



Washington  
**Patient-Centered Medical Home  
Collaborative**

A joint project of the Washington State Department of Health and the Washington Academy of Family Physicians

# Washington Patient-Centered Medical Home Collaborative

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# Objectives

- Background: Patient-Centered Medical Home (PCMH) Collaborative
- What is a PCMH: *and why is it important?*
- What strategies, tactics, performance measures and metrics are important?
- What works and what doesn't?

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# The Mission

To implement medical homes in a *variety* of primary care clinics and improve the care of patients/families using the collaborative methodology.

# Goals

*What were we trying to accomplish?*

1. Develop an implementation model for primary care medical home which improves:
  - health outcomes for patients
  - the patient and family's experience of care
  - primary care utilization and costs impacted by medical home implementation.
2. Examine overall health care utilization and costs impacted by medical home implementation\*

*\*Did not occur due to loss of funding for evaluation*

# Approach

*Two Year Commitment.....and beyond*

- 33 teams began, 31 finished
- 24 months, 2009-2011
- Five learning sessions/ 8 full days
- Five plus site visits by Quality Improvement Coach
- Monthly webinars/e-news bulletins
- Reporting of data and narrative reports
- Ongoing support by e-mail/phone/website

# Washington Patient-Centered Medical Home Collaborative Teams



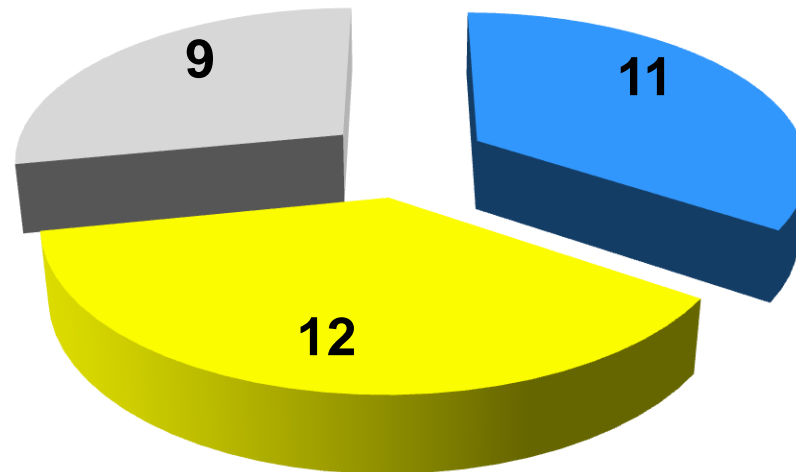
# Practice Size by Provider

*There were a Total of 755 providers*

**Number of sites that have providers in the designated number range**

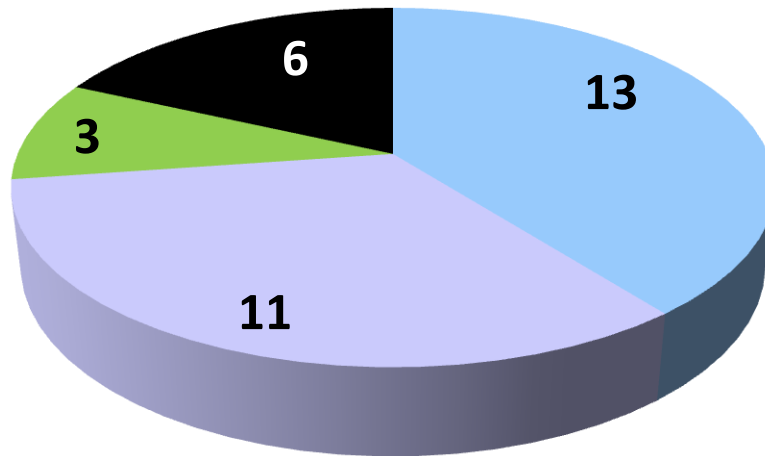
## Collaborative participants

■ 5 or fewer providers    ■ 6 to 20 providers    ■ 21+ providers



# Population density surrounding participating clinics

Participating clinics by population density



- Urban 50,000 +
- Sub-Urban 30-49% commuter flow to Urban
- Large Rural to 10,001 to 49,000
- Small town/isolated rural up to 10,000

# Patient-Centered Medical Home

## *What is it?*

The Joint Principles of the Patient-Centered Medical Home are:

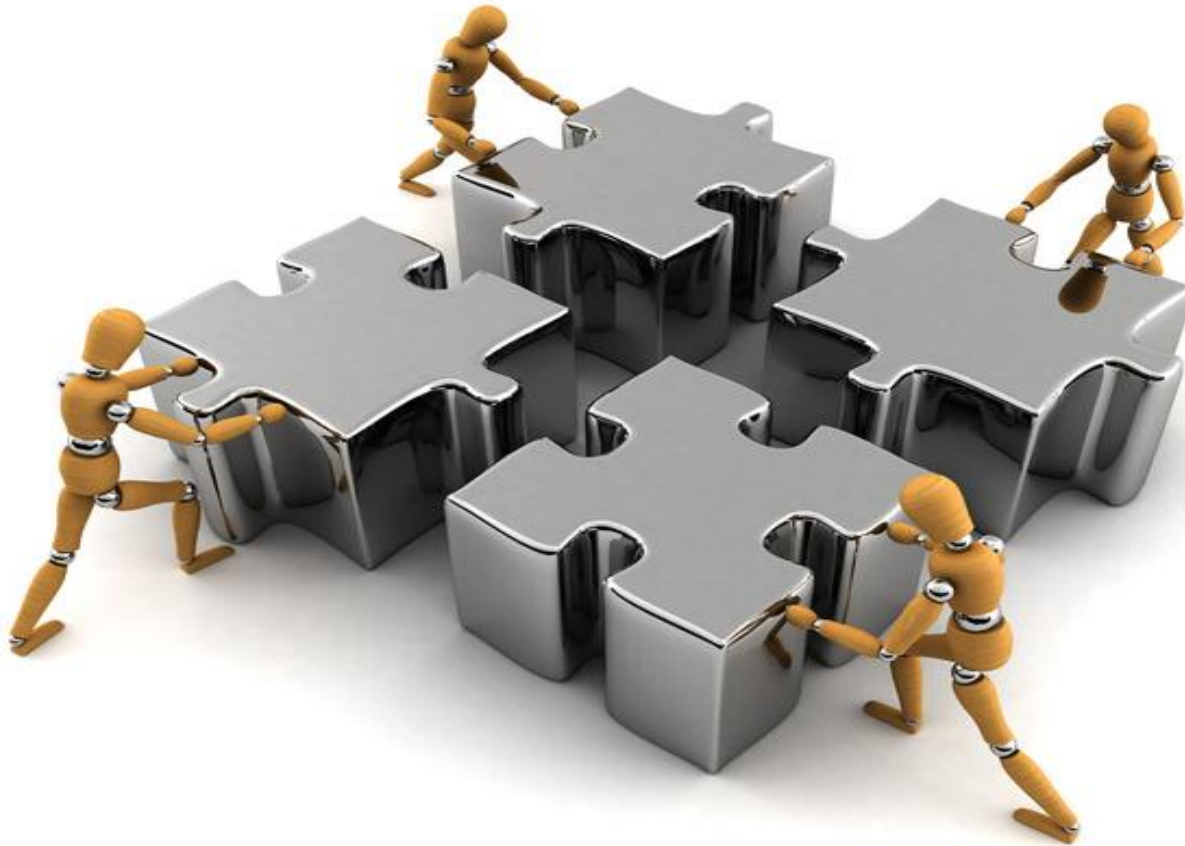
- Personal Physician – 1<sup>st</sup> contact, continuous, comprehensive care
- Team Care – collectively take responsibility for ongoing care
- Whole Person Orientation – take responsibility for all patient needs by delivering or arranging care
- Coordinated Care – across all elements of the healthcare system
- Quality and Safety – by implementation of CCM, continuous QI, and voluntary recognition process
- Enhanced access – via open scheduling, expanded hours and new options for communication
- Payment – recognizes value of the PCMH, pays for coordination and electronic communication with patients, supports IT use

\*ACP, AAFP, AAP, AOA joint statement



# Change Concepts

*The foundational pieces to becoming a PCMH*



# Building a PCMH

*Putting the pieces together*

Engaged Leadership	Visible & sustained leadership to lead culture change and quality improvement strategies
Quality Improvement	Use a model of Quality Improvement
Patient-Centered Interactions	Integrate self-management support
Organized, Evidence-Based Care	Access to care guidelines and pro-active, planned care for complex patients with multiple chronic conditions



# Building a PCMH

*Putting the pieces together (cont.)*

Continuous & Team Healing Relationships	Link patients to a provider and care team so they can work as partners in care
Enhanced Access	Provide patients with 24/7 access to provider, and care team through phone, email, or in-person visits. --Supply & Demand
Population Management	A panel of patients assigned to a care team and proactively managed to ensure timely prevention and chronic condition management
Care Coordination	Patients are proactively tracked as they go to and from specialty, hospital and emergent care.

# Practice Transformation

*Not every practice is created equally*

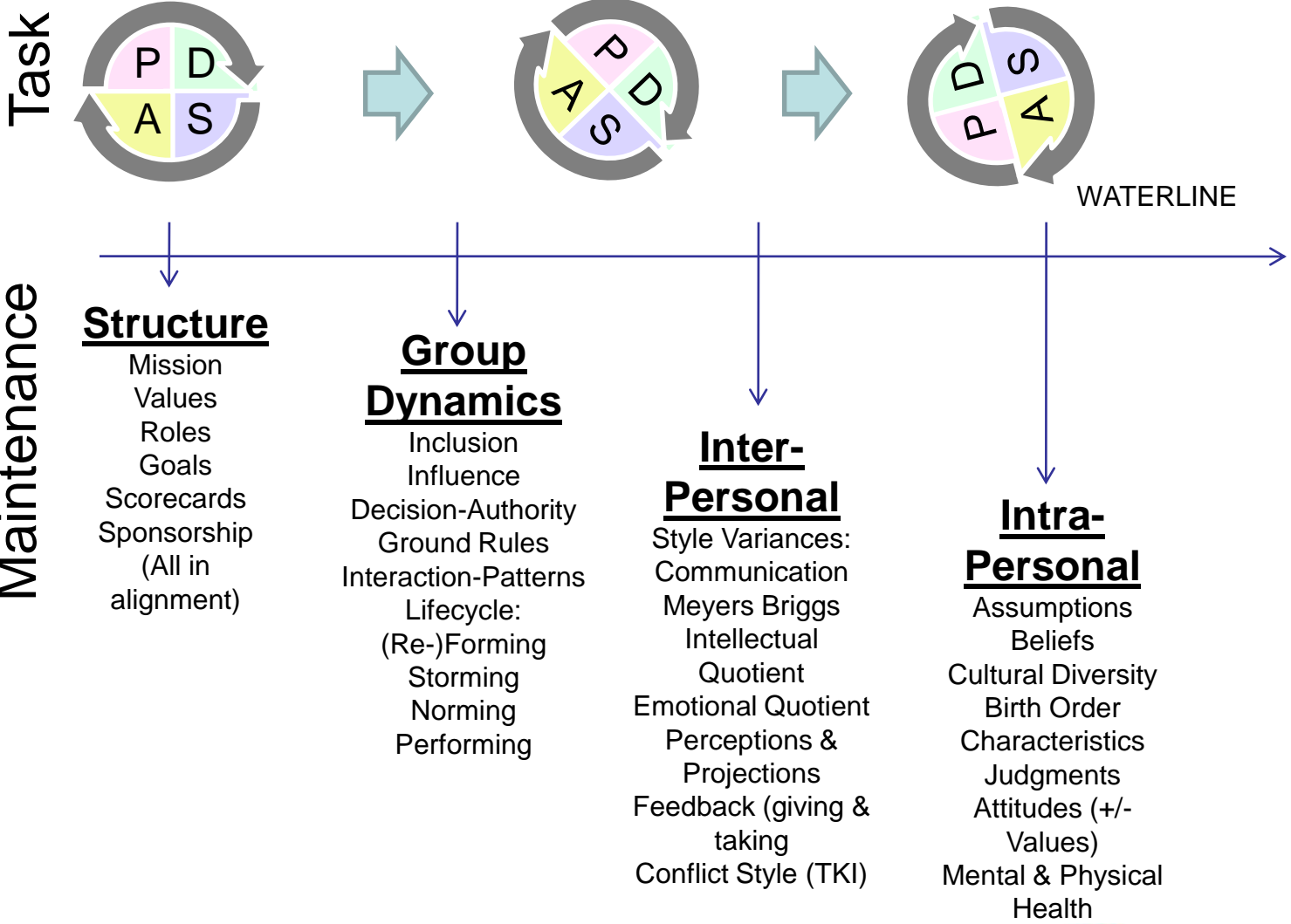
- It is important to meet a practice where they are.....
  - Beginner, experienced, or advanced
  - Small, medium or large practices
  - Stand alone, group or system infrastructures

# Practice Transformation Coaching

- Recognition that medical practices often need flexible, hands-on support when embarking on a program of practice improvement

*“flexible hands-on support”*...is something a coach can provide

# System of Continuous Improvement



System of Continuous Improvement Model, Wells Metz, K, & Cross, K: 2011 (adapted from Waterline Model, Harrison, Short, Scherer: 1970 & PDSA Cycle, Walton & Edwards Deming: 1986)

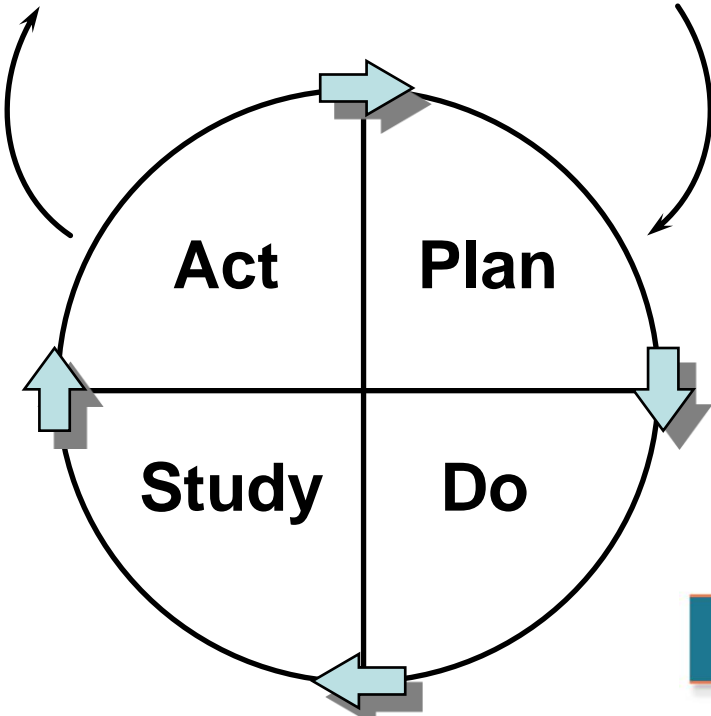
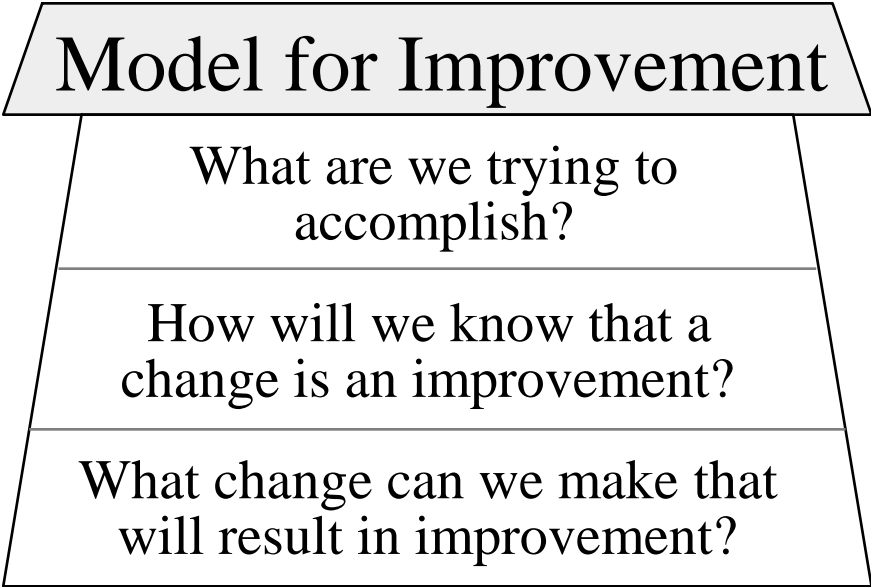


# A Coach.....

Works to facilitate:

- the necessary bridge to implementing the change concepts
- motivate and prompt people to make changes
- extend the horizons of the teams
- a positive effect on team building
- development of an emotional bond, which can be a key success factor for coaching

# More Specifically



# The Puzzle is Coming Together

*into a vision for transformation*

- Once you know what your aim is-
  - You begin to see your way to accomplishing
  - Measuring, and
  - Improving

*Through team building, education, coaching and quality improvement work.*

*Our Aim is to create a PCMH with on-going quality improvement, staff satisfaction, improved clinical outcomes that reduce the cost of care, while improving the patient experience.*

Pat will give you more details about how to go about doing this.....

# Pat Justis, MA

Manager, PCMH Collaborative  
WA State Department of Health

# Measurement

- What measures should a patient-centered medical home use?
- How do we keep the tail of measurement from wagging the dog of clinical practice?
- What are the lessons learned related to measurement from the WA Patient-Centered Medical Home Collaborative?

# Two Key Elements

## Review of the influences

- Institute for Healthcare Improvement: Triple Aim
- NCQA
- Meaningful Use

## Lessons from WA PCMH

**Collaborative** (*tips on collecting and analyzing*)

- Health information technology integration
- Data control
- Process and outcome
- Pragmatic test for measures

# Triple Aim: Ethical and Balanced

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

50 organizations from the US, Canada, England, Scotland, Sweden, Australia, New Zealand, and Singapore.

# IHI Operational Definition

## Population health

- **Health/functional status –single or multi-domain**
- Risk status-composite health risk appraisal score
- Disease burden-incidence and or prevalence, summary of predictive model scores
- Mortality-life expectancy, years of potential life list, standardized mortality rates

# IHI Operational Definition

## Patient Experience

- Standard questions for surveys (Examples: CAHPS or How's Your Health)
- Experience questions (CareQuality Commission)
- Likelihood to recommend
- Set of measures based on key dimensions  
( e.g. IOM Quality Chasm aims; safe, effective  
timely efficient, equitable and patient-centered)

# IHI Operational Definition

## Per Capita Cost

- Total cost per member per month
- Hospital and ED rates of utilization
- Admittedly the toughest for primary care, health information exchange opens the door to better data access.

# NCQA:

## PCMH Standards Relevant to Measurement

- The practice collects demographic and clinical data for population management
- The practice assesses and documents patient risk factors.
- The practice identifies patients for proactive and point-of-care reminders .

## Pediatric patients:

- Preventive measures include developmental screening, immunizations and depression screening

# NCQA:

## PCMH standards relevant to measurement

- The practice identifies vulnerable patient populations.
- Obtain performance data for key vulnerable populations.
- The practice tracks utilization measures such as rates of hospitalizations and ER visits.
- The practice demonstrates improved performance.

# NCQA:

## PCMH Standards Relevant to Measurement

- The practice uses performance and **patient experience** data to continuously improve.
  - Feedback on experiences of vulnerable patients
  - Feedback through qualitative means
  - Survey that evaluates: access, communication, coordination, self-management support
  - PCMH version of CAHPS survey tool

# Meaningful Use

- Use the free NCQA and Meaningful Use crosswalk document
- Available for free with other NCQA documents, must register with site and “purchase” for \$0.00

## Basics

- Height, weight, BP, BMI, growth rate ages 2-20, smoking status age 13+

# NCQA/Meaningful Use crosswalk

## Population management

- Generate lists of patients and proactively remind patients/families and the clinical team
  - At least three different preventive care services
  - At least three different chronic or acute care services
  - Patients not recently seen
  - Specific medications

# Tips on Defining and Collecting Measures

- Look for alignment so the fewest measures meets the greatest number of objectives and goals.
- Look for ways to embed the data collection in process steps that have to be performed for other reasons; a normal part of the work.
- The devil is in the details; work hard up front on data definitions that are clean.

# Simple Things Can Dirty the Data

- One provider records weights in metric, another in imperial.
- One provider records foot exams as “complete” and the date, another writes “WNL” and the date.
- Beware of all free text-it will not help manage population health



# Beware

- To state the obvious; an EMR is not a population health registry.
- Freestanding registries will require double entry unless you have a connective tool to mine data.
- Beware: DO NOT wait for the IT people to run reports...
- Clinical teams should be able to control reporting and access reports daily.

# Tips on Defining and Collecting Measures

- Health information technology and measurement are intertwined.
- Select tools:
  - that prevent double entry,
  - give the clinical team control of queries,
  - and can be used in “real time.”
- Canned EMR query modules may be frustrating and essentially low value.

# More Tips

- Every measure should imply what to improve.
- Make up some data; could you imagine taking action? If not, the measure is busy work.
- Look for fast cycling proxies for longer term outcomes.
- Balance outcome and process; both are needed.

# Tips on Analysis

- Define the headlines; what is the data saying to do?
- Not only the what, but the so what...
- If you have picked the right measures, your team is committed to the improvements and is excited to see the next data point.

# Best Case Scenario

*Here is what you are striving towards:*

- An office admin staff person is visibly excited to see the next report, because she is eager to see if the improvements the team has been working on have made any difference. She “owns” the improvements because she is a valued member of the team and she works for *the patient*.

# Summary

- Create a scorecard with measures that are aligned with multiple objectives, as few as feasible to meet your goals.
- Take the time to clean up data and clarify work flows.
- Use tools that make the right measures easy.
- Work towards a team that pays daily attention to a few powerful measures.

# Overall Summary

- PCMH is an important model providing a team based and patient-centered approach for improved outcomes
- Where you start, how long it takes and where you end up is clinic specific and requires a long term commitment
- Coaching and building teams focused on continuous process and quality improvement is critical
- Collecting data and measuring outcomes is key to knowing if the work you are doing is accomplishing the desired outcomes.



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# QUESTIONS?

## Contact Information

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