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Leading RHCs Through Practice Transformation & Achieving PCMH Recognition

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Overview

- Patient-Centered Medical Home (PCMH)
- NCQA PCMH Recognition
- Building Blocks for PCMH
- Journey to PCMH
- SC Rural PCMH Institute
- Learnings
- What's Next

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Patient Centered Medical Home

- 2007 Joint Principles for the Patient Centered Medical Home - American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Osteopathic Association
- **PCMH is an enhanced primary-care model that delivers comprehensive and timely care to patients, emphasizing the central role of teamwork and engagement between caregivers and patients**

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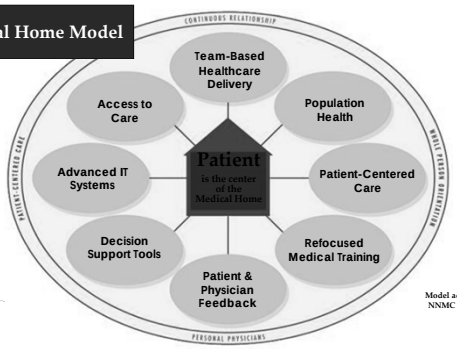
Enhancing Health and the Patient Experience

Medical Home Model



Model adapted from the NNMC Medical Home

PCMH – Potential Impact

- Right care, in the right place, and at the right time
- Better management of chronic diseases and other illnesses improves health outcomes
- Focus on wellness and prevention reduces incidence/severity of chronic disease and illness
- Less likely to seek care from ED or hospital
- Less likely to order duplicate tests, labs or procedures

Source: Patient Centered Primary Care Collaborative. Why the Medical Home Works: A Framework. Accessed at http://www.pcpcc.org/content/why-it-works

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PCMH Outcomes: Smarter Healthcare…

- Drop in hospital days - 36.3%*
- Drop in ER use - 32.2%*
- Reduction in total costs - 9.6%*
- Reduction in outpatient specialty care - 15.0%*
- Improvements in chronic disease and preventive care*
- Decreased staff burnout§
- Higher patient experience ratings§
- Increase in primary care visits+

* Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the US, K. Grumbach & P. Grundy, November 16th 2010

§ Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. Reid RJ, Fishman PA,Yu O, Ross TR, Tufano JT, Soman MP, Larson EB. Am J Man Care, 2009 Sep 1;15(9):e71-87

+ Patient Centered Primary Care Collaborative. Summary of Patient-Centered Medical Home Cost and Quality Results, 2010 – 2013. Accessed at http://www.pcpcc.org/download/4219/PCPCC%20Medical%20Home%20Cost%20and%20Quality%202013.pdf?redirect=node/6094

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Why PCMH?

- Quality Chasm
- Burden of chronic disease
- Primary care physician shortage areas
- Declining physician and staff satisfaction
- Driven by governmental & non-governmental payer, health system or ACO
- *Patient dissatisfaction*
- *New payment models*

Why Should I Go Through All of This?

- Our practice is already a "*medical home*"
- We already provide good care - our patients are satisfied
- I don't practice "cookbook medicine"
- I don't need data to tell me if I am providing good care and the data is usually wrong anyways
- The real problem is the non-compliant patient who don't do what I tell them to do
- We can't do that…it is not possible…
- PCMH recognition is all about filling out forms

PCMH Recognition Programs

- **National Committee for Quality Assurance – Patient Centered Medical Home**
- Joint Commission – Primary Care Medical Home
- URAC – Patient Centered Health Care Home
- Accreditation Association for Ambulatory Health Care – Medical Home
- Payer developed programs (i.e., BCBS MI & OK Medicaid)

NCQA PCMH 2011

- Gives practices a framework for
  - Organizing care around patients
  - Working in teams
  - Coordinating and tracking care over time
- Reflect elements that make primary care successful
- Aligns closely with MU requirements
- Clearer, more specific, and more challenging!
- Applicable to March 30, 2015

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NCQA PCMH Requirements - 2011

1. **Enhance Access and Continuity**
   - A. Access During Office Hours
   - B. Access After Hours
   - C. Electronic Access
   - D. Continuity (with provider)
   - E. Medical Home Responsibilities
   - F. Culturally/Linguistically Appropriate Services
   - G. Practice Organization
2. **Identify/Manage Patient Populations**
   - A. Patient Information
   - B. Clinical Data
   - C. Comprehensive Health Assessment
   - D. Use Data for Population Management
3. **Plan/Manage Care**
   - A. Implement Evidence-Based Guidelines
   - B. Identify High-Risk Patients
   - C. Manage Care
3. **Plan/Manage Care (continued)**
   - D. Manage Medications
   - E. Electronic Prescribing
4. **Provide Self-Care and Community Resources**
   - A. Self-Care Process
   - B. Referrals to Community Resources
5. **Track/Coordinate Care**
   - A. Test Tracking and Follow-Up
   - B. Referral Tracking and Follow-Up
   - C. Coordinate with Facilities/Care Transitions
6. **Measure & Improve Performance**
   - A. Measures of Performance
   - B. Patient/Family Feedback
   - C. Implements Continuous Quality Improvement
   - D. Demonstrates Continuous Quality Improvement
   - E. Report Performance
   - F. Report Data Externally

NCQA Measuring quality. Improving health care.

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Point Requirements

Level of Recognition	Points Required	Must Pass
Level I	35-59	6/6 must pass
Level 2	60-84	6/6 must pass
Level 3	85-100	6/6 must pass
NOTE: Must Pass elements require a ≥**50%** performance level to pass		

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PCMH 2014

- Increased emphasis on team-based care
- Focus care management on high-need patients
- Higher bar/focus in Quality Improvement (QI) on patient experience, cost, clinical quality
- Align with Meaningful Use Stage 2 (MU2)
- Further integration of Behavioral Health
- Applicable April 2014 – required April 2015

Patient-Centered Medical Home 2014

(6 standards/27 elements)

1) **Enhance Access and Continuity (10)**
   - A) ***Patient-Centered Appointment Access**
   - B) 24/7 Access to Clinical Advice
   - C) Electronic Access
2) **Team-Based Care (12)**
   - A) Continuity
   - B) Medical Home Responsibilities
   - C) Culturally and Linguistically Appropriate Services
   - D) ***The Practice Team**
3) **Identify and Manage Patient Populations (20)**
   - A) Patient Information
   - B) Clinical Data
   - C) Comprehensive Health Assessment
   - D) ***Use Data for Population Management**
   - E) Implement Evidence-Based Decision Support
4) **Plan and Manage Care (20)**
   - A) Identify Patients for Care Management
   - B) ***Care Planning and Self-Care Support**
   - C) Medication Management
   - D) Use Electronic Prescribing
   - E) Support Self-Care and Shared Decision Making
5) **Track and Coordinate Care (18)**
   - A) Test Tracking and Follow-Up
   - B) ***Referral Tracking and Follow-Up**
   - C) Coordinate Care Transitions
6) **Performance Measurement and Quality Improvement (20)**
   - A) Measure Clinical Quality Performance
   - B) Measure Resource Use and Care Coordination
   - C) Measure Patient/Family Experience
   - D) ***Implement Continuous Quality Improvement**
   - E) Demonstrate Continuous Quality Improvement
   - F) Report Performance
   - G) Use Certified EHR Technology

*Indicates Must Pass Element

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

NCQA 2014 31

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Medical Home Development

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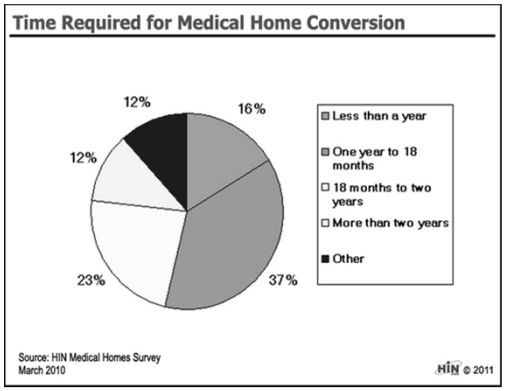

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Transformation Capacity

Infrastructure, Knowledge & Skills

- Practice Assessment – *Know thy Practice*
  - Know Patients, Practice, Processes & Patterns
  - Gap Analysis
  - Develop priorities and game plan
- Transformation Team – *Improvement is a Team Sport*
  - Multidisciplinary
  - Regular Meetings
- Improvement Framework – *Improvement is a Science*
  - Model for Improvement, Lean, Six Sigma
- Performance Measurement System – *Bedrock of Improvement*
  - Data, data, data…improvement is not achievable without data
  - Functionality of EMR – Beyond MU
- Collaboration – *A rising tide lifts all boats*
  - Efficient spread of innovation, best practices, bright spots…

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Transformation Capacity Resources

- New Reimbursement models
- Trained clinicians and staff skilled in quality improvement, change management and team-based care, chronic disease management…
- New team members (i.e., CHWs, clinical pharmacists, care coordinators…)
- New partners (community programs…)
- **Access to practice facilitation**

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Building Blocks for Transformation

- *Quality Improvement Strategy**
- *Data Driven Improvement^*
- Organized Evidence Based Care*^
- Team-Based Care*^
- Empanelment and Panel Management*^
- Enhanced Access* ^
- Care Coordination*
- Continuity^

*Wagner EH, Coleman K, Reid R, et al. Guiding Transformation: How Medical Practices Become Patient Centered Medical Homes. Accessed at www.commonwealthfund.org

^California Healthcare Foundation. The Building Blocks of High Performing Primary Care. Accessed at www.chcf.org

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Journey to PCMH

- ***Historical***: SCORH's 20+ years of experience working with SC rural physicians, from their recruitment through family medicine residency programs to their ongoing needs of practice maintenance and improvements once established in rural communities, provided an opportunity for new services.
- ***Practical***: Through the end of 2014, SCORH will have assisted 215 providers in over 50 RHCs with 90 sites to select, adopt, and implement EHRs, helping those providers achieve **over $4.6 million** in Meaningful Use incentive payments in the past two years.

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Also…

BlueCross BlueShield of South Carolina

South Carolina Healthy Connections

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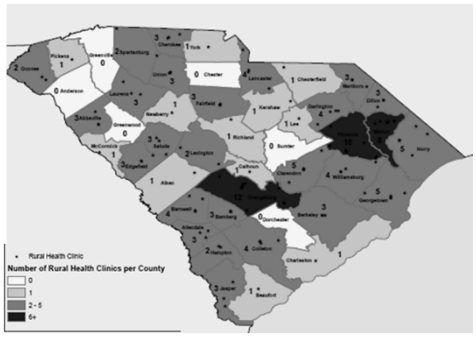
And…



Initial Investments

- FLEX Activities for CAH Provider-Based RHCs – 2012
  - RHC Provider Advisory Group
- Grant support from statewide foundation - 2013
- State contract – 2014
- Total $1.4M commitment through 2016

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Our Team

- Melinda A. Merrell, MPH, PCMH-CCE
  - SCORH Senior Program Director
  - Oversight and Direction for Program
- Michele Stanek, MHS, PCMH-CCE
  - SCORH Director of Practice Transformation
  - Assistant Professor, University of South Carolina School of Medicine
  - Developed and manages I³ Practice Improvement Collaborative
  - NCQA PCMH Reviewer

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Our Team

- Sarah Mathis, MHA
  - SCORH Innovation Program Coordinator
- Quality Improvement Coaches
  - Kortni Koutrakos
  - Lindsay Williams
- Shannon Chambers, CPC
  - SCORH Director of Provider Solutions
- Sherri Cox
  - SCORH Communications Coordinator

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PCMH in South Carolina

- SC primary care practices are transforming their practices as medical homes
  - ~180 practices which include >650 physicians have obtained NCQA recognition as a PCMH
- Organizations are working to support the development of medical homes in SC
  - SC PCMH Alliance
- Growing alignment to support practice transformation and medical home development
  - Meaningful Use
  - EMR Implementation
  - SC Healthy Outcomes Plan

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SCORH Rural PCMH Institute

- Practice facilitation for cohort of rural practices to pursue practice transformation and NCQA PCMH recognition
- Initiated December 2013 with Innovation (Cohort) 1; Innovation (Cohort) 2 – August 2014
- Institute Activities
  - Site Visits
  - Practice & PCMH Assessment
  - Monthly webinars
  - Individual practice consultations/technical assistance
  - SharePoint site
  - Face-to-Face meetings

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Learnings

- Transformation takes time
- PCMH development requires change…tweaks & "heavy lifting"…change is systems & thinking
- Engaged leadership is essential
- Maximize functionality of EHR – quality measurement & tracking
- Build team culture & team-based care
  - Role redefinition
  - Team meetings
- Practice facilitation provides "know-how" and support for practices
- Quality improvement methods is essential skill – small incremental changes over time leads to improvement
- Include all practice providers and staff in process

Learnings

- Challenges:
  - **EHRs**
  - Limited resources
  - Team development
  - Fragmentation of care within communities
  - Resistance to new models
- Facilitators:
  - Existing healing relationships
  - More nimble
  - Whole person orientation
  - Emerging payment models

What's Next?

- Quality Improvement Coaches' Ramp Up
- Development of PCMH-RHC Crosswalk
- Continued statewide collaboration through the SC PCMH Alliance
- Recruitment of Innovation III
  - January 2015

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Appendix

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PCMH 2011 Standard 1: Enhance Access and Continuity

- Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours
- The practice provides electronic access
- Patients may select a clinician
- **The focus is on team-based care with trained staff**

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PCMH 2011 Standard 2: Identify and Manage Populations

- The practice collects demographic and clinical data for population management
- **The practice assesses and documents patient risk factors**
- **The practice identifies patients for proactive and point-of-care reminders**

PCMH 2011 Standard 3: Plan and Manage Care

- **The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems**
- **Care management emphasizes:**
  - **Pre-visit planning**
  - **Assessing patient progress toward treatment goals**
  - **Addressing patient barriers to treatment goals**
- The practice reconciles patient medications at visits and post-hospitalization
- The practices uses e-prescribing

PCMH 2011 Standard 4: Provide Self-Care Support

- **Assesses patient/family self-management abilities**
- **Works with patients to develop a self-care plan and provide tools and resources**
- **Clinicians counsel patients on healthy behaviors**
- Assesses and provides or arranges for mental health/substance abuse treatments

PCMH 2011 Standard 5: Track & Coordinate Care

- Tracks, follow-up on and coordinates tests, referrals and care at other facilities
- **Follows up with discharged patients**

PCMH 2011 Standard 6: Measure & Improve Performance

- Uses performance and patient experience data to continuously improve
- Tracks utilization measures such as rates of hospitalizations and ED visits
- Identifies vulnerable patient populations
- Demonstrates improved performance