



Washington  
State **Medical**  
Association | **WSMA**

## ***Medical Homes- Understanding the Model***

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## Program Objectives:

I – Understand the Medical Home model, Learn the basic components of that model, its variations; Developments; Resources.

High level overview: Explain basic components, and Guide you to materials for further study and consideration.

II – Medical Home: Electronic Health Record “Toolkit”

*Note on the approach to this presentation:*

- *Will call out only the key points during the presentation.*
- *Provide a lot of information for your post-presentation review.*

## **Medical Homes**

Concept developed, refined and promoted through:

- National Medical Specialty Societies
- Policy centers
- State law and initiatives
- Federal law and initiatives.

Competing programs, with varying “standards,” offering:

- Accreditation
- Certification
- Achievement
- Recognition.

## Medical Homes

### *Brief history*

- 1967: American Academy of Pediatrics (AAP) introduces the term “medical home”.
- 1989: WA Medicaid *Healthy Options* Managed Care – provide patient with a “medical home”, not just a “coupon.”
- 2002 – 2004: AAFP *Future of Family Medicine* Project.  
[www.aafp.org/online/en/home/membership/initiatives/futurefamilymed.html](http://www.aafp.org/online/en/home/membership/initiatives/futurefamilymed.html)
- 2005: AAFP *TransforMED* ([www.transformed.com/](http://www.transformed.com/)) – provides consultation and support to physicians looking to transform their practices to a patient-centered medical home.
- 2006: Tested *TransforMED* with 36 practices.

## Medical Homes

### *Brief history*

- 2007:

### *Joint Principles of the Patient-Centered Medical Home:*

American Academy of Family Physicians (AAFP)

American Academy of Pediatrics (AAP)

American College of Physicians (ACP)

American Osteopathic Association (AOA)

- Set of seven principles describing the characteristics of a practice-based care model for providing comprehensive primary care for children, youth and adults in a health care setting.

### **Medical Homes – Selected Initiatives:**

- **AAFP - *TransforMED*** (2005)
- **Patient-Centered Care for the Safety Net System:**  
*The Safety Net Medical Home Initiative* (2008)

### **Washington State:**

- *Patient-Centered Medical Home Collaborative*
- *Washington State Medical Home Initiative* (SB 5891-2009)

**AAFP:** ( [www.aafp.org/value](http://www.aafp.org/value) )

*TransformMED* (2005)

[www.transformed.com/small-practice-pkg.cfm](http://www.transformed.com/small-practice-pkg.cfm)

- Small and solo practices can achieve measurable results by transforming into *Patient-centered Medical Homes* (PCMHs):
  - ▶ Improving quality outcomes; Improving financial outcomes.
  - ▶ Reducing ER visits and hospital admissions through improved ambulatory access.
  - ▶ Cutting the total cost of care for patients.
  - ▶ Making positive changes to the practice's work environment, including advanced team care.
  - ▶ Making meaningful use of EHRs and innovative technologies to improve patient care.

**AAFP:** ( [www.aafp.org/value](http://www.aafp.org/value) )

*TransformMED* (2005)

[www.transformed.com/small-practice-pkg.cfm](http://www.transformed.com/small-practice-pkg.cfm)

- The *Small Practice Package* is designed exclusively for small practices with 1 - 4 providers.
- Package bundles together the *change components* that small practices need to become PCMHs.

## ***Medical Homes- Understanding the Model***

### **AAFP: *TransformMED Small Practice Package***

- PCMH Assessment to identify expectations, define processes and clarify objectives.
- Gap Analysis to pinpoint both your practice's current state
- Comprehensive Transformation Plan to prioritize and operationalize roadmaps and timelines.
- Dedicated Program Advisor to provide guidance and feedback in 4 scheduled conference calls per year.
- 3 Memberships in Delta-Exchange - the online learning community for primary care.
- Enrollment in TransformMED's PCMH learning collaborative.
- Assistance with NCQA Recognition.

## ***Medical Homes- Understanding the Model***

### **AAFP & Medical Group Management Association (MGMA)**

<http://blog.mgma.com/new---patient-centered-medical-home-workbooks--edc/>

#### ***TransforMED - Patient-Centered Medical Home Workbooks :***

4 released to date; possible 18 in series:

- *“Is PCMH Right for My Practice?” Workbook*
- *Patient Centered Medical Home - Care Management Workbook*
- *Patient Centered Medical Home - Access Workbook*
- *TransforMED’s Care Coordination Workbook*

## ***Medical Homes- Understanding the Model***

**MGMA:** ([www.mgma.org](http://www.mgma.org))

*The Patient Centered Medical Home: 2011 Status and Needs Study - Reestablishing Primary Care in an Evolving Healthcare Marketplace*

- Survey responses - Top five challenges faced by accredited or recognized PCMH practices during their transformation to becoming a PCMH (*descending order*):
  - ▶ Establishing care coordination agreements with referral physicians.
  - ▶ Financing the transformation to PCMH.
  - ▶ Coordinating care for high-risk patients.
  - ▶ Modifying or adopting an EHR system to support PCMH related functions.
  - ▶ Projecting financial effects (practice revenue, costs, etc.) of the transformation to PCMH.

### **Patient-Centered Care for the Safety Net System:**

#### ***The Safety Net Medical Home Initiative***

- May 2008 - *The Commonwealth Fund, Qualis Health and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute* launched an initiative to help *primary care safety net clinics* become high-performing patient-centered medical homes.
- The goal is to develop a replicable and sustainable implementation model for medical home transformation.
- In PCMH practices, patients receive well-coordinated services and enhanced access to a clinical team. Clinicians practicing in PCMHs use decision support tools, measure their performance, engage patients in their own care and conduct quality improvement activities to address patients' needs.

### **Patient-Centered Care for the Safety Net System: *The Safety Net Medical Home Initiative***

Framework includes eight “[change concepts](#)”, with *Implementation Guides* available to practices:

[www.qhmedicalhome.org/safety-net/publications.cfm](http://www.qhmedicalhome.org/safety-net/publications.cfm)

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

### **Patient-Centered Care for the Safety Net System:**

### ***The Safety Net Medical Home Initiative***

#### **Empanelment**

- Determine and understand which patients should be empanelled in the medical home and which require temporary, supplemental or additional services.
- Use panel data and registries to proactively contact, educate and track patients by disease status, risk status, self-management status, community and family need.
- Understand practice supply and demand, and balance patient load accordingly.

### **Patient-Centered Care for the Safety Net System: *The Safety Net Medical Home Initiative***

- PCMH Assessment Tool allows practices to gauge their progress in implementing each of the “change concepts”.

Available as an interactive PDF that can be downloaded, completed, saved and shared.

## **Patient-Centered Care for the Safety Net System: *The Safety Net Medical Home Initiative***

### **Facilitator's Guides**

- Rapid Fire Session: Instruction Guide for Session Facilitators used to harvest best practices from improvement teams.
- Implementing the Patient-Centered Medical Home Model: A Practice Facilitator's Guide to Visiting Clinical Teams focuses on practice facilitation, used in combination with structured learning collaboratives to help practices implement a complex intervention such as the PCMH.

## ***Medical Homes- Understanding the Model***

### **Washington State – Department of Health *Patient-Centered Medical Home Collaborative***

Joint project with

#### **Washington Academy of Family Physicians**

( [www.doh.wa.gov/cfh/MH-Coll/default.htm](http://www.doh.wa.gov/cfh/MH-Coll/default.htm) )

( [www.doh.wa.gov/cfh/MH-Coll/publications/MedHmCollFacts11.pdf](http://www.doh.wa.gov/cfh/MH-Coll/publications/MedHmCollFacts11.pdf) )

- Collaborative: A learning process for medical teams to improve primary care for their patients. Through 2011, 32 *teams* in Washington will create patient-centered medical homes.
- The *physician and care team* build strong relationships with the *patient* and the *patient's family*. Patient-centered care *makes the patient a partner* in health care decisions.
- The *team coordinates care* with specialists or other health providers.

## Washington State – Department of Health *Patient-Centered Medical Home Collaborative*

- The team commits to work on *measurable improvements to quality*. A collaborative is a *quality improvement process* where 15-40 medical teams work to measure and improve the quality of care in their practices during a project period of one or two years.
- The collaborative takes a *team approach* to quality improvement, rather than focusing only on the doctor-patient relationship.
- Teams have at least *three health professionals*. Senior management support is critical to success.

## ***Medical Homes- Understanding the Model***

### **Washington State – Department of Health *Patient-Centered Medical Home Collaborative***

- The goal is to *improve health* for patients and *improve the experience of care* for patients, families, and the clinic employees.
- Participants *learn from the experience of other clinics* enrolled in the collaborative. At group sessions, teams develop knowledge and skills. They learn about current research and successes in other places.
- Between learning sessions, *coaches visit medical offices and host monthly telephone and web conferences*. Teams share their results at an outcomes session at the end of the collaborative.
- Teams are encouraged to *make changes that will continue* after the collaborative ends.

## ***Medical Homes- Understanding the Model***

### **Washington State – Department of Health *Patient-Centered Medical Home Collaborative***

***“Save the Date”:***

***Tuesday, November 15, from 12:15 - 1:15 pm (PT) to participate in the follow-up webinar:***

### ***Washington State’s Patient Centered Medical Home Collaborative: Lessons Learned***

Offered through ***Clinical Performance Improvement Network*** (CPIN) series, by the ***WSMA Foundation for Health Care Improvement***, in collaboration with ***Puget Sound Health Alliance*** and ***Washington Academy of Family Physicians***.

### **Washington State Medical Home Initiative**

- Senate Bill 5891 passed in 2009 legislature. State Health Care Authority and Puget Sound Health Alliance collaborated in convening health plans, providers, and purchasers.

[www.hca.wa.gov/medical\\_homes.html](http://www.hca.wa.gov/medical_homes.html)

- Eight health plans initially participating.
- Health plans' claims data aggregated and analyzed.
- Selection of advanced practices (experience in care management); coordination with existing Medical Home collaborative.

### **Washington State Medical Home Initiative**

- Pilot launched May 1, 2011, with seven health plans remaining, with eight practices (across 12 clinic sites), and approximately 25,000 patients.
- 32 month duration of the pilot.
- Model agreed upon pays an additional “care management” fee on a “per member per month (PMPM) basis.
- Outcomes analyzed are avoidable emergency department use and avoidable hospitalizations. Reconciliation affects the net payment to the practices (risk bearing arrangement).

### **(PP)ACA – (Patient Protection and) Accountable Care Act**

Emerging variations – March 2010

- **Sec. 1301. Qualified health plan defined.**

Requires qualified health plans to be certified by Exchanges, provide the essential health benefits package, and be offered by licensed insurers that offer at least one qualified health plan at the silver and gold levels. Section 10104 strikes the community health insurance option from this section, adds multi-state plans, and allows qualified health plans to provide coverage ***through a qualified direct primary care medical home plan*** that meets requirements established by the Secretary of HHS.

### **(PP)ACA – (Patient Protection and) Accountable Care Act**

Emerging variations – March 2010

- **Sec. 2703. State option to provide health homes for enrollees with chronic conditions.**

Provide States the option of enrolling Medicaid beneficiaries with chronic conditions into a ***health home***. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination.

### **(PP)ACA – (Patient Protection and) Accountable Care Act**

Emerging variations – March 2010

- **Sec. 3021. CMS Center for Medicare and Medicaid Innovation**

CMS Center for Innovation to test care models that improve quality and slow the rate of growth in Medicare costs. Promoting broad payment and practice reforms in primary care, including ***patient-centered medical home models*** for high-need individuals and ***medical homes*** that address women's unique health care needs. Establishing community-based health teams to support ***small-practice medical homes by*** assisting primary care providers in chronic care management, including patient self-management activities.

### **(PP)ACA – (Patient Protection and) Accountable Care Act**

Emerging variations – March 2010

- **Sec. 3502. Grants or contracts to establish community health teams to support the patient-centered medical home.**

Creates a program to establish and fund the development of community health teams to support the development of *medical homes* by increasing access to comprehensive, community based, coordinated care. Section 10321 clarifies that nurse practitioners and other primary care providers can participate in community care teams.

### PCMH Accreditation, Certification, Achievement and Recognition programs

Competing programs with varying standards:

- **Accreditation Association for Ambulatory Health Care:**  
*2011 Medical Home Standards*
- **Joint Commission:** *Primary Care Medical Home 2011 Standards and Elements of Performance* (July 2011)
- **National Committee for Quality Assurance:**  
*Patient-Centered Medical Home 2011 Standards*
- **URAC:** *Patient Centered Health Care Home (PCHCH) Practice Achievement Version 1.0* (June 2011)

Originally, URAC was incorporated under the name "Utilization Review Accreditation Commission"; shortened to only the acronym in 1996.

### **PCMH Accreditation, Certification, Achievement and Recognition programs**

- *“Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs – 2011”*

February 2011: *“Guidelines”* developed jointly by:

- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics (AAP)
- American College of Physicians (ACP), and
- American Osteopathic Association (AOA).

*“Guidelines”* offer 13 criteria for evaluating what a PCMH Recognition and Accreditation program should incorporate.

e.g.: *Guideline #3. Ensure the incorporation of patient and family-centered care, emphasizing engagement of patients, their families and their caregivers.*

### PCMH Accreditation, Certification, Achievement and Recognition programs

- **Medical Group Management Association (MGMA)**

*The Patient Centered Medical Home Guidelines:*

*A Tool to Compare National Programs 2011*

MGMA developed a *comparison tool* to assess how each of the national PCMH programs meets the “*Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs – 2011*” (which were developed by AAFP, AAP, ACP, AOA).

Retrieve the MGMA comparison tool at:

[www.ncqa.org/LinkClick.aspx?fileticket=C2iuYXLkw4I%3d&tabid=948](http://www.ncqa.org/LinkClick.aspx?fileticket=C2iuYXLkw4I%3d&tabid=948)

### Other Resources:

- **Patient Centered Primary Care Collaborative**

*Proof in Practice: A compilation of patient centered medical home pilot and demonstration projects (www.pcpcc.net)*

- **The Commonwealth Fund: *Patient-Centered Care Portal***

[www.commonwealthfund.org/Topics/Patient-Centered-Care.aspx](http://www.commonwealthfund.org/Topics/Patient-Centered-Care.aspx)

- **Health Affairs ( [www.healthaffairs.org](http://www.healthaffairs.org) )**

Rich resource of research on Medical Homes

July 2011: *Small and Medium-Size Physician Practices Use Few Patient-Centered Medical Home Processes*

[www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=25](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=25)

## **Program Objectives:**

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*II – Medical Home: Electronic Health Record “Toolkit”*

# Medical Homes- Understanding the Model

## Medical Home: Electronic Health Record “toolkit”

### EHR Rating in Support of Medical Home Functionality

Vendor:           Name of Vendor and Specific EHR Product          

<u>Item</u>	<u>Evaluation Criteria</u>	<u>Y/N</u>	<u>Weight</u>	<u>Pts</u>
<b>1</b>	<b>Disease Registry Functionality (select one only = Y)</b>			
	Fully Integrated, no duplicate data entry needed	Y	20	20
1a	Integrated, but requires duplicate data entry		12	
1b	Separate, but EHR data is loaded automatically		10	
1c	Separate, and EHR data requires re-keying		5	
1d	No current disease registry function in the EHR		0	
1e				
<b>2</b>	<b>Disease Registry supports multiple conditions</b>	Y	10	10
<b>3</b>	<b>If 2=Y, Disease Registry reports are easy to understand</b>	Y	10	10
<b>4</b>	<b>Other Important Functionality Supporting Medical Home</b>	Y	20	20
<b>5</b>	<b>Other Important Functionality Supporting Medical Home</b>	Y	20	20
<b>6</b>	<b>Other Important Functionality Supporting Medical Home</b>	Y	10	10
<b>7</b>	<b>Other Important Functionality Supporting Medical Home</b>	Y	10	10
<b>Total Score for This Vendor/Product</b>				<b>10</b>
<b>Percent of Total Possible Points</b>				<b>0%</b>

### **Medical Home: Electronic Health Record “Toolkit”**

#### **Issue:**

- Monitoring the numerous PCMH Standards imposes considerable administrative burden on practices. EHRs can help manage those data.
- The variation across the standards sets used by the four main external bodies further complicates that undertaking.
- To successfully perform that monitoring and reporting, it is important to determine if an Electronic Health Record under consideration to be acquired by the practice, or already acquired, has the inherent capability to perform those functions.
- The *EHR Toolkit*, made available by the *Washington State Medical Foundation for Health Care Improvement*, allows a practice to input different standards, using the toolkit as a repository for managing the evaluation of the specific EHR product(s), thereby managing that assessment in an objective manner.

## ***Medical Homes- Understanding the Model***

### ***Medical Home: Electronic Health Record “toolkit”***

#### **Illustration:**

- The following slides provide background on the standards used in relation to a Patient Centered Medical Home model.
- The slides also illustrate an example of a particular standard, and how that standard will be used in conjunction with the *EHR Toolkit*.

### *Medical Home: Electronic Health Record “toolkit”*

**Standards of Performance;**

**Achievement of Standards; Recognition**

External bodies that:

- assess achievement of standards, and
- provide recognition of those achievements  
(in contrast to a practice’s self-assessment)

Example:

- **NCQA** – National Committee for Quality Assurance (1990)

### ***Medical Home: Electronic Health Record “toolkit”***

#### **Using the HIT Electronic Toolkit: Overview**

1. Download *Health Information Technology (HIT) Electronic Toolkit and Instructions* from the **WSMA Practice Resource Center** webpage [www.wsma.org/practice\\_resource\\_center/practice-management-operations.cfm](http://www.wsma.org/practice_resource_center/practice-management-operations.cfm)
2. Determine which *Accreditation organization(s)* your practice already works with, or is considering (e.g.: NCQA). Download the specific *PCMH Standards* of that *Accrediting organization* (or organizations).

### **Medical Home: Electronic Health Record “toolkit”**

#### **Using the HIT Electronic Toolkit: Overview**

3. Use the *HIT Electronic Toolkit* by entering those Standards. Then begin to assess on a “by standard” basis whether the Electronic Health Record system(s) under consideration by your practice can perform the functions required by that standard. The EHR system representative should be able to provide those answers; record specifics (including assertions) in the Toolkit. Use closed end (“yes/no”) criterion and/or variable rating (e.g.: “*Low/Medium/High*”; “*1 – 5, with 5 being the highest*”).
4. Compile that information and use those findings to help inform and guide your assessment of the capabilities of the EHRs under consideration.

### **Medical Home: Electronic Health Record “toolkit”**

#### **Example**

#### **NCQA - ELEMENT 1A: Access and communication processes**

“The practice has written processes for scheduling appointments and communicating with patients.”

*“The practice should have a written process that clearly communicates its scheduling policies. Policies should reflect how the practice accommodates patient needs and medical conditions, patient access to after-hours care and type of communication patients can expect with the practice’s physician and staff. The element’s intent is that written policies offer patients timely access to care, same-day response to phone inquiries, expanded visit hours and coordination of care between the physician’s practice and other clinicians.”*

### **Medical Home: Electronic Health Record “toolkit”**

#### **Example**

#### **NCQA - ELEMENT 1A: Access and communication processes**

“The practice has written processes for scheduling appointments and communicating with patients.”

#### *Sample Standard*

#### Operations Steering Committee Goals for Advanced Access

1. Maintain percentage (%) of patients seen with 0-3 days at greater than (>) or equal to (=) 60%.
2. Maintain See Your Own (SYO) Ratio at 60% -80% to ensure patients have access to their Primary Care Provider (PCP). If SYO Ratio drops below 60%, consider closing PCP's practice to new patients.
3. Maintain same day capacity sufficient to avoid triage of patient requests, with goal that patients phoning in a given day will be offered an appointment for that same day, regardless of acuity of patient problem

# Medical Homes- Understanding the Model

## Medical Home: Electronic Health Record “toolkit”

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			<b>Total Score for This Vendor/Product</b>	<b>10</b>
				<b>0</b>
			<b>Percent of Total Possible Points</b>	<b>0%</b>

## **Medical Home: Electronic Health Record “toolkit”**

### **Physician Practice Connections - Patient Centered Medical Home**

NCQA Physician Recognition in *PPC-PCMH*

### **Electronic Capabilities (“IT Required” in *PPC-PCMH* Standards)**

These elements were developed with a small practice in mind, and so do not exclude practices with minimal electronic capabilities. Electronic capabilities are defined for each element by these three categories:

1. *Limited*: Paper-based or basic (mostly administrative; for example, scheduling, claims) electronic system.
2. *Some*: Electronic system for clinical functions.
3. *Fully Integrated*: Electronic system with connectivity or interoperability with other systems.

More than *half the elements* fall within the *Limited Electronic Capabilities* category. The practice can focus its efforts on areas where it is most likely to meet requirements with their current IT resource use.

## **Medical Home: Electronic Health Record “toolkit”**

**Standards of Performance;  
Achievement of Standards; Recognition**

### **NCQA**

Offers *Accreditation* Programs, *Certification* programs, and Physician Recognition programs.

**Physician Practice Connections - Patient Centered Medical Home**  
NCQA *Physician Recognition* in PPC-PCMH

[www.ncqa.org/tabid/440/Default.asp](http://www.ncqa.org/tabid/440/Default.asp)

[www.NCQA\\_PCMH\\_Recognition\\_Process\\_2011.pdf](http://www.NCQA_PCMH_Recognition_Process_2011.pdf)

**Patient-Centered Medical Home Standards and Guidelines**

*2011 PCMH Standards and Guidelines - free*

[www.ncqa.org/tabid/629/Default.aspx#pcmh](http://www.ncqa.org/tabid/629/Default.aspx#pcmh)

## **Medical Home: Electronic Health Record “toolkit”**

## **Patient-Centered Medical Home Standards and Guidelines**

**NCQA:** Key materials

2011 PCMH Standards and Guidelines

Item # 30004-301-11 ( Free )

[www.ncqa.org/tabid/631/Default.aspx](http://www.ncqa.org/tabid/631/Default.aspx)

Other materials:

- PCMH 2011 *Overview*
- PCMH 2011 *Content and Scoring Summary*
- *Pricing and Fee Schedule* for PCMH 2011
- PCMH 2011 *Recognition Process*

## Summary:

- The *Patient Centered Medical Home model* is getting increasing visibility as a means to improve the quality of care delivery, while concurrently making better use of clinical and financial resources.
- Pressures on physician practices, in primary care and specialty care, are likely to escalate, as external funding sources of purchasers, health plans and entitlement programs seek to accomplish “more with less” in health care delivery.
- The reliance upon electronic health records (EHRs) to manage, assess and share data on care delivery, and the downstream expectations for improvements and efficiencies, will increase.
- Practices will need to rely on EHRs to accomplish those essential functions; EHRs must be assessed *prior to* and *after* acquisition to ensure those functions can be achieved.

Thank you.

