Patient-Centered Primary Care COLLABORATIVE

The Role of Nurse Practitioners in Health Care: Providing Patient-Centered Care

Monthly National Briefing

May 26, 2016

Patient-Centered Primary Care COLLABORATIVE

AANP

American Association of NURSE PRACTITIONERS™

Cindy Cooke, DNP, FNP-C, FAANP
President, American Association of Nurse Practitioners

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Sean Lyon, MSN, FNP-CS, APRN
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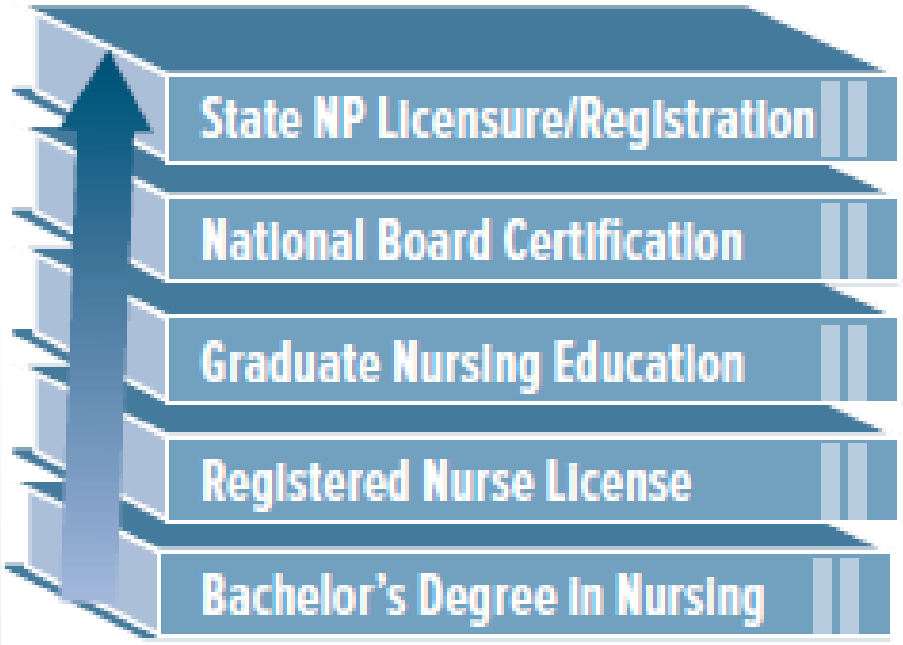
Nurse Practitioners

NPs must complete a master's or doctoral degree program, and have advanced clinical training beyond their initial professional registered nurse preparation and clinical experience.

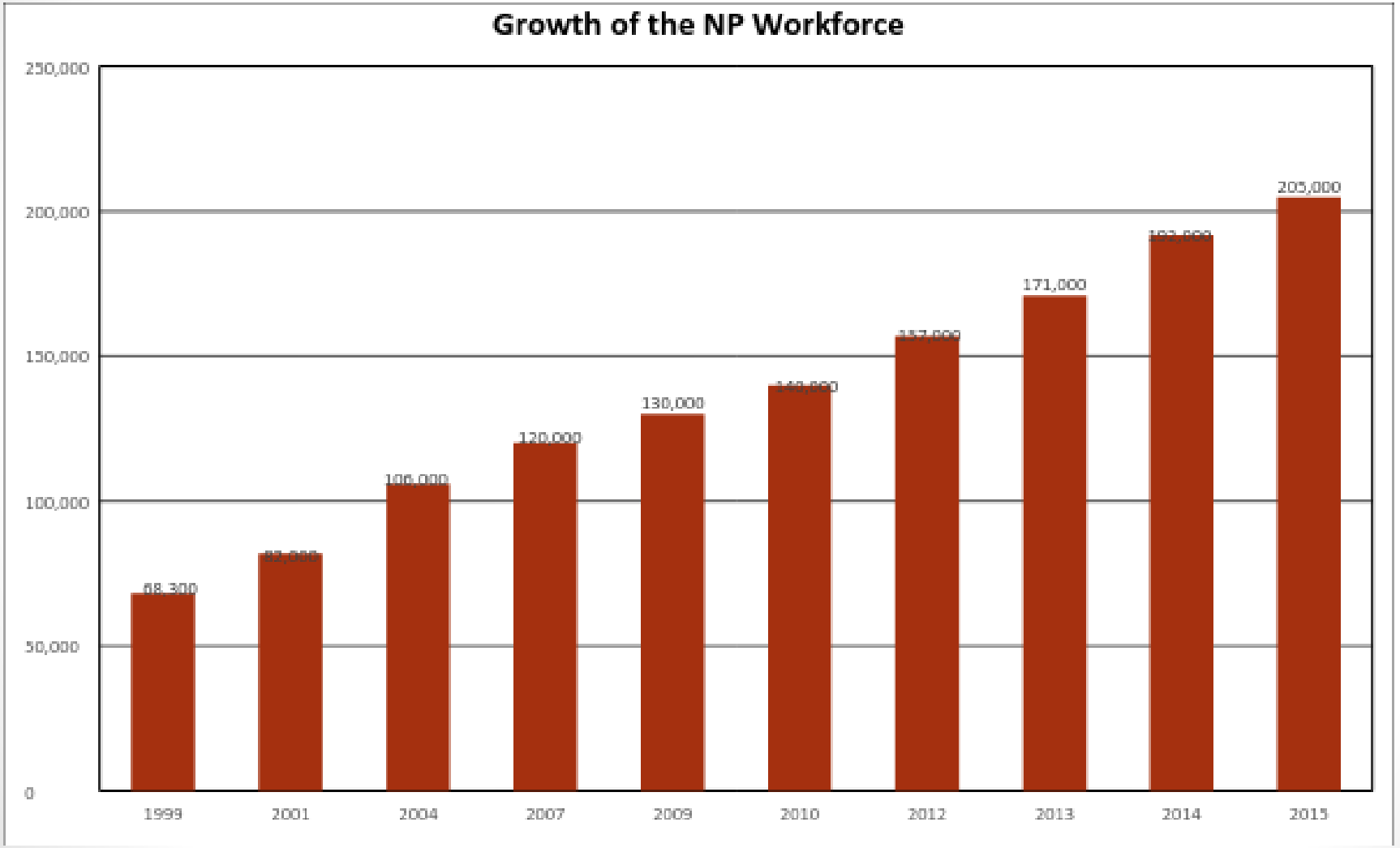


It is recommended that the doctoral degree (DNP or PhD) become the terminal degree to prepare nurse practitioners for entry into practice.

Nurse Practitioners

- NPs are licensed by their state board of nursing
- NPs are nationally certified
- There are five certifying bodies, depending on the type of NP
- AANPCP and ANCC certify the majority of NPs
- NPs re-certify every 5 years
- Requirements for CE vary slightly by the state licensing body and certifying body

NP Growth 1999-2015



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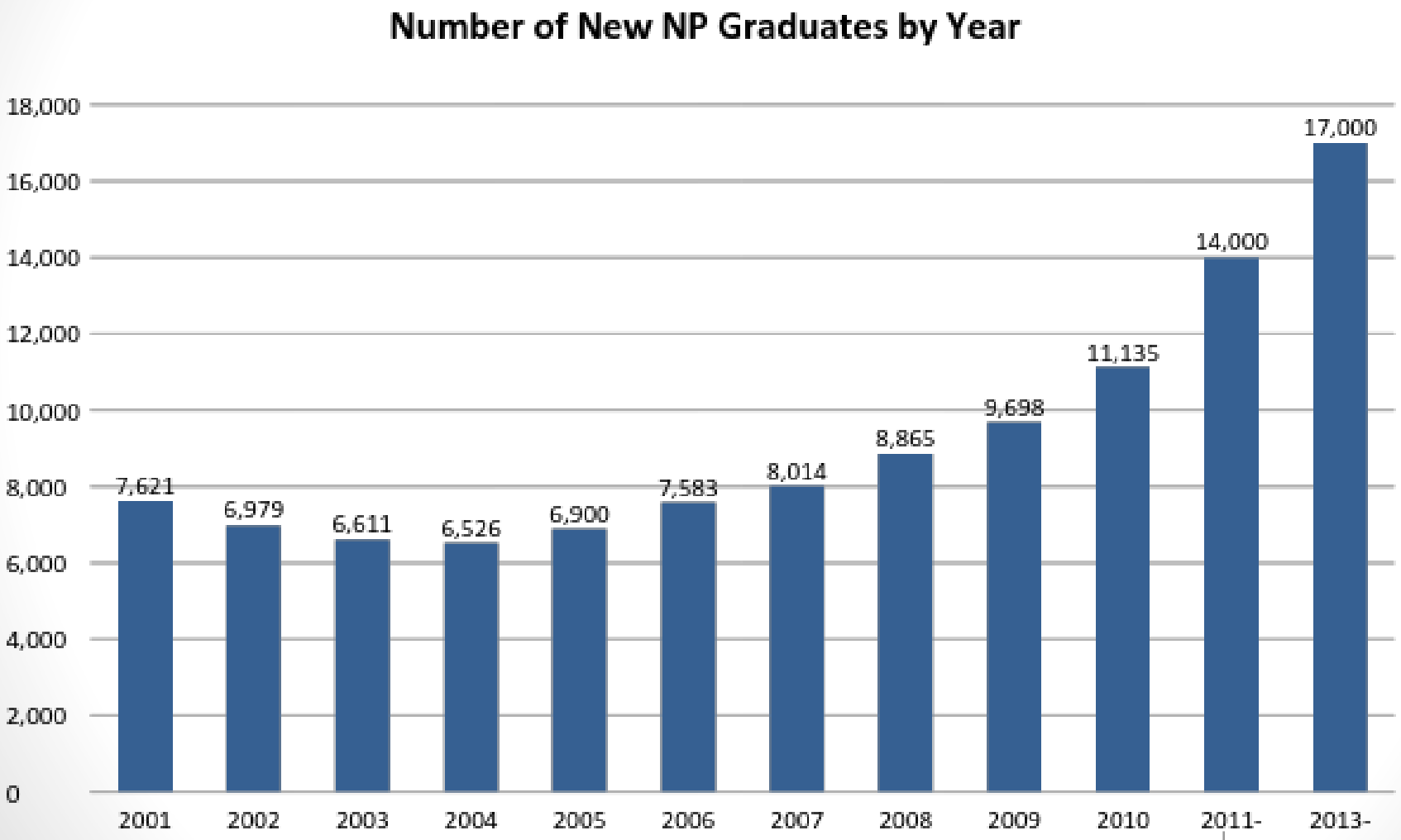
NP Graduations 2001-2014



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Nurse Practitioner Focus

- Acute Care – Adult or Pediatric
- Adult
- Adult / Gerontology - Acute Care or Primary Care
- Adult / Gerontology - Adult Psychiatric / Mental Health
- Family
- Family Psychiatric / Mental Health
- Gerontology
- Neonatal
- Pediatric
- Women's Health

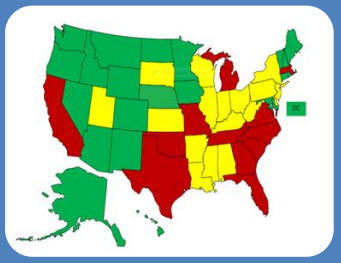
NP Scope of Practice Includes:

- Diagnosis and management of both acute episodic and chronic conditions
- Emphasis of health promotion and disease prevention
- Services include, but not limited to:
  - Ordering, conducting, supervising, and interpreting diagnostic studies
  - Prescription of pharmacologic and non-pharmacologic therapies
- Prescriptive authority in all 50 States/DC

Examples of Diagnosis Treated by NPs

- Allergy and respiratory illnesses
- Back pain/neck pain
- GERD
- Abdominal pain
- Diabetes
- Hypertension
- Depression
- Anxiety
- Insomnia

NP Prescribing



Authorized to prescribe in all 50 states and DC to include controlled substances

97.2% of NPs prescribe more than 733 million prescriptions annually

NPs in full-time practice write an average of 21 prescriptions per day.

Examples of Medications NPs Prescribe

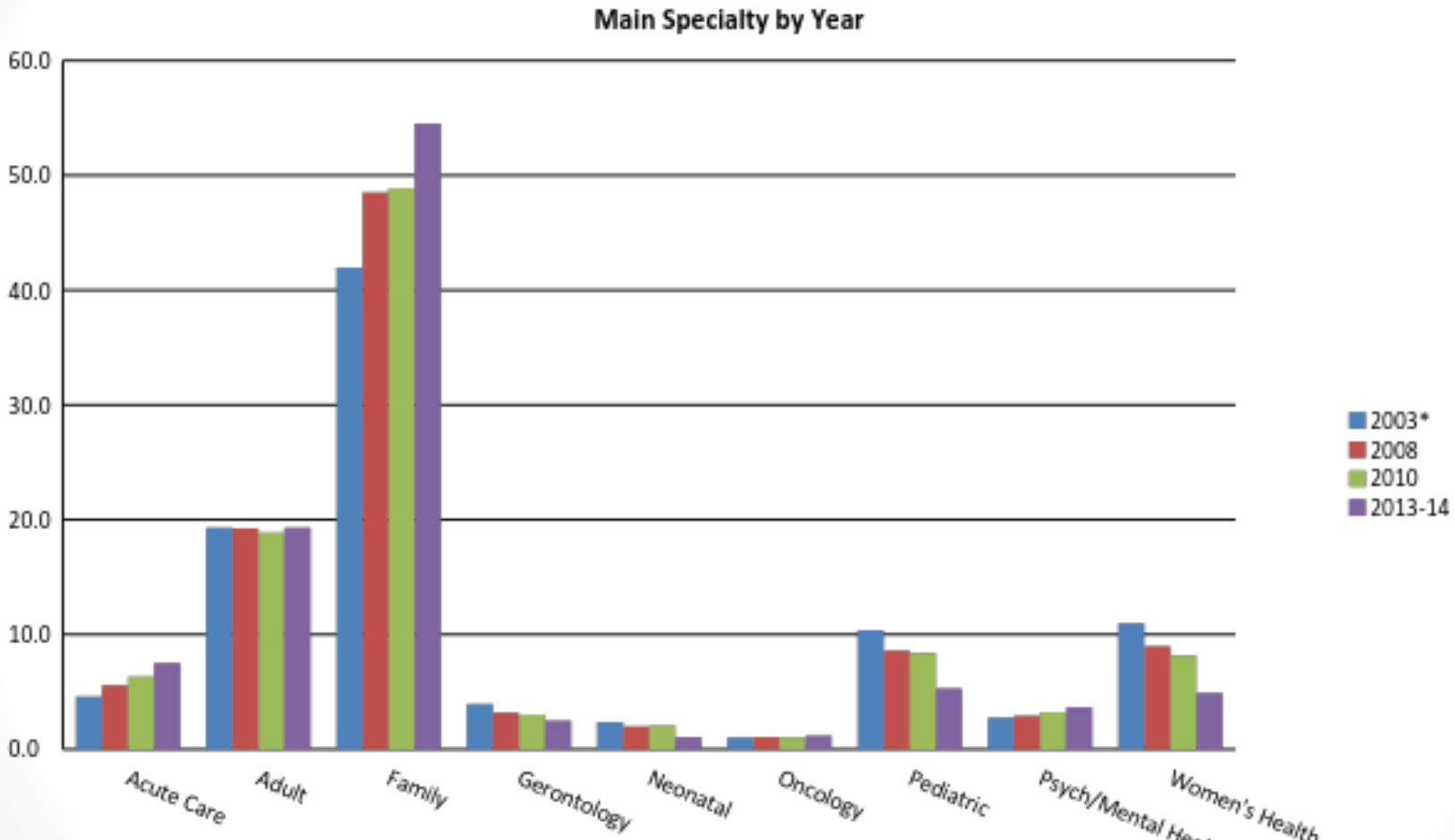
- Antihypertensives
- Antimicrobials
- Diabetic agents
- Dyslipidemic agents
- Analgesics, NSAIDS
- Antidepressants
- Vaccines, immunizations
- Narcotics

Practice Sites

- NPs are found in urban, suburban and rural communities

- NPs work in:
  - Outpatient clinics (solo and group practices)
  - Urgent care and convenient care
  - Hospitals (inpatient and emergency room)
  - Community clinics

NP Workforce



*Does not add up to 100%, three additional specialties existed in 2003

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NPs Approach to Patient Care

- NPs are educated and clinically trained to partner with patients on their healthcare journey
- NPs see patients as a whole individual as part of a family and community
- NPs are partners in health, engaging patients and their families in shared decision making to accomplish desired goals

Role of NPs

- NPs provide high-quality, affordable patient-centered care

- Care by NPs associated with decreased hospitalizations (Kuo et al, 2015)
- Care cost effective in Medicare beneficiaries (Perloff et al, 2015)
- Clinics with NPs provide better access for Medicaid patients (Richards & Polsky, 2015)

NPs in Evolving Primary Care System

- NPs meeting patient needs
  - Access, quality, and timeliness
- Patient satisfaction with NP care
- Growing number of NPs
- Economic benefit to states
- NPs make up one-third of primary care workforce

NPs and Team Based Care

- Patient center of the health care team
- Team consists of patients and their health care providers
- Health team is dynamic – needs of patient direct who best can lead the team at any given time
- Members of health care team should practice to fullest extent of their educational preparation to meet the patients needs

Focus on Federal: Current Legislation

- Certifying Patients' Need for Home Health Care H.R. 1342/S. 578
- Support Full Practice Authority in all VA Settings H.R. 1247/S. 297 & H.R. 4134/S. 2279
- Alignment of Medicaid to Medicare Primary Care Reimbursement Rates – S. 737/H.R. 2253
- Allowing NPs Patients to be assigned to ACOs – S. 2259
- Certify Patients' Need for Diabetic Shoes – H.R. 4756

Additional Federal Issues

- Primary Care
- Addiction Treatments
- Provider Non-Discrimination – Section 2706 of the ACA
- Post Acute Care Reform
- Tele-Health
- Electronic Health Records
- Title VII & VIII Reauthorization
- Rural Health
- Cardiac Rehab
- Provider Identification – Truth in Health Care Marketing Act

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Definition of Medical Home

- "A medical home is a community-based primary care setting which provides and coordinates high quality, planned, family-centered health promotion and chronic condition management."* According to the American Academy of Pediatrics (AAP) a "medical home" is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.**

*Center for Medical Home Improvement, (3/31/2008). Keys to the Medical Home-Securing the Future of Primary Care in New Hampshire: For submission to the NH Endowment for Health. Page 2
**Pediatrics, 122(2) 450.

Care Coordination

- The deliberate organization of patient care activities between two or more participants (*including the patient)* involved in a patient's care to facilitate the appropriate delivery of health care service.
- In systems utilizing coordinated care models… The health care team does not belong to a single provider, system or health care discipline.

Obtained from National Center for Medical Home Implementation at AAP.org @ https://medicalhomeinfo.aap.org/tools-resources/Pages/For-Practices.aspx
Obtained from American Association of Nurse Practitioners Position Statements and Papers https://www.aanp.org/publications/position-statements-papers.

Team Based Care

- The American Association of Nurse Practitioners (AANP) supports the implementation of the Institute of Medicine's (IOM) concept of team based care; "... the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively, to the extent preferred by each patient. The purpose of Team Based Care is to provide coordinated, high quality, and patient-centered care." (IOM - Best Practice Innovation Collaborative, 2012).
- The nurse practitioner community broadly supports patient-centered care and team-based care for health systems

Obtained from American Association of Nurse Practitioners Position Statements and Papers https://www.aanp.org/publications/position-statements-papers.

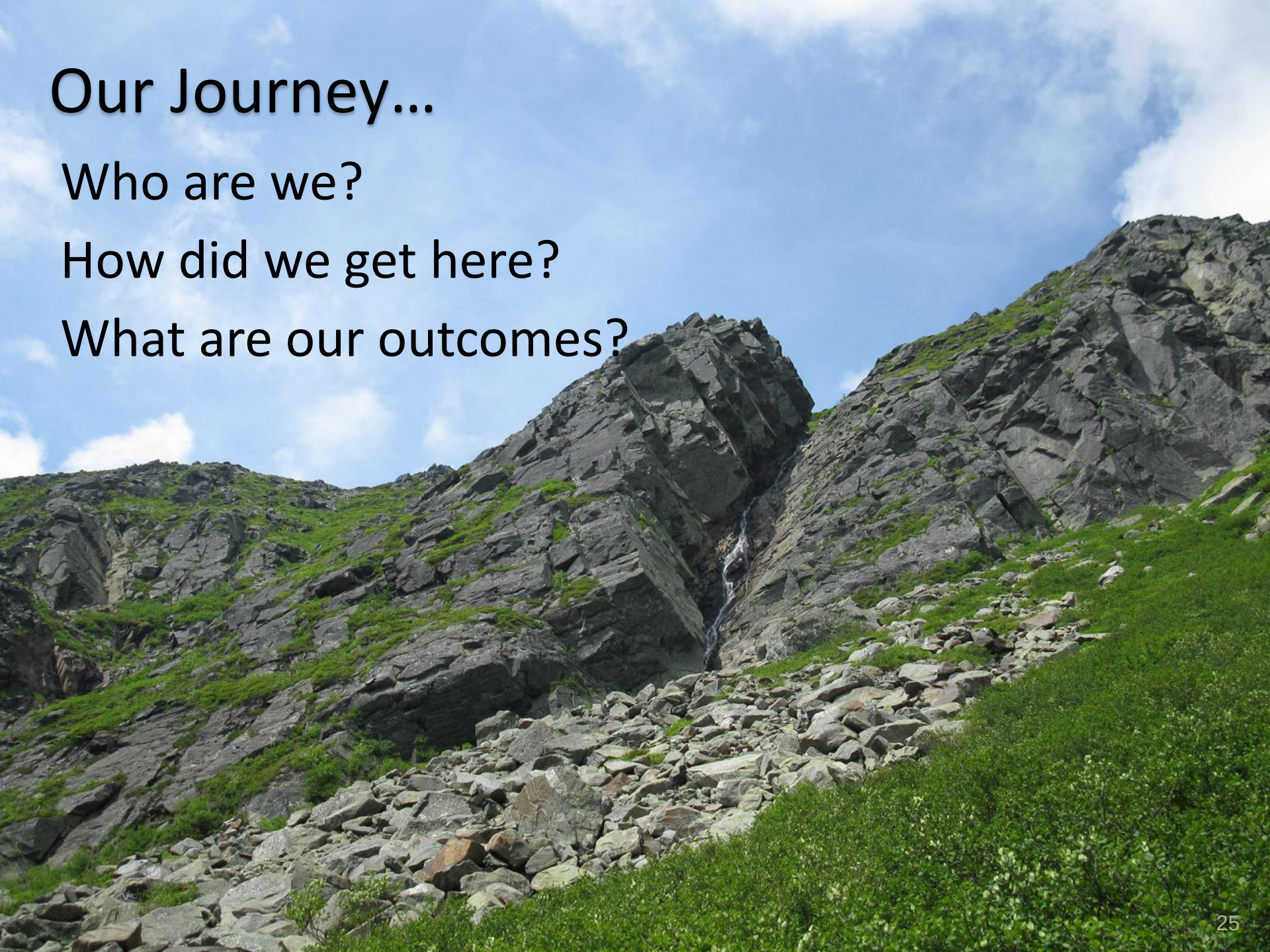
Obtained from American Association of Nurse Practitioners and the NP Roundtable Joint Statement at AANP.org @ https://www.aanp.org/component/content/article/82-legislation-regulation/state-policy-toolkit-accordion/445-aanp-and-the-np-roundtable-joint-statements

Our Journey…

Who are we?

How did we get here?

What are our outcomes?



Our Mission

To create an environment that is a safe space, that also models a healthy workplace.

Our Vision

The patients we serve will experience high quality care, feeling safe and supported through evidenced-based care within a nursing model in a patient centered medical home.

Our Values

Safety : The experience.
Nursing: What we do.
Confidentiality: Honoring the gift.
Individuality : It's about people.
Time : Moments of quality as individuals and as employees.

Our Team

4 Advanced Practice Registered Nurses

1 Registered Nurse

1 Certified Medical Assistant

1 Office Manager

1 Receptionist

This Is What Makes Us Patient-Centered

Oversized flannel gowns

Hand prints

Handmade toy box

Messages from Tonjia

Photos on the wall

Antique furniture

Lack of filing cabinets

Medical Home Getting There

Citizens Health Initiative
New Hampshire Multi-Stakeholder
Medical Home Pilot

Special thanks to
Anthem Blue Cross in New Hampshire
CIGNA Health Care
Harvard Pilgrim Health Plan
MVP Health Care

Joint Principles of the Patient-Centered Medical Home

February 2007

1. Personal physician
2. Physician directed medical practice
3. Whole person orientation
4. Care is coordinated and or integrated
5. Quality and Safety
6. Enhanced access to care
7. Payment appropriately recognizes the added value

CMHI's TAPPP™ Framework

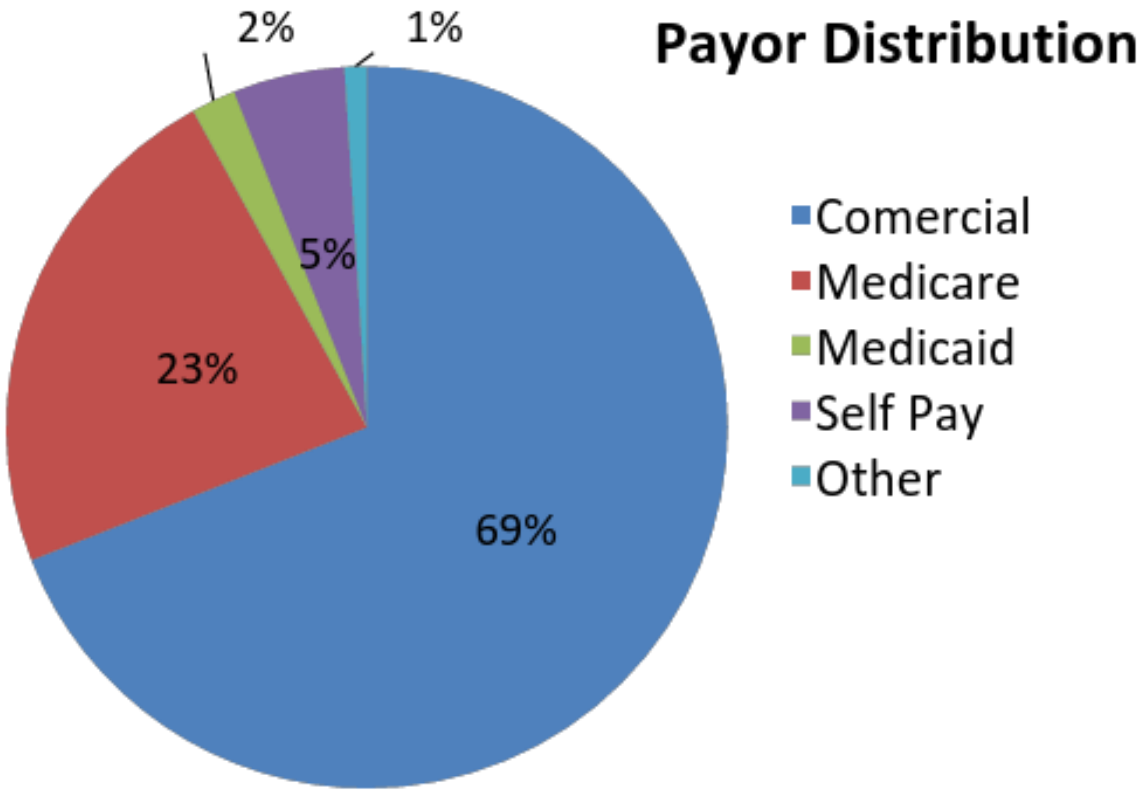
The Gap Analysis and Report

Special thanks to Jeanne McAllister, RN, and Carl Cooley, MD, at the Center for Medical Home Improvement, and Jeanne Ryer, at the New Hampshire Endowment for Health for their guidance and support.

Center for Medical Home Improvement: http://www.medicalhomeimprovement.org/

New Hampshire Endowment for Health: http://endowmentforhealth.org/

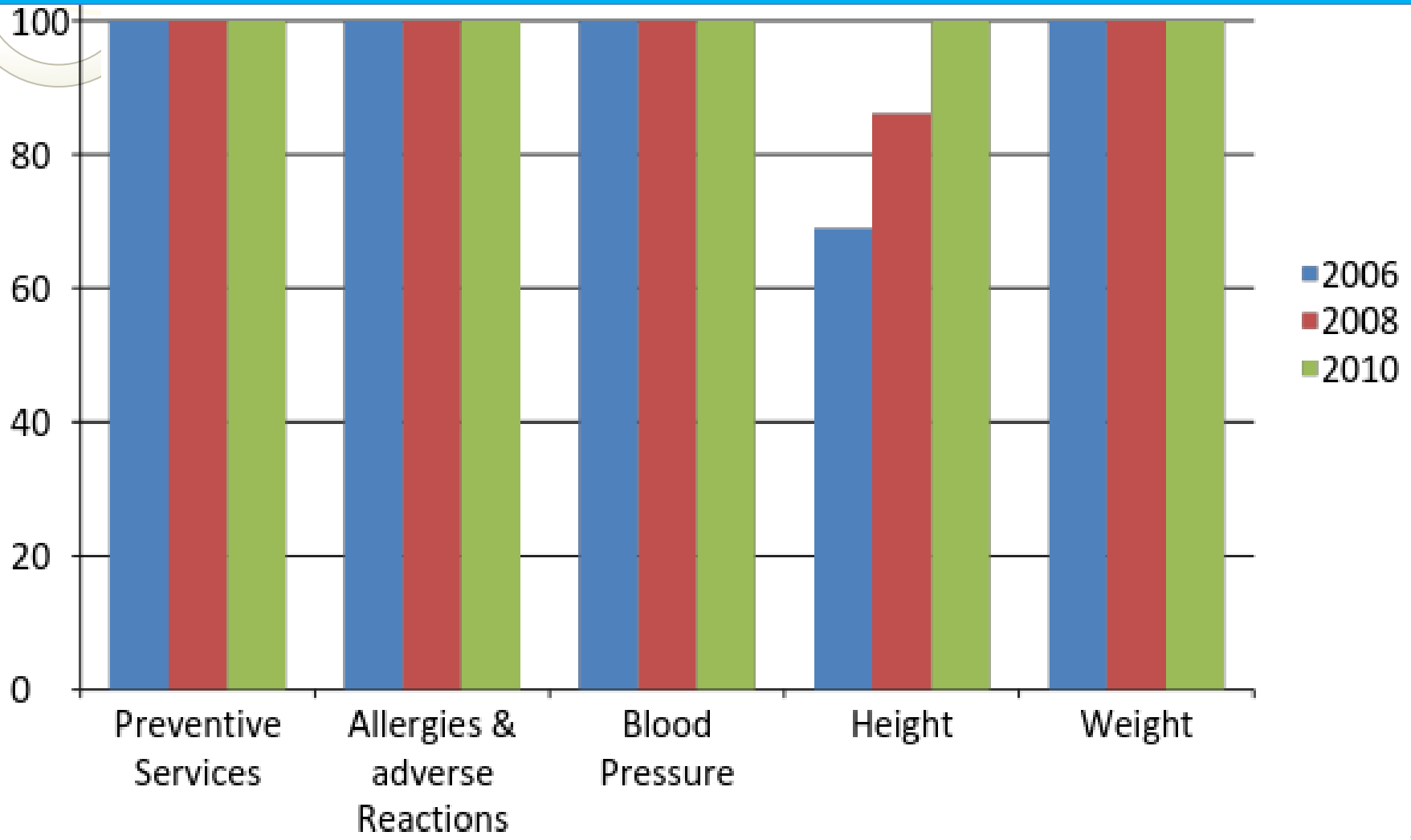
Life Long Care



Life Long Care, PLLC. (2009). NCQA PPC-PCMH Application.

Life Long Care

Documentations of Percentage of patients reaching NCQA Goals



Life Long Care

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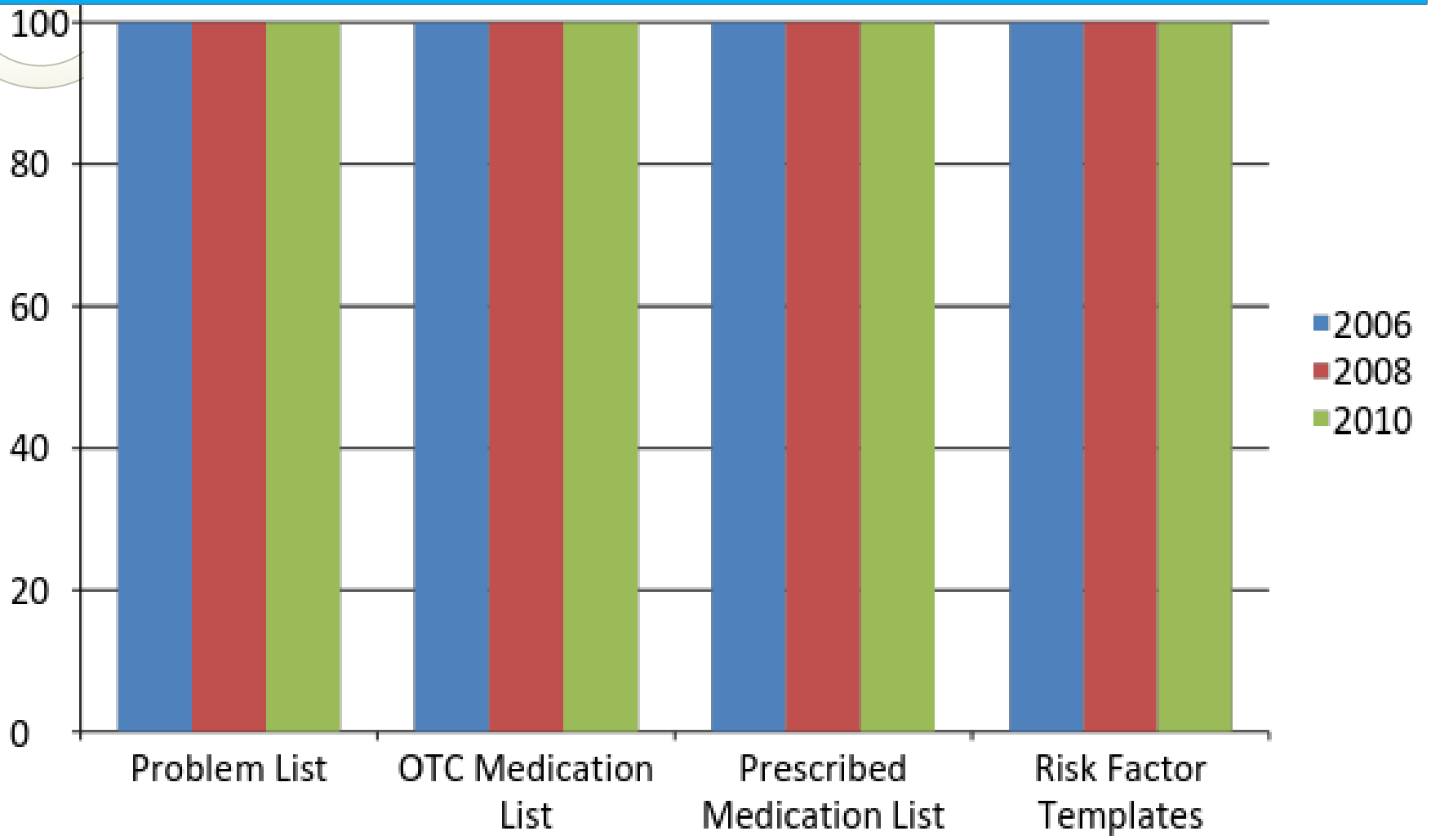

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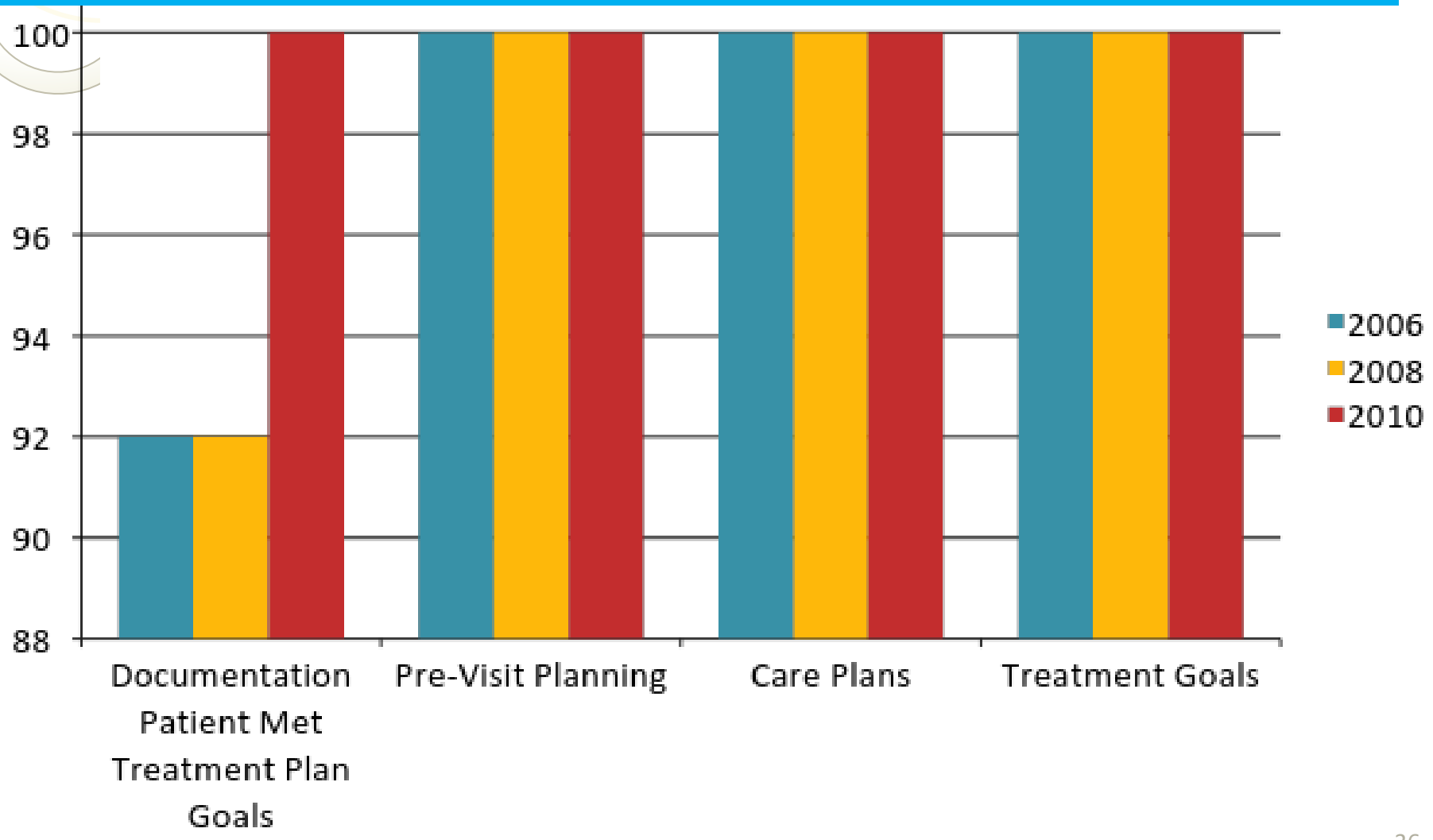


The SAS System 1
New Hampshire Multi Payer Medical Home Pilot
Prepared by UNH Center for Health Analytics
Measurement Time Period=January 2008 - June 2009
Preliminary Indicators Report: Emergency Department Visits by Practice

Type of Coverage=Commercial
Type of Payer=All

Practice	Total Procedures	Rate per 1,000
Site #1	208	268
Site #2	237	244
Site #3	325	351
Site #4	570	225
Site #5	311	256
Site #6	125	267
Site #7	64	215
Site #8	**158**	**292**
Site #9	320	299
Total	2,318	263
Non Medical Home Site 38,344		253

Report generated on: 02/22/2011
Number of Population Individuals: Individuals with at least one evaluation and management claim for a primary care provider between January 2008 and July 2009 who were at least continuously enrolled 12 months prior to and 6 months following July 2009

The SAS System 1
New Hampshire Multi Payer Medical Home Pilot
Prepared by UNH Center for Health Analytics
Measurement Time Period=July 2009 - March 2010
Preliminary Indicators Report: Emergency Department Visits by Practice

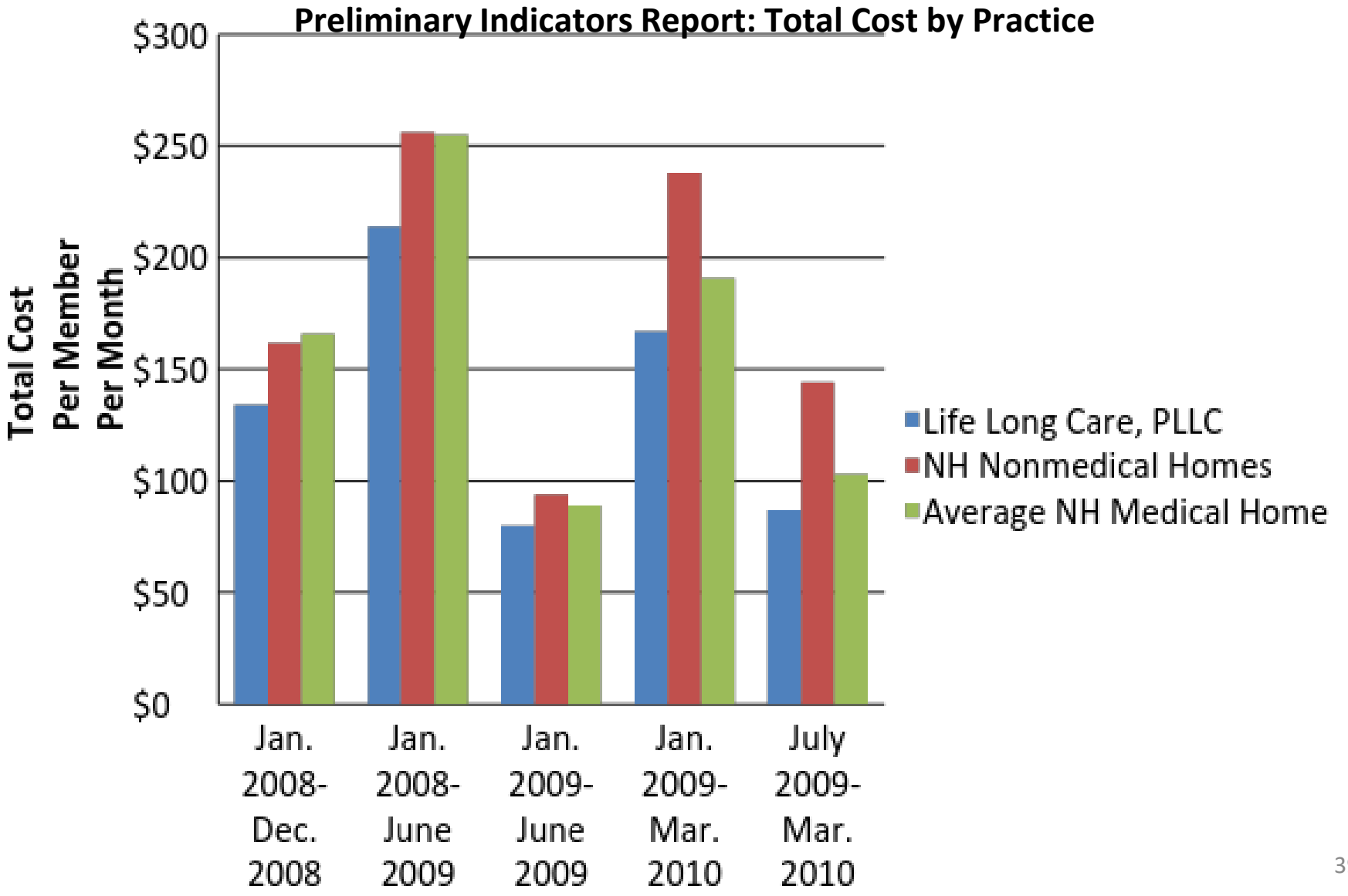
Type of Coverage=Commercial
Type of Payer=All

Practice	Total Procedures	Rate per 1,000
Site #1	97	125
Site #2	105	108
Site #3	144	155
Site #4	238	94
Site #5	189	156
Site #6	49	104
Site #7	42	141
Site #8	**74**	**137**
Site #9	143	134
Total	1,081	123
Non Medical Home Site 38,344		144

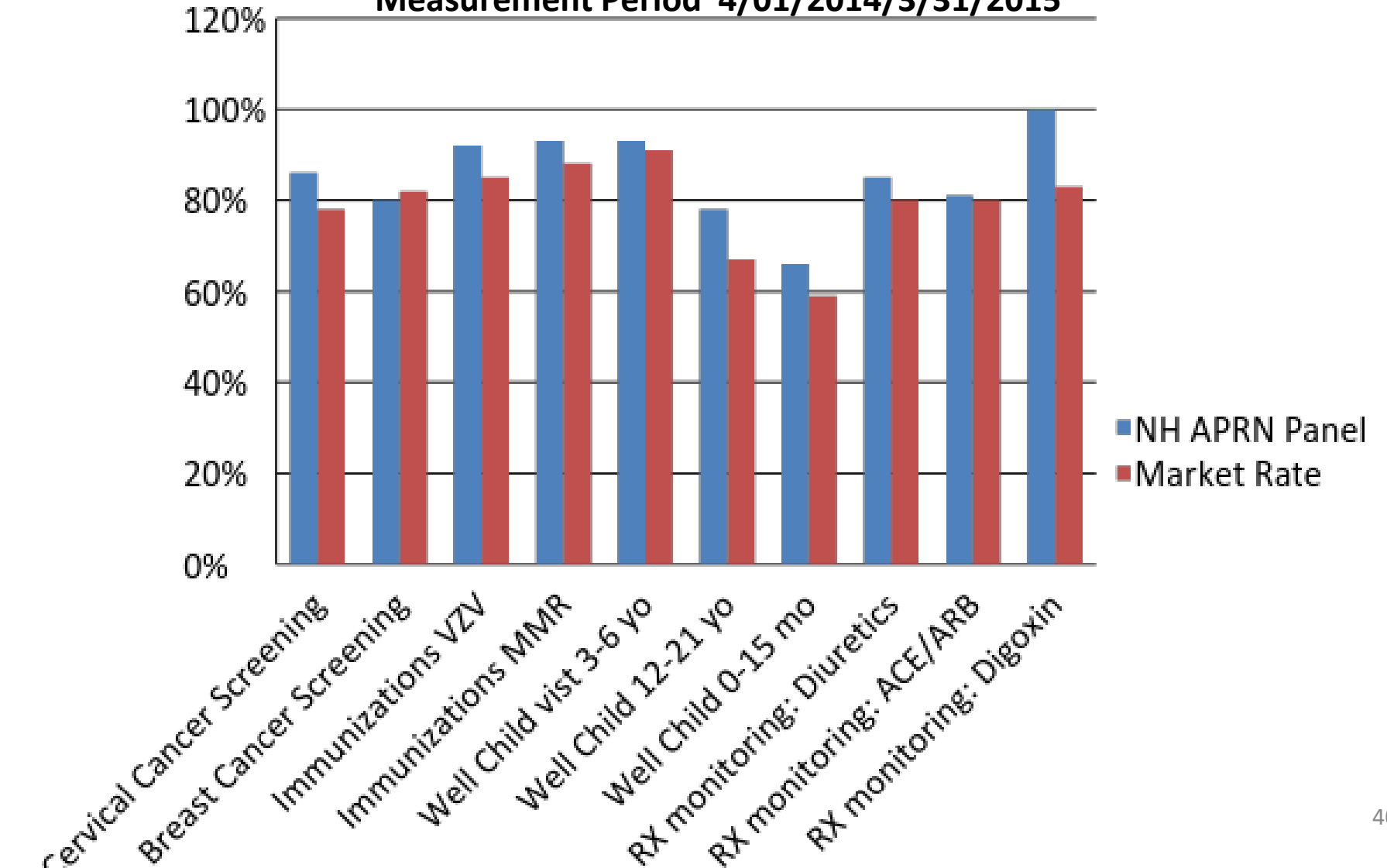
Report generated on: 02/22/2011
Number of Population Individuals: Individuals with at least one evaluation and management claim for a primary care provider between January 2008 and July 2009 who were at least continuously enrolled 12 months prior to and 6 months following July 2009

New Hampshire Multi Payer Medical Home Pilot

Prepared by UNH Center for Health Analytics



New Hampshire Anthem BCBS
Patient-Centered Primary Care Program
Enhanced Personal Health Care Program
Measurement Period 4/01/2014/3/31/2015



New Hampshire Anthem BCBS
Patient-Centered Primary Care Program
Enhanced Personal Health Care Program
Measurement Period 4/01/2014/3/31/2015

Name/Description	Provider Group Performance				Medical Panel Performance				Market Rate
	Prior Year Rate	Current Performance			Prior Year Rate	Current Performance			
		Eligible Population	Compliant w/ Measure	Rate		Eligible Population	Compliant w/ Measure	Rate	
Diabetes: LDL-C Screening	93.33%	16	16	100.00%	81.52%	304	247	81.25%	81.67%
Diabetes: Urine protein screening	93.33%	16	16	100.00%	79.09%	304	265	87.17%	86.12%
Subcomposite Total	90.00%	64	62	96.88%	71.82%	1,216	989	81.33%	
Subcomposite: Medication Adherence									

Wright Associates, Family Healthcare, PLLC
https://wrightfhc.com/

What Needs to Change…

- Outcomes measured must include relationships.
- Relationships must become the primary focus.
- Model of care must demonstrate clear nursing practice parameters.
- NP's must provide primary care as team leaders
- Relationships must be supported through reimbursement.

Resources

Agency for Healthcare Research and Quality

www.ahrq.gov

Anthem Patient-Centered Primary Care Practice

www.anthem.com (provider/state/Patient-Centered Primary Care Program/Provider Toolkit)

Center for Medical Home Improvement

www.medicalhomeimprovement.org

The Joint Commission Patient Centered Medical Home Self-Assessment Tool

www.jointcommission.org/assets/1/18/PCMH_SAT_rev_1031111.DOCX

National Center for Medical home Implementation

www.medicalhomeinfo.org

National Committee for Quality Assurance

www.ncqa.org/tabid/631/Default.aspx

National Nursing Centers Consortium

www.nncc.us/site

Patient Centered Primary Care Collaborative

www.pcpcc.net

Utilization Review Accreditation Commission Patient Centered Health Care Home Program

www.urac.org/pchch/standards/

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Questions?