Quality Quest and Patient-Centered Medical Homes

KFMC 2014 Quality Forum
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Kansas Foundation for Medical Care

Learning Objectives

- Identify the Basic Principles of PCMH
- Describe the Accreditation/Recognition programs currently available
- Discuss the Benefits & Potential Barriers to Becoming a PCMH
- Identify Opportunities to Enhance Patient Engagement
- Explore Concepts in Utilizing HIT and new field of Mobile Health to Improve Quality

NATIONAL QUALITY STRATEGY (NQS) MARCH 2011

National Quality Strategy[1]

- Better Care:
  - Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible and safe
- Healthy People, Healthy Communities:
  - Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher quality care
- Affordable Care:
  - Reduce the cost of quality healthcare for individuals, families, employers and government

NQS Priorities

- Making care safer by reducing harm caused by delivery of care
- Ensuring that each person and family is engaged as partners in their care
- Promoting effective communication and coordination of care
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models

CMS QUALITY STRATEGY NOVEMBER 18, 2013

CMS Quality Strategy[2] Goals

- Better Care and Lower Costs
- Prevention and Population Health
- Expanded Care Coverage
- Enterprise Excellence

Reducing Harm[2]

- CDC estimates 1.7 million healthcare associated infections occur each year and these conditions lead to 99,000 deaths
- Adverse medication events cause more than 770,000 injuries and deaths each year
- Cost = $5 billion annually

Patient & Family Engagement[2]

- Providing access to understandable information and decision support tools (culturally, linguistically and ability-appropriate for patients and their families)
- Enhanced, shared decision making
- Access to Tools, Education and Data
- Improved Healthcare Experience

Effective Communication & Coordination of Care[2]

- Poor coordination can result in medication errors, unnecessary procedures and treatment, avoidable hospital admissions and readmissions
  - 1 in 5 Medicare patients discharged from hospital are readmitted within 30 days
  - CMS estimates that readmissions within 30 days costs Medicare $17 billion annually

Effective Prevention & Treatment[2]

- 133 million Americans have at least 1 chronic illness; many have several
- 1 in 3 deaths in the U.S. can be attributed to cardiovascular disease and costs over $503 billion annually
- 1 in 3 American adults is obese, a condition that increases the risk of heart disease, stroke, Type 2 diabetes, and certain types of cancer; medical costs associated with obesity are estimated to be nearly $150 billion annually

Working with Communities[2]

- Encouraging providers to work with local and state public health improvement efforts
- Examples of community based programs include: exercise classes, self-management programs, support groups, food assistance programs, farmer's markets, tobacco cessation programs, etc.

Make Care Affordable[2]

- Reducing medical errors and improving care coordination
- Investing in HIT
- Public reporting of cost and quality data
- Paying providers based on the quality and efficacy of care delivered
- Developing and promulgating clinical guidelines and quality standards
- Improving team management of complex patients with multiple comorbidities
- Increasing administrative efficiency

CMS Drivers & Policy Levers[2]

- Measuring and publicly reporting providers' quality performance
- Providing technical assistance and fostering learning networks for quality improvement
- Adopting evidence-based national coverage determinations
- Setting clinical standards for providers that support quality improvement
- Creating survey and certification processes that evaluate capacity for quality assurance and quality improvement

PRINCIPLES OF PATIENT-CENTERED MEDICAL HOME (PCMH)

PCMH Development

- 1960's—Concept originated in Pediatrics as a way to coordinate care for children with special health care needs
- 1983—Translated to adult general practice (36% of patient visits were to primary care provider)
- 2004—American Academy of Family Physicians (AAFP) released a position statement that responded to the lack of patient centeredness in primary care

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PCMH Development

- 2007—American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP) and American Osteopathic Academy (AOA) published a joint statement on the principles of the medical home
- These groups represent >333,000 physicians

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Joint Principles of PCMH[3]

- Personal physician (established relationship)
- Physician directed medical practice (team based care)
- Whole person orientation (care for all stages of life and health care needs)
- Care is coordinated and/or integrated across all elements of the health care system
- Quality and safety (patient advocacy & empowerment/decision making; IT supports)
- Enhanced access (open scheduling, expanded hours, electronic communications)
- Payment should recognize the added value provided to patients

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What is a PCMH?

- Team-based model of healthcare delivery
- Primary care driven
- Comprehensive healthcare that has a “whole person orientation”
- Integrates what practices do well already but expands how we involve staff and patients (similar to FQHC)
- Way of rethinking how we care for patients
- The kind of care you want your mom to have

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Patient-Centered Care

Institutes of Medicine (IOM) defines patient-centered care as “respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.”

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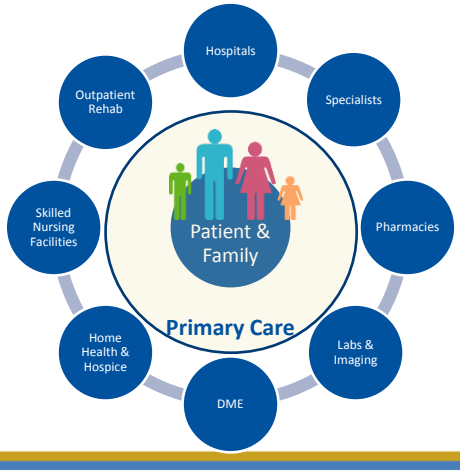
Medical Home Model

Shift in Payment Mechanisms:
- Traditional FFS
- P4P (ACOs, VBP, and other shared risk arrangements)



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Attributes of PCMH

- Patient-Focused
  - Enhanced Access (appointments, phone/email, health records via portal, reminders and education)
  - Culturally and Linguistically Appropriate Services (CLAS)
  - Continuity of Care (relationship with same provider/team)
  - Feedback (patient satisfaction surveys, focus groups and/or advisory council)
- Quality Emphasis
  - Care Planning and Management
  - Care is Coordinated if not Integrated
  - Quality Improvement (formalized program, process improvement, CQMs)
  - Evidence Based Guidelines
  - Population Health

PCMH ACCREDITATION/RECOGNITION PROGRAMS

Overview of Accreditation/Recognition

- National Committee on Quality Assurance (NCQA) [4]
- Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) [5]
- Joint Commission [6]
- Utilization Review Accreditation Commission (URAC) [7]

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NCQA's PCMH Recognition

- NCQA recognizes outpatient primary care practices that meet the scoring criteria for Level 1, 2 or 3 as assessed against the PCMH requirements
- Recognition is at the practice-site level
- Recognition is for 3 years
  - Level 3 = 85-100 points
  - Level 2 = 60-84 points
  - Level 1 = 35-59 points
  - Not Recognized = 0-34 points and/or achieve less than 6 of the "Must Pass" Elements

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NCQA Recognized Practices by Group Size[8]*

	1-2	3-7	8-9	10-19	20-50	50+	Total
Level 1	337	294	28	32	7	1	**699**
Level 2	303	392	66	79	10	2	**852**
Level 3	1764	2298	313	478	133	13	**4999**
Total	**2404**	**2984**	**407**	**589**	**150**	**16**	**6550**

*** As of 11/30/13**

NCQA PCMH Recognition Standards

2011 Standards (100 Points Possible)

- Standard 1: Enhance Access & Continuity (20 points)
- Standard 2: Identify & Manage Patient Populations (16 points)
- Standard 3: Plan & Manage Care (17 points)
- Standard 4: Provide Self-Care Support & Community Resources (9 points)
- Standard 5: Track & Coordinate Care (18 points)
- Standard 6: Measure & Improve Performance (20 points)

NCQA PCMH Recognition Standards

2014 Standards (100 Points Possible)

- Standard 1: Patient-Centered Access (10 points)
- Standard 2: Team Based Care (12 points)
- Standard 3: Population Health Management (20 points)
- Standard 4: Care Management and Support (20 points)
- Standard 5: Care Coordination and Care Transitions (18 points)
- Standard 6: Performance Measurement & Quality Improvement (20 points)

AAAHC Standards

- Patient Rights, Responsibilities and Empowerment
- Governance and Administration
- Relationship
- Accessibility
- Comprehensiveness of Care
- Continuity of Care
- Clinical Records and Health Information
- Quality

8 Standards

Joint Commission

- Standards not publicly available
- HRSA Patient Centered Medical Home Resources: Comparison Chart (2012)
- Compares AAAHC and Joint Commission to NCQA
- http://bphc.hrsa.gov/policiesregulations/policies/pcmhrecognition.pdf

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Joint Commission vs NCQA

FEATURE	THE JOINT COMMISSION	NCQA
Name	Primary Care Medical Home	Patient-Centered Medical Home
Award Label	Certification	Recognition
Accreditation of Organization also Required?	Yes	No
Levels of Achievement?	No	Yes, Levels 1, 2, 3
Need to Submit Documentation?	No	Yes
Onsite survey process for all organizations to evaluate compliance?	Yes	No (Conducted through on-line submission of documentation)
On-site consultation regarding approaches to standards compliance?	Yes	No
Copy of preliminary report available on site?	Yes	No
Scope of Evaluation	Entire Organization	Delivery Site Specific
Length of Award	3 years	3 years

Source: Joint Commission; http://www.jointcommission.org/assets/1/18/PCMH-NCQA_crosswalk-final_June_2011.pdf

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URAC Standards

- 28 Standards across 7 domains
  - 1 mandatory standard per domain
- Core Quality Care Management
- Patient-Centered Operations Management
- Access and Communications
- Testing and Referrals
- Care Management and Coordination
- Advanced Electronic Capabilities
- Performance Reporting and Improvement

URAC Practice Achievement

- 2 levels of Patient Centered Health Care Home (PCHCH)
  - Achievement
  - Achievement with Electronic Health Record (EHR) Designation

Recognition vs Transformation[9]

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"

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Published and Ongoing Research on PCMH Model Demonstrate

- Improvements in access to care
- Improvements in patient satisfaction
- Improvements in population health indicators
- Increased preventive services
- Increased provider and staff satisfaction
- Reductions in hospitalization rates & ER visits
- Reductions in unnecessary or duplicate services
- Decreased cost of care/increased savings per patient

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Research Findings[10]

- 'Significant' reduction in ER visits and hospitalization, enhanced use of team based-care, 250-400% health plan return on investment (Harbrecht 2012)
- Decrease in acute inpatient admissions, ER visits and overall PMPM cost, improved compliance with evidence-based guidelines and performance on quality measures (Raskas 2012)
- Fewer emergency room visits, hospitalizations and lower overall costs, improved access and performance on key quality indicators (Patel 2012, Patient-Centered Primary Care Collaborative 2012)
- Medicaid Pilots: Improved access to care, reduced PMPM/PMPY costs, decreased ER and inpatient utilization, greater use of evidence-based primary care (Takach 2011)

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Potential Barriers to PCMH

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

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PATIENT ENGAGEMENT

Patient Engagement

"As a nation, we've really neglected that all-important person in the corner who has the most crucial input of all: the patient.[11]"

David C. Colby
VP, Research and Evaluation
Robert Wood Johnson Foundation

Meaningful Use & Patient Engagement[12]

- The engagement of patients and their families in patients' health care is a prominent goal of the EHR Incentive Program (also called Meaningful Use)
- As the second of five health policy priorities, this policy priority aims to:
  - Improve patients' understanding of their health and related conditions so they take a more active role in their health care
  - Encourages involvement of patients' families, as many patients depend on their support
  - Use certified EHR technologies to assist with making health information available to patients and their families
  - Involve patients and their families in healthcare decision making
  - Promote patients' management of their own health [10]

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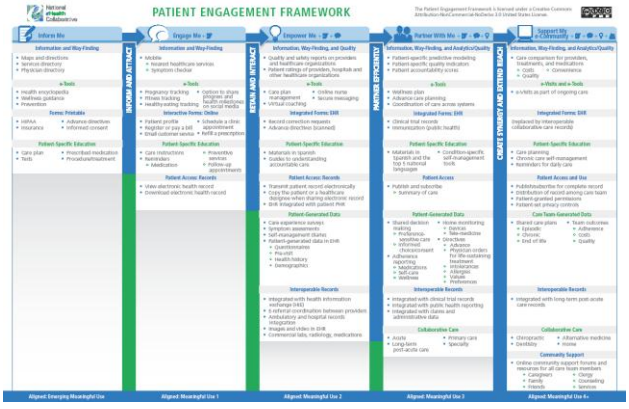
Patient Engagement Framework[13]



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Opportunities for Patient Engagement

- Integrating patient & family perspective into the planning, delivery and assessment of healthcare
  - Motivational Interviewing & Goal Setting
  - Advance Directives
  - Culturally & Linguistically Appropriate Services (CLAS)

Opportunities for Patient Engagement

- Creating processes which allow patients to become invested in their own care
  - Tools to assist with self-management of conditions
  - Education supported by evidence based guidelines
  - Online access (records, interactive forms, messaging)
  - Participatory Medicine
  - ePatients

Opportunities for Patient Engagement

- Quality Improvement Initiatives[14]
  - Patient Satisfaction
  - Participation in Focus Groups, Advisory Councils, Special Project Workgroups, and/or Quality Committees
  - Assist with development and review of patient education programs and materials

Opportunities for Patient Engagement

- Operations Redesign[14]
  - Reorganizing office systems and processes
  - Transitioning to new systems, such as electronic medical records
  - Improving patient/provider communications
  - Sharing personal stories in orientation, staff education, presentations, etc.
  - Curriculum development/teaching (staff, intern and/or resident education)

Benefits of Patient Engagement Case Study[15]

- Georgia Health Sciences, Neurosciences Center of Excellence
  - Decreased lengths of stay by 50%
  - Reduced medical errors by 62%
  - Increased patient satisfaction from 10th percentile to 95th percentile
  - Reduced staff vacancy rate from 7.5% to 0%

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Benefits of Patient Engagement

- Increased patient compliance
- Improved quality/outcomes
- Reduced health care costs
- Improved patient satisfaction
- Reduced length of stay
- Fewer fatal safety errors
- Better identification of “near misses”
- Improved population health by achieving higher rates of preventive care

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Barriers to Patient Engagement

- Culture change
  - Few organizations have partnered with patients in leadership
- Dedicated staff support / liaison
  - Recruiting advisors
  - Training
  - Meeting Planning (facilitation, feedback, communication)
  - Convenience to advisors (time commitment, child care, transportation and/or food)
- Development of materials
  - Recruiting materials Interviewing materials (selection criteria)
  - Orientation materials (learning curve, needs structure)
  - Roles & Responsibilities (engaged leadership)

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Why Engage Patients?

- Patients/Families are experts in the experience of receiving care
- Inspire and energize providers/staff
- Resources used for things that actually make a difference
- Facilitates the organizations' efforts to truly be Patient-Centered

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HEALTH INFORMATION TECHNOLOGY (HIT) & MOBILE HEALTH (M-HEALTH)

Electronic Health Record (EHR) Challenges

- Compatibility
- Cost
- Technical Support
- Privacy Concerns
- Security Risks

EHR Capabilities & Meaningful Use (MU)[16]

- ePrescribing
- Clinical Decision Support (CDS)
- Patient Recall
- Ancillary Interfaces (Lab, Imaging, etc)
- Patient Portals
- Care Transition Management
- Health Information Exchange (HIE)
- Clinical Quality Measures (CQM)
- Data

EHR Benefits

- Physician use of EHRs increased from 18% in 2001 to 57% in 2011
- 8 out of 10 physicians report overall, improved patient care with EHR use
  - 81% helped access a patient's chart remotely
  - 65% caught critical clinical lab values
  - 62% caught potential medical errors [13]

Mobile Health

- Also known as mHealth or eTools
- Practice of medicine and public health that is supported by mobile devices
  - Mobile phones
  - Tablet computers
  - Communications satellites
  - Patient Monitors

mHealth Applications

- Education and Awareness
- Helplines
- Remote Monitoring
- Diagnostic and Treatment Support
- Communication and Training for Healthcare Workers
- Disease and Epidemic Outbreak Tracking
- Remote Data Collection

mHealth Examples

- GPS technology or real time reminders and alerts
- Sending vitals from home to physicians' offices
- Virtual visits and health coaching based on clinical data transmitted
- Digital devices that measure physical parameters (weight, blood pressure, pulse, respiration, blood sugars, quantity of sleep, stress, etc) and ability to send data to healthcare providers

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Medical Apps (Hypertension)

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Medical Apps (Diabetes)

HHS & NIH mHealth Initiatives

- HHS[25]
  - National Cancer Institute's SmokeFreeTXT program
  - HRSA's TXT4Tots
  - Office of Minority Health's collaborative for smart phones use in diabetes treatment and support
- NIH[26]
  - Exposure Biology Program, a portion of the NIH Genes, Environment and Health Initiative

Mobile Technology Stats

- As of January 2014:
  - 90% of American adults have a cell phone
  - 58% of American adults have a smart phone
  - 32% of American adults own an e-reader
  - 42% of American adults own a tablet computer

Source:

Pew Research Internet Project
Mobile Technology Fact Sheet[27]

Cell Phone Use[27]

- 67% of cell owners find themselves checking their phone for messages, alerts or calls – even when they don't notice their phone ringing or vibrating
- 44% of cell owners have slept with their phone next to their bed because they wanted to make sure they didn't miss any calls, text messages or other updates during the night
- 29% of cell owners describe their cell phone as "something they can't imagine living without"

Cell Phones & Internet Use[27]

- As of May 2013:
  - 63% of adult cell owners use their phones to go online
  - 34% of cell internet users go online mostly using their phones

mHealth & Reducing Disparities

- "Minority Americans lead the way when it comes to mobile access—especially mobile access using handheld devices."[28]
  - 64% of African-Americans and
  - 63% of Latinos are wireless internet users

- Minority Americans are more likely to own a cell phone than their white counterparts (87% of blacks and Hispanics own a cell phone, compared with 80% of whites)
- Black and Latino cell phone owners take advantage of a much wider array of their phones' data functions compared to white cell phone owners

mHealth Concerns

- Speed of Development
  - Consumer demand for "health apps" and sensors has outpaced the science needed to understand their risks, benefits and impact
  - Accuracy of information (for example, apps are currently unregulated)
- Privacy & Security (Encryption and Hackers)
- Infrastructure (People and Technology)

Harnessing mHealth

- 80% of Americans who have access to their health information in EHRs use it
- Half of adult cell phone owners have apps on their phone
- 11% of users downloaded an app to help them track or manage their health (2011)[17]

iDoctor[19]

RockCenter video of Dr Eric Topal

- Originally aired 1/24/13
- Author of “The Creative Destruction of Medicine”
- Link to video: http://www.youtube.com/embed/r13uYs7jglg

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Social Media

- Web page
- Email newsletters
- Facebook
- Twitter
- Patient-activated social networks, e.g. PatientsLikeMe, Breast Cancer Alliance, etc.

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POPULATION MANAGEMENT

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Current Challenges[20]

- Emergency room visits increased by 36% between 1996 and 2006; 47% of ED visits could have occurred in a physician's office
- 20% of patients are re-admitted within 30 days of hospitalization, most of which are avoidable
- 50% of patients that are re-admitted do not see a physician after their first hospitalization
- 75% of health care spending is for patients with chronic diseases
- Over two (2) years, the typical Medicare patient sees 2 different primary care doctors and 5 different specialists
- Millions of additional Americans will enter the primary care system with healthcare reform

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Current Challenges[21]

- Five percent of the population accounts for almost half (49 percent) of total health care expenses
- The 15 most expensive health conditions account for 44 percent of total health care expenses
- Patients with multiple chronic conditions cost up to seven times as much as patients with only one chronic condition [20]

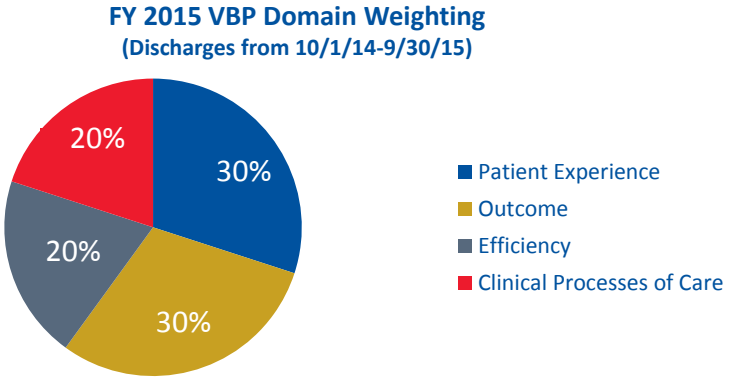
Opportunities for Population Management

- Clinical Decision Support
- Registries
- Patient Reminders/Recall
- Targeted Interventions
- Improved Health
- Preparation for Pay for Performance

Pay for Performance[22]

- Umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care
- Provides financial incentives to hospitals, physicians, and other health care providers to carry out such improvements and achieve optimal outcomes for patients
- The quality measures used in pay-for-performance generally fall into four categories: Process, Outcome, Patient Experience and Structure

Hospital Value Based Purchasing[23]



Provider Value-Based Payment Modifier[24]

- 2014 Medicare Fee Schedule includes a vast expansion of the Value-Based Payment Modifier (VBPM) program.
- 2016 VBPM will impact group practices with 10 or more Eligible Professionals (EP) based on 2014 performance
  - To avoid the 2% VBPM penalty in 2016, EP's must successfully report under Physician Quality Reporting System (PQRS) in 2014, which will also have a 2% penalty in 2016 if not met

Provider Value-Based Payment Modifier

- Impacts all physicians in 2017 (making 2015 the base year for EP's in groups of <10)
- EP's include physicians, nurse practitioners, therapists, CRNAs, physician assistants, clinical nurse specialists and more
- Mid-levels are not eligible for incentives and will not be penalized but their encounters count towards the group volume calculations
- Based on Part B claims data

Value Modifier Score

- Quality Measures
- Outcomes Measures
- Cost Measures
  - Total per capita cost (includes Part A & Part B spending), per capita cost for 4 chronic conditions and new Medicare Spending per Beneficiary
  - Risk adjusted and standardized to eliminate geographic variation
  - Adjusted for specialty mix of the EP's within the group

Quality and Resource Use Reports (QRUR)

- Includes comparative performance data on cost and quality measures and preview outcome under the Value Modifier
- CMS will calculate performance on 3 Outcomes Measures as part of VBPM quality-tiering analysis
  - Composite of Acute Prevention Quality Indicators
  - Composite of Chronic Prevention Quality Indicators
  - All cause readmission
- CMS will calculate cost measures on 4 Conditions as part of the VBPM quality-tiering analysis
  - Total per capita costs
  - Total per capita costs for beneficiaries with the 4 chronic conditions (COPD, coronary artery disease, diabetes and heart failure)
- QRURs based on 2013 data are expected to be made available to all physicians by late summer 2014

Reading the Tea Leaves

Q&A

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Acronyms

- AAAHC – Accreditation Association for Ambulatory Health Care
- AAFP - American Academy of Family Physicians
- AAP - American Academy of Pediatrics
- ACP - American College of Physicians
- AOA - American Osteopathic Academy
- CDC – Centers for Disease Control
- CDS – Clinical Decision Support
- CLAS – Culturally & Linguistically Appropriate Services
- CMS – Centers for Medicare & Medicaid
- CQM – Clinical Quality Measure(s)
- EHR - Electronic Health Records
- EP – Eligible Provider
- FQHC – Federally Qualified Health Center
- GPS – Global Positioning System
- HIE – Health Information Exchange

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Acronyms

- HIT - Health Information Technology
- HRSA – Health Resources and Services Administration
- IOM – Institutes of Medicine
- mHealth – Mobile Health
- MU - Meaningful Use
- NCQA - National Committee on Quality Assurance
- NQS – National Quality Strategy
- PCMH - Patient Centered Medical Home
- PCP – Primary Care Physician/Provider
- PQRS – Physician Quality Reporting System
- QRUR – Quality and Resources Use Reports
- URAC – Utilization Review Accreditation Commission
- VBP – Value Based Purchasing
- VBPM – Value Based Payment Modifier

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