

# Patient-Centered Medical Home Sustainability Tool

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# Objectives

- Explain the project work and theory behind our PCMH sustainability tool
- Show our tool's method of assessing PCMH sustainability and the drivers behind its creation
- Present how the tool can enable practices to start managing their PCMH costs to help sustain the PCMH model in preparation for advanced healthcare delivery models

## Question #1: Process

How are you continuing the PCMH process post-recognition?

Part of sustaining PCMH is following your PCMH related policies and procedures.

## Question #2: Performance

What impact is PCMH having on the practice?

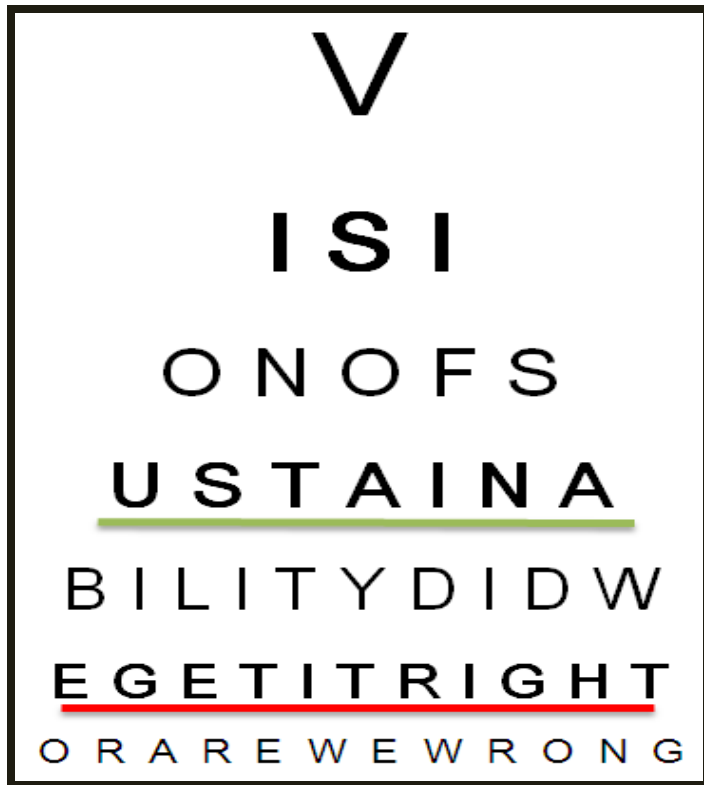
If you are spending a lot of resources to maintain your PCMH activities, is your PCMH model of care delivery sustainable?

## Question #3: Outcome

By following your processes and performing them well (or poorly), what overall impact are you having on your patient population?

The PCMH care delivery model may be costly but improves patient health and experience. This dynamic needs to be considered when making management decisions on whether to expand, reduce, or rework PCMH activities.

# How the Tool Looks at Sustainability



- Organizes & integrates PCMH recognition data
- Evaluates PCMH effectiveness
  - Breaks down data in three ways: processes, performance, and outcomes
- Provides best practices

# Relationship to Advanced Delivery Models

- PCMH is foundation of more advanced delivery models
  - ACO
  - Health Home
  - Pay for performance
- Efficiency has larger affect on bottom line under capitated payment models

# Tool Creation

- Literature Review
- Input from Expert Advisory Panel
- Interviews with CHCs and FQHCs in New York





# Literature Review: System-Focused PCMH Evaluation

- Aggregate Cost & Utilization:



- **But....**

- What was the cost to the practice?
- When are the cost savings and improvements in health realized?

## Promising Practices for Sustainability

- Geisinger's Proven Health Navigator™ & Rapid Cycle Innovation:
  - **Financial** and **quality** budgets are reviewed together
- Seattle's Group Health Cooperative's Medical Home
  - **Smaller primary care panel** size & increased visit time
- BCBS of North Dakota's MedQHome:
  - MDInsight: interactive tool that collects patient data from **multiple sources**

# Common Challenges for Primary Care Practices

- No standard measures
- No baseline data
- Right mix of process and outcome measures
- PCMH measured as sum of parts or as a whole integrated entity
- Evaluating “medical homeness” from the physician’s vs. the patient’s perspective
- Best internal practice processes for success of PCMH

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# Site Selection



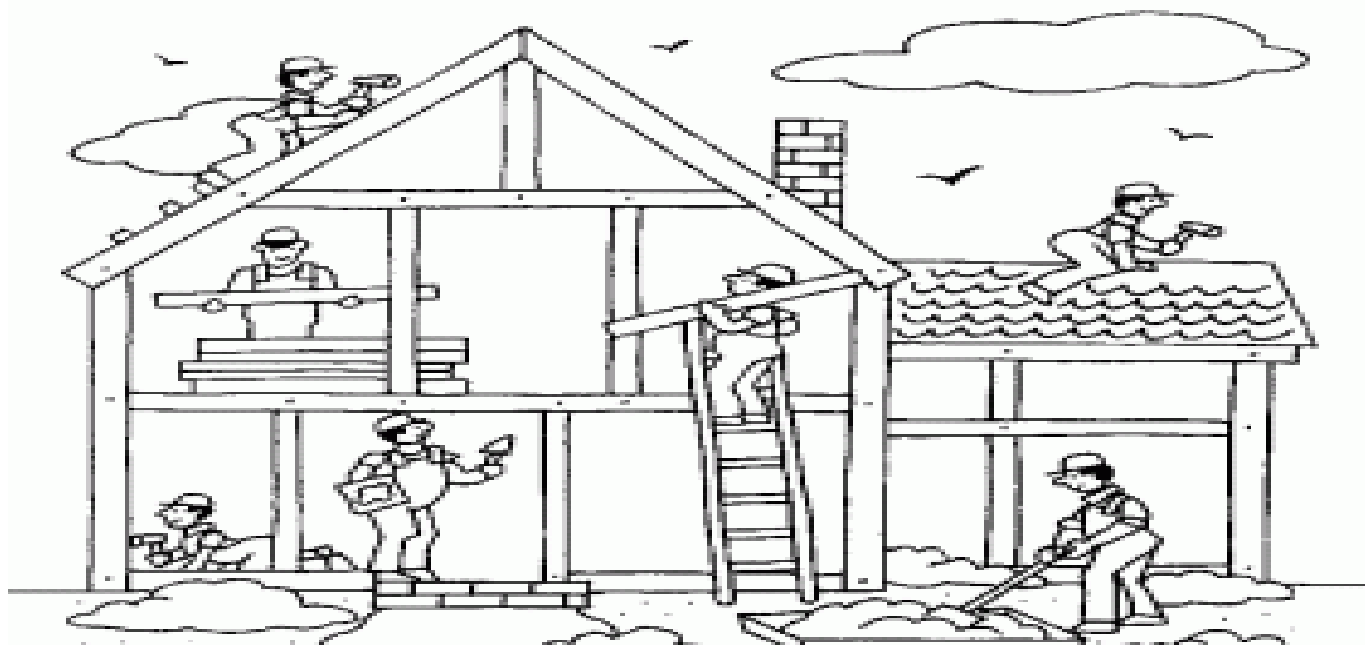
# Interview Summary

## Common Themes and Challenges:

- ‘closing the loop’ on all referrals (PCMH 5)
- Integrating patient care among all clinicians as well as the front desk staff (PCMH 1)
- Determining the effectiveness of reminder calls and patient mailings (PCMH 1 and 3)
- Defining the role of the patient navigator and determine how many are necessary to facilitate adequate care teams (PCMH 3)
- Using EMR data to effectively guide management decisions (PCMH 6)



# Building the PCMH Sustainability Tool

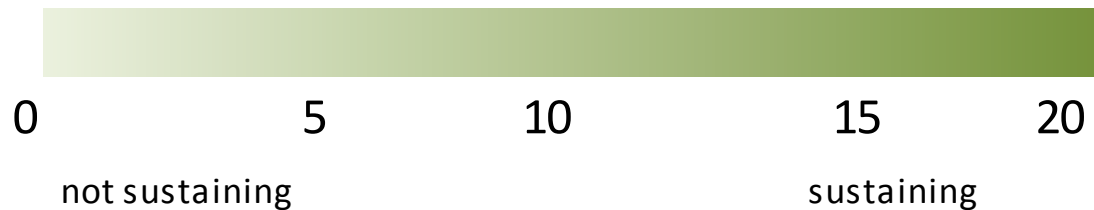


# So here's what we came up with...



# Sustainability Index

Sustainability Scores	
Section	Total Points:
Process	2
Performance	6
Outcome	2
<b>Overall Sustainability Score:</b>	<b>10</b>



# Process

PCMH Sustainability Toolkit: Process			
Question	Response	Recommendation	Sustainability Points
1. Does your practice review your medical home standards/ policies on patient access at least annually?	no	Policy review and revision should be done at least annually. A policy team should review patient experience data on patient access to assess if the clinic's policies address and meet the standard of service established by the organization.	
2. Does your practice maintain a process for performing patient experience surveys at least annually?	maintain		0.75
3. Do you <b>create and use</b> quarterly reports from an EMR to assess collection for patient demographic data:			
a. Date of Birth	yes		0.25
b. Gender	yes		0.25
c. Race	yes		0.25
d. Ethnicity	yes		0.25
e. Preferred Language	no		

# Performance

Factor 1A2	Activity:	Responding to patient calls during office hours
	Is the site performing the activity? (1=yes, 0=no)	1
	Total # of active patients for 12 month period	3000
	Avg. # of minutes per call	4
	Total time for activity (minutes)	12000
	Total time for activity (hours)	200
	<b>Inputs</b>	
	Staffs responsible	RN & MA
	Average hourly wage	\$ 25.00
	Hours for activity	200
	Total activity cost	\$ 5,000.00
	Cost per patient call	\$ 1.67

# Performance Summary

## PCMH Sustainability Toolkit: Performance PCMH Budget

	PCMH Activity	Cost	Cost/patient	Must Pass Standard Met
<b>PCMH Factors in Must Pass Elements</b>				
1A2	Responding to patient calls during office hours	\$ 6,000.00	\$ 2.00	
1A3	Responding to patients' electronic messages	\$ 10,500.00	\$ 3.50	
1A4	Documenting clinical advice given via phone or electronic message in medical record	\$ 3,000.00	\$ 1.00	

<b>Actual PCMH Budget</b>	\$ 241,316.67
<b>Projected PCMH Budget</b>	\$ 200,000.00
<b>Additional per member payments for PCMH recognition (if applicable)</b>	\$ 216,000.00

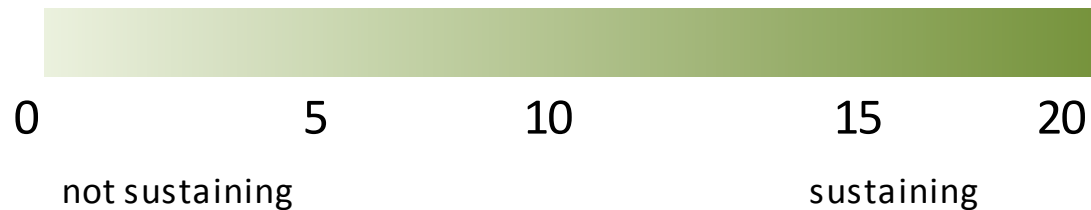
All 6 Must Pass Elements Sustained		Sustainability Points
yes		6

# Outcomes

PCMH Sustainability Toolkit:				
Outcome				
Area	Score 1	Score 2	Change: *indicate improved, same, or worsened	Sustainability Points
<b>Patient Experience Scores:</b>				
	75	80	improved	1
<b>Clinical Measures:</b>				
1. A1C < 9	80%	90%	improved	1
2. Controlled BP 140/19	70%	70%	same	0
3. LDL/HDL				
<b>Preventive Measures:</b>				
1. adult immunizations	90%	88%	worsened	-1
2. pap smear	60%	60%	same	0
3. depression screening	50%	65%	improved	1
<b>Staff Satisfaction Scores or Staff Turnover Rate:</b>				
	80%	90%	improved	1
<b>Total Sustainability Points:</b>				<b>3</b>

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**It's QUESTION TIME!!**