Practice Transformation:
Patient Centered Medical Home meets EHR Meaningful Use

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Tri-State
Regional Extension Center

Cintas Center at Xavier University
7:30am to 4:30pm
May 20, 2011

Conference Highlights

Tri-State Regional Extension Center

- Breakfast Keynote – **Greg Moody**, Director, Ohio Governor's Office of Health Transformation
- Luncheon Keynote – **Dr. Farzad Mostashari**, National Coordinator, Office of the National Coordinator for Health IT
- Breakout session topics include:
  - Proposed MU Requirements for Stages 2&3
  - Healthcare Transformation and PCMH
  - Care Coordination and Transitions in Care
  - Quality Reporting and Quality Improvement
  - Accountable Care and Payment Reform
- **Register online at;** http://2011meaningful-use-Conference.eventbrite.com/

Our Service Territory

Tri-State
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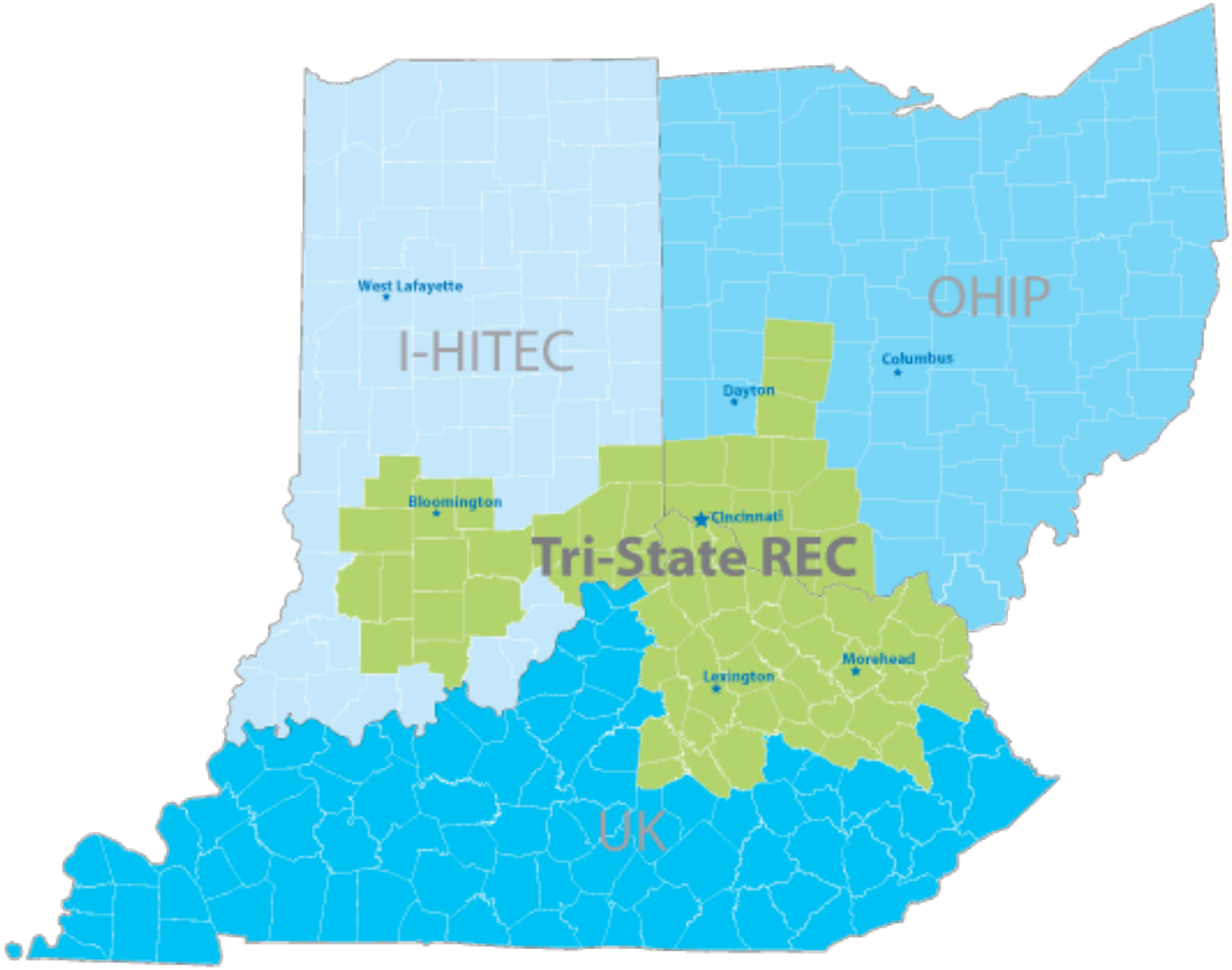
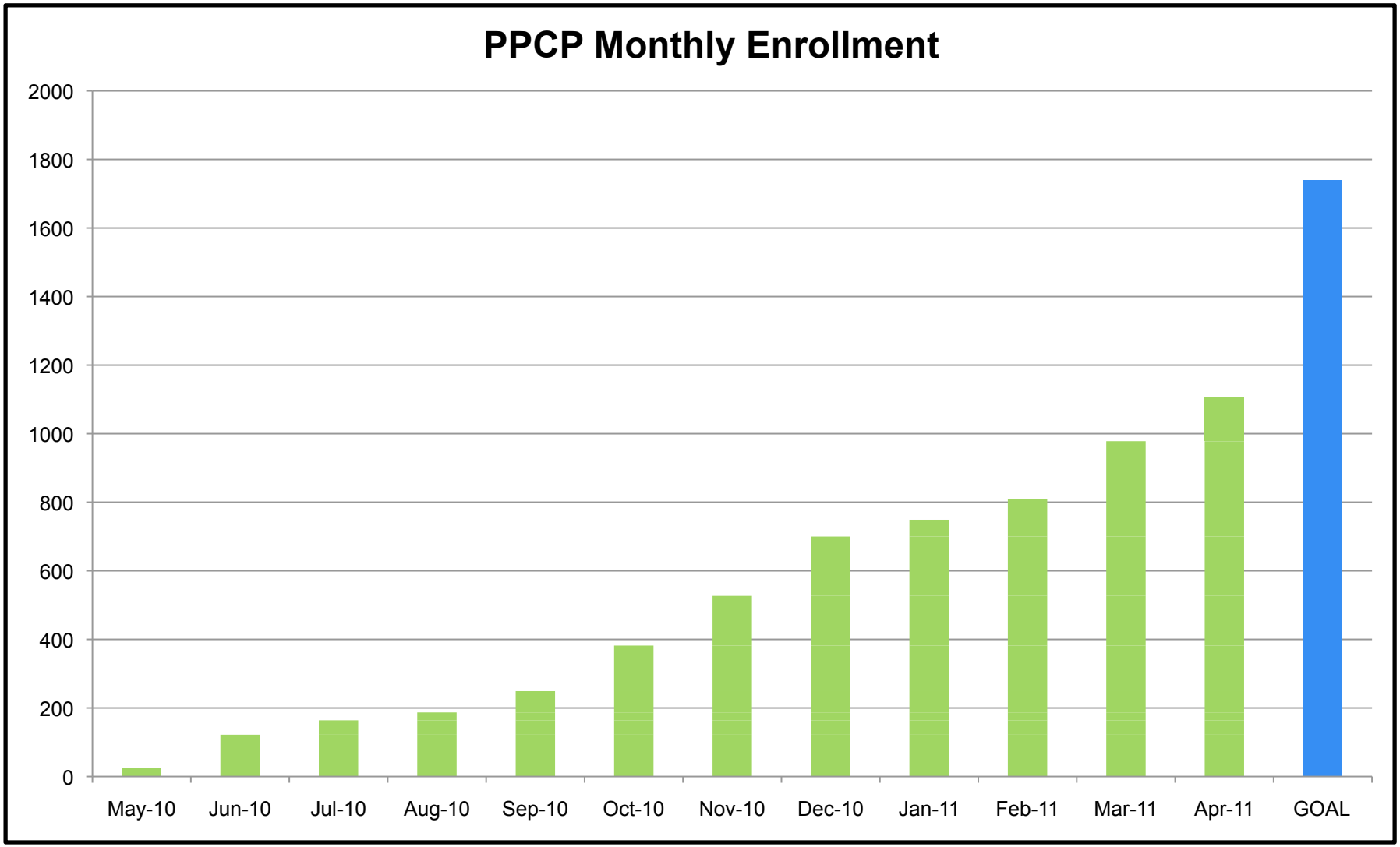


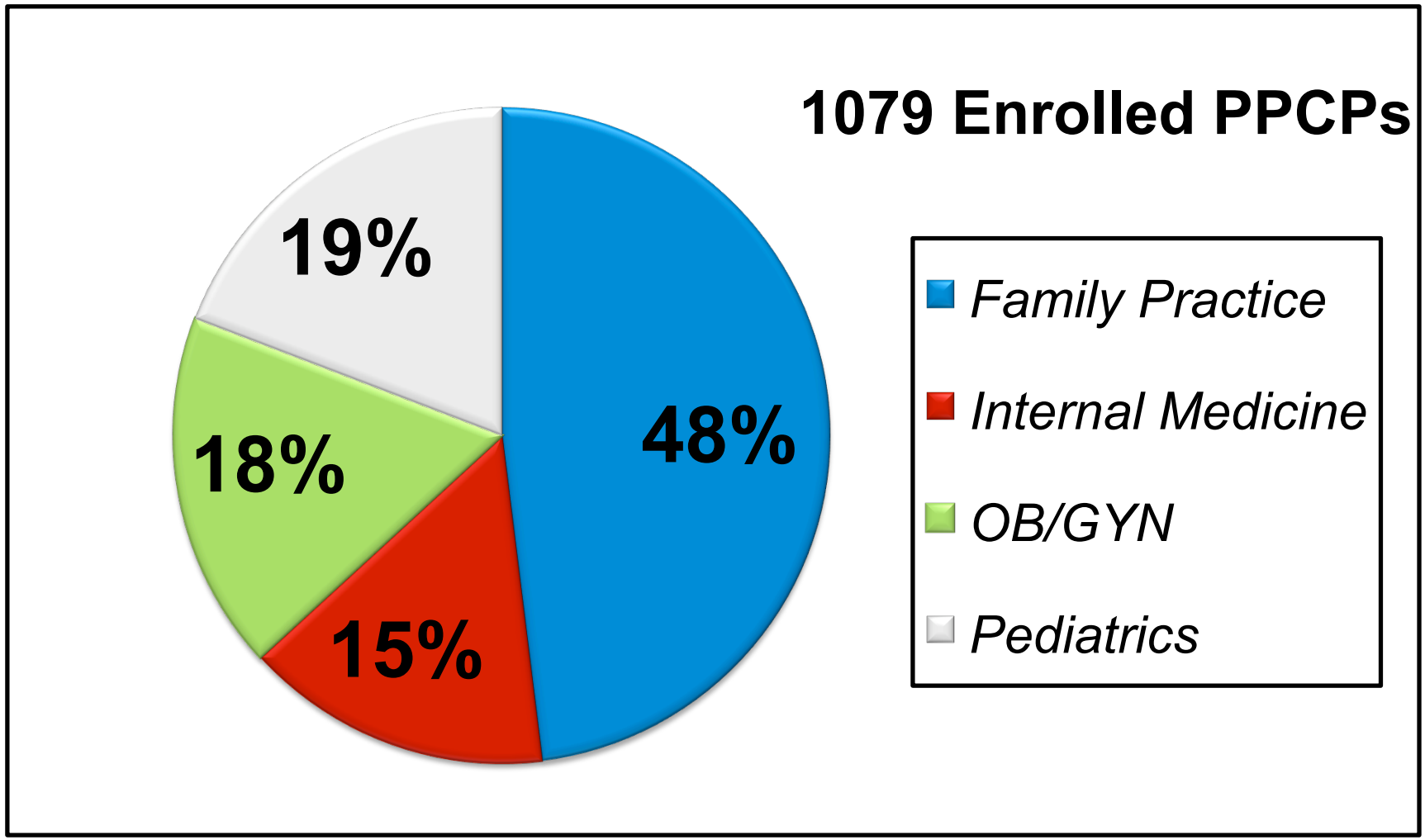
Tri-State REC Enrollment

Tri-State Regional Extension Center



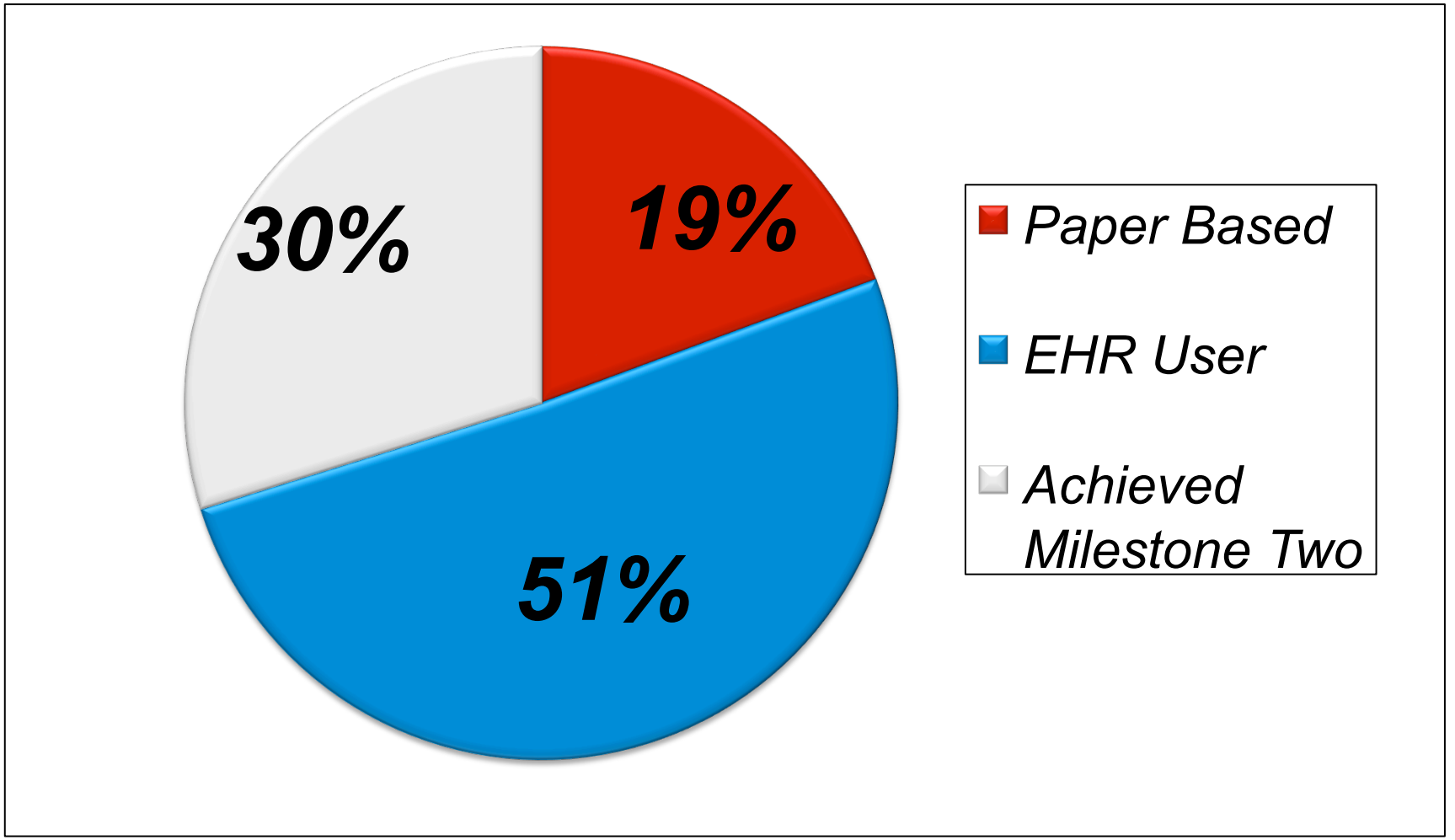
Tri-State REC Enrollment Status

Tri-State Regional Extension Center



EHR Adoption Status

Tri-State Regional Extension Center



Session Objectives

1. Introduce concept of Patient Centered Medical Home
2. Understand the distinct characteristics of an effective PCMH
3. Explore the significant changes made to the 2011 NCQA requirement for PCMH Recognition?
4. Understand how Meaningful Use of EHR technology has been integrated into the PCMH program?
5. Identify the essential Health IT capabilities that support PCMH
6. Understand how PCMH may influence Stage 2 and Stage 3 Requirements for Meaningful Use

Joint Principles of PCMH

- **Personal Physician -** each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Team Care -** the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients
- **Whole Person Orientation -** the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals.
- **Care is Coordinated -** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).
- **Care is facilitated by Information Technology** – EHRs, Registries and Health Information Exchanges are utilized to support optimal patient care, performance measurement, patient education, and enhanced communication
- ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- ***Quality and safety*** are hallmarks of the medical home and Physicians in the practice accept accountability for continuous quality improvement

Source: Patient-Centered Medical Home Collaborative -

PCMH Recognition Standards

NCQA
Measuring quality. Improving health care.

1. **Enhance Access and Continuity:** Accommodate patient needs with access and advice during and after office hours; provide patients with team-based care
2. **Identify and Manage Populations:** Collect and use data for population management
3. **Plan and Manage Care:** Use Evidence-based guidelines for preventive, acute and chronic care management.
4. **Provide Self Care Support and Community Resources** – Assist patients and their families in self-care management with information, tools, and connections to community partners
5. **Track and Coordinate Care:** Track and manage referrals, care transitions, and clinical results.
6. **Measure and Improve Performance:** Use data to continuously measure and improve care quality and patient experience.

Outcomes of Implementing Patient Centered Medical Home Interventions:

A Review of the Evidence from Prospective Evaluation Studies in the United States

UPDATED NOVEMBER 16, 2010

Kevin Grumbach, MD
Center for Excellence in Primary Care
Department of Family and Community Medicine
University of California, San Francisco

Paul Grundy, MD, MPH
IBM Global Healthcare Transformation
President, Patient-Centered Primary Care Collaborative

"The proof is in. This document shows that primary care that is more comprehensive, integrated and coordinated, that follows the model of the patient centered medical home, delivers better care and better quality at lower costs.." said Paul Grundy, MD, M.P.H, president of the Patient-Centered Primary Care Collaborative, director of healthcare technology and strategic initiatives at IBM.

http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf

Value-Driving Elements of Patient Center Medical Home and Accountable Care Organizations

1. Enhanced Access
2. Better Care Coordination
3. Better Health IT
4. Payment Reform for Primary Care

Dear Colleagues:

As you may know, the topic of patient-centered care is dear to my heart. I believe that, of the six IOM Aims for Improvement - safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity - "patient-centeredness" is the keystone and that, from it, the others properly devolve. To me, "patient-centered care" is care that respects each person as an individual, honoring his or her backgrounds, their families and their choices.

Donald M. Berwick, MD
Administrator
Centers for Medicare and Medicaid Services

Source: *Better to Best Report - Value-Driving Elements of the Patient Centered Medical Home and Accountable Care Organizations, March 2011*

Raising the Bar for PCMH

NCQA
Measuring quality. Improving health care.

NCQA Releases New Standards for PCMH

PCHM 2011

- More Patient-Centeredness required
- Increase emphasis on Patient Feedback
- Federal Meaningful Use Language is embedded in the standard
- Greater emphasis on the use of HIT
- Reinforces incentive to use HIT to improve quality
- Implements 6 “must pass” elements

PCMH 2011 Overview (6 standards/27 elements)

1. Enhance Access and Continuity

A. Access During Office Hours
B. After-Hours Access
C. Electronic Access
D. Continuity (with provider)
E. Medical Home Responsibilities
F. Culturally/Linguistically Appropriate Services
G. Practice Organization

2. Identify and Manage Patient Populations

A. Patient Information
B. Clinical Data
C. Comprehensive Health Assessment
D. Use Data for Population Management

3. Plan and Manage Care

A. Implement Evidence-Based Guidelines
B. Identify High-Risk Patients
C. Care Management
D. Medication Management
E. Use Electronic Prescribing

4. Provide Self-Care Support and Community Resources

A. Support Self-Care Process
B. Provide Referrals to Community Resources

5. Track/Coordinate Care

A. Track Tests and Follow-Up
B. Track Referrals and Follow-Up
C. Coordinate with Facilities/Care Transitions

6. Measure and Improve Performance

A. Measure Performance
B. Measure Patient/Family Experience
C. Implement Continuous Quality Improvement
D. Demonstrate Continuous Quality Improvement
E. Report Performance
F. Report Data Externally

Optional Patient Experiences Survey

NCQA Measuring quality. Improving health care.

NCQA Patient-Centered Medical Home (PCMH) 2011
March 20, 2011

PCMH 2011 and Meaningful Use

Meaningful Use Requirement	Found in PCMH Standard
1. Electronic Prescribing	➢ 3E: Use Electronic Prescribing
2. Drug Formulary, drug-drug, drug-allergy checks	➢ 3E: Use Electronic Prescribing
3. Maintain active problem list and current diagnosis and meds	➢ 2B: Clinical Data
4. Record patient demographics including race, ethnicity and preferred language	➢ 2A: Patient Information
5. Record and chart changes in vital signs	➢ 2B: Clinical Data
6. Record smoking status	➢ 2B: Clinical Data
7. Report quality measures	➢ 6F: Report Data Electronically
8. Implement clinical decision support	➢ 3A: Implement Evidence-based Guidelines

PCMH 1: Enhance Access and Continuity

PCMH 1: Enhance Access and Continuity — 20 points

The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.

Element A: Access During Office Hours — 4 points
MUST-PASS

The practice has a written process and defined standards, *and* demonstrates that it monitors performance against the standards for:	Yes	No	NA
1. Providing same-day appointments	☐	☐	
2. Providing timely clinical advice by telephone during office hours	☐	☐	
3. Providing timely clinical advice by secure electronic messages during office hours	☐	☐	☐
4. Documenting clinical advice in the medical record.	☐	☐	

Element B: After-Hours Access — 4 points

The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:	Yes	No	NA
1. Providing access to routine and urgent-care appointments outside regular business hours	☐	☐	
2. Providing continuity of medical record information for care and advice when the office is not open	☐	☐	
3. Providing timely clinical advice by telephone when the office is not open	☐	☐	
4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open	☐	☐	☐
5. Documenting after-hours clinical advice in patient records.	☐	☐	

PCMH 1: Enhance Access and Continuity

Element C: Electronic Access	2 points		
The practice provides the following information and services to patients and families through a secure electronic system.	Yes	No	NA
1. More than 50 percent of patients who request an electronic copy of their health information (including problem list, diagnoses, diagnostic test results, medication lists, allergies) receive it within three business days[+]	☐	☐	☐
2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem lists, medication lists, and allergies) within four business days of when the information is available to the practice[++]	☐	☐	
3. Clinical summaries are provided to patients for more than 50 percent of office visits within three business days[+]	☐	☐	
4. Two-way communication between patients/families and the practice	☐	☐	
5. Request for appointments or prescription refills	☐	☐	
6. Request for referrals or test results	☐	☐	

PCMH 1: Enhanced Access and Continuity

Element D: Continuity	2 points	
The practice provides continuity of care for patients/families by:	Yes	No
1. Expecting patients/families to select a personal clinician	☐	☐
2. Documenting the patient's/family's choice of clinician	☐	☐
3. Monitoring the percentage of patient visits with a selected clinician or team.	☐	☐

Element E: Medical Home Responsibilities	2 points	
The practice has a process and materials that it provides patients/families on the role of the medical home, which include the following.	Yes	No
1. The practice is responsible for coordinating patient care across multiple settings	☐	☐
2. Instructions on obtaining care and clinical advice during office hours and when the office is closed	☐	☐
3. The practice functions most effectively as a medical home if patients/families provide a complete medical history and information about care obtained outside the practice	☐	☐
4. The care team gives the patient/family access to evidence-based care and self-management support	☐	☐

PCMH 2: Identify and Manage Patient Populations

Element B: Clinical Data			4 points
The practice uses an electronic system to record the following as structured (searchable) data.	Yes	No	NA
1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients+	☐	☐	
2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients+	☐	☐	
3. Blood pressure, with the date of update for more than 50 percent of patients 2 years and older+	☐	☐	☐
4. Height for more than 50 percent of patients 2 years and older+	☐	☐	☐
5. Weight for more than 50 percent of patients 2 years and older+	☐	☐	☐
6. System calculates and displays BMI (NA for pediatric practices)+	☐	☐	☐
7. System plots and displays growth charts (length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) (NA for adult practices)+	☐	☐	☐
8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients (NA for pediatric practices if all patients <13 years)+	☐	☐	☐
9. List of prescription medications with the date of updates for more than 80 percent of patients+	☐	☐	

PCMH 2: Identify and Manage Patient Populations

Element D: Use Data for Population Management ***MUST-PASS***	**5 points**	
The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients *and* to proactively remind patients/ families and clinicians of services needed for:	**Yes**	**No**
1. At least three different preventive care services[++]	☐	☐
2. At least three different chronic care services[++]	☐	☐
3. Patients not recently seen by the practice	☐	☐
4. Specific medications	☐	☐

PCMH 3: Plan and Manage Care

The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines.

Element A: Implement Evidence-Based Guidelines		**4 points**
The practice implements evidence-based guidelines through point-of-care reminders for patients with:	**Yes**	**No**
1. The first important condition[+]	☐	☐
2. The second important condition	☐	☐
3. The third condition, related to unhealthy behaviors or mental health or substance abuse.	☐	☐

Element B: Identify High-Risk Patients		**3 points**
To identify high-risk or complex patients, the practice:	**Yes**	**No**
1. Establishes criteria and a systematic process to identify high-risk or complex patients	☐	☐
2. Determines the percentage of high-risk or complex patients in its population.	☐	☐

PCMH 5: Track and Coordinate Care

The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.

Element A: Test Tracking and Follow-Up	6 points		
The practice has a documented process for and demonstrates that it:	Yes	No	NA
1. Tracks lab tests until results are available, flagging and following up on overdue results	☐	☐	
2. Tracks imaging tests until results are available, flagging and following up on overdue results	☐	☐	
3. Flags abnormal lab results, bringing them to the attention of the clinician	☐	☐	
4. Flags abnormal imaging results, bringing them to the attention of the clinician	☐	☐	
5. Notifies patients/families of normal and abnormal lab and imaging test results	☐	☐	
6. Follows up with inpatient facilities on newborn hearing and blood-spot screening (NA for adults)	☐	☐	☐
7. Electronically communicates with labs to order tests and retrieve results	☐	☐	
8. Electronically communicates with facilities to order and retrieve imaging results	☐	☐	
9. Electronically incorporates at least 40 percent of all clinical lab test results into structured fields in medical records[++]	☐	☐	☐
10. Electronically incorporates imaging test results into medical records.	☐	☐	

PCMH 5: Track and Coordinate Care

Element B: Referral Tracking and Follow-Up *MUST-PASS*	6 points		
The practice coordinates referrals by:	Yes	No	NA
1. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information	☐	☐	
2. Tracking the status of referrals, including required timing for receiving a specialist's report	☐	☐	
3. Following up to obtain a specialist's report	☐	☐	
4. Establishing and documenting agreements with specialists in the medical record if co-management is needed	☐	☐	
5. Asking patients/families about self-referrals and requesting reports from clinicians	☐	☐	
6. Demonstrating the capability for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians[+]	☐	☐	
7. Providing an electronic summary of the care record to another provider for more than 50 percent of referrals.[++]	☐	☐	☐

PCMH 6: Measure and Improve Performance

Element F: Report Data Externally	2 points		
The practice electronically reports:	Yes	No	NA
1. Ambulatory clinical quality measures to CMS or states[+]	☐	☐	
2. Ambulatory clinical quality measures to other external entities	☐	☐	
3. Data to immunization registries or systems[++]	☐	☐	☐
4. Syndromic surveillance data to public health agencies[++]	☐	☐	☐

Summing Up

- Health IT is essential to PCMH recognition
- Health IT elements that enable practice transformation
  - Certified EHR system
  - Disease Registry (within or integrated with the EHR)
  - Patient Portal supporting
    - Electronic receipt of patient care information and results
    - Schedule requests
    - Prescription refill requests
    - Secure patient-provider e-mail
    - Information about the primary care practice and services
    - Patient surveys
  - Health Information Exchange supporting
    - Results delivery
    - Electronic Referrals and Transitions of Care
- Future EHR Certification and Meaningful Use Requirements will be influenced by evolving aspirations for PCMH