Medical Home Overview
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Paul Klintworth, Medical Home Lead
Office of the National Coordinator for Health IT
U.S. Department of Health & Human Services
# Meaningful Use as a Building Block

## Utilize technology to gather information

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<th>Stage 1 MU</th>
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<th>ACOs Stage 3 MU</th>
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<td>Basic EHR functionality, structured data</td>
<td>Care coordination</td>
<td>Patient self management</td>
<td>Connect to Public Health</td>
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<td>Connect to Public Health</td>
<td>Patient engaged</td>
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<td>Structured data utilized for Quality Improvement</td>
<td>Evidenced based medicine</td>
<td>Team based care, case management</td>
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<td>Registries to manage patient populations</td>
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## Improve access to information

- **Data utilized to improve delivery and outcomes**
- **Privacy & security protections**
- **Care coordination**
- **Evidenced based medicine**

## Use information to transform

- **Enhanced access and continuity**
- **Data utilized to improve delivery and outcomes**
- **Patient self management**
- **Patient engaged, community resources**
- **Patient centered care coordination**
- **Team based care, case management**
- **Registries for disease management**
- **Privacy & security protections**
- **Connect to Public Health**
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Public-Private Alignment for Care Delivery Transformation

Care Delivery Improvement Through Medical Home

- Commercial Payer
- Accreditation Bodies
- Medicare and Medicaid Pilots

New Payment Model Through Accountable Care

- Medicare
- Medicaid
- Commercial ACOs

Population Health Awareness

- Million Hearts
- Medicare and Medicaid EHR Incentive Programs
- State Innovation Models

Office of the National Coordinator for Health Information Technology
Medical Home Neighborhood Across the Health Care Continuum

- Lab Companies
- Home Health
- Nursing Homes
- Public Health Agencies
- Behavioral Health Providers
- Schools
- EMS
- Pharmacies
- Community Health Centers
- Patients and Caregivers
- Physician Practices
- Hospitals
Skill Demands to Support Care Delivery Transformation

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

**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
Comprehensive Support
Beyond the EHR Implementation

Primary goal:
Give providers as much support as possible

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

Transition:
• Redesign practice workflow
• Perform HIT education & training

Implement:
• Provide technical assistance
• Partner with local stakeholders, HIEs

Operate & Maintain:
• Continuous quality improvement
• MU Stages 1,2,3

Improve Care Quality:
• Assess ACO, PCMH models
• Prepare for future pay for performance
• Empower patients in their own health care
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](#)

### 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](#)

### State Initiatives
- MD (Maryland Multi-payer “SB 855 Mandate”)
- Oregon Patient Centered Primary Care Home
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
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.”
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 Practices
Louisiana State Medicaid
ONC Regional Extension Center Program
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
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. “