

## **Medical Home Overview**

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## Meaningful Use as a Building Block Putting the I in Health IT

www.HealthIT.gov

Office of the National Coordinator for Use information to Health Information Technology transform **Enhanced access and** continuity Improve access to Data utilized to Data utilized to improve delivery improve delivery information and outcomes and outcomes Patient engaged, Patient self community management resources **Patient centered Care coordination Care coordination** Utilize technology care coordination to gather **Evidenced** based Team based care, information **Patient engaged** medicine case management **Basic EHR Registries for Connect to Public** Registries to manage functionality, disease Health patient populations structured data management **Privacy & security Privacy & security Privacy & security Privacy & security** protections protections protections protections Structured data **Connect to Public Connect to Public** Connect to Public utilized for Quality Health Health Health **Improvement** 

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Stage 1 MU

Stage 2 MU

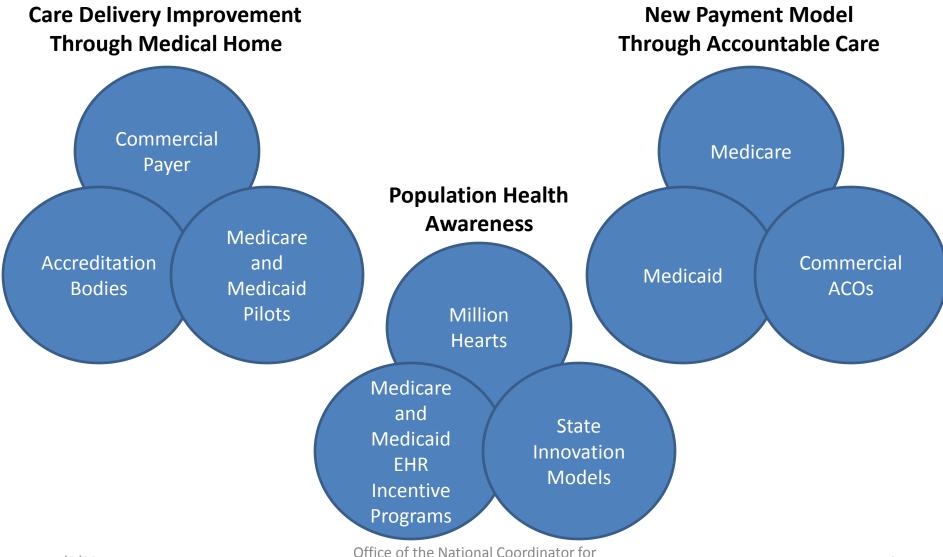
**PCMHs** 3-Part Aim

**ACOs** Stage 3 MU

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## Public-Private Alignment for Care Delivery Transformation





Health Information Technology

## Medical Home Neighborhood Across the Health Care Continuum





# **Skill Demands to Support Care Delivery Transformation**



Care Delivery

- Health Information Exchange
- Privacy and Security

Payment Models

- Consumer Engagement
- Data Aggregation, Analysis, and Reporting

Population Health

- Risk Stratification
- Practice Workflow Redesign

## **Medical Home Framework**



**PCMH Topics** 

Quality Standards Key Competency

Ability to utilize patient and practice data to improve patient care.

Detailed Competencies

Improve patient outcomes by using quality health care data in patient care.

Describe the connection between Meaningful Use and PCMH.

Collect and use data for population management.

## **Medical Home Overview**



Medical Home is essential to care coordination, aligning Health IT use, care quality, and participation in value-based health care programs.

Demographics

e-prescribe (eRx)

**Patient reminders** 

family health history

vital signs

computerized provider order entry (CPOE)

smoking status

Protect electronic health information

lab-tests

electronic notes

clinical "Summaries

view online, download and transmit (VDT)

clinical decision support

education resources

cancer registry

summary care record

## **QUALITY IMPROVEMENT**

Patient/Provider Relationship
Team-based Care practice setting
Coordinated Care across care settings
Quality and Safe healthcare delivery
Enhanced Access, Value-based payment

Agency for Healthcare Research & Quality Comprehensive Care, Patient-Centered, Coordinated Care, Accessible Services, Quality/Safety

specialized registry

**Clinical Quality Indicators** 

medication reconciliation

syndromic surveillance

Population health management

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## Comprehensive Support Beyond the EHR Implementation



#### **Improve Care Quality:**

- Assess ACO, PCMH models
- Prepare for future pay for performance
- Empower patients in their own health care

#### **Operate & Maintain:**

- Continuous quality improvement
- MU Stages 1,2,3

## **Primary goal:**

Give providers as much support as possible

### Implement:

- Provide technical assistance
- Partner with local stakeholders, HIEs
   Office of the National Coordinator for
   Health Information Technology

#### Plan:

- Conduct readiness assessment
- Identify tools needed for change (i.e. EHR system, workflow changes, etc)

#### **Transition:**

- Redesign practice workflow
- Perform HIT education & training

# Medical Home, patient centered (not inclusive)



### **National Accreditation | Certification | Recognition Programs / Initiatives**

#### **Accreditation Organizations (AOs)**

**AAAHC** - Accr Assc for Ambulatory Health Care

**Accreditation** and **Certification** 

The Joint Commission

**Accreditation with Certification** 

NCQA – National Comm. for Quality Assurance

Recognition, Certification, Accreditation

#### **URAC**

**Accreditation Achievement** 

#### **State Initiatives**

MD (Maryland Multi-payer "SB 855 Mandate"

Oregon Patient Centered Primary Care Home

#### **Payer Programs**

Humana – Star Rewards Program (4-stages)

BCBS – varies by State (CareFirst)

**Geisinger Health Innovation Model** 

**Cigna** 

**Unite HealthCare (UHC)** 

**BCBS – WellMark** 

**WellPoint** 

Aetna for Oncology

**Medicare Comprehensive Primary Care** 



## 62 Regional Extension Centers (RECs) Cover 100% of the USA



## **Initial Program Goal**

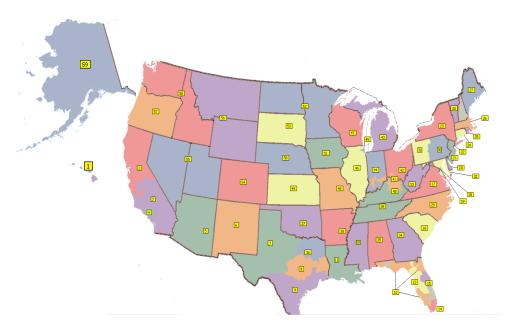
100,000 priority primary care providers achieve meaningful use (MU) by 2014

### **Every REC:**

- Has a defined service area and specific number of providers
- Provides unbiased, practical support throughout process
- Serves as two-way pipeline to federal and local resources

## **Approach differs by REC:**

- Independent operations
- Affiliation with QIOs and universities
- Partnership with other HHS grantees (HCIA, Beacon, ACO, CPC, HCCNs, QIOs, HIE)
- Variety of hospital and payer partnerships



## REC Medical Home Community of Practice (CoP)



## Medical Home Community of Practice 36 RECs of 62 active across 36 States

"The Medical Home Community of Practice (CoP) is a collaborative membership of Regional Extension Centers (RECs) supporting provider practices effective use of health IT to become patient-centered medical homes. In response to payer, state, and federal initiatives related to the medical home, the CoP is driving provider practices to attain medical home recognition/accreditation using Meaningful Use (MU) functionality.

Additionally, the Medical Home CoP provides an innovative forum leveraging expertise in Meaningful Use, EHRs and HIEs, and clinical expertise in care delivery transformation to share, discuss, and develop tools and resources supporting provider practices to become and subsequently 'live' as a patient centered medical home. "

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## ONC | Health IT Enabled Care Coordination in Medical Homes



# Regional Extension Center Louisiana Health Information Technology Resource Center (LHIT) of the Louisiana Health Care Quality Forum (LHCQF)

PCMH Practice Transformation - REC Practice Engagement Model

#### 1 - Practice Assessment

- Determine Practice PCMH recognition/certification/accreditation program
- Determine Practice Goal, i.e. Tier 3 NCQA PCMH Recognition

#### 2 - Facilitation

- In-practice REC support of enabled health IT optimization
- Partnering in support of assisting with recognition requirements attainment
- Submission to Recognition/Certification/Accrediting organization, i.e. NCQA

### 3 - Coaching

 Clinical Health Coach work with 9 to 10 practices helping the practice to live the principles after having received medical home recognition (On-going through 2015)

#### **Partners**

150 PracticesLouisiana State MedicaidONC Regional Extension Center Program

## ONC | Health IT Enabled Care Coordination in Medical Homes



### **Regional Extension Center**

### Wisconsin Health Information Technology Extension Center (WHITEC)

REC partnered with a national organization to offer medical home expertise to Wisconsin providers. Embedded in-practice REC staff serving as coach and liaison across six practices.

#### **Partners**

Six (6) Pilot Practices

National Medical Home Organization

ONC Regional Extension Center Program: 1,800+ Providers enrolled the REC

### **Regional Extension Center**

### **Rhode Island Quality Institute (RIQI)**

REC engaged a State Payor who incentivized practice enrollment in the State HIE to facilitate secure A/D/T and DSM patient transitions of care information alerts.

#### **Partners**

**National Payer** 

State Health Information Exchange

ONC Regional Extension Center enrolled Practices: 1,000+ Providers enrolled 13





## Thank you







"The implementation of Patient-Centered Team Based Care, supported by health IT, brings about many challenges for new workers and incumbents, alike. Both groups will find interpersonal dynamics to be an unexpected focus and new technologies will emerge that will have to be learned and integrated into their workflows. On the job success will likely stem from a work environment with a **consistent** understanding of the transformation process, visible leadership and support, and established outcomes that can be measured against contextual factors during delivery of care. "

Mohla, C., Reed, C., Keesey, P., McKenzie, H., Damico, D., & Sital, S. Agency for Healthcare Research and Quality, (2013). *Readying the health it workforce for patient-centered team based care:*Understanding training needs (ARRA NRC D2 HITECH)

<a href="http://healthit.gov/sites/default/files/summer\_workforce\_meeting\_paper\_508.pdf">http://healthit.gov/sites/default/files/summer\_workforce\_meeting\_paper\_508.pdf</a>