

ACP

AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*[®]

HIT and the Patient-Centered Medical Home: Enabling Advanced Primary Care

Maria Rudolph, MPH Vice President Medical Informatics e-MDs

**William S. Underwood, MPH Senior Associate American College of
Physicians**

Agenda

- **Defining a Medical Home**
 - Different Models
 - North Carolina
 - Advanced Primary Care and health care reform
- **HIT Features of the Advanced Primary Care Medical Home Model**
- **Now and the future**
- **Q&A**

Attributes of Patient-Centered Medical Home

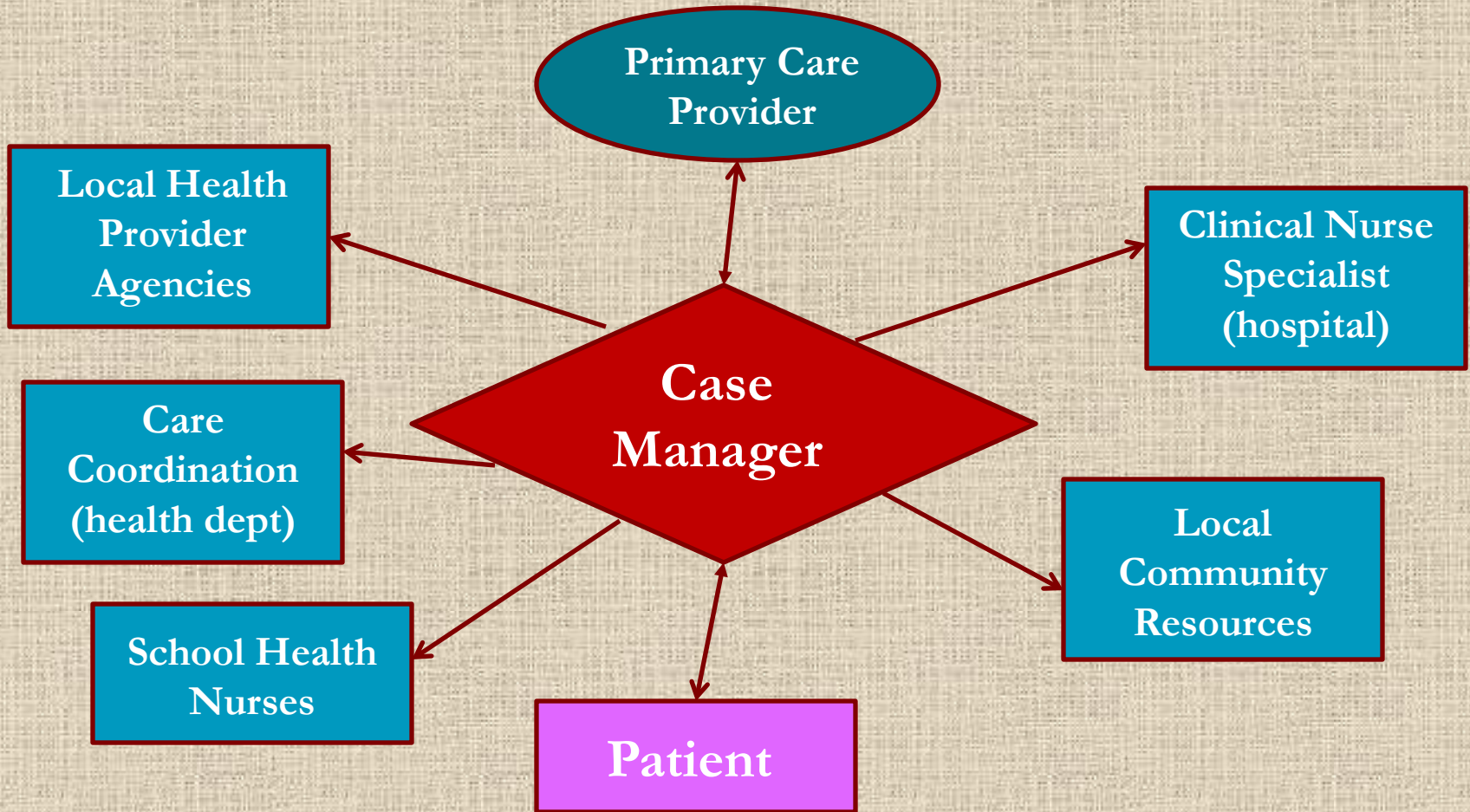
- **Superb access to care**
- **Patient engagement in care**
- **Clinical information systems that support high-quality care, practice-based learning, and quality improvement**
- **Care coordination**
- **Integrated, comprehensive care; smooth information transfer across a fixed or virtual team of providers**
- **Ongoing, routine patient feedback to a practice**
- **Publicly available information on practices**

Davis, K., Shoenbaum, S., Audet: A 2020 Vision of Patient-Centered Primary Care JGIM 2005; 20:953-957

North Carolina Access

- **Started in 1992 as Carolina Access**
 - Goal: reduce ED visits, increase Dr. reimbursement
 - Result: ED rate drops 10 %, high doctor enrollment
- **Expanded to be Community Care of NC**
 - Goals: added case management, and disease management
 - Result: achieved more than 200 mil. in savings
- **Network Pharmacist Program**
 - Goal: better medication management

North Carolina Access Org Chart



Advanced Primary Care (The New MH)

- **Joint Principles**
- **NCQA others**
- **Funding**
 - Private, Medicaid, SCHIP, Medicare
- **Supporters**
 - PCPCC, Medical Associations, Government, QA

The Joint Principles of the PCMH

- **Personal physician**
- **Physician directed medical practice**
- **Whole person orientation**
- **Care is coordinated and/or integrated**
- **Quality and safety**
- **Enhanced access to care**
- **Payment to support the PCMH**

Team-based care:
NP/PA
RN/LPN
Medical Assistant
Office Staff
Care Coordinator
Nutritionist/Educator
Pharmacist
Behavioral Health
Case Manager
Social Worker
Community resources
DM companies
Others...

NCQA: Physician Practice Connections/PCMH

1. Access & Communication
2. Patient Tracking & Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting & Improvement
9. Advanced Electronic Communication

HIT for Advanced Primary Care



- Facilitate team-based practice both within – and around the practice
- Include registry functions and customizable reports
- Provide guidance for clinical interventions for individual patients – and for groups of patients with identified needs
- Enable patient-centered care

HIT

Case
Manager

Ancillary

PCP

Public
Health

Patient

Family

Hospital

Specialist

Using HIT to support Advanced Primary Care

- Focus on “capabilities” of EHR systems:
 - A. To collect, store, manage and exchange relevant health information
 - B. To facilitate care team communications in the processes of care delivery and management
 - C. To collect, store, measure and report on the processes and outcomes of individual and population performance and quality of care
 - D. To allow providers to engage in decision support for evidence-based treatments and tests
 - E. To allow patients/consumers to be informed and increasingly literate about their health and medical conditions
 - F. To provide HIT support for patients, caregivers and family

A. Collect, store and manage data

- **Collect standardized, accurate and essential data elements, including data from outside systems**
 - Patient demographic and clinical data
 - Results reporting to ordering or covering physician
 - Patient notification of lab results
 - Send appropriate clinical information when patients enter another treatment setting
 - Online order entry and tracking
 - Ability to identify patients receiving care in another facility

B. Facilitate care team communications related to care delivery and management

■ Care Coordination

- Medication reconciliation
- E-Prescribing: interaction checking
- Evidence-based flowsheets
- Tracking referrals and labs
- Ability to send/receive health summary information
- Structured documentation: problem list, care plan, history
- Ability to create/maintain list of consulting providers/organizations for tracking

C. Report on the processes and outcomes of individual and population performance and quality of care

- **Registry-like reporting and linking to community resources**
 - Ability to identify practice-specific “important conditions,” frequent diagnoses
 - Triggers to identify patient-specific care: chronic conditions, immunizations, preventive health
 - Ability to maintain list of community resources that can support patients including disease management, nutrition or exercise programs
 - Risk stratification by age appropriate measures

D. Allow providers to engage in decision support for evidence-based treatments and tests

- **Clinical decision support at the point of care**
 - Incorporate guidance of clinical guidelines into flow sheets, standing order sets, training and other every day processes
 - Medication selection and dosing support
 - Ability to document reason when recommendation was not followed
 - Prompting/reminders for preventative care services

E. Allow patients/consumers to be informed and increasingly literate about their health and medical conditions

■ Enhanced access and patient support

- Ability to support open scheduling, group visits, appointment reminders
- Personal Health Record functionality
- Ability to print/share health summary at end of visit
- Ability to identify patient language preference, communication difficulties, etc.
- Ability to support advanced communications: email, remote monitoring/telemedicine

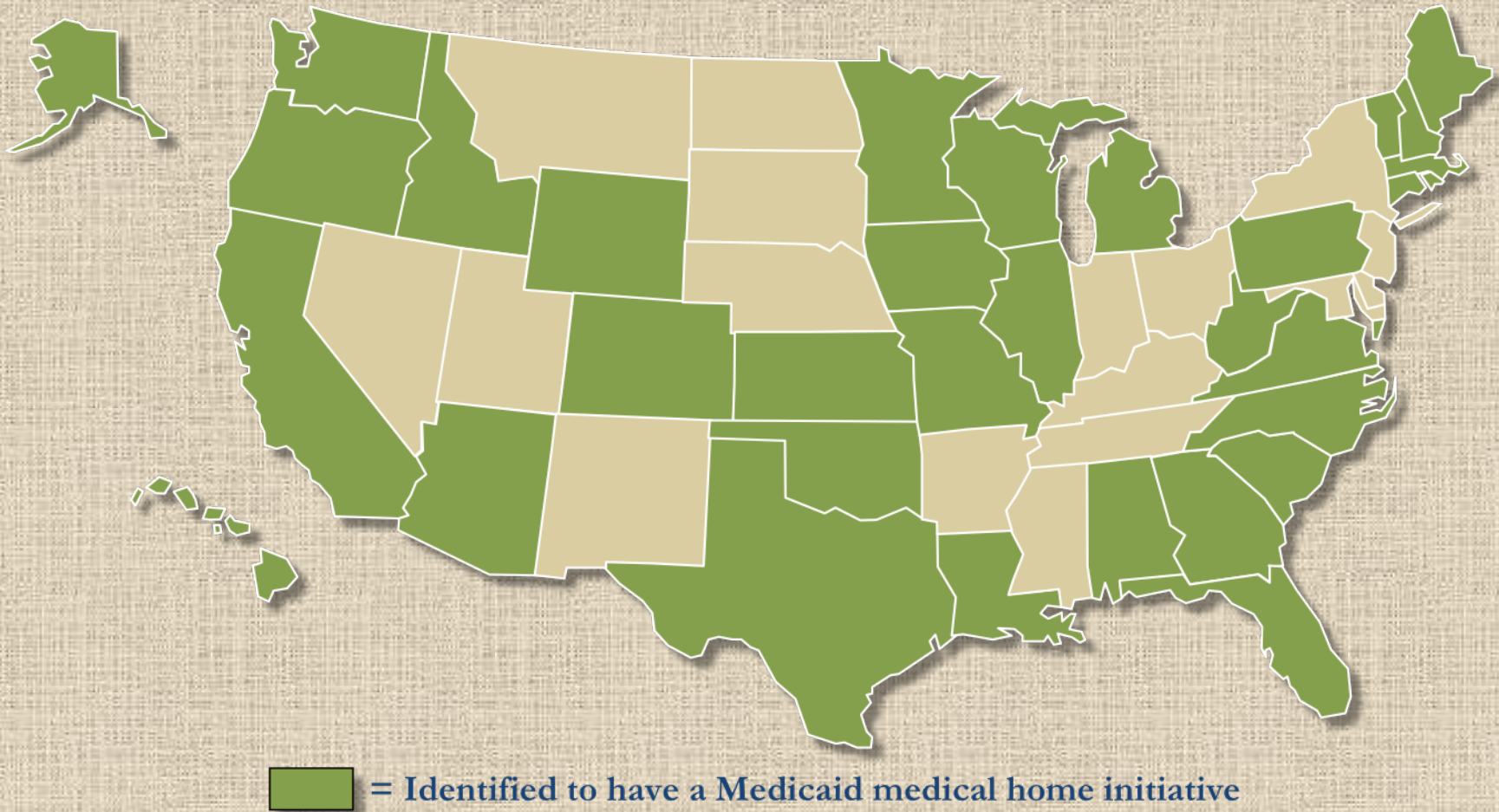
F. Provide HIT support for patients, caregivers and family

- **Patient management of personal health information**
 - **PHR: ability to enter personal health information, e.g., vital signs, blood glucose, etc.**
 - **Self-management and education tools**
 - **Ability to support online medication requests and appointments**
 - **Ability to collect information from external sources, e.g., other providers, institutions, laboratories, etc.**
 - **Ability to share information collected with other people**

Current Status

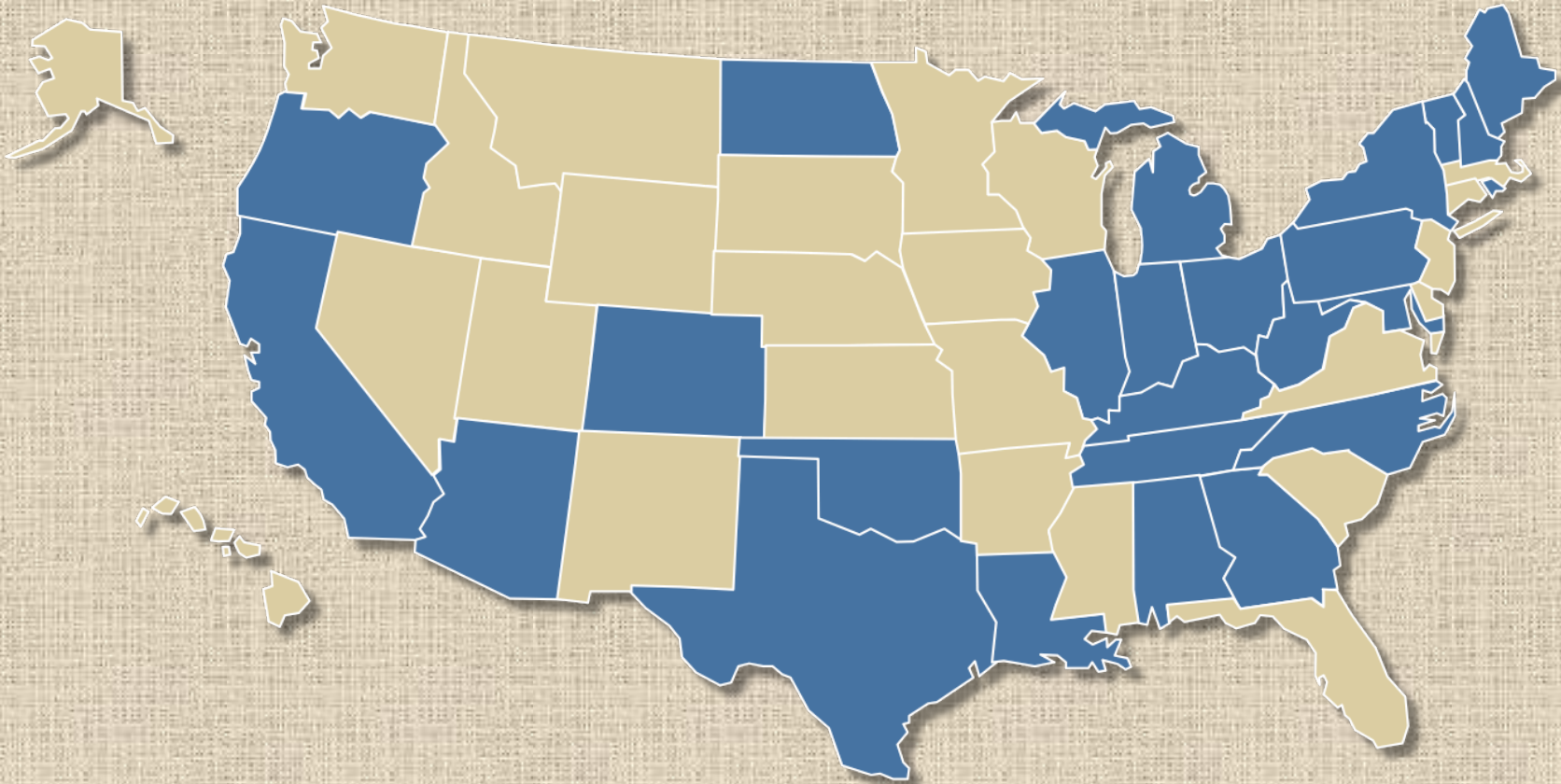
- **CMS Demo**
- **Health Reform**
- **Meaningful Use**

Initiatives to Advance Medical Homes in Medicaid/ SCHIP



Source: National Academy for State Health Policy
State Scan, November 2008

Private Payer Medical Home Projects



 = Identified to have at least one private payer medical home pilot

As tracked by the American College of Physicians

HIT Enabling the Medical Home

- ...to return the focus of medicine to the patient
- ...to describe a pathway to excellent health care
- ...to re-claim a role as advocates for our patients (with our patients & their families)
- ...to encourage team-based care
- ...to build an informed community

Resources

■ PCPCC resources on HIT and the Medical Home

- <http://www.pcpcc.net/content/meaningful-connections-it-resource-guide>
- <http://www.pcpcc.net/files/mcfaq.pdf>
- http://www.pcpcc.net/files/cehia_mc.pdf

■ Medical Home Standards:

- http://www.acponline.org/running_practice/pcmh/demonstrations/jointprinc_05_17.pdf
- http://www.acponline.org/running_practice/pcmh/demonstrations/detailed_standards.pdf
- http://www.acponline.org/running_practice/pcmh/demonstrations/crosswalk_standards.pdf

Resources (cont)

■ Medical Home Tools

- http://www.acponline.org/running_practice/pcmh/help.htm

■ CMS Demo

- <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1199247&intNumPerPage=10>

■ North Carolina's Medical Home project

- <http://www.communitycarenc.com/>

Questions

- Maria Rudolph mrudolph@e-mds.com
- William S. Underwood
wunderwood@acponline.org