

Welcome

PCMH Updates for Safety Net Providers

Thursday, February 28, 2013

We will begin promptly at 1 p.m. Eastern.

Event Host:

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This publication was supported by Grant/Cooperative Agreement Number U30CS09746-04-00 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.

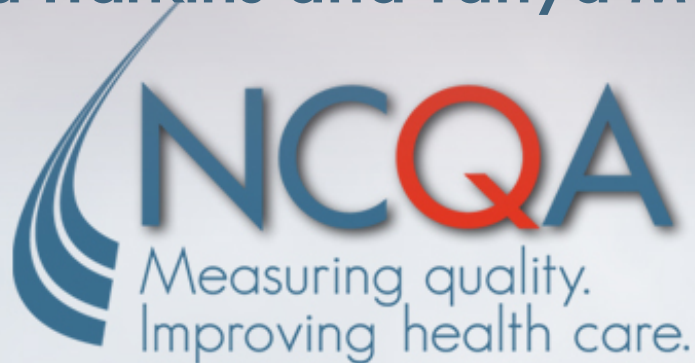
NATIONAL
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COUNCIL

PCMH Updates for Safety Net Providers

Opportunities and Challenges

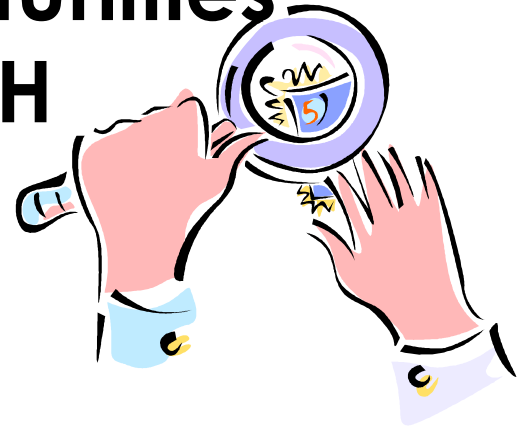


National Health Care for the Homeless Council
Mina Harkins and Tanya Medrano



Purpose of this Seminar

- **Examine the essential goals of a Patient-Centered Medical Home**
- **Facilitate the NCQA survey and application process in eligible practices participating under the HRSA grant**
- **Identify challenges and opportunities with key requirements for PCMH Recognition**



National Committee for Quality Assurance (NCQA)

Private, independent non-profit health care quality oversight organization founded in 1990

MISSION

To improve the quality of health care.

VISION

To transform health care through quality measurement, transparency, and accountability.

ILLUSTRATIVE PROGRAMS

- * HEDIS® – Healthcare Effectiveness Data and Information Set
- * Health Plan Accreditation
- * Clinician Recognition
- * Disease Management Accreditation
- * Wellness & Health Promotion Accreditation
- * Quality Compass™
- * Accountable Care Organization Accreditation

Patient-Centered Medical Homes (PCMH)

Transforming Primary Care Into What Patients Want

1. Long-term partnerships, not hurried visits
2. Care that is coordinated among providers
3. Better access through expanded hours and online tools
4. Shared decisions so patients make informed choices, get better results
5. Lower costs from reduced ER/hospital use
6. More satisfied patients and providers

IOMs Crossing the Quality Chasm: Ten Simple Rules for the 21st Century Health Care System

- 1. Care based on continuous healing relationships**
- 2. Care based on patient needs and values**
- 3. Patient as the source of control**
- 4. Patient access to medical information and clinical knowledge**
- 5. Evidence-based decision making**
- 6. Patient safety**
- 7. Transparency of information**
- 8. Anticipation of needs**
- 9. Continuous decrease in waste**
- 10. Cooperation among clinicians.**

The Triple Aim

- **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
- **These three key concepts are embedded throughout the NCQA PCMH requirements**

Meaningful Use of Health Information Technology (HIT)

- NCQA emphasizes HIT because good primary care is **information-intensive**
- PCMH 2011 **reinforces incentives** to use HIT to improve quality
- Meaningful Use **language is embedded**, often verbatim, in PCMH 2011 evaluation standards
- **Synergy/virtuous cycle**: PCMH 2011 medical practices will be well prepared to qualify for meaningful use, and vice versa

PCMH Federal Initiative

HRSA Patient-Centered Medical Health Home Initiative (PCMHHI)

- **Community health centers**
 - For rural, underserved, often nurse-led practices
- **Recognition costs and technical assistance**
- **Program began in 2010**
- **Up to 500 approved centers per year; 5-year contract**
- **285 Recognized sites to date**
- **Managed by Government Recognition Initiatives and Projects Staff**

PCMHHI – How to apply and Technical Assistance

- Under HRSA PCMHHI contract, cost for Survey Tools and Application fees covered by agency
- Interested Community Health Centers must file Notice of Intent with HRSA
 - Indicates Center is within 12 months of Recognition
- Centers can attend monthly trainings – conference calls and Webinars
 - Standards and Survey Process/Interactive Survey System
- Mock Surveys also available
 - Opportunity for feedback from trained surveyors
 - Highlights areas on which center should focus

PCMHHI – Survey Process

- **Survey Preparation**
 - Time to prepare depends on practice's current ability to function as a medical home
 - Minimum 3 months experience with policies, procedures, protocols and electronic systems
 - Most sites take 12 – 18 months to prepare
- **Survey Completion**
 - Survey Tool takes approximately 80 hours of staff time to complete
 - Most sites spend 3 – 4 months processing and finalizing Survey Tool

Focus on Must Pass Elements First

Rationale for Must Pass Elements

- Identifies critical concepts of PCMH
- Helps teams focus on most important aspects of PCMH
- Guides PCMH evolution and continuous quality improvement
- Standardizes “Recognition”

Must Pass Elements

- 1A: Access During Office Hours
- 2D: Use Data for Population Management
- 3C: Care Management
- 4A: Support Self-Care Process
- 5B: Referral Tracking and Follow-Up
- 6C: Implement Continuous Quality Improvement

Focus on the Most Critical Critical Factors

- **PCMH 1A factor 1**
 - Providing same day appointments
- **PCMH 4A factor 3 (patient chart element)**
 - Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families
- **Good places to begin early changes**
- **There is no Recognition without these**

Master the Record Review Workbook

- Read the instructions in the RRWB carefully– twice.
- Watch the recorded instructions on www.ncqa.org.
- A condition for 3A factor 3 must be included.
- The right number of patients must be selected for each condition identified in 3A and 3B.
- Patients must be selected using the instructed methodology.
- Abstracted responses are subject to audit.

Completing this worksheet
used" option available in the drop-down boxes for Patient Number 1.

C. Care Management						
	4	5	6	7	1	2
Assesses and addresses barriers when the patient has not met treatment goals	Yes	No	Identifies patients/families who might benefit from additional care management support	Follows up with patients/families who have not kept important appointments	Reviews and reconciles medications with patients/families	
	Yes	No	Yes	NA	Yes	Yes
	NA	Yes	Yes	NA	Yes	Yes
	NA	Yes	Yes	NA	Yes	Yes
	Yes	Yes	Yes	NA	Yes	Yes
	Yes	No	Yes	NA	Yes	Yes
	NA	No	Yes	NA	Yes	Yes

In God We Trust, All Others Must Provide Data

- **While all 6 of the PCMH Must Pass Elements require data for submission none require the use of an EMR**
- **A practice can achieve PCMH Recognition without an EMR***
 - **Assuming the practice utilizes other forms of HIT e.g. Practice Management Systems, eRx, registries**
- **24 of 28 Elements require some quantitative data**

***electronic medical record system**

Sources of Data for Documentation

- **Regional Extension Centers**
- **Health Information Exchanges**
- **Meaningful Use Certified Electronic Health Record Systems**
- **Practice Management and Billing Systems**
- **Physician Quality Reporting System Submissions**
- **Registries**
- **Health Plans**
- **Professional Specialty Organizations**
- **Medical Boards Maintenance of Certification**

Special Populations

- **Enhanced applicability to pediatric populations was a PCMH 2011 goal**
 - Family incorporated where appropriate
 - Age appropriate immunizations and screenings
 - Well-child care identified as an important condition
- **Practices with limited diversity in payer, ages, clinicians or HIT have some data challenges**
 - Single payer (Medicaid)
 - Geriatric (Medicare and Commercial)
 - FQHCs and CHCs
 - Pediatric Practices
 - Solo Practices

The Challenges of Increasing Patient Engagement

- **Discuss with patients the importance of having a clinician and care team responsible for coordinating care**
- **Provide patients with information about the obligations of the medical home and the responsibilities of patients/families as partners in care.**
- **Address cultural and linguistic needs**
- **Contact patients who may have been over-looked or missed important appointments**

Opportunities for Patient Engagement

- **Support self-management, self-efficacy and behavior change with trained staff**
- **Collaborate with patients on care plans and treatment goals and on self-management plans and goals**
- **Assess patient/family understanding of medications**
- **Establish opportunities for group classes and peer support groups**
- **Explore qualitative means for patient feedback conducive to its population**
- **Involve patients/families in quality improvement activities**

Resources for Patient Self-Management

- **Partnering in Self-Management Support: A Toolkit for Clinicians (2009).** Institute for Healthcare Improvement.

<http://www.ihl.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx>

- **Living Well Sustainability Toolkit(2012).** Oregon Department of Health.

<http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Documents/Toolkit/lwtoolkit.pdf>

- **Health and Human Services Initiative on Multiple Chronic Conditions.**

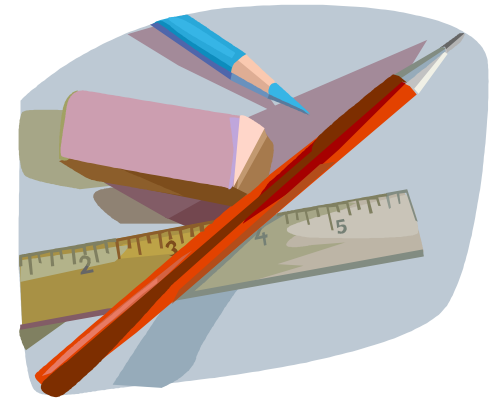
<http://www.hhs.gov/ash/initiatives/mcc/index.html>

- **Stanford's Chronic Disease Self-Management Program.**

<http://patienteducation.stanford.edu/programs/cdsmp.html>

Why Measure Performance?

- **Internal**
 - Assess current performance
 - Demonstrate and verify performance
 - Control performance
- **External**
 - Accountability
 - Decision-making
 - Public reporting
 - Organization evaluation



Determining Action

- **Engage clinicians, practice staff and patients/families**
- **Qualitative analysis will direct action**
 - If patients less likely to have certain benefits, can clinic find alternative means of providing/obtaining same service?
 - If clinical process is faulty, what changes can make it more effective?
 - If noncompliance is a factor, what methods can team use to increase patient understanding/knowledge/care plan buy-in?

Effective Actions

- **Actions should try to change behavior**
 - Patient, provider and/or staff
- **Often easier/faster to focus on staff and provider changes**
 - Internally there is more direct control
 - Focus on individuals who understand and support PCMH model
- **Patient behavior changes can take longer, but may have greater impact**

Effective Action Examples

- **Creating new workflows/templates/ processes and providing training to ensure staff and provider knowledge of care steps**
- **Creating support groups/group visits to provide additional perspective to patients on self-care**
- **Varying methods of reminders to encourage patient compliance with care plans**

What NCQA has Learned About Practice Change

Whole person, patient-centered means change

- Embracing the principles of PCMH
- Maximizing team-based care
- Enabling access to care
- Implementing systematic approach to care, e.g. track and coordinate care
- Coordinating with specialists, facilities
- Including patients to plan/manage their evidence-based care
- Educating patients about PCMH
- Establishing performance measurement and quality improvement
- Evaluating patient experience
- Managing populations of patients
- Understanding/meeting cultural and linguistic needs of patients

A Practice is a System

- **Making change is easy...but making change stick is hard**
 - For every action there will be a reaction
 - Break down occurs because of failure to consider the human side of change
- **Art of managing change is key**
- **Technical side of change is important, but the human side is just as vital**

Involve The Entire Team

- **Systems thinking is the cornerstone!**
 - **How does everyone's role fit into the desired improvement**
- **Recognize that changes do not occur overnight or in one big leap**
 - **Systematic increases in action may be necessary**
- **“Change” must be managed in order to be sustained**

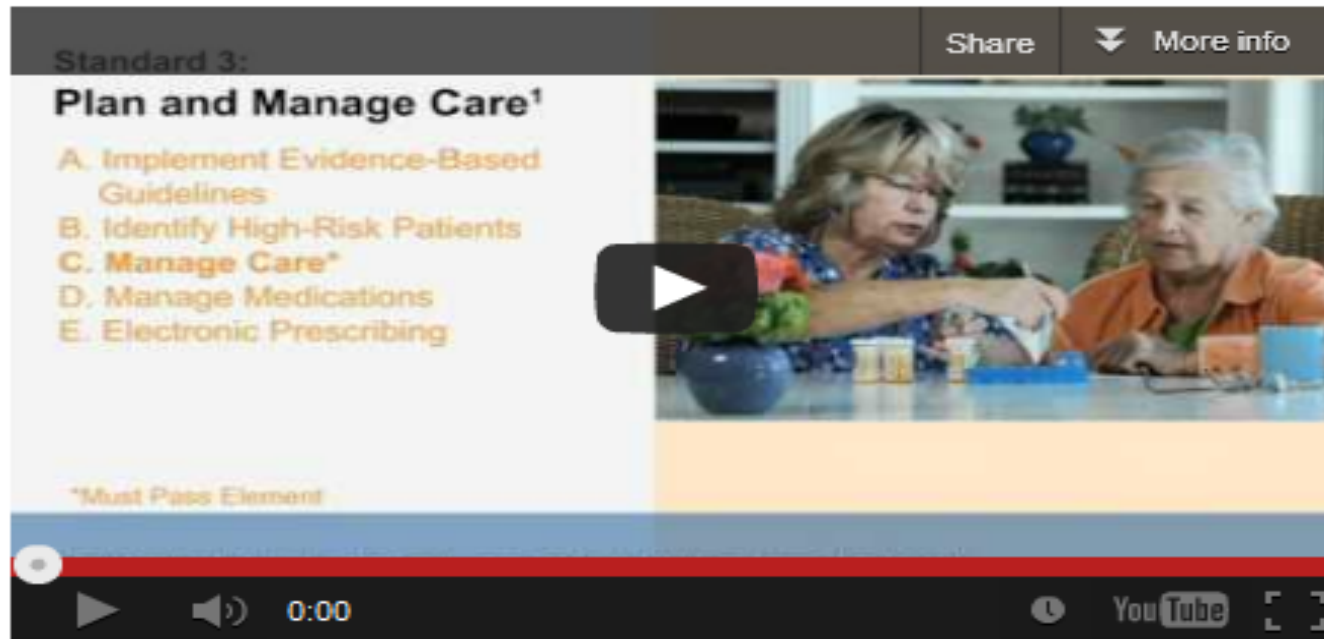
NCQA Web Resources and FAQs

- **Worked with AAP to publish FAQs for Pediatric Practices**
- **Use of NCQA DRP and HSRP for PCMH 2011 are covered in an FAQ**
- **ABFM offers credit for PCMH 2011 Level 2 or 3 Recognition towards the physicians Part IV Maintenance of Certification**
- **Other Medical Home Resource links on NCQA's web site show many organizations with toolkits, guides, templates, eg. www.medicalhomeinfo.org**

NCQA Web Resources

A Video Guide for NCQA PCMH Recognition

NCQA worked with Merck to create this PCMH Transition video for clinicians, who are interested in PCMH Recognition.



Standard 3:
Plan and Manage Care¹

- A. Implement Evidence-Based Guidelines
- B. Identify High-Risk Patients
- C. Manage Care***
- D. Manage Medications
- E. Electronic Prescribing

*Must Pass Element

Share More info

0:00 YouTube

Contact Information

Contact NCQA Customer Support to:

- Acquire standards documents, application account, and survey tools
- Questions about your user ID, password, access
- 1-888-275-7585

Visit GRIP Web Site to:

- View Frequently Asked Questions
- View Recognition Programs Training Schedule

Submit to questions to PCMH-GRIP@ncqa.org

Please use this e-mail box to:

- Ask about interpretation of standards or elements
- Request registration for ISS Survey Tool demonstration (Web-ex)

Q & A

- Mina Harkins and Tanya Medrano
 - National Committee for Quality Assurance

Resources

- 2013 National Health Care for the Homeless Conference & Policy Symposium
<https://www.nhchc.org/training-technical-assistance/2013-national-conference/>

- Publications
 - [*Anatomy of Implemenation:The Structural Framework for Meaningful Use of Electronic Medical Records*](#) | June 2012
 - [*Frequently Asked Questions: Patient-Centered Medical Home for Health Care for Homeless Projects*](#) | 2012
 - [*Healing Hands: Pursuing National Quality Recognition*](#) | Spring 2012

- Webinars
 - [*Leading Transformation to a Patient Centered Medical Home*](#) | November 2012
 - [*Moving Forward with Meaningful Use in the HCH Setting*](#) | November 2012
 - [*Ready, Set, Go:The Road to Meaningful Use of HER*](#) | May 2012

For more information about the National HCH Council

- Contact us at council@nhchc.org.
- Other educational opportunities including technical assistance and regional trainings can be found online at www.nhchc.org.