Welcome

Patient Centered Medical Home Case Study featuring Mary Howard Health Center

December 1, 2011

We will begin promptly @ 2PM EST

M.C.

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Patient Centered Medical Home Case Study featuring

Mary Howard
Health Center
Presenters

Elaine Fox, MA
• Vice President of Specialized Health Services
• Director, HCH Program for Philadelphia Program
• Public Health Management Corporation

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• Consultant/PHMC Nursing Network
• Independence Foundation Professor of Urban Community Nursing
• Dept. of Nursing, CHP and SW, Temple University
Presentation Overview

Patient-Centered Medical Homes: Provide High Patient and Provider Satisfaction

- Background
- What is a medical home
- The Pennsylvania experience
- How to do it: Steps
- Benefits of NCQA
- Standards and process
Public Health Management Corporation (PHMC)

- Philadelphia-based public health institute, established in 1972
- Governed by 22-member board of directors
- Non-profit public health institute committed to improving the health of the community through outreach, education, research, planning, technical assistance and direct services
- [www.phmc.org](http://www.phmc.org)
Health Care for the Homeless Program

Outreach

- Shelter outreach - Health care in 40 shelters and day programs
  - street
  - cafes-low-demand sites
  - behavioral health sites
  - large shelters for single adults
  - large shelters for families
- Private providers
- Public agencies - Health Dept. Office of Services to homeless
- Outreach coordination center (street outreach providers)
- “Word of mouth” - Other homeless people

- Primary care and follow-up (as possible)
- Chronic disease management
- Screenings
- Immunizations
- Case Management
- Health Education
- TB Surveillance
- Shelter outbreak management
- Staff training
- Training of medical, NP, public health students

Mary Howard Health Center

- Comprehensive primary health care
- Management of chronic diseases
- Behavioral health
- Social services
- Limited optometry
PHMC HEALTH CENTERS

HRSA-funded Federally Qualified Health Center

* Recognized by NCQA as medical homes

Health Center Network

Public Housing

* Mary Howard Health Center
  Chronically homeless adults

PHMC Care Clinic
  Chronically homeless adults and families specializing in treating people with HIV/AIDS

* Rising Sun Health Center
  Public housing population plus nearby increasingly diverse community

* PHMC Health Connection
  Public housing population plus surrounding community

Congreso Health Center
  Public housing and homeless population
MARY HOWARD HEALTH CENTER

- Serving the chronically homeless since 1996
- 4.5 CRNPs
- 2010: 1,772 clients
- Total DM Population (18-75): 188
- Nurse Practitioners
- Nutritionist
- Optometrist
- Psych. Nurse Practitioners
- Behavioral Health Specialists
- Social Worker
Concept of “medical home”

- Introduced by American Academy of Pediatricians in 1967 as a model of care for children with specialized health needs.

- Subsequently, evolved into an integrated primary care model.

- Nurse-led practices can now earn National Committee for Quality Assurance (NCQA) Medical Home Recognition where state law allows independent practice (October 22, 2010).
Characteristics of the Medical Home

- **Whole-person** focus
- **Long-term provider partnerships**, not sporadic, hurried visits
- **Provider-led teams** coordinate care, especially prevention/chronic conditions, plus other providers’ care, community support
- **Enhanced access** and patient engagement
Recent recognition of Medical Homes in Federal, State and Payer Initiatives

- “Patient Centered Medical Homes” save money through lower hospital and emergency room admissions.

- Provide pay for performance to primary care practices
  - Medicare demonstrations
  - State initiatives
  - Payer initiatives
Pennsylvania’s Approach: The Chronic Care Initiative

- In 2008, the Governor’s Office of Health Care Reform began the implementation in selected primary care practices in Southeastern PA. Eight of the initial 32 practices were nurse-led. Three were PHMC CRNP led primary care practices. One was a PHMC Affiliate.

- Components included:
  - Wagner’s Chronic Care Model
  - Improve Performance In Practice Goals for Diabetes
  - Continuation, beyond year one, required NCQA recognition
  - Learning Collaborative with Coaching
  - Pay for Performance Standards
    - Mary Howard receives over $22,000 per quarter at NCQA Level 1.
    - Will double that to over $44,000 per quarter at NCQA Level 3.
Integration of Chronic Care Model Concepts

Community
- Resources and Policies
- Self-Management Support

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

Improved Outcomes
- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Productive Interactions

Health System
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Self-Management

■ Effective self-management is very different from telling patients what to do.

■ Patients have a central role in determining their care, one that fosters a sense of responsibility for their own health.

■ Created a report card with patient’s SM goal and how confident they are of meeting that goal.
If You Have Diabetes, Know and Control Your ABCS: A1C, Blood Pressure and LDL “bad” Cholesterol

<table>
<thead>
<tr>
<th>My A1C</th>
<th>My Blood Pressure</th>
<th>My LDL “bad” Cholesterol</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Goal less than 130/80</td>
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<tr>
<td></td>
<td></td>
<td>My BP: Date:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goal less than 100 mg/dL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>My LDL: Date:</td>
</tr>
</tbody>
</table>

Self Management Goal

How sure am I that I can meet my goal?

<table>
<thead>
<tr>
<th>Not Sure At All...</th>
<th>Very Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10</td>
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<tr>
<td>1</td>
<td>9</td>
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<tr>
<td>2</td>
<td>8</td>
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Delivery System Design

The delivery of patient care requires:

- Clarifying roles and tasks to ensure the patient gets the care;
- Making sure that all the clinicians who take care of a patient have centralized, up-to-date information about the patient’s status; and
- Making follow-up a part of standard procedure.

Redesign included: Hiring RN Care Managers; MA performs LEAP exam after passing competency testing; $5 gift certificates from local grocers as an incentive for keeping appointments or to come to group classes.
Decision Support

- Treatment decisions need to be based on explicit, proven guidelines supported by at least one defining study.

- Health care organizations creatively integrate explicit, proven guidelines into the day-to-day practice of the primary care providers in an accessible and easy-to-use manner.

Clinical Information System

- A registry — an information system that can track individual patients as well as populations of patients — is a necessity when managing chronic illness or preventive care.

- Refinement of EMR to meet requirements for registry and outcome measures.
Outcomes from the PA Chronic Care Initiative

- Outcomes are extremely positive - 2009 data shows that participating diabetics are 33% more likely to have control of their blood sugars, 40% more likely to have control of cholesterol levels and 25% more likely to have normal blood pressures when compared to non-participating diabetics.

- In 2010, the initiative was expanded throughout the state and now includes 151 participating practices.

- PA has received a Medicare demonstration grant.

- Program survived change in state administration, because payers happy with outcomes and anticipate reduced emergency room and hospital admissions.
You can do it!
We did 4 at the same time.

- Need committed staff, who like detail work – one clinical and one IT.
- Purchase an NCQA survey.
- Compare requirements to current status within your health center.
- Create needed policies, procedures, documents.
- Attend an NCQA workshop to learn how best to demonstrate that you have met standards.
- Set times for clinical and IT staff to devote to project.
- Divide work, but come together to critique and upload.
- Meet contract and payment requirements.
Other Changes required

- EMR and electronic prescribing were not required, but very helpful – with 2011 NCQA standards and “meaningful use” funding, even more important today.

- Patient registry and performance reporting required.

- Practice re-engineering included:
  - Improved tracking of referrals and tests
  - Hiring RN care managers for self-management and to follow patients at high risk for admission to the ER or hospital

- Opted not to do advanced electronic communication to date because of the populations PHMC serves.
Benefits of NCQA Recognition:

**Improved Health Care Value**

- **Higher quality, lower costs** preventing the need for hospital and ER admissions
  - Quality Gains And Cost Savings Through Adoption Of Medical Homes, Fields, Leshen, Patel, *Health Affairs*, May 2010

- **Improved satisfaction** – patients & clinicians

- Multiple PCMH findings documented [http://www.pcpcc.net/content/pcmh-outcome-evidence-quality](http://www.pcpcc.net/content/pcmh-outcome-evidence-quality)
Additional Benefits of NCQA Recognition

1. NCQA’s program is the most widely used medical home program.

2. It’s a practical plan for practice transformation and definition of what is best in primary care.

3. It’s evidence based and built on solid research.

4. It’s collaborative, improves team-based care.

5. It addresses and solves a problem with a common solution for payers and practices. Payers acknowledge the value.
NCQA Standards 2011

**Core components**

- Enhance Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Provide Self-Care and Community Support
- Track and Coordinate Care
- Measure and Improve Performance

**Must pass elements**

- Access during office hours
- Use data for population management
- Care management
- Support self-care process
- Track referrals and follow-up
- Implement continuous quality improvement
Meaningful Use and Medical Homes

- Updated Medical Home guidelines align with “meaningful use” standards for electronic medical records.

- Meaningful use can be difficult to meet without technical assistance.

- Assistance in achieving meaningful use is available through Regional Extension Centers funded by the Health Resources and Services Administration.
Changes Made to NCQA Medical Home Standards in 2011

In addition to aligning with meaningful use requirements, NCQA has strengthened and added to existing elements of the Medical Home model.

Changes include:

- A stronger focus on integrating behavioral health
- Adding an optional standardized patient experience survey
- Greater involvement for patients and families in quality of care improvement
- Pediatric examples and explanations
What’s Next for Mary Howard

- Mary Howard will reapply for recognition in May of 2012 under the new 2011 NCQA Medical Home Standards.
- Intended to apply earlier – transition to new EMR did not go smoothly and need 3 months of good data.
- Re-application must occur no later three years after the most recent review.
- PHMC was accepted to receive recognition survey services for next NCQA review under HRSA’s Patient-Centered Medical Home Initiative.
NCQA 2011 Standard 1: Enhanced access and continuity (20 points)

- Access During Office Hours * (4 points)
- After-Hours Access (4 points)
- Electronic Access (2 points)
- Continuity - with provider (2 points)
- Medical Home Responsibilities (2 points)
- Culturally/Linguistically Appropriate Services (2 points)
- The Practice Team (4 points)

*Must pass element of any level of PCMH
NCQA 2011 Standard 2: Identify and Manage Patient Populations (16 points)

- Patient Information   (3 points)
- Clinical Data   (4 points)
- Comprehensive Health Assessment   (4 points)
- Use Data for Population Management * (5 points)

*Must-pass element for any level of PCMH Recognition
NCQA 2011 Standard 3: Plan and Manage Care (17 points)

- Implement Evidence-Based Guidelines (4 points)
- Identify High-Risk Patients (3 points)
- Care Management * (4 points)
- Medication Management (3 points)
- Use Electronic Prescribing (3 points)

*Must-pass element for any level of PCMH Recognition
NCQA 2011 Standard 4: Provide Self-Care and Community Resources (9 points)

- Support Self-Care Process* (6 points)

- Provide Referrals to Community Resources (3 points)

*Must-pass element for any level of PCMH Recognition
NCQA 2011 Standard 5: Track/Coordinate Care (18 points)

- Referral tracking and Follow-Up * (6 points)
- Test Tracking and Follow-Up (6 points)
- Coordinate with Facilities/Care Transitions (6 points)

*Must-pass element for any level of PCMH Recognition
NCQA 2011 Standard 6: Measure and Improve Performance (20 points)

- Measure Performance (4 points)
- Measure Patient/Family Feedback (4 points)
- Implement CQI * (4 points)
- Demonstrate CQI (3 points)
- Report Performance (3 points)
- Report Data Externally (2 points)

*Must-pass element for any level of PCMH Recognition
Scoring for NCQI

- Level 1: 35-59 points plus 6/6 must pass
- Level 2: 60-84 points plus 6/6 must pass
- Level 3: 85-100 points plus 6/5 must pass

Must pass elements - = or >50% of performance level
PCMH IA: Access during office hours

- Practice has written process/standards and demonstrates that it monitors performance against the standards to:
  - Provide same day appointments (critical factor)
  - Timely advise by telephone
  - Timely advise by electronic message
  - Document clinical advise

- Scoring: 4 factors = 100%; 3 factors including critical factor = 75%; 2 factors including critical factor = 50%
**Process**

- Obtain PCMH Standards and Guidelines on-line
- PCMH Online Application – one for each site (free)
- PCMH 2011 Interactive Survey System (ISS) Tool – purchase one ISS license for each site @ $80 per site
- Training – on website www.ncqa.org
  - free on-line and monthly training
  - regional classroom training (fee-$850=$995)
Process (cont’d)

- Complete on-line application
- Have NCQA enable ISS Tool
- Complete ISS Tool
- Pay fee by check or credit card – based upon number of providers
  - $400-$500 per clinician
- Submit ISS
Single site vs. Multi-site

- One survey for 3 or more practices
- Use same EMR
- One person authorized to sign
Take the Challenge....

All indications are that receiving NCQA recognition leads to quality care for patients and quality work environments for providers.
Questions & Answers

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Resources

- Patient-Centered Medical Home Resource Catalog:

- Nine Steps to NCQA Recognition:
  http://www.nhchc.org/Publications/9_Key_steps_to_NCQA_PCMH_Recognition.pdf

- Archived Webinars:
  - PCMH and HCH: an introduction:
    http://www.nhchc.org/Webinars/PCMH.mp4
  - Steps to NCQA Recognition:
    http://www.nhchc.org/Webinars/NCQAPCMHfinal.mp4
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