

HRSA Health Information Technology and Quality Webinar

**“Tips on Using Health IT Within A Patient
Centered Medical Home For The Safety Net
Community”**

Date: 6/24/2011

**US Department of Health and Human Services
Health Resources and Services Administration**

Office of Health Information Technology and Quality

Additional HRSA Health IT and Quality Toolboxes and Resources including past webinars can be found at:

<http://www.hrsa.gov/healthit>

<http://www.hrsa.gov/quality>

Additional questions can sent to the following e-mail address:

HealthIT@hrsa.gov

- US Department of Health and Human Services
- Health Resources and Services Administration

Upcoming HRSA Health IT and Quality Announcements

- **New Items to the HRSA Health IT Site:**
 - **New HRSA Quality Improvement Website**
 - **New HRSA Meaningful Use Stage 1 Clinical Quality Measures For the Safety Net Community Webpage**
 - **New Health IT and Quality Improvement Website Grantee Spotlights**
- **Two HRSA HIT and Quality webinars in July**
 - **“Mobile Health Clinics – Opportunities and Challenges” Fri, July 8th, 2011. 2pm EST.**
 - **“ Tips For Generating Quality Data Reports Using Health IT.” Fri, July 22nd, 2pm EST**
- **New HRSA Health IT and Quality Newsletter**
- **HHS Releases Prevention Strategy**

Introduction

Presenters:

- Lindsay Farrell, Open Door Family Medical Centers
- Dr. Victor Freeman, Medical Director, HRSA Office, Health Information Technology & Quality
- Bill Bolt, CIO/Practice Administrator, Spanish Peaks Regional Health Center



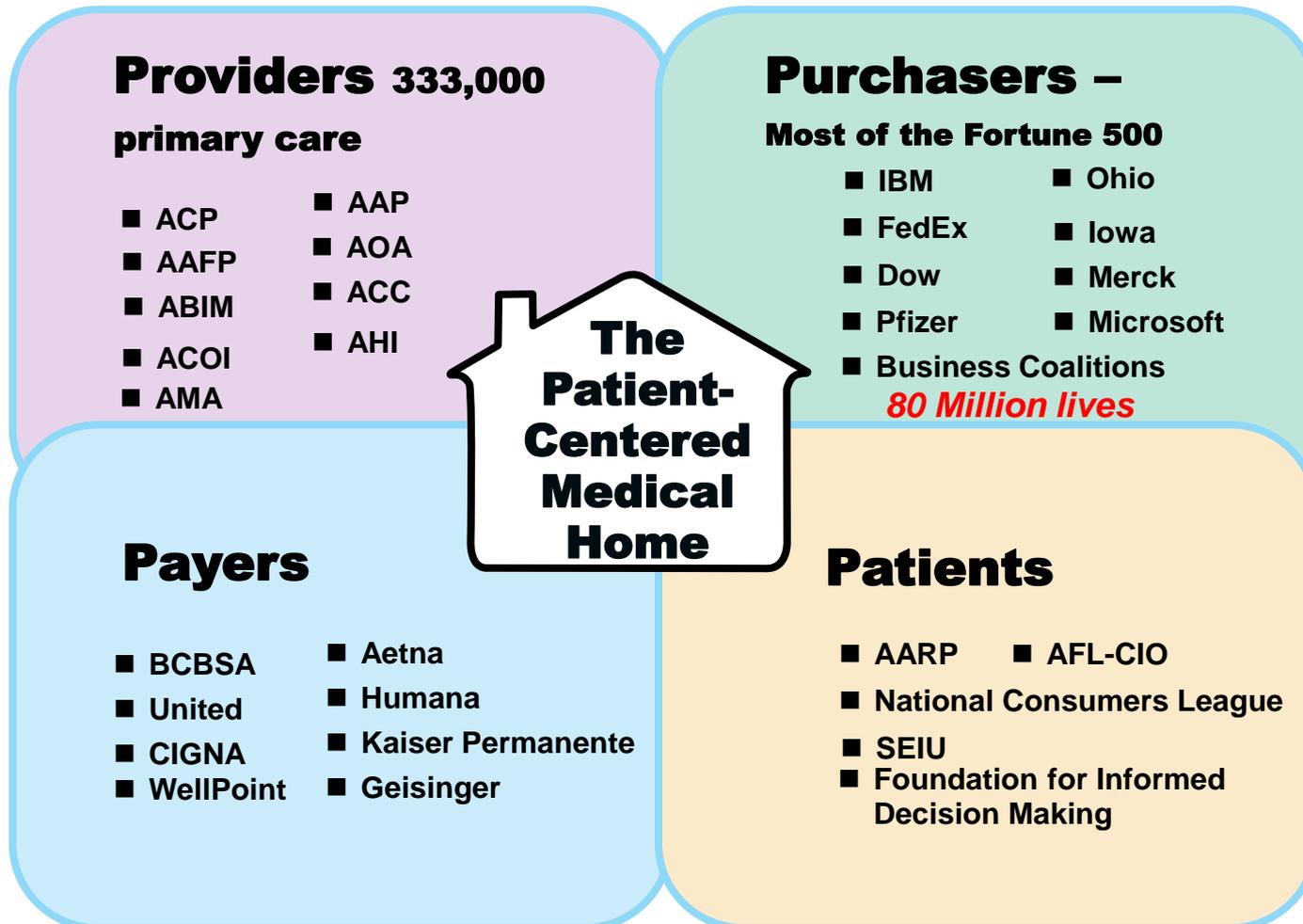
What IS A Patient-Centered Medical Home...?

Victor Freeman, MD, MPP
Medical Officer

U.S. Department of Health and Human Services
Health Resources and Services Administration
Office of Health Information Technology and Quality



Patient-Centered Primary Care Coalition (PCPCC)





History of The Medical Home Concept

- The first known documentation of the term---
“**Medical Home**” Standards of Child Health Care,
AAP in 1967 by AAP Council on Pediatric Practice--
“medical home” = one central source of a child’s
pediatric records”

History of the Medical Home Concept Calvin Sia, Thomas F. Tonniges, Elizabeth Osterhus and Sharon Taba Pediatrics 2004;113;1473-1478

- 2010 “Medical Home” Wikipedia page:
http://en.wikipedia.org/wiki/Medical_home



Joint Principles for PCMH (Feb 2007)

Agreed upon by 4 initial physician organizations:

American Academy of Family Physicians

American Academy of Pediatrics / American College of Physicians

American Osteopathic Association.

Principles:

Ongoing relationship with a Personal Physician

Physician directed medical practice / Whole person orientation

Coordinated care across the system / Quality and Safety Focus

Payment recognizes the value added / Enhanced access to care



Defining the Medical Home

Publicly Available Practice Information:

- *Patients have accurate, standardized information on physicians to help them choose a practice that will meet their needs*

Superb Access to Care:

- *Patients easily make appointments and select the day/time.*
- *Waiting times are short & Off-hour service is available.*
- *eMail and telephone consultations are offered.*

Clinical Information Systems:

- *Support quality care, practice-based learning & quality improvement.*
- *Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; receive reminders, decision support. Info. on recommended treatments.*



Defining the Medical Home (Cont'd)

Team Care:

- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals (including BH specialists).
- Duplication of tests and procedures is avoided.

Care Coordination:

- Specialist care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved.
- Follow-up and support is provided.



Defining the Medical Home (Cont'd)

Patient Engagement in Care:

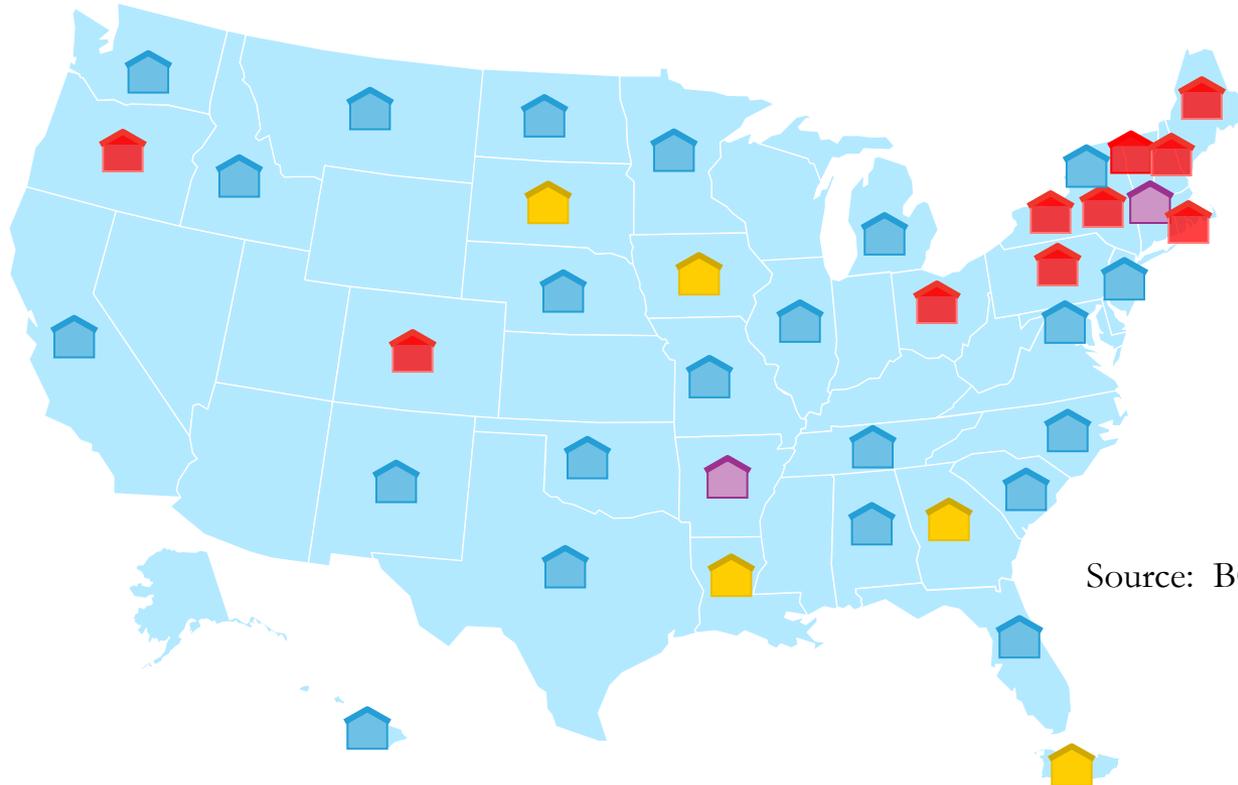
- Patients have option of being informed/engaged partners in their care.
- Practices provide information on treatment plans, preventative and follow-up care reminders, access to medical records, assistance with self-care, and counseling.

Patient Feedback:

- Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans.



Blue Cross Blue Shield Plan Initiatives (as of April 2011)



Source: BCBS (www.bcbs.com)



Pilots in progress



Pilot activity in early stages of development



Pilots in planning phase for 2011 implementation



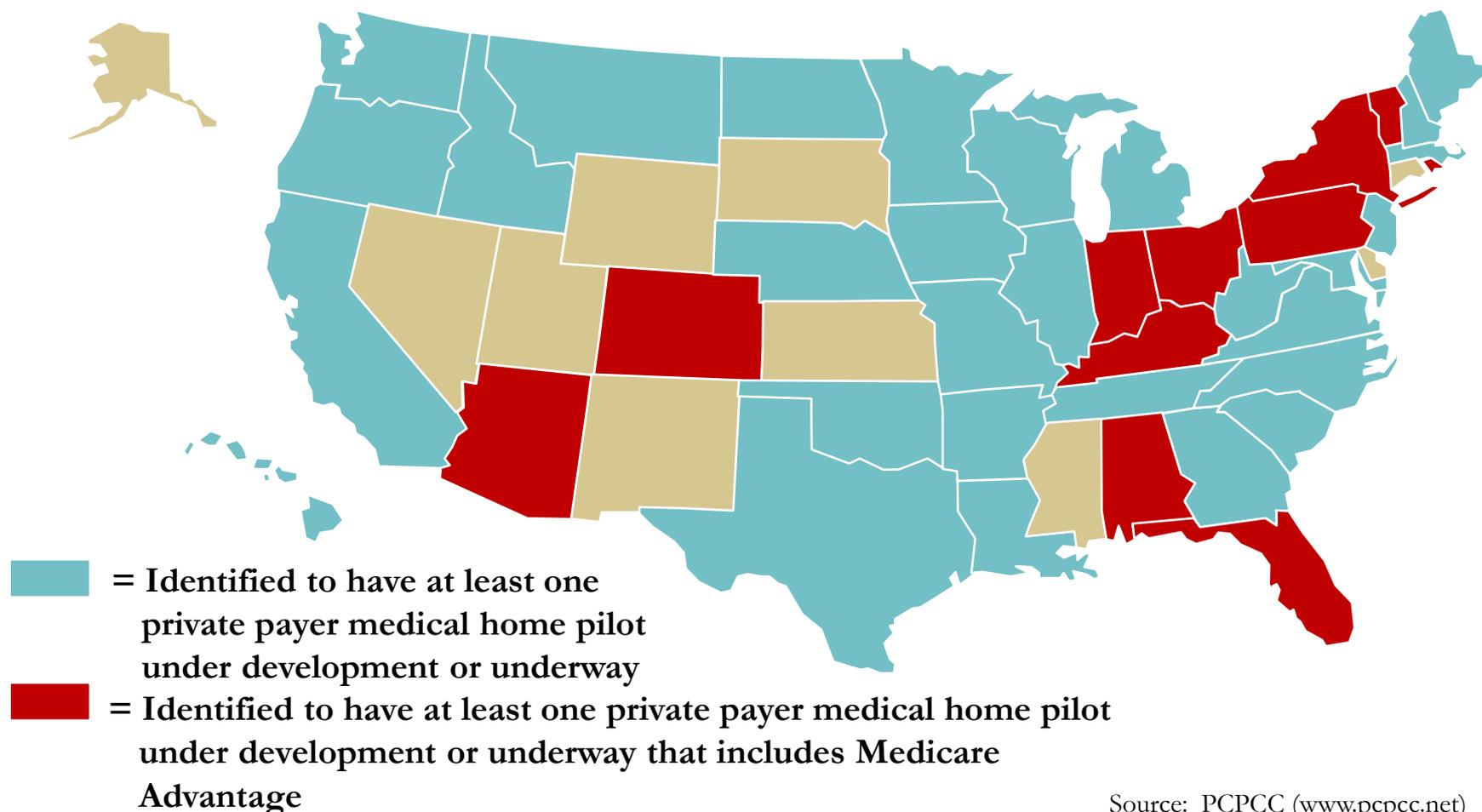
Multi-Stakeholder demonstration



**Additional
commercial PCMH
projects under
development or
underway in at least
21 more states:**

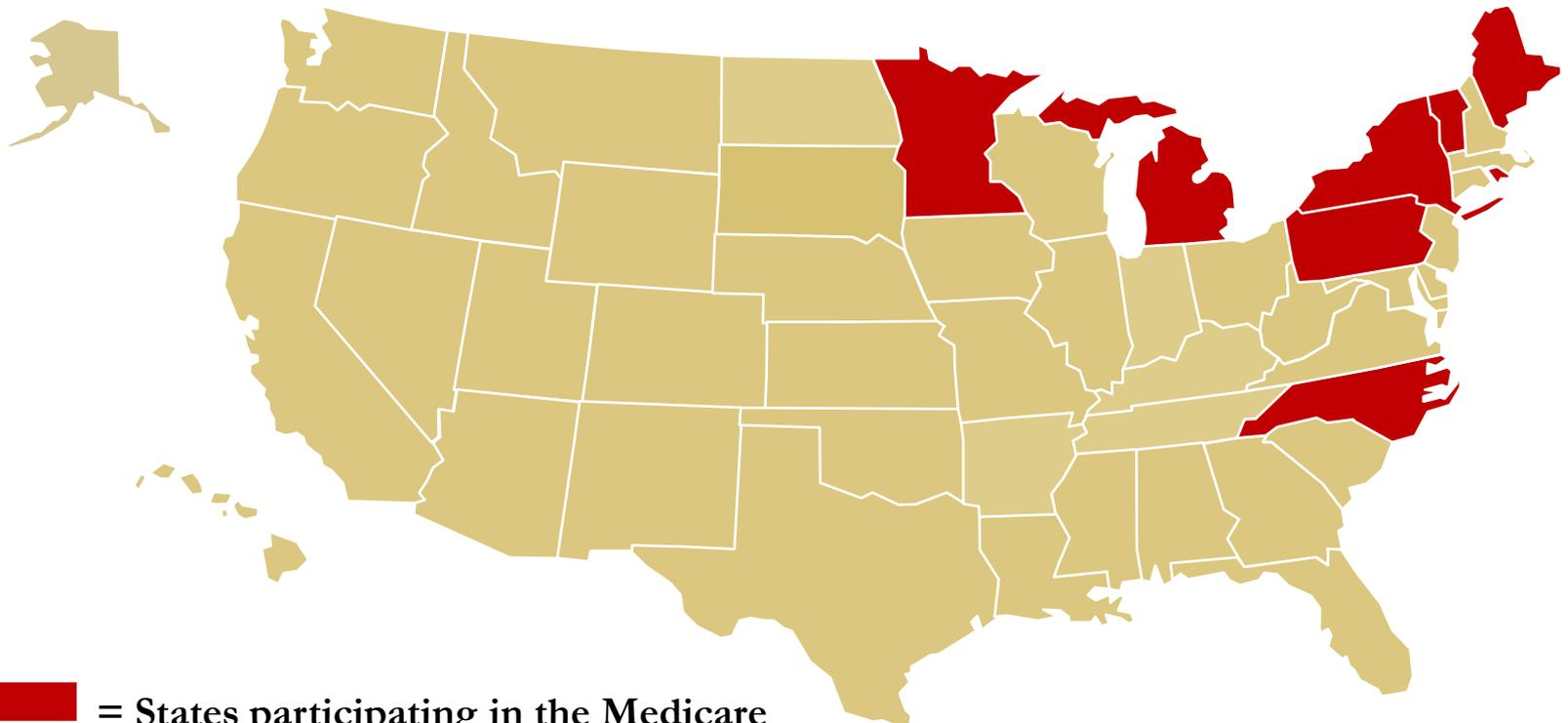
- Arkansas
- California
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Massachusetts
- Minnesota
- Missouri
- Montana
- Nebraska
- New Jersey
- North Carolina
- North Dakota
- Oregon
- South Carolina
- Tennessee
- Virginia
- Washington
- Wisconsin

Medicare Advantage Initiatives (in Red)





Medicare Multi-Payer Advanced Primary Care Initiative States

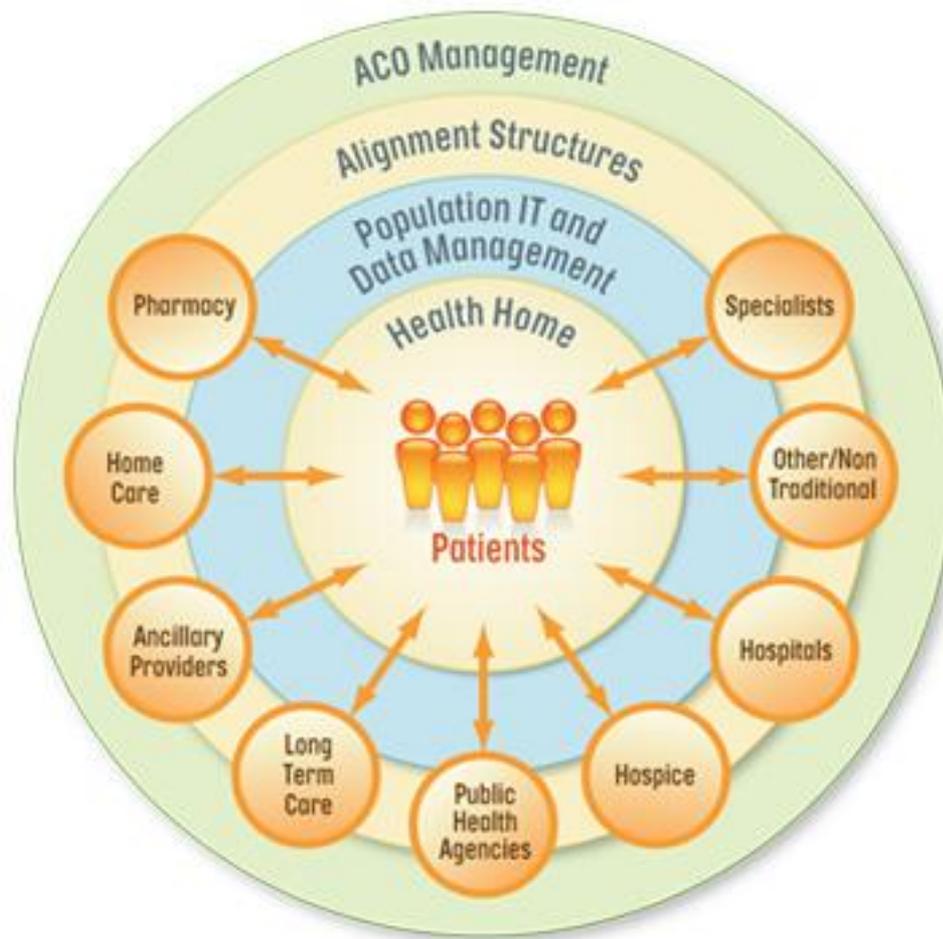


■ = States participating in the Medicare
Multi-Payer Advanced Primary Care
Initiative

Source: CMS, March 2011

(<http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=cms1230016>)

PCMH = Foundation for Accountable Care Organizations





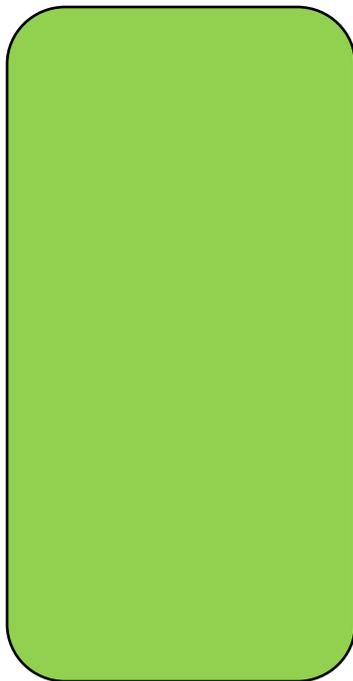
PCMH = Foundation for Accountable Care Organizations

ACOs are defined as a group of providers that has the legal structure to receive and distribute incentive payments to participating providers.

- The CMS Innovation Center announced on May 17, 2011 a new Pioneer ACO Model, which provides a faster path for mature ACOs.
- The Innovation Center has sought comment on the idea of an Advance Payment Initiative that gives certain ACOs participating in the Medicare Shared Savings Program access to their shared savings up front.



CURRENT STATE



FEE FOR SERVICE

\$0



CARE MGMT FEE (PMPM)

\$0



PAY FOR PERFORMANCE (BONUS)

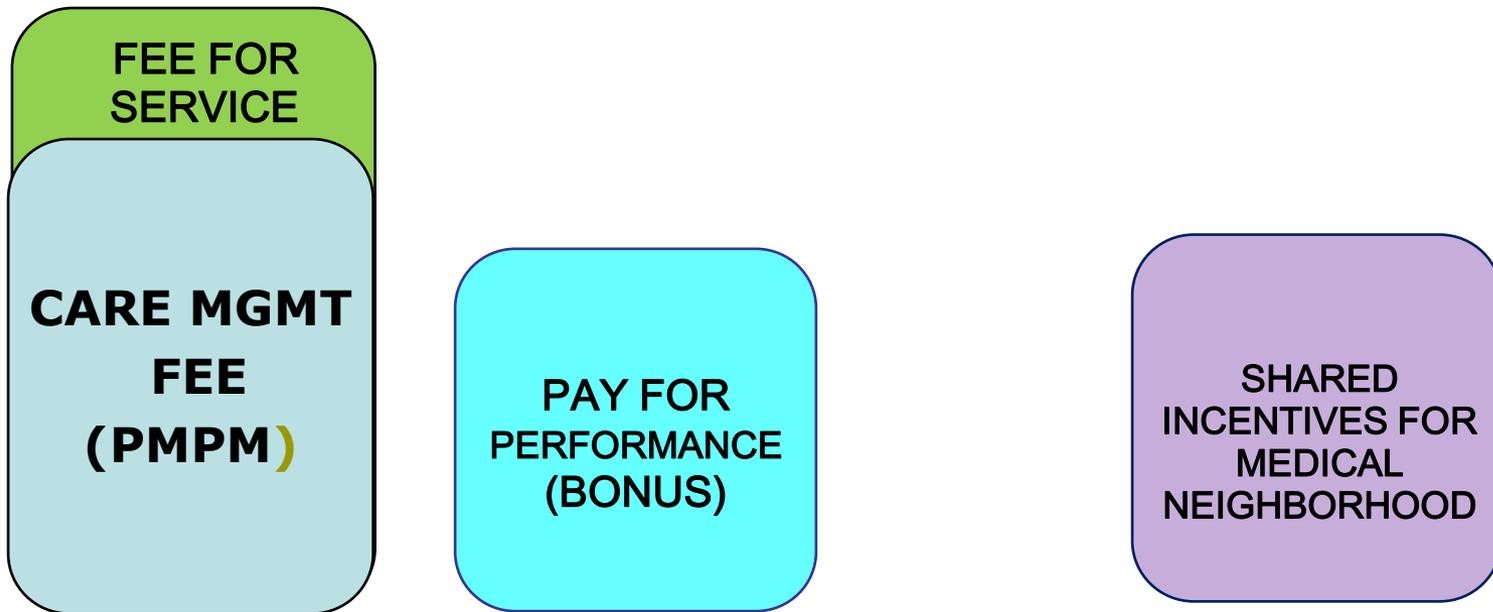
\$0



SHARED INCENTIVES FOR MEDICAL NEIGHBORHOOD



FUTURE STATE





Group Health Cooperative of Puget Sound

- 29% reduction in ER visits
- 16% reduction in hospital admissions
- Reduced cost

Geisinger Health System

- 18% decrease in hospital admissions
- Improvements in diabetes and heart disease care
- 7% reduction in costs



Veterans Health Administration

- Improved Chronic Disease treatments
- 27% reduction in ER visits & hospitalizations
- Lower median costs - veterans w/ chronic conditions (\$4,491 vs. \$5,084)

HealthPartners Medical Group MN

- 39% decrease in ER visits
- 24% decrease in hospital admissions
- Enrollment cost reduced to 92% of the state average



Intermountain Healthcare Medical Group Care Management Plus

- 39% Decrease in emergency room admissions
- 24% Decrease in hospital admissions
- Net reduction cost of \$640/patient and 1,650\$ among high risk patients

BlueCross BlueShield of SC-Palmetto Primary Care Physician

- 12.4% decrease in ER visits
- 10% decrease in hospital admissions
- Total medical and pharmacy costs were 6.5% lower



Medicaid Sponsored PCMH initiatives

- North Carolina: \$974.5 Million cumulative savings over 6 years and 16% lower ER visits
- Colorado: PCMH Children's annual median cost was \$2,275 compared to those not enrolled \$3,404

Miscellaneous PCMH Programs

- John Hopkins: 24% Reduction in total Inpatient days
- Genesee MI: 50% Reduction in ER visits
- Erie County: Organizational savings of 1\$ million per 1000 enrollees

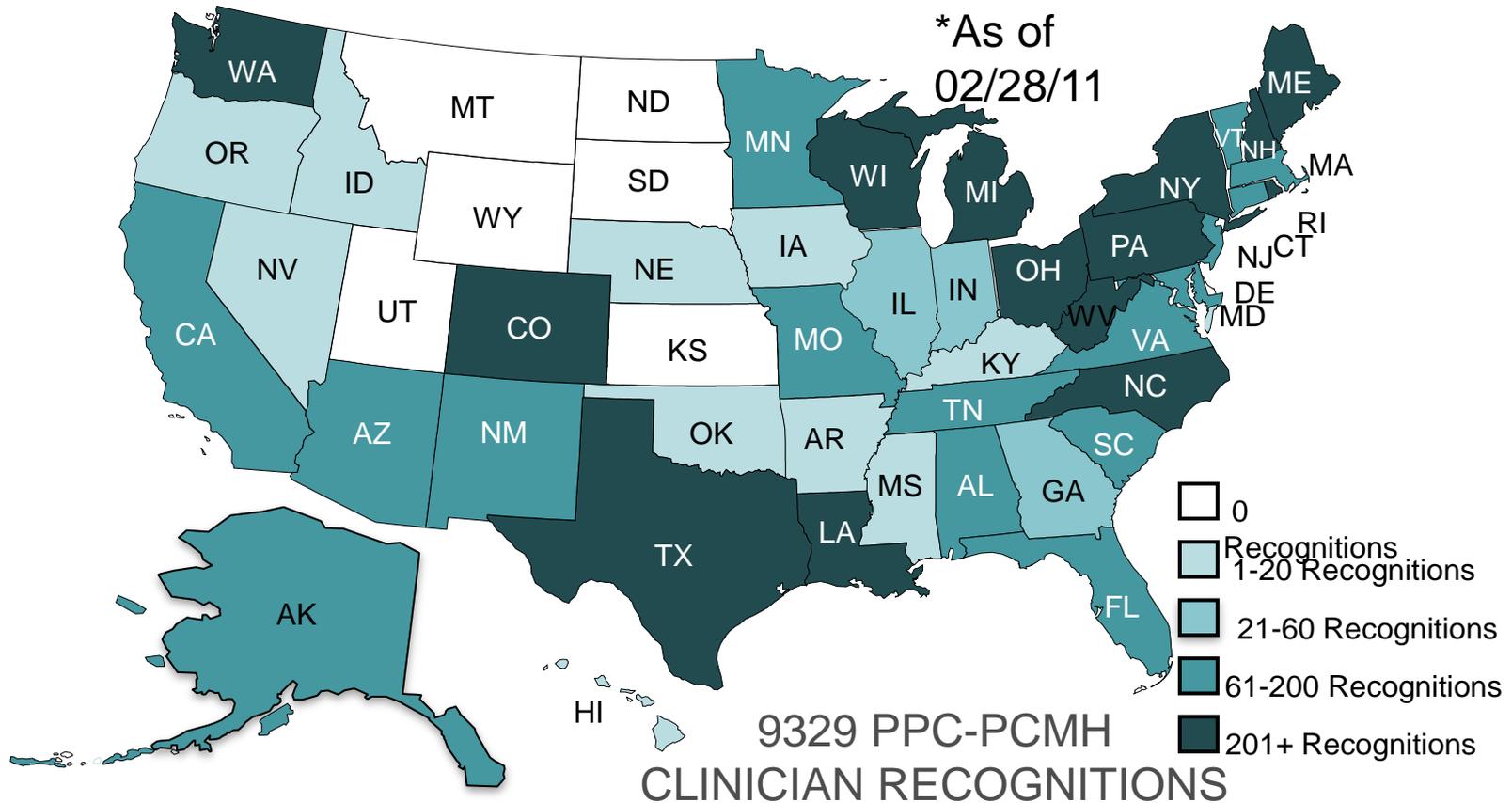


Patient-Centered Medical Homes...





NUMBER OF PPC-PCMH CLINICIAN RECOGNITIONS BY STATE





Federal Efforts in PCMH

Veterans Administration

- 820 primary care sites
- 4.5 million primary care patients

Department of Defense

- National Naval Medical Center PCMH Pilot
- Tri-Service Medical Home Summit
- “The PCMH model of care will be implemented across the Services” – MHS Policy Statement on September 18, 2009



HRSA Efforts in PCMHs

- Patient-Centered Med/Health Home Initiative (PCMHHI) with BPHC
 - Support FQHC recognition as PCMHs via NCQA
 - Support a “Culture of Quality” throughout FQHCs
 - Leverage Incentive payments for PCMHs and MU

NOTE: The PCMH model aligns with the quality initiatives BPHC is currently working on with FQHCs and also addresses many key FQHC program requirements.



HRSA Efforts in PCMHs

- PCMHHI (BPHC) cont'd...
 - Contract awarded Oct . 2010 – Covers NCQA fees
 - 125 Initial Sites - Education & Technical Assistance
 - 18 of 125 Initial sites - Achieved Level III Recognition
 - Will be adding 400 additional sites soon...
 - SEE: BPHC Program Assistance Letter (PAL)

<http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html>



HRSA Efforts in PCMHs

- PCMH via Accreditation (BPHC)
 - Accreditation: Thru The Joint Commission –or– Accreditation Association for Ambulatory Health Care
 - A Comparison Chart is available for the different types of accreditation (TJC vs AAAHC)
 - SEE: BPHC Program Assistance Letter (PAL)
<http://bphc.hrsa.gov/policiesregulations/accreditation.html>



HRSA Efforts in PCMHs

- Medicare Advanced Primary Care Practice Demo
(CMS with BPHC support)
 - A rolling application for up to 500 FQHC Sites that have >200 Medicare Beneficiaries in last 12 months
 - Receiving “Per Member/Per Month” Payments with expectation to achieve NCQA Level III in 3 years
 - See: Nat’l Center for Medical Home Implementation
http://www.medicalhomeinfo.org/national/projects_and_initiatives.aspx



HRSA Contact Information - PCMH

General Questions

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PCMH (NCQA) for FQHCs

Barbara Easterling, MS, CNS, RN – BPHC
301-443-2174 // BEasterling@HRSA.gov

PCMH via Accreditation for FQHCs

Harriet McCombs, PhD – BPHC
301-594-4457 // HMcombs@HRSA.gov

Medicare Adv. Prim. Care Practice Demo for FQHCs

Emily Jones – BPHC
301-443-1904 // EJones@HRSA.gov

Health IT and PCMH in a Rural Environment

Spanish Peaks Regional Health Center
Bill Bolt, PhD. ACMPE
CIO/Practice Administrator

Meeting Accreditation

- ▶ Registries
 - ▶ Tracking our referrals
 - ▶ Tracking lab results
 - ▶ Drug to drug interaction/allergy checks
 - ▶ Performance measurements
 - ▶ Data collection and reporting for QI
 - ▶ Better communication with our patients
- 

Meaningful Use

- ▶ Our Health Information System (Healthland) is certified by CCHIT
 - ▶ We run daily, weekly and monthly reports to verify we are a “meaningful user”
- 

Provider Led Teams

- ▶ Healthland allows our teams to assign tasks to other team members as well as other teams
 - ▶ Our teams then “huddle” to discuss and determine proper avenues of care
- 

Evidence Based Medicine

- ▶ Healthland uses templates and tree style menus to guide our providers
 - ▶ Healthland provides alerts when results are out of a predetermined range
 - ▶ The use of templates and trees allow us to collect and report in a consistent manner
 - ▶ System has the ability to demonstrate medical necessity which reduces our denials
- 

Barriers During Transition

- ▶ As with all change the main barrier is the change itself
 - ▶ We needed to win the minds and hearts of our providers and staff
 - ▶ We brought in outside speakers who had already walked this path
 - ▶ We sent our staff to IHI conferences
- 

Tips on Using Health IT Within a Patient Centered Medical Home for the Safety Net Community June 24, 2011



Building stronger, healthier communities... One patient at a time



Open Door Family Medical Center: Overview

Federally Qualified Health Center serving Ossining, Port Chester, Sleepy Hollow, and Mt. Kisco, New York

4 health centers, 5 school based health centers, 1 mobile dental

170,000 billable visits in 2010; 30,000 non-billable visits

Over 40,000 patients served in 2010

250 FTEs: 17 MDs, 11 NPs, 5 CNMs, 7 other LIPs

\$25M Operating Budget in 2010

% of Net Patient Revenue from Managed Care: 52.6%



A 15 Year Journey



From **Reengineering Patient Visit** to
Chronic Disease Collaboratives to
Patient Centered Medical Home via
Meaningful Use of our Certified EMR



A Simple Comparison

Chronic Care Model

Self Management

Decision Support

Delivery System Design

Clinical Information System

Organization of Health Care

Community

Medical Home

PPC1: Access and Communication

PPC2: Patient Tracking & Registry

PPC3: Care Management

PPC4: Pt Self Management Support

PPC5: Electronic Prescribing

PPC6: Test Tracking

PPC7: Referral Tracking

PPC8: Performance Rpt/Imprvmnt

PPC9: Advanced Electronic Comm

Meaningful Use

Improve quality, safety, efficiency,
& reduce health disparities

Engage Patients and Families

Improve Care Coordination

Improve Population
and Public Health

Ensure Adequate Privacy &
Security Protection for PHI



NCQA's Patient Centered Medical Home Recognition Program

Recognized by New York State Medicaid

Attractive financial incentives for Capitation & FFS

Increasing amount paid for Levels 1, 2, 3

Technical Assistance was available through our RHIO

RHIO needed FQHC participation – and placed equal emphasis on community-wide EMR implementation and practice transformation



NCQA's Patient Centered Medical Home Recognition Program

PCMH participation from numerous practices
large & small, primary care & multi-specialty



Open Door's assessment determined we would
obtain Level 2 based on then current practice

Open Door recognized by NCQA as a Level 3 PCMH in March 2010

FQHCs became PCMHs with far greater ease
than private practices



Federal Quality Improvement Initiatives beginning in the mid-1990s

1. Work Flow Improvements

Patient Visit Redesign, Revenue Cycles

2. Population Health

HIV, Well-Child/Immunizations, Diabetes, Cancer Screening,
Asthma, Depression

3. External Accreditation

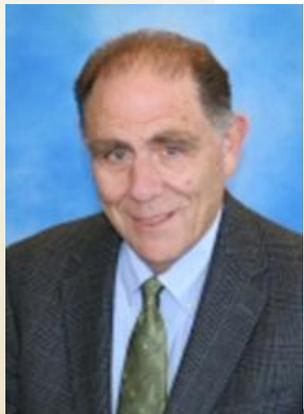
Joint Commission on Accreditation of Healthcare Organizations

All efforts involved reporting progress to HRSA
with comparisons to other health centers

“Management by Measurement” embedded in our DNA



The Chronic Care Model



Developed by The MacColl Institute
© ACP-ASIM Journals and Books



Wagner's Chronic Care Model and Population Health

1. Moved us from reactive care to planned, pro-active care

Alerts & Reminders in PECS and EMR

Emphasis on screenings and recommended care

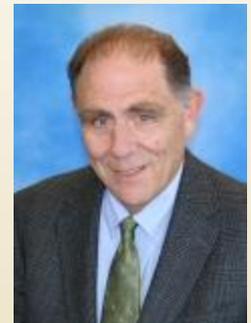
Evidence based standards promoted and followed

Templates & CDSS in the EMR

2. Focus on transitions of care to specialists, hospitals and back

Greater efficiency with referrals in EMR

Health Information Exchange (HIE) coming



Edward Wagner, MD



Wagner's Chronic Care Model and Population Health

3. Patient Engagement

Patients receive visit summaries

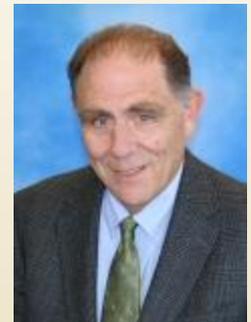
Registries & Reports identify patients lost to follow-up

EMR provides better access to patient educational materials

4. Team based approach to care – PCPs can't do it all!

Pre-visit planning huddles – usually virtual

Open Door uses Patient Advocates
to support care teams

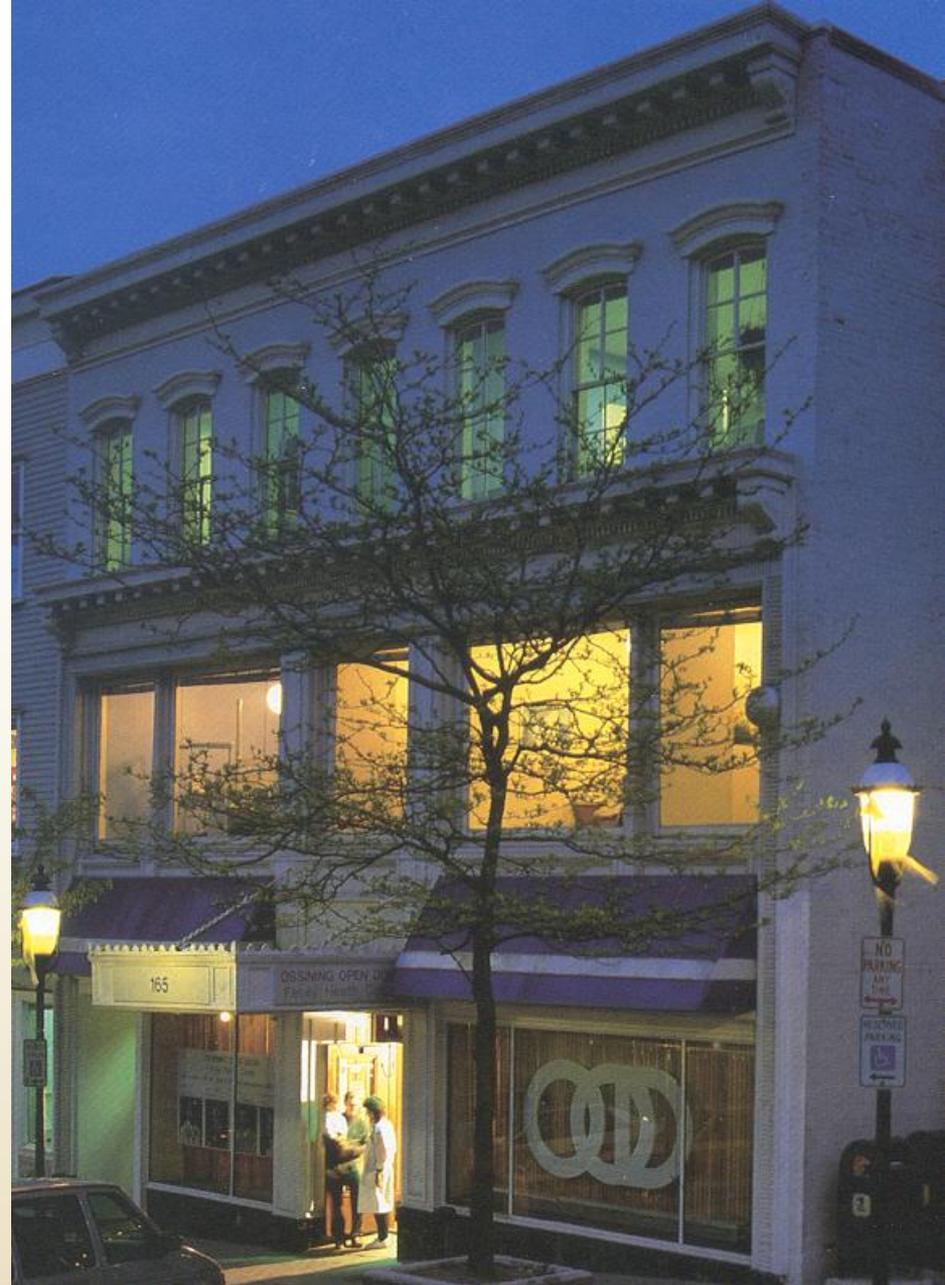


Edward Wagner, MD



Developed Core Capabilities

1. **Process Mapping** for workflow improvement & technology integration
2. **Clinical Data Capture** from chart audits to electronic data capture using registries (HEMS, DEMS, PECS) then EMR and Data Warehouse
3. **Improvement Cycles** – plan, do, study, act – to determine what will work best and last
4. **Planned Care/ Care Coordination** – to be proactive for patients



Health Information Technology = Critical

Workflow efficiencies, electronic structured data

From the Practice Management/Billing System
plus Registries for population management to
Integrated EMR with Data Warehousing for
reporting....

It's all about analytics!



Monitoring Performance

Robust and on-going performance monitoring program organization-wide.

- * Clinical
- * Operational
- * Financial
- * Patient Safety Metrics

Facilitates **Pay for Performance** programs from Commercial and Medicaid Managed Care insurance plans.



Clinical Report Cards

Clinical “Report Cards” for key **clinical metrics by provider, site, organization** tell us how we are doing against goals and national standards.

Physician compensation will have quality component in 2012.



**Open Door Family Medical Center
Lindsay C. Farrell, MBA, FACMPE
President & CEO**



Patient Centered Medical Home Resources

- Additional PCMH questions can be sent to healthIT@hrsa.gov
- Agency for Healthcare Research and Quality (AHRQ)
 - New AHRQ Article: Health Information Technology: Turning the Patient-Centered Medical Home From Concept to Reality
- National Committee for Quality Assurance (NCQA)
- Patient Centered Primary Care Collaborative (PCCC)
- March 2011 Health Affairs Journal focusing on “Profiles of Innovation in Health Care Delivery
- Accreditation Association for Ambulatory Health Care