Patient Centered Medical Home: Connecting the Dots to Access, Quality, and Cost

SC PCA Clinical Network Retreat
June 8-10, 2012

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Primary Health Care Mission

Improve the health of the Nation’s underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services

Learning Objectives

Understand:
1. The National Quality Strategy
2. The Bureau of Primary Health Care Quality Strategy;
3. Key concepts of the PCMH model;
4. The components of the PCMH model, paths to PCMH recognition, and processes available to support health centers through transformation;
5. How the PCMH model supports the number of quality initiatives and activities within the Bureau;
6. How PCMH leads to enhanced access, improved quality, and reduced cost in health centers.

BPHC Quality Strategy

Better Care Healthy People & Communities Affordable Care

1. Implementation of QA/QI Systems
   All Health Centers fully implement their QA/QI plans
2. Adoption and Meaningful Use of EHRs
   All Health Centers implement EHRs across all sites & providers
3. Patient Centered Medical Home Recognition
   All Health Centers receive PCMH recognition
4. Improving Clinical Outcomes
   All Health Centers meet/exceed HP2020 goals on at least one UDS clinical measure
5. Workforce/Team-Based Care
   All Health Centers are employers/providers of choice and support team-based care

Patient Centered Medical Home

PCMH

Components

Connect the Dots

Process

South Carolina Patients - 2010

Health Center Snapshot

<table>
<thead>
<tr>
<th>No. of Patients</th>
<th>Male Patients %</th>
<th>Female Patients %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>312,135</td>
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</tbody>
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Age 85 and Over 9%
Age <= 19 33%
Age 20-64 58%
Age 65 and Over 9%

INTEGRATED HEALTH SYSTEM
INTEGRATED SERVICES
COMPREHENSIVE SERVICES
ACCESS

Priorities & Goals

1. Implementation of QA/QI Systems
   All Health Centers fully implement their QA/QI plans
2. Adoption and Meaningful Use of EHRs
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Components of PCMH

- Empanelment
- Continuous and Team-based Healing Relationships
- Patient-Centered Interactions
- Engaged Leadership
- Quality Improvement (QI) strategy
- Enhanced Access
- Care Coordination
- Organized, Evidence-Based Care

Why PCMH?

- Demonstrates the quality of care provided in health centers and provides opportunity for continuous quality improvement.
- Positions health centers at an advantage for the changing health care landscape.
- Investment in the health center workforce through reduced staff turnover and improved recruitment.
- Transforms patient care to help health centers achieve the three part aim of: better care, better health and communities, and affordable care.

The Patient Centered Medical Home

- BPHC Quality Strategy Priority Goal 3: Patient Centered Medical Home Recognition
  - All Health Centers receive PCMH recognition
- HHS Priority Recognition Goal
  - Goal: 25% of grantees recognized by 9/30/2013
  - Goal: 13% of grantees recognized by 12/31/2012
- HRSA investments in the patient centered medical home
  - Patient-Centered Medical Health Home Initiative
  - Accreditation Initiative
  - PCMH Supplemental funds
  - Partnership with the CMS Primary Care Demonstration
Paths to PCMH Recognition

• Many entities across the country are embracing the PCMH model:
  – Private Payers: Blue Cross Blue Shield, United Health Care, etc.
  – States: Oregon & Minnesota
• HRSA supports 2 initiatives to assist grantees with the survey costs and assistance in achieving PCMH recognition.
  – The Accreditation Initiative: The Accreditation Association for Ambulatory Health Care & The Joint Commission
  – The Patient Centered Medical Health Home Initiative: National Committee for Quality Assurance

Many Paths to PCMH

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Paths Available Through HRSA

<table>
<thead>
<tr>
<th>AAAHC</th>
<th>The Joint Commission</th>
<th>NCQA</th>
</tr>
</thead>
<tbody>
<tr>
<td>‣ Patient and provider relationship</td>
<td>‣ Patient-Centeredness</td>
<td>‣ Plan and Manage Care</td>
</tr>
<tr>
<td>‣ Accessibility</td>
<td>‣ Easy Access to Care</td>
<td>‣ Enhance Access and Continuity</td>
</tr>
<tr>
<td>‣ Comprehensive care</td>
<td>‣ Comprehensive Care</td>
<td>‣Track and Coordinate Care</td>
</tr>
<tr>
<td>‣ Continuity of care</td>
<td>‣ Coordinated Care</td>
<td>‣ Identify and Manage Patient Populations</td>
</tr>
<tr>
<td>‣ Quality</td>
<td>‣ System-based Performance</td>
<td>‣ Measure and Improve Performance</td>
</tr>
</tbody>
</table>

The Process

PCMH Process

I Want to Join a HRSA Initiative, Now What?

• HRSA supports 2 federal initiatives to support health centers in achieving PCMH recognition.
  • Submit a Notice of Interest/Intent (NOI) to the respective Initiative
    – HRSA Accreditation Initiative
      o AAAHC and The Joint Commission
      o E-mail: AccreditInit@hrsa.gov
      o http://bphc.hrsa.gov/policiesregulations/accreditation.html
    – HRSA Patient Centered Medical Home Initiative
      o National Committee for Quality Assurance (NCQA)
      o E-mail: PCMHInitiative@hrsa.gov
      o http://bphc.hrsa.gov/policiesregulations/pal201101.html

HRSA PCMHHI Recognition Process

NOIs → HRSA → Accrediting or Recognizing Organization → Surveys Completed → Recognized

- HRSA Accreditation
- HRSA PCMHHI State/Payer

- CMS Demo

- NCQA Recognized Level III

- 12 Months
- 36 Months
Practice Transformation

- **Health center program requirements align with PCMH transformation efforts**
- **Practice transformation is a process that takes time**
  - Experience from HRSA PCMHH: 12-18 months to transform practice
- **Before you begin complete a Readiness Assessment**
  - Many available online for free!
    - PCDC, Safety Net Medical Health Home Initiative, etc.
- Assemble a multi-disciplinary PCMH Team
  - Staff that understand the clinical and operational systems

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**Tips From Grantees**

- “Spend some time understanding the standards. Review the standards and do an evaluation of your readiness before beginning the process.”

- “Use your partners and colleagues in the Health Center world who have done this for advice.”

- “You can get recognized without an EMR but it makes it a lot harder. Work on implementing your EMR first.”

- “Build a solid multi-disciplinary team, (nursing, care management, human resources rep. etc.), that has protected time to meet on a regular basis.”
Patient Centered Medical Home and EHR Implementation

- BPHC Priority & Goal 2:
  - Adoption and Meaningful Use of EHRs
    - All Health Centers implement EHRs across all sites & providers
- NCQA 2011 Standards align with State 1 Meaningful Use Requirements (Core and Menu)

<table>
<thead>
<tr>
<th>South Carolina</th>
<th>No EHR</th>
<th>EHR at Some Sites</th>
<th>EHR at all Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>45%</td>
<td>40%</td>
<td>15%</td>
</tr>
<tr>
<td>2011</td>
<td>40%</td>
<td>15%</td>
<td>45%</td>
</tr>
</tbody>
</table>

- NCQA 2011 Standards align with State 1 Meaningful Use Requirements (Core and Menu)

25 South Carolina

- No EHR
- EHR at Some Sites
- EHR at all sites

2010 45% 40% 15%
2011 40% 15% 45%

Patient Centered Medical Home and Quality Improvement

- PCMH 6: Measure and Improve Performance
  - Practice measures and receives data on the following measures:
    - Minimum 3 preventive care measures
    - Minimum 3 chronic or acute care measures
- BPHC Priority & Goal 4:
  - Improving Clinical Outcomes
    - All Health Centers meet/exceed HP2020 goals on at least one UDS clinical measure

Changes to CY 2012 UDS:
1. New staff tenure table;
2. Three new clinical measures;
   - Coronary Artery Disease (CAD): Lipid Therapy
   - Ischemic Vascular Disease (IVD): Aspirin Therapy
   - Colorectal Cancer Screening
3. Reporting on all (versus primary) diagnoses for selected conditions; and
4. Questions about electronic health record capabilities and national quality recognition

Refer to the UDS website for more information:
http://bphc.hrsa.gov/healthcenterdatastatistics/index.html

Patient Centered Medical Home and Quality Improvement

- BPHC Priority 1:
  - Implementation of QA/QI Systems
    - All Health Centers fully implement their QA/QI plans
- FTCA Deeming Application enhancements
- Focus is on implementation of risk management and quality improvement systems
- FTCA site visits
- Risk Management Training and Technical Assistance Available - https://www.ecri.org/clinical_rm_program
- FTCA Claims Management

Patient Centered Medical Home Recognition: Supplemental Funding South Carolina Awardees

- Open to all 330 grantees
- 904 Health Centers funded across the U.S.
  - 15 (75%) Grantees in funded in South Carolina

- BEAUFORT-JASPER COMPREHENSIVE HLTH. SERVICES, INC.
- BLACK RIVER HEALTHCARE, INC.
- CARE SOUTHERN CAROLINA, INC.
- CAROLINA HEALTH CENTERS, INC.
- EAU CLAIRE COOPERATIVE HEALTH CENTER, INC.
- FAMILY HEALTH CENTER, INC.
- FRANKLIN C. FETTER FAMILY HEALTH CENTER
- HOPE HEALTH, INC.
- LITTLE RIVER MEDICAL CENTER, INC.
- LOW COUNTRY HEALTH CARE SYSTEM, INC.
- NEW HORIZON FAMILY HEALTH SERVICES, INC.
- RICHLAND COMMUNITY HEALTH CARE ASSN
- RURAL HEALTH SERVICES, INC.
- SANDHILLS MEDICAL FOUNDATION, INC.
- ST. JAMES-SANTEE FAMILY HEALTH CENTER, INC.
Patient Centered Medical Home Recognition: Supplemental Funding Domains of Focus

- Enhanced Access & Continuity
- Identity & Quality Management
- Planning & Managing Care
- Providing Staff Care & Community Support
- Measuring & Improving Performance

Patient Centered Medical Home Recognition: South Carolina Advance Primary Care Demonstration Enrollees

- Beaufort Jasper Hampton Comprehensive
- New Horizons Family Health Services
- Sandhills Medical Foundation

Patient Centered Medical Home Recognition: South Carolina PCMHHI Participants

- Eau Claire Cooperative Health Center, Inc.
- Rural Health Services, Inc. d/b/a/ Margaret J. Weston Community Health Centers
- Sandhills Foundation, Inc.

Patient Centered Medical Home Recognition: Resource to Help You Decide

- PCMH Comparison Chart
- Fact Sheet: Quality Improvement Initiatives Available to HRSA Supported Health Centers

Patient Centered Medical Home and Cost Savings

- Changing Payment Models
  - Accountable Care Organization, CMS Demonstration, Various state and private payer pilots
- Increase in staff and provider satisfaction
  - Reduced staff turnover and improved recruitment
- BPHC Priority Goal 5:
  - Workforce/Team-Based Care
    - All Health Centers are employers/providers of choice and support team-based care
- Cost savings for payers and communities
  - Preliminary research shows 15%-20% reduction in total healthcare spending

Source: Engaged Leadership - Strategies for Guiding PCMH Transformation from Within
PCMH Supports Shared Accountability for Quality in Health Centers

Health Centers
- NCAs
- PCAs
- HCCNs

Project Officers
- Site Visits – integration and support of Quality Priorities (with Consultants)
- UDS Data and Performance Reports
- Annual Progress Reviews
- Discuss Quality Priorities and progress during quarterly calls

Summary
PCMH is a health care delivery model that:
- Aligns with the health center program requirements.
  - Enhanced Access & Comprehensive Services
- Supports the implementation and meaningful use alignment of EHR.
  - Tracking and Coordinating Care
  - Using Data to Manage Populations & Performance Improvement
- Requires a functioning QA/QI system for continuous QI
  - Made easier with a functional EHR
- Results in system & infrastructure changes that demonstrate full transformation to a PCMH
- 100% PCMH recognition in health centers ultimately leading to cost savings

Contact Information
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301-443-1921

Better Care Healthy People & Communities Affordable Care

Quality Improvement Resources
- National Quality Recognition
  - Accreditation: http://bphc.hrsa.gov/policiesregulations/accreditation.html
    - AAAHC, TJC
  - NCQA recognition: http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html
- ECRI Institute Resources
  - Available to all Health Centers and FQHC LALs
    - HRSA
      - FTCA Resources http://bphc.hrsa.gov/ftca/index.html
      - HIV/AIDS Bureau Quality Resources http://www.aids.gov/resources
      - Safety Net Medical Home Initiative http://www.qhmedicalhome.org/safety-net/qistrategy.cfm

Quality Improvement Resources
### HIT Resources

  - HIT Health IT Adoption Tool Boxes: [http://www.hrsa.gov/healthit/](http://www.hrsa.gov/healthit/)
- The Office of the National Coordinator for Health Information Technology: [http://healthit.hhs.gov/](http://healthit.hhs.gov/)
  - HIT Regional Extension Center program: [http://www.pcpcc.net/content/pcmh-outcome-evidence-quality](http://www.pcpcc.net/content/pcmh-outcome-evidence-quality)

### Data Resources

- **HRSA Data Warehouse**: [http://hrsrcwCorp.arsic.gov/](http://hrsrcwCorp.arsic.gov/)
- **Public site for UDS Data**: [http://www.udsmapper.org/](http://www.udsmapper.org/)
- **UDS Performance Reports**: 
  - Health Center Trend Report (National/State/Grantee)
  - Health Center Summary Report (National/State/Grantee)
  - Performance Profile (National/State) – Performance on Key Indicators

### PCMH Resources

- **PCMH Readiness Assessment Tools**
  - **Primary Care Development Corporation (PCDC)**: [http://www.pcpcc.net/content/pcmh-outcome-evidence-quality](http://www.pcpcc.net/content/pcmh-outcome-evidence-quality)
  - **PCMH Assessment (PCMH-A) from the Safety Net Medical Home Initiative**: [http://www.safetynetmedicalhome.org/practice](http://www.safetynetmedicalhome.org/practice)
  - **Medical Home Implementation Quotient Assessment (MHIQ) from TransforMED**: [http://www.transformed.com/userLogin.cfm](http://www.transformed.com/userLogin.cfm)
- **Patient-Centered Primary Care Collaborative (PCPCC)**: [http://www.pcpcc.net/content/pcmh-outcome-evidence-quality](http://www.pcpcc.net/content/pcmh-outcome-evidence-quality)

### Behavioral Health Resources

- **Center for Integrated Health Solutions**:
  - Motivational Interviewing for Better Outcomes
  - Peer Support Wellness Respite Centers
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Clinical Settings
  - Person-Centered Health Homes
  - Introduction to Effective Behavioral Health in Primary Care
- **SAMHSA SBIRT page**: [http://www.ssbirt.org/SBIRT/](http://www.ssbirt.org/SBIRT/)