportation, etc.)
11	Sends reminders between visits to ensure that patients receive care on a timely basis
12	Communicates with patients through email, text, or a patient portal, etc.
13	Collects quality data, creates quality improvement plan, tests and implements changes

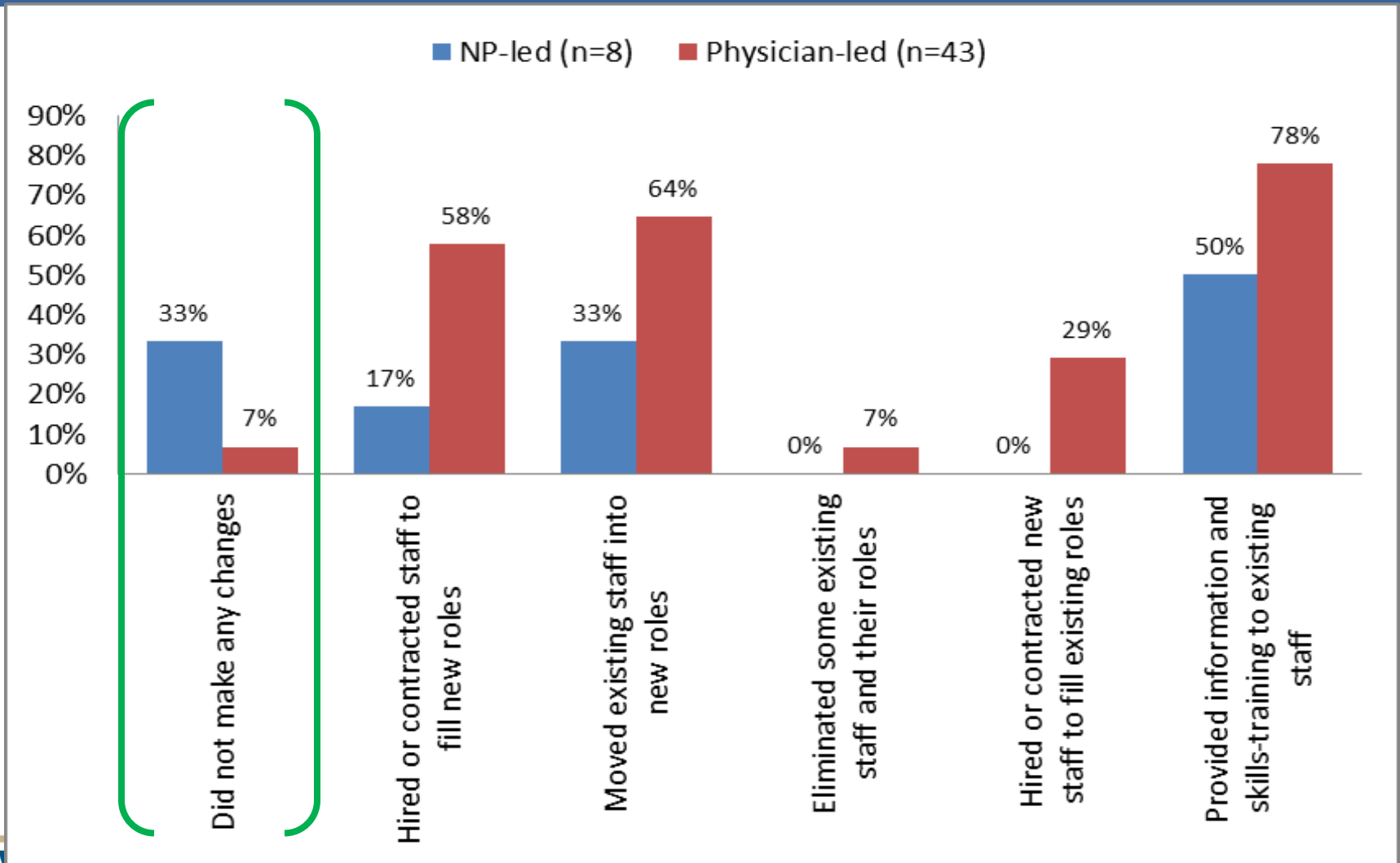
Preliminary Findings: Issues Addressed through Team Care



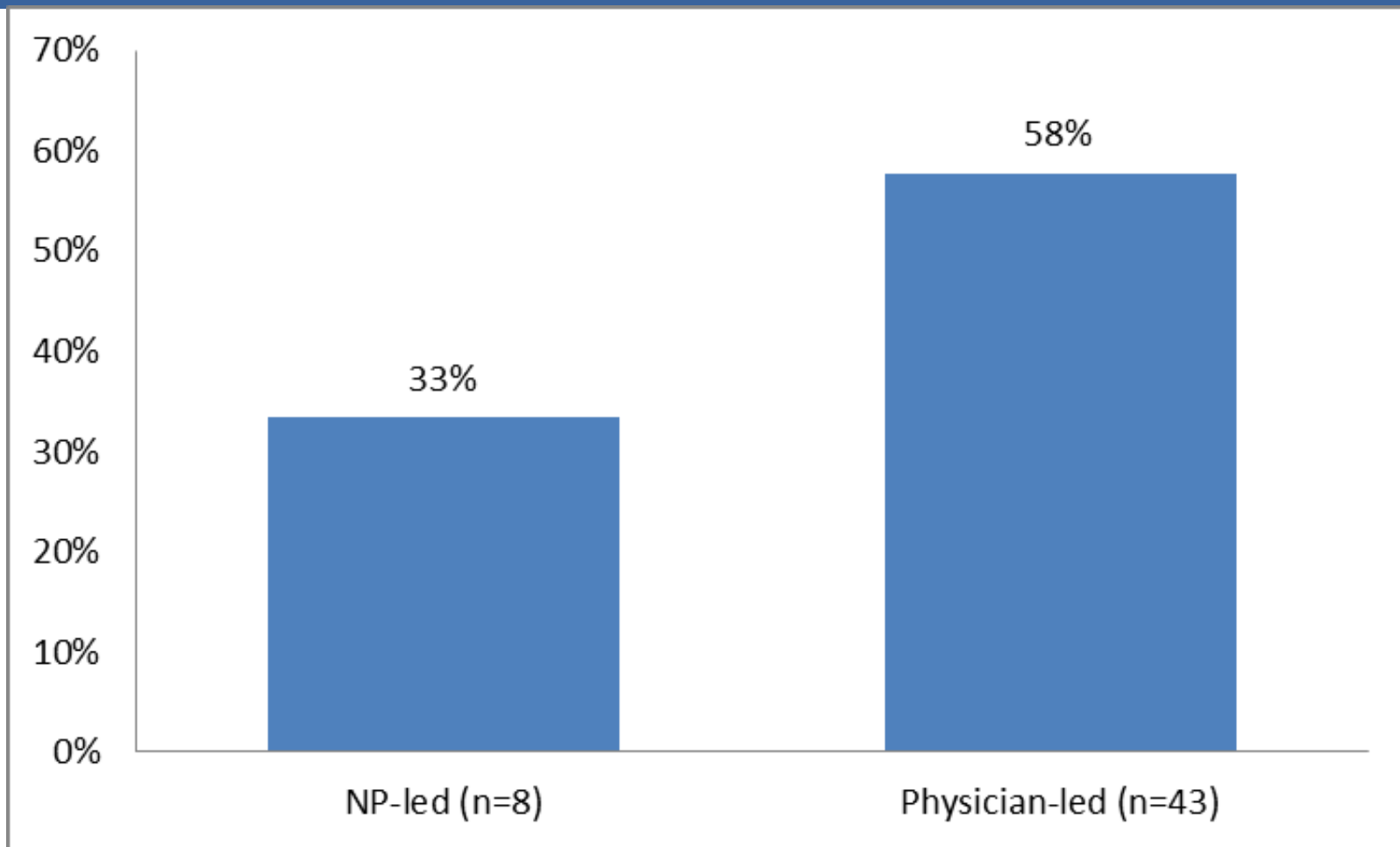
Preliminary Findings: Practice Transformation



Preliminary Findings: Workforce Transformation



Preliminary Findings: Additional Payments



Puzzled: why do we expect to see differences between NP-led vs. Physician-led PCMHs?

- Given that NP-led PCMHs were more likely to be located in rural and underserved areas, we expected them to provide more comprehensive and integrated care to meet both medical and non-medical health care needs for vulnerable population
- Despite these expectations, (preliminary) survey findings do not support this

Thoughts and Feedback?