

Using Patient Centered Medical Home Principles to Enhance Accountable Care Models of Care



Massachusetts eHealth Collaborative

The Massachusetts eHealth Collaborative (MAeHC) was created in 2004 as a non-profit under the leadership of the American College of Physician, the Massachusetts Medical Society, and Blue Cross Blue Shield.

Founded as a collaborative of Massachusetts healthcare providers, payers, purchasers, and other health care stakeholders, we now serve customers across the country.

Our business experience and technical expertise ensures success for clients as diverse as large healthcare networks, health information organizations, government agencies, foundations, and physician practices large and small.

Speakers

Samantha Sawdon, PCMH CCE

Samantha Sawdon is a Managing Consultant with MAeHC. Ms. Sawdon is an experienced professional with the ability to manage operations, implement change, processes and people. Well-versed in business and office management and able to effectively multi-task and re-prioritize as needs change. She has expertise in managing enterprise-wide health information technology projects, including coordination of stakeholder and vendors, project research, specifications, and deliverables, implementation strategies, user application definition and workflow design, validation processes, quality assurance, and support. She has strong leadership skills to focus her teams on project timelines and deliverables.



Speakers

Courtney Beach, PCMH CCE

Courtney Beach is a Senior Consultant with MAeHC. Ms. Beach is an experienced professional with extensive knowledge in practice and operations management, medical management compliance, and overall workflow optimization. Ms. Beach has provided guidance and assistance to ACO's, EHR vendors, and various types of healthcare organizations in practice transformation services and the facilitation of NCQA Patient Centered Medical Home. Ms. Beach has assisted multiple organizations to provide expertise on clinical workflow designs, care-standardization protocols, and quality improvement activities, care coordination and population health management.



Agenda

Webinar Overview

Basic Principals of PCMH

Applying Principals for ACO success

Risk Based Contracts

Webinar Overview

Many state and federal initiatives are built upon the same principles of patient centered care:

- Patient Centered Medical Home (PCMH)
- Comprehensive Primary Care + (CPC+)
- Delivery System Reform Incentive Payment (DSRIP)
- Accountable Care Organizations (ACO)

The fundamental principals of these programs are aligned for care management of high-risk and high-cost patients and care coordination for all patients.

Understanding the core concepts of these programs will help organizations to streamline workflows and build a foundation for success for the evolving world of risk-based contracts.

Learning Objectives

At the conclusion of this educational activity, participants will be able to:

- Understand the basic principles of a PCMH model of care
- Understand workflow changes and health information technology (HIT) requirements to support care coordination activities
- Apply PCMH principles to advance care coordination among community partners within an ACO
- Understand how to apply these principles to maximize risk-based contracts

Defining the Programs

Value and Risk Based Contracting – Work together to reduce cost on a set group of metrics, agreed upon in a contract with a payer.

Patient Centered Medical Home (PCMH) – Lead by the Primary Care office to improve quality, lower costs, and provide patient focused care through individual and coordinated care to promote health.

Bundled Payments – one payment to cover the services for the patient across health sectors

Accountable Care Organization (ACO) – Groups of doctors, hospitals and other health care providers, who come together voluntarily to work together to lower costs and improve quality for Medicare and/or Medicaid patient populations.

Agenda

Webinar Overview

Basic Principals of PCMH

Applying Principals for ACO success

Risk Based Contracts

Basic Principals of NCQA Patient Centered Medical Home (PCMH)

PCMH can be broken out into four high-level categories around patient care:

- Team Based Care
- High Risk patient population
- Care Coordination
- Quality Performance & Improvement

By focusing on these categories, an organization can be prepared for a number of state and federal programs and for the evolving risk based payment systems.

Same Themes, Different Programs

	Team Based Care	High Risk Patients	Care Coordination	Quality Improvement
PCMH	√	√	√	√
DSRIP	√	√	√	√
CPC+	√	√	√	√
ACO	√	√	√	√

Health Information Technology (HIT)

The use of HIT is key for success in the Medical Home; high risk patients, care coordination, QI.

- **Electronic Medical Record** - An electronic medical record (EMR) is a digital version of the traditional paper-based medical record for an individual. The EMR represents a medical record within a single facility, such as a doctor's office or a clinic.
- **Health Information Exchange** - Health information exchange (HIE) is the mobilization of health care information electronically across organizations within a region, community or hospital system. In practice the term HIE may also refer to the organization that facilitates the exchange.
- **Population Health Management** – HIT that aggregates patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes.
- **Reporting** – HIT that is a business intelligence application used to design and generate reports from a wide range of data sources.

Team Based Care

Structured Communication

- Huddles focused on the care of individual patients
- Chart or scheduling notes
- Pre-visit planning

Defined Roles

- Job descriptions
- Standing orders
- Team and organization roles mapped and defined
- Training

Champions

- Clinical and administrative leadership
- Lead MD or NP
- PCMH Lead within each role



Team Based Care - Health Information Technology (HIT)

The use of HIT is key for success in the Medical Home; high risk patients, care coordination, QI.

Electronic Medical Record

- Pre-visit planning templates
- Messaging functionality
- Outreach documentation

Health Information Exchange

- Sending and receiving referral and discharge information

Population Health Management

- Proactive outreach for preventive care and chronic conditions

Reporting

- Break out quality data by care team
- Population analytics

Care Management for High Risk Patients

Identification

- PCMH – Conditions from four of five categories
 - Behavioral Health
 - High-cost/high/utilization
 - Poorly controlled or complex condition
 - Social Determinant of Health
 - Referrals from outside organizations
- AAFP risk stratification matrix - <https://nf.aafp.org/Shop/practice-transformation/risk-stratified-care-mgmt-rubric>



Stratification

- Monitor population over time

Care Planning

- Individual, patient focused care plans
- Treatment goals
- Self-management goals
- Barriers
- Copy of care plan

Care Management - Health Information Technology (HIT)

Electronic Medical Record

- Care plan templates
- Flagging patients for care management
- Messaging
- Evidence-based care guidelines

Health Information Exchange

- Sharing and receiving information from outside providers and facilities

Population Health Management

- Patient care management tracking
- Proactive outreach
- Evidence-based care guidelines

Reporting

- List of high-risk/high-utilization patients

Care Coordination

Referral Management

- Closed loop processes
- Documenting of outside care team members

Test Management

- Closed loop processes for lab and imaging tests

ED and Hospital Discharge

- Notification of ED and Hospital discharge
- Follow up within 48 hours

Preventive Outreach

- Due and overdue services

Community Resources

- Tracking of referrals
- Lists of available resources



Care Coordination – Health Information Technology

Electronic Medical Record

- Structured orders
- Queue of outstanding orders
- Telephone and web notes – track outreach and communication

Health Information Exchange

- CCDA Information Exchange
- Direct messaging with outside providers
- Event Notification System

Population Health Management

- Care plan for high-risk patients
- Continuous, proactive and responsive actions for high-risk patients

Reporting

- ED and hospital discharge reports
- Outstanding referrals and tests

Quality Performance & Improvement

Metric alignment across programs

- PCMH, ACO, MIPS/MACRA, AQC

Goals

- Review baseline data and set goals for improvement.
- Share goals with staff

Action plans

- Work with all levels of staff to create action plans for improvement
- Incorporate patients/families/caregivers into advisory councils

Sharing data

- Track performance over time
- Share performance and trending with all levels of staff
- Share data publicly



Quality Performance & Improvement – Health Information Technology

Electronic Medical Record

- Capture of discrete data – Problems, medications, vitals, demographics
- Alerts and Clinical Decision Support Systems (CDSS)
- Flowsheets
- Lab and radiology interfaces

Health Information Exchange

- Receiving data from outside specialists or chronic and preventive care

Population Health Management

- Lists of patients due for services
- Analytics for preventive and quality benchmarks

Reporting

- Reports on metrics by provider, team and organization
- Trending of performance over time
- Patient experience

Agenda

Webinar Overview

Basic Principals of PCMH

Applying Principals for ACO success

Risk Based Contracts

PCMH as a “Leg Up” for ACOs

In a first-ever study of its kind, the Patient-Centered Primary Care Collaborative’s (PCPCC) 2018 Evidence Report shows the benefits of PCMH providers.

Both PCMH and ACOs were conceived as models to better integrate and coordinate care and to incentivize providers to provide proactive care focused on a defined population’s needs as opposed to reactive, visit-based care

Findings suggest that a strong foundation of advanced primary care, as embodied by PCMH, is critical to the success of care delivery reforms.

Source: Patient-Centered Primary Care Collaborative “Advanced Primary Care: A Key Contributor to Successful ACOs” <https://www.pcpcc.org/sites/default/files/resources/PCPCC-Whitepaper-AdvancedPrimaryCare.pdf>

A Few Findings

Patient-Centered Primary Care Collaborative's (PCPCC) 2018 Evidence Report examines the interaction between these two models through both qualitative and quantitative methods.

- 923 ACOs around the country, across 50 states plus Washington DC and Puerto Rico
- 10 percent, or 32 million, of the US patient population receives their care within an ACO. This number is growing.
- More than 20 percent of primary care physicians practicing in PCMHs
- Medicare ACOs with a higher proportion of PCMH primary care physicians were more likely to generate savings
- Medicare ACOs with a higher proportion of PCMH primary care physicians demonstrated higher quality scores, including on a significant number of process and outcome measures
- Having a higher share of PCMH PCPs was associated with higher health promotion and higher health status scores. The preventive service scores were also generally higher:

Source: Patient-Centered Primary Care Collaborative “Advanced Primary Care: A Key Contributor to Successful ACOs” <https://www.pcpcc.org/sites/default/files/resources/PCPCC-Whitepaper-AdvancedPrimaryCare.pdf>

Applying PCMH Principals in an ACO Environment

Team Based Care

- Identify and document outside care partners
- Have an agreed process and needed information for exchange

High Risk patient population

- Identify patient population
- Integrated care plans
- Care management resource or program

Care Coordination

- Event Notification Systems
- Shared EMR within systems

Quality Performance & Improvement

- Understanding of ACO required metrics
 - Reporting vs Performance measures
- Review and discuss performance, goals and action plans

Agenda

Webinar Overview

Basic Principals of PCMH

Applying Principals for ACO success

Risk Based Contracts

Risk-Based Contracting

At its core, fee-for-service incentivizes providers to see more patients. Risk-based contracting flips the incentive, where providers profit when patients are healthier and don't require as many hospitalizations.

- Care management plays an important role
- Addressing gaps in care and standardizing care

Recognize that this is not a one year initiative; it is a multi-year journey, and depending on where you are starting from, it could easily take five to 10 years to really transform your system



Tips for Success

It is especially critical for providers to carefully examine the terms of the contract. All staff should fully understand the terms of the agreement and what quality metrics will determine financial success under the risk-based model.

- Know the metrics
- Know your data - claims data, EMR data, admissions, transfer and discharge data, patient reported data, eligibility and pharmaceutical data

Make sure the payer will provide claims data on an ongoing basis to show how risk is changing over time, what interventions are working and which ones are not.

Pro-actively manage data for patient outreach and improvement.



Applying PCMH Principals in Risk-Based Contracting

Team Based Care

- Identify and document outside care partners
- Have an agreed process and needed information for exchange

High Risk patient population

- Identify patient population

Care Coordination

- Event Notification Systems
- Lab and Referral Tracking

Quality Performance & Improvement

- Understanding the risk-based contract metrics and requirements
- Learn how to maximize reimbursement
 - Review key utilization data
- Review and discuss performance



www.maehc.org

Samantha Sawdon
Managing Consultant, PCMH CCE
ssawdon@maehc.org
339-226-2283

Courtney Beach
Senior Consultant, PCMH CCE
cbeach@maehc.org
339-222-6128