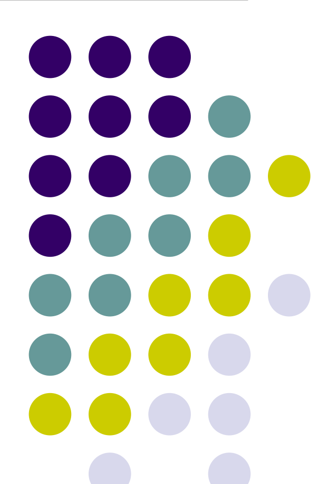
The Medical Home 2009

Paul Kaye, MD

Region II Conference

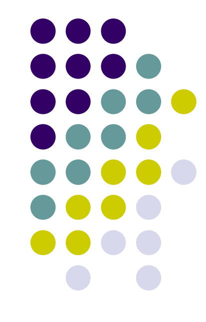
July 12, 2009



Medical Homes

- Old idea: American Academy of Pediatrics 1960s
- Patient Centered Primary Care Collaborative (2006)
  - Employers (IBM)
  - Payers (Wellpoint, Aetna, many others)
  - Primary Care Academies
  - Consumer groups

Patient Centered Primary Care Collaborative

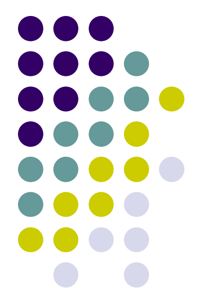


- 130+ organizations
- NACHC
- AFL-CIO
- AARP
- AAFP
- AAP
- ACP
- AOA
- BC/BS
- IBM
- Microsoft
- Fedex
- GE
- Walgreens
- Wellpoint
- ERIC (payer assoc.)
- Aetna
- United

Medical Home Development

- Standardized definition and qualification
- NCQA Physician Practice Connection-Patient Centered Medical Home
- Reimbursement reform: payment per patient in addition to FFS payment and P4P bonuses
- Aims to increase primary care compensation

Proposed Hybrid Blended Reimbursement Model

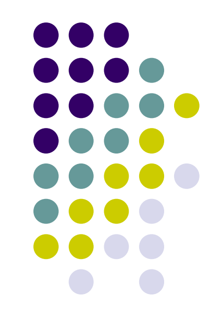


Performance-based Payment

Care Coordination Payment

Visit-based Reimbursement

State Medicaid Medical Home Initiatives

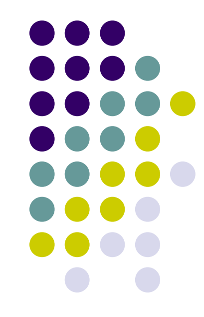


- From NASHP 2008 Scan: 31 states actively pursuing Medical Home initiatives
- 7 States participating in multi-payor projects
- New York: legislative initiative, DOH in final stages of planning
- New Jersey: proposed project for special needs children; otherwise no activity
- Puerto Rico/USVI-no activity reported

NCQA PPC-PCMH

- **Access and Communication**
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management Support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communications

NCQA Medical Home Domains and FQHC Characteristics



1. Access and communication

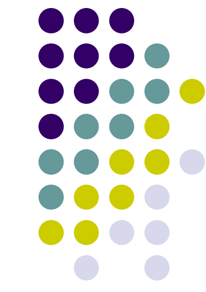
24-hour coverage on-site (86%)
Urgent medical care on-site care (86%)
Emergency medical services (43%)
Pharmacy services on-site (74%, including provider dispensed medications)

2. Patient tracking and registry

86% maintain disease registries for clinical support
80% in Health Disparities Collaborative (HDC)

3. Care management

92% provide case management services
97% provide health education
86% maintain disease registries for clinical support
80% in Health Disparities Collaborative (HDC)



4. Patient self-management support

92% provide case management services

97% provide health education

13% of health centers had a full electronic health record system

60% plan to adopt a system in the next three years

80% in HDC, which includes these elements

86% maintain disease registries

All participate in UDS data system

9. Advanced electronic health communications

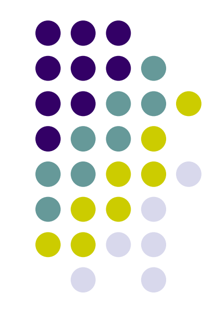
13% of health centers had a full electronic health record system

60% plan to adopt a system in the next three years

From: FINANCING COMMUNITY HEALTH CENTERS AS PATIENT- AND COMMUNITY-CENTERED MEDICAL HOMES: A PRIMER

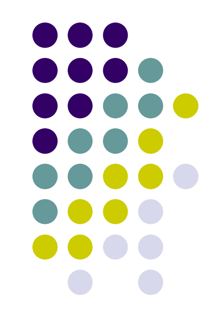
Shin, Ku, Jones, Finnegan, Rosenbaum, 2009
The George Washington University
Department of Health Policy
Geiger Gibson Program in Community Health Policy

Beyond the Medical Home



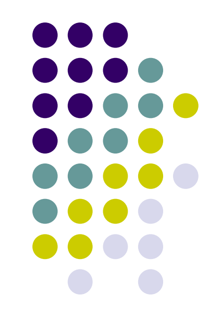
- Addressing the deeper roots of disparities
  - Economic Security
  - Educational and Career Opportunities
  - Addressing Racism and Building Trust
- Linkages to educational and economic community institutions
- Assistance in accessing economic benefits
- Building a diverse healthcare workforce and delivering care in a team-based setting
- Whole person care

Expanding the Medical Home Definition: Future Directions



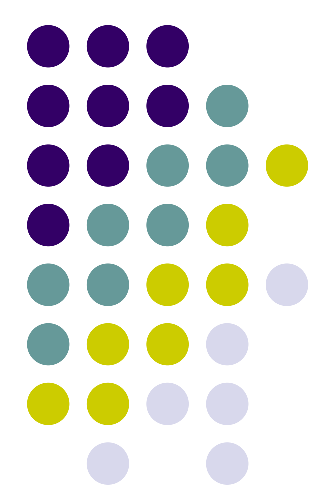
- NCQA revisions for ?2011-seeking input now
- More emphasis on outcomes and data
- More emphasis on Patient Surveys
- Diversity of staff
- Measurement of enabling services
- Access: What about financial access?
- Family involvement & Group Visits
- Medication Management, including access to medications
- Comprehensiveness of services-onsite

Beyond the Medical Home: A Health Care Home



- Integration of medical, oral, and behavioral health
- Pharmacy and lab services
- Facilitated enrollment into public benefit programs
- On site WIC services
- Outreach and transportation
- Community involvement and linkages

THINC Medical Home Demonstration Project



Project Design

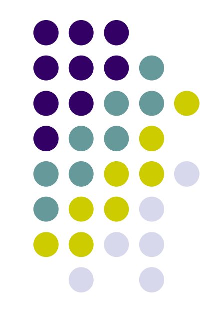
- Working with Weill Cornell Medical College to conduct a robust academic evaluation of project
- Goal is to determine incremental effects of P4P incentives and medical home implementation on quality and costs
- Five-group study with before-and-after evaluation and concurrent control groups (Groups 1 and 3) not adopting P4P

	Chart Type	P4P	Medical Home Practice Redesign
Group 1	Paper	No	No
Group 2	Paper	Yes	No
Group 3	EHR	No	No
Group 4	EHR	Yes	No
Group 5	EHR	Yes	Yes

Project Participants: Physicians

- 460 primary care physicians in Hudson Valley
  - 250 in quality metrics group only
  - 210 in quality metrics and medical home group
- Primary care is family practice, internal medicine, pediatrics, etc.
  - Does not include cardiology or OB/GYN
- Medical Home group diversity is unique
  - 3 FQHCs, 5 large multi-specialty groups, 1 pediatric practice, 4 small family physician practices

Project Participants: Health Plans and Employers

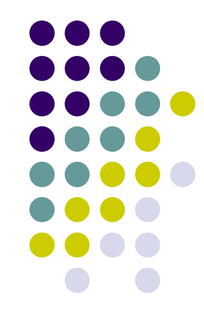


Six health plans

- Participate actively in project governance and design via the THINC Quality Committee
  - Formal committee of THINC's Board
  - All project design decisions are vetted through committee to ensure collaborative decision-making
- Provide claims data for metrics to data aggregator
- Pay incentives at end of 2009 after quality report card is issued

- IBM has pledged support with incentive payments

Hudson Valley Differentiators



- Key component is the existing EHR install base
- Multi-payor collaborative involving six health plans the approximately 53% of cover lives in region
  - Aetna, CDPHP, Hudson Health Plan, MVP, United, WellPoint
  - Includes Medicaid Managed Care
- With 210 physicians in medical home group, project appears to be second largest

Project Management

THINC

- Manage project and deliverables
- Work with health plans to determine payment process and triggers
- Work with THINC Quality Committee to ensure collaborative governance process for development of project goals and implementation MedAllies
- Enable development of quality reporting
- Staff support for medical home transformation initiative

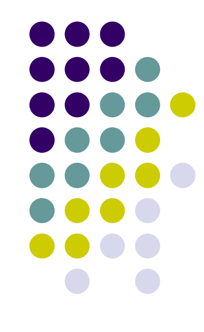
Taconic IPA

- Intensive planning for and leadership of medical home transformation initiative
- Project Medical Director experienced in HRSA Health Disparities Collaboratives
- Physician recruitment

Cornell

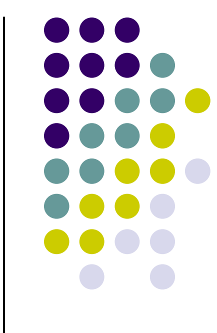
- Conduct evaluation, data gathering, develop and administer surveys, analysis, etc.

Incentive Payments

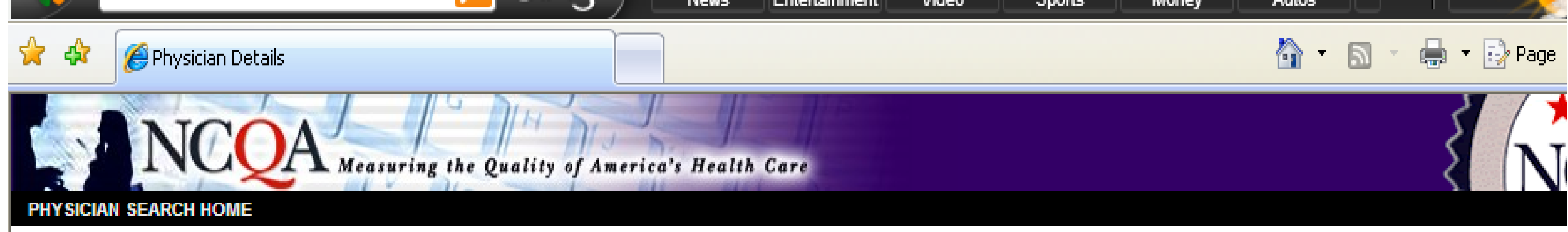


- 2009 Incentive payments will be issued after quality metrics report card in Q4 2009
- 20% of incentive payments goes to scoring on quality metrics and 80% goes to achievement of NCQA PPC-PCMH Medical Home Level 2 certification
- Health plans are in process of declaring incentive payment budgets for 2009
  - Looks like ~$1.5million of incentives in 2009

Evaluation



- Will use four years of quality data
- Includes measurement of utilization outcomes
- Surveys of physicians, office staff and patients to gather their input about implementation of medical home
- Evaluation design should produce results rigorous enough to inform policy debate as well as participant health plans' decisions about value of medical home



PHYSICIAN SEARCH HOME

Physician Details

Return to Search Results | New Search

Physician Details

Bedford Stuyvesant Family Health Center

Bedford Stuyvesant Family Health Center
1413 Fulton Street
Brooklyn, NY 11216

Tel: (708) 636-4500

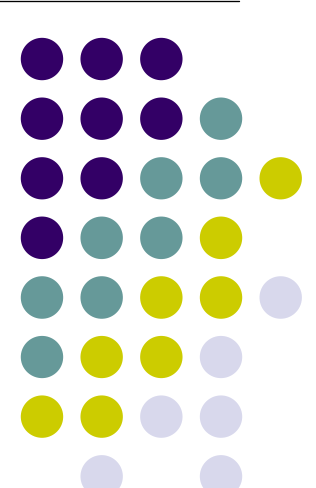
Fax: (718) 636-4564

* NCQA independently verifies licensure but all other information is self-reported by the physician and has not been independently verified.

Clinical Recognition

Physician Practice Connections - Patient Centered Medical Home

Hudson River HealthCare: NCQA Experiences



Paul Kaye, MD

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Hudson River HealthCare

- 16 practice sites in 6 counties of NY
- 75 primary medical care providers
- 225,000 visits/year
- Urban, migrant, homeless, public housing, and Ryan White funding
- JCAHO 1998, 2001, 2004, 2007
- Open Access(IHI),Diabetes, HIV, Prevention Pilot Collaboratives

Hudson River Healthcare's Quality Journey

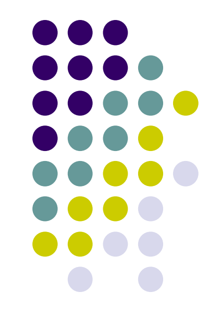
Year	Initiative
1993	Together for Tots
1996	Reengineering
1998	IHI Access and Efficiency
2000	Diabetes Collaborative
2000	Introduction of EMR
2002	HRSA HIV Collaborative
2004	Prevention Collaborative
2005	Patient Visit Redesign
2005	IHI Planned Care
2006	Harvesting Meetings
2006	Strategic Aims

Common Themes of the Projects

- Integrated Teams
- Consistent support staff with defined roles
- Work centered around the patient
- Planning of visits-chart review in advance
- Standing orders
- All tools readily available
- Use of information systems

Quality Lessons Learned

- System change should precede technology introduction
- Relentless Board and Senior Leadership essential
- Quality management IS management-not a separate function
- National expertise in change (IHI,HRSA) adds value



HRHCare and NCQA

- Applied in 2006
- Assistance from Taconic IPA
- Fees paid for by IPA
- Notified of recognition in 2007

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. **Has written standards for patient access and patient communication****	4
B. **Uses data to show it meets its standards for patient access and communication****	5
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. **Uses paper or electronic-based charting tools to organize clinical information****	6
E. **Uses data to identify important diagnoses and conditions in practice****	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. **Adopts and implements evidence-based guidelines for three conditions ****	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. **Actively supports patient self-management****	4
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. **Tracks tests and identifies abnormal results systematically****	7
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. **Tracks referrals using paper-based or electronic system****	4
	4

Standard 8: Performance Reporting and Improvement	Pts
A. **Measures clinical and/or service performance by physician or across the practice****	3
B. Survey of patients' care experience	3
C. **Reports performance across the practice or by physician ****	3
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. **Availability of Interactive Website**	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

**Must Pass Elements

NCQA PPC-PCMH

- **Access and Communication**
- Patient Tracking and Registry Functions
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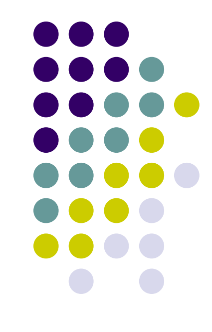
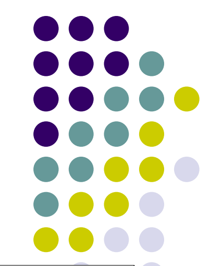
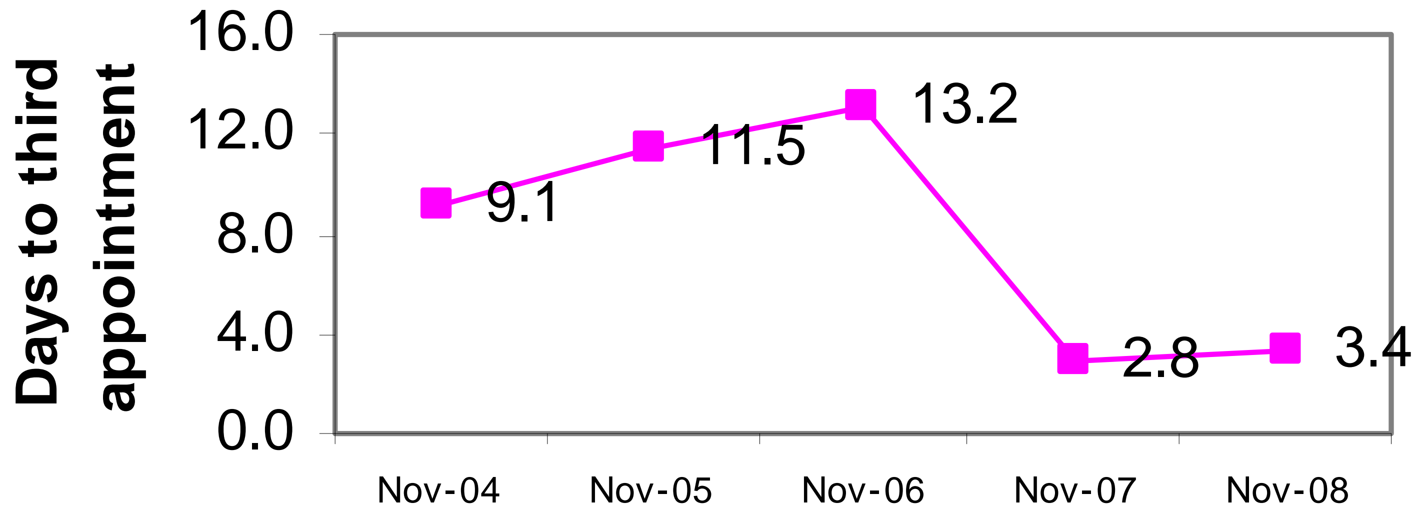
NCQA Standards: Access and Communication



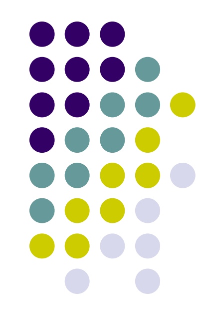
- Patients should have a regular source of care
  - ***Metric: TCNY/ECW Measure***
- Patients should have easy access to appointments
  - ***Metric: Time to third appointment***
- Patients should find it easy to contact their provider
  - ***Metric : Patient experience data***
- After Hours Access to Care and Advice
  - ***Metric: Answering service logs, test of system***
- Visits organized and on time
  - ***Metric: Cycle Time***





Access to Appointments (Number of Days Until 3rd Appointment Available)
Days to third appointment
16.0
12.0
8.0
4.0
0.0
9.1
11.5
13.2
2.8
3.4
Nov-04
Nov-05
Nov-06
Nov-07
Nov-08

NCQA PPC-PCMH



- Access and Communication
- **Patient Tracking and Registry Functions**
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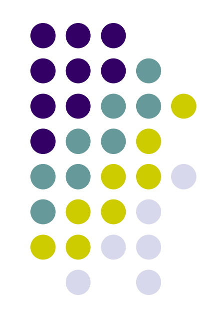
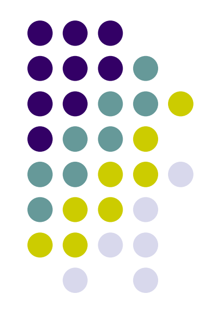
- Advanced Electronic Communications

NCQA Standards : Patient Tracking and Registry Functions



- Basic EMR functionalities
- Problem lists, medication lists, allergies
- Registry functions of EMR
- Population Management functions
- Use of system-chart audit

NCQA PPC-PCMH



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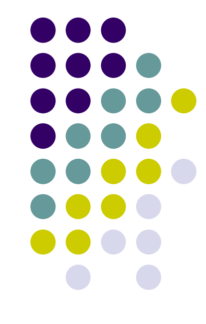
NCQA Standards: Care Management



- Care of Chronic Conditions
  - Use of practice guidelines (3 conditions)
  - Resources for case management, care coordination, and medication management
- Preventable Admissions
  - Community Care Partners in ER:

  NYS Patient Safety Award 2006
- Care of a High Risk Condition: HIV
  - Counseling and adherence support

NCQA PPC-PCMH

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- **Patient Self-Management Support**
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
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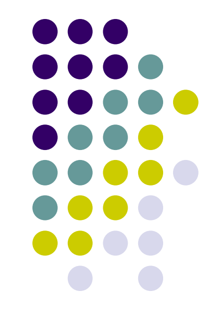
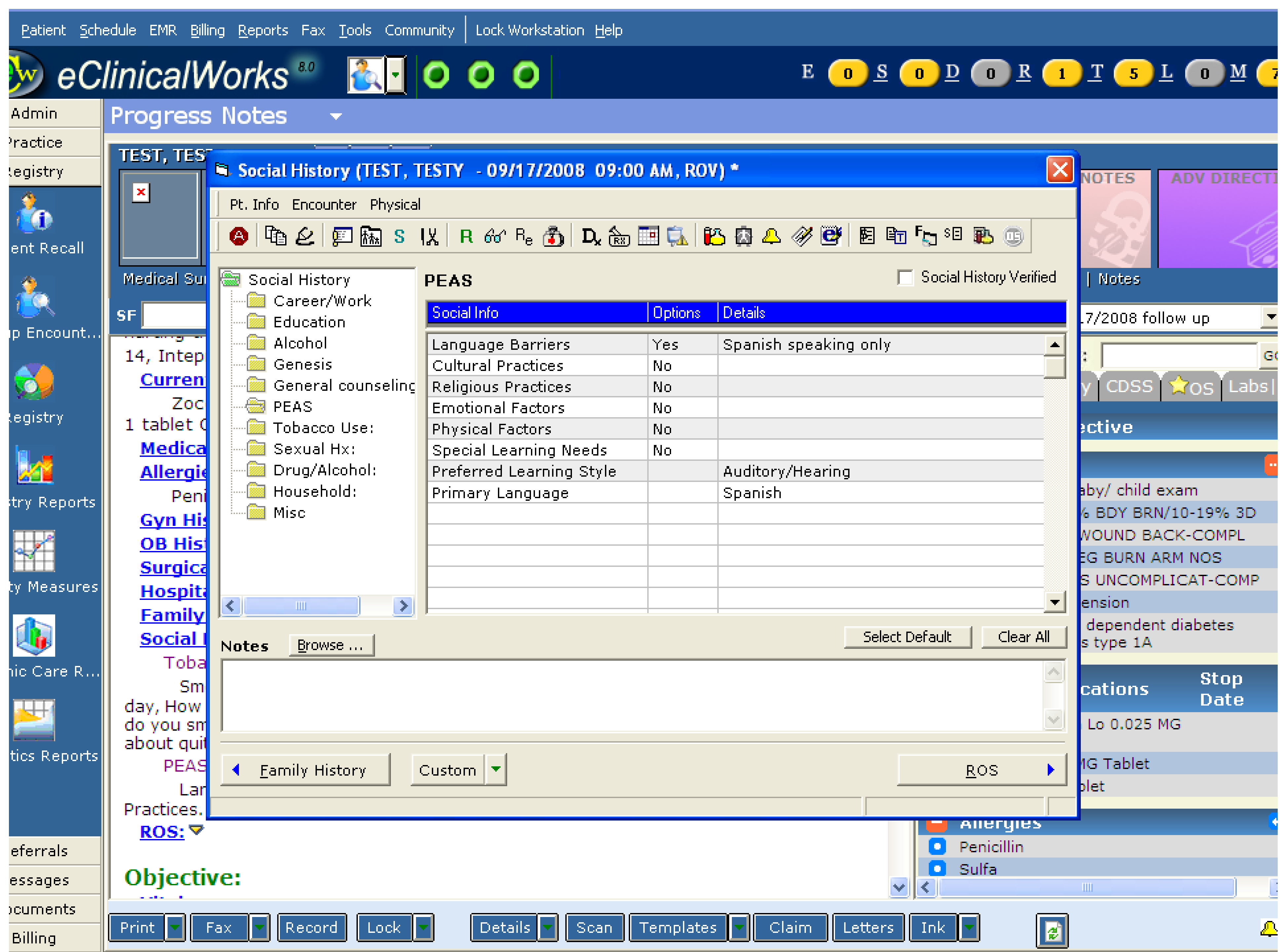
NCQA Standards: Self Management Support



- Educational Resources
  - Assessment of language and learning needs
    - PEAS Assessment form
  - Availability of multilingual resources
    - Medical Translation services and training
- Goal setting
  - Structured data fields for patient goals



Patient Schedule EMR Billing Reports Fax Tools Community Lock Workstation Help
eClinicalWorks 8.0
Progress Notes
Social History (TEST, TESTY - 09/17/2008 09:00 AM, ROV) *
Pt. Info Encounter Physical
Social History
Career/Work
Education
Alcohol
Genesis
General counseling
PEAS
Tobacco Use:
Sexual Hx:
Drug/Alcohol:
Household:
Misc
PEAS
Social History Verified
Social Info
Options
Details
Language Barriers
Yes
Spanish speaking only
Cultural Practices
No
Religious Practices
No
Emotional Factors
No
Physical Factors
No
Special Learning Needs
No
Preferred Learning Style
Auditory/Hearing
Primary Language
Spanish
Select Default
Clear All
Notes
Browse ...
Family History
Custom
ROS
Objective:
Penicillin
Sulfa
Print
Fax
Record
Lock
Details
Scan
Templates
Claim
Letters
Ink

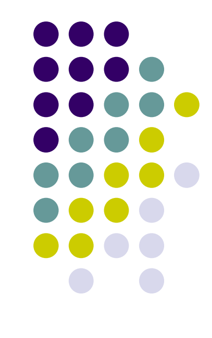
NCQA PPC-PCMH

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management Support
- **Electronic Prescribing**
- **Test Tracking**
- **Referral Tracking**
- Performance Reporting and Improvement
- **Advanced Electronic Communications**

NCQA: Electronic Functions

- Test Tracking
- Referral Tracking
- E-prescribing
- Electronic Communication with patients

NCQA PPC-PCMH



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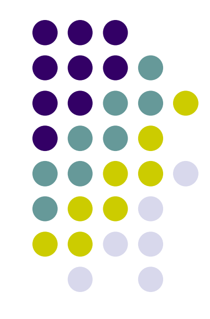
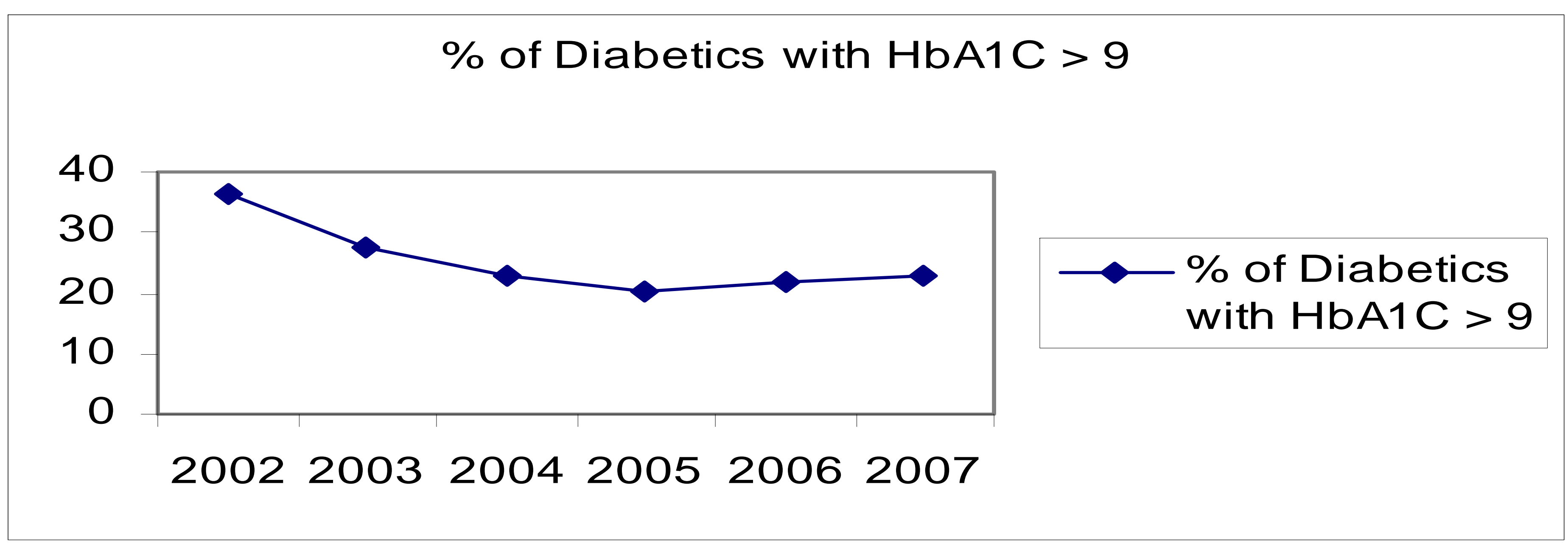
NCQA: Performance Reporting and Improvement



- Performance Improvement
  - Data for performance improvement, goals, implementation of changes
    - National Health Disparities Collaboratives



Hudson River NCQA Experience

- Awarded 6 of 9 modules
- All sites and providers listed on NCQA website
- Certificate for each practice
- 3 year recognition
- Migration to PPC-PCMH available

Physician Search Results

Page

PHYSICIAN SEARCH HOME

Physician Search Results

New Search

Search results: (201 - 250) of 516

Physician	Address	Recognition Program(s)
Hudson River Healthcare, Inc. - Beacon	**Hudson River Healthcare, Inc. - Beacon** 6 Henry Street Beacon, NY 12508	Physicians Practice Connections NCQA Recognized Practice
Hudson River Healthcare, Inc. - Dover Plains	**Hudson River Healthcare, Inc. - Dover Plains** 3147 Route 22 Dover Plains, NY 12533	Physicians Practice Connections NCQA Recognized Practice
Hudson River Healthcare, Inc. - Goshen	**Hudson River Healthcare, Inc. - Goshen** 888 Pulaski Highway Goshen, NY 10924	Physicians Practice Connections NCQA Recognized Practice
Hudson River Healthcare, Inc. - Monticello	**Hudson River Healthcare, Inc. - Monticello** 60 Jefferson Street, Suite 3 Monticello, NY 12701	Physicians Practice Connections NCQA Recognized Practice

Done

Internet

NCQA PPC-PCMH Projection

- We estimate a score of 60-65 without any changes from present practice
- **Health Centers should achieve Level 1 if they are in compliance with HRSA Program Expectations**
- Health Centers participating in Health Disparities Collaboratives using registries should achieve Level 2