Welcome

Leading Transformation to a Patient-Centered Medical Home

Thursday, November 15, 2012

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

Event Host:

Melissa DaSilva, MS, RN
Deputy Director
National Health Care for the Homeless Council

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Leading Transformation to a Patient-Centered Medical Home

November 15, 2012
Presenters

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Leading Transformation to a Patient Centered Medical Home

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HRSA National Quality Recognition
Initiatives Resources

Accreditation Association for Ambulatory Health Care (AAAHC) Accredited

Joint Commission Designated

NCQA Recognized
NCQA Patient Centered Medical Home Standards

- Access
- Quality Improvement Measures
- Population Management
- Patient Tracking
- Plan and Manage Care
- Self Care and Community Resources
Roles of Team Members

- Provider
- LPN
- Clinical Assistant
- Patient Representative
- Patient Care Partners

- All clinical assessment, evaluation, treatment and care is managed through the partnership between provider and patient.

- Vitals
- Smoking and PHQ assessment
- Referrals to HRHCare classes

- Self Management
- Clinical management questions
- Goal assessment
- Review and management of treatment plan
- Use of registries for planned care visits

- Use of interface between EHR and health center staff.

- Care Manager
- Patient
- Past
- Patient Care Partner

- Medication Management
- Review of referrals
- Instruction on self-management

- Assistance with translation, transportation, appointments with referrals; PAP; diagnostic tests
- Dietitian referrals

- External Lab
- Behavioral Health
- Specialists
- Dietitian
- Pharmacy

- Evaluation, assessment and counseling of patients
- Self management

- Assessment, Evaluation, and Nutrition Counseling
- Self management support for patients

- Medical Provider
Challenges in HCH Population

- Identification and management of mental illness/addiction/cognitive dysfunction
- Management of transitions of care (respite)
- Care coordination and Team based care
- Complex co-morbidities
- Pharmacologic Management: access and adherence
Patient Engagement
Opportunities through Meaningful Use of HIT

**Improve Quality and Safety**
- Utilize clinical decision support within EMR to prompt clinicians
- Utilize quality measurement capability to track adherence, and to evaluate impact

**Engage Patient and Families**
- Utilize patient engagement technologies to assist them in managing their health

**Improve population and public health**
- Utilize aggregate patient level data to identify population level strategies
MU along the spectrum of PCMH

1. Just beginning the PCMH journey, no tech in place
   - MU can be used to ‘jump-start’ PCMH efforts by acquiring the necessary technology
   - MU incentive money can help finance PCMH efforts

2. Designated, but don’t have all the tech in place – or aren’t fully utilizing the tech.
   - MU can be used to fully understand and use the technology you’ve invested in
   - * MU incentive money can help finance PCMH efforts.

3. PCMH designated
   - MU can be used to investigate how to use technology even further to achieve efficiencies in your practice that automate processes critical to PCMH.
   - * MU incentive money can help finance PCMH efforts.
Alignment with organizational priorities is a great place to start.

### PCMH 2011 Draft Standards

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Set</th>
<th>Component</th>
<th>Ind #</th>
<th>GPRO #</th>
<th>Measure</th>
<th>Dept</th>
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</thead>
<tbody>
<tr>
<td>2B</td>
<td>Identify and Manage Patient Populations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2B - 1</td>
<td>Uses nationally standardized codes for patients, clinicians and clinical data, including medication and allergy data</td>
<td>Core</td>
<td>Active Problem, Med, and Med Allergy Lists as structured data</td>
<td></td>
<td></td>
<td>Notes documented/signed within required timeframe</td>
<td>Various 75% &gt;80% 85%</td>
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<tr>
<td>2B - 2</td>
<td>Documentation of age-appropriate preventive services [NCCDA will specify based on USPSTF recommendations]</td>
<td>Menu</td>
<td>Preventive and F/U reminders</td>
<td>112</td>
<td>Prev-5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2B - 3</td>
<td>Documentation of results of screenings and risk factor assessments</td>
<td>Core</td>
<td>Smoking Status</td>
<td>114</td>
<td>Prev-8</td>
<td>Notes documented/signed within required timeframe</td>
<td>Various 75% &gt;20% of 25+ 75 years old 85%</td>
</tr>
<tr>
<td>2B - 4</td>
<td>Allergies and adverse reactions</td>
<td>Core</td>
<td>Active Med Allergy List, Drug-Drug/Allergy Checks</td>
<td></td>
<td></td>
<td>Documented in record</td>
<td>Medicine 75% &gt;80% 85%</td>
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<td>2B - 5</td>
<td>Blood pressure with date of update</td>
<td>Core</td>
<td>Vitals Charted</td>
<td>117</td>
<td></td>
<td>DTN-1</td>
<td>Pediatrics 75% &gt;50% 85%</td>
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<tr>
<td>2B - 6</td>
<td>BMI (N/A for pediatric practices)</td>
<td>Core</td>
<td>Vitals Charted</td>
<td>118</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2B - 7</td>
<td>Length, weight, head circumference plotted on growth chart for ≤ 2 years of age (N/A for adult practices)</td>
<td>Core</td>
<td>Vitals Charted</td>
<td>119</td>
<td></td>
<td>Weight documented</td>
<td>Pediatrics 75% &gt;50% 85%</td>
</tr>
<tr>
<td>2B - 8</td>
<td>BMI percentile plotted on growth chart for 2 – 17 years (N/A for adult practices)</td>
<td>Core</td>
<td>Vitals Charted</td>
<td>120</td>
<td></td>
<td></td>
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<td>2B - 9</td>
<td>Lists of prescription medications with date of updates</td>
<td>Core</td>
<td>Vitals Charted</td>
<td>121</td>
<td></td>
<td></td>
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<tr>
<td>2B - 10</td>
<td>Lists of over-the-counter medications with date of updates</td>
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<td>Vitals Charted</td>
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<tr>
<td>2B - 11</td>
<td>Lists of supplements and alternative therapies with date of updates</td>
<td>Core</td>
<td>Active Med List</td>
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<td></td>
<td>Antibiotics/DVT prophylaxis documented</td>
<td>Various 75% &gt;80% 85%</td>
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<tr>
<td>2B - 12</td>
<td>Laboratory test results</td>
<td>Menu</td>
<td>Lab Results</td>
<td>124</td>
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<td>Process TAT</td>
<td>Path/Lab Med 75% &gt;40% 90%</td>
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<td>2B - 14</td>
<td>Care in other facilities and dates</td>
<td>Menu</td>
<td>Transition Summary</td>
<td>125</td>
<td></td>
<td>D/C Summaries completed within required timeframe</td>
<td>Various 75% &gt;50% 85%</td>
</tr>
</tbody>
</table>

### Comprehensive Health Assessment

| 2C - 3 | Medical history of patient and family                                      | Core | Updated Problem List                          | 126   |       |                                              |               |
| 2C - 4 | Advance care planning (N/A for pediatric practices)                        | Menu | Adv Directives (Hosp only)                    | 127   |       |                                              |               |
| 2C - 5 | Depression screening for patients with chronic conditions using a standardized tool | Core | Decision Support Rule                          | 128   |       |                                              |               |
| 2C - 6 | Behaviors (smoking, nutrition, physical activity, dental care) and family risk factors (e.g. second hand smoke) | Core | Record Smoking status                         | 129   |       |                                              |               |
| 2C - 7 | Patient and family mental health/substance abuse (stress, alcohol, prescription drug abuse or illicit drug use, maternal depression) | Core | Updated Problem List                          | 130   |       | Documented in record                         | Psychiatry 75% >80% 85% |
Implementation guides

Empanelment
Team Based Healing Relationships
Patient Centered Interactions
Engaged Leadership
QI Strategy
Enhanced Access
Care Coordination
Organized, Evidenced Based Care
Change Care Delivery  
Reducing Barriers to Care

Patient-Centered Interactions  
Organized, Evidence-based Care  
Enhanced Access  
Care Coordination

Continuous team-based relationships  
Empanelment

Engaged Leadership  
Quality improvement strategy

Laying the Foundation
The Mission of CNHC

Is to serve the community through services that improve the health of families including people experiencing financial, social or cultural barriers to health care…
CNHC Clinical Sites

- West Side Health Center
- East Central Health Center
- Columbus North East Health Center
- JM South Side Health Center
- St. Stephens Health Center
- Mary Haven
- CNHC at Columbus Public Health
CNHC Demographics

6.50% Homeless
13.72% Public housing
79.78% Non homeless

Homeless = 1702
Public housing = 3591
Non Homeless = 20880
Total = 26173
PCMH - Principles

- One stop service center for all medical needs
- Continuity of care with same provider
- Same day appointment(s)
- Quality Care
“Look across the community at people who go to the hospital but are not able to pay”

PCMH helps us to provide care for patients who may otherwise require several days of hospitalization

How can you invest $2 to save $10?
Implementation Steps

1. Understanding the PCMH concept, followed by motivation and commitment to change.

2. Time demands of PCMH implementation - Define timeframe for the project.

3. Designated individuals to become “PCMH experts” by attending education sessions.

4. Regular meetings to evaluate implementation progress and continued efforts on developing team approach.

5. Using technology to enhance patient experiences.
January
• Identification of three conditions
• Completes initial audit as a baseline
• Evaluate current policies compared to NCQA criteria and current treatment guidelines.

February
• Policies are developed and reviewed on Access and Communication
• Identify practice lead
• Identify documentation updates that are needed to capture such as language, age related screenings/immunizations.

March
• Identify job descriptions, roles and responsibilities.
• Identify measures of performance current and/or areas practice will set target/actions needed.
• Identify current patient satisfaction survey process and if it captures the PCMH/NCQA area.

April
• Assure capability and process for test and referral tracking
• Run baseline report on access and communication policies.
• Combine all practice policies into one document.

May
• Capture screen shots for basic system; preventative clinical reminders
• Complete basic system reports
• Report on policy implementation and documentation on care management

June
• Complete and send in application to NCQA for approval
• Send all documents as complete to practice coach for review and feedback
• Load documents to the survey tool for submission.
Clinical Indicators

![Geriatric Immunizations Chart]

- **2009**: Target 70, Achievement 5
- **2010**: Target 70, Achievement 39
- **2011**: Target 70, Achievement 59

Columbus Neighborhood Health Center, Inc.
Barriers...

• Communication- Lack of understanding of changes, purpose and value
• Time Involvement
• Inadequacy – Worry over meeting new goals and expectations
• Policy Changes - e.g. Same day appointments
• New Protocols, processes and job descriptions
• Resistance to Collaboration
• Fear- Wanting to avoid the unknown
• Control – Personal agendas
• Inconsistency – in how staff members understand the medical home philosophy, adopt patient-centered processes and present the PCMH message to each other and beyond the practice
Solutions

1. Education on PCMH to Leadership and knowledge gaps
2. Embedding evidence-based guidelines into care
3. Reminders on preventative measures
4. After visit summary
5. Creating a patient-centered care process
6. Leadership Development and the dynamics of team approach to care
7. Use of Data, culture change enable practice transformation
Key to Success

1. Extended Awareness
   - Board Members
   - Leadership team
   - Clinical staff
2. Prioritizing the tasks
   - Following the deadlines on monthly basis
   - Dedicated team members
   - Team members well versed with EHR
3. Robust QI Plan
   - Annual Report and Quarterly reports shared with the staff
   - Patient Satisfaction Surveys
Next Steps – Care Coordination

1. Patient Navigation Center
   a. *Eliminate barriers to care* - To ensure that patients get to follow-up appointments, and can access needed services
   b. *Ensure timely delivery of services* - Assist patients in moving through the health care system as needed in a timely manner

2. Modified Open Access
   a. No-show rates decreases
   b. Continuity preserved since primary care physician has daily open appointments

3. Medication Therapy Management
Q&A

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Health Care and Housing are Human Rights
Resources

- National HCH Council Webinars
  - PCMH: Introduction to Concept
    http://www.nhchc.org/2012/01/patient-centered-medical-home/
  - Steps to NCQA Recognition for PCMH

- National HCH Council Publications
  - FAQs: PCMH for HCH Projects
  - Healing Hands: Pursuing National Quality Recognition

- Other PCMH & MU publications, webinars, and case studies
  https://www.nhchc.org/resources/general-information/health-care-reform/
Resources

- **National Health Care for the Homeless Conference**
  - Washington, D.C.
  - March 14-16, 2013
  - Workshops include “the ABCs of PCMH” and more

- **Upcoming Regional Training**
  - Morristown, NJ
  - May 2013
  - Workshops focused on PCMH and MU
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.