It Takes a Village to Become a Medical Home
Kirsten Platte & Marcy Doyle
Conflict of Interest Disclosure

Marcy Doyle has no real or apparent conflicts of interest to report.

Kirsten Platte has no real or apparent conflicts of interest to report.
Learning Objectives

• Perform a PCMH readiness assessment
• Identify challenging elements of the PCMH 2011 application and understand tools utilized to meet these elements
• Develop a collaborative model and tools to support PCMH initiatives, while realizing health center cost savings
Lamprey Health Care, Inc.

- Federally Qualified Health Center with 1 urban site, 2 rural sites, 1 Behavioral Health site
- Over 16,000 users, over 70,000 annual encounters
- Offers primary care and health-related services, with a focus on prevention and lifestyle management, to individuals & families of all ages – regardless of their insurance status or ability to pay.
CHAN- a Health Center Controlled Network (HCCN)

Current Membership: 24 sites
FULL Members
➢ 15 sites + 1 Healthcare for the Homeless van
AFFILIATE Members
➢ 9 sites

Recognition and Awards:
➢ 2008 HIMSS Davies Award of Excellence for Community Health Organizations for improving healthcare through the use of HIT
➢ 2007 HRSA Certificate of Appreciation for visionary leadership in enhancing care through effective use of HIT
Network Benefits - Economies of Scale

- Centrally hosted EHR, PM systems for health center members supporting standardization
- Robust data warehouse: supports Uniform Data Set, Meaningful Use, Patient Centered Medical Home, Quality Improvement reporting
- Shared Staffing
- Health Center Staff training
- Facilitation of large scale initiatives
PCMH Readiness Assessment (’08-’10): a Health Center Perspective

- PCMH history in the state of NH
- LHC Strategic Plan
- LHC Staff education re: PCMH
  - Visit by Martin’s Point, Dr. Howe
- LHC PCMH Team Identification
- Area Health Education Center (AHEC) Health Coach training – Dartmouth Microsystems Improvement Curriculum
- LHC Staff survey
- PCMH A (Rand Assessment tool)
PCMH Partnerships

- **Universities/Colleges**: use of interns and medical students
- **Area Health Education Center (AHEC)**: clinical micro-systems, 5 P’s
- **Hospitals**: information exchange w/admitting hospitals
- **New Hampshire Health Information Organization (NH State Health Information Exchange)**: CHAN ED on NHHIO BOD
- **Bi-State Primary Care Association**: NE Cluster Partner PCA member
- **NH Regional Extension Center**: CHAN is a sub-recipient
Microsystem Name

Purpose/AIM

Microsystem Approach 6/17/98
Revised: 03/04
Eugene C. Nelson, DSc, MPH
Paul B. Batalden, MD
Dartmouth-Hitchcock Clinic, June 1998
Functional & Risks

- Biological

Expectations

Costs
People with healthcare needs met

Functional & Risks

Biological Satisfaction

Costs
## Performance Patterns

### Measuring Team Performance & Patient Outcomes and Costs

<table>
<thead>
<tr>
<th>Measure</th>
<th>Current</th>
<th>Target</th>
<th>Measure</th>
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<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panel Size Adj.</td>
<td></td>
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<td>External Referral Adj. PMPM-Team</td>
<td></td>
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<tr>
<td>Direct Pt. Care Hrs: MDAssoc.</td>
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<td>Patient Satisfaction</td>
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<tr>
<td>% Panel Seeing Own PCP:</td>
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<td>Access Satisfaction</td>
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<tr>
<td>Total PMPM Adj. PMPM-Team</td>
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<td>Staff Satisfaction</td>
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</tbody>
</table>

**Microsystem Approach 6/17/98**
**Revised: 03/04**

© Eugene C. Nelson, DSc, MPH
Paul B. Batalden, MD
Dartmouth-Hitchcock Clinic, June 1998
The Dartmouth Microsystem Improvement Ramp

- Global Aim
- Specific Aim
- Change Ideas
- Measures
- PDSA

- Theme
- Assessment
- Cause & Effect

- * 5P Assessment/Effective Meeting Skills
The Dartmouth Microsystem Improvement Ramp

* 5P Assessment/Effective Meeting Skills
Assessing Readiness (’08-’10) cont.

- Existing CHAN Network infrastructure supported ’08-’10 recognition for health center members
- LHC made request of CHAN for
  - Report development (minimal)
  - Screen shots (to prove EMR capability)
  - No form development was required
  - Minimal network staff time
  - Minimal timeline (network staff participated 1 of 3mos)
  - Health Center 2 followed- approx 1 yr later
Assessing Readiness PCMH 2011 Standards; CHAN/LHC collaboration

• Existing network infrastructure did NOT fully support 2011 Standards
• MU Initiative supported PCMH
• LHC/CHAN weekly PCMH meetings (begin Nov ’11)
  ➢ Reviewed PCMH manual vs. existing capabilities
  ➢ Identified gaps in reports, forms, operations, technology gaps (i.e. interfaces re: lab recon, upgrades)
  ➢ Identified training gaps
CHAN: Supporting PCMH Recognition

• Leadership
  Transfer of 2008 process knowledge from LHC (who had capacity and knowledge) to CHAN

• Knowledge Sharing
  PCMH Steering Committee (modeled SC after PMCH team approach, to include site administrators, medical directors, MAs)

• Collaboration
  - Gathering all that had been done individually (resulted in PCMH tracking tool for all, form development)
  - CHAN sub-contract with Bi-State PCA to participate in Northeast Cluster Partner PCAs
Collaborative Tools Development

• Development of tracking tool (w/hyper links to forms, policies, screen shots)
• Development of electronic forms (transitions of care form, PCMH form)
• Patient portal development
# PCMH Network Collaborative Tool

**PCMH 1: ENHANCE ACCESS & CONTINUITY**

<table>
<thead>
<tr>
<th>Measure, Element, Factor #</th>
<th>Description</th>
<th>MU?</th>
<th>Source</th>
<th>Supporting Documentation Description</th>
<th>CHC1</th>
<th>CHC2</th>
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</thead>
<tbody>
<tr>
<td>PCMH1 Element A: Access During Office Hours</td>
<td>The practice has a written process and defined standards, &amp; demonstrates that it monitors performance against the standards for:</td>
<td></td>
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<tr>
<td>MUST PASS (50% score or higher)</td>
<td>Providing Same-Day Appointments</td>
<td></td>
<td>EMR</td>
<td>Screenshot of same-day appt book</td>
<td>H</td>
<td>P</td>
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<td></td>
<td>EMR</td>
<td>Policy Title: Secure Email</td>
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**ELEMENT A Status**

*FACTOR 1 MANDATORY TO PASS ELEMENT A*

<p>| | FAIL | FAIL |</p>
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Specific PCMH Challenges/Resolutions

• Providing Same Day Appointments (PCMH 1: Element A, Factor 1)
• Clinical Visit Summaries (PCMH 1: Element C, Factor 1)
• Care Management (PCMH 3: Element C)
• Medication Management (PCMH 3: Element D)
• Coordinate with Facilities and Care Transitions (PCMH 5 Element C)
Transitions of Care Form

<table>
<thead>
<tr>
<th>General/Med Reconc./Hx</th>
<th>Care Coord/Follow Up</th>
<th>Self Mgmt Goals</th>
<th>References</th>
</tr>
</thead>
</table>

### General Info
- Spoke with: [Dropdown]
- Designated personal rep? [Yes/No]
- Language: Portuguese-susan [Dropdown]
- Interpreter: [Yes/No]
- Hospital: [Field]
- Reason for admission: [Field]
- Discharge Date: [Field]
- Received discharge notes? [Yes/No]
- Discharge notes reviewed with patient? [Yes/No]
- Current concerns or signs & symptoms? [Yes/No]

### Medication Reconciliation - Review: name, strength, formulation, dose, route, frequency, last dose taken
- Meds listed on discharge instructions taken as prescribed? [Yes/No]
- Meds listed on consult instructions taken as prescribed? [Yes/No]
- Discrepancies between note & EMR med list identified & addressed? [Yes/No]
Medical Home Form

Medications

- Previsit Summary: done
- NB Hearing: 
- NB Hosp Labs: 
- Taking medications from another provider: yes
- Assessed understanding of meds: yes
- Assessed pt response to meds & barriers: yes

Information to include: side effects, drug interactions, instructions, consequences of not taking

- Provided info on NEW meds: yes
- Provided info on EXISTING meds: yes

Add'l Care Management Services Needed

referral to nutritionist given by provider. Jessica Hatch RN
September 13, 2012 10:33 AM

Medication Management Goal: Last updated: 09/13/2012

remember to take medication on time each day. call earlier when refill needed

Self Management Goals

Goal #1: Last updated: 09/13/2012

reviewed - no changes required
Medical Home Form

**Medications**

Previsit Summary: [ ] done  
NB Hearing: [ ]

Taking medications from another provider?  [ ] yes  [ ] no

Assessed understanding of meds?  [ ] yes  [ ] N/A

Assessed pt response to meds & barriers?  [ ] yes  [ ] N/A

Information to include: side effects, drug interactions, instruction

Provided info on NEW meds?  [ ] yes  [ ] N/A

Provided info on EXISTING meds?  [ ] yes  [ ] N/A
## Current CHAN member PCMH status

<table>
<thead>
<tr>
<th>Agency Name/Site</th>
<th>NCQA PCMH Certified (Y/N)</th>
<th>Level/Submission date/Standards</th>
<th>Planned (Re)Submission Date</th>
<th>3 Important Conditions</th>
<th>High Risk Identifier(s)</th>
<th>Medicare APCP Demo Participant (Y/N)</th>
<th>HRSA Supplemental Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHC 2 (1 site)</strong></td>
<td>Yes</td>
<td>Yes 3/July 2011 stds</td>
<td>Done: Submitted 11/2012</td>
<td>DM w/ A1c &gt;8, HTN with BP &gt;160/100, Pedi BMI &gt; 95%ile</td>
<td>4+ ER Visits in the past 12 months</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>CHC 3 (1 site)</strong></td>
<td>No</td>
<td>n/a</td>
<td>After Jan 2013</td>
<td>DM, HTN, Childhood Obesity</td>
<td>4+ ER Visits in the past 12 months</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Lamprey Health Care (3 sites)</strong></td>
<td>Yes, 1 site</td>
<td>Yes, 3/July 2011 stds</td>
<td>1 site Done: Submitted 10/2012 Raymond, Nashua Spring 2013</td>
<td>DM, HTN, Childhood Obesity</td>
<td>2 or more hospitalization s in past 12 months</td>
<td>Yes</td>
<td></td>
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<tr>
<td><strong>CHC 5 (2 sites)</strong></td>
<td>No</td>
<td>n/a</td>
<td>As of Dec 2012: “not for a few months, yet”</td>
<td>DM, HTN, Tobacco Abuse</td>
<td>Yes</td>
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<tr>
<td><strong>TOTAL; 8 sites</strong></td>
<td>3 sites (38%)</td>
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<td></td>
<td></td>
<td>7 sites (88%)</td>
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Health Center Savings/Revenue Generation

- Centralized EMR
- Shared Staffing Model
- Evidence based form generation by large scale multidisciplinary committee (ID an cost out form, Report Development)
- Facilitated Meeting Structure
- CMS MU Year 1 Incentive Program (Year 1, attestation)
Health Center MU Stage 1 Attestation ROI 2:1

- Expense:
  EMR Upgrade, Total CHAN and member health centers $600,000
  (CHAN staffing paid through member shared systems fees)

- Revenue:
  Health Centers $21,250 per Eligible Provider = $1,211,250
LHC PCMH Revenue/Potential

To date: $230K
- $90K, Citizens Health Initiative PCMH Demonstration Project (commercial insurers)
- $140K, Grant Funding (HRSA, CMS Advanced Primary Care Practice Demonstration)

Potential:
- $3 - $7 per member per month (commercial insurers)
  Annual Revenue Potential = $108K - $252K
Thank You!

Contact Information
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Lamprey Health Care, Inc.
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603-292-7268

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Community Health Access Network (CHAN)
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603-292-7205