# PCMH and DSRIP
## What does it mean to me?

Nicole Harmon, MBA, PCMH CCE
Senior Director, PCMH Advisory Services

HANYS Solutions

© 2015 HANYS Solutions Patient-Centered Medical Home Advisory Services

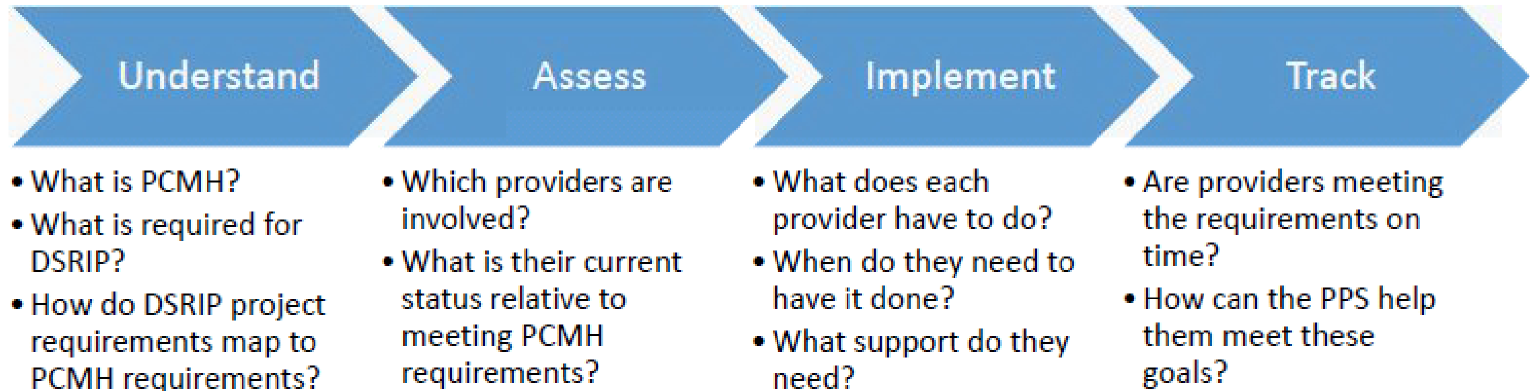
# Objectives

- After today's presentation, you will
  - Understand how Patient Centered Medical Home (PCMH) relates to DSRIP
  - Have a basic understanding of PCMH transformation
  - How the transformation impacts clinical integration, your clients, patients and the care continuum

# DSRIP Roadmap for PCMH

***The PPS needs to have a plan for how they will:***

- ***Provide appropriate support to their network partners that need to reach PCMH Level 3***
- ***Track PPS-wide progress towards meeting DSRIP requirements related to PCMH***




**The information and tools presented here and on the NCQA website are intended to help PPSs and providers work towards achieving PCMH certification, as required by many DSRIP projects.**

# Eligibility Requirements

***The NCQA PCMH Recognition program is for practices that provide first contact, continuous, comprehensive, whole person care for patients across the practice. The program evaluates primary care provided to all patients in the practice.***

**Clinicians who qualify for PCMH:**

- Clinicians who hold a current, unrestricted license as a doctor of medicine (MD), doctor of osteopathy (DO), advanced practice registered nurse (APRN), or physician assistant (PA).
- Physicians, APRNs (including nurse practitioners, clinical nurse specialists) and PAs who practice in the specialty of internal medicine, family medicine or pediatrics, with the intention of serving as the Personal Clinician for their patients.

Only clinicians that a patient/family can select as a Personal Clinician are eligible to be listed in addition to the practice Recognition on NCQA's website.

A practice may define a "Personal Clinician" as:

- A residency group under a supervising clinician or faculty physician
- A combination physician and APRN or PA who share a panel of patients



Source: Medicaid Redesign Team

# DSRIP Projects Requiring PCMH

| PPS | 2.a.i | 2.a.ii | 2.a.iii | 2.a.iv | 2.a.v | 2.b.i | 2.b.ii | 2.b.iii | 3.a.i | 3.b.i | 3.c.i | 3.e.i | 3.f.i | 3.h.i |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Advocate | ✓ | | ✓ | | | | | ✓ | ✓ | ✓ | ✓ | | | |
| AHI | ✓ | ✓ | | ✓ | | | | | ✓ | | | | | |
| Albany | ✓ | | ✓ | | ✓ | | | ✓ | ✓ | ✓ | | | | |
| Bassett | | ✓ | | | | | | | ✓ | | | | | |
| Bronx Leb | ✓ | | ✓ | | | ✓ | | | ✓ | | | | ✓ | |
| CNY | ✓ | | ✓ | | | | | ✓ | ✓ | ✓ | ✓ | | | |
| CPWNY | ✓ | | | | | | | ✓ | ✓ | ✓ | | | ✓ | |
| Ellis | ✓ | | | | | | | ✓ | ✓ | | | | | |
| Finger Lakes | ✓ | | | | | | | ✓ | ✓ | | | | ✓ | |
| HHC | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | | | | |
| Lutheran NY | ✓ | | | | | | | ✓ | ✓ | | ✓ | | | |
| Maimonides | ✓ | | ✓ | | | | | ✓ | ✓ | ✓ | | | | |
| Millennium | ✓ | | | | | | | ✓ | ✓ | ✓ | | | ✓ | |
| Montefiore | ✓ | | ✓ | ✓ | | | | ✓ | ✓ | ✓ | | | | |
| Mt. Sinai | ✓ | | | | | | | | ✓ | ✓ | ✓ | | | |
| NUMC | ✓ | | | | | | ✓ | | ✓ | ✓ | ✓ | | | |
| NYH Queens | | ✓ | | | | | | | ✓ | ✓ | | | | |
| Presbyterian | ✓ | | | | | ✓ | | ✓ | ✓ | | | ✓ | | |
| Refuah | ✓ | ✓ | | | | | | | ✓ | | | | | |
| NCI | ✓ | ✓ | | ✓ | | | | | ✓ | ✓ | ✓ | | | |
| Southern Tier | ✓ | | | | | | | | ✓ | ✓ | | | | |
| St. Barnabas | ✓ | | ✓ | | | | | ✓ | ✓ | ✓ | ✓ | | | |
| Staten Island | | | ✓ | | | | | | ✓ | | ✓ | | | |
| Stony Brook | ✓ | | | | | | | | ✓ | ✓ | ✓ | | | |
| Westchester | ✓ | | ✓ | ✓ | | | | | ✓ | | ✓ | | | |

★**Note:** CNYCC selected 3.g.i not 3.c.i – Integration of Palliative Care in Patient Centered Medical Home

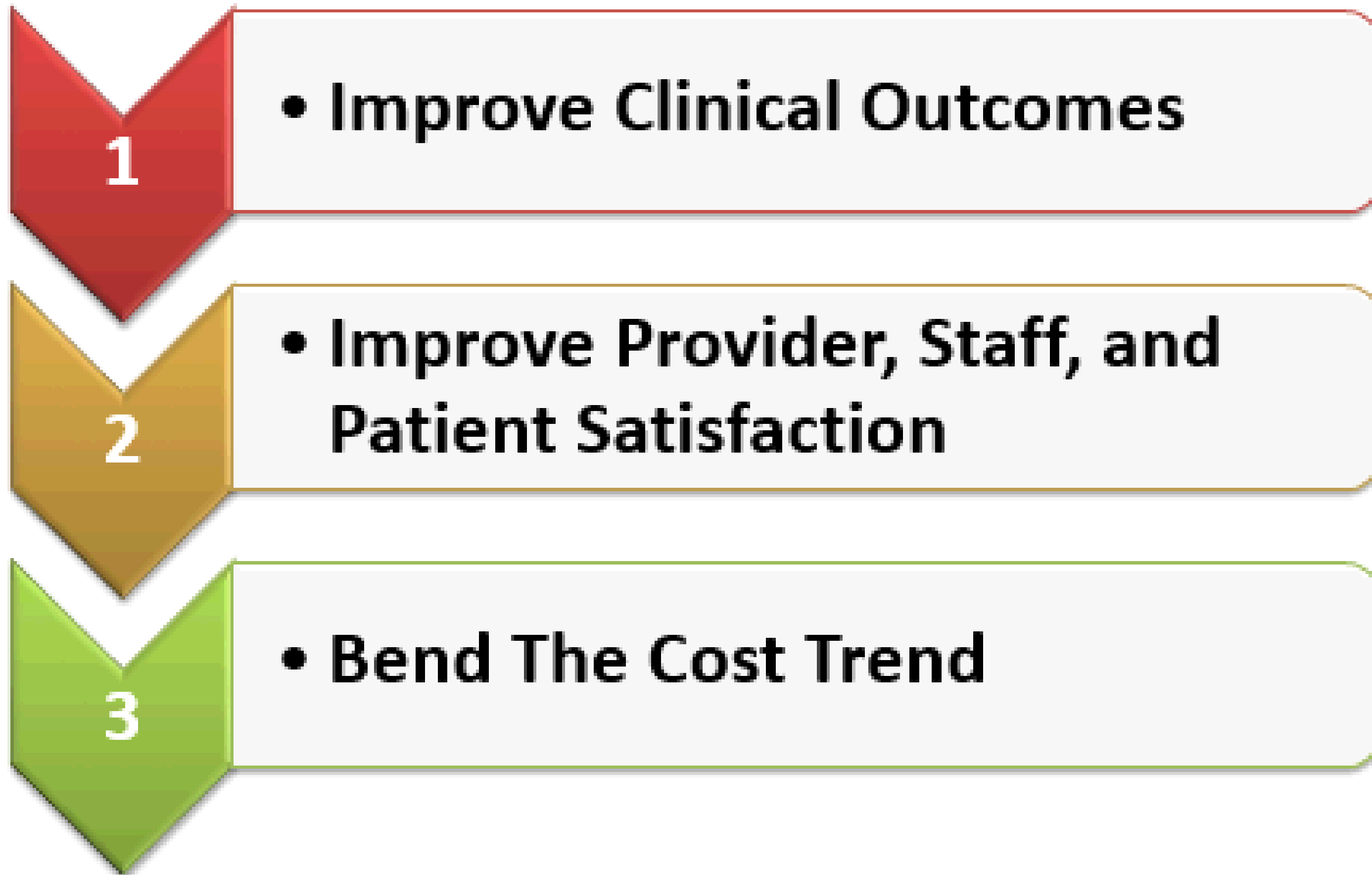
# CNYCC DSRIP Projects

| Project # | Project Name |
| --- | --- |
| 2.a.i | Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management |
| 2.a.iii | Health Home At-Risk Intervention Program: Proactive Management of Higher Risk Patients Not Currently Eligible for Health Homes through Access to High Quality Primary Care and Support Services |
| 2.b.iii | ED care triage for at-risk populations |
| 2.b.iv | Care Transitions Intervention model to reduce 30 day readmissions for chronic health conditions |
| 2.d.i | Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care |
| 3.a.i | Integration of primary care and behavioral health services |
| 3.a.ii | Behavioral Health community crisis stabilization services |
| 3.b.i | Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only) - Cardiovascular Care |
| 3.g.i | Integration of palliative care into the PCMH Model |
| 4.a.iii | Strengthen Mental Health and Substance Abuse Infrastructure across Systems |
| 4.d.i | Reduce premature births (Focus Area 1; Goal 1) |

# *What is Patient-Centered Medical Home?*

# A Building, Place, or People?

# The "Triple Aim"

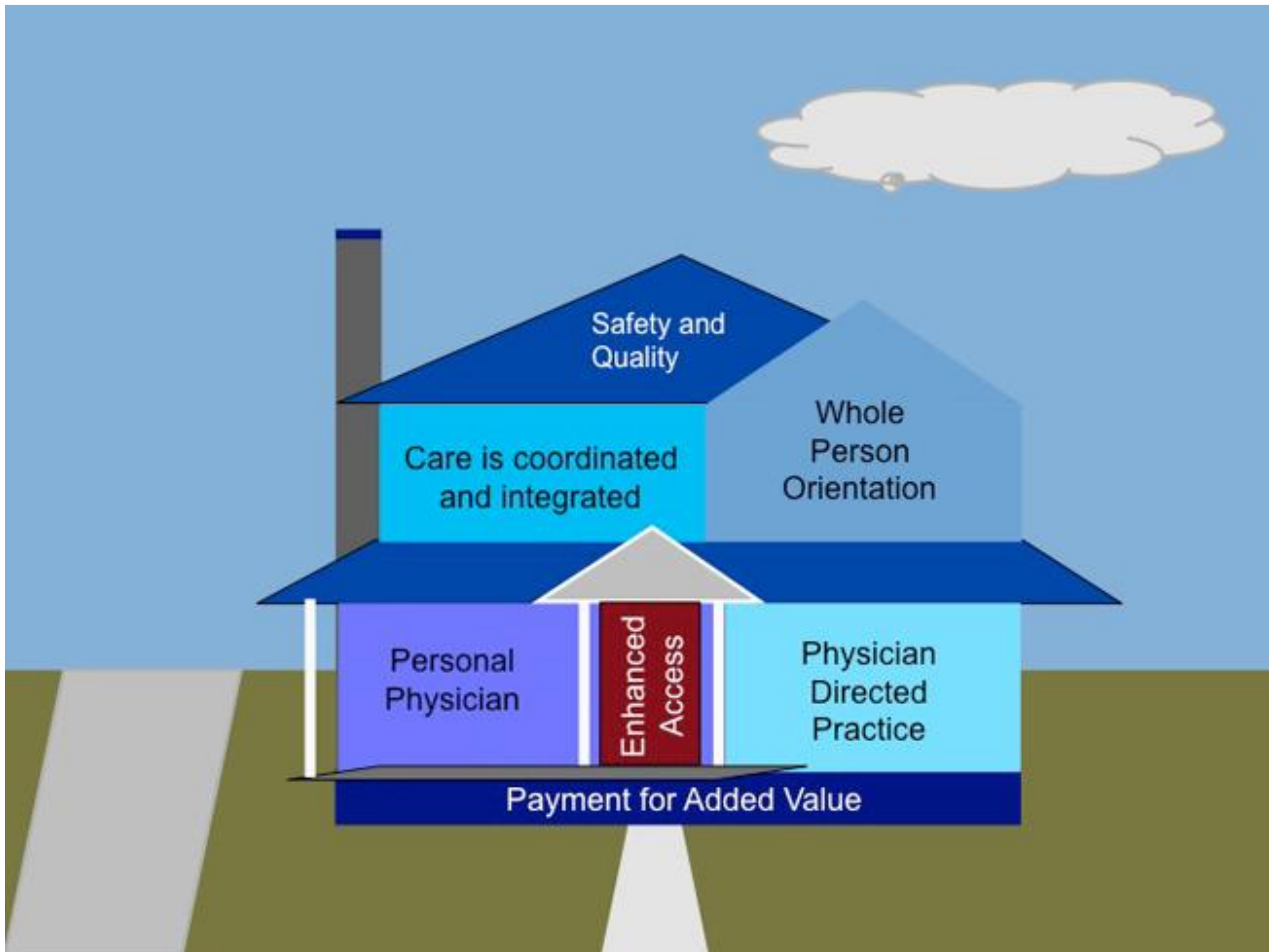


# Patient-Centered Medical Home (PCMH)

- Empowers the patient to be an active part of his/her health care team
- Physician-led team approach
  - Staff works to the highest capability of license/skill
- The right care, at the right place, at the right time

# WHY NOW? WHY SHOULD WE?

"Sorry the doctor is running behind. You can keep today's appointment or I can fit you in tomorrow...whichever comes first."




Source: http://www.ch-dc.org/programs-initiatives/patient-centered-medical-home/

# Patient-Centered Planned Care

COLORADO CLINICAL GUIDELINES COLLABORATIVE

**Improved Outcomes**

- Increased Healthy Behaviors
- Improved Quality, Safety, and Clinical Outcomes
- Increased Collaboration between Patient, Care Team, and Medical Neighborhood
- Improved Physician and Staff Satisfaction and Retention
- Reduced Cost Trends

Adapted from:
www.NewHealthPartnerships.org

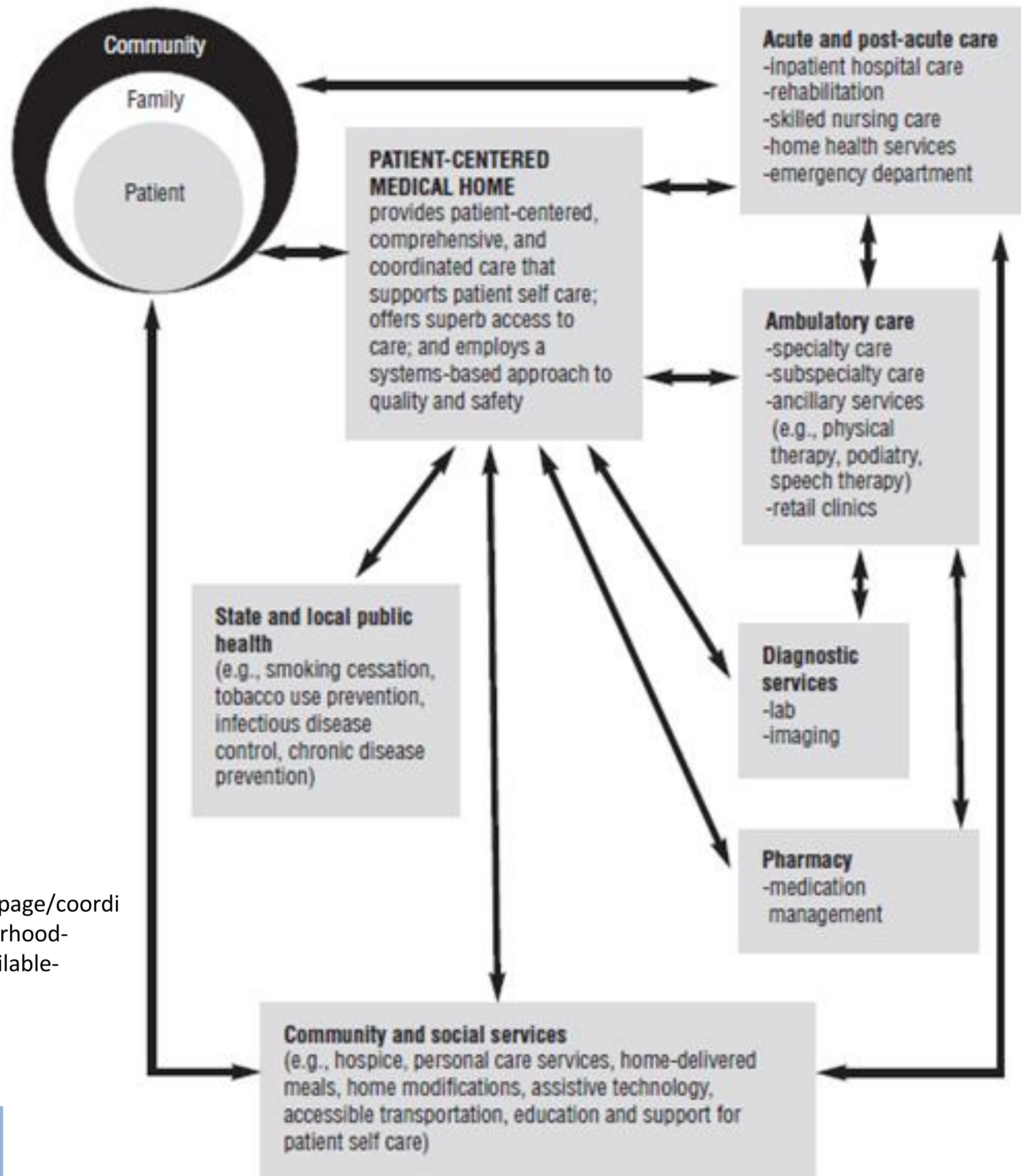
© Copyright 2009 Colorado Clinical Guidelines Collaborative. All rights reserved.

# Benefits for Patients/Clients

- Engaged, happier, and more satisfied patients
- Better coordinated, more comprehensive and personalized care
- Improved access to medical care and services
- Improved health outcomes, especially for patients who have chronic conditions

Source: http://www.aafp.org/practice-management/transformation/pcmh/benefits.html

# Medical Neighborhood




Source: http://www.pcmh.ahrq.gov/page/coordinating-care-medical-neighborhood-critical-components-and-available-mechanisms

# NCQA PCMH 2014 Standards

- Tell us what you do, show us how you do it
- Team-Based Care
- Record Review Workbook
- Aligned with Stage 2 Meaningful Use
- Quality Improvement (QI) focus
- Patient-experience-with-care survey

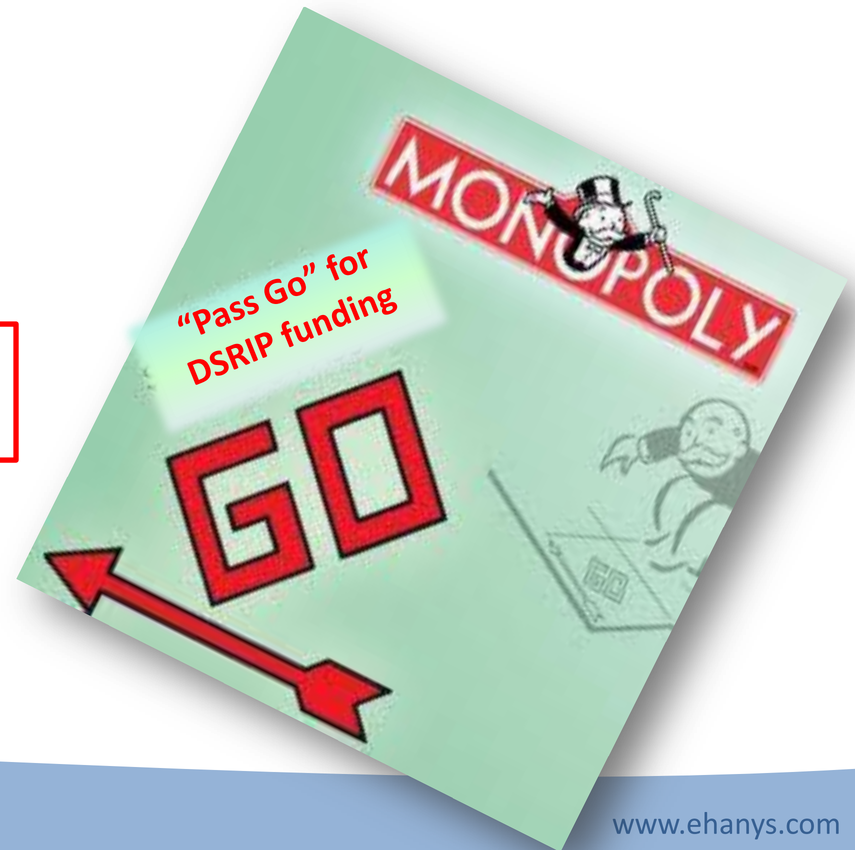
# NCQA PCMH 2014 Standards and Must-Pass Elements

- PCMH 1: Patient-Centered Access
  - Element A: Patient-Centered Appointment Access
- PCMH 2: Team-Based Care
  - Element D: The Practice Team
- PCMH 3: Population Health Management
  - Element D: Use of Data for Population Management
- PCMH 4: Care Management and Support
  - Element B: Care Planning and Self-Care Support
- PCMH 5: Care Coordination and Care Transitions
  - Element B: Referral Tracking and Follow-up
- PCMH 6: Performance Measurement and Quality Improvement
  - Element D: Implement Continuous Quality Improvement

**Must meet all must-pass elements to obtain* ***any*** *recognition; a 50% score equals pass for a must-pass element*

# Scoring Considerations

- Each standard has elements and factors
- How many and how well they are performed translates into points:
  - ~~Level 1: 35-59 points~~
  - ~~Level 2: 60-84 points~~
  - Level 3: 85-100 points



# Team Based Care

- Physician led
- Work to the top of license
- Defined roles and responsibilities
- Patient care communication strategy

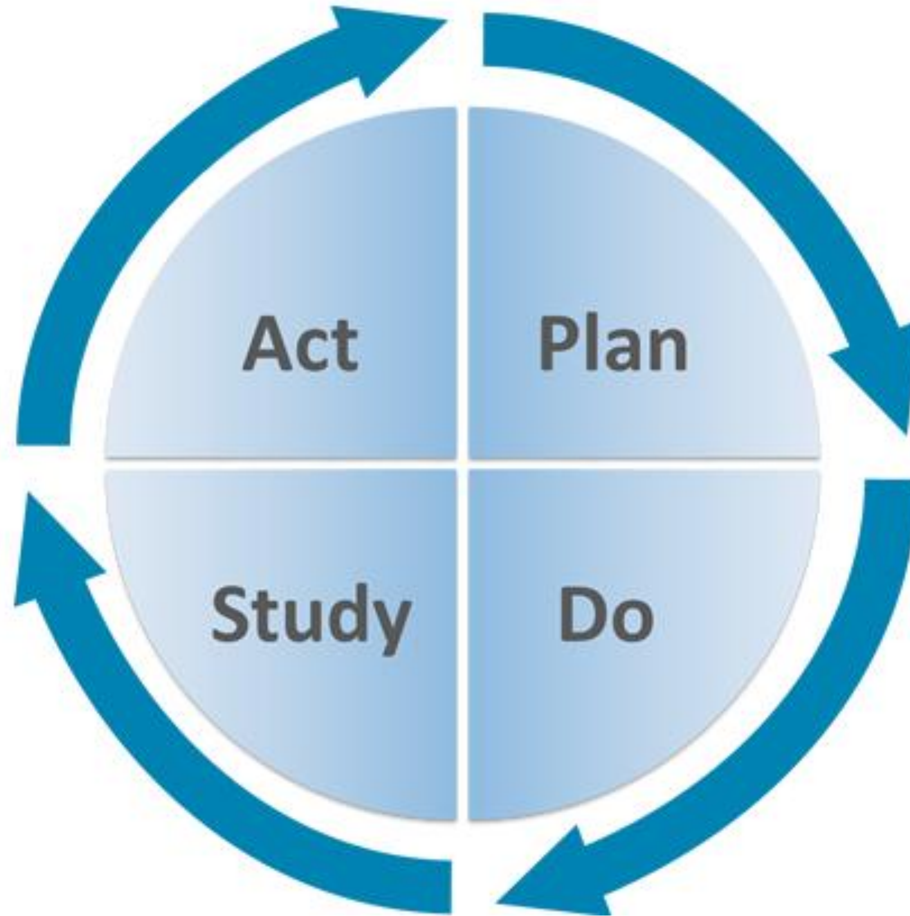
# The “Cares”

- Care coordination
- Care management
  - Care planning
  - Patient self-management
- Care transitions

# Health Information Technology

- An important part of the equation, but *not* the solution
- Redesigned workflows
- Understand data and reporting

# Improvement Cycles



# Workforce Engagement

- Inclusive
- Communication
- Training
- Consistently monitor progress and compliance

# PCMH RESULTS

# American Journal of Managed Care

- Published in 2014
- 17 PCMH practices over 3 years
- Philadelphia, PA area
- Statistically significant reductions ***in all 3 years*** for identified high risk patients
  - Inpatient utilization
  - Overall medical costs

Source: https://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_03_14_Higgins_hasApx_e61to71.pdf

# Patient-Centered Primary Care Collaborative (PCPCC)

- 2014 report
  - 20 national PCMH project evaluations
  - 2012-2013 service years
- Evaluated on "Triple Aim" metrics:
  - 60% reported cost reductions or reduced emergency department (ED) visits
  - 40% reported fewer hospital admissions
  - 30% reported improved population health or increased provision of preventive services

Source: http://www.milbank.org/publications/milbank-supported-reports

# CareFirst PCMH Results

- Improved healthcare access for at-risk populations while lowering costs
  - Overall rate of increase in medical care spending slow from an avg of 7.5% per year to 3.5%
  - 4% fewer hospital admissions
  - 11.1% fewer days in the hospital
  - 8.1% fewer hospital readmissions for all causes
  - 11.3% fewer outpatient health facility visits among its members

# Horizon BCBSNJ

- 2013 PCMH Results
  - 14% higher rate - improved diabetes control
  - 12% higher rate - cholesterol management
  - 8% higher rate - breast cancer screenings
  - 6% higher rate - colorectal cancer screenings
  - 4% lower rate - Emergency Room (ER) visits
  - 2% lower rate - hospital admissions
  - 4% lower cost - care for diabetic patients
  - 4% lower total cost of care
- Members under the care of a patient-centered practice
  - Avoid more than 1,200 ER visits and 260 hospitals admissions
  - Savings of approximately $4.5 million

# Revisit - CNYCC DSRIP Projects

| Project # | Project Name |
|---|---|
| 2.a.i | Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management |
| 2.a.iii | Health Home At-Risk Intervention Program: Proactive Management of Higher Risk Patients Not Currently Eligible for Health Homes through Access to High Quality Primary Care and Support Services |
| 2.b.iii | ED care triage for at-risk populations |
| 2.b.iv | Care Transitions Intervention model to reduce 30 day readmissions for chronic health conditions |
| 2.d.i | Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care |
| 3.a.i | Integration of primary care and behavioral health services |
| 3.a.ii | Behavioral Health community crisis stabilization services |
| 3.b.i | Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only) - Cardiovascular Care |
| 3.g.i | Integration of palliative care into the PCMH Model |
| 4.a.iii | Strengthen Mental Health and Substance Abuse Infrastructure across Systems |
| 4.d.i | Reduce premature births (Focus Area 1; Goal 1) |

# Questions

Nicole Harmon, MBA, PCMH CCE
nharmon@hanys.org
716-201-1170