Tobacco Control and the Patient-Centered Medical Home

At the conclusion of this activity, participants should be able to:

- Explain the concept of a patient-centered medical home
- Articulate the benefits of a patient-centered medical home
- Describe how tobacco prevention and control in the practice setting complements the patient-centered medical home
- Highlight examples of tobacco control within the pediatric- and family medicine-focused patient-centered medical home
Julie K. Wood, MD, FAAFP
Vice President for Health of the Public & Interprofessional Activities
American Academy of Family Physicians
Sam Weir, MD
Associate Professor,
Department of Family Medicine
UNC School of Medicine
Adam Goldstein, MD, MPH
Professor
Department of Family Medicine
UNC School of Medicine
Judith A Groner, MD, FAAP
Clinical Professor of Pediatrics
Nationwide Children’s Hospital
Columbus, Ohio
Patients and families today are savvy consumers of health care and have higher expectations.

– Communication
– Access
– Convenience
– Coordination
– Responsiveness
An effective and efficient health-care system is a primary care-based health-care system

- Provides access to basic health-care services
- Manages health disparities
- Coordinates care
- Controls cost
- Offers sustainability

• [www.aafp.org/valueoffamilymedicine](http://www.aafp.org/valueoffamilymedicine)
• [http://www.medicalhomeinfo.org/about/medical_home](http://www.medicalhomeinfo.org/about/medical_home)
Brief History Of The PCMH

1960s
- AAP "Medical Home" Records

1990s
- AAP Medical Home Provider Policy
- AAFP "Medical Home" Policy
- PCPCC
- Joint Principles of PCMH

2000s
- AAFP Future of Family Medicine
- NCQA-PCMH
- PPACA
- CMMI
- ACOs
- Private Payer Initiatives

2010s
- Future
- Direct Primary Care
- CPCI
- Advanced Primary Care
Innovative Solution: History of the PCMH Concept

• Introduced by American Academy of Pediatrics (AAP) in 1967.
• Initially referred to a central location for medical records.
• The medical home concept was expanded in 2002 to include:
  – Accessible
  – Continuous
  – Comprehensive
  – Family centered
  – Coordinated
  – Compassionate
  – Culturally sensitive care
• In 2007, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the American Osteopathic Association (AOA), and the American College of Physicians (ACP) adopted a set of joint principles to describe a new level of primary care.
“Joint Principles” of the PCMH

- A **personal physician** who coordinates all care for patients/families and leads the team.
- Physician-directed medical practice – a **coordinated team** of professionals who work together to care for patients.
- **Whole person orientation** – this approach is key to providing comprehensive care.
- **Coordinated care** that incorporates all components of the complex health-care system.
- **Quality and safety** – medical practices voluntarily engage in quality improvement activities to ensure patient safety is always being met.
- **Enhanced access** to care – such as through open-access scheduling and communication mechanisms.
- **Payment** – a system of reimbursement reflective of the true value of coordinated care and innovation.
Growing Support for the PCMH

• Partnerships are developing as more and more stakeholders see value in the Joint Principles.
• The Patient Centered Primary Care Collaborative (PCPCC)* is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians and others to develop and advance PCMH.
• The PCPCC has well over 1,000 members.

*www.pcpcc.net
Great Outcomes

• Good for patients
  – Patients enjoy better health.
  – Patients share in health care decisions.

• Good for physicians
  – Physicians focus on delivering excellent medical care.

• Good for practices
  – Team works effectively together.
  – Resources support the delivery of excellent patient care.

• Good for payors and employers
  – Ensures quality and efficiency.
  – Avoids unnecessary costs.
Does PCMH Work?

• Fully implemented, the PCMH hits the triple AIM—better health, better care, lower costs.
• Improves practice organization, work environment and job satisfaction.
• No longer a pilot...Now a program with proven results.

www.pcpcc.net/publications
PCMH Model and Health-Care Reform

- Attempts to fix part of the problem without addressing it comprehensively will **not** lead to viable solutions.
- Advocacy by all stakeholders is necessary.
  - Community projects through local hospitals and resource networks.
  - State projects for regional payors and state Medicaid programs.
  - National support for changing how care is delivered and for ensuring a prepared workforce to deliver care.
Family Physicians, Pediatricians, and the PCMH

• PCMH is a place, not a person.
• Patient centered, physician directed.
• Family physicians and pediatricians
  – Provide comprehensive care
  – Care for patients and families
  – Coordinate care
  – Provide care that is effective and efficient*

• Future of Family Medicine
• *Starfield data
Primary Care Delivers Better Health Outcomes

- ↓ Mortality
- ↓ Morbidity
- ↓ Medication use
- ↓ Per-capita expenditures
- ↑ Patient satisfaction
- ↑ Greater equity in health care

PCMH Recognition Programs

- National Center for Quality Assessment (NCQA)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Joint Commission’s Primary Care Home Designation Standards
- Utilization Review Accreditation Committee (URAC)
- Private Payor Medical Home Recognition Programs
Why the Medical Home Works: A Framework

**Feature**

**Patient-Centered**
- Supports patients and families to manage & organize their care and participate as fully informed partners in health system transformation at the practice, community, & policy levels.

**Comprehensive**
- A team of care providers is wholly accountable for patient’s physical and mental health care needs – includes prevention and wellness, acute care, chronic care.

**Coordinated**
- Ensures care is organized across all elements of broader health care system, including specialty care, hospitals, home health care, community services & supports, & public health.

**Accessible**
- Delivers consumer-friendly services with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations.

**Committed to quality and safety**
- Demonstrates commitment to quality improvement through use of health IT and other tools to ensure patients and families make informed decisions.

**Definition**

**Sample Strategies**
- Dedicated staff help patients navigate system and create care plans.
- Focus on strong, trusting relationships with physicians & care team, open communication about decisions and health status.
- Compassionate and culturally sensitive care.
- Care team focuses on ‘whole person’ and population health.
- Primary care could co-locate with behavioral and/or oral health, vision, OB/GYN, pharmacy.
- Special attention is paid to chronic disease and complex patients.
- Care is documented and communicated across providers and institutions, including patients, specialists, hospitals, home health, and public health/social supports.
- Communication and connectedness is enhanced by health information technology.
- More efficient appointment systems offer same-day or 24/7 access to care team.
- Use of e-communications and telemedicine provide alternatives for face-to-face visits and allow for after hours care.

**Potential Impacts**

- Patients are more likely to seek the right care, in the right place, and at the right time.
- Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated.
- Providers are less likely to order duplicate tests, labs, or procedures.
- Better management of chronic diseases and other illness improves health outcomes.
- Focus on wellness and prevention reduces incidence / severity of chronic disease and illness.
- Cost savings result from:
  - Appropriate use of medicine
  - Fewer avoidable ER visits, hospitalizations, & readmissions.

All rights reserved. PCPCC 2013.
AAFP Healthy Interventions
Tobacco and Nicotine

Office-Based Tools
- Ask and Act
- Office Champions
- Patient Education and Engagement
- Coding Reference

Community Engagement
- Tar Wars
- Primary Care and Public Health
- Chapter Involvement
- At-Risk Populations

Advocacy
- National
  - State/Local Advocacy Resources
  - Tobacco-Free Champions

Evidence-Based Knowledge
- Policies
  - Position Paper
  - Member Education

AMERICAN ACADEMY OF FAMILY PHYSICIANS
Quitline Cards

Lapel Pin
Stop Smoking Guide

Treating Tobacco Dependence Practice Manual
Through a Systems-Change Approach

www.askandact.org
AAFP PCMH Resources & Tools

• New PCMH web content – [www.aafp.org/pcmh](http://www.aafp.org/pcmh)
• Three new PCMH checklists:
  • [Final Touches](http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/PCMHAAdvancedChecklist.pdf)
PCMH and Level 3 Recognition
Tobacco Use Treatment and Cessation
Patient-Centered Medical Home

• The patient-centered medical home way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be."
• Medical homes designed to lead to higher quality, lower costs, and improve patients/providers’ experience of care
• Can lead to higher reimbursement in FFS contracts
• **Treatment for tobacco use applies to multiple measures**
## PCMH 2014 Content and Scoring

(6 standards/27 elements)

<table>
<thead>
<tr>
<th>1: Enhance Access and Continuity</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. *Patient-Centered Appointment Access</td>
<td>4.5</td>
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<tr>
<td>B. 24/7 Access to Clinical Advice</td>
<td>3.5</td>
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<tr>
<td>C. Electronic Access</td>
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<table>
<thead>
<tr>
<th>2: Team-Based Care</th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. Continuity</td>
<td>3</td>
</tr>
<tr>
<td>B. Medical Home Responsibilities</td>
<td>2.5</td>
</tr>
<tr>
<td>C. Culturally and Linguistically Appropriate Services (CLAS)</td>
<td>2.5</td>
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<tr>
<td>D. *The Practice Team</td>
<td>4</td>
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<table>
<thead>
<tr>
<th>3: Population Health Management</th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. Patient Information</td>
<td>3</td>
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<tr>
<td>B. Clinical Data</td>
<td>4</td>
</tr>
<tr>
<td>C. Comprehensive Health Assessment</td>
<td>4</td>
</tr>
<tr>
<td>D. *Use Data for Population Management</td>
<td>5</td>
</tr>
<tr>
<td>E. Implement Evidence-Based Decision-Support</td>
<td>4</td>
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<tr>
<td>Total</td>
<td>20</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>4: Plan and Manage Care</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Identify Patients for Care Management</td>
<td>4</td>
</tr>
<tr>
<td>B. *Care Planning and Self-Care Support</td>
<td>4</td>
</tr>
<tr>
<td>C. Medication Management</td>
<td>3</td>
</tr>
<tr>
<td>D. Use Electronic Prescribing</td>
<td>5</td>
</tr>
<tr>
<td>E. Support Self-Care and Shared Decision-Making</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5: Track and Coordinate Care</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Test Tracking and Follow-Up</td>
<td>6</td>
</tr>
<tr>
<td>B. *Referral Tracking and Follow-Up</td>
<td>6</td>
</tr>
<tr>
<td>C. Coordinate Care Transitions</td>
<td>6</td>
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<td>Total</td>
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<table>
<thead>
<tr>
<th>6: Measure and Improve Performance</th>
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<tr>
<td>A. Measure Clinical Quality Performance</td>
<td>3</td>
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<tr>
<td>B. Measure Resource Use and Care Coordination</td>
<td>3</td>
</tr>
<tr>
<td>C. Measure Patient/Family Experience</td>
<td>4</td>
</tr>
<tr>
<td>D. *Implement Continuous Quality Improvement</td>
<td>4</td>
</tr>
<tr>
<td>E. Demonstrate Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td>F. Report Performance</td>
<td>3</td>
</tr>
<tr>
<td>G. Use Certified EHR Technology</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

**Scoring Levels**

- Level 1: 35-59 points.
- Level 2: 60-84 points.
- Level 3: 85-100 points.

*Must Pass Elements*
Relevant PCMH Standards: *Population Health Management*

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>PCMH 2: Identify and Manage Patient Populations</strong></td>
<td>The practice systematically records patient information and uses it for population management to support patient care. <strong>16 point</strong></td>
<td><strong>PCMH 3: Population Health Management</strong></td>
<td>The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population. <strong>20 point</strong></td>
</tr>
</tbody>
</table>
| 8. Status of tobacco use for patients 13 years and older for >50% of patients+ | | | • PCMH 2011 factor 5 aligns with PCMH 2014 factor 5, with these differences:  
  — PCMH 2011: Evaluates how practices record weight for patients 2 years and older and whether practices have data for >50% of patients. |
| 9. List of prescription medications with date of updates for more than 80 percent of patients+ | | |
| **Documentation** | • Factors 1-5 & 9: Report showing percentage of | | |
| 8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients+ | | |
## Relevant PCMH Standards:

### Use Data for Population Management

<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>MUST-PASS</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Element 2D: Use Data for Population Management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients/families and clinicians of services needed for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. At least three different preventive care services++</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. At least three different chronic or acute care services++</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. Patients not recently seen by the practice</td>
<td></td>
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</tr>
<tr>
<td>4. Specific medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Factors 1-4: Lists or summary reports of patients who need services within past 12 months. (Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 points</td>
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</tr>
<tr>
<td><strong>MUST-PASS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Element 3D: Use Data for Population Management</strong></td>
<td></td>
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</tr>
<tr>
<td>At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1. At least two different preventive care services+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. At least two different immunizations+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. At least three different chronic or acute care services+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Patients not recently seen by the practice</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Medication monitoring or alert</td>
<td></td>
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</tr>
<tr>
<td>+ Stage 2 Core Meaningful Use Requirement</td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>General:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- PCMH 2011: Evaluates whether practices use patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients/families and clinicians of services needed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- PCMH 2014: Evaluates whether practices proactively identifies populations of patients and reminds patients/families/caregivers of needed care based on patient information, clinical data, health assessments and evidence-based guidelines.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- PCMH 2011 factor 1 aligns with PCMH 2014 factor 1, with these differences:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- PCMH 2011: Evaluates whether practices generate lists of patients and remind patients for at least 3 different preventive services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- PCMH 2014: Evaluates whether practices...</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Relevant PCMH Standards:

**Plan and Manage Care**

<table>
<thead>
<tr>
<th>PCMH 3: Plan and Manage Care</th>
<th>CRITICAL FACTOR = FACTOR 3</th>
<th>CRITICAL FACTOR = FACTOR 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines.</td>
<td><strong>Element 3A: Implement Evidence-Based Guidelines</strong></td>
<td><strong>Element 3E: Implement Evidence-Based Decision Support</strong></td>
</tr>
<tr>
<td><strong>4 points</strong></td>
<td></td>
<td><strong>4 points</strong></td>
</tr>
<tr>
<td>The practice implements evidence-based guidelines through point of care reminders for patients with:</td>
<td></td>
<td>The practice implements clinical decision support + (e.g. point-of-care reminders) following evidence-based guidelines for:</td>
</tr>
<tr>
<td>1. The first important condition+</td>
<td>1. A mental health or substance use disorder</td>
<td>1. A mental health or substance use disorder</td>
</tr>
<tr>
<td>2. The second important condition+</td>
<td>2. A chronic medical condition</td>
<td>2. A chronic medical condition</td>
</tr>
<tr>
<td>3. The third condition, related to unhealthy behaviors or mental health or substance abuse</td>
<td>3. An acute condition</td>
<td>3. An acute condition</td>
</tr>
<tr>
<td></td>
<td>4. A condition related to unhealthy behaviors</td>
<td>4. A condition related to unhealthy behaviors</td>
</tr>
</tbody>
</table>

- **General:**
  - **PCMH 2011:** Evaluates whether practices implement evidence-based guidelines through point of care reminders.
  - **PCMH 2014:** Evaluates whether practices implement clinical decision support following evidence-based guidelines.
- **PCMH 2011 factors 1 and 2 have no PCMH 2014 equivalent.**
- **PCMH 2011 factor 3 has been split into PCMH 2014 factors 1 and 4.**
## Relevant PCMH Standards:

### Plan and Manage Care

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCMH 2: Identify and Manage Patient Populations</strong></td>
<td>The practice systematically records patient information and uses it for population management to support patient care.</td>
<td><strong>PCMH 3: Population Health Management</strong></td>
<td>The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.</td>
</tr>
<tr>
<td>MUST-PASS</td>
<td><strong>Element 3C: Care Management</strong></td>
<td><strong>Element 4B: Care Planning and Self-Care Support</strong></td>
<td></td>
</tr>
<tr>
<td>Element 3C: Care Management</td>
<td>The care team performs the following for at least 75 percent of the patients for the patients identified in Elements A and B:</td>
<td>The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A:</td>
<td></td>
</tr>
<tr>
<td>1. Conducts pre-visit preparations</td>
<td>1. Incorporates patient preferences and functional/lifestyle goals</td>
<td>1. Identifies treatment goals</td>
<td></td>
</tr>
<tr>
<td>2. Collaborates with the patient/family to develop an individualized care plan, including treatment goals that are reviewed and updated at each relevant visit</td>
<td>2. Identifies treatment goals</td>
<td>3. Assesses and addresses potential barriers to meeting goals</td>
<td></td>
</tr>
<tr>
<td>3. Gives the patient/family a written plan of care</td>
<td>3. Assesses and addresses potential barriers to meeting goals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 4. Assesses and addresses barriers when patient has not met treatment goals | | |}

- **PCMH 2011 factor 1 has no PCMH 2014 equivalent.**
- **PCMH 2011** Element C stem and factor 2 have merged into PCMH 2014 Element B stem, with these differences:
  - **PCMH 2011**: Evaluates whether practices collaborate with patient/family to develop an individualized care plan.
  - **PCMH 2014**: Stem expanded to include caregivers and evaluate patient/family/caregiver collaboration to develop and update a relevant visits individualized care plans.
Relevant PCMH Standards:  
**Measure and Improve Care**

**MUST-PASS**

**Element 6C: Implement Continuous Quality Improvement**  
*4 points*

The practice uses an ongoing quality improvement process to:

1. Set goals and act to improve on at least three measures from Element A
2. Set goals and act to improve quality on at least

**MUST-PASS**

**Element 6D: Implement Continuous Quality Improvement**  
*4 points*

The practice uses an ongoing quality improvement process to:

1. Set goals and analyze at least three clinical quality measures from Element A
2. Act to improve at least three clinical quality

**PCMH 2011 factor 1 aligns with PCMH 2014 factors 1 and 2, with these differences:**

---

- **PCMH 2011:** Evaluates whether the practice sets goals and acts to improve on at least three measures from Element A.
- **PCMH 2014:** Evaluates whether the practice sets goals, analyzes (factor 1) and acts to improve (factor 2) on at least three measures from Element A.
PCMH and Level 3 Recognition
Tobacco Use Treatment and Cessation
UNC Family Medicine
PCMH- Tobacco Use Registry

---

**FAMILY MEDICINE CENTER**

**Tobacco History**

- **Date**
- **Smoking Status**
- **Counseled to quit**
- **Plan to quit**
- **Importance**
- **Blood Pressure**

**Previous NOF referral**

- **Quitline Referral**
- **Previous NOF visit**
- **Result of quitline referral**

**Clinical Support Staff Responsibilities**

- **Cigarette use**
- **Other tobacco use**
- **Chew/dip**
- **Cigar**
- **Cigaretlo**
- **Puff**

**Important of quitting (0-10)**

- **Interested in quitting NOW or within 30 days?**
  - **Yes**
  - **No**

**Referral to Nicotine Dependence Program**

- **Referral to Quitline (phone counseling)**

**Provider Responsibilities**

- **Depression Screen (PHQ-9)**
  - **Positive**
  - **Negative**
  - (If PHQ-9 is positive, please give PHQ-9 to patient)

**Check Tobacco Use disorder ICD 9 305.2**

**Recommended services**

- **Meds/Treatments**
- **Counseled**
- **Social support**
- **Coping skills**
- **Motivational interviewing**
- **Nicotine replacement (N)**
- **Supplementation**
- **Varenicline**
- **Depression treatment**

---

**JABFM**

*The Implementation of a Tobacco Use Registry in an Academic Family Practice*

**Dana Neutez, MD, PhD, Carol Ripley-Moffitt, MD, Mark Gwynne, DO and Adam O. Goldstein, MD, MPH**

**Author Affiliations**

*Correspondence author: Dana Neutez, MD PhD, Department of Family Medicine.*

---

*Please Attach Registry Form to the Encounter Form***
### Tobacco Cessation Medication Prescribed, by Physician

<table>
<thead>
<tr>
<th>Medication</th>
<th>P Value</th>
<th>Before Implementation</th>
<th>After Before Implementation</th>
<th>Daily Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicotine gum</td>
<td></td>
<td>7.0</td>
<td>7.8</td>
<td>Tobacco use registry forms returned</td>
</tr>
<tr>
<td>Resident</td>
<td>.19</td>
<td>7.4</td>
<td>8.8</td>
<td>88</td>
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<tr>
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<td>8.2</td>
<td>Tobacco use registry initialed by medical assistant and/or provider</td>
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<tr>
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<td></td>
<td>4.9</td>
<td>5.9</td>
<td>Tobacco use registry updated or changed</td>
</tr>
<tr>
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<td>.01</td>
<td>4.8</td>
<td>7.2</td>
<td>73</td>
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<tr>
<td>Nicotine inhaler</td>
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<td>4.0</td>
<td>4.6</td>
<td>No difference in mean duration of the office visit cycle times between tobacco users and nontobacco users before or after implementation</td>
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<td>Resident</td>
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<td>4.8</td>
<td>6.3</td>
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<tr>
<td>Nicotine spray</td>
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<tr>
<td>Combination NRT</td>
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### Mean Daily Rates of Registry Forms Returned, Initialed, and Updated, September Through October 2013

<table>
<thead>
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<th>Category</th>
<th>Daily Rate (%)</th>
<th>Mean</th>
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<td>47–100</td>
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<td>40–100</td>
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PCMH Tobacco Use Quality Improvement
PCMH Tobacco Use Self-Management Tools (4E, Factor 3)

Systematic provision of education and supportive interventions by staff (before, during and after visit) to increase patients’ skills and confidence in managing their health problems

– Individual Goal Setting
– Assessment progress and problems
– Measures of confidence in ability to manage condition
– Problem solving support
– Culturally appropriate educational materials
– Referral for additional help/community resources
– For more information:
  » http://www.swselfmanagement.ca/smtoolkit/
PCMH Tobacco Use Self-Management Tool

Being tobacco free makes a difference!
- Increased energy
- Decreased chance of cancer and heart disease
- Improved skin tone
- Fewer signs of premature aging, like wrinkles
- Better healing from illness and surgery
- More money to spend on things that are life-giving
- More time to spend with those you love
- Knowing you’re in control of your life

What works?
By using both medication and counseling support you can greatly increase your chances of becoming tobacco free, even if you’ve tried before.

It takes practice
Just like any new skill or behavior, it may take repeated attempts to become tobacco free. Most of us didn’t get up on a bicycle and ride the first time we tried. Each time you try, you’ll be learning something to help you the next time, until you are able to say:

“I’m tobacco free!”

………..a clear path to becoming tobacco-free

First Step
Talk with your health care provider about medications that have been proven to help people become tobacco free.
- These medications don’t make you quit using tobacco. Instead, they help you manage withdrawal symptoms (e.g., irritability, depression)
- Medications can also help decrease urges and cravings to smoke.
- Most people use these medications for 3-6 months.

Next
Try out new behaviors that can replace smoking, chewing, or dipping.
- Practice ways of dealing with triggers, including the big one—STRESS
- You already have effective planning and organizing skills for having your cigarettes/fighters with you, knowing when/where you can smoke. Use those same skills to plan to be tobacco free.

On the way
☐ Set your date for being tobacco free or a schedule for cutting down
☐ Make your car and home tobacco free
☐ Plan how you will say “no” if offered a cigarette or other tobacco
☐ Make a list of 20 things you can do instead of using tobacco
☐ Make a list of 10 stress reducers—including things that bring you joy
☐ Make a list of ways you will reward yourself for being tobacco free

Get the support that you need and deserve
☐ Let friends & family know specific ways that they can offer support
☐ Use the free NC Quitline telephone coaching service 1-800-784-8669 (1 800 QUIT NOW)
☐ Schedule an appointment with UNC’s Nicotine Dependence Program by calling 919-966-0210. Learn more at www.ndp.unc.edu
☐ Visit online sites like www.becometobaccofree.org, www.trytostop.org or www.smokefree.gov (which also offers text support program)
Audit for PCMH Level 3
24 patients with tobacco-related condition
(12 tobacco only, 12 high-risk)

- Provided self management (SM) tools: 8.3%
- Documentation of SM abilities: 62.5%
- Provided educational resources to assist SM: 66.7%
- Developed & documented SM plan: 83.3%
- Counseled on healthy behavior: 83.3%

Percent of patients in audit sample
PCMH Tobacco Use Quality Improvement

• Small Practice Quality Improvement
  – Low touch, minimally-disruptive intervention:
  – Needs assessment
  – Readiness to Implement assessment
  – Group interview: current approach, barriers, potential strategies

• Six “lunch and learn” meetings with entire clinic staff

• Pharmacotherapy for physicians
PCMH Tobacco Use
Quality Improvement Tool

Designed and/or implemented tools to:

- Clarify roles/clinic flow using quality improvement approach to develop feasible standard processes
- Assess patient readiness to talk with provider about tobacco use
- Assist patients with self-management support tool
- Refer patients to NC Quitline
PCMH Tobacco Use
Quality Improvement Outcomes
## PCMH and Billing

### Visits coded for tobacco use counseling

**UNC Family Medicine**  
**February 2011-February 2012**

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<thead>
<tr>
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<td>20</td>
<td>39</td>
<td>44</td>
<td>63</td>
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</tbody>
</table>
PCMH Tobacco Use Measures

2014 PCMH Standards, patient groups and patient advisory groups *may be used to meet several factors (based on the structure of the groups).*
PCMH Potential Patient Engagement

1- Enhance Access and Continuity
   • A3- Patient Centered Access- Providing alternative types of clinical encounters
     • Multiple patients are seen as a group for follow-up care or management of chronic conditions; Voluntary; Allows patient interaction with other patients and members of health team

2- Team based care
   • D10- A team that involves patients/families in QI or on advisory council

4- Plan and Manage Care
   • A6 Care Management/Registry
   • E5-Care Management/Support
     • Support self-care and shared decision-making
     • Offers or refers patients to structured health education programs, such as group classes and support
PCMH Potential Patient Engagement

5- Care coordination/Transitions
   • B4 Referral Tracking
     • Integrates Behavioral healthcare providers

6- Performance Measures/Quality Improvement-
   • C3&4- Patient/Family Experience
     • Practice obtains feedback from vulnerable patient groups
     • Practice obtains feedback through qualitative means
   • D5,6&7- Quality Improvement
     • Set goals, analyze and improve 1 patient experience/disparity
   • E4 Demonstrates Quality Improvement
     • Achieves performance on 1 patient experience measure
PCMH- Patient Engagement

- Four Focus Groups
- Experience of being a tobacco user (inconvenience, shame, isolation, risks, and benefits)
- The medical encounter (expectations of providers, trust and respect, and positive, targeted messaging)
- High-value actions (consistent dialogue, the addiction model, point-of-care nicotine patches, educational materials, carbon monoxide monitoring, and infrastructure)
- Patient-centered outcomes

Patient Perspectives on Tobacco Use Treatment in Primary Care
Jacqueline R. Halladay, MD, MPH; Maihan Vu, DrPH, MPH; Carol Ripley-Moffitt, MDiv, CTTS; Sachin K. Gupta, MD; Christine O’Meara, MD; Adam O. Goldstein, MD, MPH


Abstract
PCMH- Other Tobacco Models

Pilot PCMH study reports improved outcomes without workflow disruptions

In a new study, a PCMH pilot was implemented in a busy, urban primary care practice, with promising results.

January 20, 2015  By Rachael Zimlich

Time and cost won’t necessarily prevent your practice from becoming a patient-centered medical home (PCMH).

In a new study, a PCMH pilot was implemented in a busy, urban primary care practice and resulted in improved patient outcomes without workflow disruptions. The PCMH pilot was well-received by both providers and patients in the practice, and patients involved in the pilot program experienced increased life expectancy (12 months versus 6.7 months for those in the control group) and improvements in smoking cessation efforts.

PCMH- 4E, Factor 5: Health Education

Group Tobacco Health Education Class

• 1-1.5 hours

• Objectives
PCMH- 4E, Factor 6: Resources

Thinking of Quitting?

The Nicotine Dependence Program (NDP) primary goal is to support tobacco-free individuals and communities. We are here to help with the support that you need to live tobacco-free.

NDP can provide you with the information and tools you need to become tobacco-free. A treatment specialist will work with you to make a plan that works for you and your lifestyle, including dealing with withdrawal, using tobacco cessation medications, and strategies for changing behaviors that are linked to your tobacco use. We will follow-up with you for adjustment of the treatment plan and medications, as needed, and give you ongoing support to stop smoking and prevent relapse.

Individual appointments with a tobacco treatment specialist at the UNC Family Medicine are scheduled on Tuesday mornings and Wednesdays. In order to spend the majority of the first visit focusing on the treatment plan, we ask new patients to complete an Initial Assessment online before the first appointment.

To make an appointment today, call (919) 966-0211 or email ndphelp@unc.edu.

Additional Resources

- QuitlineNC is a free telephone counseling service for all North Carolina residents. Trained quit counselors are available 7am-7pm, 365 days per year. Services available in English and Spanish.
  - Call 1-800-QUIT-NOW (1-800-784-8689) or visit www.quitline.nc.gov to sign up for Quitline services.
- BecomeAnEX.org is free and provides information and techniques as well as blogs, community forums, ask the experts, and many other features.
- Smokefree.gov is an excellent web resource for learning more about the quit process and getting resources to help.
  - Test messaging service is also available through these websites, including personalized reminders about a smoking cessation plan are also available.

Medications that can help with quitting (PDF download)

Information about Secondhand Smoke (PDF download)
PCMH and Meaningful Use (MU)

- PCMH is allied in many circumstances to Meaningful Use criteria for Medicaid and Medicare around HER for quality.
- Medicare and Medicaid EHR Incentive Programs provide financial incentives for the meaningful use of certified EHR technology to improve patient care.
- To receive an EHR incentive payment, providers have to show that they are meaningfully using their EHRs by meeting thresholds for a number of objectives.
- Providers must attest to demonstrating meaningful use every year to receive an incentive and avoid a Medicare payment adjustment.
Summary: PCMH and Tobacco Use

• Complicated
• Achievable
• Better quality
• Improved patient experience
• Improved provider experience
Patient-Centered Medical Home

• Model of Primary Care
  • Evidence-based
  • Patient-centered processes
  • Focus on highly coordinated care
Patient-Centered Medical Home

• Model of Primary Care
  • Long term relationships/ partnerships between patients/ families and clinicians (as opposed to episodic care)
  • Use of clinician-led teams
  • Implementation of information technology to benefit patient/families
The AAP emphasizes the family role

• The “family” centered medical home
• Team works in partnership with child and child’s family…..
• Through partnership, pediatric care team can help family access, coordinate, and understand services that are important for the overall health of the child and family..
Pediatrician’s Role in Tobacco Control

• Tobacco/Nicotine use prevention in teens
• Tobacco Cessation in teens
• Reducing secondhand smoke (SHS) exposure for children - engaging the parents and family members in smoking cessation
• All of these require patient/family partnerships with clinician in terms of long term management/prevention
Tobacco Control and Medical Home

• Contextualize child as part of a family
  Exposure to SHS – intervene with family
  Risk of smoking increases with parental modeling

• Incorporation of evidence-based guidelines into primary care practice
  5As, or 2As & R for Pediatrics (Ask, Advise, Refer)
How Does this Relate to Patient- (Family) Centered Medical Home?

• **Best office practices** have been shown to increase likelihood that clinicians will counsel youth to quit smoking (Pbert et al, 2015)
  – Incorporate screening for tobacco use as standard of care
  – Systems to identify & document tobacco use status & SHS exposure

*Cues or EMR prompts are effective in promoting delivery of prevention and cessation counseling*
Use of ‘Disease Registries’

- Key Component of Medical Home Concept
- Interact pro-actively with patients and families through registries
- Potential for use with teen tobacco users and families with smokers in pediatric primary care
- Can be used to guide & evaluate intervention with high risk families
- Tracking of outcomes
Use of Registries for Tobacco Control

• Potential model with Accountable Care Organizations (ACOs)
• Care coordinators are used to manage other chronic diseases
• Care coordinators pro-actively reach out to patients with chronic conditions
• The model using SHS exposure (parental smoking) and/or teen tobacco use has not been tested
Use of Clinician-Led Teams for Tobacco Control in Pediatric Primary Care

• National survey of primary care physician and practice factors – having trained office staff available significantly increased physicians advising patients to quit at each visit

• Team work can optimize workflow in office and reduce burden on physician
PCMH Resources from AAP

• Medical Home Chapter Champions Program on Asthma, Allergy and Anaphylaxis
  

• AAP Medical Home
  
  http://www.aap.org/medicalhome

• National Center for Medical Home Implementation
  
  http://www.medicalhomeinfo.org/

• Program Contact:

  Nkem Chineme, MPH
  Program Manager
  Medical Home Chapter Champions Program on Asthma, Allergy and Anaphylaxis

  nchineme@aap.org
AAP Richmond Center

- Visit us: www.aap.org/richmondcenter
  - State-specific resources
  - AAP Provisional Section on Tobacco Control
  - Funding opportunities
  - Tobacco control listserv

- Tobacco Prevention Policy Tool

- Contact us: richmondcenter@aap.org

www.facebook.com/aaprichmondcenter
Questions?

Submit questions into the box in the control panel. If we aren’t able to answer your question live, we will send a response to you after the webinar ends.