Patient Centered Medical Home: A Current State Analysis

Host: Dr. Adrienne Mims
Facilitator: Dr. Sharon Eloranta

Presenters:
Dr. Jonathan Sugarman, Qualis Health
Karlen Haury, Kansas Foundation for Medical Care (KFMC)

**This is a recorded presentation.**
Adrienne Mims, MD MPH

Dr. Mims is board certified in family medicine and geriatrics with an expertise in clinical epidemiology and quality improvement. She is the Vice President and Chief Medical Officer for Medicare Quality Improvement for Alliant GMCF, the Quality Improvement Organization for Georgia. She serves as the current president of AHQA, the national trade association for QIOs.
QIO Learning & Sharing

The AHQA Physician Leadership Network Clinical Discussions Webinar Series

AHQA’s Physician Leadership Network, which connects Medical Directors and physicians working in other capacities at QIOs across the nation, has conducted a series of educational webinars designed to drive discussion and foster sharing of best practices among the QIOs, health care providers, and the broader health care quality improvement community. These presentations touch on topics including improving medication safety, reducing hospital readmissions, and cardiac preventive care, among others. The webinars, available in video and PDF format at the links below, exemplify AHQA’s and the QIOs’ commitment to fostering a continuously learning health care system in our nation.

Upcoming Presentations

Educational webinars for the QIO community are scheduled for the following dates. Links to presentation videos and slide decks will be made available in the “On-demand Webinars” area shortly thereafter.
Sharon Eloranta, MD

Sharon I. Eloranta, MD, is the Medical Director for Quality and Safety Initiatives at Qualis Health in Seattle. She provides leadership and consultation for a variety of patient safety and quality improvement programs including the Safety Net Medical Home Initiative, other Patient Centered Medical Home initiatives, and the CMS programs focusing on Patient Safety and Reducing Rehospitalizations. Dr. Eloranta is a George W. Merck Fellow at the Institute for Healthcare Improvement (IHI) and a member of the IHI faculty. During her Fellowship year in Cambridge, she concentrated on the study of sustaining and spreading change, prevention of surgical site infections, and innovations in the prevention of birth trauma. Dr. Eloranta is an associate clinical professor at the University of Washington in the Health Services Department.
Overview of Topic
Patient Centered Medical Home: A Current State Analysis

Sharon Eloranta, MD

June 18, 2014
A rose by any other name…

- Medical home
- Advanced primary care
- Patient-centered medical home
- Personal medical home
- Health home

- Integrated health home
- TransforMED model
- New model of family medicine
- Primary care medical home
- Ambulatory ICU and more…
What is the PCMH?

“The Patient Centered Medical Home is a model of care articulated by principles that embrace the aspirations of the Institute of Medicine, the design of the Future of Family Medicine new model of care and The Wagner Care Model, and the relationship desired by some of this country’s largest employers for their employees.”

Not simply a description of a delivery system model…

“It is also a political construct* that takes advantage of a 40 year-old name and organizing these previous articulations into a mutually agreeable model that has now begun to capture the collective psyche of Federal and State Government, employers, and health plans.”

*italics added

High aspirations…

“It is likely to be the best opportunity for aligning physician and patient frustration, demonstrated models for improving care, and private and public payment systems to produce the most profound transformation of the health care system in anyone’s memory.”

Today’s Presenters
Jonathan R. Sugarman, MD, MPH is President and CEO of Qualis Health, a national leader in improving the quality, safety and efficiency of healthcare delivery. Qualis Health provides patient-centered medical home consulting to community health centers, academic teaching practices, private practices, and others on behalf of a broad range of public and private sector clients. Dr. Sugarman is a graduate of Harvard College, the Albert Einstein College of Medicine, and the University of Washington School of Public Health and Community Medicine, He serves as Clinical Professor in the Departments of Family Medicine and Epidemiology at the University of Washington.
Karlen Haury

Karlen joined KFMC in 2011 with more than two decades of experience in office management and consulting for small to mid-size physician practices and rural health clinics. Recently, she earned her certification as a Patient-Centered Medical Home Certified Content Expert (PCMH CCE) through the National Committee for Quality Assurance (NCQA). Karlen has a bachelor’s degree and MBA from Baker University, and she currently lives in Goddard, Kansas.
Presentations
The Patient-Centered Medical Home: Savior, Road Kill, or Something In Between?

(and if it is not road kill, how to make it happen…)

Jonathan R. Sugarman, MD, MPH
AHQA Physician Leadership Network
June 18, 2014
Objectives

• Provide a brief update on research regarding the impact of the PCMH on quality, costs, patient experience, and physician satisfaction

• Describe a few “need to knows” for practices wishing to become PCMHs, and entities wishing to help them
Are medical homes living up to the high expectations set for them?
1. PCMH studies continue to demonstrate impressive improvements across a broad range of categories including: cost, utilization, population health, prevention, access to care, and patient satisfaction, while a gap still exists in reporting impact on clinician satisfaction.

“This evidence indicates some favorable effects on all three triple aim outcomes, a few unfavorable effects on costs, and mostly inconclusive results (because of insufficient sample sizes to detect effects that exist or uncertain statistical significance of results because analyses did not account for clustering of patients within practices).”
Data Synthesis: In 19 comparative studies, PCMH interventions had a small positive effect on patient experiences and small to moderate positive effects on the delivery of preventive care services (moderate strength of evidence). Staff experiences were also improved by a small to moderate degree (low strength of evidence). Evidence suggested a reduction in emergency department visits (risk ratio [RR], 0.81 [95% CI, 0.67 to 0.98]) but not in hospital admissions (RR, 0.96 [CI, 0.84 to 1.10]) in older adults (low strength of evidence). There was no evidence for overall cost savings.
"There are folks who believe the medical home is a proven intervention that doesn't even need to be tested or refined. Our findings will hopefully change those views," said Mark W. Friedberg, a researcher at RAND Corp. and lead author of the study, published Tuesday in the Journal of the American Medical Association.

(Friedberg et al. JAMA. 2014;311(8):815-825).
What are the researchers studying when they evaluate “medical homes”? 
Medical Home Accreditation and Recognition Programs
Examples of Medical Home Transformation “Frameworks”

SNMHI Change Concepts (Qualis Health/MacColl Center for Healthcare Transformation”

Bodenheimer et al’s “Building Blocks” (Univ Cal San Francisco)
Supporting Practice Transformation: Lessons Learned*

* And a few places to go to learn more…
Some of Qualis Health’s PCMH Clients
The Safety Net Medical Home Initiative (SNMHI)

http://www.safetynetmedicalhome.org/

- 5-year demonstration project to help 65 safety net primary care sites accelerate implementation of the “patient-centered medical home” (PCMH) model of care
- 5 Regional Coordinating Centers employ practice coaches who provide direct support to sites and support state-based learning communities
- Administered by Qualis Health in partnership with the MacColl Center for Health Care Innovation
The SNMHI Framework: Change Concepts for Practice Transformation

1. Laying the Foundation
   - Engaged Leadership

2. Building Relationships
   - Empanelment
   - Continuous and Team-Based Healing Relationships

3. Changing Care Delivery
   - Organized, Evidence-Based Care
   - Patient-Centered Interactions

4. Reducing Barriers to Care
   - Enhanced Access
   - Care Coordination

PCMH Implementation Resources

- Patient-Centered Medical Home Assessment (PCMH-A)
- 12 Implementation Guides provide implementation strategies, tools and case studies
- 23 tools that can be used to test or apply the key changes, including an NCQA PMCH Recognition Crosswalk
  - Downloadable registry of tools and resources
- 38 webinars
- 3 policy briefs on medical home payment and health reform

Available at: http://www.safetynetmedicalhome.org/
Facilitating Improvement in Primary Care: The Promise of Practice Coaching

KEVIN GRUMBACH, EMMA BAINBRIDGE, AND THOMAS BODENHEIMER
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

ABSTRACT: Practice coaching, also called practice facilitation, assists physician practices with the desire to improve in such areas as patient access, chronic and preventive care, electronic medical record use, patient-centeredness, cultural competence, and team-building. This issue brief clarifies the essential features of practice coaching and offers guidance for health system leaders, public and private insurers, and federal and state policymakers on how best to structure and design these programs in primary care settings. Good-quality evidence demonstrates that practice coaching is effective. The authors argue that primary care delivery in the United States would benefit from a more systematic approach to the training and deployment of primary care practice coaches.
An example of a tested approach to practice facilitation

http://pcmh.ahrq.gov/sites/default/files/attachments/Qualis_020413comp.pdf

Also see http://www.coachmedicalhome.org
Patient-Centered Care for the Safety Net

The Safety Net Medical Home Initiative is a national Patient-Centered Medical Home demonstration project that is helping 65 primary care safety net sites become high-performing medical homes and improve quality, efficiency and patient experience. Learn more about the initiative.

The Initiative created a framework for PCMH transformation and has published a library of resources and tools to help practices implement the PCMH Model of Care. Access our PCMH materials.

http://www.safetynetmedicalhome.org/
The Hype Cycle: Waves of Irrational Exuberance

Adapted from Gartner Research

Medical Homes?
Questions?

jonathans@qualishealth.org
Patient-Centered Medical Home: A Current State Analysis

AHQA PLN Webinar
June 18, 2014
Karlen Haury, MBA, PCMH CCE
Kansas Foundation for Medical Care
Overview

• Describe PCMH efforts in Kansas
• Highlight KFMC’s PCMH Development
• Share Lessons Learned
• Identify Resources and Best Practices
Kansas
Kansas Quick Facts

Kansas
- Population 2.8 million
- Population per sq mile 34.9
- Median household income $51k
- Persons living below poverty 13.2%
- White, non-Hispanic or Latino 77.5%

USA
- Population 316 million
- Population per sq mile 87.4
- Median household income $53k
- Persons living below poverty 14.9%
- White, non-Hispanic or Latino 63%
Kansas Quick Facts

• 105 Counties
  – 90 out of 105 counties are designated as Primary Care Health Manpower Shortage Areas (HPSA’s)
  – 6 Urban (150 or more persons per sq mile)
    • 55.18% of state’s population
  – 32 Rural (6-19.9 persons per sq mile)
  – 36 Frontier (Less than 6.0 persons per sq mile)
    • 12.08% of state’s population living in 68 counties
Our Mission: *Leading innovation to improve the quality, effectiveness and safety of healthcare.*

- Quality Improvement Organization (QIO)
- External Quality Review Organization (EQRO)
- QI, Data & Analysis
- HIT Regional Extension Center (HITREC)
Kansas PCMH Environment

- Two payers offering incentives for NCQA recognition
- Uninsured population 13.1%³
- Not expanding Medicaid
- As of January 1, 2013, Medicaid is 100% managed care (3 different MCOs)
- Current Medicaid Health Home initiative
KFMC PCMH Survey

• More than half of those surveyed are interested in or have started the process of becoming a PCMH
• A quarter of those surveyed have been offered enhanced reimbursement or incentives from contracted payers
• A majority of practices are becoming or considering the PCMH model to prepare for the P4P initiatives and/or to improve the quality of care and patient satisfaction
• More than 85% of the largest physician networks are, or have plans to become, PCMH recognized within 2 years
• The majority of those undertaking the PCMH recognition process have engaged external assistance
KFMC PCMH Project Partners

- Primary Care practices
- 4 or fewer providers per practice location
- Implemented EHR
- 6 clinics selected (geographically disbursed)
  - 2 Urban
  - 1 Semi-Urban
  - 1 Densely Settled Rural
  - 2 Rural
- 1 year partnership with TransforMED to “train the trainer”
KFMC PCMH Project Status

- May 2013 – Kick-off meetings and Baseline Assessments
- Jun 2013 – Survey reports
- Jul 2013 – Ongoing practice facilitation
- Oct 2013 – First practice consultant received NCQA Content Expert Certification
- Mar 2014 – Second practice consultant receives NCQA Content Expert Certification
- Nov 2014 – Through March 2015 anticipate all 6 practices will submit for NCQA for PCMH Recognition
Lessons Learned

• Barriers to Practice Transformation
• Practice Realities
• Considerations for Developing a Practice Facilitation Program
Barriers to Practice Transformation

- Leadership Commitment
- Change Management
- Transformation vs Recognition
- Delegated Decision Making
- Developing Patient Engagement
- Systems Redesign
- Time & Resources
Recognition vs Transformation

Discuss the different processes:

• Recognition:
  “the action or process of recognizing or being recognized, in particular; appreciation or acclaim for an achievement, service, or ability”

• Transformation:
  “a thorough or dramatic change in form or appearance”
Patient Engagement

- Quality Improvement Initiatives
- Creating processes which allow patients to become invested in their own care
- Integrating patient & family perspective into the planning, delivery and assessment of healthcare
- Operations Redesign
- Patient Perspectives
Practice Realities

- Most do not have a mission statement
- Many lack written job descriptions, policies and procedures, quality improvement programs and other formal mechanisms
- Many do not have regular staff meetings and/or training
- Most, if not all staff, are cross-trained and have to cover other positions in the practice
- Limited resources (time, money, people, expertise)
Considerations for Developing a Practice Facilitation Program

- Staffing
- Delivery Model
- Tools & Resources
Resources

• Developing and Running a Practice Facilitation Program: A How-To Guide, Agency on Healthcare Research and Quality (AHRQ); http://pcmh.ahrq.gov/sites/default/files/attachments/Developing_and_Running_a_Primary_Care_Practice_Facilitation_Program.pdf
• Institute for Healthcare Improvement (IHI); www.ihi.org
• Safety Net Medical Home Initiative, Qualis; http://www.safetynetmedicalhome.org/practice-transformation
• Practice Transformation Video, HealthIT.gov; http://healthit.gov/providers-professionals/video/practice-transformation-video-providers
• Patient Engagement; http://forces4quality.org/
References

1. Kansas Quick Facts; http://www.kansashealthmatters.org
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Discussion/Q&A
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“The nation’s health and economic futures — best care at lower cost — depend on the ability to steward the evolution of a continuously learning health care system.”

- Institute of Medicine of the National Academies, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America