# Patient-Centered Health Home Overview
## Angela Herman, MPA, CPHQ| May 15, 2012

Missouri Primary Care Association

Health Care & Housing Are Human Rights

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

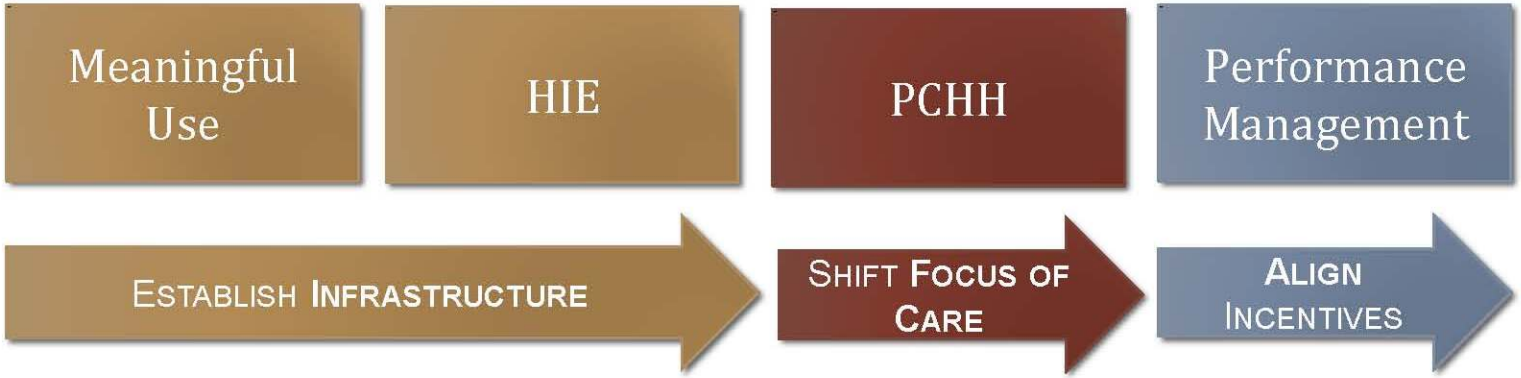
# What is a Patient-Centered Medical/Health Home (PCMH/PCHH)?

- Comprehensive and coordinated care in the context of individual, cultural, and community needs
- Medical, behavioral, oral health and related social service needs and supports are coordinated and provided by provider and/or arranged
- Emphasize education, activation, and empowerment through interpersonal interactions and system-level protocols
- At the center of the health/medical home are the patient and their relationship with their primary care team

# Key Trends Affecting Primary Care Organizations

- Meaningful Use Incentives and Expectations
- Patient Centered Health Home
- Accountable Care Organizations
- Public Reporting

# Health Home as a Methodology



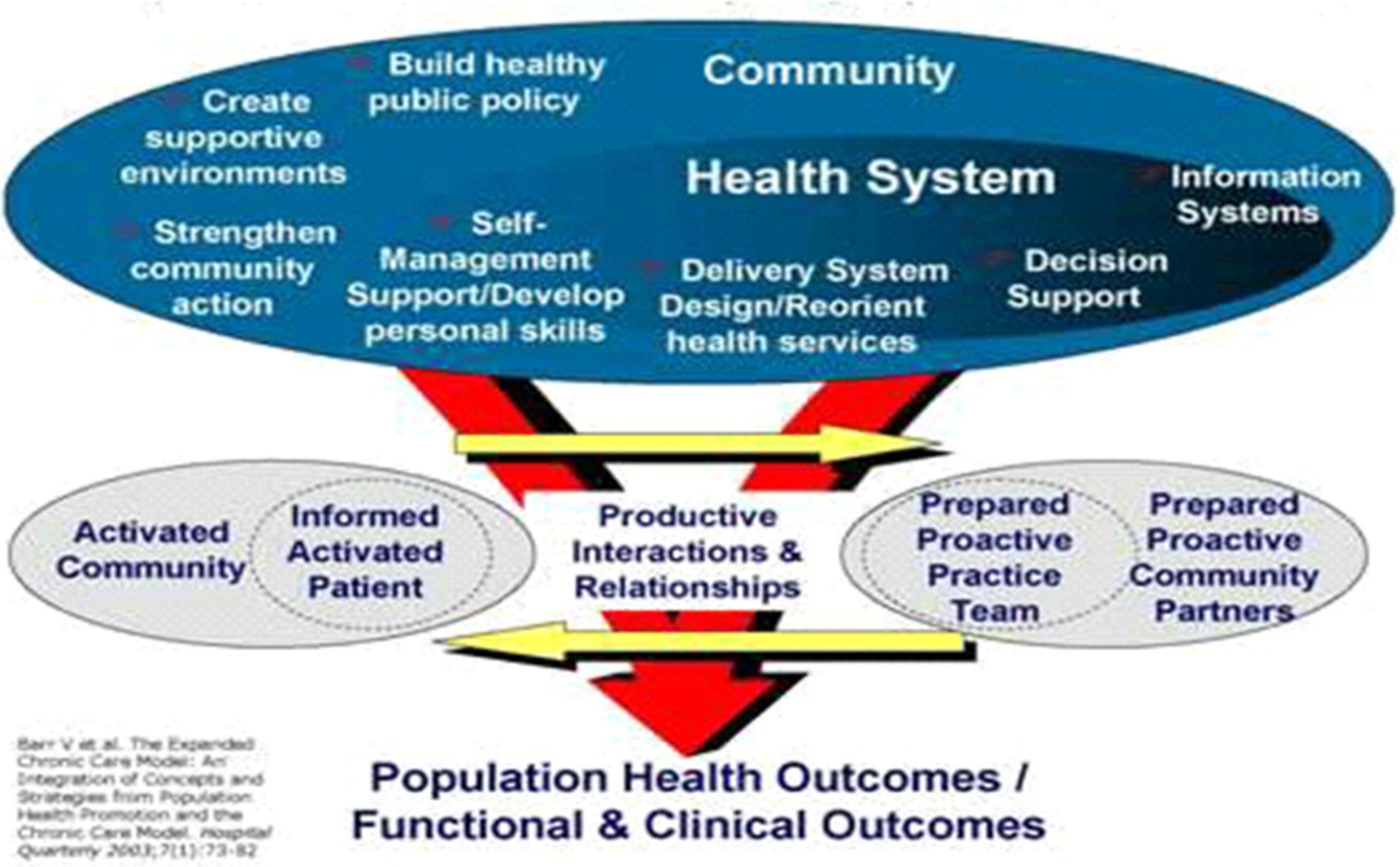

The National agenda for Health IT & Payment Reform are our tea leaves:

- Meaningful Use of EHR will be the "floor" not the "ceiling."
- "Recognition" as a Health Home will be a requirement, top-performers will go beyond.
- Competition will be increasingly fierce as the overall system re-evaluates the value assigned to Primary Care.
- **How you are paid is how you should pay. This creates more opportunities than down-side, but will be a painful transition.**

# Evolution of Patient-Centered Health Home

- Community-Oriented Primary Care
  - Foundation for CHC movement
  - Access entry point
  - Continuity of care
  - Comprehensive coordinated care
- Chronic Care Model
  - System focus for quality improvement and disease management
- Patient-Centered Medical Home

# The Expanded Chronic Care Model




Source: http://www.improvingchroniccare.org/index.php?p=Expanded_CCM&s=157

# PCMH Joint Principles

- Personal Physician
- Physician Directed Medical Practice
- Whole Person Orientation
- Care is Coordinated and/or Integrated
- Quality and Safety
- Enhanced Access
- **Payment Reform**

# Benefits of PCMH Process

- Provides an excellent review of the organization's :
  - Quality Improvement Programs
  - Care Coordination- Both internal and external
  - Community Linkages and access to specialty care
  - Policies and procedures
  - Corporate compliance
  - Data extraction/reporting
  - Meaningful Use of EMR

# National Committee for Quality Assurance (NCQA) and the PCMH

- NCQA standards
- Application includes extensive documentation of policies and processes
- Recognition is offered at three levels:
  - Level 1 – basic
  - Level 2 – intermediate
  - Level 3 – advanced

# PCMH 2011 Content and Scoring

| PCMH1: Enhance Access and Continuity | | Pts |
|---|---|---|
| A. | **Access During Office Hours**** | **4** |
| B. | After-Hours Access | 4 |
| C. | Electronic Access | 2 |
| D. | Continuity | 2 |
| E. | Medical Home Responsibilities | 2 |
| F. | Culturally and Linguistically Appropriate Services | 2 |
| G. | Practice Team | 4 |
| | | 20 |

| PCMH2: Identify and Manage Patient Populations | | Pts |
|---|---|---|
| A. | Patient Information | 3 |
| B. | Clinical Data | 4 |
| C. | Comprehensive Health Assessment | 4 |
| **D.** | **Use Data for Population Management**** | **5** |
| | | 16 |

| PCMH3: Plan and Manage Care | | Pts |
|---|---|---|
| A. | Implement Evidence-Based Guidelines | 4 |
| B. | Identify High-Risk Patients | 3 |
| **C.** | **Care Management**** | **4** |
| D. | Manage Medications | 3 |
| E. | Use Electronic Prescribing | 3 |
| | | 17 |

| PCMH4: Provide Self-Care Support and Community Resources | | Pts |
|---|---|---|
| **A.** | **Support Self-Care Process**** | **6** |
| B. | Provide Referrals to Community Resources | 3 |
| | | 9 |

| PCMH5: Track and Coordinate Care | | Pts |
|---|---|---|
| A. | Test Tracking and Follow-Up | 6 |
| **B.** | **Referral Tracking and Follow-Up**** | **6** |
| C. | Coordinate with Facilities/Care Transitions | 6 |
| | | 18 |

| PCMH6: Measure and Improve Performance | | Pts |
|---|---|---|
| A. | Measure Performance | 4 |
| B. | Measure Patient/Family Experience | 4 |
| **C.** | **Implement Continuously Quality Improvement**** | **4** |
| D. | Demonstrate Continuous Quality Improvement | 3 |
| E. | Report Performance | 3 |
| F. | Report Data Externally | 2 |
| | | 20 |

****Must Pass Elements**

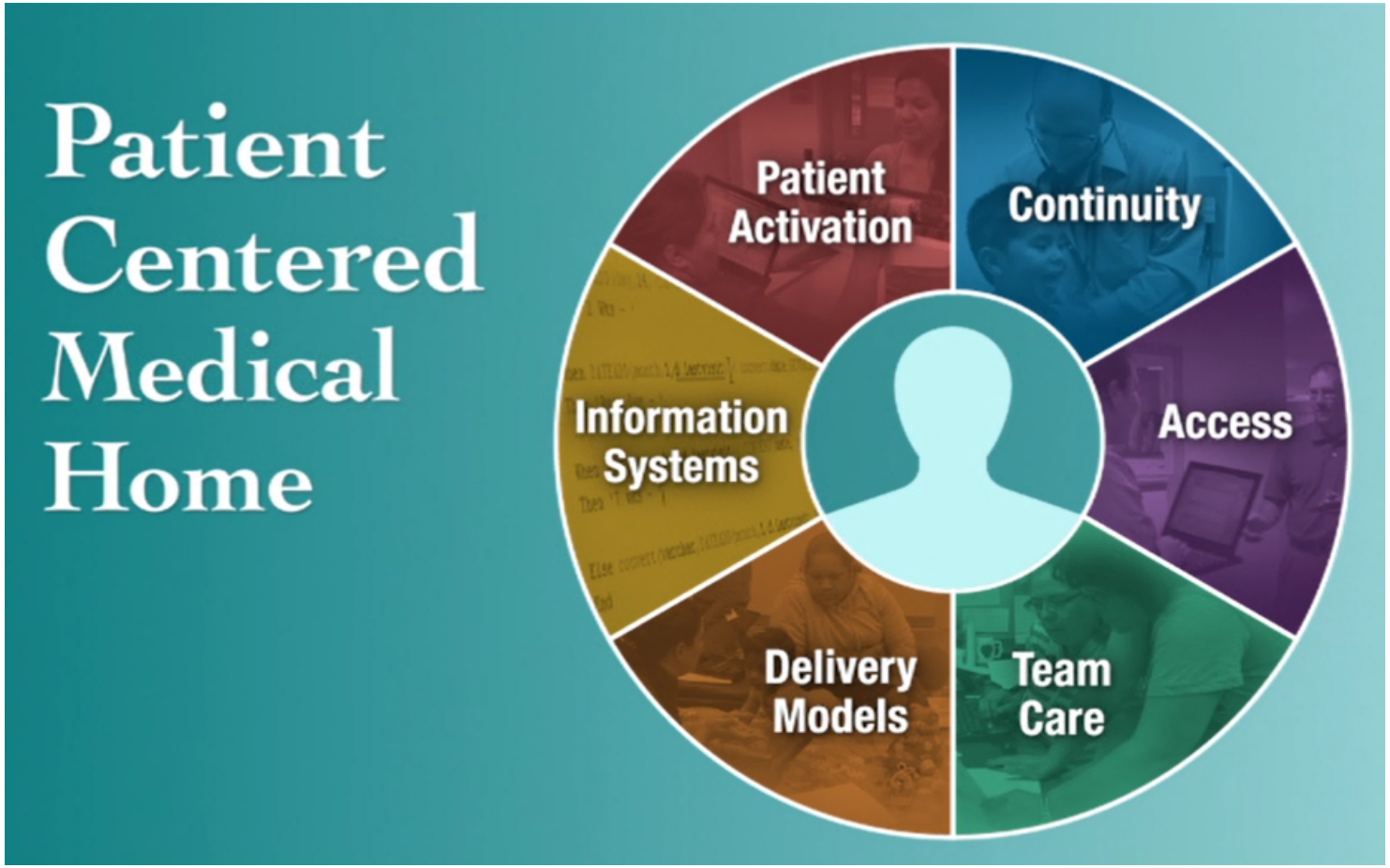
# PCMH Closely Aligned with Meaningful Use

- Electronic prescribing
- Drug formulary, drug-drug, drug allergy checks
- Maintaining an up-to date problem list of current and active diagnoses and medications
- Recording demographics on preferred language gender, race, ethnicity and date of birth
- Recording and charting changes in vital signs
- Recording smoking status
- Reporting ambulatory quality measures
- Implementing clinical decision support rules…

# Payers are Driving PCMH Recognition and Performance

- Centers for Medicare and Medicaid
- Health Resources and Services Administration: Bureau of Primary Health Care (HRSA-BPHC)
- Insurers-Private and Public
- Foundations
- **Payers want value: better outcomes with cost savings**

# Clinica PCMH




Clinica
Family Health Services

# Insights from the Video

- What aspects of care at your organization are similar to those highlighted in the Clinica video?
- What ideas or test of change would you like to try at your organization?
- Other thoughts/reflections

# Clinica Lessons Learned

- Solid and trusting leadership partnership
- Create the will…is what you are doing working?
- Have a change management strategy
- Put the patients first
- Find ways to add the patient's voice
  - On teams
  - Scan comment
  - Media
  - Have them choose content threads
- Start small but start!
- Optimize the team-hold on to the good, out with the bad

Clinica
Family Health Services

# Tools and Resources

- National Committee for Quality Assurance: www.ncqa.org/tabid/631/Default.aspx
- Commonwealth Fund: Safety Net Medical Home Initiative

www.qhmedicalhome.org/safety-net/change-concepts.cfm

- Improving Chronic Illness Care: www.improvingchroniccare.org/index.php?p=Patient-Centered_Medical_Home&s=224
- The Joint Commission:

http://www.jointcommission.org/accreditation/pchi.aspx

- Patient-Centered Primary Care Collaborative: www.pcpcc.net/content/patient-centered-medical-home
- American College of Physicians: www.acponline.org/running_practice/pcmh/

# Contact Information

- Susan Wilson- swilson@mo-pca.org
- Angela Herman- aherman@mo-pca.org

Missouri Primary Care Association

3325 Emerald Lane

Jefferson City, MO  65109-6879

(573) 636-4222

www.mo-pca.org