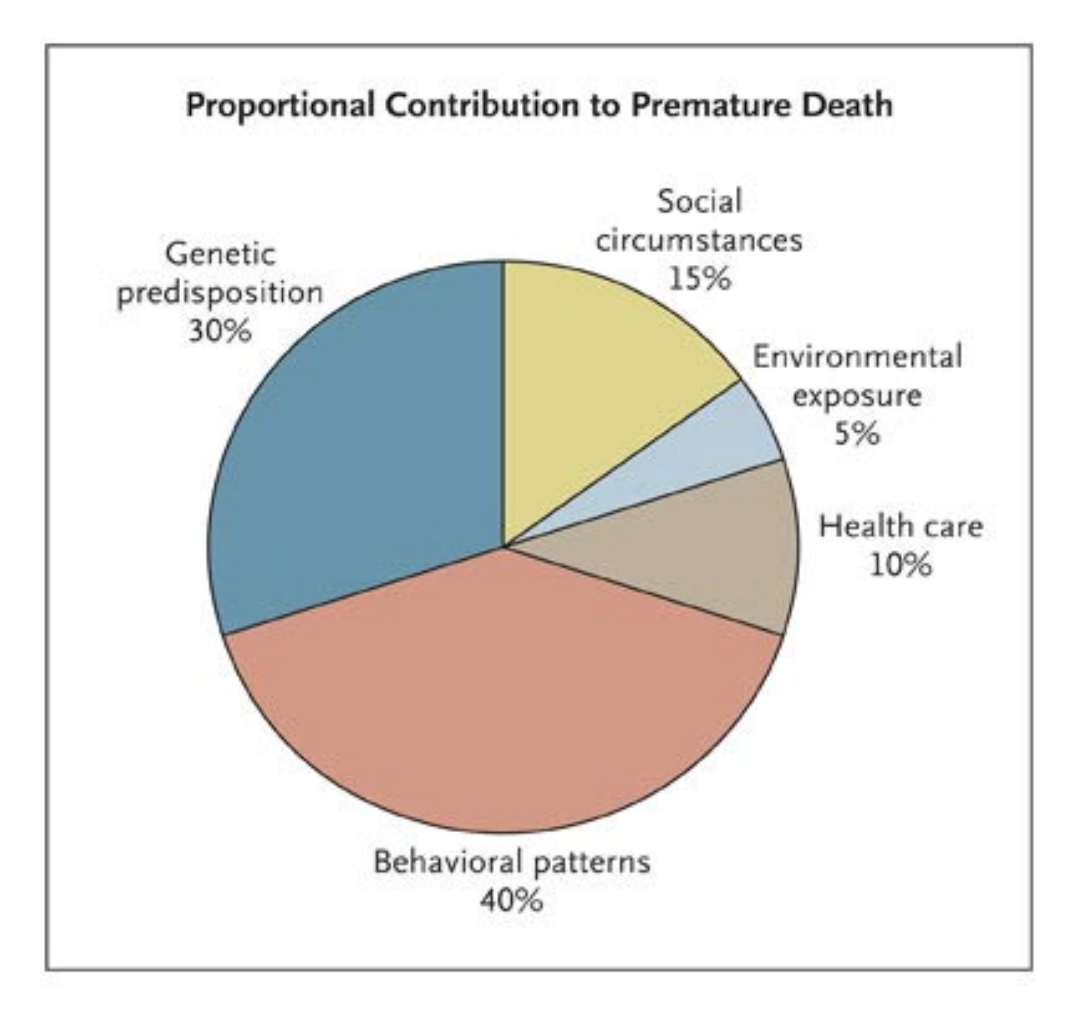
# Patient Centered Medical Home

# The Road To

# MDH Health Care Home Certification


"The WIZARD of OZ"

## Determinants of Health and Their Contribution to Premature Death.




Schroeder SA. N Engl J Med 2007;357:1221-1228.

The NEW ENGLAND JOURNAL of MEDICINE

**Practical Wisdoms As You Embark On This Project**

1."A dream you dream alone is only a dream.
A dream you dream together is a reality."

John Lennon

2. "None of us is as smart as all of us."

Japanese proverb

3."Plan the work, Work the plan.”

4. "The people that do the work need to transform the work."

# Objectives of the Health Care Home

- Better patient satisfaction
- Better staff satisfaction (all working to make a difference)
- Better utilization of staff and resources
- Improved patient health outcomes (quality)
- Lower cost of delivering care (clinic and patient)
- More equitable, fewer disparities
- Lower utilization rates
- Healthier patient lives

# The Health Care Home Is

- a community-based primary care setting which provides and coordinates high **quality**, **planned**, **patient and family centered health care promotion**, and **acute and chronic condition management**.

# Ideal Care in a Health Care Home

- “The care the patients want and need, when and how they want it..”
- Care for a patient is not only visit based, we care for our patients before, during, after, and between visits
- Responding to patient needs is our most important issue.

# The Journey (to Health Care) Home

- Objectives – why we left “Kansas”
- Key Concepts – Is it really better somewhere else?
- Key Steps to Certification – the “Brains” to make it happen
- Health Care Home Team – the “Heart” of the process
- Implementation Steps – the road to get there
- Example Revenue Analysis – rewards at the end
- Successes – “There’s no place like (health care) home!”
- Challenges – the “Courage” to go on
- Lessons Learned – Would we take the journey again?

# Objectives

- Define why and how to develop and successfully implement a health care home in a community clinic environment.
- Leverage previous process improvement initiatives to enhance and expedite certification as a Health Care Home.
- Achieve at least a cost neutral position to provide health care home services.
- Increase the level of service we provide to our patients to improve their overall health.

# Key Concepts

- A health care home is not a place, but more of a philosophy of coordinated, forward thinking (pay me some now, or pay me more later) health care based on a team approach to overall care management. Care coordination is a function, not a person.
- The health care home is a primary care setting focused on high quality, accessibility, and planned patient and family centered health partnerships.
- Replace episodic care based on illnesses and patient complaints with continuous coordinated care for acute and preventive services, chronic condition management, pre-visit planning, medication management, and a long term holistic care approach.
- Those who do the work must transform the work. Right person – right job.
- Patients need to agree to participate and to be active participants in maintaining good health.

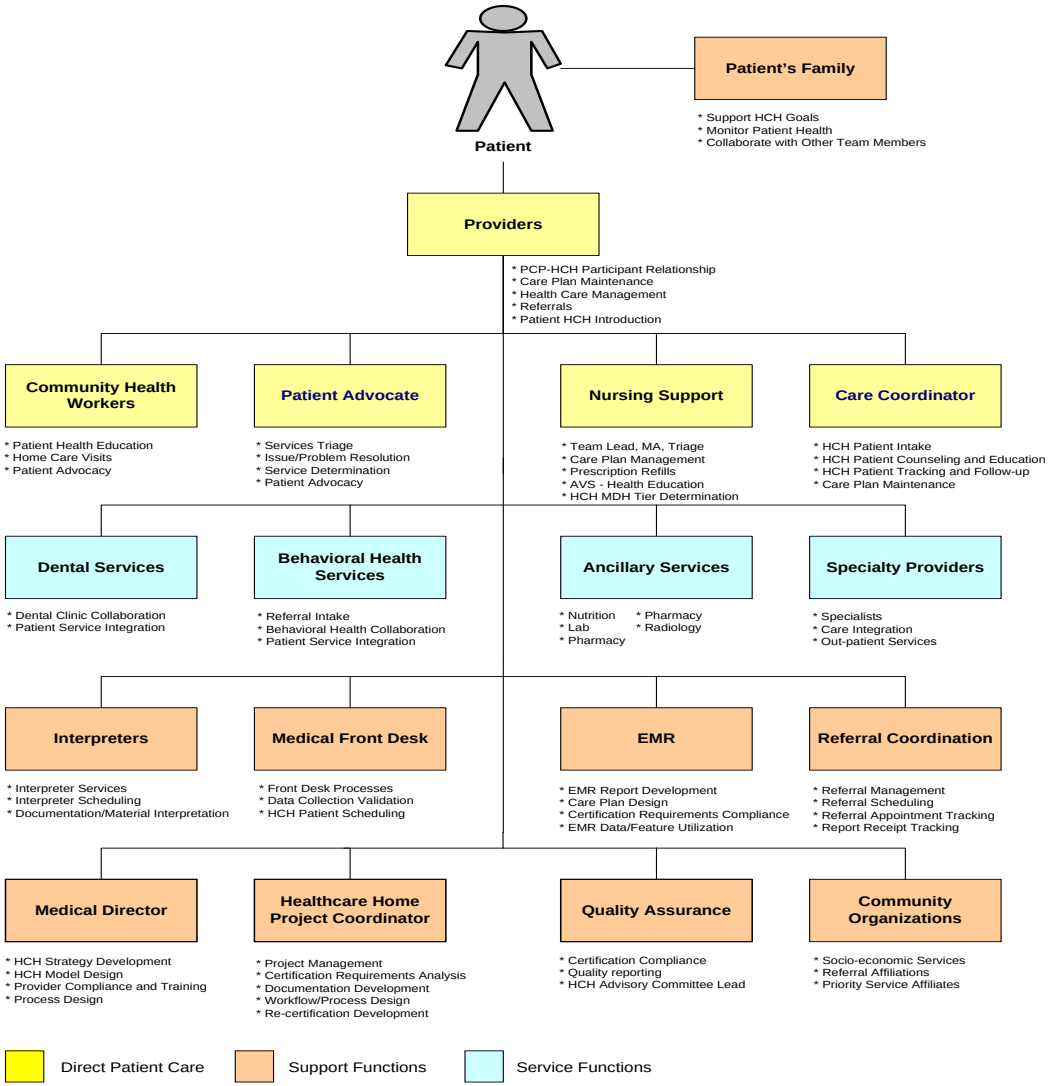
# Key Steps to Certification:

- Create a Health Care Home Development Plan and team charged with attaining MDH certification. That team keeps the process alive with post-certification PDSA activities.
- Review the MDH Health Care Home certification criteria and requirements.
- Conduct a gap analysis to determine if the organization does/can meet the individual and collective certification requirements.
- Refine or develop the necessary workflow, process and procedure documentation for each MDH requirement
- Revise job descriptions and responsibilities to include care coordination functions

# Key Steps to Certification

- Review and investigate EMR system functionality that supports HCH data collection, analysis and reporting requirements. Develop EMR system reports to support HCH Tier reporting, clinical data analysis, and the patient registry.
- Review industry direction, guidelines, and strategies to stay in sync with achieving health care home status under any number of certification/designation organizations (i.e. MDH, NCQA, JC, CMS).
- Create a Health Care Home Advisory Committee to provide ongoing direction and feedback, and monitor the process and results.

# NorthPoint Health and Wellness Center
# Health Care Home Team



# Implementation Steps

- Conduct training for all affected staff to introduce the HCH concepts.
- Institutionalize all of the processes, procedures and workflows created or refined during Health Care Home development (and refine as necessary).
- Communicate often to educate staff and patients on their role in the Health Care Home.
- Market the Health Care Home to patients and begin enrollment.
- Apply for MDH HCH certification (Letter of Intent).
- Prepare for and conduct the MDH HCH site visit.

# MDH HCH Certification

- A program that will reimburse primary care clinics that are certified as “health care homes”
- Focus is on chronic conditions
- Payments to the clinics per month for care coordination based on severity

# MDH HCH Payment

- Tier system based on complexity
  - Tier 1: $10.14/month — 1-3 chronic conditions
  - Tier 2: $ 20.27/month — 4-6 chronic conditions
  - Tier 3: $ 40.54/month — 7-9 chronic conditions
  - Tier 4: $ 60.81/month — 10 or more
- 15% increase in the rate if:
  - A primary language other than English
  - A serious and persistent mental illness

# MDH HCH Criteria

- **Access and communication**
- **Registry and tracking participant care**
- **Care coordination**
- **Care Plan**
- **Quality improvement** and **Performance reporting**

- **“Quality C*A*Re Plan”**

# Site Visit Components

- Schedule of Events
  - Opening and Closing Sessions
  - Interviews
  - Review of Records
- Evaluation Team Representatives
  - MDH
  - Provider or Nurse
  - Patient
- Approval Process

# Successes:

- Team work:
  - Have a ‘champion’ who believes in the strategy
  - HCH Development Team (the ‘small team’)
  - All affected staff (the ‘big’ team)
  - HCH Advisory Committee including patient members
  - HCH post-certification team (using PDSA model)
- Communication:
  - Continually sharing the vision and obtaining buy-in
  - Medical and support staff meetings
  - Patient education (brochure, discussions)
  - Patient focus groups
  - Screen saver, queue cards, “potty” posters

# Successes (cont):

- Modeling Industry Best Practices
  - Applying Open Access model (review/refine all clinic processes)
  - Function and role workflows
  - Scheduling; access is key
  - Customer and family orientation

- Quality Activities:
  - Patient Perception Survey
  - Quality Plan and Progress Reporting
  - PDSA Cycles

# Example Revenue Analysis ***

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Tier 1 Participants * | | $10.14 | 440 | $4,461.60 | 880 | $8,923.20 | 2200 | $22,308.00 |
| Tier 2 Participants ** | | $20.27 | 40 | $810.80 | 80 | $1,621.60 | 200 | $4,054.00 |
| Tier 3 Participants ** | | $40.54 | 15 | $608.10 | 30 | $1,216.20 | 75 | $3,040.50 |
| Tier 4 Participants ** | | $60.81 | 5 | $304.05 | 10 | $608.10 | 25 | $1,520.25 |
| | | | | | | | | |
| **Monthly Total** | | | **500** | **$6,184.55** | **1000** | **$12,369.10** | **2500** | **$30,922.75** |
| | | | | | | | | |
| **Add-on Revenue - 15% Per Case** | **Percent of Cases** | **Bonus Payment** | | **Amount** | | | | |
| | | | | | | | | |
| Percent of Non-English Speaking | 20 | 15% | | $185.54 | | $371.07 | | $927.68 |
| Percent with SPMI | 5 | 15% | | $46.38 | | $92.77 | | $231.92 |
| | | | | | | | | |
| **Total Add-on Revenue** | | | | **$231.92** | | **$463.84** | | **$1,159.60** |
| | | | | | | | | |
| **Total Monthly Revenue** | | | | **$6,416.47** | | **$12,832.94** | | **$32,082.35** |
| | | | | | | | | |
| **Total Annual Revenue** | | | | **$76,997.65** | | **$153,995.30** | | **$384,988.24** |
| | | | | | | | | |
| * Tier 1 participants are managed by the MA assigned to the participants primary care provider (no incremental cost) | | | | | | | | |
| | | | | | | | | |
| ** Tier 2-4 participants are managed by the care coordinator (full time position); a care coordinator can manage up to 200 participants | | | | | | | | |
| Cost per care coordinator is figured at $5,000 per month/$60,000 per year including benefits | | | | | | | | |
| | | | | | | | | |
| *** Insured patients/participants; Medicare, Medicaid, health plans | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

# Challenges:

- Obtaining and maintaining senior management support and funding.
- Complacency/resistance of care team members and staff (preventing “slippage” into old habits).
- Having the necessary staff (internal or external) with the applicable time and skills to develop, document, train, and support the HCH.
- Sustaining momentum if things don’t go well, take too long, or not seeing the results expected quickly.
- Changing concepts, rules, and reporting within the health care industry (regulators, trade associations, and other agencies).
- Paying for the ongoing costs of the program while reimbursement is growing.
- Ensuring the necessary functionality is available in the EMR.
- Pre-visit planning implementation.

# Challenges (cont):

- The reality of tiering patients.
- How to bill for uninsured patients.
- Keeping up with changing quality measurements.
- How to expand when care coordination demand exceeds staff supply.
- Annual re-certification (including additional reporting and process requirements).

# Lessons Learned

- Do it right – don't try to just get by, but define what is 'good enough'.
- There are many ways to get the job done- pick a path and go with it.
- Have some fun! Get staff and patients engaged and enthused.
- Keep the momentum going – it's easy to slide back to business as usual.
- We can only change those things within our scope of control.
- Implement incrementally and go after low hanging fruit.


**There's No Place Like Home**

# Q & A