Utah Partnership for Value-driven Health Care (UPV)

The Utah Medical Home

Proposed Standards and Measures

Created by UPV Medical Home Standards and Measures Work Group

12/17/2013

Utah Medical Home Whitepaper

ABSTRACT

The Patient Centered Medical Home (PCMH) is a model of care delivery that allows primary care providers, families and patients to work together to improve health at a lower cost. National standards for PCMHs vary and include requirements that would be challenging for some of Utah's primary care providers to meet. In the spirit of alignment of measurement for Utah physicians, UPV Standards and Measures Workgroup, a multi-stakeholder group, convened over 2013 to discuss and develop these proposed baseline standards for a Utah Medical Home model. After a review of national standards and discussion of initiatives already in place in Utah, the Workgroup believes that the development and adoption of a ***Utah Medical Home*** model will allow all interested Utah primary care providers to transform into medical homes, regardless of their size, location, or affiliation, and will be aligned with all other PCMH efforts already underway. This transformation of care will raise the bar for primary care delivery in Utah and focus energy on patient and provider satisfaction.

This whitepaper proposes to make the Utah Medical Home the standard for primary care delivery in Utah. We request that:

- This set of standards is shared amongst providers, payers, patients, and policymakers to further the discussion of a model that prepares Utah for new value-based payment models. We request input and action on areas that make the most sense for each stakeholder group; and
- The Utah Medical Home model is adopted as the standard of care for primary care delivery.

UTAH PARTNERSHIP FOR VALUE-DRIVEN HEALTHCARE

The Utah Partnership for Value-driven Health Care (UPV) is a community collaborative comprised of stakeholders representing health care purchasers, payers, providers and the public. UPV seeks to advance higher value health care in our community, through shared strategies that address transparency, variation in cost and quality, and community approaches to delivery system improvement.

UPV Medical Home Standards and Measures Work Group

The UPV Standards and Measures Work Group consisted of representatives from multiple stakeholders.

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Steve Oostema	Analyst, HealthInsight
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Deanne Pranke	Previous Clinical Programs Director, Association for Utah Community Health
Alan Pruhs	Executive Director, Association for Utah Community Health
Gail Rapp	Assistant Medicaid Director, Utah Department of Health
Teresa Rivera	President, Utah Health Insurance Network
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OVERVIEW

Patient Centered Medical Homes (PCMHs) are a cornerstone of comprehensive health reforms that are being implemented across the nation. The Medical Home is a model of care delivery in which primary care providers, families and patients work in partnership to improve the health and quality of life for patients, especially those with chronic and complex conditions. Medical Homes put the patient and family at the center of their care, develop proactive approaches through personalized care plans, and offer more continuity through increased care coordination. The Medical Home is a systemic change in how we care for patients.

And, there is growing proof that Medical Homes deliver higher quality health care at a lower cost:

- Decreased acute inpatient admissions and Emergency Room (ER) visits[1,2,8,9,10]
- Improved patient compliance with evidence-based guidelines[3,7,8,9]
- Improved provider performance on quality measures[4,57,8,9,10]
- Improved access to care for persons with low incomes, and reduced health inequities for medically underserved populations[6,7,9]
- Increased patient activation and adherence[9]

In addition:

- Primary Care providers report increased job satisfaction with implementation of a PCMH care model[8,9,10]
- PCMHs shift the provider's emphasis from simply delivering care to fully incorporating input from the patient, family, and caregivers in decision-making processes that impact their health
- PCMHs allow resources to be more appropriately directed to those who need them by identifying and supporting higher-risk patients
- PCMHs allow providers to survey their entire patient population for overall well-being measures to ensure that all patient outcomes are maximized
- PCMHs facilitate coordination of care between multiple providers of care, thereby reducing duplication of services and ensuring intended patient outcomes

Many of Utah's primary care providers have already committed to becoming a Medical Home, and we urge the community to commit to making this kind of health care available for all Utahns. We believe a commitment to the adoption of a ***Utah Medical Home*** model will allow all interested Utah primary care providers to transform, regardless of size, location, or affiliation. With the adoption and implementation of a Utah Medical Home model, we anticipate better health outcomes for all Utahns in the near-term and over time. We feel a Utah model with streamlined measurements will provide guidance for providers in this time of rapid change in the healthcare environment.

The UPV Standards and Measures Work Group, representing multiple stakeholders, convened over the course of a year to discuss and develop a set of proposed baseline standards for the Utah Medical Home model (see Appendix C). The baseline standards were designed to accommodate all primary care delivery settings, recognize existing PCMH standards, and raise the bar for care delivery in Utah.

Open discussion and input from all stakeholders is needed to take the Utah Medical Home to the next level. This whitepaper proposes a set of basic measures to serve as a starting point for further discussion. The Work Group recognizes that development of a Utah Medical Home model will require a commitment from all stakeholders and support from Utah's policy makers. The long-term sustainability of the Utah Medical Home model will require that payers reimburse primary care providers differently for providing a "medical home" for their patients.

AUDIENCE

The audience for this whitepaper includes patients, family members, health care providers, payers, and policy makers. The Work Group intends that this whitepaper be consistent and integrated with the Utah State Innovation Model (SIM) plan as it is further developed and implemented.

Constituent Input and Buy-in

Utah's Medical Home model will be most successful when all the stakeholders are involved in its development and implementation. Key constituents include:

- **Patients/ families** - To ensure that patients and their families are involved in all aspects of medical home development, it is recommended that UPV and its membership convene a volunteer patient, family, and caregiver council to advise the process.

  INITIAL ACTION: The UPV members and their organizations will convene a council consisting of people who represent Utah, including individuals from different age-gender groups, socioeconomic status, and different cultures, as well as individuals who have chronic disease conditions to review these elements and gather their feedback.

- **Primary care providers –** As primary care providers will be most impacted by Medical Home development and must be reimbursed for achieving improved patient outcomes, their input and approval of these measures is required.

  INITIAL ACTION: Representatives from the primary care provider community will fully vet these measures and ensure they are practical and fully align with their goals for patient care delivery. Primary care providers must also define what is needed from payers and policy makers for Utah Medical Homes to be financially viable. Input is requested from the Utah Academy of Family Physicians, Utah Chapter of the American College of Physicians, the Utah Academy of Pediatrics, the Utah Medical Association, The Utah Academy of Physician Assistants, and the Utah Nurse Practitioner Association.

- **Specialists -** Utah Medical Homes require better coordination among all health care providers. The success of the Utah Medical Home model will depend on having ongoing support and cooperation from specialists.

  INITIAL ACTION: Representatives from the specialty community will review these measures and ensure they are aligned with their goals for patient care delivery.

- **Hospitals** – Utah Medical Homes require better coordination among all health care providers. The success of the Utah Medical Home model will depend on having ongoing support and cooperation from hospitals partners.

  INITIAL ACTION: Hospitals will need to actively facilitate optimal sharing of health information, support the connection of each patient to a medical home, and better communicate with primary care providers. Input and support is requested from the Utah Hospital Association.

- **Coordinating Care Providers** (Hospice, Home Care, Pharmacists, DME, Infusion) **-** Utah Medical Homes require better coordination among all health care providers. The success of the Utah Medical Home model will depend on having ongoing support and cooperation from providers in home health, pharmacy, hospice, and social work.

  INITIAL ACTION: Representatives from coordinating care providers will review these measures and ensure they are aligned with their goals for patient care delivery. Input is requested from

the Utah Healthcare Association, Utah Pharmacists Association, American Society of Health-System Pharmacists, and the Utah Chapter of the National Association of Social Workers.

- **Behavioral Health Providers -** While Utah Medical Homes will require better coordination among all health care providers, the success of the Utah Medical Home model will depend on better integration with behavioral health specialties.

  INITIAL ACTION: Representatives from behavioral health will review these measures and ensure they are aligned with their goals for patient care delivery. Input is requested from the members of National Alliance on Mental Illness of Utah.

- **Payers** – Payers, both insurers and employers, will have to fully support a movement from the traditional fee-for-service (FFS) payment structure to a value-based payment structure in order for Utah's Medical Home model to be financially viable.

  INITIAL ACTION: Payers will need to fully participate in the development and evaluation of the Utah Medical Home model to identify patient-care metrics and outcomes that will drive their payment processes and incentives. UPV members and their organizations will ask all payer groups to review and give input on these initial proposed standards. Our goal is to streamline requirements for providers to allow for greater success in transforming care delivery.

- **Policy Makers** – Ongoing financial and policy support from relevant agencies and lawmakers of the State of Utah is necessary for the implementation and sustainability of the Utah Medical Home model.

  INITIAL ACTION: Policy makers are needed to advise the Utah Medical Home model development process, to support the adoption of the Utah Medical Home model, and to ensure that primary care providers are adequately reimbursed for providing improved primary care through a medical home. UPV membership will continue to monitor health care policy in Utah and revise the Utah Medical Home standards as needed to ensure that they remain consistent with other Utah innovations, including the Utah State Innovation Model (SIM) plan. Input is requested from the Utah Department of Health, Department of Insurance, and Utah's health policy leaders.

ELEMENTS

The key building blocks for a PCMH consist of at least the following 6 elements. For each of these elements, the UPV Work Group proposes a set of standards with minimum thresholds for primary care practices to achieve recognition as Utah Medical Homes.

- **Appropriate Access –** The practice offers extended hours of operation, timely access to appointments, and enhanced non-appointment access to provider care.
- **Using Data for Population Management** – The practice uses patient data to take a holistic and pro-active view of their patients' needs in order to more effectively focus their resources and deliver better health outcomes at a lower cost.
- **Care Management/ Care Coordination** - The practice coordinates care within and outside the medical home, tracks and follows through on patient referral information, and participates in a health information exchange. The practice identifies patients with complex needs that require additional care and provides them with care coordination services.
- **Ongoing and Continuous Quality Improvement** –The practice has continuous quality improvement processes in place and encourages patient involvement.

- **Patient Empowerment and Activation** - The practice actively fosters patient self-management and engagement.
- **Electronic Health Record Utilization** - The practice uses patient data from an electronic health record or robust registry system to identify areas for improvement in patient care and measure the improvements over time.

The standards will encompass metrics for primary care providers, the provider's care team, the health care facility and, where appropriate, the patient. The Work Group recognizes the patient and family as critical to the success of the Utah Medical Home and recommends that practices seek and respond to patient and family input.

MOVING FORWARD

This whitepaper is intended to start a meaningful discussion on how to improve the delivery of patient and family-centered care in Utah and prepare Utah's healthcare delivery system for new value-based models of reimbursement. The successful development and implementation of a Utah Medical Home model will ultimately require cooperation and input from all stakeholders.

Implementation Considerations:

- Solicit input and support from all constituencies listed above
- Identify primary care providers who are already in pursuit of national PCMH recognition and align with their accomplishments to the fullest extent possible
- Ensure that independent, small primary care practices can fully participate in Utah's Medical Home model
- Ensure that the Utah Medical Home model is compatible with the Utah SIM plan
- Seek and ensure active payer participation, including Utah employers interested in maintaining a healthy workforce

Payment Reform and Value-based Payment Structures

The ultimate sustainability of Utah's Medical Home model depends on the implementation of a value-based payment structure. A value-based payment structure will financially reward primary care providers for keeping their patients healthy; the current fee-for-service payment structure does not do so. The transition to value-based payment is gaining momentum in Utah. Different payers will choose different paths, but all must have the same premise: reward primary care providers for keeping people healthy and for providing high quality, coordinated care when patients need it.

The Centers for Medicare and Medicaid indicate that medical homes foster better care coordination and management of chronic diseases, and have made these a priority of their current Quality Strategy. Future payment models are likely to require elements of a medical home for complex patients.

Governance and Ongoing Administration

The sustained success of Utah's Medical Home will depend on its prudent administration and governance. This is not a short-term project and will require an ongoing commitment from patients and their families, health care providers, payers, and Utah's policy makers. The Utah Medical Home standards and the methods for demonstrating compliance with the standards will need to be refined and revised over time. The Workgroup discussed having a simple accreditation process for the Utah Medical Home and recommends that such a process be implemented as the Utah Medical Home is fully developed.

APPENDICES

Appendix A: Citations

1. Harbrecht MG, Latts LM. Colorado's patient-centered medical home pilot met numerous obstacles, yet saw results such as reduced hospital admissions. Health Affairs (Millwood); 2012;31(9):2010-17.
2. Takach M. Reinventing Medicaid: State Innovations to qualify and pay for Patient-Centered Medical Homes show promising results. Health Affairs; 2011;30(7):1325-34.
3. Carol J. Lessons learned in building the Patient-Centered Medical Home. Managed Care; 2010.
4. Grumbach K., Grundy P. Outcomes of implementing Patient-Centered Medical Home interventions: A review of the evidence from prospective evaluation studies in the United States. Patient-Centered Primary Care Collaborative; 2010.
5. MetCare press release. Metropolitan Health Network's Patient-Centered Medical Home Pilot delivers outstanding results; 2010, February 23.
6. Berenson J, Doty MM, Melinda K. Abrams, MK, & Shih A. Achieving better quality of care for low-income populations: The roles of health insurance and the Medical Home in reducing health inequities; 2012; Commonwealth Fund; Issue Brief, 1-18.
7. Jaén CR, Ferrer RL, Miller WL et al. Patient Outcomes at 26 Months in the Patient-Centered Medical Home National Demonstration Project; Annals of Family Medicine; 2010; 8(supp.1) s57-s67.
8. Arend J, Tsang-Quinn J, Levine C, Thomas D. The Patient-Centered Medical Home: History, Components, and Review of the Evidence; Mount Sinai Journal of Medicine; 2012; 79:433-450.
9. Rathert C, Wyrwich MD, Boren, SA. Patient-Centered Care and Outcomes: A Systematic Review of the Literature; Medical Care Research and review; 2013; 70(4):351-379.
10. Jackson GL, Powers BJ, Chatterjee R, et al. The Patient-Centered Medical Home: A Systematic review; Annals of Internal Medicine; 2013; 158(3):169-178.
11. CMS. CMS Quality Strategy 2013 – Beyond; Centers for Medicare and Medicaid Services. November 18, 2013. Accessed December 3, 2013 at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf.

Appendix B: Sources

- NCQA Standards: http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx
- CMS MU standards: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_EP_MeasuresTable_June2013.pdf
- Minnesota DPH on HMH: http://www.health.state.mn.us/healthreform/homes/
- Minnesota Fact Sheet: http://www.health.state.mn.us/healthreform/homes/education/FactSheet_overview.pdf

Appendix C: Standards by Element

- **Appropriate Access**
- **Using Data for Population Management**
- **Care Management/ Care Coordination**
- **Ongoing and Continuous Quality Improvement**
- **Patient Empowerment and Activation**
- **Electronic Health Record Utilization**

APPROPRIATE ACCESS

Patient/Clinical Outcomes Impacted

- ER Utilization for ambulatory care sensitive conditions[1,2]
- Patient satisfaction[4]
- Chronic disease measure[3]
- Acute measures
- ER visits/1000[1,2]
- Less use of urgent care
- Preventive measure[3]

How collected

- Billing records-HEDIS
- cHIE
- Scheduling – Practice Management System
- Electronic health records
- Practice Self-report
- ADTs
- Patient satisfaction survey (CAHPS)
- Claims data
- IBIS for baseline data measures

Element	Measurement (Office)	Measurement (Patient)	Example alignment with one national standard (NCQA)
Extended hours – well, urgent, and acute visits available outside typical business hours	• Practice provides 4 hours of access outside "usual" business hours	• Patients receive education on appropriate access for phone, email, and office visits	**NCQA Standard 1: Enhance Access and Continuity** Element B
Timely access to appointments including same day appointments	• Practice has standard for same day appointments and evidence of regular measurement of access • Practice has process for patients being contacted by practice for follow-up within 2 weeks of hospital discharge		**NCQA Standard 1: Enhance Access and Continuity** Element A
Non-appointment access to providers for appropriate care	• Practice has process for attending to communication needs • Practice offers continuous telephonic access and/or electronic access • Practice has process for efficient medication refills	• Patients receive education on all access policies	**NCQA Standard 1: Enhance Access and Continuity** Element B & C

Evidence for these elements impacting outcomes

1. Appropriate access is critical to decrease inpatient admissions and ER visits improving patient care and decreasing costs. Enhanced access to care is beneficial in improving population health by decreasing disparities, particularly that of low-income populations. Increasing patients' access to medical providers includes alternative visit methods, such as same day, extended hours, use of patient portals or other electronic means, on-call services, and other approaches.

Access involves continued patient education to promote understanding of choices and options available to them, subsequently minimizing the use of inappropriate and unnecessary care.

Institute of Medicine (IOM). 2001. Crossing the Quality Chasm. Crossing the Quality Chasm:A New Health System for the 21st Century. Washington, D.C: National Academy Press

Takach M. Reinventing Medicaid: State Innovations to qualify and pay for Patient-Centered Medical Homes show promising results. Health Affairs; 2011;30(7):1325–34.

Berenson J, Doty MM, Melinda K. Abrams, MK, & Shih A. Achieving better quality of care for low-income populations: The roles of health insurance and the Medical Home in reducing health inequities;2012;Commonwealth Fund; Issue Brief, 1-18.

Loxterkamp D. Benefits of continuity of care. *Family Medicine: 2009;41(5):312.*

2. Reduction in ER use and Inpatient admissions for patients cared for in PCMH models (Geisinger and Michigan BCBS programs)

   Oklahoma Medicaid saw a reduction from 1,670 to13 patient inquiries related to same-day/next day appointment availability, an 8% increase in patients “always getting treatment quickly.”

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012 Accessed at http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

3. The Wisconsin Longitudinal Study survey (years 2003-2007) examined the relationship between primary care office wait times for appointments, office hours, availability of telephone advice and whether patients were more likely to receive recommended preventive services. The study found that patients in primary care practices with “excellent” or “very good” access in these areas experienced an increase in the rate of cholesterol screenings, flu shots and prostate screenings in the prior year.

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012 Accessed at http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

4. The Pediatric Alliance for Coordinated Care compared care before and after the PCMH pilot. 68.4 percent of families reported it was easier to get the same nurse to talk to, 60.9 percent of families said it was easier to communicate with their child’s doctor, 60.5 percent reported it was easier to get referrals from the doctor, and 61.4 percent reported it was easier to get early medical care.

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012 Accessed at http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

USING DATA FOR POPULATION MANAGEMENT

Patient/Clinical Outcomes Impacted

- Chronic disease measures[3]
- Preventive measures[1,3]
- Utilization[2,3]
- Total Cost of Care[4]

How collected

- Self-reports on QI activities
- Patient Satisfaction Surveys
- Chart Audits
- EHR data (MU or other)
- cHIE
- Claims Data
- IBIS
- USIIS or other public health reporting system

Component	Measurement (Office)	Measurement (Patient)	Example alignment with one national standard (NCQA)
Practice able to develop lists of patients based on condition or preventive service needed	• Practice demonstrates ability to manage patient lists for at least 3 chronic conditions and 3 preventive measures for their population		**NCQA Standard 2: Identify and Manage Patient Population** Element D
Practice proactively reminds patients of clinical services needed based on condition or preventive service due	• Practice demonstrates the ability to conduct appropriate recall of patients for at least 3 chronic conditions and 3 preventive services	• Patients are educated on how to receive and act on information from practice for preventive and chronic care • Patient preferences for being reached are recorded at the practice	**NCQA Standard 2: Identify and Manage Patient Population** Element D **NCQA Standard 3: Plan and Manage Care** Element A

Evidence for these elements impacting outcomes

1. Evidence suggests that PCMH may improve care processes, especially for preventive services. This is based on a combination of moderate evidence of an effect for prevention services. Outcomes for functional status of veterans in a medical home as well as depression scores for patients in the IMPACT trial were improved and statistically y significant.

   Jackson, G.L. **The Patient-Centered Medical Home: A Systematic Review**. *Ann Intern Med.* 2013;158(3):169-178. doi:10.7326/0003-4819-158-3-201302050-00579

   Early Evidence on the Patient-Centered Medical Home Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services AHRQ Publication No. 12-0020-EF February 2012 http://www.integration.samhsa.gov/integrated-care-

models/Early_Evidence_on_the_PCMH_2_28_121.pdf

2. Michigan: BCBS of Michigan 13.5% fewer ED visits among children in PCMH (vs. 9% non-PCMH) 10% fewer ED visits among adults in PCMH(vs. 6.5% non-PCMH), 7.5% lower use of high-tech radiology, 17% lower ambulatory-care sensitive inpatient admissions, 6% lower 30-day readmission rates.

   Minnesota HealthPartners 39% lower ER visits, 24% fewer hospital admissions, 40% lower readmission rates 30% lower length of stay, 20% lower inpatient costs due to outpatient case management program for behavioral health,10% decrease in diagnostic imaging scans in the first year.

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012

   Accessed at http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home
   http://www.pcpcc.org/sites/default/files/media/Results%20Grid%201-2013.pdf

3 Hill Air Force Base (Utah) saved $300,000 annually through improved diabetes care Management, 77% of diabetic patients had improved glycemic control.

   University of Pennsylvania Medical Center improved patient outcomes for diabetics: Increases in eye exams from 50% to 90%, 20% long-term improvement in control of blood sugar, 37% long-term improvement of cholesterol control.

   Independence Blue Cross—Pennsylvania Chronic Care Initiative (Southeast Pennsylvania) 2012: 49% improvement in HbA1c levels, 25% increase in blood pressure control, 27% increase in cholesterol control, 56% increase in patients with self-management goals. Increased diabetes screenings from 40% to 92%.

   Group Health of Washington saw 18% reduction in use of high-risk medications among elderly, 36% increase in use of cholesterol-lowering drugs, 65% increase in use of generic statin drug.

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012

   Accessed at http://www.pcpcc.org/sites/default/files/media/Results%20Grid%201-2013.pdf

4. Pennsylvania Geisinger Health System Longer exposure to medical homes resulted in lower health care costs: 7.1% lower cumulative cost savings (from 2006 to 2010) with an ROI of 1.7, 7% lower cumulative total spending (from 2005 to 2008).

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012
   Accessed at http://www.pcpcc.org/sites/default/files/media/Results%20Grid%201-2013.pdf

5. Facilitating Patient-Centered Medical Home Recognition;2012;Washington DC: NCQA

CARE MANAGEMENT/ CARE COORDINATION

Patient/Clinical Outcomes Addressed

- Chronic disease measures[2,3]
- ER utilization for ambulatory care sensitive conditions[1,3]
- Hospital readmissions[1,3]
- Patient satisfaction[4]
- Total Cost of Care
- Care transitions done successfully
- Medication adherence

How Collected

- Patient satisfaction survey
- cHIE
- EHR data
- All Payer Claims Database
- Claims data

Component	Measurement (Office)	Measurement (Patient)	Example alignment with one national standard (NCQA)
Patients are on a consistent provider team panel and considered part of the team	• Practice has empanelment process	• Patients receive education about their primary care team	**NCQA Standard 1: Enhance Access and Continuity** Elements D, E
Practice coordinates care outside the office medical home (including specialty services, diagnostics, hospitalizations, ER visits, care by any other provider, behavioral health, second opinions, and community resources)	• Practice has referral process in place		**NCQA Standard 5: Track and Coordinate Care** Element B, C
Follows up and collaborates with referrals/specialists and test results	• Practice uses a standard referral template for all referrals • Practice has relationships with providers committed to the medical home model		**NCQA Standard 5: Track and Coordinate Care** Element A, B

Ability to exchange clinical information with other facilities and clinicians[4]	• Practice is able to send a summary of care record to other providers at care transition • Practice participates in an HIE	• Patients are educated about the appropriate exchange of information • All patients have an opportunity to sign a CHIE consent form (regardless of choice)	**NCQA Standard 5: Track and Coordinate Care** Element C

Evidence for these elements impacting outcomes

1. The Medical Home Initiative for Children with Special Health Care Needs from the Minnesota Department of Health. Data from the project show that all of its providers agree that the emphasis on care coordination has improved their patients' health and well-being. ED visits and inpatient admissions decreased since 2004 implementation.

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012 Accessed at http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

2. Renaissance Medical Management Company an Independent Practice Association (RMMC) in southeastern Pennsylvania has nurses engage patients with a diabetes-specific Education module and tracks patients electronically. For diabetic patients in commercial plans, savings totaled $5.5 million over 4 years, 46 percent of medical home patients met their goals for blood sugar (HbA1c) as compared to the control group patients (at 33 percent), and 55 percent of medical home patients met their goals for low-density lipoprotein (LDL) cholesterol compared to the control group patients (at 38 percent).

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012 Accessed at http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

3. Multidisciplinary teams have been shown to improve select patient outcomes in stroke, heart failure, severe mental illness, and terminal conditions. Among patients with mental illness, multidisciplinary teams can reduce hospitalizations and improve the rates with which clients remain in contact with services. In patients with heart failure and stroke, multidisciplinary teams can improve mortality and dependency and reduce hospital admissions also reduced by Multidisciplinary teams are more effective when team members deliberately coordinate their activities.

   McDonald K.M., V. Sundaram, D.M. Bravata, R. Lewis, N. Lin, S. Kraft, M. McKinnon, H. Paguntalan, D.K. Owens. "Care Coordination." In *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies,* volume 7, edited by K.G. Shojania, K.M. McDonald, R.M. Wachter, and D.K. Owens. AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality, June 2007.

4. CareMore Medical Group in California, a Medicare Advantage plan, has a central focus on coordinating care for patients and meeting their individual needs. CareMore reports an impressive 97 percent patient satisfaction rate.

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012 Accessed at http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

5. EMRs facilitate within-office care coordination, chiefly by providing access to data during patient encounters and through electronic messaging.

   Metzger J, Zywiak W. Bridging the care gap: Using web technology for patient referrals. *California Health Foundation; 2008*. Oakland, CA: CHCF

   O'Malley AS, et. al. Are Electronic Medical Records helpful for care coordination? Experiences of physician practices. *Journal of General Internal Medicine; 2010;25(3);177-185.*

Chumbler, Neale R., William C. Mann, Samuel Wu, Arlene Schmid, and Rita Kobb. "The Association of Home-Telehealth Use and Care Coordination with Improvement of Functional and Cognitive Functioning in Frail Elderly Men." *Telemedicine Journal and e-Health,* vol. 10, no. 2, 2004, pp. 129-137.

ONGOING AND CONTINUOUS QUALITY IMPROVEMENT

Patient Goals/Clinical Outcomes Impacted

- Chronic disease measure[2,3]
- Preventive measure[2,3]
- Acute measure[2,3]
- Utilization[2,3,4]
- Patient satisfaction[3,4]

How collected

- Self-reports on QI activities
- Patient Satisfaction Surveys
- Chart Audits
- EHR data (PQRS/MU or other)
- cHIE
- Claims Data (APCD)
- IBIS
- USIIS or other public health reporting system

Component	Measurement (Office)	Measurement (Patient)	Example alignment with one national standard (NCQA)
Regular Quality Improvement (QI) process in place [1]	• Practice demonstrates it has a dedicated QI structure and process. • Practice evaluates data/performance/trends • Practice compares performance to external and internal benchmarks using clinical areas of importance to the clinic's populations		**NCQA Standard 6: Measure and Improve Performance** Elements A,C-F
Patient and Family Involvement in Quality Improvement[3]	Required: • Practice demonstrates regular assessment of patient satisfaction Optional: Patients are part of CQI process[4] • Patients give feedback via survey or other method • Patients are offered opportunity to be a member of CQI team • Practice convenes a Patient Advisory Council	• Patients receive offer to participate in quality process as available at the practice	**NCQA Standard 6: Measure and Improve Performance** Elements B &C

Evidence for these elements impacting outcomes

1. Quality Improvement Processes are fundamental to the transformation of any care delivery. Practices must adopt a model that support a "culture of quality", allowing for the data collection, interpretation, testing, and time it takes to assess and alter processes.

   Safety Net Medical Home Initiative. Altman Dautoff D, Van Borkulo N, Daniel D. Quality Improvement Strategy: Tools to Make and Measure Improvement. In: Phillips KE, Weir V, eds. Safety Net Medical Home Initiative Implementation Guide Series. 2nd ed. Seattle, WA: Qualis Health and The MacColl Center for HealthCare Innovation at the Group Health Research Institute; 2013.

   Institute of Medicine (IOM). 2001. Crossing the Quality Chasm. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press

2. Reduction in ER use and Inpatient admissions for patients cared for in PCMH models (Geisinger and Michigan BCBS programs)

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012 Accessed at http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home http://www.pcpcc.org/sites/default/files/media/Results%20Grid%201-2013.pdf

3. Yearly improved Patient Satisfaction measures and 3 statistically significant areas and yearly improvement on Diabetes, heart disease, preventive measures, generic medication use (HealthPartners Medical Group, Minnesota)

   Nielsen M, Langer B, Zema C, Hacker T, Grundy P. *Benefits of Implementing the Primary Care Patient-Centered Medical Home*: Patient-Centered Primary Care Collaborative; 2012 Accessed at http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

   http://www.pcpcc.org/sites/default/files/media/Results%20Grid%201-2013.pdf

4. Patient advisory councils have produced innovative delivery design ideas, lowered cost, reduced error, reduced litigation costs and improved satisfaction (Blanchfield Army Comm. Hospital, MCG Health System, Neuroscience Center for Excellence, Georgia).

   Bev Johnson et al. *Partnering with Patients and Families to Design a Patient and Family-Centered Health Care System: Recommendations and Promising Practices*

   California HealthCare Foundation. Bethesda, MD. Institute for Family-Centered Care, April 2008. Available at: http://www.ihi.org/knowledge/Pages/Publications/PartneringwithPatientsandFamilies.aspx

PATIENT EMPOWERMENT AND ACTIVATION

Patient Goals/Clinical Outcomes Discussed

- Patient satisfaction[1]
- BMI/activity measures
- Adherence to medical therapies[2]
- Improved activation[3]
- Improved functional health status
- Appropriate wellness/prevention measures

How collected

- Meaningful Use Stage 2 care management plan documentation
- Patient goals set
- BRFSS questions on ability to manage disease
- Medication adherence from Sure Scripts or plan data
- REALM-SF tool used to assess and document health literacy
- Self-care plans documented for chronic condition patients
- Hibbard's Patient Activation Score
- SF-8 for Functional Health status
- Direct EHR data
- Chart audits
- Self-report

Component	Measurement (Office)	Measurement (Patient)	Example alignment with one national standard (NCQA)

Provides an office system that fosters patient self-management[4]	• Practice has a process for goal setting and making care plans with patient, family, and care-givers
	• Practice demonstrates use of self-management tools (ehealth, literature)
	• Practice has a current community resource list
	• Staff are trained yearly in –
	  ○ Motivational Interviewing;
	  ○ Stages of Change; or
	  ○ Self-management goal setting
	• Practice has staff trained in the roles of care coordinator, care manager, health educator, health coach, behavioral specialist, or uses integrated care teams to ensure access to all these services
	
	Optional: Practice has a documented process for:
		• Patients communicate back to the practice on chronic care items
		• Patients use Teach-Back to demonstrate understanding of self-management expectations
		• Patients set goals with team
		• Patients reports level of confidence in learning and using new skills
		• Patients are knowledgeable about how to access social, peer, and family support
			NCQA Standard 3: Plan and Manage Care
			Element C
			
			Standard 4: Provide Self-Care Support and Community Resources
			Element A, B

	• Assessment of stages of readiness to change • Assessment of patient confidence to execute goal • Assessment of whether patients have adequate social or peer support		

Communication methods for patient engagement are employed	• Practice demonstrates care plans reflecting shared decision making
	  ○ Alternative care options
	  ○ Cost information
	• Educational tools are at 5th grade reading level
	• Practice uses health literacy assessments[5]
	
	Optional:
	
	• Practice uses a cultural competence checklist
	○ Practice uses Teach Back technique regularly and documents this
		• Patient receives education about how to understand diagnosis, prognosis, and treatment options	**Standard 1: Enhance Access and Continuity** Element F

Evidence for these elements impacting outcomes

1. Chronic disease management is improved with measurement processes in the Patient-Centered Medical Home as providers and staff use EHR registries and health maintenance alerts to monitor individual and population health. Chronic diseases, such as diabetes, asthma, and kidney diseases are better controlled when subjected to data analysis and actionable improvement plans.

   Rosenthal TC. The medical home: Growing evidence to support a new approach to primary care. *Journal of the American Board Family Medicine;2008;21(5):427–440.*
   Schnipper JL, et al. Effects of documentation-based decision support on chronic disease management. *American Journal of Managed Care;2010*.

   T Bojadzievski, RA Gabbay. Patient-Centered Medical Home and diabetes. Diabetes Care;2011.

   DuBard CA, Cockerham J. Community Care of North Carolina and the medical home approach to chronic kidney disease. *North Carolina Medical Journal;2008;69(3):229–232.*

2. Patients' adherence to medical treatments and medications is improved in the PCMH as providers have improved skills to determine and address patients' barriers. High-risk patients can be referred for care management and coordination.

   O'Connor AM, Llewellyn-Thomas HA, Flood AB. Modifying unwarranted variations in health care: Shared Decision Making. *Health Affairs-Web Exclusive;2004;VAR 63-72.*

Calvert, S.B., Kramer, J.M., Anstrom, K.J., et al. (2012). Patient-focused intervention to improve long-term adherence to evidence-based medications: A randomized trial. *American Heart Journal;2012;* 163(4).

3. Patient activation is crucial to improved self-management and clinical outcomes as well as decreased costs. Patient activation is associated with PCMH elements, with studies determining improvements in patient self-management abilities and subsequent clinical outcomes.

Parchman ML, Zeber JE, Palmer RF. Participatory decision making, patient activation, medication adherence and intermediate clinical outcomes in Type 2 diabetes: A STARNet study. *Annals of Family Medicine;2010;8(5);410-417.*

Greene J, Hibbard JH, Sacks R, Overton V. When seeing the same physician, highly activated patients have better care experiences than less activated patients. *Health Affairs;2013;32(7);**1299-1305.***

Delaney C. Patient activation: Key to the Patient-Centered Medical Home. *Medical Home News;2010;2(2);3-4.*

4. Improved health outcomes are often the result of increased patient self-management training and goal setting with patients. Significant health behavior change is associated with improved patient confidence and skills gained from self-management education. Non-traditional methods, such as use of health coaches and peer counseling are also showing significant improvement in patients' clinical outcomes.

Green LW, Cifuentes M, Glasgow RE, Stange KC. Redesigning primary care practice to incorporate health behavior change: prescription for health round 2 results. Am J Prev Med. 2008;35:S347–S349.

Otero-Sabogal R, et. al. Physician-community health worker partnering to support diabetes self-management in primary care. *Quality in Primary Care;2010;18(6);363-372.*

Bodenheimer, T., & Abramowitz, S. (2010). *Helping patients help themselves: How to implement self-management support*. Oakland, CA: California HealthCare Foundation.

Mead N, Bower P. Patient-centered consultations and outcomes in Primary Care: A review of the literature. *Patient Education and Counseling;2002;48;51-61.*

5. Assessing patients' health literacy, a key component of the PCMH model, is crucial to successful patient outcomes, safety, and improved adherence.

National Quality Forum. *Improving Patient Safety through Informed Consent for Patients with Limited Health Literacy.* Washington, D.C.: NQF 2005.

Schillinger D, Piette J, Grumbach K, et al. Closing the loop: physician communication with diabetic patients who have low health literacy. *Archives of Internal Medicine;2003;163(1):83-90.*

Kessels RP. Patients' memory for medical information. *Journal of Social Medicine;2003;96(5):219-22.*

ELECTRONIC HEALTH RECORD UTILIZATION

Patient/Clinical Outcomes Impacted:

- Chronic Disease Measures[3]

How Collected:

- Meaningful Use (MU) Attainment through Office of the National Coordinator for HIT[1]
- Self-report list of elements for non-EMR users[2]

Component	Measurement (Office)	Example alignment with one national standard (NCQA)
Using Electronic health records	Practices able to meet MU Stage 2 would have achieved the benchmark for EHR utilization for Utah Medical Home Standards[4]	**NCQA Standard 6: Measure and Improve Performance** Element G
Not using Electronic health record with electronic practice management system in place	1. Be able to generate patient lists for at least three different preventive care services and at least three chronic disease case services. 2. Use the above lists to proactively remind patients, their families, and clinicians (where applicable) of services needed. 3. Record the following data in a structured data format for more than 50% of their patients: gender, date of birth, race, ethnicity, preferred language, preferred telephone contact number, email address, previous visit date(s), information on legal guardian/health care proxy, presence of advanced directives (N/A for pediatric practices), primary caregiver, and health insurance information. 4. Conduct and document comprehensive health assessments for patients and families to include: age and gender specific immunizations and screenings; family, cultural and social characteristics; communication needs; family and patient medical history; advance directives (N/A for pediatric practices); mental health and/or substance abuse in patient and/or family; developmental screening (N/A for adult practices); and depression screening for adolescents and adults.[2]	**NCQA Standard 2: Identify and Manage Patient Populations** Element A-D **NCQA Standard 3: Plan and Manage Care** Elements A

References

1. Qualifications Listed: ONC. (2013, n.d.). *Meaningful Use.* Retrieved November 18, 2013, from HealthIT.gov: http://www.healthit.gov/policy-researchers implementers/meaningful-use-stage-2

2. Facilitating Patient-Centered Medical Home Recognition; 2012; Washington DC: NCQA.

3. Nurse care managers supported by specialized information technology in primary care to manage chronically ill patients saw reduced mortality for patients enrolled, especially in patients with complex diabetes disease.

   Dorr DA, Wilcox AB, Brunker CP, Burdon RE, Donnelly SM. The effect of technology-supported, multidisease care management on the mortality and hospitalization of seniors. J Am Geriatr Soc 2008;56(12):2195-202.

4. Electronic Record Capability is critical for PCMH readiness.

   Safran D, Coltin K, Dresser M. Readiness for the Patient-Centered Medical Home: Structural capabilities of Massachusetts Primary Care Practices. *Journal of General Internal Medicine; 2009;24(2);162-169.*