A Journey
PCMH & Practice Transformation
“PCMH 101”

Kentucky Primary Care Association
Lexington Kentucky | June 11, 2014
Overview of Journey Today

- What – an overview of PCMH
- Why – PCMH & practice transformation
- How – Process & Change Concepts
- PCMH Recognition Programs
- Outcomes & Sustainability of PCMH
- Resources
Patient Centered Medical Home and Practice Transformation

• WHAT:

Medical homes provide patients with coordinated health care delivery, develop strong physician-patient relationships, encourage communication, and incorporate electronic tracking systems to monitor health outcomes in real time.

- Improve patient health outcomes
- Improve patient experience in navigating health care system
PCMH Recognition vs. Practice Transformation

• **PCMH recognition/certification** provides a structure/blueprint for practice re-design and re-engineering efforts with a defined end point.

• **Practice transformation** is an ongoing process of implementing practice policies and processes and does not have a defined end point.

• **Eight Key Change Concepts** of the Safety Net Medical Home Initiative provide a framework for practice transformation.
Based on the Joint Principles

<table>
<thead>
<tr>
<th>Team-based care:</th>
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</thead>
<tbody>
<tr>
<td>NP/PA</td>
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<tr>
<td>RN/LPN</td>
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<tr>
<td>Medical Assistant</td>
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<tr>
<td>Office Staff</td>
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<tr>
<td>Care Coordinator</td>
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<tr>
<td>Nutritionist/Educator</td>
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<td>Pharmacist</td>
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<td>Behavioral Health</td>
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<td>Case Manager</td>
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<td>Social Worker</td>
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<tr>
<td>Community resources</td>
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<tr>
<td>DM companies</td>
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<tr>
<td>Others…</td>
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</table>

- **Personal physician** in physician-directed **practice teams**
- **Whole person orientation** responsible for care or arranging care for all health care needs
- **Coordinationed care**, integrated across health care settings and community facilitated by registries, IT, HIE etc
- **Quality and safety emphasis** with EBM, point of care support, performance reporting, patient input
- **Enhanced patient access to care** through open scheduling, expanded hours, new option for communication
- **Supported by payment structure** that recognizes services and value
What are the key features of a PCMH?

• Engaged leadership
• Quality improvement strategy
• Empanelment (link patients with a provider team)
• Continuous, team-based healing relationships
• Organized, evidence-based care
• Care coordination
• Enhanced access

Source: Safety Net Medical Home Initiative
1. Enhance Access and Continuity of Care
2. Identify and manage patient populations
3. Plan and manage care
4. Provide self-care and community support
5. Track and coordinate care
6. Measure and improve performance
7. Template of the future
Why PCMH?

Pilot PCMH programs have yielded demonstrable benefits:

<table>
<thead>
<tr>
<th>Improves</th>
<th>Reduces</th>
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<tbody>
<tr>
<td>• <strong>Patient Outcomes/Loyalty</strong></td>
<td>• <strong>Cost per Member</strong></td>
</tr>
<tr>
<td>• A study published in the Annals of Family</td>
<td>• Various pilot projects have demonstrated</td>
</tr>
<tr>
<td>Medicine showed that nearly 2/3rds of</td>
<td>reduction of per patient cost ranging from</td>
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<td>outcomes were significantly improved</td>
<td>$71-640 PMPY</td>
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<td>where patients had a strong &amp; ongoing</td>
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<td>• <strong>Access to Care</strong></td>
<td>reduction in ER admission from 12-29%</td>
</tr>
<tr>
<td>• <strong>Physician Leadership/Ownership</strong></td>
<td>• <strong>Hospital Readmissions</strong></td>
</tr>
<tr>
<td>• <strong>Chronic Disease Management</strong></td>
<td>• Pilot projects have demonstrated</td>
</tr>
<tr>
<td>• <strong>Patient Centered Focus</strong></td>
<td>reduction in hospital stays from 6-40%</td>
</tr>
<tr>
<td>• <strong>Patient Compliance</strong></td>
<td>• <strong>Unnecessary Tests and Procedures</strong></td>
</tr>
<tr>
<td>• <strong>Employee Workplace Productivity</strong></td>
<td>• <strong>Illness and Injury</strong></td>
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Improves

- Patient Outcomes/Loyalty
  - A study published in the Annals of Family Medicine showed that nearly 2/3rds of outcomes were significantly improved where patients had a strong & ongoing relationship with a PCP
- Access to Care
- Physician Leadership/Ownership
- Chronic Disease Management
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- Patient Compliance
- Employee Workplace Productivity

Reduces

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- Emergency Room Utilization
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- Hospital Readmissions
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- Unnecessary Tests and Procedures
- Illness and Injury
Health Care Trends

Challenges...
- Significant increase in reporting burden
- Rapidly changing reimbursement and competitive environment

Alignment...
- Common data / reporting needs across various trends
- Health Centers face common challenges

Opportunities...
- Shared-learning opportunities
- Existing best-practices
- Potential for investment in CHCs

“Meaningful Use”

Patient-Centered Medical Home

Accountable Care Organizations

Public Reporting
Getting Started “How”

• Leadership/Management Buy-In & Support
• All Staff Buy-In & Support
• BOD Buy-In & Support
• Patient/Family Buy-In & Support
• Education/Awareness
• Engagement
• Capacity
• Alignment
ICD9
UDS
PECS Registry
No EMR

Patient Centered Medical Home

The Quality Chasm

* You are here

Predictions – What position are we in relative to Healthcare reform ACA, ACO etc.

- 45+ million uninsured
- 15+ million under-insured
- HIE Inflows
- PCP shortage is worsening: 35K-44K by 2025
- In-bound from medical neighborhood

Health Home
ACO
Big Data
Triple Aim
ACA

PCMH is a Bridge Process
Implementing PCMH

A successful PCMH program needs to take participants beyond the NCQA recognition process by leveraging a variety of resources at the program level, incorporating lessons learned and best practices that can be shared across sites.

- Establish a Program Management Office
- Develop a scalable process for helping practices achieve NCQA recognition and develop necessary PCMH competencies
- Provide on-the-ground support to practices throughout the NCQA recognition process
- Layer in the appropriate technology tools to support evaluation and measurement, as well as core PCMH activities such as care planning
- Ensure that program controls are in place to facilitate ongoing operation of the patient-centered care model (post-recognition)
Medical Home: Aligned with (Chronic) Care Model

Health System:
- Health Care Organization
- Self-Management Support
- Decision Support
- Delivery System Design
- Clinical Information Systems

Community
- Resources and Policies

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Functional and Clinical Outcomes
The Sustainable PCMH Model

PCMH is a platform that helps address the systemic cost, quality and access problems permeating the current healthcare landscape for payers, providers and employers. Effective PCMH transformation and sustainability relies on three key focus areas:

- **Management Tools & Performance Tracking:**
  - Program wide monitoring of progress with practice-level visibility
  - Access to standardize education & Learning Modules
  - Scales and accelerates the transformation process
  - Coaching communication platform to support exchange of information with practices

- **Data & Analytics:**
  - Measure performance against quality measures.
  - Improve care coordination by sharing data within the medical home and neighborhood
  - Clinical & Claims Integration to measure total medical expense

- **Clinical Insight & Practice Transformation:**
  - Workflow change management
  - Care team design & implementation
  - Internal education to build sustainable capacity and support for the medical home model
Business case overview: What will it cost?

• Practice transformation costs to become a PCMH:
  – New staff
  – Staff training
  – PCMH recognition
  – Infrastructure upgrade
  – Health information technology

Transformation is an investment in a practice’s future.

Costs will depend on existing staffing model, existing health infrastructure and other factors.
Characteristics of a Medical Home

• Personal Physician in a Physician-directed practice
• Whole person orientation
• Care is coordinated and/or integrated
• Quality and safety improvements are ongoing
• Enhanced access to visits, phone, or e-mail
• Payments = Enhanced Payments for Coordination, Fee for Service for direct care, Pay for Quality
Capacity

- Team (establish and identify goals)
- Lead (practice change, monitor progress)
- Create a Plan (time line)
- Staffing Model
  - Team based care, train and cross train
- Documentation
  - Reports
  - Tracking: RRWB
  - QA Plan
- Emphasis on processes, support and efficiency (not working harder)
Quality Care

• Coordinate Care Across Neighborhood
  – Team oversees care transitions
  – Specialists, subspecialists, facilities
  – Care transitions
  – Community resources

• Health Information Systems – Support
  – E.H.R. - population management
  – Patient registries for population management
Patient Centered Care

• Self-management support
  – Implement
  – Assess patients

• Use patient care and action plans

• Chronic condition monitoring

• Coaching/education of patients
Tips for Developing Your Team

• Have a **core team** and bring in others as needed

• Time required can vary across team
  - Project lead: up to **10 hrs / week**
  - Other team members: approx. **4-6 hrs / week**

• If network is looking to get multiple locations recognized, need **knowledge of on-the-ground operations for ALL locations included**

Source: PCDC
Self-Assessment & Gaps Analysis

- Self-Assessment
- Gaps Analysis
- Timeline
- Policies and Procedures
- Health Information Systems
  - E.H.R., patient registries, HIE, interface
Kentucky Sites PCMH Recognized

• # sites = 15
• # practices = 125
• Federal efforts:
  – Medicare advanced primary care demonstration project CMS
  – Veterans Administration
  – Department of Defense
  – Others: AHRQ, SAMSHA, CDC
Launching the transformation process

- Relationship building
- Readiness assessment
- Developing and implementing a plan
- Monitoring and maintenance planning

Coach Medical Home: Module 1
Key Change Concepts for Practice Transformation

Laying the Foundation
- Engaged Leadership
- Quality Improvement Strategy

Building Relationships
- Empanelment
- Continuous & Team-Based Healing Relationships

Changing Care Delivery
- Patient Centered Interactions
- Organized, Evidence-Based Care

Reducing Barriers to Care
- Enhanced Access
- Care Coordination

http://www.safetynetmedicalhome.org/change-concepts
Common Practice Support Approaches for PCMH

- Payment: PMPM, performance bonus, shared savings
- Learning Collaborative: face-to-face and/or virtual
- Practice facilitation: on-site and/or virtual
- Provision of and support for information technology – e.g., registries, E.H.R.s
- Data Services: e.g., aggregation for patient population management and performance reporting
- Engagement of patients as advisors
Every system is perfectly designed to get the results that it produces.
PCMH Recognition Programs
Guides and Tools to assist your Health Center for PCMH Readiness

• PCMH Background
• HRSA BPHC – PCMH QI Strategy
• NCQA PCMH 2011 & 2014 Standards (self assessment)
• PCMH-A
• Timeline
• Documentation Tracking Tool
• Cheat Sheet
• Training/TA Opportunities
• Practice Facilitation
• PCHH Team
# 2011 PCMH Content and Scoring

## Standard 1: Enhance Access and Continuity

<table>
<thead>
<tr>
<th>Element</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Access During Office Hours**</td>
<td>4</td>
</tr>
<tr>
<td>B. After-Hours Access</td>
<td>4</td>
</tr>
<tr>
<td>C. Electronic Access</td>
<td>2</td>
</tr>
<tr>
<td>D. Continuity</td>
<td>2</td>
</tr>
<tr>
<td>E. Medical Home Responsibilities</td>
<td>2</td>
</tr>
<tr>
<td>F. Culturally and Linguistically Appropriate Services</td>
<td>2</td>
</tr>
<tr>
<td>G. Practice Team</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20</td>
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</tbody>
</table>

## Standard 2: Identify and Manage Patient Populations

<table>
<thead>
<tr>
<th>Element</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Patient Information</td>
<td>3</td>
</tr>
<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><strong>Total</strong></td>
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## Standard 3: Plan and Manage Care

<table>
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<tr>
<th>Element</th>
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</thead>
<tbody>
<tr>
<td>A. Implement Evidence-Based Guidelines</td>
<td>4</td>
</tr>
<tr>
<td>B. Identify High-Risk Patients</td>
<td>3</td>
</tr>
<tr>
<td>C. Care Management**</td>
<td>4</td>
</tr>
<tr>
<td>D. Medication Management</td>
<td>3</td>
</tr>
<tr>
<td>E. Use Electronic Prescribing</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
</tr>
</tbody>
</table>

## Standard 4: Provide Self-Care Support and Community Resources

<table>
<thead>
<tr>
<th>Element</th>
<th>Pts</th>
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</thead>
<tbody>
<tr>
<td>A. Support Self-Care Process**</td>
<td>6</td>
</tr>
<tr>
<td>B. Provide Referrals to Community Resources</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9</td>
</tr>
</tbody>
</table>

## Standard 5: Track and Coordinate Care

<table>
<thead>
<tr>
<th>Element</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 with Facilities/Care Transitions</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
</tr>
</tbody>
</table>

## Standard 6: Measure and Improve Performance

<table>
<thead>
<tr>
<th>Element</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Measure Performance</td>
<td>4</td>
</tr>
<tr>
<td>B. Measure Patient/Family Experience</td>
<td>4</td>
</tr>
<tr>
<td>C. Implement Continuously Quality Improvement**</td>
<td>4</td>
</tr>
<tr>
<td>D. Demonstrate Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td>E. Report Performance</td>
<td>3</td>
</tr>
<tr>
<td>F. Report Data Externally</td>
<td>2</td>
</tr>
<tr>
<td>G. Use of Certified EHR Technology</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20</td>
</tr>
</tbody>
</table>

**Must Pass Elements**
NCQA PCMH 2014

PCMH 2014
(6 standards/27 elements/100 points)

1) Patient-Centered Access (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) Population Health Management (20)
   A) Patient Information
   B) Clinical Data
   C) Comprehensive Health Assessment
   D) *Use Data for Population Management
   E) Implement Evidence-Based Decision Support

4) Care Management and Support (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 & Shared Decision Making

5) Care Coordination and Care Transitions (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) *Implement Continuous Quality Improvement
   D) Demonstrate Continuous Quality Improvement
   E) Report Performance
   F) Use Certified EHR Technology

* Must-pass
NCQA PCMH 2011 vs. 2014: Timeframe

• 2011 Survey Tool is available for purchase until June 30, 2014
  – Practices may submit applications and surveys until March 31, 2015
  – To upgrade to 2014 before expire, purchase the 2014 survey tools and complete the “Start to Finish” pathway between March 24, 2014 and March 31, 2015

• After March 31, 2015 only the new survey tool will be accepted
2011 vs. 2014

• Emphasis on team-based care
• Care management focus on high-need populations
• Alignment of quality improvement activities with the “triple aim”
• Further integration of behavioral health
• Sustained transformation
Connecting the Dots

- 330 grant Health Center Requirements
- UDS
- ACO
- NCQA PCMH
- Others?
- MU
- Community Needs
- Health Care Insurance Requirements
- Patients
Outcomes and Sustainability

- Demonstration Results
- Learning Collaborative
- Independent evaluation
- Latest research
- Health Outcomes
- Community Implications
- PCDC Sustainability Toolkit
- What get’s measured get’s done!
PCMH is our vision for the future of primary care

• Expectations for PCMH transformation
  - Improve quality & outcomes
  - Improve patient experience
  - Improve practice efficiency
  - Improve provider & staff satisfaction
  - Reduce burnout & turnover
  - Stabilize or reduce overall costs

PCMH improves quality, affordability, and patient satisfaction with care through collaborations and aligned incentives.
Significant Challenges with PCMH

- Change Management
- Infrastructure
- Buy-In
- Reporting
- Time
- Care Coordination
- Training
- Engagement
- Org Endurance/Morale
- Communications
- Care Planning
- Empanelment
- Capacity

What are your top three challenges?
Key Messages Regarding PCMH

• Not a separate project or program but a way of health care delivery

• Requires support from CEO, CHC Board, and Senior Management Team

• Requires buy-in from providers, clinical staff, support staff, and most importantly patients

• Aligned with health centers’ mission, Health Center Program requirements, and state/regional quality improvement initiatives

• Assists with quality improvement, risk management, patient safety, improved outcomes, and patient satisfaction/experience
The setting for a BIG Idea

Assess

Understand

Decide/Plan

Take Action

Support & Sustain
Evaluation Questions - Poll

1. Did you identify strategies and resources for your PCMH toolbox?
2. Will you take something you learned/heard today and go back and apply it still this summer?
3. Do you want any assistance with your PCMH journey, such as documentation review for your PCMH application?
4. What didn’t work well today?
5. What worked well today?
Questions/Discussion
Tools and Resources

- Agency for Healthcare Research and Quality
  http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483

- National Committee for Quality Assurance:

- Safety Net Medical Home Initiative
  http://www.safetynetmedicalhome.org/

- Improving Chronic Illness Care
  www.improvingchroniccare.org

- The Joint Commission:
  http://www.jointcommission.org/accreditation/pchi.aspx

- Patient-Centered Primary Care Collaborative:
  www.pcpcc.net/content/patient-centered-medical-home

- American College of Physicians:
  www.acponline.org/running_practice/pcmh/
Resources con’t

• February 26, 2014, *JAMA*, “Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care”

• http://jama.jamanetwork.com/article.aspx?articleId=1832540&guestAccessKey=50476f73-3817-47e6-a2e8-ae96ff4cea75&utm_campaign=wihi&utm_source=hs_email&utm_medium=email&utm_content=12792426&_hsenc=p2ANqtz-8KkAZIA5Kf_NDtZ_cW9aWvol9Ucu21WrdS2KngH4-lot4uvVeZlPNtQvtMYuYBm3rI_3naUSX3qmuYVYYbl9OO6PB0Bg&_hsml=12792426

• Guests also discussed this accompanying editorial, “The Patient-Centered Medical Home: One Size Does Not Fit All”

• http://jama.jamanetwork.com/article.aspx?articleId=1832517&guestAccessKey=0d4ef1b1-2cf4-4f0f-994a-64ae7460f5dc&utm_campaign=wihi&utm_source=hs_email&utm_medium=email&utm_content=12792426&_hsenc=p2ANqtz-9rpzyNT_jCc7YtrvDp1Q4g3ldRx8NLnADE95UxBiUxOe9D6sqAc3aUibDQbCK8KNCe1NeR8kWFdMzydlfjPs0V5puXQ&_hsml=12792426
Leading PCMH Organizations

• Qualis Health
  http://www.qhmedicalhome.org

• Primary Care Development Corporation
  www.pcdc.org

• Coleman Associates – Patient Visit Redesign
  http://www.patientvisitredesign.com/coleman-associates/

• National Center for Medical Home Recognition
  http://www.medicalhomeinfo.org/about/
Keeping Connected

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