Welcome

Patient Centered Medical Home Webinar

March 10, 2011

We will begin promptly @ 1PM EST

Event Host

Melissa Da Silva

Deputy Director,

National Health Care for the Homeless Council

This presentation is supported through a Cooperative Agreement with the Health Resources and Services Administration.

Patient-Centered Medical Home:

Introduction to Concept

March 10, 2011

Health Care & Housing Are Human Rights

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Patient-Centered Medical Home

- A widely used term
- National Committee for Quality Assurance- the gold standard?
- What does this mean for HCH programs?

Presenters

Heidi Nelson, MHSA, FACHE

- CEO, Duffy Health Center, Hyannis
- Member, National HCH Council
- Health Homes Work Group

Joslyn Strupp Allen, MSSW

- Director, Government Grants and Special Projects, Boston Health Care for the Homeless Program
- 12 years experience working with homeless populations
- Patient-Centered Medical Home Project Leader

Patient Centered Medical Home (PCMH) and Homeless Health Care:

A Brief Introduction

Health Care & Housing Are Human Rights

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Agenda

- A review of the PCMH concept
- The reasoning behind one HCH's plans to prioritize seeking PCMH recognition
- A discussion of the early challenges and foreseeable hurdles to recognition for HCH programs

Patient Centered Medical Home (PCMH):

What is it and why should we care?

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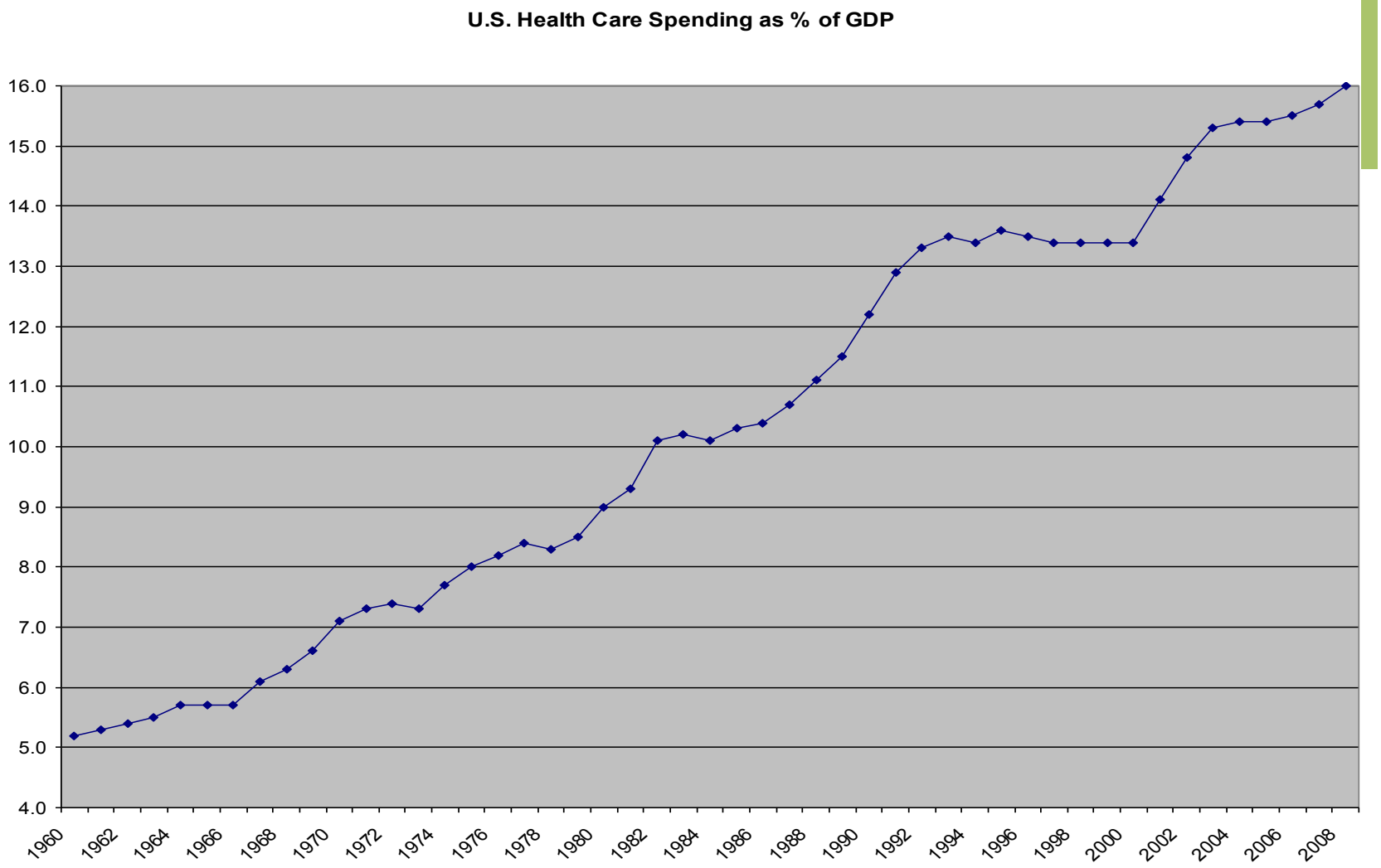
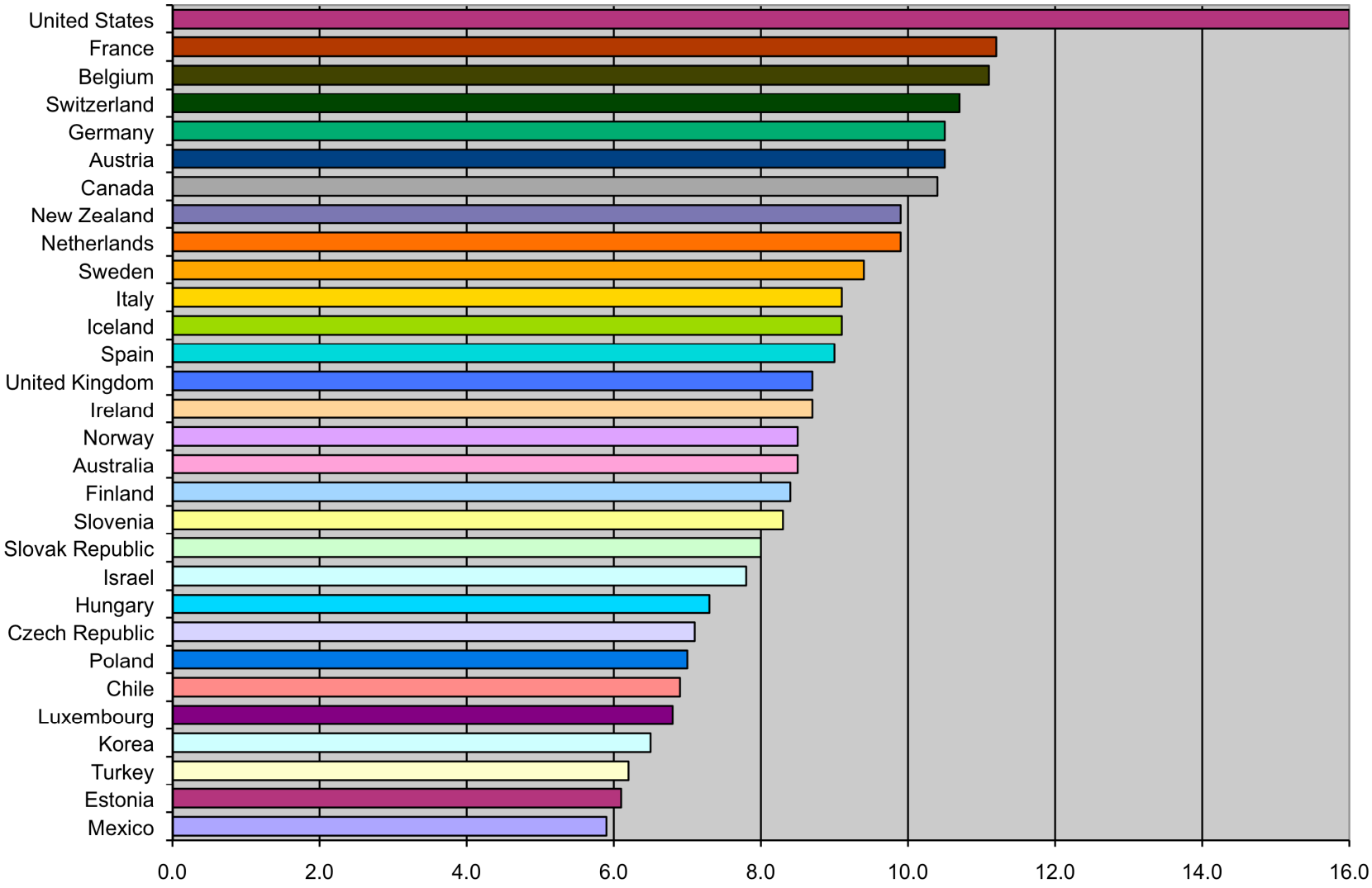
Today's Health Care System: Rising Costs



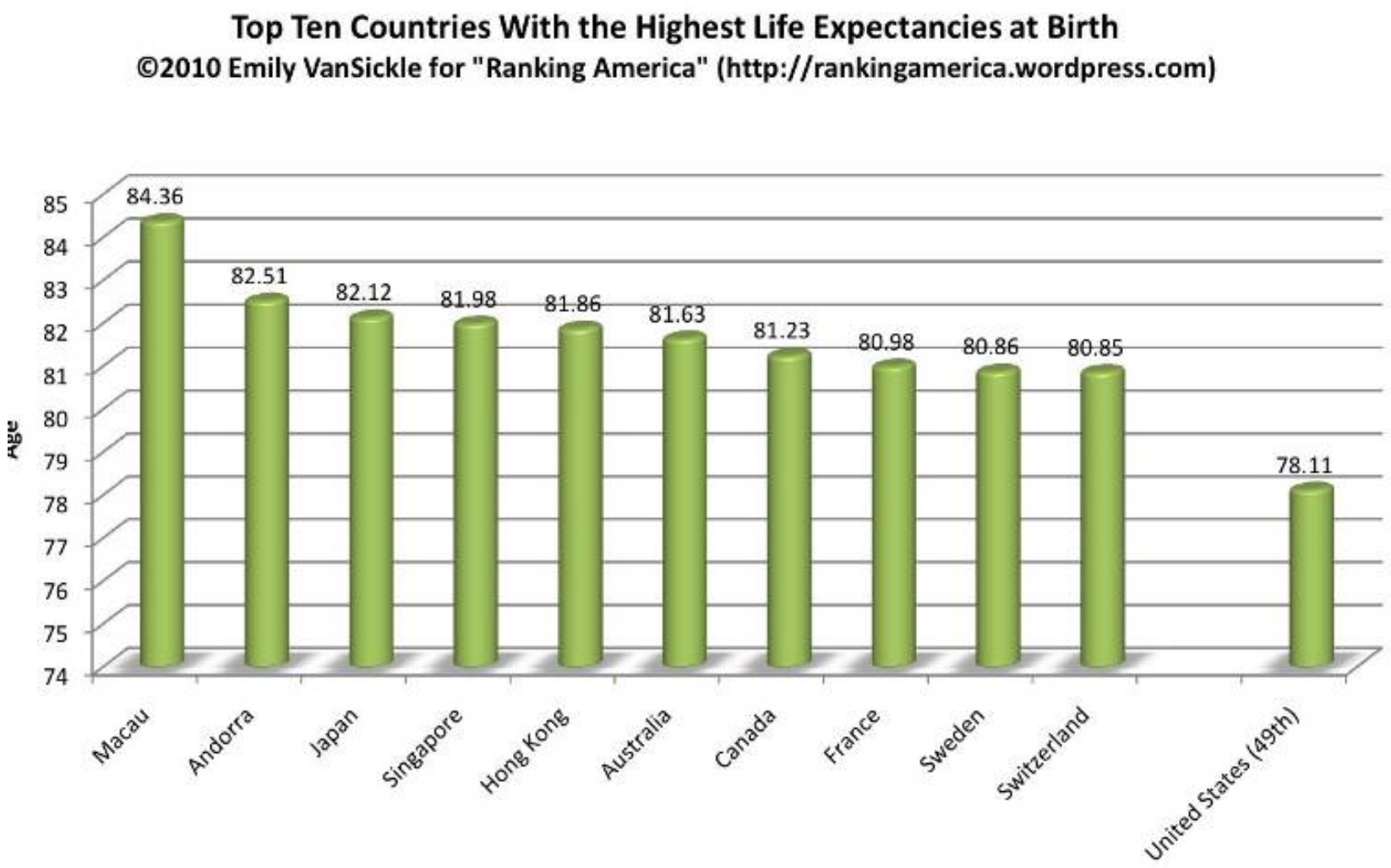
Data from Organization for Economic Cooperation and Development (OECD) Health Data. 2008.

Health Expenditure on Health as % of GDP, 2008



Data from Organization for Economic Cooperation and Development (OECD) Health Data. 2008.

Today's Health Care System: Poor Quality



Data from CIA World Factbook: https://www.cia.gov/library/publications/the-world-factbook/rankorder/rawdata_2102.text

Today's Health Care System: Explanations for Poor Quality

Fragmentation

Inequality

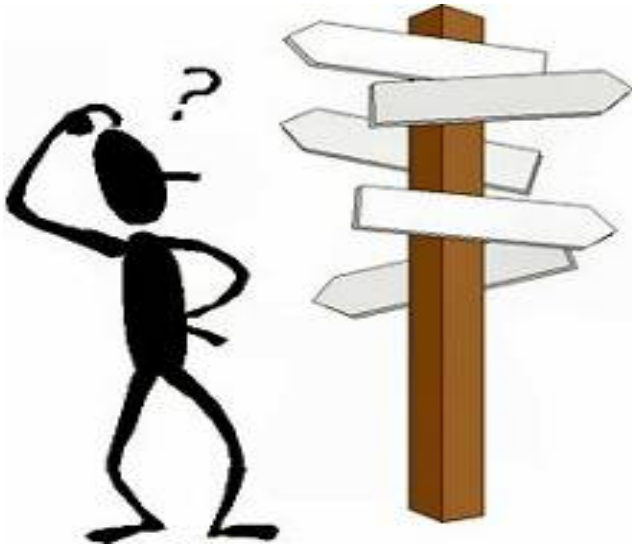
Increase in chronic illness

Today's Health Care System: Explanations for Poor Quality

Shift away from primary care

Growing complexity of

science and technology



In comes PCMH…

The **Patient Centered Medical Home** is a health care setting that facilitates partnerships between individual patients and their personal primary care team. Care is facilitated by health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Adapted from NCQA website

Joint Principles
Key Tenets of PCMH

- Personal Physician/Primary Care Provider
- Team-based Care*
- Whole person orientation
- Care is coordinated and integrated
- Quality and safety are hallmarks
- Enhanced Access
- Payment reform

National Committee for Quality Assurance. 2008. Standards and Guidelines for Physician Practice Connections - Patient-Centered Medical Home (PPC-PCMH).

NCQA and PCMH

The National Committee for Quality Assurance has adapted these joint principles to set standards and guidelines for:

- Working in teams
- Organizing care around patients
- Coordinating and tracking care over time

National Committee for Quality Assurance. 2011. Standards for Patient-Centered Medical Home (PCMH) 2011.

PCMH 2011 Standards

Standard	Content Summary
Enhance Access/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
Identify/Manage Patient 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
Plan/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 practice uses e-prescribing

PCMH 2011 Standards (cont' d)

Provide Self-Care Support/ Community Resources	• The practice assesses patient/family self-management abilities • The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources • Practice clinicians counsel patients on healthy behaviors • The practice assesses and provides or arranges for mental health/substance abuse treatment
Track/Coordinate Care	• The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals) • The practice follows up with discharged patients
Measure/Improve Performance	• The practice uses performance and patient experience data to continuously improve • The practice tracks utilization measures such as rates of hospitalizations and ER visits • The practice identifies vulnerable patient populations • The practice demonstrates improved performance

Why PCMH? Why now?

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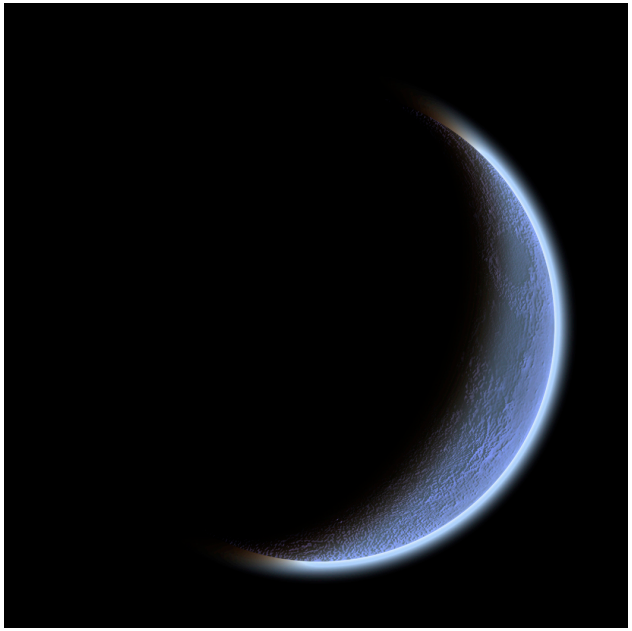
- The Gold Standard
- Quality improvement
- Centering care around patients
- Staff satisfaction
- State initiative
- Reimbursement restructuring

Goals in Seeking Recognition

- Improved processes with high-functioning teams providing high quality care for well-defined panels of patients

- Level 3 Recognition



Challenges

Transformation requires substantial investment and can be costly. The PCMH model itself is likely very resource intensive.

SOLUTIONS:

- Seek alternative funding
- Transformation must include gains in efficiency
- Manage spread of change gradually

Health Care for the Homeless Programs are often built on outreach and are necessarily decentralized.

SOLUTION:

- Multidisciplinary teams with shared panels

Patients in crisis prioritize acute issues over chronic and preventive care

SOLUTIONS:

- "Do today' s work today"
- Shared ownership of the patient – multidisciplinary team and patient

PCMH emphasizes tracking and follow-up for referrals and tests, but homeless patients are often transient and follow-up can be challenging

SOLUTIONS:

- Maximize HIT whenever possible
- Build relationships with other parts of the health care system
- Tap relationships with the homeless service system

Homeless patients can be among the most costly, but many payer systems are focused on reductions in utilization and overall costs.

SOLUTIONS:

- Improve your system
- Build your case
- Compare apples

Questions & Answers

Joslyn Strupp Allen, MSSW

- Director, Government Grants and Special Projects, Boston Health Care for the Homeless Program
- 12 years experience working with homeless populations
- Patient-Centered Medical Home Project Leader

Resources

- Join the Council! www.nhchc.org
- On this page you will find links to a myriad of helpful tools and information including: Meaningful Use, Standards and Certification, and Medicare/Medicaid EHR Incentive Programs, Health Center EHR Selection Guidelines. http://www.hrsa.gov/healthit/
- Assistance and resources for the various stages in implementing Health IT.http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/index.html
- Regional Extension Centers (REC) offer technical assistance, guidance and information on best practices to health care providers for becoming meaningful users of EHRs http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=1835
- A list of Health IT Partners and Collaborators http://www.hrsa.gov/healthit/healthitpartners.html

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