# *Patient Centered Medical Home – The Model, It's Value & Growth for NV CHCs with PCMH*

Presented To: Nevada PCMH Sub-Committee

March 8, 2019

NEVADA
PRIMARY CARE ASSOCIATION

## Areas of Focus

- PCMH Model of Care
- NCQA PCMH Recognition – product
- Growth of PCMH Recognition in NV by CHCs
- Value and ROI for PCMH practices
- Discussion

**The patient-centered medical home** is a model of care that puts patients at the forefront of care. PCMHs build better relationships between people and their clinical care teams.

# Defining the Medical Home

The medical home is an *approach* to primary care that is:


Source: www.ahrq.gov

## Why the Medical Home Works: A Framework

Patient-Centered Primary Care COLLABORATIVE

| Feature | Definition | Sample Strategies |
|---|---|---|
| Patient-Centered | **Supports patients and families** to manage & organize their care and participate as **fully informed partners** in health system transformation at the **practice, community, & policy** levels | • **Dedicated staff help patients navigate system** and create care plans<br>• **Focus on strong, trusting relationships** with physicians & care team, open communication about decisions and health status, compassionate/culturally sensitive care |
| Comprehensive | **A team of care providers** is wholly accountable for patient's **physical and mental health** care needs – includes prevention and wellness, acute care, chronic care | • Care team focuses on '**whole person**' and **population health**<br>• Primary care could **co-locate** with behavioral, oral, vision, OB/GYN, pharmacy, etc.<br>• Special attention paid to **chronic disease** and complex patients |
| Coordinated | Ensures care is **organized across all elements** of broader health care system, including specialty care, hospitals, home health care, community services & supports, & public health | • Care is **documented and communicated** effectively across providers and institutions, including patients, primary care, specialists, hospitals, home health, etc.<br>• Communication and connectedness is enhanced by **health information technology** |
| Accessible | Delivers **consumer-friendly services** with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations | • Implement efficient appointment systems to offer **same-day or 24/7 access** to care team<br>• Use of **e-communications and telemedicine** to provide alternatives for face-to-face visits and allow for after hours care |
| Committed to quality and safety | Demonstrates commitment to quality improvement through use of **health IT** and other tools to ensure patients and families make informed decisions | • **EHRs, clinical decision support, medication management** to improve treatment & diagnosis.<br>• Establish **quality improvement goals**; use data to monitor & report about patient populations and outcomes |

**Potential Impacts**

Patients are more likely to seek the right care, in the right place, and at the right time

↓

Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated

↓

Providers are less likely to order duplicate tests, labs, or procedures

↓

Better management of chronic diseases and other illness improves health outcomes

↓

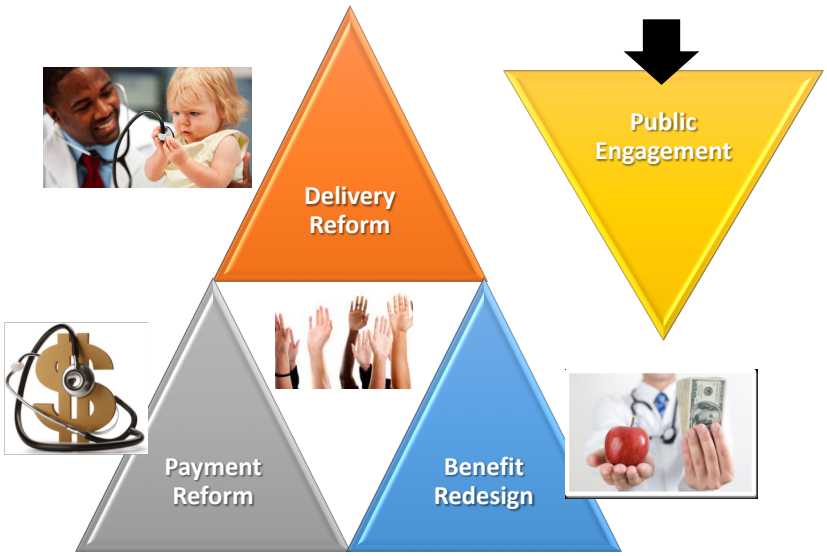
Focus on wellness and prevention reduces incidence / severity of chronic disease and illness

↓

Lower use of ER & avoidable hospital, tests procedures & appropriate use of medicine = $ savings

Patient-Centered Primary Care COLLABORATIVE

## Health System transformation requires…




Patient-Centered Primary Care COLLABORATIVE

## Solutions point to strengthened Primary Care

**Significant problems**

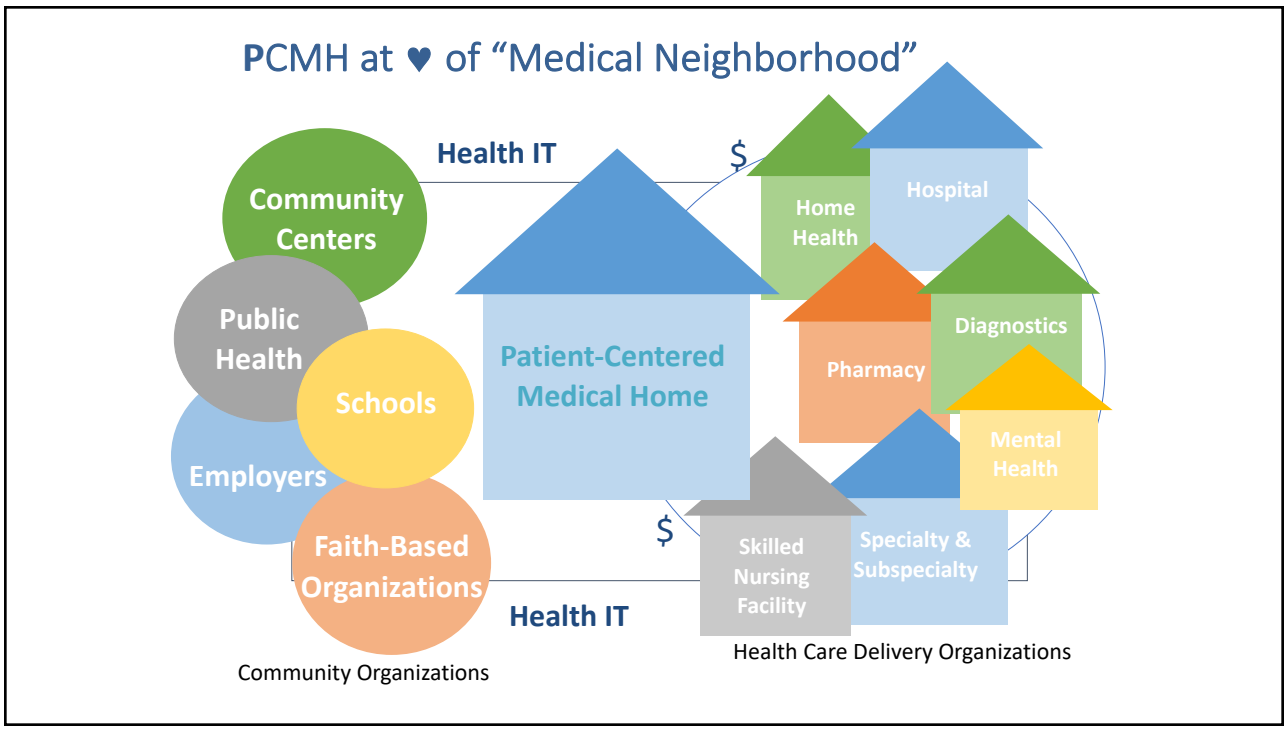
- Rising healthcare costs → $2.4 trillion (17% of GDP)
- Gaps/variations in quality and safety
- Poor access to primary care providers
- Below-average population health
- ↑ Aging population & chronic disease

**… "Experiments" underway**

- PCMHs
- ACOs
- EHR/HIE investment
- Disease-management pilots
- Alternative care settings
- Patient engagement
- Care coordination pilots
- Health insurance exchanges
- Top-of-license practice

**… Primary care-centric projects have proven results**

Across 300+ studies, better primary care has proven to increase quality and curtail growth of health care costs




# Research shows that PCMHs:

- Improve quality. Patients get the treatment they need, when they need it.
- Reduce costs. They prevent extensive and available hospitalizations, emergency room visits and complications – especially for patients with complex chronic conditions.
- Improve the patient experience. They provide the personalized, comprehensive coordinated care that patients want.
- Improve staff satisfaction. Their systems and structures help staff work more efficiently.

**PCMH Video** by Emmi Solutions: https://www.youtube.com/watch?v=EUuvTusJQhQ

# Benefits of PCMH Recognition

For Practices:

- Align with where healthcare is headed
- Integrate services across your entire organization
- Support reverse growth
- Improve your practice
- Keep staff happy
- Market your practice

For Clinicians:

- Earn higher reimbursement
- Succeed to MACRA
- Earn Maintenance of Certification (MOC) credits
- Focus on patient care

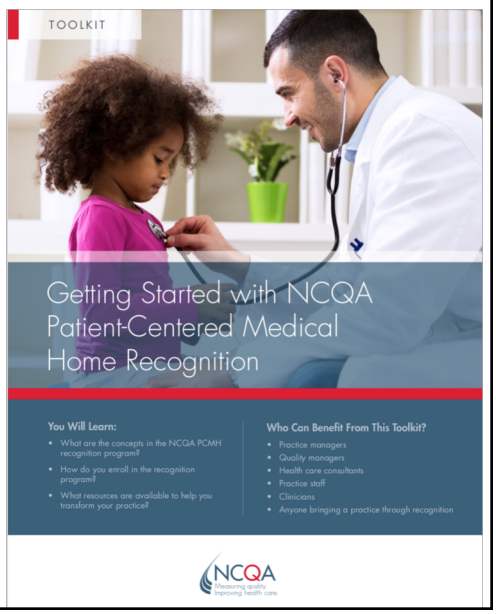
For Patients:

- Stay healthy
- Better communication
- Better management of chronic conditions
- Have a better experience

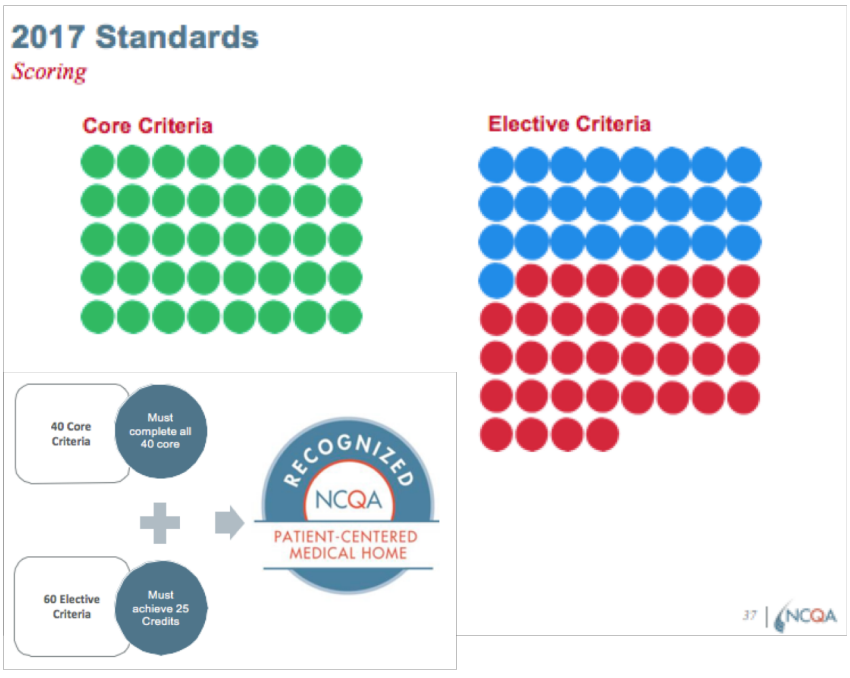
# NCQA PCMH 2017 Nomenclature

| 2014 Structure | 2017 New Structure | Description |
|---|---|---|
| Standards | Concepts | Over-arching components of PCMH |
| Elements | Competencies | Ways to think about and/or bucket criteria |
| Factors | Criteria | The individual things/tasks you do that make you a PCMH |

Source:
http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-and-guidelines-epub/




**Eligible Providers:**
MD, DO, PA, ARNP
- With panel of patients
- % = any
- Not residents
- Not locum tenens



## Recognition Process

*3 Pathways*

*New Customer*

Full Transform Process

*Recognized PCMH 2011 Levels 1-3 & PCMH 2014 Levels 1-2*

Accelerated Renewal Process (Transform w/ Attestation)

*Recognized PCMH 2014 Level 3*

Bypass Transform Direct to Sustaining Process



## Transform "Check-in" process

*Up to 3 "Check-ins" During Review*

*Determine Criteria to Address*

- Focus on core & documented processes first
- Identify criteria for 25 elective credits

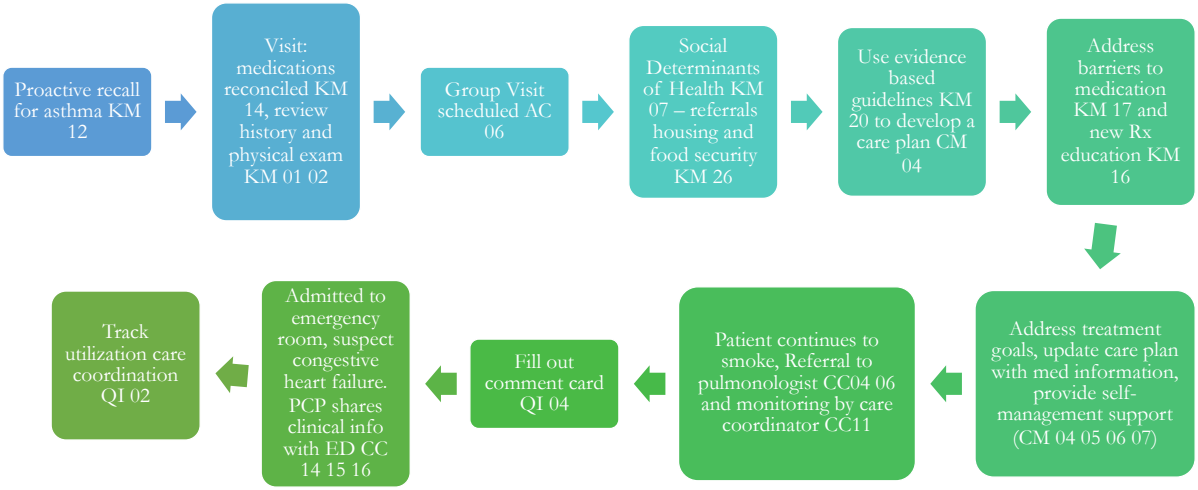
*Provide Documents for Offsite Review*

- Policies, procedures & protocols
- Website links
- Public information
- Attestation

*Provide Evidence during Virtual Review*

- Communicate with Evaluator
- Substitute evidence if not sufficient
- Demo systems
- Provide reports

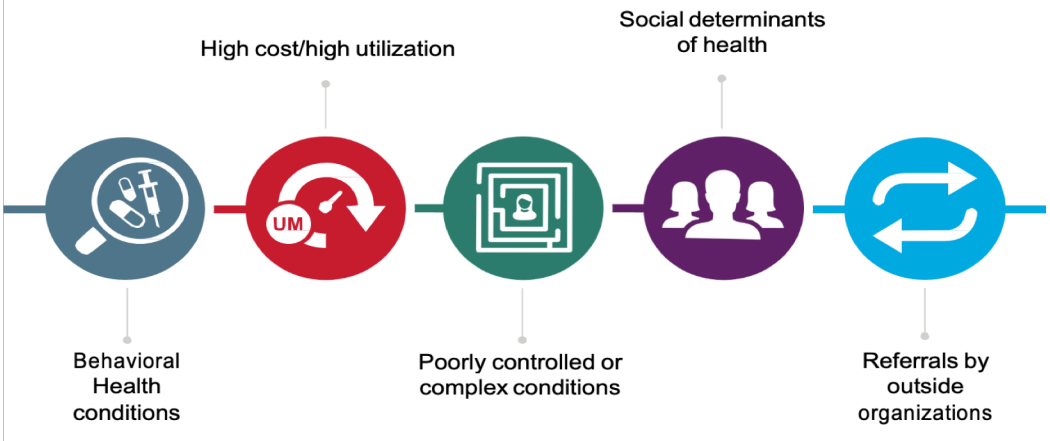
# Complex Patient 2017 – PCMH tracer




## Care Management and Support

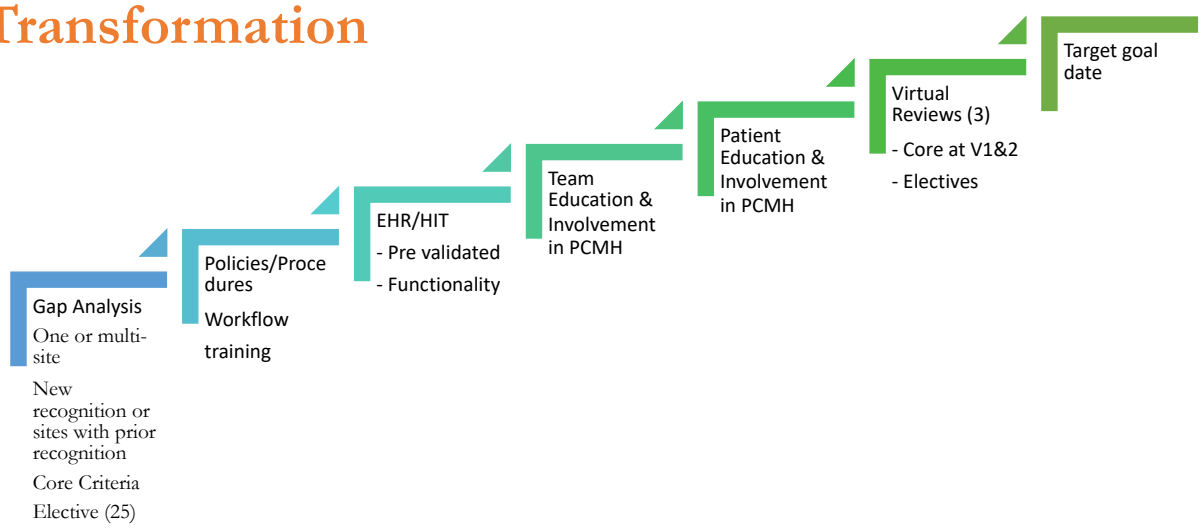
*CM 01-02: Core Criteria*

- The practice must include at least three categories in its criteria




CM 01 - *Protocol OR CM 03*
CM 02 - *Report*

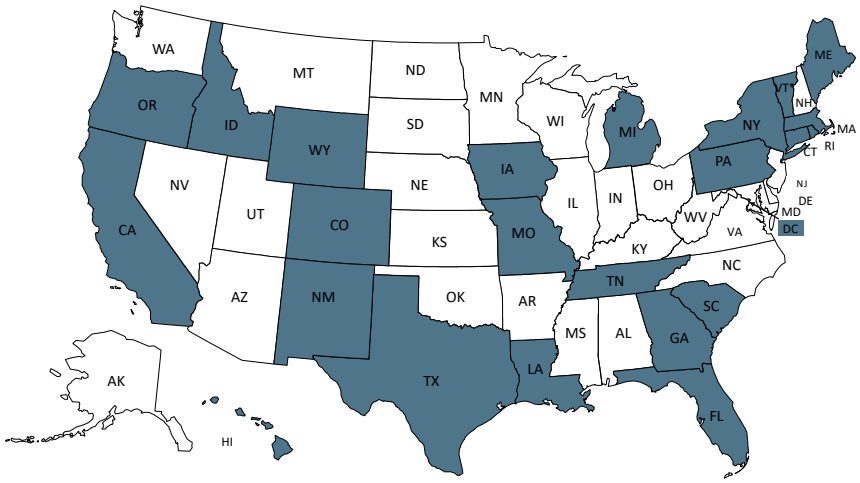
# Practical Approaches – PCMH Practice Transformation




# PCMH Policy/Legislation & Other Resources

- PCMH policy – legislation resources
  - https://www.pcpcc.org/legislation
  - https://www.cdc.gov/dhdsp/pubs/docs/SLFS-PCHM-508.pdf
  - https://pcmh.ahrq.gov/page/papers-briefs-and-resources
- NACHC
  - http://www.nachc.org/wp-content/uploads/2016/03/Useful-Resources-June-2014.pdf
  - https://www.fqhc.org/blog/2017/8/3/macra-for-me
- NCQA eCQM reporting for PCMH. https://www.ncqa.org/wp-content/uploads/2018/09/20180701_PCMH_Quality_Measures_Crosswalk.pdf

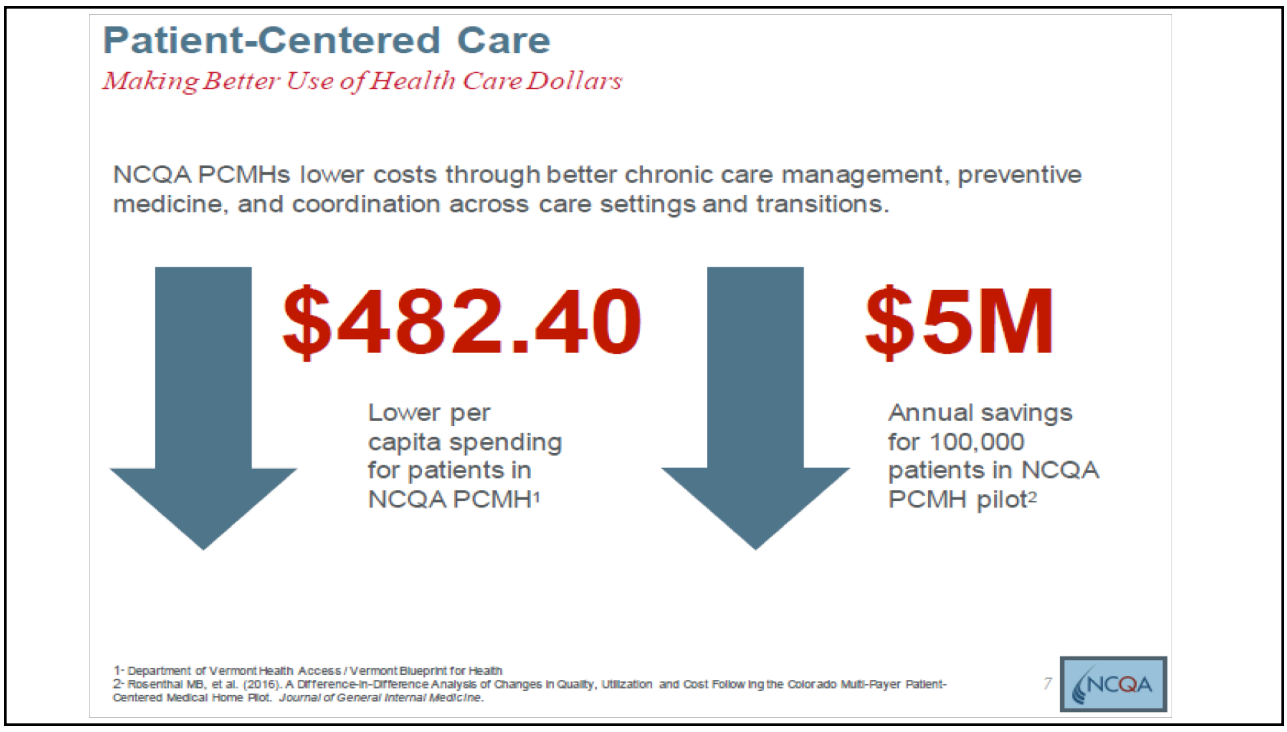
# 29 Public Sector PCMH Initiatives Across 24 States Require or Use NCQA PCMH Recognition *(October 2018)*




# List of Public Sector PCMH Initiatives that Require or Recognize NCQA PCMH (October 2018)

1. California – CoveredCalifornia QHP Marketplace Contract
2. Colorado – Primary Care Advanced Payment Model
3. Connecticut – HUSKY Health*
4. Connecticut - SIM Initiative*
5. DC – Health Home Program
6. Florida – MMA PCMH Program
7. Georgia – Medicaid P4P Incentive Program
8. Hawaii – QUEST Integration Managed Care PCMH Program*
9. Idaho – Healthy Connections
10. Idaho – SIM Initiative
11. Iowa – Health Home Program*
12. Louisiana – Bayou Health
13. Maine – Health Home Program*
14. Massachusetts – DSRIP
15. Massachusetts – Health Policy Commission PCMH PRIME Certification*
16. Michigan – SIM Initiative
17. Missouri – Health Home Program*
18. New Mexico - Centennial Care - New Mexico Medicaid Managed Care
19. New York - Medicaid PCMH Incentive Program*
20. New York - DSRIP
21. New York – NY PCMH*
22. Oregon – Patient-Centered Primary Care Home Program
23. Pennsylvania - HealthChoice – Managed Care Contracts
24. Rhode Island - Care Transformation Collaborative*
25. South Carolina - South Carolina MCO Provider Quality Incentive Program
26. Tennessee – SIM Initiative*
27. Texas – DSRIP
28. Vermont – BluePrint for Health/MAPCP Demo
29. Wyoming – Department of Health - WyHealth Care Management Program

**Exclusively Requires NCQA PCMH*




# PCMH Recognition in NV & Focusing Provider Practices

**Over 207 Nevada clinicians across 47 practices are already NCQA PCMH Recognized**. (Five Nevada practices are recognized as a Patient-Centered Specialty Practice).

Focusing provider practices on a single approach to accountability like the PCMH model can yield multiple beneficial results including:

- readiness for value-based payment,
- increased access to care,
- lower emergency department utilization,
- better management of chronic conditions, and
- provision of preventive health care services.

As the state continues to move the needle on value-based purchasing, the need for a single approach is critical in order to support providers and reduce the measurement burden that can result from the use of varying approaches by MCOs.

## States Leading the Way

A number of states are taking action to promote the PCMH model as a tool for driving change in their Medicaid programs. Each of the states below are using NCQA's PCMH model to accomplish a series of goals:

- *Targeting Incentives*. Florida statute, for example, gives preference in managed care procurements to plans that have well-defined programs for recognizing PCMH practices and providing increased reimbursement to these practices. The state's managed care contracts require the MCOs to have such PCMH programs. South Carolina and Tennessee require NCQA PCMH as part of their incentives model.
- *Broaden Access to the PCMH model*. A number of states, including Georgia and Louisiana, are including timelines and targets (e.g., percent of network providers or percent of patients in PCMHs) for plans to contract with PCMH Recognized practices.
- *Tracking Advance/Alternative Payments*. New York and Tennessee are also using the NCQA PCMH model as a transformation pathway and tool to target and track providers for alternative payment models (APMs).

## Patient Centered Medical Home Recognition

**NVPCA** priority since 2012

- 2015 NV Legislation established PCMH definition
- As of 2017 UDS, 57% of NV FQHCs are recognized
- Maintain and sustain PCMH practice transformation changes
- NVPCA FQHCs 2014 Recognition:
  - Community Health Alliance, Inc. Reno (4 sites)
  - Hope Christian Health Center, Las Vegas (1 site)
  - Nevada Health Centers, Inc., various locations (11 sites)
  - Northern Nevada HOPES, Reno (1 site)
  - Lake Powell Medical Center – Canyonlands Healthcare, Page AZ (1 site)
- Changes & Growth: Access, Team-Based Care, Population Health Management, Care Management & Support, Care Coordination & Transitions, Performance Measurement & Quality Improvement
- Annual Reporting Renewal; Distinctions in eCQM Reporting, Patient Satisfaction, Behavioral Health

# NVPCA FQHC'S

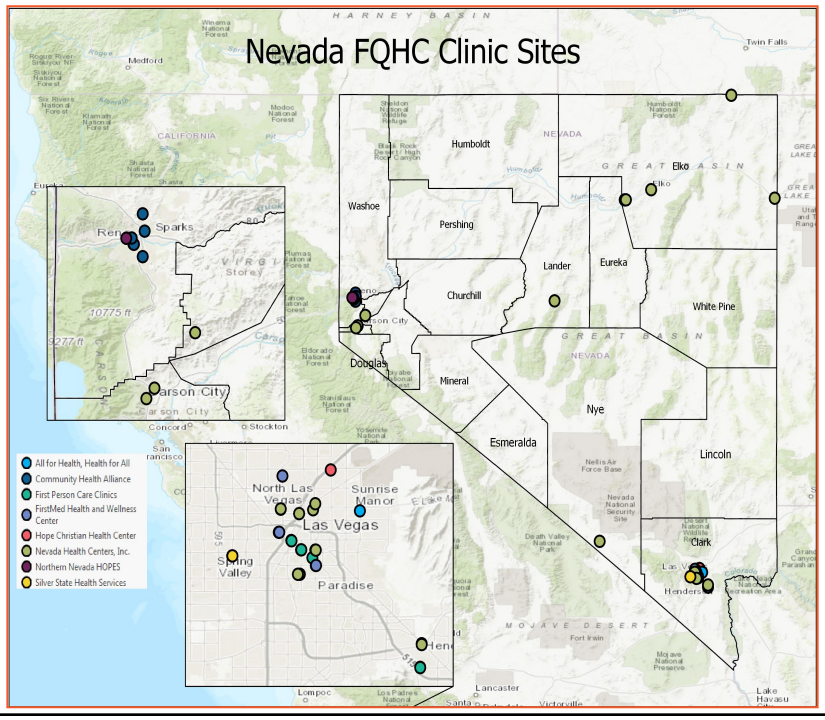
Nevada has **8** CHCs with 33 sites state-wide.

- Nevada Health Centers
- Community Health Alliance
- Northern Nevada HOPES
- FirstMed Health and Wellness Center*
- Hope Christian Health Center
- Silver State Health Services
- All for Health, Health For All*
- First Person Care Clinic
- Canyonlands – An Arizona FQHC that has a clinic on the border of Nevada

- Not a NVPCA member as of January 2019

**Associate Members**

- American Cancer Society
- Community Outreach Medical Center
- Office of Rural Health, UNR
- Silver Springs Hospital District
- Western Institute Commission for Higher Education (WICHE)



# NV FQHC's with NCQA PCMH Recognition

- **Community Health Alliance, Inc.** (all sites have PCMH 2014 recognition until May 2020)
  - Neil Road Health Center, October 2017
  - Sparks Health Center, October 2017
  - Sun Valley Health Center, October 2017
  - Wells Avenue Health Center, May 2017
- **Hope Christian Health Center**, January 2018 through January 2021
- **Nevada Health Centers, Inc.** (all sites have PCMH 2014 recognition until December 2019)
  - Amargosa Valley Medical Center, August 2017
  - Cambridge Family Health Center, May 2017
  - Carlin Community Health Center, October 2017
  - Eastern Family Medical & Dental Center, May 2017
  - Elko Family Medical and Dental Center, October 2017
  - Jackpot Community Health Center, October 2017
  - Las Vegas Outreach Clinic, May 2017
  - Martin Luther King Health Center, December 2016
  - North Las Vegas Family Health Center, May 2017
  - Sierra Nevada Health Center, October 2017
  - Wendover Community Health Center, May 2017 Level 3
  - **Sites with 2011 Recognition until April 2018:**
  - Austin Medical Center, April 2015
  - Crescent Valley Medical Clinic, April 2015
- **Northern Nevada HOPES, June 2017 through June 2020**
- Lake Powell Medical Center, Canyonlands; Page AZ


NEVADA HEALTH CENTERS

NORTHERN NEVADA HOPES
Your partner in health

COMMUNITY HEALTH ALLIANCE

Hope Christian Health Center

# NCQA PCMH Recognition in NV = CHC Changes

- Huddles & improved communications by care teams
- Data validity & reliability
- Expanded proactive outreach
- Improved access: measure SDA, TNAA, supply/demand
- Expanded hours of operation
- Serving high-need populations (barriers, patient preferences)
- Care coordination & care transitions - *Often most improved for patients with complex chronic conditions or chronically ill.*
- Increase in meeting quality measures (clinical, cost, coordination, patient satisfaction)

# PCMH – Lessons Learned

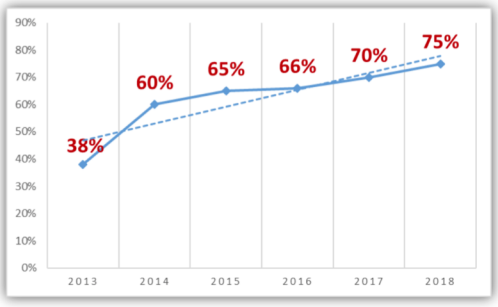
- It takes a team. It takes dedicated and consistent time.
- It takes leadership and all staff buy-in, patients too.
- Willingness to review, evaluate and modify – change.
- Functionality of EHR/HIT for PCMH (use it, training, changes).
- Writing out the process, workflows, things already doing.
  - Modifications to encompass all of the requirements.
- Training, reminders, benefits, diligence, patience …
- Patient satisfaction and staff satisfaction does improve.

- Determine key aspects of medical home that are most influential in terms of impacting outcomes of care (not just process)
- *There is a dose-response element to PCMH – the longer the initiative is implemented, the more impressive the results (PCPCC 2015 Reported: Group Health, Kaiser, numerous state programs)*



## Patient-Centered Medical Home (PCMH) (1/2)

**Percentage of Health Centers with PCMH Recognition**




Source: HRSA Accreditation and Patient-Centered Medical Home Report, 2013-18

**Recognition. Transformation. Value-Based Care.**

Health centers with longer periods of PCMH recognition see more improvement on adult weight screening, child weight assessment, and prenatal care clinical quality measures (CQMs).

PCMH transformation is critical to advance value-based care system through the following:

- Maximizing health IT
- Rapid adoption of bold new care delivery models
- Optimizing care coordination
- Increasing access to comprehensive primary care
- Enhancing patient experience
- Improving population health and outcomes

1. Hu, R. et al. (2018) The Association of Patient-centered Medical Home Designation With Quality of Care of HRSA-funded Health Centers. Medical Care, 56(2), 130-138.
2. Azar AM. (2018) Remarks on Value-Based Transformation and Innovation. World Health Care Congress.
3. NEJM Catalyst. (2017) What Is Value-Based Healthcare? URL: https://catalyst.nejm.org/what-is-value-based-healthcare/

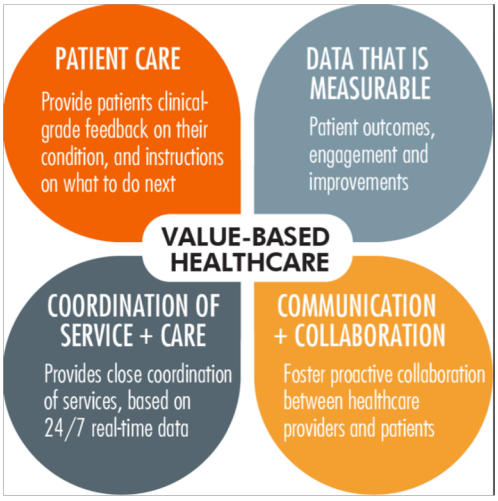
HRSA Health Center Program

Source: FY2018 HRSA BPHC QIA Technical Assistance Webinar 09.13.18

# Current healthcare payment system does not:

Pay for:

- Health IT
- Care Coordination
- E-visits, phone, video or telehealth
- Services by nurses
- Teams
- Other services (enabling, supportive …)




# Primary Care (Private): PCMH Support

Professional Medical Organizations (all supported PCMH Joint Principles in 2006)

- State associations

- American Academy of Pediatrics
  - https://www.aap.org/en-us/professional-resources/practice-transformation/medicalhome/Pages/home.aspx
- American Academy of Family Physicians
  - https://www.aafp.org/about/policies/all/medical-home.html
- American Osteopathic Association
- American College of Physicians
  - https://www.acponline.org/practice-resources/business-resources/payment/delivery-and-payment-models/patient-centered-medical-home

PCMH Legislation

- https://www.pcpcc.org/legislation

Federal Funding for PCMH (e.g. ACA)

# ROI for PCMH

- Robert Wood Johnson Foundation, February 2013. The ROI for PCMH Payment
  - Good ROI for Employers
  - CMS Advanced Primary Care Demonstration
  - https://www.pcpcc.org/resource/payment-matters-roi-patient-centered-medical-home-payment
- Producing an ROI with a PCMH. April 2016. hfma.org

  A PCMH is an investment that will not result in immediate payout; organizations should not expect to see a tangible ROI from a PCMH for at least three years after the initial investment

  > Align care with payment.
  > Develop a realistic timeline.
  > Define expenses.
  > Identify new revenue streams.
  - https://www.ecgmc.com/thought-leadership/articles/producing-an-roi-with-a-patient-centered-medical-home
- PCMH ROI Calculator: www.coachmedicalhome.org/sites/default/files/...org/pcmh-roi-calculator.xls

# Physician Interviews about NCQA PCMH

Podcast Dr. Ted Abernathy, founder of Pediatric and Adolescent Health Partners, a NCQA-Recognized Patient-Centered Medical Home in Midlothian, Virginia. 2.7.19

- care helps enhance clinicians' responsiveness, significantly reduces patient stress, and improves cohesiveness among staff.
- experience working with NCQA during the transformation process and offers advice to providers hesitant to make the leap to NCQA PCMH

https://blog.ncqa.org/inside-health-care-011-dr-ted-abernathys-patient-centered-medical-neighborhood/

Drs. Scott Keel and Ted Abarnathy discuss:

- how this care helps improve clinicians' responsiveness and significantly reduce patient stress
- rewards of becoming a PCMH and give advice to practices interested in transforming.

https://blog.ncqa.org/patient-centered-coordinated-care-in-midlothian-village/

# PCMH Criteria and Value

You could make the argument that each NCQA PCMH criteria correlates to Value

- Use of evidence based medicine
- Health care utilization patterns (expanded access)
- Medication reconciliation
- Care coordination
- Disease management
- Prevention
- Identification of high-risk patients
- Quality Improvement (clinical – chronic/prevention/population, cost, experience)

https://www.pcpcc.org/sites/default/files/media/better_best_guide_full_2011.pdf

# PCMH Value References

- To Err is Human http://www.iom.edu/Reports/1999/To-Err-is-Human-Building-A-Safer-Health-System.aspx
- Crossing the Quality Chasm http://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st- Century.aspx
- Institute of Medicine www.iom.org
- Institute for Healthcare Improvement (IHI) Organization www.ihi.org
- www.Improvingchroniccare.org
- https://www.healthaffairs.org/do/10.1377/hblog20170510.060008/full/

## PCMH Cost and Value Resources

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5939952/
- http://www.familydocs.org/f/PMNSeptember2012.pdf
- https://www.bcbsm.com/providers/value-partnerships/physician-group-incentive-prog/models-of-care/patient-centered-medical-home-initiatives.html
- http://marketing.ecgmc.com/acton/attachment/10977/f-0268/1/-/-/-/-/HFMA_Producing%20an%20ROI%20with%20a%20PCMH_April%202016_FINAL.pdf

## The Future – PCMH in Nevada

- Engage all primary care – market PCMH as Model of Care to Adopt
- Start small, adopt and change
- Utilization of EHR and HIT (population health registry)
- eCQM reporting – consistency and transparency
  - Improvement in NV health outcomes
- CHCs/FQHC: PCMH renewal recognition - expansion
- Professional Medical organizations – engagement
- Rural Health Centers – national/state support
- Private Primary Care clinics – team based care
- Access to care – pediatric focus
- Payment reform & alignment with PCMH
  - incentives

# Thank you!

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