Meeting Agenda

Date: Tuesday, February 2, 2016 **Time: 1:00pm – 2:30pm**
Location: The Riverside Hotel - Clearwater Room **Dial: 1-571-317-3122, #445-965-021 - Audio Pin: 4**

Next meeting: Tue, April 5, 2016 1:00pm – 2:30pm

Mission: To organize healthcare stakeholders by providing a structured forum for sharing valuable knowledge, finding common solutions, and identifying resources to improve health outcomes, improve quality and patient experience of care, and to lower costs of care in the region.

Agenda Item	Outcome	Process	Person
Welcome New Members 1:00-1:05	CHC representation	Introductions	Russ Duke
PCMH Recognition Process 1:05-1:45	Increase knowledge on PCMHs commitment to change when seeking recognition	Presentation PHMG Pediatrics: Medical Home Coordinator Perspective FMRI: Physician Perspective	Gina Pannell Gina Pannell Kevin Rich
CHC Member Roles 1:45-2:10	Improve understanding of why you were selected for the CHC	Discussion	Russ Duke Gina Pannell Kevin Rich David Peterman
Group Discussion 2:10-2:30	Identify contributions, solutions, next steps.	Discussion	All

Please note there will be no meeting in March.

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February 2
2016

CENTRAL HEALTH Collaborative

Ada, Boise, Elmore & Valley Counties

PCMH Transformation

Statewide Healthcare Innovation Plan

Improved health, improved healthcare, and lower cost for all Idahoans

PCMH Key Components*

- **Personal Clinician**: first contact, continuous, comprehensive, care team
- **Whole Person Orientation:** all patient health care needs, all stages of life, acute; chronic; preventative; end of life
- **Coordinated Care:** when and where needed/wanted; culturally and linguistically appropriately use information technology

*based on the Joint Principles

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PCMH Recognizing Bodies

- National Committee for Quality Assurance (NCQA) PCMH Recognition 2014
- Accreditation Association for Ambulatory Health Care, Inc. (AAHC) Medical Home Accreditation
- The Joint Commission (JC) Primary Care Medical Home (PCMH)
- Oregon Patient-Centered Primary Care Home (PCPCH)

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PCMH 2014 Content and Scoring

(6 standards/27 elements)

1: Enhance Access and Continuity	Pts
A. ***Patient-Centered Appointment Access**	**4.5**
B. 24/7 Access to Clinical Advice	3.5
C. Electronic Access	2
	10

2: Team-Based Care	Pts
A. Continuity	3
B. Medical Home Responsibilities	2.5
C. Culturally and Linguistically Appropriate Services (CLAS)	2.5
D. ***The Practice Team**	**4**
	12

3: Population Health Management	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. ***Use Data for Population Management**	**5**
E. Implement Evidence-Based Decision-Support	4
	20

4: Plan and Manage Care	Pts
A. Identify Patients for Care Management	4
B. ***Care Planning and Self-Care Support**	**4**
C. Medication Management	4
D. Use Electronic Prescribing	3
E. Support Self-Care and Shared Decision-Making	5
	20

5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. ***Referral Tracking and Follow-Up**	**6**
C. Coordinate Care Transitions	6
	18

6: Measure and Improve Performance	Pts
A. Measure Clinical Quality Performance	3
B. Measure Resource Use and Care Coordination	3
C. Measure Patient/Family Experience	4
D. ***Implement Continuous Quality Improvement**	**4**
E. Demonstrate Continuous Quality Improvement	3
F. Report Performance	3
G. Use Certified EHR Technology	0
	20

Scoring Levels

Level 1: 35-59 points.
Level 2: 60-84 points.
Level 3: 85-100 points.

***Must Pass Elements**

Eligible Applicants

- **Outpatient primary care practices that meet the scoring criteria for Level 1, 2, or 3 as assessed against Patient-Centered Medical Home (PCMH) requirements**
- **Practice defined: a clinician or clinicians practicing together at a single geographic location**
  - Includes nurse-led practices in states where state licensing designates Advanced Practice Registered Nurses (APRNs) as independent practitioners
  - Does not include urgent care clinics or clinics opened on a seasonal basis

PCMH Eligibility Basics

- **Recognitions are conferred at geographic site level -- one Recognition per address, one address per survey**
- **MDs, DOs, PAs, and APRNs practicing at site with their own or shared panel of patients are listed with Recognition**
- **Clinicians should be listed at each site where they routinely see a panel of their patients**
  - Clinicians can be listed at any number of sites
  - Site clinician count determines program fee
  - Non-primary care clinicians should not be included

PCMH Clinician Eligibility

- **At least 75% of each clinician's patients come for:**
  - First contact for care
  - Continuous care
  - Comprehensive primary care services
- **Clinicians may be selected as personal PCPs**
- **All eligible clinicians at a site must apply together**
- **Physicians in training (residents) should not be listed**
- **Practice may add or remove clinicians during the Recognition period**

Must Pass Elements

Rationale for Must Pass Elements

- Identifies critical concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes "Recognition"

Must Pass Elements

- 1A: Patient Centered Appointment Access
- 2D: The Practice Team
- 3D: Use of Data for Population Management
- 4B: Care Planning and Self-Care Support
- 5B: Referral Tracking and Follow-Up
- 6D: Implement Continuous Quality Improvement

Documentation Types

1. **Documented process** Written procedures, protocols, processes for staff, workflow forms (not explanations); must include practice name and date of implementation.
2. **Reports** Aggregated data showing evidence
3. **Records or files** Patient files or registry entries documenting action taken; data from medical records for care management.
4. **Materials** Information for patients or clinicians, e.g. clinical guidelines, self-management and educational resources

***NOTE:* Screen shots or electronic "copy" may be used as examples (EHR capability), materials (Web site resources), reports (logs) or records (advice documentation)**

PCMH 2D: The Practice Team

The practice uses a team to provide a range of patient care services by:

1. Defining roles for clinical and nonclinical team members.
2. Identifying the team structure and the staff who lead and sustain team based care.
3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. (CRITICAL FACTOR)
4. Using standing orders for services.
5. Training and assigning members of the care team to coordinate care for individual patients.

NOTE: Critical Factors in a Must Pass element are essential for Recognition

PCMH 2D: The Practice Team (cont.)

6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.
7. Training and assigning members of the care team to manage the patient population.
8. Holding scheduled team meetings to address practice functioning.
9. Involving care team staff in the practice's performance evaluation and quality improvement activities.
10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council.

PCMH 2D: Scoring

MUST-PASS

4 Points

Scoring

- 10 factors = 100% (including factor 3)
- 8-9 factors = 75% (including factor 3)
- 5-7 factors = 50% (including factor 3)
- 2-4 factor = 25%
- 0-1 factor = 0%

PCMH 2D: Documentation

Documentation

- F1,2, 4-7: Staff position descriptions or responsibilities
- F3: Description of staff communication processes including frequency of communication **and** 3 examples showing that practice follows its process.
- F4: Written standing orders
- F5-7: Description of training process, schedule, materials
- F6: Description of staff communication process and examples of training materials.
- F8: Description of staff communication processes and sample
- F9: Description of staff role in practice improvement process or minutes demonstrating staff involvement
- F10: Process demonstrating how it involves patients/families in QI teams or advisory council

Pre-PCMH	Post-PCMH
What is she doing in my charts?	Are those audits complete yet?

PRE-PCMH

You want me to give up what?

POST-PCMH

Can you take this on for me?

Pre-PCMH

I don't have time for another meeting

Post-PCMH

I still don't have time for another meeting, but I will make time

Pre-PCMH

I take on more complex patients than my colleagues

Post-PCMH

We put a process in place to distribute complex patients equally.

PRE-PCMH

I will lose my autonomy

POST-PCMH

Giving up *some* autonomy for *some* unity has it's benefits

Pre-PCMH

I am only one provider, I cannot do it all.

Post-PCMH

We're a team and I cannot do it without you.

Pre-PCMH

We already have policies and procedures for that.

Post-PCMH

We can adapt some of our policies for our patient and staff needs.

Pre-PCMH

We don't do PDSA's, we perfect at admin and then deploy.

Post-PCMH

What did we do without PDSA's? Every player needs input.

Pre-PCMH

PCMH Transformation is hard work.

Post-PCMH

PCMH Transformation is hard work.

Motivation

- **Perceived Value of PCMH**
  - Higher Scoring: benefits and cost for providers, practice, and patients
  - Lower Scoring: external imposition by payers; another hurdle to jump
- **Understanding of PCMH Domains and Tasks**
  - Higher Scoring: pro-active, sought clear understanding of PCMH components, operational requirements
  - Lower Scoring: passive learning, asking external groups to do more for them
- **Financial Incentives**
  - Higher Scoring: necessary to take steps, but not the sole reason to transform, used incentives to add team members
  - Lower Scoring: skeptical of payments and sustainability, slower growth without additional incentives
- **Commitment to change**
  - Higher Scoring: Embraced change, strong team culture and communication
  - Lower Scoring: Change was sporadic, supported by some team members, varying cultures

Journey toward PCMH: Readiness for Change in Primary Care Practices (2011); The MILBANK (Multidisciplinary Journal of Population Health and Health Policy) Quarterly; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3214716/

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CAPABILITY

- **Time Demands of PCMH Implementation**
  - Higher Scoring: time investment is worth the outcome; relied on various team members
  - Lower Scoring: did not share PCMH tasks as a team, left physician out, leading to slow progress
- **Prospect of Changing Patient Behavior**
  - Higher Scoring: PCMH is a good framework to inform patients about mutual expectations, define PCP role
  - Lower Scoring: skeptical about patients ability to be accountable in mutual partnership
- **Health Information Technology**
  - Higher Scoring: more advanced/experience with HIT, valued HIT as catalyst for QI and workflow efficiencies
  - Lower Scoring: challenged by the expense and time requirements for implementation of HIT
- **Setting Implementation Expectations**
  - Higher Scoring: understood length of time to implement, less frustrated, better pace
  - Lower Scoring: tried standardizing approaches/timelines, easily frustrated, quicker pace

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