Crescent City Beacon Community: Innovative Solutions for Using HIT to Implement the NCQA PCMH Model

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CCBC is focused on reducing the burden of diabetes and cardiovascular disease in the Greater New Orleans area by accomplishing the following goals:

• Reduce healthcare costs by improving transitions of care (TOC) between hospitals and primary care practices.

• Improve chronic care management (CCM) through patient-centered medical homes, enabled by HIT.

• Test innovative technologies and strategies to engage patients and the public in health care process.
Community Collaborative Approach

• Statewide hospital providers
• Community health centers (including FQHCs)
• School-based health centers
• LA Department of Health & Hospitals
• LAHIE & REC (Regional Extension Center)
• BlueCross BlueShield of LA
• Local & state public officials
• Community Advisory Groups (GNOHIE, txt4health)
Transitions of Care Use Cases

• Health information exchange with central data repository
  – Care coordination
  – Population management
  – Community-wide registries
  – Data analytics

• **ED/Inpatient Notification**
  – Notification to the patient’s PCP
  – Transmission of relevant clinical information from the ED/Inpatient setting to the PCP.

• **Electronic Specialty Care Referral**
  – Electronic transmission of referral requests/documentation by PCP
  – Appointment confirmations from specialist to PCP electronically
  – Specialty consult summaries electronically sent to PCP’s EMR system
Consumer Engagement – Txt4health

• Text messaging campaign “txt4health” for diabetes risk awareness
• Based on text4baby national campaign concept
• Three main components:
  – Risk awareness for diabetes
  – Personal goal-setting (weight, physical activity)
  – Connecting patients to appropriate resources (clinical, educational, support)
• Evaluate effectiveness for national spread
Chronic Care Management

• Clinical Quality Improvement Workgroup
• Quality Improvement subaward funding
• Clinical seminar series
• Centralized registry and care management capacity through health information exchange
• Practice coaching in partnership with PCDC
• EMR Optimization for PCMH role; working with vendors for reporting and NCQA certification
Clinical Transformation Efforts
• Greater New Orleans Area
  • Poor Health Outcomes
  • Large uninsured population

• Health Care Delivery System
  – Prior to Hurricane Katrina
    • Hospital based emergency department care (public hospital system)
  – Post-Hurricane Katrina
    • Participated in large federal program to stabilize and expand primary care
    • Federal 1115 Waiver in place of federal grant, expanded primary care access for uninsured to Medicaid demonstration
    • Quality incentivized and monitored by Payors
    • Anticipated in 2014
      – Third of population to be covered by Medicaid or exchange
CCBC Community Provider Profile

• CCBC Provider Profile
  – 18 primary care practices; 12 organizations
  – 58,000 patients; avg. 3,000
  – 79 providers; avg. 2-5 provider/practice

• Types of Sites
  – FQHCs
  – Academic Medical Center Community Based Practices
  – Grassroots

• NCQA PCMH Recognized
  – 13 Practices recognized under 2008 standards
Facilitating Factors for Project

• All 13 PCMH recognized sites up for renewal in 2012;
• 12-month intensive CCBC-sponsored Practice Coaching on Chronic Care Management for participating practices;
• 2011 NCQA PCMH Standards increased population based reporting;
• Meaningful Use 1 product enhancement workflows challenging to use; concerns for MU 2;
• Vendor interested in PCMH, Beacon alignment
• Local Superuser already engaged with vendor
• One dominant EMR vendor for community-based primary care providers in region
  – SuccessEHS (13 practices, 52,000 lives)
  – Allscripts (3 practices, 3,500 lives)
  – Aprima (1 practice, 1,500 lives)

• Pre-Beacon relationship to SuccessEHS
  – EMR implementation in FQHCs post-K (2006-2007)
  – Convened SuccessEHS Users Group (2008-2009)
PCMH Mapping Project: System Enhancements to Improve EMR Workflow
Pilot site for PCMH Mapping Project

Initially adopted an EMR in 2006

Tier 3 NCQA PCMH under 2008 standards

Switched to SuccessEHS 2010

AHRQ e-Recommendation pilot site 2010-2011

Tier 3 NCQA PCMH under 2011 standards
NCQA PCMH-driven practice change

**Re-assess health IT impact on PCMH workflow efficiency**

Diagram existing processes, identify deficiencies relevant to PCMH standards, and revise workflow to maximize adherence.

- **Telephones Scheduling Registration**
- **Interoperability Task Organizer**
- **Clinical Decision Support & Patient Registry**
- **Reporting Tool**

**Access & Communication**

**Lab & Referral Tracking; eRx**

**Care Management**

**Performance Reporting**
EMR workflow inefficiency

- Multi-step work-arounds within each respective system revealed software deficiencies

- End-users of the same EMR vendor created different workflows

- End-users of the same EMR vendor mastered use of different parts of the system → knowledge and skills gap
Objectives
- Determine best practices under the current system limitations
- Share workflow analyses with EMR vendor
- Make formal recommendations for system redesign

Challenges
- Workgroup consensus prioritization of requests to vendor
- EMR vendor response time suboptimal
External pressure from national initiatives

- **Beacon Community Programs**
  - Build and strengthen HIT infrastructure and exchange capabilities to improve care coordination, improve quality of care and slow growth of health care spending

- **HIT for Economic & Clinical Health Act (HiTech)**
  - Adopt certified technology
    - Meaningful use - capture, move and report data

- NCQA revises PCMH standards to align with meaningful use standards
<table>
<thead>
<tr>
<th>Standard 1: Enhance Access and Communication</th>
<th>Standard 4: Provide Self-Care Support &amp; Community Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. <strong>Access During Office Hours</strong></td>
<td>A. <strong>Support Self-Care Processes</strong></td>
</tr>
<tr>
<td>B. After Hours Access</td>
<td>B. Provide Referrals to Community Resources</td>
</tr>
<tr>
<td>C. Electronic Access</td>
<td></td>
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<tr>
<td>D. Continuity</td>
<td></td>
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<tr>
<td>E. Medical Home Responsibilities</td>
<td></td>
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<tr>
<td>F. Culturally Linguistically Appropriate Services</td>
<td></td>
</tr>
<tr>
<td>G. Practice Team</td>
<td></td>
</tr>
<tr>
<td><strong>Total Points:</strong> 20</td>
<td><strong>Total Points:</strong> 9</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Standard 2: Identify and Manage Patient Populations</th>
<th>Standard 5: Track &amp; Coordinate Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Patient Information</td>
<td>A. Test Tracking and Follow Up</td>
</tr>
<tr>
<td>B. Clinical Data</td>
<td>B. <strong>Referral Tracking and Follow Up</strong></td>
</tr>
<tr>
<td>C. Comprehensive Health Assessment</td>
<td>C. Coordinate with Facilities/Care Transitions</td>
</tr>
<tr>
<td>D. <strong>Use Data for Population Management</strong></td>
<td><strong>Total Points:</strong> 18</td>
</tr>
<tr>
<td><strong>Total Points:</strong> 16</td>
<td></td>
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<thead>
<tr>
<th>Standard 3: Evidence-Based Guidelines</th>
<th>Standard 6: Measure and Improve Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Identify High Risk Patients</td>
<td>A. Measure Performance</td>
</tr>
<tr>
<td>B. <strong>Care Management</strong></td>
<td>B. Measure Patient/Family Experience</td>
</tr>
<tr>
<td>C. Manage Medications</td>
<td>C. <strong>Implement Continuous Quality Improvement</strong></td>
</tr>
<tr>
<td>D. Use Electronic Prescribing</td>
<td>D. Demonstrate Continuous Quality Improvement</td>
</tr>
<tr>
<td></td>
<td>E. Report Performance</td>
</tr>
<tr>
<td></td>
<td>F. Report DataExternally</td>
</tr>
<tr>
<td><strong>Total Points:</strong> 17</td>
<td><strong>Total Points:</strong> 20</td>
</tr>
</tbody>
</table>
“...health IT per se is unlikely to lead to better care. But health IT built, implemented, and used in “meaningful ways” is very likely to result in better care.”

Peter Blausch, Health Affairs Blog, Feb 11, 2011
Electronic medical record
end-user workgroup task revisions

• Use *Crescent City Beacon Community Initiative* as platform for unified customer voice

• Realign suggestions for EMR product redesign/upgrade with NCQA PCMH & meaningful use workflow

• Develop a toolkit to instruct other clients on how to use the new system updates to facilitate adherence to PCMH standards
How We Started

- Assigned Project Team (July 2011)
  - Community Superuser Lead
  - LPHI Chronic Care Management Project Team
  - Vendor Team
    - Project Facilitator / Director of Client Services
    - Project Manager / System Architect
    - Project Coordinator / Account Manager
    - Product Management / Manager Project Management
    - Clinical Product Management
    - Senior Report Builder
    - Clinical Consultant
    - Government Affairs
How we started

- Created NCQA 2011 Worksheet by standard, element, factor
  - Definitions (*highlighted* Renewal, MU, Must Pass, Critical Factor)
  - Reporting requirements (policy, lists, reports)
  - Current EMR workflow (modules, functionality)
- Reviewed system capacity
  - To collect info required
  - To report
## Mapping PCMH standards to EMR features

<table>
<thead>
<tr>
<th>PCMH 2011 Standards and Elements</th>
<th>Clinical Protocol Required</th>
<th>EMR Functionality Required for PCMH</th>
<th>EMR Functionality Exists</th>
<th>EHS Module Name</th>
<th>Extractable and Reportable on population basis (% of patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCMH 1: Enhance Access and Continuity</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1A: Access During Office Hours MUST PASS</td>
<td>The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Providing same-day appointments (CRITICAL)</td>
<td>Same Day Appointment Protocol</td>
<td>Yes</td>
<td>Yes</td>
<td>Scheduling</td>
<td>Unknown</td>
</tr>
<tr>
<td>2. Providing timely clinical advice by telephone during office hours</td>
<td>Patient Call Protocols During Office Hours</td>
<td>Yes?</td>
<td>Yes</td>
<td>Clinical Console - Telephone Log</td>
<td></td>
</tr>
<tr>
<td>3. Providing timely clinical advice by secure electronic messages during office hours</td>
<td>Policy on Electronic Messaging during office hours</td>
<td>Yes</td>
<td>Unknown (Patient Portal?)</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>4. Documenting clinical advice in the patient medical record.</td>
<td>Policy for documenting calls/secure messaging in Medical Record</td>
<td>Yes</td>
<td>Yes</td>
<td>Chart</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
Crosswalk EMR-PCMH Worksheet

• For each standard, element, factor
  – Tested system capacity
  – Identified workflow challenges
  – Developed recommended system enhancements
  – Developed list of standardized reports
Community provider engagement

- **2 Day Kick-Off Meeting Attendees** (August 2011)
  - Community provider representation
    - Clinical and practice management superusers
    - Care Team Members
  - LPHI Chronic Care Management Project Team
  - Senior Vendor Team

- **Review and provide feedback on** vendor suggested system enhancements

- **Weekly Project Calls**
  - Full project team +/- advanced superusers
  - Refine request, clarifications, testing functionality
Key system enhancements

- First round of enhancements released (Dec. 2011)
  - Organize data display
    - Order tracking details
  - Capture data in reportable format
    - Response times to medical calls
  - Reduce steps to document data
    - Care management templates linked to care plan forms
  - Build standardized reports
PCMH Toolkit

• Reviews requirements for documenting adherence to NCQA PCMH standards

• Provides instruction to standardize use of existing features and system enhancements to implement PCMH standards and capture data for reporting

• Report templates imported into customer database

• Sample policies and procedures from NCQA PCMH recognized customers
Next steps

• Beta testing system enhancements
  – Examine experience of customers
    • Typical vs. advanced end users
    • Impact on workflow for different care team members

• Piloting PCMH toolkit
  – CCBC partners undergoing NCQA PCMH recognition process