# Patient Centered Medical Homes

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Regional Extension Assistance Center for HIT

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# Conflict of Interest

- Dr. Kleeberg is the Clinical Director for the Minnesota - North Dakota Regional Extension Assistance Center for HIT (REACH) – An ONC REC
- Dr Kleeberg also serves on the Physician Advisory Board for Elsevier
- No other conflict of interest

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# Objectives

- Understand the push to adopt Patient Centered Medical Homes (PCMH)
- Familiarize you with the requirements
- Have you share some of your stories
- Conceive of a process in which you can work toward the goals of a Patient Centered Medical Home

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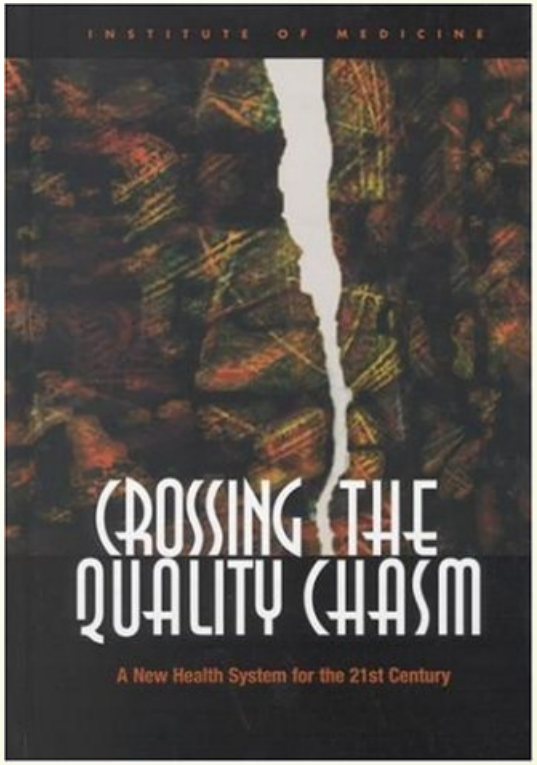
# Institute of Medicine: Crossing the Quality Chasm (2001)

## "A new Health System for the 21st Century"

- Our common purpose as a health system is that care should be:
  - Safe
  - Effective
  - Patient-Centered
  - Timely
  - Efficient
  - Equitable

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# Crossing the Quality Chasm: Health Care Redesign Rules:

1. Care is based on continuous healing relationships
2. Care is customized based on patient needs and values
3. The patient is the source of control
4. Knowledge is shared and information flows freely
5. Decision making is evidence-based
6. Safety is a system property
7. Transparency is necessary
8. Needs are anticipated
9. Waste is continuously decreased
10. Cooperation among clinicians is a priority

Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System of the 21st Century. Washington: National Academy Press, 2001.

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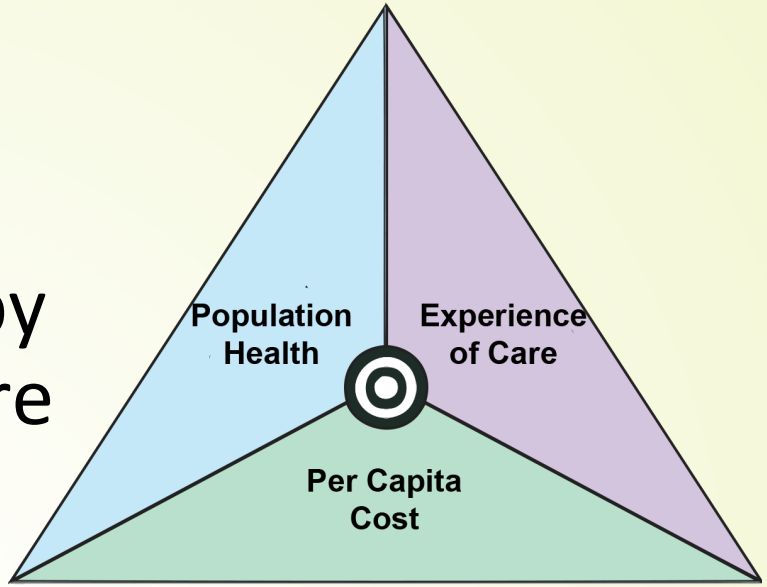
# The Triple Aim (2008)

- A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to health system performance
- The three dimensions are:
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations
  - Reducing the per capita cost of health care




IHI Triple Aim

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# Health Care Reform

- Moving away from an episodic, fee for service payment approach and towards a coordinated model that is focused on delivering high-quality, low-cost care across the continuum of care.


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# Proposed Physician Payment Reform (SGR Fix)

- A one-year fix to avoid a 24.4% decrease in physician reimbursement
- Allows physicians and other professionals to earn revenue-neutral performance-based incentive payments beginning in 2017
- Reform the fee-for-service payment system and "encourage participation in alternative payment models."
  - Accountable care organizations
  - Patient centered medical homes
- Freezes current physician payment levels until 2023
- After 2023
  - 2% annual increase for physicians participating in payment models that involve two-sided financial risk and a quality measure component.
  - 1% annual increase for other physicians

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# The Joint Principles of the PCMH (2007) Endorsed by the ACP, AAFP, AAP, AOA

- Key Characteristics of the Medical Home:
  - Personal physician
  - Physician directed medical practice
  - Whole person orientation
  - Care is coordinated and/or integrated across all elements of the complex health care system and the patient's community

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# The Joint Principles of the PCMH

- Also included that:
  - Quality and safety are hallmarks of the medical home
    - Care planning, evidence-based medicine, clinical decision support, continuous quality improvement, patient participation and feedback, and appropriate Health Information Technology
  - Enhanced Access
  - Payment Based on Value not Volume

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# The National Committee for Quality Assurance (NCQA) and PCMH


- Private, independent non-profit healthcare quality oversight organization
- >32 States have Public and Private PCMH initiatives that use NCQA recognition
- >6,350 NCQA-Recognized medical homes nationwide as of Nov 2013
- 2011 PCMH Standards are aligned with Meaningful Use stage 1 objectives and will be revised for 2014.
- 3 Levels of recognition

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# Patient Centered Medical Home: A Strategy for Quality Improvement

- Long-term partnerships, not hurried visits
- Care that is coordinated among providers
- Better access through expanded hours and on-line tools
- Shared decisions so patients make informed choices
- Lower costs from reduced ER/hospital use
- More satisfied patients and providers

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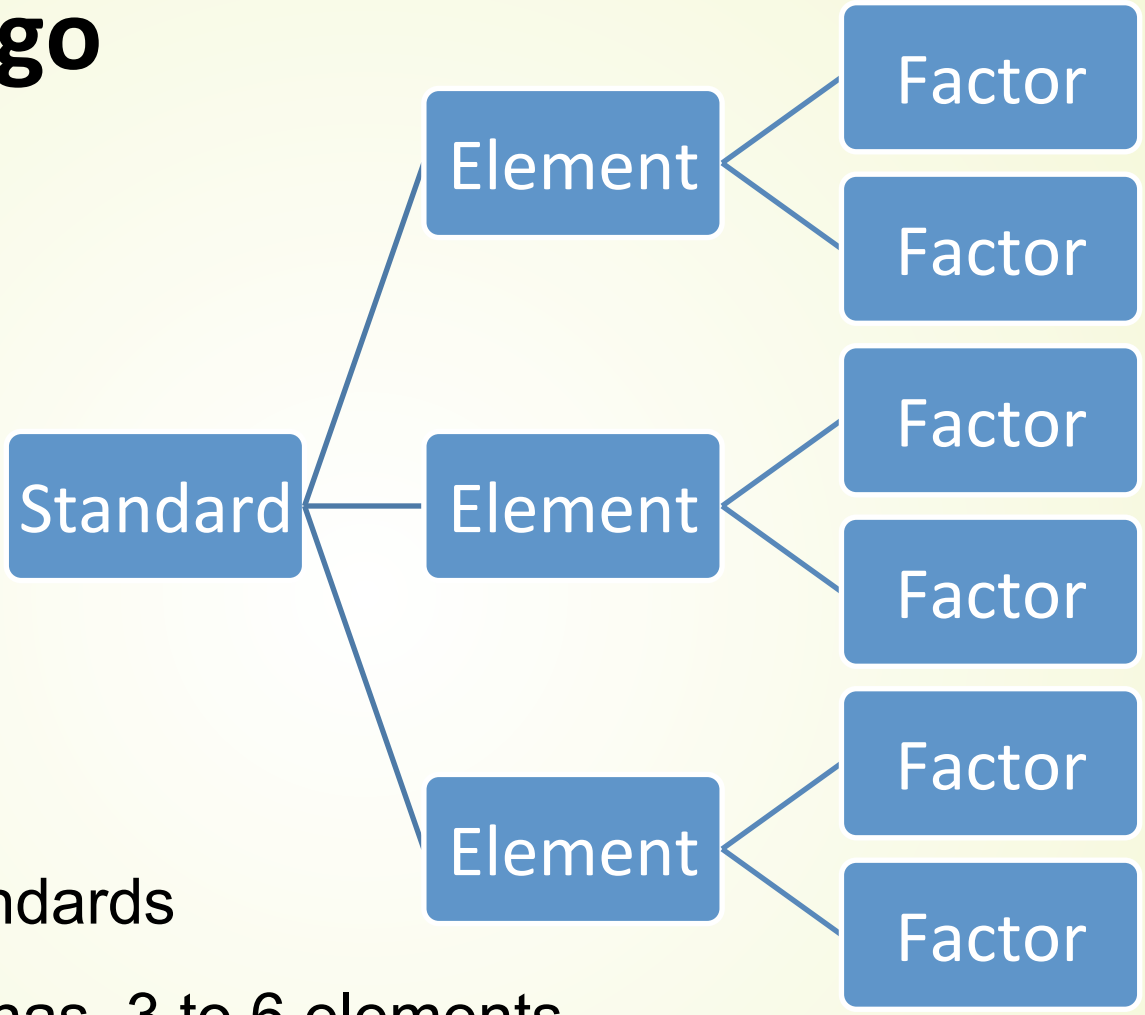
# PCMH Lingo




- There are 6 standards
- Each Standard has  3 to 6 elements
- Each Element has 2 to 12 factors

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# 6 PCMH Standards

1. Enhance Access and Continuity (20 pts)
2. Identify and Manage Patient Populations (16 pts)
3. Plan and Manage Care (17 pts)
4. Provide Self-Care Support and Community Resources (9 pts)
5. Track and Coordinate Care (18 pts)
6. Measure and Improve Performance (20 pts)

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# PCMH Levels

| Recognition Level | Required Points |
|---|---|
| Level 1 | 35 – 59 points |
| Level 2 | 60 – 84 points |
| Level 3 | 85 – 100 points |

- Each of the standards has a Must-Pass element
- Passing the Must-Pass element is required for each level
- Score for each Must-Pass element must be ≥ 50%

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# 1. Enhance Access and Continuity (20 pts)

A. Access during office hours ***Must Pass***
   i. Providing same-day appointments ***Required***
   ii. Providing timely clinical advice by telephone during office hours
   iii. Providing timely clinical advice by secure electronic messages during office hours
   iv. Documenting clinical advice in the medical record.

B. After-hours access

C. Electronic access

D. Continuity

E. Medical home responsibilities

F. Culturally and linguistically appropriate services

G. Use a team to provide a range of patient care service

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# 2. Identify and Manage Patient Populations (16 pts)

A. Patient Information (Demographics)
B. Clinical Data (Meaningful Use Data)
C. Comprehensive Health Assessment
D. Use Data for Population Management *Must Pass*
   Generate lists of patients and to proactively remind patients/ families and clinicians of
   i. At least three different preventive care services
   ii. At least three different chronic care services
   iii. Patients not recently seen by the practice
   iv. Services needed for specific medications

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# 3. Plan and Manage Care (17 pts)

A. Implement Evidence-Based Guidelines

B. Identify High-Risk Patients

C. Care Management—*Must Pass*
The care team performs the following for at least 75 percent of the patients identified in Elements A and B.

   i. Conducts pre-visit preparations

   ii. Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit

   iii. Gives the patient/family a written plan of care

   iv. Assesses and addresses barriers when the patient has not met treatment goals

   v. Gives the patient/family a clinical summary at each relevant visit (MU1)

   vi. Identifies patients/families who might benefit from additional care management support

   vii. Follows up with patients/families who have not kept important appointments

D. Medication Management

E. Use Electronic Prescribing

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# 4. Provide Self-Care Support and Community Resources (9 pts)

A. Support Self-Care Process ***Must Pass***

i. Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management

ii. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate (MU1)

iii. Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families ***Required***

iv. Documents self-management abilities for at least 50 percent of patients/families

v. Provides self-management tools to record self-care results for at least 50 percent of patients/families

vi. Counsels at least 50 percent of patients/families to adopt healthy behaviors

B. Provide Referrals to Community Resources

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# 5. Track and Coordinate Care (18 pts)

A. Test Tracking and Follow-Up

B. Referral Tracking and Follow-Up ***Must Pass***

   i. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information

   ii. Tracking the status of referrals, including required timing for receiving a specialist's report

   iii. Following up to obtain a specialist's report

   iv. Establishing and documenting agreements with specialists in the medical record if co-management is needed

   v. Asking patients/families about self-referrals and requesting reports from clinicians

   vi. Demonstrating the capability for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians

   vii. Providing an electronic summary of the care record to another provider for more than 50 percent of referrals (MU1)

C. Coordinate With Facilities and Manage Care Transitions

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# 6. Measure and Improve Performance (20 pts)

A. Measure of Performance
B. Measure Patient/Family Experience
C. Implements Continuous Quality Improvement ***Must Pass***
   i. Set goals and act to improve performance on at least three measures from Element A
   ii. Set goals and act to improve performance on at least one measure from Element B
   iii. Set goals and address at least one identified disparity in care or service for vulnerable populations
   iv. Involve patients/families in quality improvement teams or on the practice's advisory council.
D. Demonstrates Continuous Quality Improvement
E. Report Performance
F. Report Data Externally

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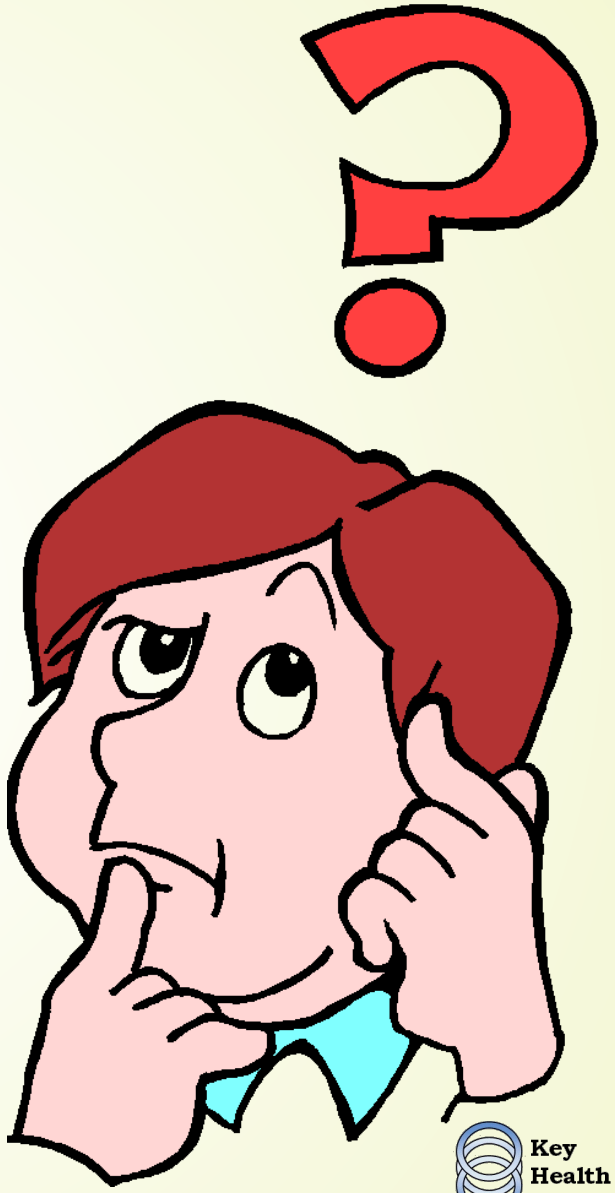
**This seems so hard! Remind me why we want to do this?**



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# Benefits

- Alaskan Native Medical Center:
  - 50% reduction in urgent care and ER utilization
  - 53% reduction in hospital admissions
  - 65% reduction in specialist utilization

Reference: Asinof, R. (2012, May 28). A new model of health care. Retrieved June 14, 2012 from Providence Business News: http://www.pbn.com/A-new-model-of-health-care,67796

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# Benefits

- Community Care of North Carolina (Medicaid) Improvements in asthma care
  - 21% increase in asthma staging
  - 23% lower ED utilization and costs
  - 25% lower outpatient care costs
  - 11% lower pharmacy costs
  - 112% increase in influenza inoculations


Reference: PRNewswire: http://www.marketwatch.com/story/blue-cross-and-blue-shield-companies-patient-centered-medical-home-programs-are-improving-the-practice-and-delivery-of-primary-care-in-communities-nationwide-2012-06-04

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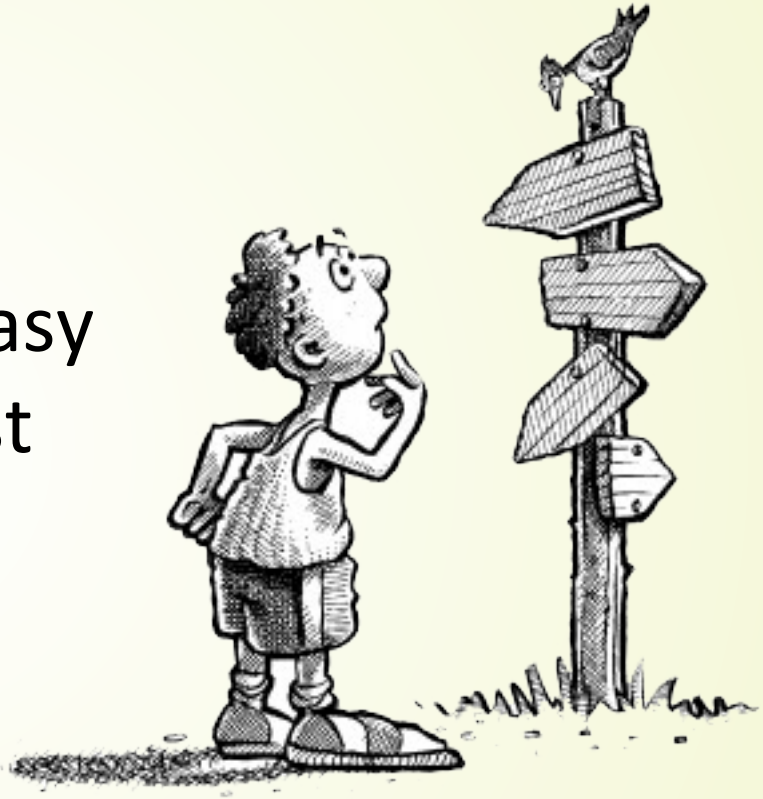
# Benefits

- Oklahoma Medicaid
  - Reduction from 1,670 to 13 patient inquiries related to same-day/next-day appointment availability
  - 8% increase in patients “always getting treatment quickly.”

Reference: Takach, Mary. (2011, July 7). Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results. Health Affairs, 30(7):1325-34.

# Where does one start?

- Start with a small team
- Select a couple of items which you think will be easy to tackle or have the most value
- Enlist a clinical champion
- Track and measure your results



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# Resources

- "Benefits of a Patient Centered Medical Home:
  - http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home
- PCMH page from the NCQA
  - http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx
- NCQA Standards and Guideline details for PCMH 2011
  - https://inetshop01.pub.ncqa.org/publications/product.asp?dept%5Fid=2&pf%5Fid=30004%2D301%2D11
- Agency for Healthcare Research and Quality (AHRQ) PCMH Guide
  - http://pcmh.ahrq.gov

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# In Conclusion

- Being a PCMH has been demonstrated to:
  - Improve quality
  - Increase patient access
  - Reduce costs
  - Increase patient satisfaction
  - And succeed in keeping people healthier and out of acute settings
- Achieving certification is a challenge, but in today's environment will become a necessity
- Getting a head start, will put you in a better position in the future

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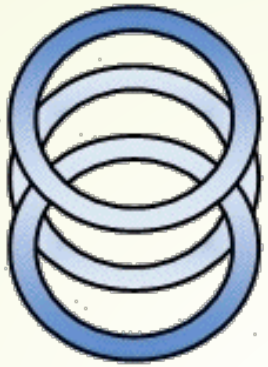

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