Metro Community Provider Network

Development of a Medical Home and Chronic Care Model for the Potomac Street Health Center (PSHC)

By

JSI John Snow, Inc.

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I. Introduction and Background

A. Potomac Street Health Center

Potomac Street Health Center (PSHC) was created in 2004 with support from the Colorado Health Foundation ("the Foundation") and the Medical Center of Aurora. Potomac Street Health Center was formed to provide a specialized source of care for older adult populations (primarily 55 and older) with chronic and complex health conditions as well as individuals with physical and developmental disabilities. While the specific needs of these two populations can be different both demand a higher level of care and greatly benefit from patient-centered, comprehensive, well-coordinated health care services.

PSHC is part of Metro Community Provider Network, Inc. (MCPN). MCPN is a Section 330 funded Federally Qualified Health Center that has provided medical and health education services to the underserved since 1989. MCPN's mission is to provide excellent health-related services focusing on those that face financial, cultural, linguistic, and other barriers to accessing health care services. MCPN has a strong focus on chronic care management and fully supports developing Potomac Street Health Center as a medical home, and eventually spreading the medical home concept throughout the organization.

In 2007, Potomac Street Health Center provided care to 1,700 users (unique patients). Nearly 70% of PSHC's users come from a 10-zip code area in and around the city of Aurora that make up the center's primary service area (80010, 80011, 80012, 80013, 80014, 80015, 80017, 80231, 80239, and 80247). PSHC's mission of serving older adults is reflected in the demographics of its users. Patients age 55 and older represent 72% of total user population and 25% are age 65 and older. PSHC user demographics also reflect MCPN's mission to serve the low income, uninsured and underinsured. Twenty-one percent (21%) of PSHC users are covered through the Colorado Indigent Care Program (CICP), 26% are covered by Medicaid, and 20% are self pay/330 sliding fee scale. Thirty percent (30%) of PSHC patients are covered by Medicare and a small percentage (1.5%) are enrolled in a Medicare Advantage plan. The most common diagnoses for PSHC patients include heart disease/hypertension, diabetes, depression/anxiety, and those related to developmental delay.

Potomac Street Health Center has adopted the term "patients with exceptional health care needs" to refer to the majority of the patients that it serves. Patients with exceptional health care needs (PEHCN) parallels the term "children with special health care needs" used to identify children that are developmentally disabled and/or have complex health care conditions. PSHC patients with exceptional health care needs (PEHCN) include individuals born with developmental disabilities that have reached adulthood, individuals that become disabled through traumatic injury or disease, and individuals that simply age into disabilities caused by complications from aging with chronic health conditions. Through the proposed Medical Home initiative, PSHC, as a medical home, will serve as the basis for accessible, continuous, comprehensive, and integrated care for all of its patients with exceptional health care needs. Patients within this spectrum will require varying levels of care coordination and ongoing support. Initially the medical home initiative will focus on those patients with the

most complex medical and social conditions and that require ongoing care coordination and support. PSHC estimates that out of its total active patient population, 160 older adult patients with complex chronic conditions and 275 patients with developmental disabilities would be defined as patients with exceptional health care needs (PEHCN) that need this highest level of ongoing care coordination and monitoring. When fully operational, PSHC will serve as medical home for all of its patients with exceptional health care needs and provide the appropriate level of care coordination. For example, some patients may function well with self management based upon a care plan developed in concert with the patient. The proposed initiative will develop Potomac Street Health Center as a Medical Home.

In early 2008, as part of the Medical Home Initiative, MCPN engaged John Snow, Inc. (JSI) to assist in the development of a Medical Home Model and Chronic Care Model for Potomac Street Health Center. The results of that effort are reflected in this report.

B. Overview of Medical Home Model and Chronic Care Management

There is a growing understanding and appreciation among health care providers that the current health care system often does not effectively or efficiently manage the provision of services to the public at-large. This is especially true for those with chronic diseases or who have exceptional health, rehabilitative, and/or social service needs. Overall, the system's shortfalls are driven by ever increasing health care costs, primary care provider shortages, and the increased prevalence of many chronic diseases. Patient-level health care services can be fragmented, hard to access, uncoordinated, and impersonal and too often focused on addressing acute episodes rather than on prevention and the day-to-day management of chronic disease.

The "Medical Home" is an emerging concept that places primary care providers (PCP) at the locus of a patient's diagnostic and therapeutic services. As a result, the PCP coordinates the full range of needed services and serves as the patient's primary advocate. In a well-functioning medical home, the PCP would not only be expected to address acute episodes but would work with the patient and a team of allied primary and specialty care providers to proactively coordinate all preventive, diagnostic, and disease management activities, whether they are available in the primary care setting or not. The underlying intent or motivation of the medical home is to: 1) empower patients to take a more active role in their care, 2) promote better care coordination, 3) encourage more regular screening, education, and preventive activities, and 4) avert unwarranted tests and hospital admissions as well as avoidable complications.

The "Medical Home" is not a house, hospital or other building. Rather, it is a term used to describe a health care model in which individuals use primary care practices as the basis for accessible, continuous, comprehensive and integrated care. The goal of the medical home is to provide a patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives.[1]

[1] AAFP and AAP Deloitte Article

Chronic care management is a subset of primary care and of the services that are provided within the Medical Home. At its essence, chronic care management is the on-going coordination of primary and specialty care services with an eye towards promoting independence and self-care (e.g., behavior modification), reducing fragmentation and unnecessary use of services (e.g., avoidable emergency room visits and hospital admissions related to complications from chronic condition).

Chronic care management programs come in a wide variety of forms and are targeted at a variety of different populations. Some programs target people with complex or extensive needs and/or who are disabled. Other programs target individuals with specific diseases such as diabetes, Down syndrome, depression or spinal injuries. Others target people with high risk of hospitalization and/or adverse outcomes, such as those with high hospitalization rates, multiple medications, or high specialty care utilization. Nearly all care management programs provide services based on specific evidence-based, management guidelines that include educational materials or interventions designed to promote self-management, treatment compliance, and/or behavior change. Some programs rely on the PCP to provide the bulk of services and others rely on a team-oriented model where certain “advanced care" interventions are provided by nurses or other health professionals. In all cases, the patient is expected and hopefully empowered to take an active role in their care and the management of their disease or condition.

On January 2, 2008, NCQA released standards for *Physician Practice Connections®–Patient-Centered Medical Home (PPC-PCMH™).* This program identifies primary care practices that function as patient-centered medical homes. The definition NCQA uses to define a patient-centered medical home is the same one that PSHC and JSI have been looking at, the one developed by The American College of Physicians, the American Academy of Family Practice, the American Academy of Pediatrics and the American Osteopathic Association.

NCQA believes that this model of care “holds significant promise for better health care quality, improved involvement of patients in their own care and reduced avoidable costs over time.” Some of the aspects of care that PPC-PCMH measures include:

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management Support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communications

PSHC will look to NCQA measures as a basis for developing as a medical home and plans to apply to be recognized by NCQA as a Patient-Centered Medical Home at the appropriate time.

On a local level, the state of Colorado and healthcare organizations operating within Colorado are undertaking several initiatives that directly and indirectly support the development of medical homes such as the one being proposed for PSHC. Two such initiatives are:

- Colorado Regional Integrated Care Collaborative (CRICC) Program; and
- Colorado Medical Home Commission

Colorado Health Care Policy and Financing (HCPF) has undertaken an initiative to rethink chronic care management in Colorado. Through a grant from the Robert Wood Johnson Foundation (RWJF), HCPF contracted with the Center for Health Care Strategies (CHCS) to assist with this effort. CHCS developed an algorithm to identify patients that are high users of health care services and that could benefit from coordinated care. The CHCS also provided to HCPF guidance on developing an effective chronic care management program. HCPF contracted with Colorado Access, a Medicaid managed care organization, to provide services to Medicaid eligibles that would be enrolled in the program referred to as CRICC. Colorado Access will in turn contract with eligible providers, including MCPN/PSHC, to provide medical and possibly care coordination services to enrollees. MCPN/PSHC is currently working with Colorado Access on this initiative. The medical home initiative being undertaken by PSHC aligns well with the CRICC program and PSHC will be in a strong position to appropriately care for those enrolled in the program and to meet relevant evaluation standards. Colorado Access, with assistance from an outside consultant, is in the process of developing evaluation criteria and once defined, PSHC will build these evaluation criteria into their own evaluation plan for the medical home initiative.

In a separate but related initiative, the Medical Home Advisory Committee, a committee convened by Colorado Department of Public Health and Environment, developed and promulgated Medical Home Standards. The standards were developed based upon the results of a broad survey of stakeholders and industry standards. Currently, the medical home standards are defined only for individuals ages 21 and under, but it is not unreasonable to assume that similar standards will be applied to adult care. Application of the standards to medical practices will be slow, allowing medical practices time to implement necessary changes to meet the new standards. Eventually, there will likely be reimbursement around qualifying as a medical home. PSHC's vision for a medical home meets or exceeds the standards set forth by the Medical Home Advisory Committee. The Colorado Medical Home Standards are included in this report as an appendix.

II. Potomac Street Health Center (PSHC) as a Medical Home – Vision Statement

PSHC's vision for a medical home was influenced significantly by knowledge and principles drawn from the American Academy of Family Practitioners (AAFP), the American Academy of Pediatrics (AAP), and the Chronic Care Management model developed through the Institute for Healthcare Improvement (IHI). However, it is firmly rooted in ideas and systems that have been part of PSHC's operations since its inception.

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PSHC will serve as a Medical Home for its "patients with exceptional health care needs (PEHCN)." PSHC patients with exceptional health care needs include – individuals born with developmental disabilities that have reached adulthood, individuals that become disabled through traumatic injury or disease, and individuals that age into disabilities caused by complications from aging with chronic health conditions.

PSHC's vision for a medical home was formed through a series of activities that culminated in an all-day retreat attended by PSHC staff and key outside stakeholders. Potomac Street Health Center's vision for a medical home is outlined below and organized according to the six domains that define a medical home.

Organizational Capacity

- A Medical Home Advisory Group is formed and meets regularly to promote and refine the patient-centered strategies, policies and practices that defined PSHC's Medical Home/Chronic Care model. Medical Home Advisory Group meetings provide a forum to monitor and openly discuss the progress of the medical home initiative as well as continually explore ways to improve care provided to PEHCN. PSHC's Medical Home Advisory Group will include PSHC/MCPN staff and physicians, patient/caregivers, community partners, and other key stakeholders.

- An enhanced intake process is used to obtain information from patients/caregivers about patient health beliefs, social situation, behavioral issues, communication preferences, and other relevant information. This information is stored within PSHC's electronic medical record and used by staff and physicians to plan visits and to provide appropriate health care services.

- Feedback from patients/caregivers is solicited on a regular basis through "mini-surveys" and other means; feedback is then used to improve care.

- All PSHC staff members (physician and non-physician) are trained on the concepts of medical home and chronic care management, disability awareness and best practices with respect to providing care to persons with disabilities. Staff is encouraged to participate in ongoing regularly scheduled educational workshops and information sessions organized or facilitated by MCPN/PSHC.

- MCPN/PSHC collaborates with managed care organizations (Colorado Access, etc) to develop reimbursement systems that support care coordination activities.

- MCPN/PSHC collaborates with educational institutions to develop training programs (e.g., residency programs, practicum, fellowships, or internships) that will facilitate the promotion and dissemination of medical home concepts and the model being developed by MCPN/PSHC.

Chronic Condition Management

- All patients will go through a screening process that places them into the appropriate level of care for patients with exceptional health care needs (PEHCN) – self management, annual evaluation, and ongoing monitoring and support. The appropriate level of care is based upon diagnosis, functioning, as well as social and behavioral factors. Patients will be enrolled into evidence-based care management programs that will allow PSHC to monitor and track utilization and outcomes. Patient charts are clearly marked and computer generated registries are used by staff and physicians for follow up and care management of defined patient groups.

- PEHCN are provided services based on a comprehensive individualized care plan that has been developed in collaboration with patient/caregiver, including self management goals. The care plan is actively used to guide care and is reviewed and updated on a regular basis. Primary care providers anticipate transition points, for example, when elderly patient transitions from independent living at home to living within an assisted living facility, and the care plan is updated to include a transition plan.

- Care is provided in accordance with evidence-based guidelines for chronic conditions. Guidelines are incorporated into electronic medical record flow sheets and linked to individualized care plans and an overall evaluation plan.

- Information and education is provided to patients/caregivers as needed and desired, for example, information about specific diagnosis or general information on effective self management. Education is provided by skilled educators who are trained on using motivational techniques and other best practices in patient/caregiver education and support.

- Patients are linked to a primary care provider (PCP) and patients see their PCP whenever possible.

Care Coordination

- Specifically identified care coordinators work with patients/caregivers to define care coordination needs and provide activities as needed, for example, coaching patients on behavior change and appropriate self-management techniques, identifying community resources, advocating on behalf of patients to obtain these services. Care coordinators are clinically trained individuals. Care coordinators will support physicians as well as nurse practitioners that provide medical care to patients with exceptional health care needs.

- Care is provided by clinical teams that include primary care provider (physicians, nurse practitioners), care coordinator, patient/caregiver, and other relevant health center staff.

- Primary medical care is fully integrated with mental health care in a co-located manner. Patients are referred to an on-site mental health provider as needed including during a medical visit. The on-site mental health provider assesses service needs, provides short-term therapy, in particular for patients suffering from depression and/or anxiety. Patients needing

longer-term care or with more complex needs are referred to collaborating mental health providers such as Aurora Mental Health. The on-site mental health provider will also provide in-service training to PSHC primary care staff on mental health related issues.

- PSHC coordinates referrals to outside providers. More formalized collaboration will be developed with preferred providers (Durable Medical Equipment, Pharmacy, specialty physician services, etc), including the ability to share information electronically and in real time. For patients with more complex health concerns, key specialty providers may be a part of the care team and will have direct input into the care plan and participate in team meetings.

Community Outreach

- PSHC organizes and conducts community outreach activities and works to make Aurora a friendly place for all persons with disabilities including persons with developmental disabilities as well as elderly.

Data Management

- MCPN/PSHC's health information system, including its electronic medical record (Centricity), is used to support the documentation of need, monitoring of clinic care, care plan, related coordination and the determination of outcomes (clinical, functional, satisfaction, and cost outcomes).

- The health information system is continually evaluated and enhanced to support medical home/chronic care management.

Quality Improvement

- A Medical Home Core Team oversees the activities necessary to build a medical home within Potomac Street Health Center and to continually improve the model of care. The Medical Home Core Team is a multi-disciplinary group that includes representatives from management, clinical leadership, and all key functional areas as well as patient/caregiver partners. Corinne Carrigan, PSHC Clinic Manager will serve as the Team Leader and in this capacity will facilitate meetings and coordinate team work as well as be the "medical home champion" for MCPN/PSHC.

- The Medical Home Core Team will be responsible for quality assurance (QA) and continuous quality improvement (CQI) activities related to medical home/chronic care management. The Quality Assurance and Continuous Quality Improvement efforts will be facilitated by a rigorous data collection and process evaluation system. A core and secondary set of outcome and operational measures will be collected and reported on a periodic basis to assist the Medical Home Core Team to monitor operations. In addition, the Team will conduct ongoing mini-evaluations using a Plan-Do-Study-Act format that will allow the Team to make improvements to the services, systems, and day-to-day operations of the

clinic. Quality improvement related to this effort will be led by the Medical Home Core Team leader, Corinne Carrigan.

- PSHC Medical Home meets the standards for a medical home as defined by the Colorado Medical Home Advisory Committee and NCQA, and the evaluation plan incorporates evaluation criteria defined for Colorado's Chronic Regional Integration Care Collaborative (CRICC) Program.

III. Building a Medical Home at PSHC - Implementation Plan

A. Steps for Medical Home Development and Improvement

Step 1. Make a commitment to building a medical home and complete ground work. Potomac Street Health Center has already made a commitment to become a medical home and has completed much of the ground work for moving forward. PSHC used remaining funds from its Colorado Health Foundation grant to engage JSI to assist the Team in their medical home initiative. Qualitative and quantitative information was gathered to assess PSHC's current operations and evaluate what would be needed to build a medical home. Information was gathered through the following means:

- Conducted literature review on best practices and incorporated guidance provided by Center for Medical Home Improvement (CMHI) and Institute for Health Improvement (IHI);

- Conducted workshop on the key concepts of Medical Home and Chronic Care Management (JSI presentation discussed at workshop is included as an appendix);

- Conducted a self –assessment of medical homeness and chronic care management using CMHI Medical Home Index and IHI Assessment of Chronic Illness Care Version 3 tools;

- Conducted key informant interviews with outside stakeholders (payors, providers, advocacy organizations, patients/caregivers) to obtain insights into perceptions of PSHC, potential areas for collaboration, and systems of care across providers.

- Conducted individual interviews with health center staff to obtain insights into practice operations and roles and responsibilities;

- Obtained relevant information about PSHC users, and

- Conducted analysis of PSHC current practice workflows.

Potomac Street Health Center conducted self-assessments of their "medical homeness" and the extent to which they are providing chronic care management. The self-assessments were facilitated by John Snow, Inc. Potomac Street Health Center staff participating in the self-assessments included Dr. Barry Martin, PSHC Medical Director, Dr. Felipe Amador, PSHC Geriatrician, Corinne Carrigan, PSHC Clinic Manager, John Reid, MCPN Vice President of

Development, and Kara White, MCPN Operations Project Manager. The Center for Medical Home Improvement (CMHI) Medical Home Index was used to assess PSHC's medical homeness. The CMHI Medical Home Index is a nationally validated measurement tool to help pediatric practices assess their medical homeness or how well they are providing comprehensive family-centered care for children with special health care needs and their families. CMHI's Medical Home Index has been developed to provide a scoring mechanism or measurement of "medical homeness." Although the Medical Home Index was developed for pediatric practices that serve children with special health care needs, there is general agreement that the medical home concept and index can be meaningfully applied to adult practices serving patients with exceptional health care needs. JSI adapted the CMHI Medical Home Index to fit with PSHC practice that includes adults with development disabilities and older adults with disabilities related to aging with chronic health conditions.

The CMHI Medical Home Index measures activities within six domains that encompass what makes for a well-functioning medical home:

1) Organizational Capacity
2) Chronic Condition Management
3) Care Coordination
4) Community Outreach
5) Data Management
6) Quality Improvement

In addition to the CMHI Medical Home Index, Potomac Street Health Center used the Assessment of Chronic Illness Care Version 3 matrix to evaluate their level of chronic care management. Chronic Condition Management is one of the six domains included in the CMHI Medical Home Index, but PSHC thought it was beneficial to conduct this additional assessment specific to chronic care management given the large number of older adult patients with chronic care conditions that are served by the health center. The Assessment of Chronic Illness Care Version 3 was developed by Institute for Healthcare Improvement (IHI) and similar to the Medical Home Index provides a score on three Parts and activities within each Part. The three Parts are:

Part 1: Organization of the Health Care Delivery System
Part 2: Community Linkages
Part 3: Practice Level Self Management Support, Decision Support, Delivery System Design, and Clinical Information System.

There is significant overlap between the Medical Home Index and the Assessment of Chronic Illness Care but there are slight differences in their focus. Both assessments were used to evaluate PSHC's current capacity for providing comprehensive patient-centered care for their patients with exceptional health care needs (PEHCN) and their families/caregivers.

Copies of the CMHI Medical Home Index (adapted by JSI for PSHC) and the Assessment of Chronic Illness Care are included as in the appendix. Also included in the appendix are PSHC's assessment scores.

Major points from the assessments are presented below.

- In general, PSHC physicians are aware of the clinical needs of their patients and are dedicated to doing all that they can to provide the best care that they can within the center and to gain access to specialty care and other outside services as needed. These efforts, however, are performed individually for each patient and practice-wide systems are not in place to ensure that this happens for all patients on a consistent basis. Information about patients' social situation, health beliefs, and preferences are not solicited from patients/caregivers and do not inform how care is provided.

- Physicians provide care based upon specific medical condition of the patients, but patients are not pro-actively involved in making care decisions including what is needed for self-management.

- Chronic care management protocols are in place for certain conditions, for example diabetes, but not other conditions that affect PSHC's patients. In addition, PSHC has not defined its own outcome goals for chronic care management.

- The assessment revealed specific areas for improvement that will move PSHC toward becoming a medical home for its patients with exceptional health care needs.

The results of the self-assessment and the findings from the interviews with internal staff and outside stakeholders were thoroughly analyzed and used to prepare for a PSHC Medical Home Retreat held on May 15, 2008. The retreat was held at the Green Valley Ranch Conference Center in Aurora, Colorado and those in attendance included key PSHC and MCPN staff as well as a cross-section of outside stakeholders including a representative from a developmental disability agency and a parent/caregiver. The retreat was facilitated by the JSI project team.

The goal of the retreat was to "build a shared vision [among attendees] of PSHC as a Medical Home." At the end of the retreat there was complete agreement that the goal had been accomplished. The vision of PSHC as a medical home as developed during the retreat was presented in Section 2 of this report. The retreat also resulted in gaining consensus on the process that will be used to develop PSHC into a medical home and the specific areas for improvement – short term and longer term. The specific areas for improvement, additional ground work needed to begin the improvement process, and the desired result are presented at the end of this section.

A follow on review of practice work flows at the health center completed by JSI team further identified how changes needed to build a medical home might be incorporated into existing work flows as well as what changes to work flows are needed to implement the medical home model. Key findings from the review and general recommendations are provided in the following paragraphs. A more in depth analysis of these internal patient workflows is proposed to have specific recommendations on each component of PSHC's internal operations and how to align them with the medical home model developed by PSHC.

One of the common themes of the workflows observed was the extensive use of paper in all processes. Most forms were in paper form, as well as notes and alerts. These need to be in electronic format to increase efficiency, privacy, room capacity and decrease the high load of scanning conducted by the Medical Assistances (MAs). Furthermore, the having MAs conduct the scanning is not the best use of their skills and has been causing burnout. We recommend hiring temporary employees to assist with the scanning process, to alleviate the workload of the staff and have MAs focus on more clinical vs. clerical work. Longer-term solutions would be to have all information entered electronically.

A few of the processes are repetitive and could be condensed into one step. For example, patient demographic information is gathered or verified at check-in on a paper form and also by the MAs in the EMR when they are rooming the patients. The redundancy not only creates more work for the MAs, but it sends the message to the patient that information is not being shared amongst the medical team. Furthermore, after the patient checks-in and fills out the "check-in slip", the front desk staff uses another piece of paper to alert the back office staff that the patient is here and if s/he is diabetic. This posted note is discarded once the patient is roomed and a separate sign is used to alert the provider that the patient is ready to be seen and the room s/he is in. This process needs to be analyzed to determine how it could be condensed and if it could be completely electronic.

There is a lack of protocols for many of the processes within PSHC. Most staff and providers are well aware of the system they function in and coach each other if there is a problem, however it would be easier for training and for audits to have written protocols of all processes. These should be developed together with the staff and providers at the clinic, and though they would be specific to PSHC, regional and MCPN guidelines should be used as references.

One of the protocols that is not documented is how results, such as lab results, are reported to patients. Each provider uses a different approach. When we discussed this process with the PSHC staff and providers, one option proposed was to call all patients that have results that fall outside the normal range and send a letter to the rest. This might be a good pilot to test, however, prior to the pilot, we recommend looking at indicators, such as patient satisfaction and call volume, to test the effectiveness of the new process vs. the existing one.

Another process that would be beneficial to document is selecting a PCP. Currently, the process is quite relaxed and it is mostly verbal. Furthermore, we recommend creating provider bios to hand out to new patients to help them select a PCP, even if there are few providers at PSHC, it helps the patient to have specific information of the providers available that they can take home and discuss with their family/caregiver. Furthermore, along the lines of duplication, currently the responsible provider and PCP are the same so there is no need in having both fields in the EMR. We recommend to either only have one field for staff to fill out, or to have two and use one to enter the name of the primary/responsible provider and the other field for a secondary provider, such as a care coordinator or a specialist that the patient frequents and might be coordinating the care of the patient.

Team building and training are very important for staff/provider moral, skills building and consistency. Due to being understaffed and high workload, there is very limited time spent on team building activities and ongoing training, other than required MCPN wide training sessions. We recommend creating and formalizing together with staff and providers both training and team building activities that are specific to PSHC. Also, it would be beneficial to try other staff rotations to analyze the effect they have on patient and provider satisfaction. For example, create physician/medical assistant teams where medical assistants are teamed with specifically defined physicians.

Documentation is extremely important in the medical field, and it needs to be looked at in detail for all processes within PSHC. For more detailed information on the existing patient workflows, look at attachment "PSHC Internal Process Evaluation."

Step 2. Form a Medical Home Core Team. The MH Core Team will have the responsibility of designing, developing, and implementing the improvements needed to build a medical home at Potomac Street Health Center. Corinne Carrigan, will be the team leader. Other members of the team will include Dr. Barry Martin, Dr. Felipe Amador, Kate Michaud and two patient/caregivers (the parent/caregiver who attended the medical home retreat expressed interest in continuing to be a part of PSHC's medical home initiative and so did a patient who was interviewed) will be invited to join the MH Core Team. Team members will meet on a regular basis and meetings will have an agenda with expected outcomes and will end with defining open tasks and next steps.

Step 3. Begin work on shorter-term improvement initiatives. Several shorter-term improvement initiatives were identified through the Medical Home retreat held on May 15. The subsequent analysis of PSHC work flows indicated where changes to work flows may be needed to fully implement improvement initiatives. The Medical Home Core Team will select the improvement initiative, create a plan for design, development, implementation, and evaluation, and implement the improvement. Improvements will be implemented on a test basis using the PDSA (Plan > Do > Study > Act) process. The shorter-term initiatives, identified through a group process at the Medical Home Retreat, are listed at the end of this section.

Step 4. Establish Medical Home Advisory Group. The Medical Home Advisory Group will allow for on going dialogue about PSHC's Medical Home. It will promote patient/caregiver-centered strategies, practices, and policies, and will provide feedback to PSHC's Medical Home Core Team for ongoing improvements to the medical home model. The Medical Home Advisory Group will consist of key PSHC staff and at least two patients/caregivers.

Step 5. Develop and implement robust evaluation plan. Evaluation will be conducted yearly and will include pre and post measures on clinical outcomes, patient quality of life including patient satisfaction, access and financial indicators. The evaluation plan will include at a minimum the following items:

- Key indicators that will evaluate the effectiveness of the Medical Home (MH) model and that will be aligned with the indicators used by Colorado Access for the CRICC program and the NCQA MH accreditation measures. Indicators will be tracked over time to trend progress.

- Tools for both quantitative and qualitative measures, such as surveys, interviews, and/or focus groups will be developed and utilized to measure key indicators.

- In-depth analysis of PSHC's internal processes, including intake, rooming and scheduling to determine which processes need to be adapted to better fit the MH model.

- Evaluate staff/provider teaming.

- Continue to evaluate Centricity's EMR in respect to the MH model and determine what other templates or fields need to be added.

Step 6. Develop methodology and process for placing patients with exceptional health care needs into appropriate care level – Create screening tools and/or other processes for stratifying patients with exceptional health care needs into varying levels of care management and monitoring, for example, self management, annual evaluation, or ongoing monitoring and support. Implement screening tools/processes and process for appropriately identifying patients by care level within the electronic medical chart.

Step 7. Create pilot program to build care teams that include the patient/caregiver and processes for pro-actively engaging the patient/caregiver in care decisions including self-management. The care team (primary care provider, patient/caregiver, and staff) is what sets the medical home apart from more traditional care delivery models. During the retreat, it became clear that additional research and groundwork is needed to 1) provide care as a team, 2) include the patient/caregiver as a member of the care team, 3) and pro-actively involve patient/caregiver in care decisions, and 4) involve key specialists and other outside providers in care plan development and implementation. Additional ground work would include but not necessarily be limited to:

- Build care team - starting with PSHC physicians/providers and staff and the mental health provider decide how best to work together as a team. Through this process, refine the role of the care coordinator and how he/she will carry out care coordination activities.

- Obtain input from patients/caregivers through focus groups and individual interviews on how best to incorporate patients/caregivers into development of care plan, including self management, and to solicit information from patients about their preferences and beliefs, for example, method of communication, point of care coordination, etc.

- Provide training to PSHC staff on team building, care plan development, and how to involve patient/caregiver into care plan development and care management. Training would be based upon best practices as well as incorporate findings from focus groups and

interviews.

- Create care plan for each PEHCN in pilot – build template for care plan and input into electronic medical record, integrate use of care plan into office visit and clinic work flows, serve as point of coordination of care if requested by patient/caregiver. After pilot has been implemented and tested, revise as needed an implement for all PEHCN served by PSHC. The long term goal is to develop care plans for all patients with exceptional health care needs.

- After pilot has been successfully implemented, create plan for implementation for all relevant patients. If necessary, implementation can take a phased approach with small groups of patients in each phase. It is projected that full implementation will be completed over a three-year period.

Step 8. Develop relationships with medical schools, allied health institutions, and/or other academic organizations to explore the possibility of placing residents, fellows, allied health students or interns at PSHC. These "students" would work along side PSHC clinical staff members and learn practical skills and knowledge about medical home concepts, care coordination, and chronic disease management, as well as best practices on how to care for older adults and developmentally delayed/physically disabled adults with exceptional needs.

B. Shorter-term Improvements by Medical Home Domain

The following process improvements for building a medical home were identified during PSHC's medical home retreat held on May 15, 2008. The Medical Home Core Team (and subcommittees of the Team) will develop an "AIM" or goal statement for each area, a process for implementation, and plan for evaluation. The improvements are grouped by medical home domain. Section 6 of this report provides a time line for completing the process improvements listed below.

Enhance Organizational Capacity

Staff training

- Staff education – Disability awareness and training on serving persons with disabilities for all staff, training will be provided primarily through in-service sessions led by Dr. Barry Martin, PSHC Medical Director, adequate time will be allotted for staff training.

- Physician/Provider education – physicians/providers will receive training on how best to integrate patient education into the office visit and effective training methods, training will be provided through in-service sessions that are specific to PSHC patients and work flows.

Improvements to scheduling and intake process

- Patient/caregiver communication preferences – communication preferences (e.g., best method of communication) will be solicited from patient/caregiver and documented in medical chart.

- Prepare for visit of patients with developmental disabilities based upon responses to questionnaire – "20 questions" to be answered by developmental disability (DD) agency staff and sent along with patient/caregiver when patient comes for a medical visit, responses to the questions will alert PSHC staff to recent events (for example, changes in sleeping patterns) that may affect the patient's health and/or what issues should be covered during the visit. Timely information provided by DD agencies will be especially important for patients that are not communicative.

- PSHC-issued Patient ID card – the card will identify the individual as PSHC patient and provide the name of the individual's Primary Care Provider (PCP).

- Patients are linked to a designated Primary Care Provider (PCP) and patients see their own PCP whenever possible (may need to revise scheduling protocols).

- Implement/enforce scheduling protocols to ensure that calls from PSHC patients to schedule appointments are placed directly/transferred directly to PSHC to schedule appointments, appointments for PSHC patients require more time and special consideration, use scheduling process as opportunity to "pack" appointments (combine upcoming visit with visit being scheduled and combine care into one visit).

- Information gathered from patient/caregiver includes medical/ social/behavioral and all information is used by PSHC staff and medical providers to adequately prepare for visit and provide appropriate, patient-centered care. Information is documented and becomes part of medical record.

Care coordination and chronic care management

- Incorporate evidence-based best practices into flow sheets for major diagnostic categories (already done for diabetes, need to identify other conditions, create/locate best practice protocols, create/modify flow sheets in electronic medical record, include self management protocols and information for patients/caregivers) Areas: diabetes, asthma, down syndrome, spinal cord injury, mental health, etc.

- Implement integrated mental health model at Potomac Street Health Center. PSHC will partner with Aurora Mental Health (AMH) to develop and implement an integrated mental health model at PSHC. Under the proposed plan, a master or doctorate level licensed mental health provider will be located at PSHC to provide mental health assessments of patients, short-term therapy to patients, consultations to medical providers, and training on mental health related issues to all health center staff. Patients needing longer-term therapies will be referred to Aurora Mental Health or other provider as appropriate. AMH will provide clinical supervision to the mental health provider, but he/she will be fully integrated into PSHC Medical Home model. The mental health provider will be a member of the care team and will provide input into the patient's care plan. The mental health provider will offer an "open door" to medical staff, being available to consult with medical staff at any time.

- Develop care coordinator position – roles, responsibilities, and incorporation into clinic work flows. Kate Michaud has been an employee of MCPN for the last year and was recruited to fill the position of care coordinator for PSHC as well as the new North Health Center when it opens. Kate has a Masters in Clinical Psychology and Substance Abuse and her interest is in serving older adults, adults with chronic conditions, and developmentally delayed individuals. Kate's experience in this position will be used to clarify roles and responsibilities as well as how best to carry out care coordination activities within the health center.

- Hire at least one trained educator to provide education to patients with chronic conditions on how best to manage their health conditions and adopt healthy behaviors, for example, smoking cessation. The trained educator will be skilled in using motivational education methods, for example, motivate patients to self manage their chronic disease. And, if possible, PSHC will hire an educator that is trained in using sign language. PSHC physicians/medical will also receive training on how best to integrate patient education into the office visit for brief, targeted interventions and how to effectively refer patients to the patient educator.

- Strengthen referral relationships with key specialty and ancillary providers. The initial step will be to set up lunch meetings with key referral partners to discuss ways to strengthen referral relationships and to incorporate specialists and other key providers into the care coordination process, for example, helping to develop patient care plans. Explore the possibility of scheduling periodic on-site specialty care clinic sessions for certain high-need specialties (e.g., endocrinology, neurology, cardiology, etc.). Key specialty providers will be identified by Dr. Barry Marin, Dr. Felipe Amador and Corinne Carrigan through their personal experience working with patients and through analysis of referrals logged into the referral system.

- Input specialty referrals into the electronic medical record (EMR). Although referrals are not processed through the EMR, inputting them into the medical record will provide the ability to report out referrals made and percentage referral visits completed.

Community Outreach

- Build on work PSHC and other community-based organizations have done to make Aurora "senior friendly" by expanding this concept to individuals with developmental disabilities. Sponsor community-based activities to build awareness and provide education on developmental disabilities.

- PSHC will work to identify needs of patients with exceptional health care needs (PEHCN) and their caregivers and work with patients and caregivers to sponsor activities that raise community awareness to resource and support needs (e.g., respite care, recreation opportunities, or improving home/provider communication).

- Proactively build relationships and collaborations with key community organizations; identify key organizations through Medical Home Advisory Group and through current community work.

- Identify transportation needs and explore possibilities of improving transportation for patients with exceptional health care needs.

Data Management

- Make enhancements to electronic medical record to allow for input of social/behavioral information and patient preferences into the EMR.

Quality Improvement

- Create Medical Home Core Team that will be responsible for implementation of medical home initiative. Systematically incorporate CQI activities into Medical Home Core Team meeting agendas.

- Take steps that instill in entire clinic staff the importance of on-going quality and performance improvement.

- Develop robust evaluation plan.

IV. Time Line of Activities

Year 1 Major Activities

1. Convene Medical Home Core Team.
   - Designate Corinne Carrigan as Medical Home Core Team Leader, 20% of time dedicated to this role
   - Hire Project Manager – will provide project management and administrative support to Medical Home initiative
   - Deliverables: team meetings and activities

2. Convene Medical Home Advisory Group.
   - Designate Dr. Barry Martin, Dr. Felipe Amador, and Ms. Corinne Carrigan as Co-chairs of the Medical Home Advisory Group
   - Conduct Kick-off meeting as soon as CHCF Award is made to formally announce plans and confirm responsibilities of group
   - Set quarterly or bi-annual meeting schedule of Advisory Group

3. Develop clinical and educational guidelines for at least one selected disease category/patient group based upon user data (possibilities include depression/anxiety [high prevalence], hypertension, geriatric care in general, fall prevention and adult immunizations).

- Deliverables: categories selected, written guidelines, flow sheet templates incorporated into EMR

4. Set definition of tiers/levels of care for patients with exceptional health care needs and develop screening tool and process for identifying PEHCNs by level of care. Create protocols of care by tier/level.
   - Deliverables: tiers defined, screening tools, process for identification of PEHCN developed and implemented, PEHCN level notation in medical charts

5. Develop templates for improved intake process.

6. Conduct staff training - serving persons with disabilities, care protocols for selected disease categories/patient groups, and team approach to providing care.

7. Hire at least one care coordinator and re-define work of existing care coordinator.

8. Hire master or doctorate level mental health worker, develop protocols for integrating mental health services into primary care.
   - Deliverables: mental health provider hired and providing clinic services for 32 clinic hours per week and referral protocols

9. Conduct patient flow analysis.
   - Deliverables: recommendations for more effective patient flow that supports medical home model (opportunities for teaming, scheduling and visit planning, incorporate 20 questions into visit, etc)

10. Create evaluation plan, identify report needs and build report templates – written evaluation plan and report templates.

11. Develop and implement collaboration agreements with key specialty and ancillary providers, set up lunches and other meeting.

12. Explore the development and implementation of collaboration agreements with medical schools, allied health institutions, and/or other academic organizations that would place residents, fellows, allied health students, or interns at PSHC.

<u>Year 2</u>

1. Continue Medical Home Advisory Group.

2. Conduct research on best approaches to include patients in care decisions and care plan development; use participatory research methods that include focus groups, role play, and individual interviews.

3. Provide training of PSHC staff on team approach to providing care.

4. Start pilot of team based care including patient/caregiver.

5. Build and implement template for care plan within EMR.

6. Hire at least one additional care coordinator, ideally two, refine roles and responsibilities as needed to fit Medical Home model.

7. Implement changes to work flow as needed.

8. Evaluate results for year 1 – data collection and analysis.

9. Develop clinical guidelines/care management protocols for one more diagnostic patient group.

10. Place residents, fellows, allied health students, or interns at PSHC who would learn practical skills about care coordination, chronic disease management, and best practices on how to care for adults with exceptional needs.

Year 3

1. Evaluate results of pilot and revise model as needed – evaluation.

2. Implement medical home model to larger number of patients with exceptional health care needs.

3. Hire at least one additional care coordinator, ideally two.

4. Evaluate results for Year 2 – data collection and analysis.

V. Funding Medical Home Development Initiative

MCPN will submit a grant application to Colorado Health Foundation to fund the Potomac Street Health Center Medical Home development initiative. MCPN will submit a grant application to the Foundation by July 15, 2008. Grant funds will be used to fund the following activities and staff positions:

A. Budget Justification

Project Management Personnel

Medical Home Core Team Lead – Corinne Carrigan, PSHC Clinic Manager, will serve in this capacity and will dedicate 20% of her time to this effort.

Project Manager – A full time Project Manager will be hired to provide project management and support to Medical Home Core Team Lead and facilitate

implementation of the initiative. The project manager will be funded for the three years of project implementation at which time the position would be re-evaluated.

Direct Patient Care Personnel

Care Coordinators - Care coordinators will serve as a member of the care team and will provide care coordination for patients/caregivers of PSHC. Care Coordinators will be licensed social workers and others with similar experience and training. Care Coordinators will be hired based on a ratio of 75 PEHCN to 1 Care Coordinator. It is anticipated that two Care Coordinators are hired in each of the three grant years as the medical home initiative is rolled out within PSHC.

Patient Educator - A full time patient educator will be hired to provide patient education to all patients, but in particular those with chronic health conditions. Recruitment for the position will begin upon grant funding and it is assumed position would be filled within three months.

Mental Health Provider - A full time master or doctorate level mental health provider will be hired to provide integrated mental health services for PSHC patients. The individual will be an employee of Aurora Mental Health but will be funded by PSHC. The budgeted salary is $44,000 plus AMH fringe benefit rate of 17%. It is assumed that the position will be filled within three months of grant funding in Year 1. Salary and benefit costs will be offset with reimbursements for services provided by the mental health providers. AMH will be responsible for credentialing and billing for services provided. Reimbursement amounts were estimated based upon PSHC's payor mix and AMH's average reimbursement for relevant CPT codes by payor. Assume $0 for CICP because MH services are covered only for those under age 18 under CICP. The mental health worker will provide 32 clinic hours per week and produce on average 1200 billable encounters per year.

Other Direct Costs

Enhancements to EMR -

Enhancements to Centricity, the electronic medical record system used by MCPN/PSHC, will be completed in part by outside health information technology (HIT) consultants in collaboration with MCPN and in part by MCPN qualified staff. Proposed enhancements in support of the medical home initiative include developing flow sheet templates, developing data entry screens, and developing reports/patient registries for care management. The budgeted cost per enhancement is $5,000 and is based upon MCPN past experience. Enhancements are planned for each of the three grant years.

Outside Consultants/Evaluators

Focus groups with patients/caregivers - , Focus groups were budgeted at $18,000 (3 focus groups at $6,000 each). The costs of focus groups include development of focus group moderator guides, recruitment of participants, stipends for participants, focus group facilitation, and reporting of findings.

Patient/Work Flow Analysis – Outside consultants will be used to conduct a more in depth patient flow analysis and the results of the analysis will be used to effectively integrate medical home concepts into practice work flows.

Program Evaluation – An outside evaluator will be engaged to develop an evaluation plan for the medical home initiative. The evaluation will include process measures as well as clinical and cost outcome measures and patient/caregiver satisfaction measures. Program evaluation costs include Year 1 costs for plan design, development, and implementation and follow up work in Years 2 and 3.

Staff training – Staff training costs related to teaming (involving all clinic staff) were budgeted based upon lost clinic productivity (patient revenues) for 2 ½ to 3 days, estimated at $3360. Other staff training costs include purchasing training sessions and materials and were estimated as $2500 per year.

Patient education materials – Materials for distribution to patients (hand outs, etc) are budgeted at $20 per PEHCN. It is assumed that materials will be purchased from outside sources.

Stipends – Stipends of $100 per meeting will be provided to patient/caregiver members of Medical Home Core Team and Medical Home Advisory Group. It is assumed that there will be 2 patient/caregiver members on the Core Team and 2 on the Advisory Group. The Core Team will meet an estimated 12 times per year and the Advisory Group will meet an estimated 4 times per year.

General – Assume a 4% inflation rate on salaries, benefits, and other costs.

B. Sustainability

Grant funds from Colorado Health Foundation and other private foundations will be used to cover costs for developing PSHC as a medical home. These costs include one time costs, for example, the cost to build a health plan template as an enhancement to the electronic medical record as well as ongoing operating costs not covered through reimbursements, for example, the use of designated care coordinators. PSHC anticipates that over the long term the added costs related to serving as a medical home will be at least in part covered through enhanced reimbursements and payment methods that allow primary care providers to share in cost savings. Enhanced reimbursements may be in the form of care management fees per enrollee. Payment methods may be in the form of capitation arrangements or gain sharing arrangements with risk corridors. Colorado Access is working to develop reimbursement/payment models for members enrolled in the CRICC program that incorporates the concepts of enhanced reimbursement and gain share. MCPN, as a federally qualified health center, could also recover some of the costs through increased cost-based reimbursement for those patients covered by Medicaid and Medicare as the medical home model is rolled out across other MCPN centers and incorporates a larger number of patients.

Revenues in the form of enhanced reimbursements, gain share, and other sources were not reflected in the medical home initiative three-year budget because at this point, methods and amounts are not known. MCPN/PSHC will collect data and information needed to demonstrate costs savings across the spectrum of service delivery and use this information to make a case for reimbursement methods that allow primary care practices that serve as medical homes to share in the cost savings associated with more effective care.

Appendices

1. Proposed Initiative Budget and Assumptions.
2. JSI Presentation for Medical Home/Chronic Care Management Workshop
3. Medical Home Index (produced by CMHI and adapted by JSI for PSHC)
4. Assessment of Chronic Illness Care Version 3, produced by IHI
5. PSHC Assessment Results – Medical Home Index and Chronic Illness Care
6. JSI Presentation for Medical Home Retreat
7. JSI Report on initial Work Flow Analysis
8. Colorado Medical Home Standards (released 2008)

	Year 1		Year 2		Year 3		Totals Year 1 -3
	FTEs	Amount	FTEs	Amount	FTEs	Amount	
Project Personnel							
Medical Home Core Team Lead	0.20	$ 11,000	0.20	$ 11,440	0.20	$ 11,898	$ 34,338
Project Manager/Support	0.75	$ 25,586	1.00	$ 35,479	1.00	$ 36,898	$ 97,963
Direct Patient Care Personnel							
Care Coordinators	2.00	$ 80,000	4.00	$ 166,400	6.00	$ 259,584	$ 505,984
Patient Educator	1.00	$ 56,243	1.00	$ 58,493	1.00	$ 60,833	$ 175,569
Mental Health Provider (co-located)	0.75	$ 33,000	1.00	$ 45,760	1.00	$ 47,590	$ 126,350
(less: reimbursement for services)		$ (21,600)		$ (28,800)		$ (28,800)	
Total Salaries	4.70	$ 184,229	7.20	$ 288,772	9.20	$ 388,003	$ 861,003
Fringe benefits		$ 48,817		$ 75,732		$ 100,393	$ 224,943
Total Personnel Costs		$ 233,046		$ 364,504		$ 488,396	$ 1,085,946
Other Direct Costs							
Health information system enhancements		$ 20,000		$ 30,000		$ 5,000	$ 55,000
Outside Consultants/Evaluator							$ -
Research - patients/caregivers		$ -		$ 18,000		$ -	$ 18,000
Patient/work flow analysis		$ 20,000				$ -	$ 20,000
Evaluation (plan design/ongoing)		$ 45,180		$ 10,000		$ 10,000	$ 65,180
Staff training		$ 2,500		$ 5,860		$ 2,500	$ 10,860
Patient education materials		$ 1,500		$ 3,000		$ 4,350	$ 8,850
Stipends for parents/caregivers partners		$ 2,200		$ 3,200		$ 3,200	$ 8,600
Total Other Direct Costs		$ 91,380		$ 70,060		$ 25,050	$ 186,490
Total Projected Budget		$ 324,426		$ 434,564		$ 513,446	$ 1,272,436

Additions to budget need to quantify

Physician care coordination activities (non-billable clinic hours per week)

Space - added for CC, Educator, Project Mgr

Renovations - one time costs

Lease Costs

	Year 1	Year 2	Year 3	
Project Personnel				
Medical Home Core Team Lead	$ 55,000	$ 57,200	$ 59,488	
FTE	0.20	0.20	0.20	
Project Manager/Support	$ 34,114	$ 35,479	$ 36,898	
FTE	0.75	1.00	1.00	
Direct Patient Service Personnel				
Care Coordinators	$ 40,000	$ 41,600	$ 43,264	
FTE	2.00	4.00	6.00	
Patient Educator	$ 56,243	$ 58,493	$ 60,833	
FTE	1.00	1.00	1.00	
MCPN/PSHC fringe benefit rate	25%	25%	25%	
Mental Health Provider (co-located)	$ 44,000	$ 45,760	$ 47,590	
FTE	0.75	1.00	1.00	
# of clinic hours per week	24.00	32.00	32.00	
% billable time	60%	60%	60%	
billable hours per week	14.40	19.20	19.20	
billable visits per hour (assess = 1hr, session = 1/2 hour)	1.25	1.25	1.25	
work weeks per year	48.00	48.00	48.00	
billable visits per year	864	1,152	1,152	
avg reimbursement per billable visit (estimated)	$ 25	$ 25	$ 25	
AMH Fringe benefit rate	17%	17%	17%	
Other Direct Costs				
Health Information System Enhancements				
Template and Report Design and Programming				
Care Plan Template		1		
Intake Templates	2			
Diagnosis-specific/patient group flow sheet	1	2	1	
Patient registries	1	1		
Evaluation reports		2		
Cost per template/report	$ 5,000	$ 5,000	$ 5,000	per Doug Boch
Outside Consultants/Evaluator				
Market Research - care model design				
# of focus groups	0	3	0	
Cost per focus group	$ 6,000	$ 6,000	$ 6,000	
Patient Flow Analysis	$ 20,000			
Evaluation -design and implementation	$ 45,180			
Evaluation updates		$ 10,000	$ 10,000	
Staff Training				
Training on medical home and team based care (3, 1/2 days sessions		$ 3,360.00		lost productivity $70 visit
Other ongoing training (estimated)	$ 2,500.00	$ 2,500.00	$ 2,500.00	
Patient Education Materials				
Cost per PEHCN	$ 10	$ 10	$ 10	
Advisory Group Stipends				
# of patients/caregivers members	2	2	2	
# of meetings per year	2	4	4	
Stipend per pat/caregiver per meeting	$ 100	$ 100	$ 100	
MH Core Team Stipends				
# of patients/caregivers members	2	2	2	
# of meetings per year	9	12	12	
Stipend per pat/caregiver per meeting	$ 100	$ 100	$ 100	
Number of PEHCN, require ongoing care coordination	150	300	435	
PEHCN/care coordinator	75	75	75	
Annual inflation rate	-	4%	4%	
Additions to budget need to quantify				
Physician care coordination activities				
% time or hours per week for care coordination activities, case conferencing, etc.				
Lost productivity per clinic hour				
Space - added for Care Coordinators, Educator, Project Mgr				
Renovations - cost per square foot				
Lease Costs - cost per sq ft, per year				
Square footage per person			100	
Total Square footage			900	

Potomac Street Health Center Medical Home Project

Kick-off Meeting and Medical Home / Chronic Care Model Workshop March 18, 2008

John Snow, Inc.

Goals of Workshop

- Confirm / agree on goals of project overall
- Begin to develop a broad common vision for a PSHC-specific medical home / chronic care model geared to your target population
- Discuss and confirm next steps for project and moving process forward

Objectives of Workshop

- Review the basic components of “medical home” (MH) and chronic care (CC) initiatives
- Review how other organizations have adapted and applied these models
- Explore potential components of a Potomac Street Health Center (PSHC)-Specific medical home/chronic care model
- Discuss implementation
- Discuss and agree on next steps

Background and Rationale for MH and CC Models

- Issues driving adoption of MH & CC Model
  - Increasing health care costs
  - High prevalence rates of chronic disease
  - Desire for higher quality
- Increase burden of chronic disease on PCP setting
  - Increase morbidity and complexity, leading to more time and expense, in the face of decreasing reimbursement rates
  - Burden has led private providers to cap Medicaid and uninsured roles, driving people to emergency services
- Safety net providers taking disproportionate share of those with chronic conditions

Background and Rationale for MH and CC Models

- Opportunities and benefits
  - Greater patient satisfaction and engagement in care
  - Improved outcomes and satisfaction
  - Reduced-costs in short- and long- run
  - More efficient use of resources

Background and Rationale for MH and CC Models

- Challenges of MH / CC Models
  - Limited incentives to properly manage chronic conditions
  - Some studies have shown higher rates of misdiagnosis and inaccuracy in treatment in the medical home setting
  - Current emphasis and importance on productivity
  - Potentially higher start-up and operating costs

Major Program-Types

- Medical home programs (AAP, AAFP, ACM, and AOA)

- Chronic care management programs
  (IHI Breakthrough Series, HRSA/IHI Disease Collaboratives, Broad adoption of these principles)

Medical Home

(Adapted from AAFP and IOM Definition)

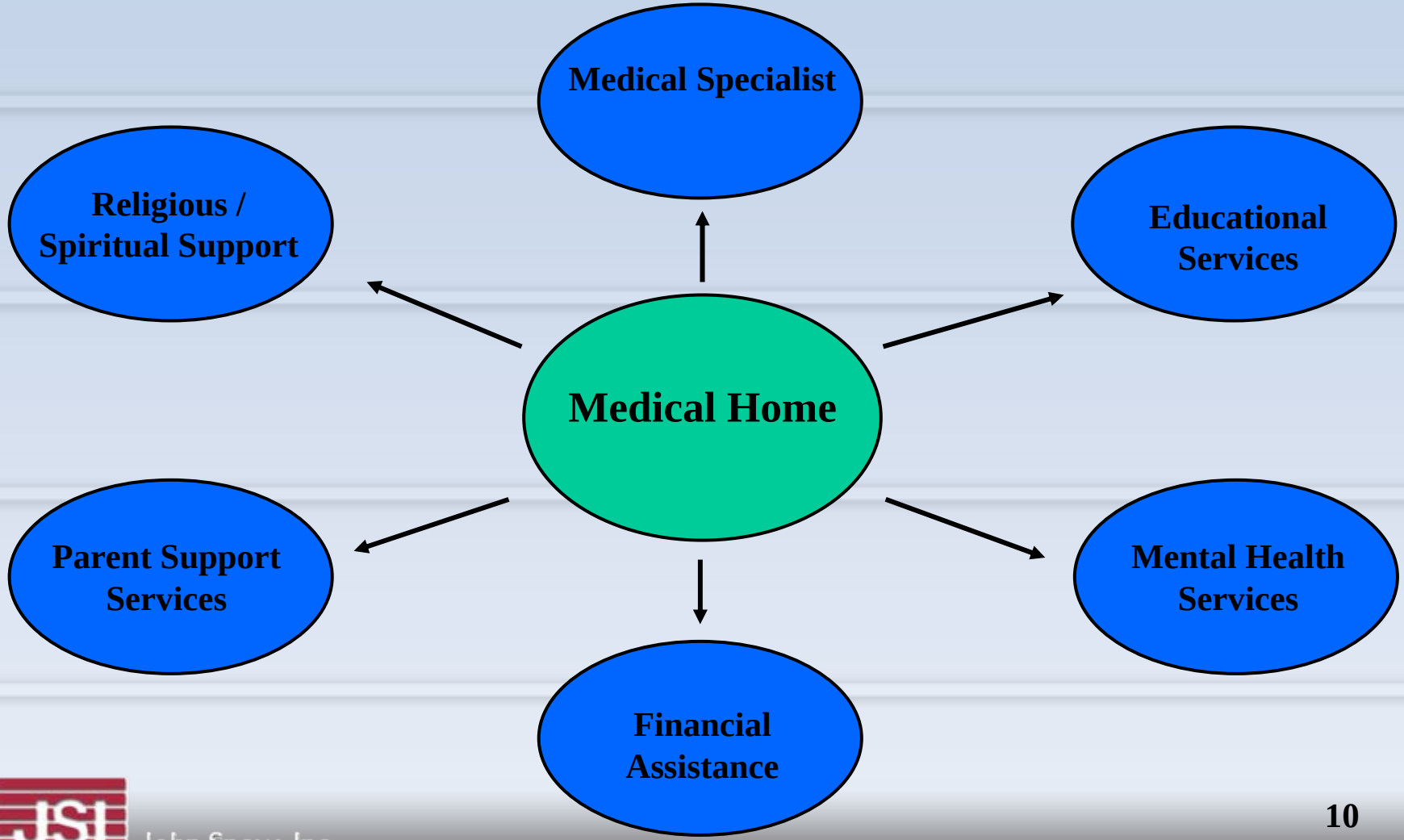
"The Medical Home provides an **easy-to-use** point of entry into the health care system, **coordinates** ongoing, **comprehensive medical care** that is appropriate and consistent with the **patient's needs and values**, and places the patient at the center of all choices concerning their care.

The Medical Home's structure supports the patient establishing and maintaining **long-term relationships** within the medical team *and* ***other community-based resources*** while utilizing **health information technology** and other innovations to provide **seamless and timely access** to **all essential care**."

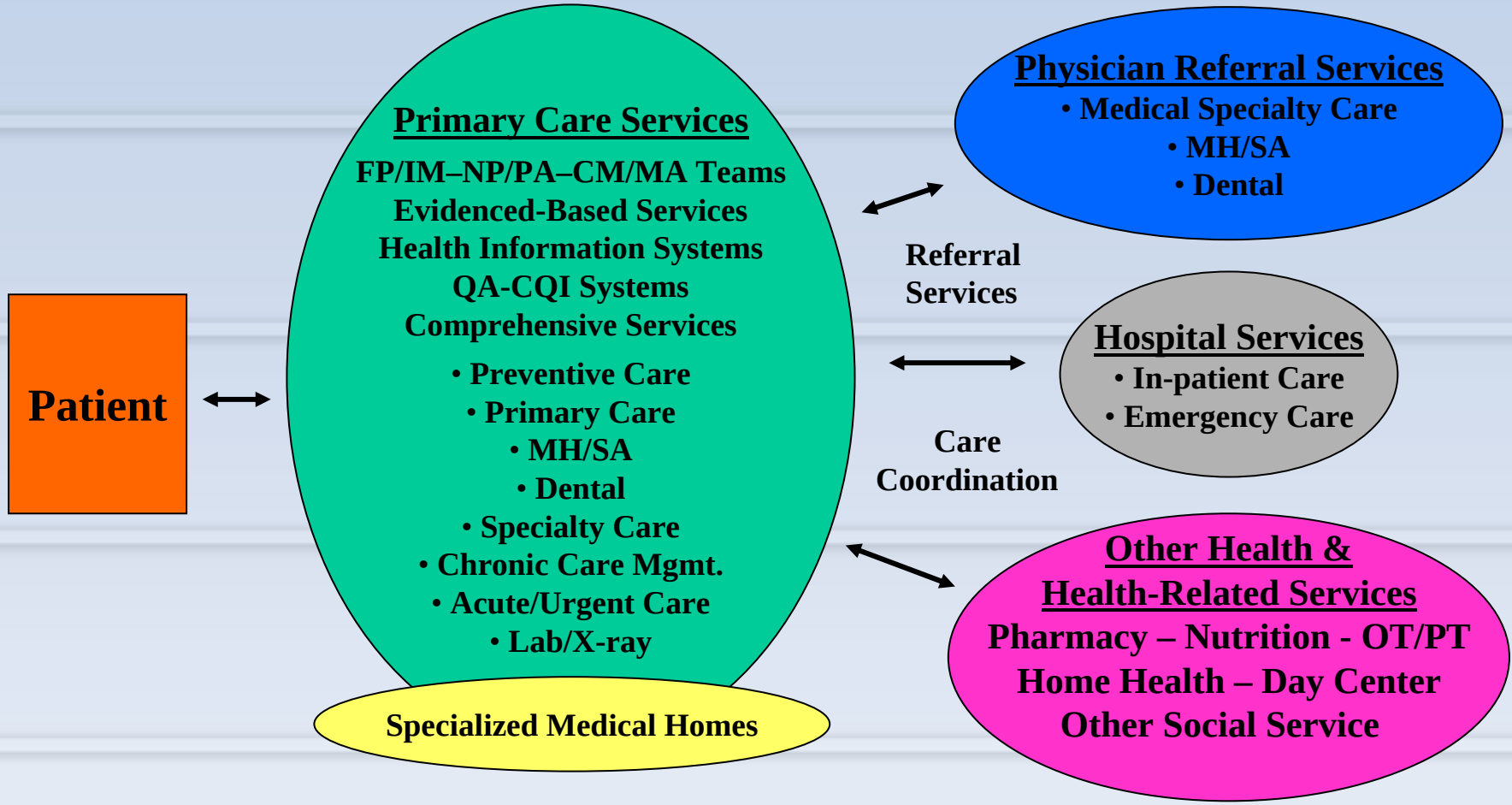
Core Elements of a Medical Home (AAFP)

- Personal medical home
- Patient-centered care
- Team approach
- Elimination of barriers to access
- Advanced information systems
- Redesigned offices
- Whole-person orientation
- Care provided within a community context
- Emphasis on quality and safety
- Enhanced practice finance
- Commitment to provide Comprehensive services

Medical Home Model



Medical Home Model



Core Elements of a Medical Home (AAP)

- A Medical Home is:
  - Accessible
  - Patient/family-Centered
  - Continuous
  - Coordinated/Comprehensive
  - Compassionate
  - Culturally Effective

Primary Care Core Competencies (IOM)

"All health professions should be educated to deliver patient centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement practices, and informatics."

- Patient Centered Care
- Interdisciplinary Teams
- Health Information Technology
- Quality Improvement
- Evidence-Based Practices

Chronic Care Management

- Identification, Assessment and Care Planning
  - Screening
  - Needs assessment
  - Initial Care planning
- Care Management (Primary Care, Medical Specialty, Social Services)
  - Self-management support
  - Optimization of medical treatment
  - Care coordination and service integration
  - Community linkages
- Monitoring patient progress and program performance
  - Patient outcomes
  - Patient compliance
  - Program performance (QA and CQI)

Identification, Assessment and Care Planning

- Formal In-take and Screening Processes
  - Formal in-take/annual assessment
  - Regular / universal / targeted Screening for high-risk conditions
- Initial and on-going care planning
  - Education and motivational interviewing
  - Personal interventions
  - Medical interventions, monitoring and follow-up
  - Community Interventions

Care Management

- Self-management support (PCPs, CMs, MAs)
  - Education
  - Brief “counseling”
  - Motivational interviewing
- Medical treatment (PCPs, RNs, MAs)
  - Evidence-based guideline driven care

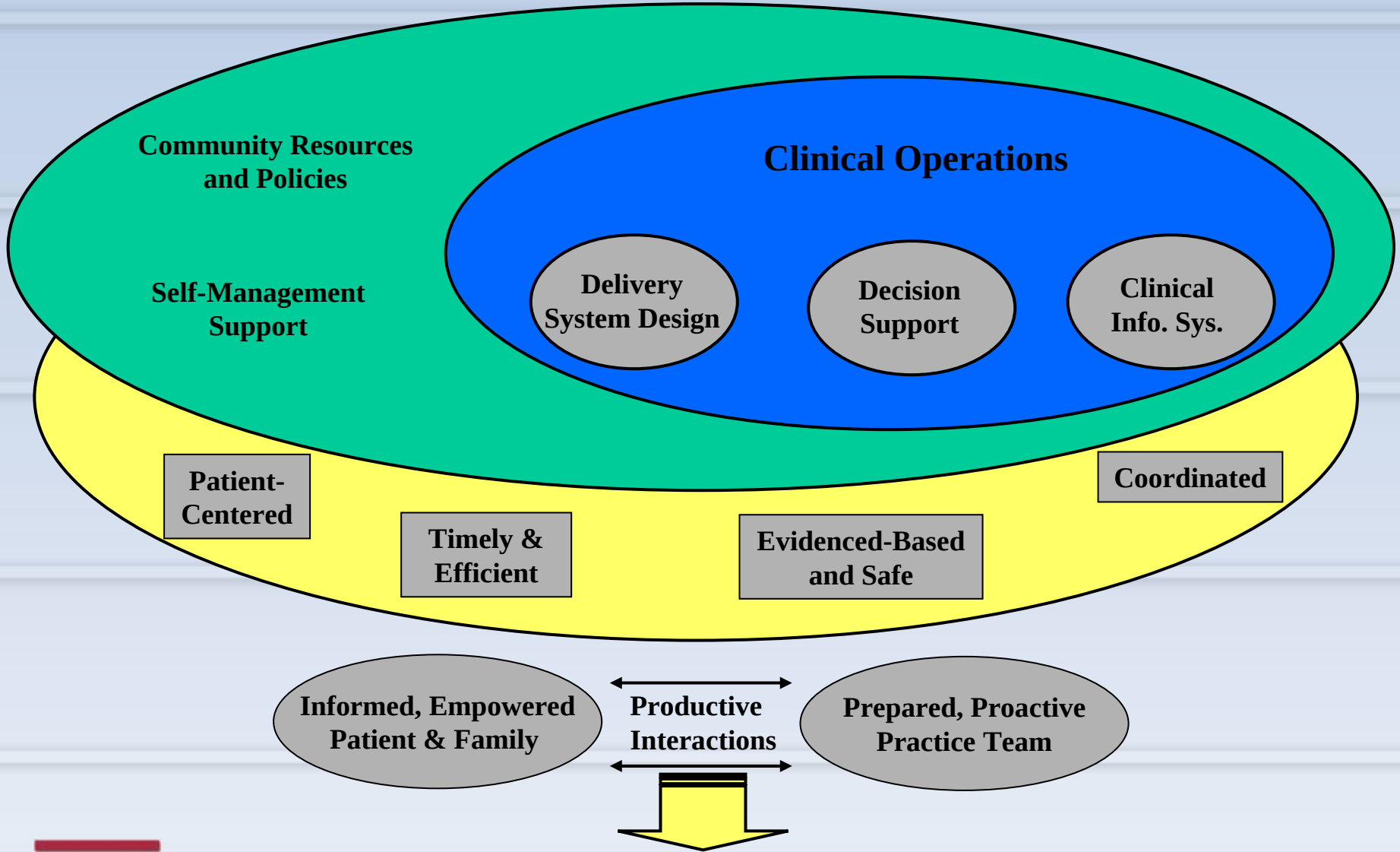
Care Management (Cont.)

- Care coordination and service integration (Internal and external)
  - Co-location of services
  - Information sharing
  - Quality assurance and tracking (HIT-assisted)
  - Enhanced referral arrangements
  - Community linkages / partnerships
  - Case management

Care Management (Cont.)

- Monitoring patient progress and program performance
  - Patient outcomes
  - Patient compliance
  - Program performance (QA and CQI)

Medical Home Model



Case Study: Lifelong Medical Care and the Over 60 Clinic

- Mission:
  - LifeLong provides high-quality health and social services to underserved people of all ages; creates models of care for the elderly and people with disabilities; and advocates for continuous improvements in the health of our communities.
- Range of Services
  - Full continuum of Home-, community-, clinic-based services
  - Emphasis on social, emotional, and functional, as well as medical
  - Chronic disease focus
- Community Partnerships
  - Housing
  - Legal assistance
  - Independent living

Case Study: Commonwealth Care Alliance (CCA) (Medical Component)

- Mission / Vision:
  - See Handouts
- Statement of what they do:
  - Partnerships between those receiving/providing/managing care
  - Promote autonomy, independence, and function
  - Evidences-based chronic care management
  - Inter-disciplinary teams
  - Provide responsive, continuous care that:
    - Reduces secondary medical complications
    - Substitutes support, home and community services for institutional care
  - Contain and stabilize medical costs
- Community Partnerships
  - See Handouts

IHI / HRSA Health Disparities Disease Collaboratives

- IHI Breakthrough Series
- HRSA / IHI Health Disparities Disease Collaboratives
  - Screening / Prevention
  - Patient Self-Management
  - Interdisciplinary Teams
  - Co-location of PC and Specialty Care
  - Care Management
  - CQI - QA - HIT - Performance Measurement

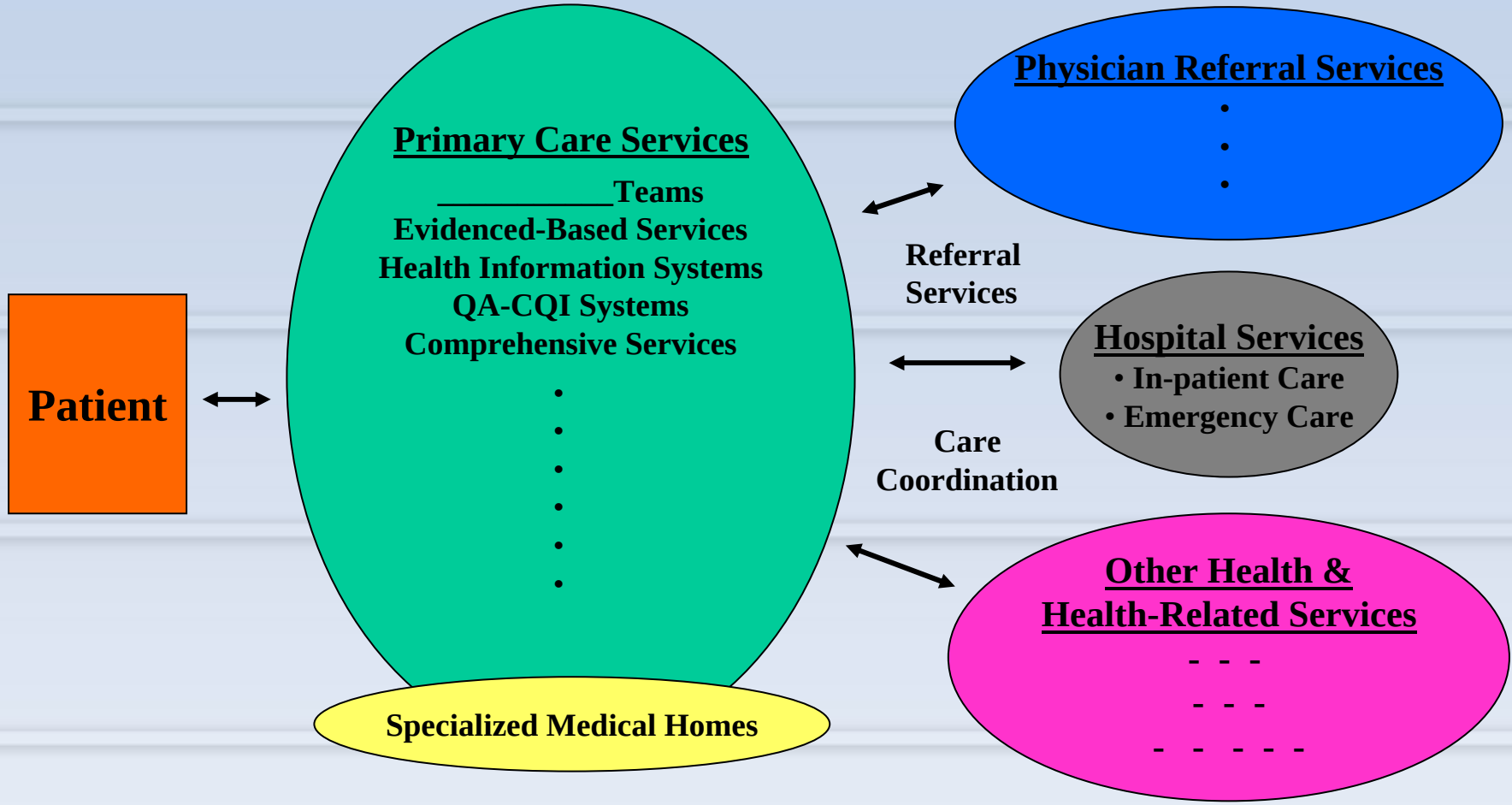
Quality Assurance and Monitoring Impact

- Medical Home-ness
  - Adoption of medical home components
  - Comparison of core/secondary process measures to baseline overtime
- Patient Outcomes
  - Condition specific health indicators (Medical)
  - ADL-based assessments (Functional and Social)
  - MH/SA assessments (Emotional and Social)
- Performance / Process
  - Operational assessments (Process measures)
  - Continuous quality improvement (On-going measurement)

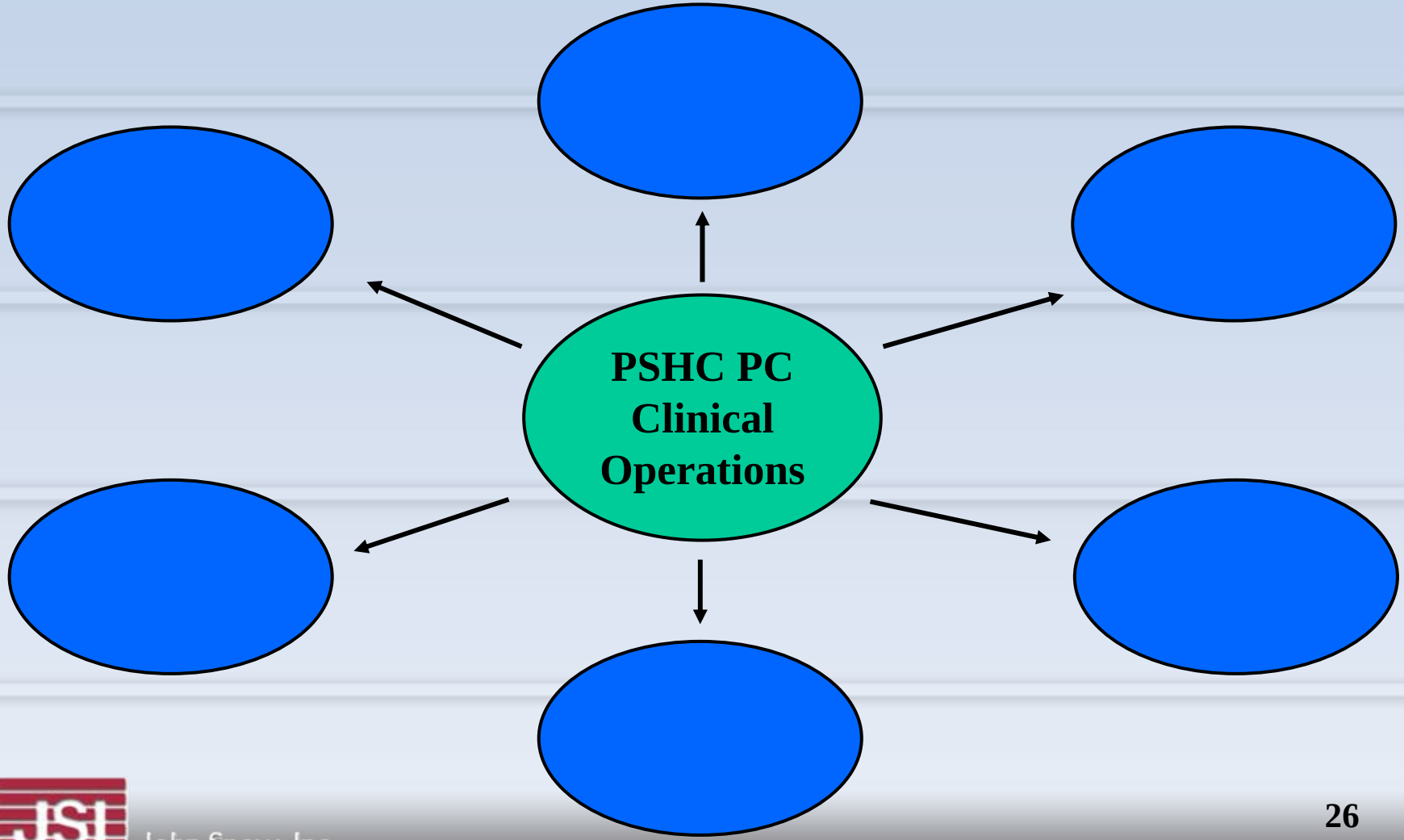
Exploration of a PSHC-Specific MH / CC Model

- What are the major needs, challenges, opportunities, barriers, and service gaps for the service area's target population?
- What resources does PSHC currently have in-place to address these needs and challenges?
- What resources or services could or should be developed or enhanced?
- What community organizations or stakeholders should be included?

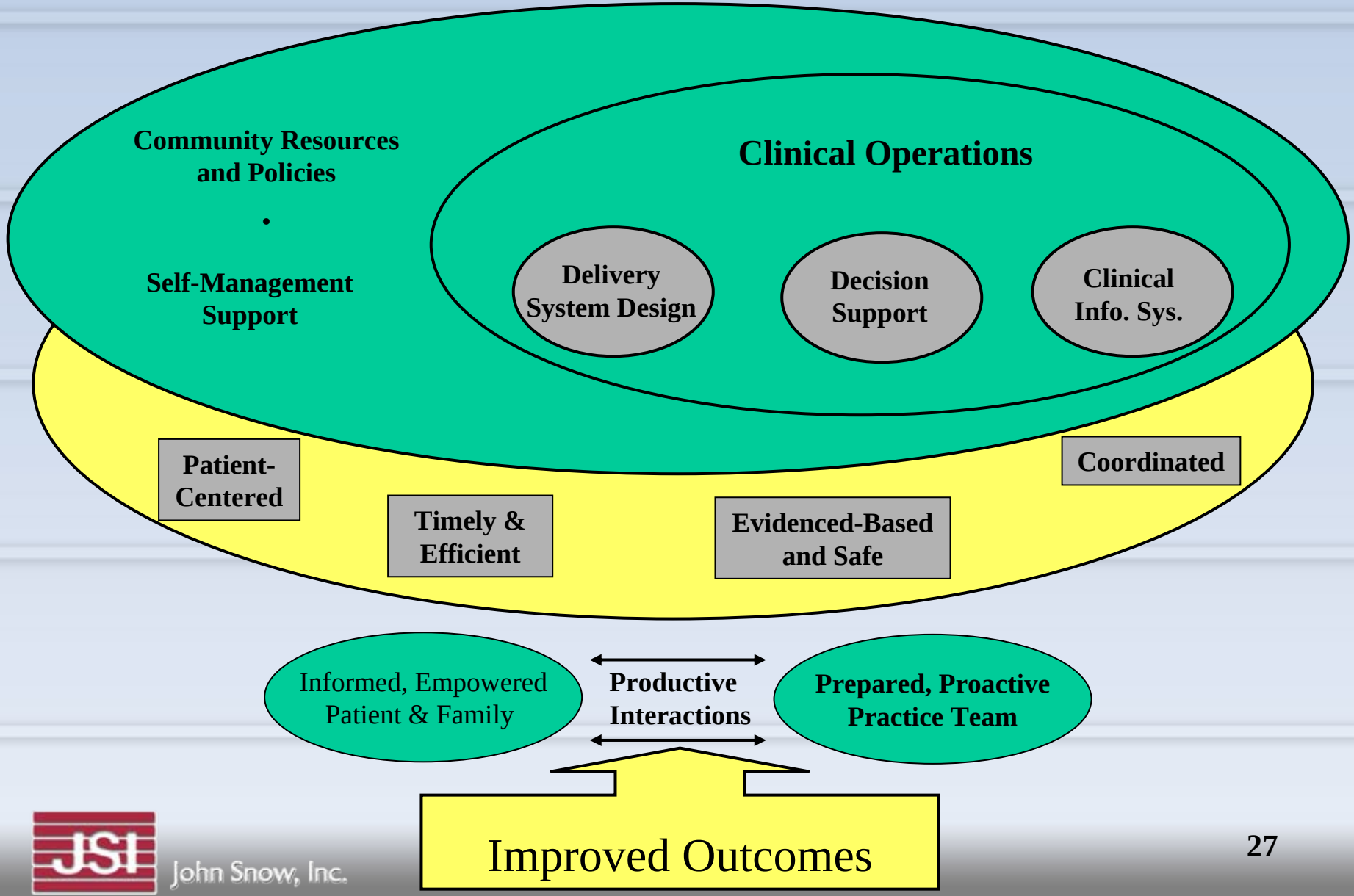
Medical Home Model



Medical Home Model



Medical Home Model



Domain 1: Organizational Capacity: For Patients with Exceptional Health Care Needs (PEHCN) and Their Caregivers				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
#1.1 The Mission of the Practice (Potomac Street)	*Primary care providers (PCPs)* at PSHC have individual ways of delivering care to *Patients with Exceptional Health Care Needs (PEHCN)*, their own education, experience, and interest drive quality. ☐ Partial ☐ Complete	Approaches to the care of PEHCN at PSHC are patient-centered; office needs drive the implementation of care delivery. ☐ Partial ☐ Complete	PSHC uses a patient/caregiver approach to care, they assess PEHCN and the needs of the caregivers in accordance with its mission, feedback is solicited from patients and caregivers and influences office policies (e.g., the way things are done). ☐ Partial ☐ Complete	In addition to Level 3, an "advisory group" promotes patient/caregiver-centered strategies, practices, and policies (e.g., enhanced communication methods); a written, visible mission statement reflects practice commitment to quality of care for PEHCN and their caregivers. ☐ Partial ☐ Complete
#1.2 Communi-cation/ Access	Communication between the *patient/caregivers (P/C)* and PCP occurs as a result of P/C inquiry. PCP contacts with the P/C are for test result delivery or planned medical follow up. ☐ Partial ☐ Complete	In addition to Level 1, standardized office communication methods are identified to the P/C by PSHC (e.g., call-in hours, phone triage for questions, or provider call back hours). ☐ Partial ☐ Complete	Practice and P/C communicate at agreed upon intervals and both agree on "best time and way to contact me"; individual needs prompt week-end or other special appointments. ☐ Partial ☐ Complete	In addition to Level 3, office activities encourage individual requests for flexible access; access and communication preferences are documented in the care plan and used by other practice staff (e.g., fax, e-mail or web messages, home, or residential care visits). ☐ Partial ☐ Complete
#1.3 Access to Medical Record	A policy of access to medical records is not routinely discussed with patient/caregiver; records are provided only upon request. ☐ Partial ☐ Complete	In addition to Level 1, it is established among staff that patients can review their record, but this fact is not explicitly shared with patients and their caregivers. ☐ Partial ☐ Complete	All patients and caregivers are informed that patients (and caregivers within regulations) have access to their record; staff facilitates access within 24-48 hours. ☐ Partial ☐ Complete	In addition to Level 3, practice orientation materials include information on record access; staff locates space for patients (along with their caregivers) to read their record and make themselves available to answer questions. ☐ Partial ☐ Complete
#1.4 Office Environment	Special needs concerning physical access and other visit	Assessments are made during the visit of PEHCN with special	In addition to Level 2, staff asks about any new or pre-existing	In addition to Level 3, key staff identify patients scheduled each day with special health care needs,

Domain 1: Organizational Capacity: For Patients with Exceptional Health Care Needs (PEHCN) and Their Caregivers				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
	accommodations are considered at the time of the appointment and are met if possible. ☐ Partial ☐ Complete	health care needs and the needs of their caregiver, any physical access & other visit accommodations needs are addressed at the visit and are documented for future encounters. ☐ Partial ☐ Complete	physical and social needs when scheduling appointments, chart documentation is updated and staff are informed /prepared ahead of time ensuring continuity of care. ☐ Partial ☐ Complete	prepare for their visit and assess and document new needs at the visit, an office care coordinator prepares both office staff and the office environment for the visit, s/he advocates for changes (office/environmental) as needed. ☐ Partial ☐ Complete
#1.5 Family Feedback	P/C feedback to PSHC occurs through external mechanisms such as satisfaction surveys issued by a health plan, this information is not always shared with practice staff. ☐ Partial ☐ Complete	Feedback from P/C is elicited sporadically by individual practice providers or by a suggestion box; this feedback is shared informally with other providers and staff. ☐ Partial ☐ Complete	Feedback from P/C regarding their perception of care is gathered through systematic methods (e.g., surveys, focus groups, or interviews); there is a process for staff to review this feedback and to begin problem solving. Electronic survey ☐ Partial ☐ Complete	In addition to Level 3, ad advisory process is in place with P/C which helps to identify needs and implement creative solutions; there are tangible supports to enable P/C to participate in these activities (e.g., stipends, transportation). ☐ Partial ☐ Complete
#1.6 Cultural Competence	The primary care provider (PCP) attempts to overcome obstacles of language, literacy, or personal preferences on a case by case basis when confronted with barriers to care. ☐ Partial ☐ Complete	In addition to Level 1, resources and information are available for families of the most common diverse cultural backgrounds; others are assisted individually through efforts to obtain translators or to access information from outside sources. ☐ Partial ☐ Complete	In addition to Level 2, materials are available and appropriate for non-English speaking families, those with limited literacy; those materials are appropriate to the developmental level of the PEHCP (child/young adult). ☐ Partial ☐ Complete	In addition to Level 3, P/C assessments include pertinent cultural information, particularly about health beliefs, the information is incorporated into care plans, PSHC uses these encounters to assess patients & community cultural needs. ☐ Partial ☐ Complete
#1.7 Staff	For all staff, an orientation to internal office practices,	In addition to Level 1, PSHC supports (paid time/tuition)	In addition to Level 2, educational information on community-based	In addition to Level 3, caregivers are integrated into office staff orientation and educational

Domain 1: Organizational Capacity: For Patients with Exceptional Health Care Needs (PEHCN) and Their Caregivers				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
Education	procedures and policies is provided. ☐ Partial ☐ Complete	continuing education for all staff. ☐ Partial ☐ Complete	resources for PEHCN, including diagnosis specific resource information, is available for all staff. ☐ Partial ☐ Complete	opportunities as teachers or "faculty"; support for caregivers to take this role is provided. ☐ Partial ☐ Complete

Domain 2: Chronic Condition Management (CCM) For PEHCN and Their Caregivers				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
#2.1 Identification of Patients in Practice with Exceptional Health Needs	Patients with exceptional health care needs (PEHCN) can be counted informally (e.g. by memory or from recent acute encounters); comprehensive identification can be done through individual chart review only. ☐ Partial ☐ Complete	Lists of patients with exceptional health care needs are (can be) extracted electronically by diagnostic code. ☐ Partial ☐ Complete	A PEHCN list is generated by PSHC, the list is used to enhance care and/or define practice activities (for example, flag charts for special attention) Do only for diabetes. ☐ Partial ☐ Complete	In addition to Level 3, diagnostic codes for PEHCN are documented, problem lists are current, and complexity levels are assigned to each patient; this information creates an accessible practice database of PEHCN. ☐ Partial ☐ Complete
#2.2 Care Continuity (CCM 3.c.1)	Visits occur with the patient's own primary care provider (PCP) as a result of acute problems or well visit schedules, the P/C determines follow up. ☐ Partial ☐ Complete	Non-acute visits occur with P/C and their PCP to address chronic condition care; the PCP determines appropriate visit intervals, follow-up includes communication of tasks to staff and of lab and medical test results to the P/C. ☐ Partial ☐ Complete	The team (including PCP, P/C, and staff) develop a plan of care for PEHCN which details visit schedules and communication strategies, home and community concerns are addressed in the plan. Practice back up/cross coverage providers are informed by these plans. ☐ Partial ☐ Complete	In addition to Level 3, PSHC /teams use condition protocols; they include goals, services, interventions and referral contacts. A designated care coordinator uses these tools and other standardized office processes which support patients and caregivers. ☐ Partial ☐ Complete
#2.3 Continuity Across Settings (CCM 3.c.6)	Communication among the PCP, specialists, therapists, and other providers happens as needs arise for PEHCN.	A PCP makes requests and/or responds to requests from agencies on behalf of PEHCN (e.g., medical orders or approvals); all communication is documented.	Systematic practice activities foster communication among PSHC, caregivers, and external providers such as specialists and other community professionals for PEHCN; these methods are documented and may include	In addition to Level 3, a method is used to convene the P/C and key professionals on behalf of the patients with more complex health concerns, specific issues are brought to this group and they all share and use a written

Domain 2: Chronic Condition Management (CCM) For PEHCN and Their Caregivers				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
	☐ Partial ☐ Complete	☐ Partial ☐ Complete	information exchange forms or ad hoc meetings with external providers. ☐ Partial ☐ Complete	plan of care. ☐ Partial ☐ Complete
#2.4 Cooperative Management Between Primary Care Provider (PC) and Specialist	Specialty referrals occur in response to specific diagnostic and therapeutic needs; P/C are the main initiators of communication between specialists and their PCP. ☐ Partial ☐ Complete	In addition to Level 1, specialty referrals use phone, written and/or electronic communications; the PCP waits for or relies upon the specialists to communicate back their recommendations. ☐ Partial ☐ Complete	The PCP and P/C set goals for referrals and communicate these to specialists; together they clarify co-management roles among P/C, PCP and specialists and determine how specialty feedback to the P/C and PCP is expressed, used and shared. ☐ Partial ☐ Complete	In addition to Level 3, the P/C has the option of using PSHC in a strong coordinating role; P/C as partners with PSHC manage the patient's care using specialists for consultation and information (unless they decide it is prudent for the specialist to manage the majority of the patients care). ☐ Partial ☐ Complete
#2.5.1 Supporting Transition in Health Status and Living Arrangements	Primary care providers adhere to defined health maintenance schedules for adults with special health care needs and older adults with chronic conditions.	Primary care providers offer age/condition appropriate anticipatory guidance for patients/caregivers related to their chronic conditions, self-care, nutrition, fitness, sexuality and other health behavior information.	Primary care providers support patients and caregivers to manage their health using a transition guidelines and developmental approach, they assess need and offer culturally effective guidance related to: • Health and wellness • Guardianship and legal & financial issues • Community supports and recreation • Transition to assisted living arrangements	Progressively as the patient ages, patient/caregiver and PCP develop a written transitions plan within the care plan, it is made available to families and all involved providers, including physical and mental health providers. Patients/caregivers receive transition support to link their health with community based supports for independent living and when needed assisted living arrangements.

Domain 2: Chronic Condition Management (CCM) For PEHCN and Their Caregivers				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
	☐ Partial ☐ Complete	☐ Partial ☐ Complete	☐ Partial ☐ Complete	☐ Partial ☐ Complete
#2.6 Family Support	Patients/Caregivers are responsible for carrying out recommendations made to them by their PCP when they specifically ask for support or help. ☐ Partial ☐ Complete	PSHC responds to clinical needs; broader social and P/C needs are addressed and referrals to support services facilitated. ☐ Partial ☐ Complete	PSHC actively takes into account the overall impact when a patient has a chronic health condition by considering both the patient and caregivers in care; when requested, staff will assist them to set up caregiver support connections. ☐ Partial ☐ Complete	In addition to Level 3, PSHC sponsors caregiver support activities (e.g., skills building for caregivers on how to become a supportive caregiver); they have current knowledge of community or state support organizations and connect caregivers to them. ☐ Partial ☐ Complete

Domain 3: Care Coordination for PEHCN and Their Caregivers				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
#3.1 Care Coordination/ Role Definition	The P/C coordinates care without specific support; they integrate office recommendations into the patient's care. ☐ Partial ☐ Complete	The primary care provider (PC) or a staff member engages in care support activities as needed; involvement with the caregiver is variable. ☐ Partial ☐ Complete	Care coordination activities are based upon the ongoing assessments of patient and caregiver needs; PSHC partners with the P/C to accomplish care coordination goals. ☐ Partial ☐ Complete	Practice staff offers a set of care coordination, their level of involvement fluctuates according to P/C needs/wishes. A designated care coordinator ensures the availability of these activities including written care plans with ongoing monitoring. ☐ Partial ☐ Complete
#3.2 Caregiver Involvement	The PCP makes medical recommendations and defines care coordination needs, the P/C carries them out. ☐ Partial ☐ Complete	Patients/caregivers (P/C) are regularly asked what care supports they need; treatment decisions are made jointly with the PCP. ☐ Partial ☐ Complete	In addition to Level 2, P/C are given the option of centralizing care coordination activities at and in partnership with PSHC. ☐ Partial ☐ Complete	In addition to Level 3, P/C contribute to a description of care coordination activities; a care coordinator specifically develops and implements this practice capacity which is evaluated by patients/caregivers and designated supervisors. ☐ Partial ☐ Complete
#3.4 Assessment of Needs/Plans of Care	Presentation of PEHCN with acute problems determines how needs are addressed.	PCPs identify specific needs of PEHCN; follow-up tasks are arranged for, or are assigned to patients, caregivers, and/or available staff.	The patient with exceptional health needs, caregivers, and PCP review current patient health status and anticipated problems or needs; they create /revise action plans and allocate responsibilities at least 2 times per year or at individual	In addition to Level 3, the PCP/staff and P/C create a written plan of care that is monitored at every visit; the office care coordinator is available to the patient and caregiver to implement, update, and evaluate the care plan.

Domain 3: Care Coordination for PEHCN and Their Caregivers				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
	☐ Partial ☐ Complete	☐ Partial ☐ Complete	intervals. ☐ Partial ☐ Complete	☐ Partial ☐ Complete
#3.5 Resource Information and Referrals	Information about resource needs and insurance overage is gathered during regular patient visit intakes, PSHC addressed immediate patient/ caregiver information and resource needs. ☐ Partial ☐ Complete	Using a listing of community, state, and national resources which cover physical, developmental, social and financial needs PSHC responds to P/C requests for information; the P/C seeks out additional information and may share back lessons learned. ☐ Partial ☐ Complete	Significant office knowledge about caregiver and medical resources and insurance options is available; assessment of needs leads to supported use of resources and information to solve specific problems. ☐ Partial ☐ Complete	In addition to Level 3, practice staff works with P/C helping solve resource problems; a designated care coordinator provides follow up, researches additional information, seeks and providers feedback and assists with the family to integrate new information into the care plan. ☐ Partial ☐ Complete
#3.6 Advocacy	The PCP suggests that the P/C find support services & resources outside of PSHC when specific needs arise (e.g., diagnosis specific support groups, disability rights organizations). ☐ Partial ☐ Complete	All patients with exception health care needs and their caregivers are routinely provided with basic information and advocacy resources during scheduled practice visits. ☐ Partial ☐ Complete	PSHC team identifies resources to the P/C for support and advocacy, facilitates the connections, and advocates on a patient's behalf to solve specific problems pertinent to PEHCN. Follow up for specific patients in specific instances ☐ Partial ☐ Complete	In addition to Level 3, PSHC helps to create opportunities for community forums, discussion or support groups which address specific concerns. Don't do routinely for broad base of patients. ☐ Partial ☐ Complete

Domain 4: Community Outreach for ESHCN and Their Families				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
#4.1 Community Assessment of Needs for ESHCN	Primary care provider (PCP) awareness of the population of PEHCN in their community is directly related to the number of patients for whom the provider cares (needs assessment/target population penetration). ☐ Partial ☐ Complete	PSHC learns about issues and needs related to PEHCN from key community informants; providers blend this input with their own personal observations to make an informed and personal assessment of the needs of PEHCN in their community. ☐ Partial ☐ Complete	In addition to Level 2, providers raise their own questions regarding the population of PEHCN in their practice community(ies); they seek pertinent data and information from the community(ies) and local/state sources and use data to inform practice care activities. ☐ Partial ☐ Complete	In addition to Level 3, at least one clinical practice provider participates in a community-based public health need assessment about PEHCN, integrates results into practice policies, and shared conclusions about population needs with community and state agencies. ☐ Partial ☐ Complete
#4.2 Community Outreach to Agencies and Schools	When the caregiver or agency request interactions with the PCP on behalf of the patient's community needs, the provider responds, thereby establishing PSHC as a resource. ☐ Partial ☐ Complete	In addition to Level 1, when a community agency requests technical assistance or education from PSHC about PEHCN, PSHC communicates, collaborates, and educates based upon availability and interest. ☐ Partial ☐ Complete	PSHC initiates outreach to community agencies that directly serve PEHCN (e.g., by representation on one or more advisory boards or committees); they advocate for improved community services and inter-organizational collaborations & communication. ☐ Partial ☐ Complete	In addition to Level 3, PSHC identifies needs of PEHCN and their caregivers, they work with patients and caregivers to sponsor activities that raise community awareness to resource and support needs (e.g., respite care, recreation opportunities, or improving home/provider communication). ☐ Partial ☐ Complete

Domain 5: Data Management for PEHCN and Their Caregivers				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
#5.1 Electronic Data Support	Primary care provider (PCP) retrieve information/ data by individual chart review; electronic data are available and retrievable from payer sources only. ☐ Partial ☐ Complete	Electronic recording of data is limited to billing & scheduling; data are retrieved according to diagnostic code in relation to billing and scheduling; these data are used to identify specific patient groupings. ☐ Partial ☐ Complete	As electronic data system includes identifiers and utilization data about patients with exceptional health care needs; these data are used for monitoring, tracking, and for indicating levels of care complexity. ☐ Partial ☐ Complete	In addition to Level 3, an electronic data system is used to support the documentation of need, monitoring of clinical care, care plan and related coordination and the determination of outcomes (e.g., clinical, functional, satisfaction, and cost outcomes). ☐ Partial ☐ Complete
#5.2 Data Retrieval Capacity	PCP retrieves patient data from paper records in response to outside agency requirements (e.g., quality standards, special projects, or practice improvements). ☐ Partial ☐ Complete	PSHC retrieves data from paper records and electronic billing and scheduling for the support of significant office changes (e.g. staff or allocation of resources) and/or pay for performance documentation. ☐ Partial ☐ Complete	Data are retrieved from electronic records to identify and quantify populations and to track selected health indicators and outcomes. ☐ Partial ☐ Complete	In addition t Level 3, electronic data are produced and used to drive practice improvements and to measure quality against benchmarks (those producing and using data practice confidentiality). ☐ Partial ☐ Complete

Domain 6: Quality Improvement/Change for PEHCN and Their Caregivers				
THEME:	***Level 1***	***Level 2***	***Level 3***	***Level 4***
#6.1 Quality Standards (structures)	Quality standards for patients with exceptional health care needs (PEHCN) are imposed upon PSHC by internal (e.g., MCPN) or external organizations. ☐ Partial ☐ Complete	In addition to Level 1, an individual staff member participates on a committee for improving processes of care at PSHC. This person communicates and promotes improvement goals to the whole practice. ☐ Partial ☐ Complete	PSHC has its own systematic quality improvement mechanism for PEHCN; regular provider and staff meetings are used for input and discussion on how to improve care and treatment for this population. No documenting, tracking ☐ Partial ☐ Complete	In addition to Level 3, PSHC actively utilizes quality improvement (QI) processes, staff and P/C are supported to participate in those QI activities, resulting quality standards are integrated into the operations of PSHC. ☐ Partial ☐ Complete
#6.2 Quality Activities (processes)	Primary care providers (PCPs) have completed courses or have had an adequate orientation to continuous qualify improvement methods. ☐ Partial ☐ Complete	MCPN administrators or payors indentify practice deficits and set goals for improvements; practice providers and staff are identified to fix problems with limited participation in the process. ☐ Partial ☐ Complete	Periodic formal and information quality improvement activities gather staff input about practice improvement ideas and opportunities for PEHCN; efforts are made toward related changes and improvements for this population. ☐ Partial ☐ Complete	In addition to Level 3, PSHC systematically learns about PEHCN & draws upon P/C input; together PSHC and P/C design and implements office changes that address need and gaps; they then study their outcomes and act accordingly. ☐ Partial ☐ Complete

Part 1: Organization (PSHC) of the Health Care Delivery System. Chronic illness management programs can be more effective if the overall system (organization) in which care is provided is oriented and led in a manner that allows for a focus on chronic illness care. Evaluate at both PSHC and MCPN levels.				
Components	**Level D**	**Level C**	**Level B**	**Level A**
Overall Organizational Leadership in Chronic Illness Care **Score**	… does not exist or there is a little interest. 0 1 2	… is reflected in vision statements and business plans, but no resources are specifically earmarked to execute the work. 3 4 5	… is reflected by senior leadership and specific dedicated resources (dollars and personnel). 6 7 8	… is part of the system's long-term planning strategy, receive necessary resources, and specific people are held accountable. 9 10 11
Organizational goals for chronic care **Score**	… does not exist or are limited to one condition. 0 1 2	… exist but are not actively reviewed. 3 4 5	… are measurable and reviewed. 6 7 8	… are measurable, reviewed routinely, and incorporated into plans for improvement. 9 10 11
Improvement strategy for chronic care illness. **Score**	… is ad hoc and not organized or supported consistently. 0 1 2	… utilizes ad hoc approaches for targeted problems as they emerge. 3 4 5	… utilizes a proven improvement strategy for targeted problems. 6 7 8	… includes a proven improvement strategy and uses it proactively in meeting organizational goals. 9 10 11
Incentives and regulations for chronic illness care **Score**	… are not used to influence clinical performance goals. 0 1 2	… are used to influence utilization and costs of chronic illness care. 3 4 5	… are used to support patient care goals. 6 7 8	… are used to motivate and empower providers to support patient care goals. 9 10 11
Senior leaders **Score**	… discourage enrollment of the chronically ill. 0 1 2	… do not make improvements to chronic illness a priority. 3 4 5	… encourage improvement efforts in chronic care. 6 7 8	… visibly participate in improvement efforts in chronic care (e.g. disease collaborative). 9 10 11

Part 1: Organization (PSHC) of the Health Care Delivery System. Chronic illness management programs can be more effective if the overall system (organization) in which care is provided is oriented and led in a manner that allows for a focus on chronic illness care. Evaluate at both PSHC and MCPN levels.				
Reimbursement arrangements	… discourage patient self-management or system changes.	.. neither encourage nor discourage patient self-management or system changes.	… encourage patient self-management or system changes.	… are specifically designed to promote better chronic illness care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Total Organization Score _____43		**Average Score (/6)_____7, Range 5-11_____**		

Part 2: Community Linkages. Linkages between the PSHC and community resources play important roles in the management of chronic illness.				
Components	**Level D**	**Level C**	**Level B**	**Level A**
Linking patients to outside resources	…is not done systematically.	… is limited to a list of identified community resources in an accessible format.	… is accomplished through a designated staff person or resource responsible for ensuring providers and patients/ caregivers make maximum use of community resources.	…is accomplished through active coordination between the health system, community service agencies, and patients.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Partnerships with community organizations	… do not exist.	… are being considered but have not yet been implemented.	… are formed to develop supportive programs and policies.	… are actively sought to develop formal supportive programs and policies across MCPN.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Major health plans that enroll PSHC patients (list):	… do not coordinate chronic illness guidelines, measures, or care resources at the practice level.	… would consider some degree of coordination of guidelines, measures, or care resources at the practice level but have not yet implemented changes.	… currently coordinates guidelines, measures, and care resources in one or two chronic illness areas.	… currently coordinates chronic illness guideless, measures, and resources at the practice level for most chronic illnesses.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Total Community Link Score ___20_____		**Average Score (/3) ____7_____**		

Part 3: Practice Level. Several components that manifest themselves at the level of the individual provider practice have been shown to improve chronic illness care. These characteristics fall into general areas of self-management support, and delivery system charge issues that directly affect the practice, decision support, and clinical information systems.
Part 3a: Self Management Support. Effective self management support can help patients and their caregivers cope with the challenges of living with and treating chronic illness and reduce complications and symptoms.

Components	**Level D**	**Level C**	**Level B**	**Level A**
Assessment and documentation of self-management needs and activities.	… are not done.	… are expected.	… are completed in a standardized manner.	… are regularly assessed and recorded in standardized form linked to treatment plan available to practice and patients.
Score	0 1 2.5	3 4 5	6 7 8	9 10 11
Self management support	… is limited to the distribution of information (pamphlets, booklets).	… is available by referral to self-management classes or educators.	… is provided by trained clinical educators who are designated to do self-management support, affiliated with each practice, and see patients on referral. For specific conditions	… is provided by clinical educators affiliated with each practice, trained in patient empowerment and problem-solving methodologies, and see most patients with chronic illness.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Addressing concerns of patients and caregivers	… is not consistently done.	… is provided for specific patients and family through referrals.	… is encouraged and peer support, groups, and mentoring programs are available.	… is an integral part of care and includes systematic assessment and routine involvement in peer support, groups or mentoring programs.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Part 3: Practice Level. Several components that manifest themselves at the level of the individual provider practice have been shown to improve chronic illness care. These characteristics fall into general areas of self-management support, and delivery system charge issues that directly affect the practice, decision support, and clinical information systems. **Part 3a: Self Management Support.** Effective self management support can help patients and their caregivers cope with the challenges of living with and treating chronic illness and reduce complications and symptoms.				
Effective behavior change interventions and peer support **Score**	… are not available. 0 1 2	… are limited to the distribution of pamphlets, booklets, or other written information. 3 4 5	… are available only by referral to specialized centers staffed by trained personnel. Internal: wt mgmt, smoking, diabetes 6 7 8	… are readily available and an integral part of routine care (e.g., smoking cessation). 9 10 11
Total Self Management Support Score _____19.5		**Average Score (/4)____just below 5, range 2.5 to 8_____**		

Part 3b: Decision Support. Effective chronic illness management programs assure that providers have access to evidence-based information necessary to care for patients – decision support. This included evidence-based practice guidelines or protocols, specialty consultation, provider education, and activating patients to make provider teams aware of effective therapies.				
Components	**Level D**	**Level C**	**Level B**	**Level A**
Evidence-based guidelines	… are not available.	… are available but are not systematically integrated into care delivery; individual provider choice.	… are available and supported by regular provider education.	… are available, supported by provider education, and integrated into care through reminders and other proven provider behavior change methods.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Involvement of specialists in improving primary care (MH #2.4)	… is primarily through traditional referral.	… is achieved through specialist leadership to enhance the capacity of the overall system to routinely implement guidelines.	… includes specialist leadership and designated specialists who provide primary care team training.	… includes specialist leadership and specialist involvement in improving.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Provider education for chronic care illness care (MH #1.7)	… is provided sporadically.	… is provided systematically through traditional methods (CME/CPE).	… is provided using optimal methods (e.g., academic detailing).	… includes training all practice teams in chronic care methods such as population-based management, and self management support.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Informing patients about guidelines (MH #3.3)	… is not done.	… happens through request or through MCPN system-wide publications.	… is done through specific patient education materials for each guideline. For diabetes	… includes specific materials developed for patients which describe their role in achieving guideline adherence.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Part 3b: Decision Support. Effective chronic illness management programs assure that providers have access to evidence-based information necessary to care for patients – decision support. This included evidence-based practice guidelines or protocols, specialty consultation, provider education, and activating patients to make provider teams aware of effective therapies.	
Total Decision Support Score _____13	**Average Score /4 just over 3, range 2 to 5_____**

Part 3c: Delivery System Design. Evidence suggests that effective chronic illness management involves more than simply adding additional interventions to a current system of acute care. It may necessitate changes to the organization of practice that impact provision of care.				
Components	**Level D**	**Level C**	**Level B**	**Level A**
Practice team functioning	… is not addressed.	… is addressed by assuring the availability of individuals with appropriate training in key elements of chronic illness care.	… is assured by regular team meetings to address guidelines, roles, and accountability, and problems in chronic illness care.	… is assured by teams who meet regularly and have clearly defined roles including patient self-management education, proactive follow-up, and resource coordination and other skills in chronic illness care.
Score	0 1 2	3 4 5.5	6 7 8	9 10 11
Practice team leadership	… is not recognized locally or by MCPN.	… is assumed by the organization to reside in specific organizational roles.	… is assured by the appointment of a team leader but the role in chronic illness is not defined.	… is guaranteed by the appointment of a team leader who assures that roles and responsibilities for chronic illness care are clearly defined.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Appointment systems	… can be used to schedule acute care visits, follow-up and preventive visits.	… assures scheduled follow-up with chronically ill patients.	… are flexible and can accommodate innovations such as customized visit length or group visits.	… includes organization of care that facilitates the patient seeing multiple providers in a single visit.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Follow-up	… is scheduled by patients or providers in an ad hoc fashion.	… is scheduled by PSHC in accordance with guidelines. Can only book out for 2 months	… is assured by the practice team by monitoring patient utilization (tickler system).	… is customized to patient needs, varies in intensity and methodology (phone, in person, email) and assures guideline follow-up (exception reporting).
Score	0 1 2	3 4 5	6 7 8	9 10 11

Part 3c: Delivery System Design. Evidence suggests that effective chronic illness management involves more than simply adding additional interventions to a current system of acute care. It may necessitate changes to the organization of practice that impact provision of care.				
Planned visits for chronic illness care **Score**	… are not used. 0 1 2	… are occasionally used for complicated patients. 3 4 5	… are an option for interested patients. 6 7 8	… are used for all patients and include regular assessment, preventive interventions and attention to self-management support. 9 10 11
Continuity of care (MH #2.3) **Score**	… is not a priority. 0 1 2	… depends on written communication between primary care providers and specialists, case managers, or health plan representatives. 3 4 5	… between primary care providers and specialists and other relevant providers is a priority but not implemented systematically. 6 7 8	… is a very high priority and all chronic disease interventions include active coordination between primary care, specialists, and other relevant groups. 9 10 11
Total Delivery System Score _____29.5		**Average Score (/6)__just below 5, range 2 to 6_____**		

Part 3d: Clinical Information System. Timely useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective programs, especially those that use population-based approaches.				
Components	**Level D**	**Level C**	**Level B**	**Level A**
Registry (list of patients with specific conditions) (MH 5.2)	… is not available.	… includes name, diagnosis, contact information, and date of last contact either on paper or in a computer database.	… allows queries to sort subpopulations by clinical priorities.	… is tied to guidelines which provide prompts and reminders about needed services.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Reminders to Providers	… are not available.	… include general notification of the existence of a chronic illness, but does not describe needed services at time of encounter.	… includes indications of needed service for populations of patients through periodic reporting.	… includes specific information for the team about guideline adherence at the time of individual patient encounters.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Feedback	… is not available or is non-specific to the team.	… is provided at infrequent intervals and is delivered impersonally. Better for diabetes	… occurs at frequent enough intervals to monitor performance and is specific to the team's populations.	… is timely, specific to the team, routine and personally delivered by a respected opinion leader to improve team performance.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Information about relevant subgroups of individual patients needing services	… is not available.	… can only be obtained with special efforts or additional programming.	… can be obtained upon request but is not routinely available.	… is provided routinely to providers to help them deliver planned care.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Part 3d: Clinical Information System. Timely useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective programs, especially those that use population-based approaches.				
Patient treatment plans (MH #3.4)	… are not expected.	… are achieved through a standardized approach, prepared by the primary care provider.	… are established collaboratively with patient/ caregiver and include self management as well as clinical goals. Not done with patient involvement	… are established collaboratively with patient/ care giver and include self management as well as clinical management goals. Follow up to plan occurs and guides care at every point of service.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Total Clinical Information System_ Score_____25		**Average Score ___(/5)____5, range 3 to 6_____**		

Evaluation Rating for PSHC Medical Home

Domain 1	Complete	Partial	Avg Complete	Avg Partial
Mission	1	2		
Communication	1	1		
Access Medical Record				
Office Environment	1	2		
Family Feedback	0	3		
Cultural Competence	2	2		
Staff Education	0	3		
			0.80	2.20
Domain 2	Complete	Partial		
Identification of PEHCN	1	2		
Care Continuity	0	2		
Continuity Across Settings	1	3		
Coordinate with Specialists	2	1		
Transition				
Family Support	2	1		
			1.2	1.8
Domain 3	Complete	Partial		
Role Definition	2	1		
Caregiver Involvement	1	2		
Assess Needs/Care Pllan	2	1		
Resource Info/Referrals	3	1		
Advocacy	2	2		
			2	1.4
Domain 4	Complete	Partial		
Needs Assessment	4	0		
Outreach	3	1		
			3.5	0.5
Domain 5	Complete	Partial		
Electronic Data Support	0	4		
Data Retrieval Capacity	2	2		
Quality Standards	2	2		
Quality Activities	1	2		
			1.3	2.5

	Avg Complete	Avg Partial
Org Capacity	0.8	2.2
Chronic Care Mgmt	1.2	1.8
Care Coordination	2.0	1.4
Community	3.5	0.5
Data Mgmt/CQI	1.3	2.5

Evaluation Rating for PSHC Chronic Illness Care

Part 1	Part 1	
	Organization of Health Care D	9
	Goals	5
	Improvement strategy	5
	Incentives	8
	Senior leader support	11
	Average Score	7.60
Part 2	Community Linkages	
	Community linkages	8
	Community partnerships	3
	MCO care coordination	3
	Average Score	4.67
Part 3a	Self Management Support	
	Assess/document needs	2.5
	Self management support	6
	Address concerns	5
	Behavior change	8
	Average Score	5.38
Part 3b	Decision Support	
	Evidence-based guidelines	5
	Involvement of specialists	2
	Provider education	4
	Educate patients	2
	Average Score	3.25
Part 3c	Delivery System Design	
	Practice team functioning	5.5
	Practice team leadership	5
	Appointment system	6
	Follow up care	2
	Planned visits	6
	Continuity of care	5
	Average Score	4.92
Part 3d	Clinical Information System	
	Registry of PEHCN	3
	Reminders to providers	5
	Feedback to team	5
	Patient information available	6
	Patient treatment plans	6
	Average score	5.00

Average Scores	
Organization of Health Care Delivery	7.60
Community Linkages	4.67
Self Management Support	5.38
Decision Support	3.25
Delivery System Design	4.92
Clinical Information System	5.00

Potomac Street Health Center Medical Home Project

Planning Retreat: Building a Medical Home

May 15, 2008

John Snow, Inc.

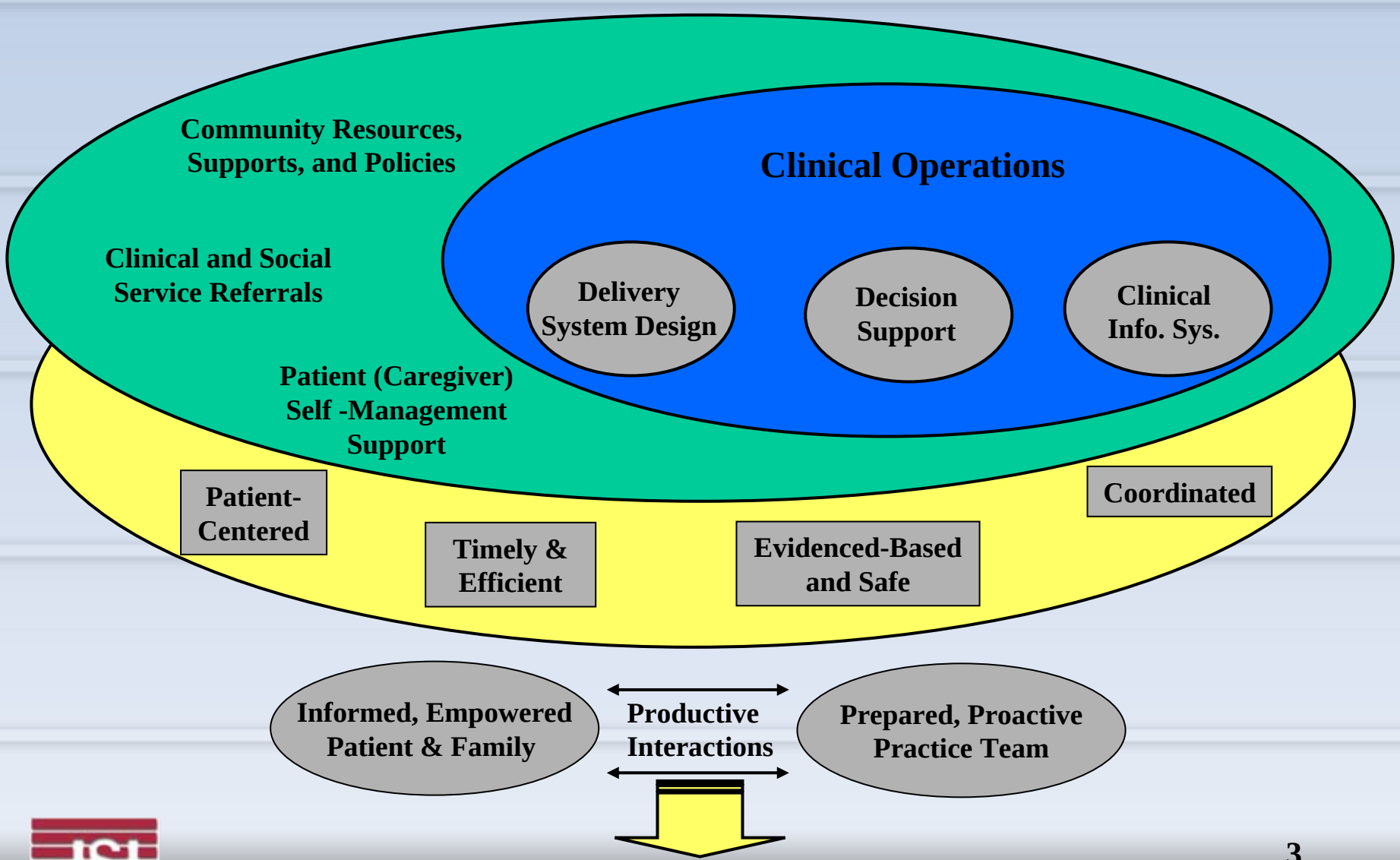
Medical Home

(Adapted from AAFP and IOM Definition)

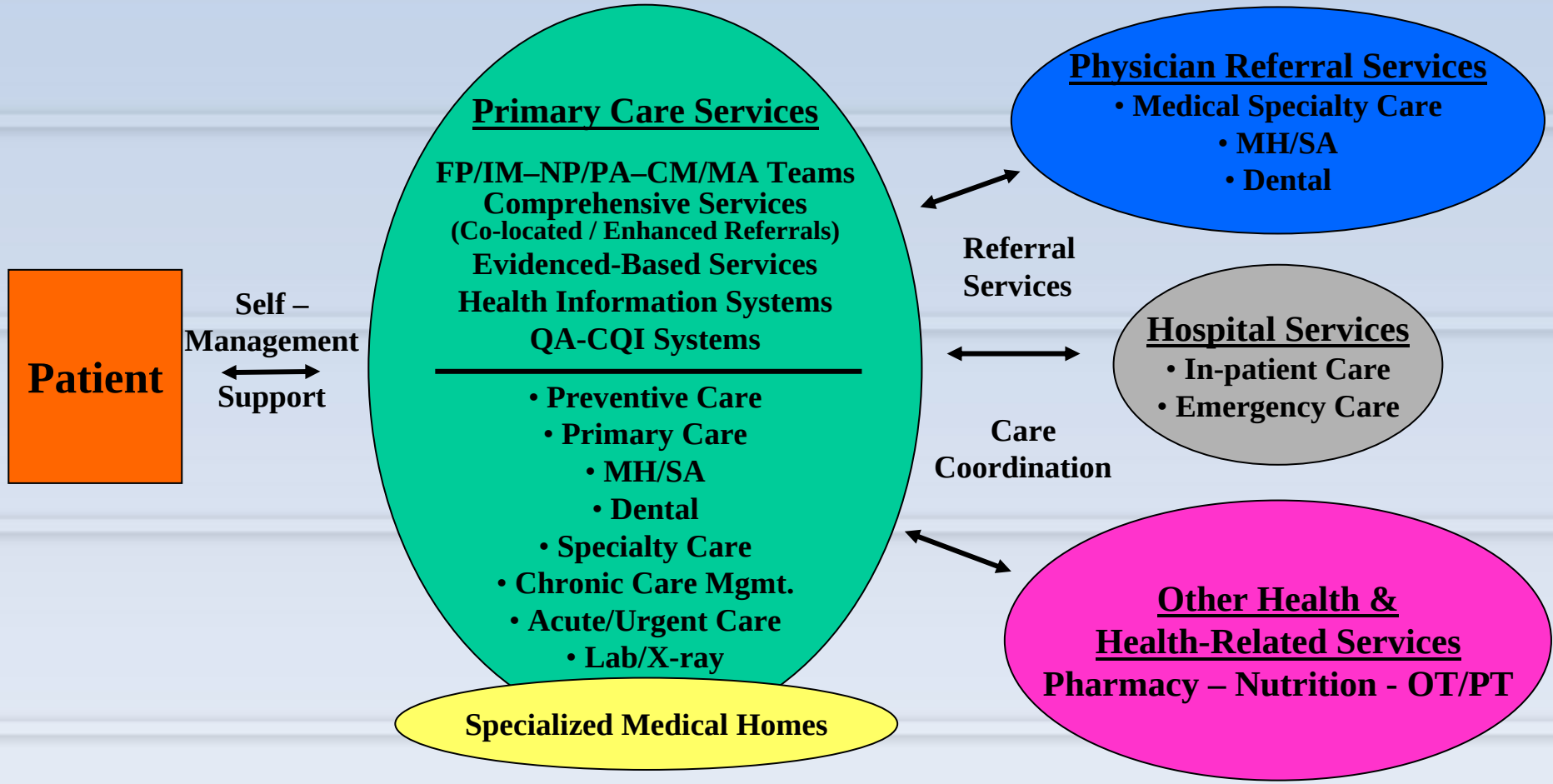
"The Medical Home provides an **easy-to-use** point of entry into the health care system, **coordinates** ongoing, **comprehensive medical care** that is appropriate and consistent with the **patient's needs and values**, and places the patient at the center of all choices concerning their care.

The Medical Home's structure supports the patient establishing and maintaining **long-term relationships** within the medical team *and* ***other community-based resources*** while utilizing **health information technology** and other innovations to provide **seamless and timely access** to **all essential care**."

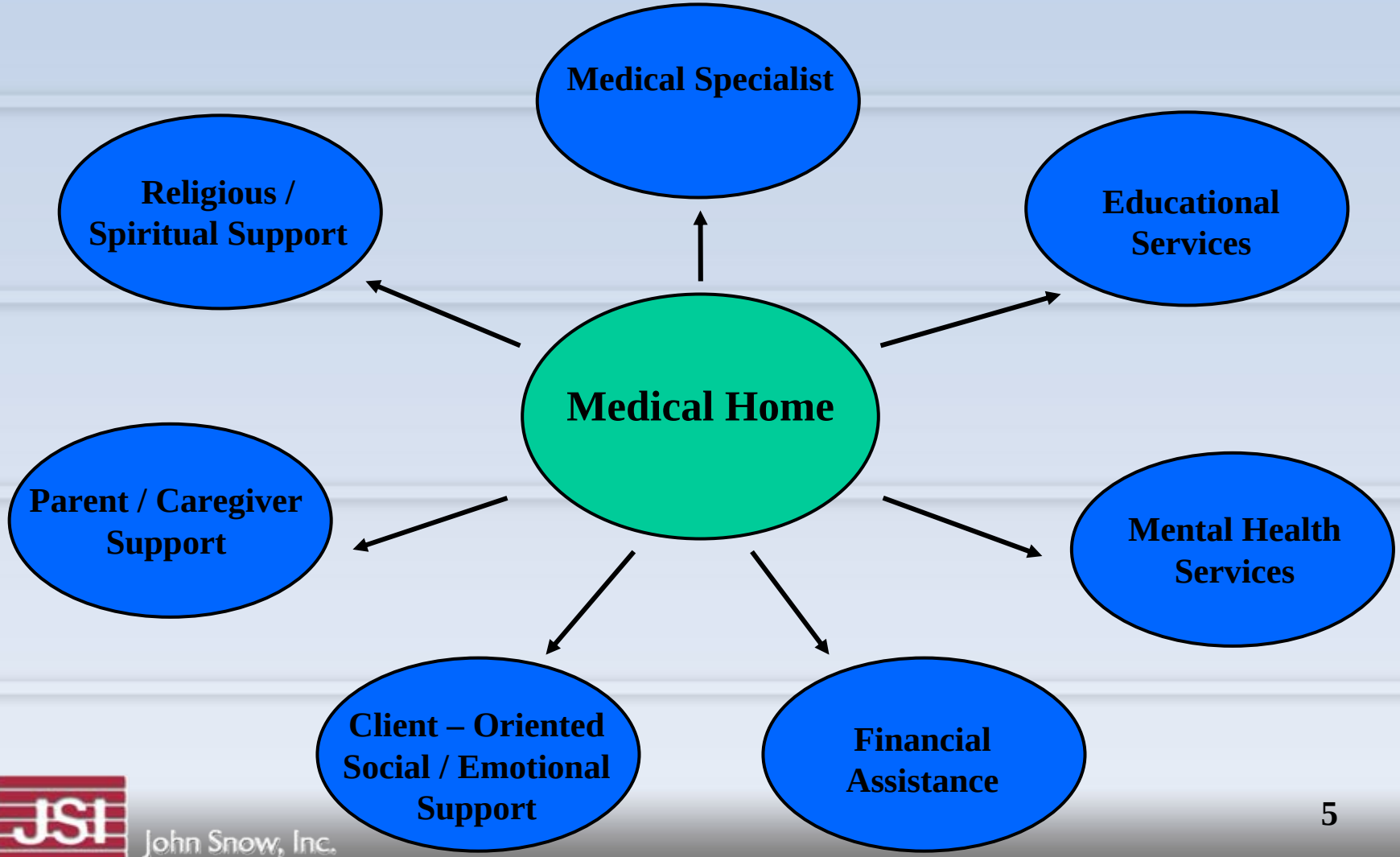
Medical Home Model



Chronic Care Model



Medical Home Model



Rating on "Medical Homeness"

Level 1 Level 2 Level 3 Level 4

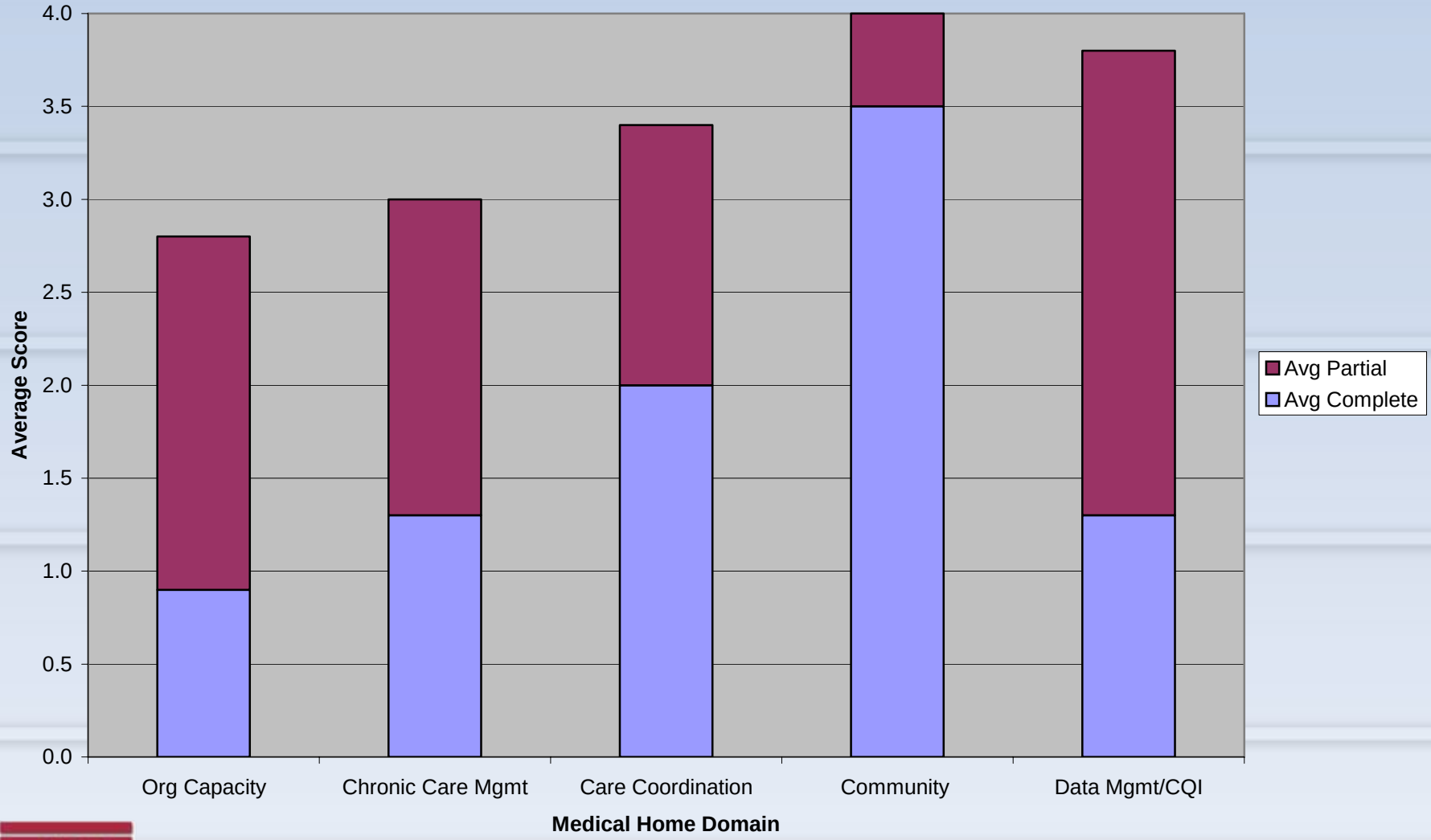
Increasing integration of Medical Home aspects into practice strategies, practices, and policies

Increasing coordination with patients/caregivers

Proactive versus reactive to medical/emotional/social needs

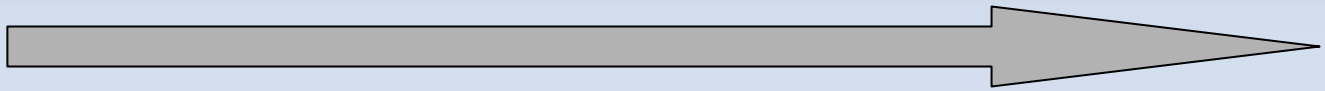
Strengthening linkages with outside medical and social providers

Potomac Street Health Center
Medical Home Assessment - Average Scores



Strong Chronic Care Management

Level D	Level C	Level B	Level A
(0-2)	(3-5)	(6-8)	(9-11)



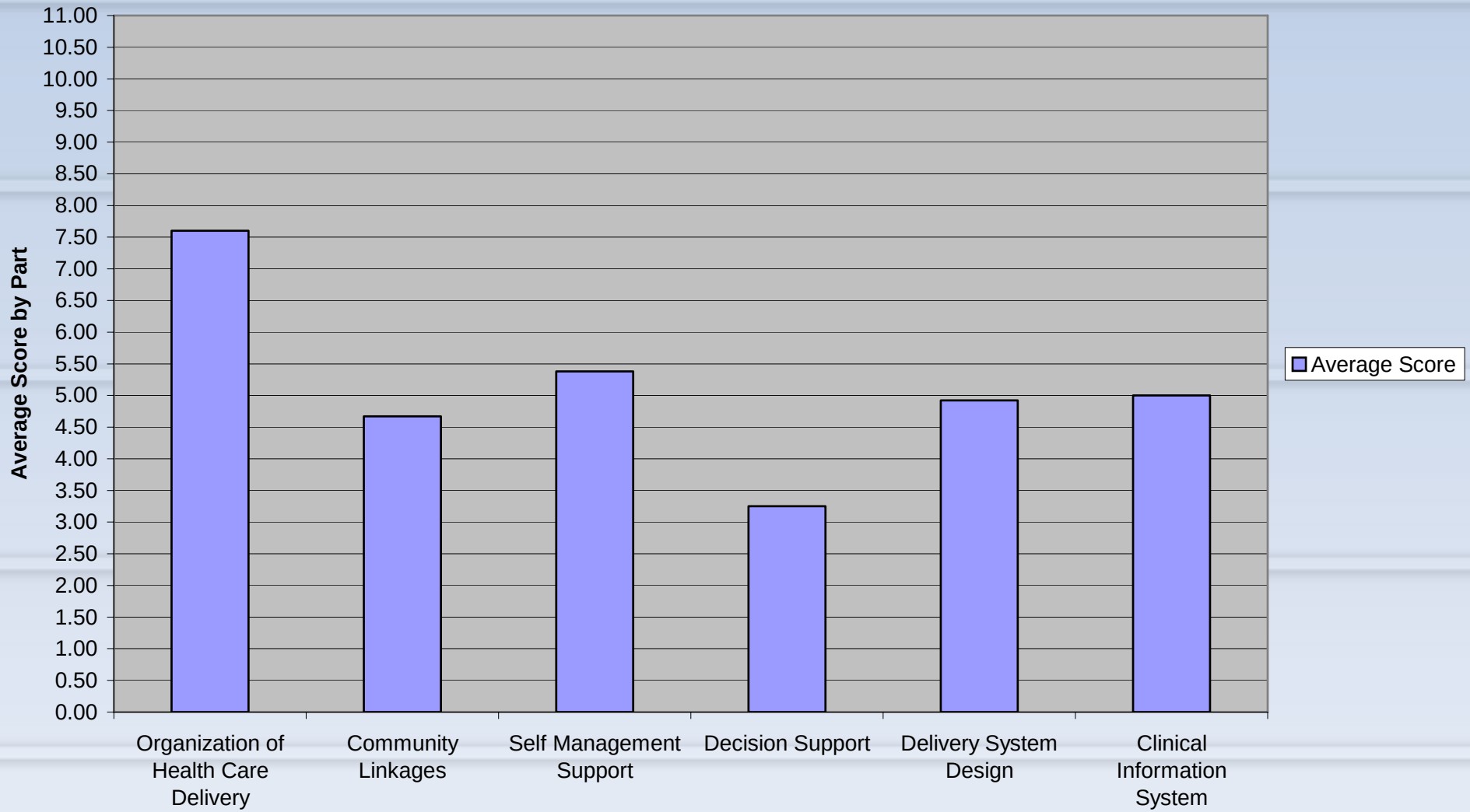
Increasing integration of care management into practice processes

Increasing organizational support

Increasing involvement of patient/caregiver into care, including self management

Increasing use of Continuous Quality Improvement activities, including patient/caregiver feedback

Potomac Street Health Center
Chronic Care Assessment- Average Score by Area



Medical Home and Chronic Care Model Domains

- Organizational / Clinical Capacity
- Clinical Operations / Systems
- Self Management Support
- Community Resources and Policies

Organizational/Clinical Capacity

Organizational/Clinical Capacity

- Written, visible **mission** that reflects commitment to MH/CC
- MH/CC **advisory group** (Clinical/Admin staff, patients, collaborators)
- Well equipped **facility tailored to target population**
- Comprehensive, **accessible services** (on-site or enhanced-referral)
- Flexible, **patient-centered scheduling systems** that facilitate access
- **Quality assurance and continuous quality improvement**
- Enhanced **information and communication systems**
- Patient access to **clinical reports** and full medical record
- **"Culturally" sensitive staff**
- On-going **medical education and training** on guidelines and research
- **Reimbursement/provider incentive structures** that promote MH/CC

PSHC Organizational Capacity

- What's in place
  - Mission and senior leadership support MH/CC efforts
  - Good individual communication with patients
  - Medical chart upon request
  - Accessible facility
  - CME for physicians
  - Culturally competent
  - Reimbursement neutral; improvement plans in motion

Clinical Operations / Systems

Clinical Operations / Systems

- Comprehensive **in-take process**
- Detailed, on-going **care planning / management**
- Multi-disciplinary **clinical teams**
- **Evidenced-based, guideline-driven care**
- Enhanced **coordination of specialty/non-PC service**
- Comprehensive **information/communication systems** that facilitate care continuity, coordination, management, and planning
- **Quality assurance and continuous qualify improvement**
- **Reimbursement/provider incentive structures** that promote MH/CC
- Clinical operations that put the **patient at the center** of care
- Coordination/integration of **community resources and advocacy**

PSHC Clinical Operations

- **What's in place**
  - PCP informally identifies PEHCN
  - Visits occur as result of acute problems or well visit schedule
  - PCP communication with specialists as needed
  - Patient/caregiver initiate communication between PCP and specialist
  - Patient/caregiver coordinate care and carry out PCP medical recommendations, PCP engages in care supports as needed

PSHC Clinical Operations

- **What's in place (Continued)**
  - Assess individual patient needs and define follow up tasks
  - Provide resource information to patients as needed; hiring social worker to resolve resource needs
  - Electronic medical record
  - Diabetic registry tied to reminder flags
  - Goals for selected chronic conditions (e.g., diabetes, asthma) at MCPN level

Community Linkages/Collaborations

Community Linkages and Collaborations

- Participation in community **needs assessment**
- Proactive community **outreach, education, and awareness activities**
- Community **involvement / advocacy**
- Systematic **collaboration with key community service organizations**
- **Resource coordinator** facilitates access to community services
- Proactive **partnerships with health plans** to identify high need patients and coordinate care

PSHC Community Linkages and Collaboration

- **What's in place**
  - Community needs assessment results integrated into practice policies and practices
  - Providers and staff sponsor activities to raise community awareness, primarily for older adults
  - Linkages to community based organizations
  - Partnerships developing with health plans

Self-Management Support

Self-Management Support

- Self-management support is **fully integrated into clinical operations**
- Systematic **care planning** that includes the development and regular assessment of **self-management** needs, activities, and goals
- Trained educators/counselors provide **"motivational interviewing" that promotes self-management**
- Patients are encouraged to participate in **peer support, mentoring programs**, and other support groups

PSHC Self Management

- **What's in place**
  - Patients with selected conditions referred to self management support internal to MCPN or outside
  - Concerns of patients/caregivers addressed as requested

PSHC Overall Assessment

- **What's in place**
  - PSHC and staff know their patients and work very hard to provide the best care to meet the individual patients' needs
  - Chronic care management is provided for selected conditions

Initial Process Evaluation
of the
Potomac Street Health Center (PSHC)
Internal Operations

May 27 and 28, 2008

Process Questions

1. How are both the responsible provider (billing provider) and PCP currently assigned for new patients?
   - Responsible provider should match PCP, both for physicians and midlevel providers. MAs are currently switching any responsible provider that they see that does not match the PCP.
   - Assignment is determined by patient preference. There are no provider bios, so front desk staff will give a verbal description of each provider to patient.
   - Patients are assigned a doctor, but see other providers depending on medical needs, visit, and availability.
   - All assignments are documented in EHR

2. What is the process if an existing patient wants to switch PCP?
   - Patient requests the switch. A conversation with the doctor takes place to see what the issues are and once the OK is given the patient's chart information is changed to reflect the switch.
   - Information in EHR is easily changed. The new PCP name is posted on the first page of the Scheduling Module of Centricity.
   - On some visits the patient may ask to see a specific provider, but request is only for that visit. PCP assignment does not change.

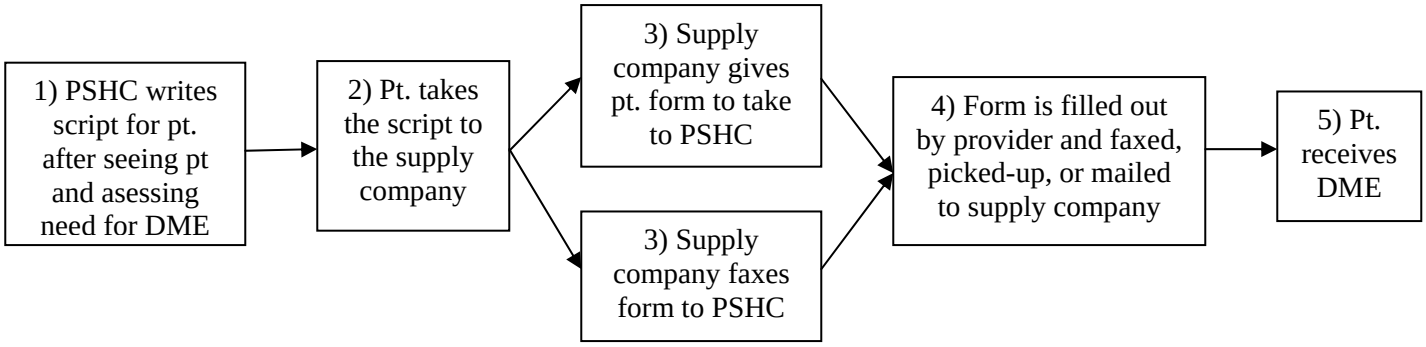
3. What happens if there is a dangerous or extremely irate individual?
   - Dr. Wolf is paged by the staff.

4. What happens if a patient faints or collapses?
   - Every staff member and Corinne carries a walkie-talkie which they use to communicate amongst themselves. When there is a Stat or Code call, it is done via walkie-talkie. The staff will come to the scene and determine if a provider needs to be called. If so, the first physician available will be summoned. The MD determines if the patient needs to go to the ER or can be treated at PSHC.
   - Protocol states that staff in each area are assigned to get specific medical equipment.
   - Corinne is updating the protocol and will review it with staff and providers as well as conduct a mock code blue.

5. What is the process to give a patient results over the phone?
   - For an MA to give results to a patient, these need to be within the normal range and signed by a provider.

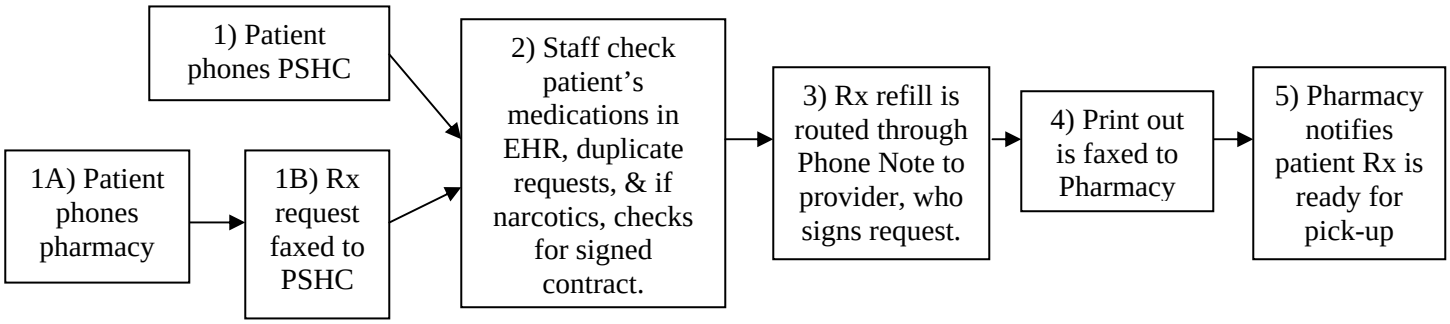
6. What is the process to fill out a form for the patient?
   - Every exam room has a file with all type of forms in it. Also, patient might bring their own form for the provider to fill out.
   - MA or provider requests patient to fill out their section, and states to pt. that it will take a few days for the form to be signed by the provider.
   - When the form is signed, the patient is called to pick it up. If preferred it can be mailed or faxed to patient or appropriate agency.

Process to order Durable Medical Equipment (DME)



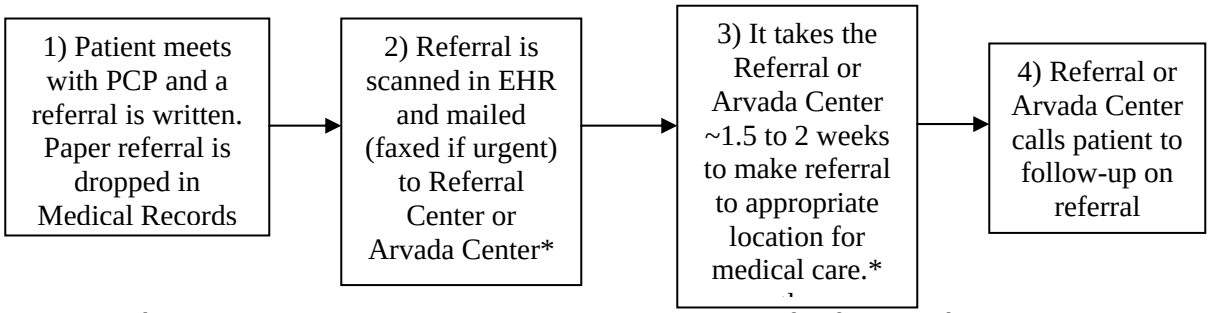
Note: In some cases, DME needs prior authorization through the patient's medical carrier, which makes the process longer.

Faxed or Called Prescription Refills



- Refilling a prescription usually takes 24 hours, while a narcotic usually takes between 48-72 hrs, depending on the urgency. Narcotic prescriptions are picked up at PSHC and signed for in narcotics log folder. Identification is required for a non-patient who is picking up a prescription, and person has to be authorized to do so on the pt.'s HIPAA form.
- Prior authorization is required for some insurance carriers (i.e. Medicaid). Obtaining prior authorization can take up to 72 hrs.
- The entire process is documented on a Phone Note.

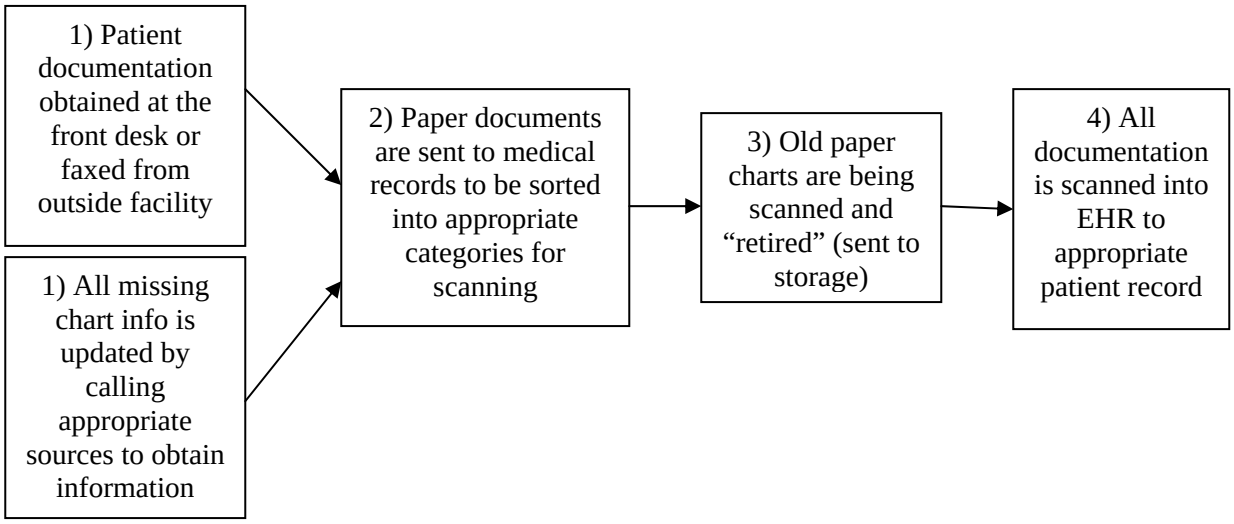
Referrals



- Referrals are documented in Doctors Documentation for future reference.
- * Arvada Center is for referrals related to a grant or MCPN specialty clinics.

*Letter is mailed to patient to schedule an appt with the specialist. For an urgent referral the call center will call pt and help pt schedule an appt. The Call Center will then call specialist to see if appt was scheduled and kept.

Medical Records



- EHR went live at PSHC in July 2007. Since then, patient charts are being scanned into EHR. Due to staff turnover and being understaffed, there are still quite a few patient charts that are in paper form.
- MA in Med Records will check providers' schedules the night prior and make sure that all patients that are coming to the clinic will have their chart in the EHR. This doesn't always happen.
- Med Records training includes a training guide. However, training is conducted mainly through hands-on experience and by asking questions to more knowledgeable staff.
- The front desk is responsible for scanning financial and admissions documents. The medical record room scans all other documents.

Training

Medical Assistants (MAs) participate of a MCPN one week long training that can either be on or off site depending on number of new MAs and location. New MAs rotate through each station (front desk, rooming patients and medical records) every month. Staff that is more senior (3 months or more) rotate through each station every week. New MAs shadow other more experienced staff. There is no formalized check off mechanism for new staff, however if they have questions or one of the other staff or Corinne notices they are doing something wrong, they will help the new staff person correct it. PSHC training is tailored to the specific needs of the clinic, while the general MCPN one sometimes does not correspond with processes at PSHC.

Triaging Calls

If patient calls stating they have life threatening pain or potential loss of a limb (i.e. Chest pain, shortness of breath, etc.), they are told to go to the emergency room or call 911. If pain is not life threatening, MA will try to bring patient in that day, if no available appointment, MA will consult with PCP or Corinne to see what to do. This may result in double booking for the provider.

Scheduling and Triage

While shadowing each staff member at the front desk the following was documented.

1) What type of information was gathered during the call?
- First and last name of patient, D.O.B., and last four digits of the patient's Social Security number.

2) What were the reasons for the calls?
- M.I.R. results. Staff stated results were not in and that they would check with University Hospital. Staff also stated that if anything abnormal, University Hospital would notify them. Once the results came in, the staff member said they would call the patient back.
- Patients called to make new appointments. After the staff member checked for date and time availabilities, an appointment was set up and date and time was given to the patient.
- Patients called for directions.
- Prescription refills.

3) Were any calls transferred?
- During the shadowing of the staff, no calls were transferred. However, patients were put on hold in order to solicit assistance from office manager.

4) Where was the phone call documented?
- Most calls were not documented on the spot due to high volume of work. Although staff members stated phone calls were documented in Phone Note.
- New appointments were documented in the Scheduling Module of Centricity.

5) Was the note forwarded and to whom?
- The note was forwarded to the appropriate staff member or provider.

Intake Process

1) What questions are asked when patient checks-in?
- Patients are asked if they have an appointment today and if they do, they are given a check-in slip to fill out that has demographic information and copay payment type.

2) What happens if the patient is new to PSHC?
- New patients fill out an admissions packet of varying information, about 12 pages long.

3) How are new patients determined?
- Typically, staff or a provider can tell when a patient is new, if there isn't anything in their EHR, since Med Records will load problem list, allergies, immunizations, etc. in their chart prior to the visit. New patients are mostly referred by other physicians or facilities in the Aurora City area if not age or illness appropriate.

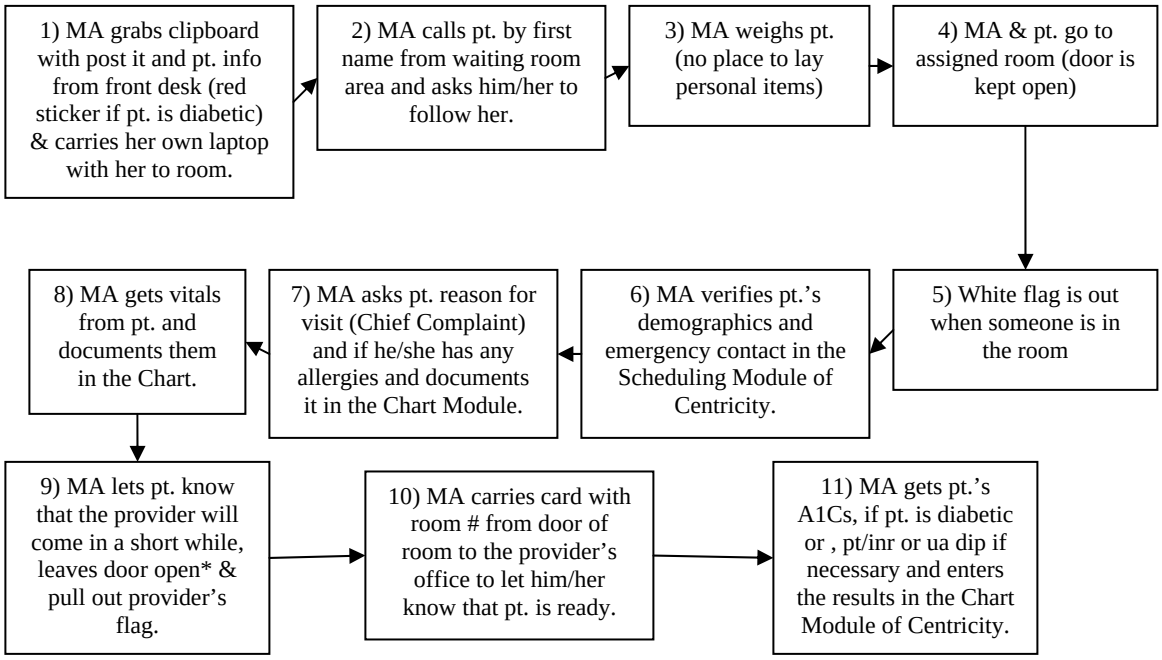
4) What information appears on the screen when patient's EHR is opened?
- Information displayed depends on the tab opened in the record; demographic information, history, medication, etc.

5) What information is documented?
- The information the patient writes in the check-in slip is verified with the EHR and with the eligibility system for insurance status (i.e. Medicaid). Patient's information is also checked by the MA while the patient is in the room.

6) Are any behavioral or emotional questions asked?
- Staff did not ask any of these questions, and stated that these questions are not usually asked by them. However, some mental health disorders (i.e. depression, dementia, etc.) are treated in the clinic by providers. There is no tool used to assess mental health disorders, but evaluations are done when specifically requested. Also, there is a visiting psychiatrist, Dr. Markey, once a month.

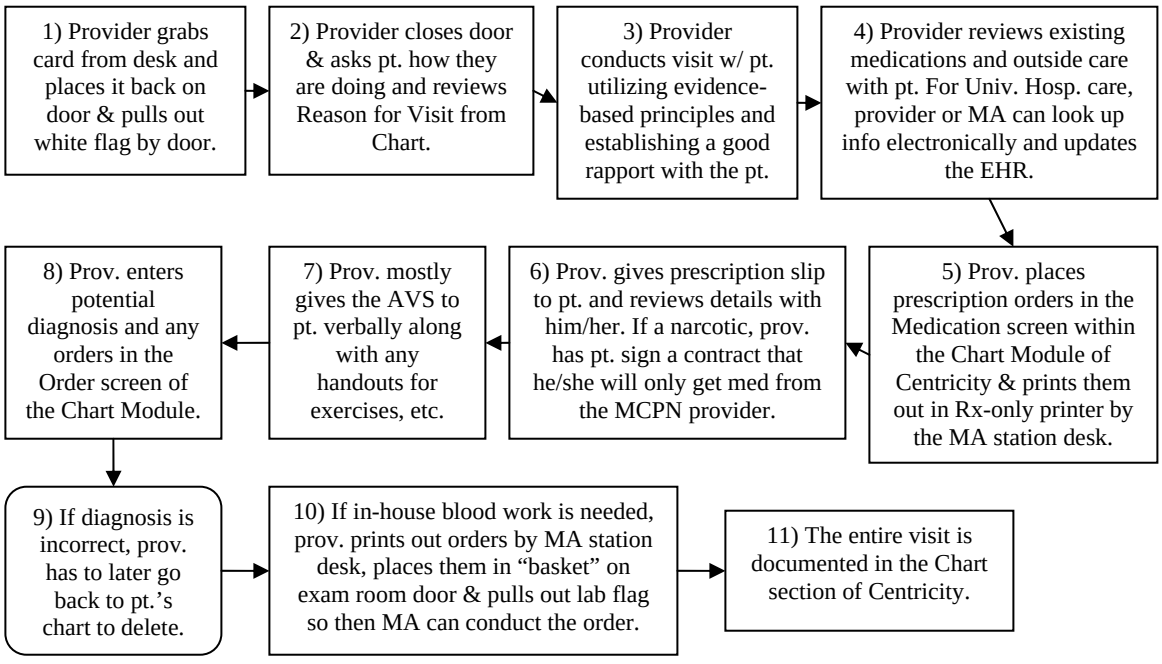
Note: We do not use SS# because many of our patients do not have SS#s

Patient Rooming



*MA is supposed to ask patient if it's ok to leave door open, though this was not witnessed on this day.

Patient Visit



Back Office Process Notes

- MAs are expected to check their e-mail & EMR desktops first thing in the morning and before leaving. They also check it between patients when they have time.
- Patient's chart is reviewed the day prior to make sure there is an up to date HIPAA form and all admission packet pages are complete.
- Blood and urine samples are taken in house. Hemoglobin A1Cs, urine dips, PT/INR (used to assess both bleeding and clotting tendencies) and glucose are measured in house, the other labs are sent to LabCorp. Lab results are shared with patients if significant abnormalities are found. For DD patients lab results are sent to the agency (i.e. Developmental Pathways, Good Sheperd, etc.)
- Results from specialists are faxed to PSHC, except for University Hospital care, which is loaded to MedXplore.
- High volume of prescription refills.
- There is currently team building activities, other than potlucks for birthdays or special occassions. There are 2 hour staff meetings once a month which includes any regional training.
- Appointment lengths:
    - New patients, physicals, consultations and certain patients – 40 minute appts.
    - Routine and follow-up appts. – 20 minutes
- Computers sometimes are slow and freeze up. If computer goes down, paper is used.
- Smoking cessation and family history are documented by the provider.

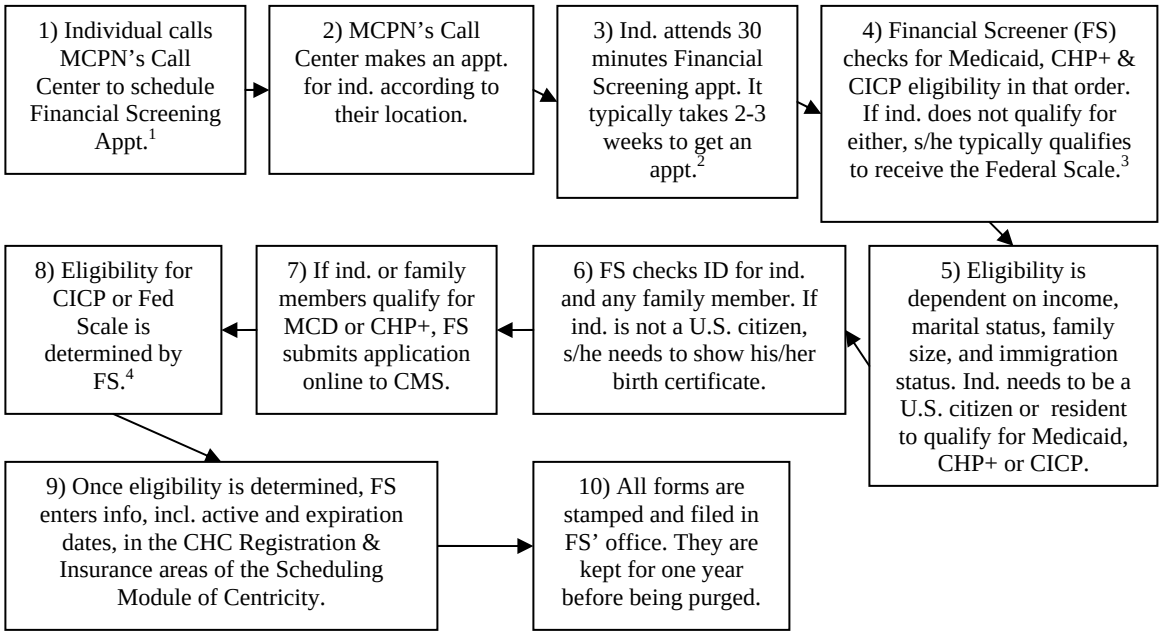
IDEAS

- Incorporate a light system to communicate rooming status and needs. Since the building is owned by the hospital it might be difficult to get approval for wiring, etc. Cost is also an issue. Flag system was recently added. Room cards have been used for a long time.
- Have a universal form for all referrals independent of hospital or insurance company.
- Send a letter to patients letting them know their labs are normal. Felipe is willing to pilot this for a week or so with one of the MAs to see if feasible and worthwhile. Need to figure out applicable measures.
- Enter AVS in the Instructions section of the Chart and print them out to give to patients.
- Cultural Competence training for all staff and providers, including care coordinator and financial screener.
- Schedule follow-up visits for all patients that received an MRI.
- Have MAs document smoking history. MAs used to do this in paper system, not in EHR.

Some Issues Identified by Core Team

- There is not an area next to Allergies to enter the reaction to it. It all needs to be documented within the same box. Currently provider is doing this at times, MAs do not document reaction.
- Two people cannot access a patient's chart at once so if the provider is in with the patient and the MA just got the Hemoglobin A1C results, she cannot enter them in the patient's EMR because the provider is using it. However, the provider needs to know the results to discuss with patient.
- Not all providers are updating diagnosis and medications, especially not psych meds.
- Various filing systems throughout the office. Lots of paper.
- Temperature is controlled centrally by the hospital, so sometimes rooms get very warm. Someone needs to call the hospital to alert them of the temperature problem.
- IT help is very slow.
- Every insurance company has a different formulary, which makes it very hard for the providers to know what prescriptions to order for their patients.
- Prescription requests and lab results come in one at a time even if they are for the same pt.

Financial Screening Process



[1]It's the patient's responsibility to remember to renew their coverage.
[2]Typically, the 8th of each month the schedule for the next month is released.
[3]If individual does not qualify for the Federal Scale, FS gives him/her a list of available resources in the community.
[4]CICP covers ER visits for true emergencies; however the Federal Scale only covers routing and prenatal care plus delivery.

COLORADO MEDICAL HOME STANDARDS

GUIDING PRINCIPLES AND ASSURANCES

A MEDICAL HOME IS A CONCEPT OF QUALITY HEALTH CARE.

5 GUIDING PRINCIPLES

1. THE STANDARDS ARE A FRAMEWORK FOR CONTINUOUS QUALITY IMPROVEMENT.
2. THE STANDARDS ARE MEANT TO DESCRIBE COLORADO'S GOALS FOR QUALITY HEALTH CARE FOR ALL CHILDREN, THEY ARE NOT MEANT TO BE PUNITIVE OR PRESCRIPTIVE.
3. THE STANDARDS, BASED ON THE NATIONAL COMPONENTS OF A MEDICAL HOME, WERE DEVELOPED IN COLLABORATION WITH MULTIPLE COLORADO STAKEHOLDERS, INCLUDING: PHYSICAL AND BEHAVIORAL HEALTH CARE PROVIDERS & PHYSICIANS, FAMILY MEMBERS, COMMUNITY ADVOCATES AND EVALUATORS, AND ARE ALIGNED WITH ESTABLISHED NATIONAL STANDARDS.
4. THE STANDARDS ARE A WAY TO ACKNOWLEDGE GOOD PRACTICE WHILE PROVIDING A SHARED VISION AND COMMON LANGUAGE FOR A QUALITY SYSTEM OF CARE FOR ALL CHILDREN IN COLORADO.
5. THE STANDARDS PROVIDE A MEANS FOR EVALUATION TO ESTABLISH STATE, PAYER, FAMILY, AND PRACTICE ACCOUNTABILITY.

5 ASSURANCES

1. THE COLORADO MEDICAL HOME INITIATIVE WILL CONTINUE TO PROVIDE A PLATFORM WHEREBY STAKEHOLDERS' INPUT IS ENCOURAGED, VALUED AND INCORPORATED.
2. PROVIDERS WHO CHOOSE TO BE ACKNOWLEDGED AS PROVIDING A MEDICAL HOME APPROACH WILL BE OFFERED RESOURCES AND SUPPORT.
3. THE TERM 'PROVIDER' IS INTENDED TO BE INCLUSIVE OF BEHAVIORAL, ORAL AND PHYSICAL HEALTH CARE PROVIDERS AND SPECIALISTS.
4. DEVELOPMENT AND REFINEMENT OF THESE STANDARDS IS ONLY THE *FIRST* STEP IN THE PROCESS OF IMPLEMENTATION.
5. MEDICAID PROVIDERS CAN CHOOSE TO BE ACKNOWLEDGED AS MEDICAL HOME PROVIDERS ON A VOLUNTARY BASIS.

The standards, guiding principles and assurances were developed in a joint effort by the Colorado Department of Public Health and Environment and the Colorado Department of Health Care Policy and Financing.

For more information, please contact:

Eileen Forlenza, Director
Colorado Medical Home Initiative
Children and Youth with Special Health Care Needs Unit
eileen.forlenza@state.co.us
303-692-2794

Gina Robinson
Office of Client & Community Relations
Colorado Department of Health Care Policy and Financing
gina.robinson@state.co.us
303-866-6167

Colorado Department of Public Health and Environment

Colorado Department of Health Care Policy and Financing

COLORADO MEDICAL HOME STANDARDS

STANDARDS

Standard	Statutory Link*	Zoomerang Survey Response
1. Provides 24 hour 7 day access to a provider or trained triage service.	**Accessible Family Centered Comprehensive Culturally Competent Compassionate Coordinated Continuous Community based**	**89% of respondents agreed with this standard.**
2. Child/family has a personal provider or team familiar with their child's health history.	**Accessible Family Centered Culturally Competent Coordinated Continuous**	**96% of respondents agreed with this standard.**
3. Appointments are based on condition (acute, chronic, well or diagnostic) and provider can accommodate same day scheduling when needed.	**Accessible Family Centered Compassionate**	**96% of respondents agreed with this standard.**
4. A system is in place for children and families to obtain information and referrals about insurance, community resources, non-medical services, education and transition to adult providers.	**Family Centered Comprehensive Culturally Competent Compassionate Coordinated Continuous Community based**	**95% of respondents agreed with this standard.**
5. Provider and office staff communicates in a way that is family centered and encourages the family to be a partner in health care decision making.	**Accessible Family Centered Culturally Competent Compassionate**	**94% of respondents agreed with this standard.**
6. Provider and office staff demonstrate cultural competency.	**Accessible Family Centered Culturally Competent Compassionate Community based**	**89% of respondents agreed with this standard.**
7. The designated Medical Home takes the primary responsibility for care coordination.	**Family Centered Comprehensive Coordinated Continuous**	**92% of respondents agreed with this standard.**

COLORADO MEDICAL HOME STANDARDS

STANDARDS

Standard	Statutory Link*	Zoomerang Survey Response
8. Age appropriate preventive care and screening are provided or coordinated by the provider on a timely basis.	**Accessible Comprehensive Coordinated Continuous Community based**	**94% of respondents agreed with this standard.**
9. The designated Medical Home adopts and implements evidence-based diagnosis and treatment guidelines.	**Comprehensive Coordinated Continuous Community based**	**92% of respondents agreed with this standard.**
10. The child's medical records are up to date and comprehensive, and upon the family's authorization, records may be shared with other providers or agencies.	**Accessible Family Centered Comprehensive Coordinated Continuous Community based**	**96% of respondents agreed with this standard.**
11. The Medical Home has a continuous quality improvement plan that references Medical Home standards and elements.	**Accessible Family Centered Comprehensive Culturally Competent Compassionate Coordinated Continuous Community based**	**Recommended by the Evaluation Taskforce**

* Recommendations were developed based on the original medical home model as described by Carl Cooley, MD as well as the statutory language found in C.R.S. 25.5-1-103. Colorado Revised Statute requires that a medical home to "verifiably ensures continuous, accessible, and comprehensive access to and coordination of community based medical care, oral health care and related services for a child…All medical homes shall ensure the following: health maintenance and preventive care; anticipatory guidance and health education; acute and chronic illness care; coordination of medications, specialists, and therapies; provider participation in hospital care; and twenty-four hour telephone care."

COLORADO MEDICAL HOME STANDARDS

MEDICAL HOME STANDARDS BY DOMAIN

Standard	Domain							
	Accessible	**Family Centered**	**Comprehensive**	**Culturally Competent**	**Compassionate**	**Coordinated**	**Continuous**	**Community Based**
1. 24 hour 7 day access to a provider or trained triage service.	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
2. Child/family has a personal provider or team familiar with their child's health history.	**X**	**X**		**X**		**X**	**X**	
3. Appointments are based on condition (acute, chronic, well or diagnostic) and provider can accommodate same day scheduling when needed.	**X**	**X**			**X**			
4. A system is in place for families to obtain information and referrals about insurance, community resources, non medical services, education and transition to adult providers.		**X**	**X**	**X**	**X**	**X**	**X**	**X**
5. Provider and office staff communicates in a way that is family centered and encourages the family to be a partner in health care decision making.		**X**		**X**	**X**			
6. Provider and office staff demonstrate cultural competency	**X**	**X**		**X**	**X**			**X**
7. The Medical Home takes the primary responsibility for care coordination.		**X**	**X**			**X**	**X**	
8. Age appropriate preventive care and screening are provided or coordinated by the provider on a timely basis.			**X**			**X**	**X**	**X**
9. The designated Medical Home adopts and implements evidence-based diagnosis and treatment guidelines.			**X**			**X**		
10. The child's medical records are up to date and comprehensive, and upon the family's authorization, records may be shared with other providers or agencies.	**X**	**X**	**X**			**X**	**X**	**X**
11. A Medical Home has a continuous quality improvement plan that references Medical Home standards and elements.	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**