Advancing Quality & Patient-Centered Medical Homes in Health Centers

National Advisory Council on the National Health Service Corps

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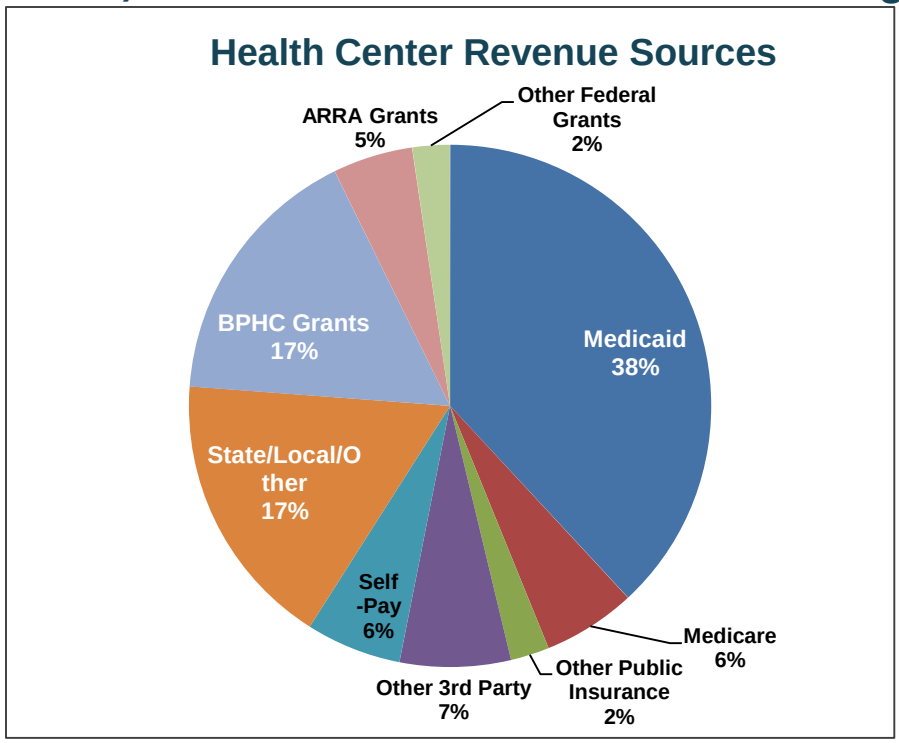
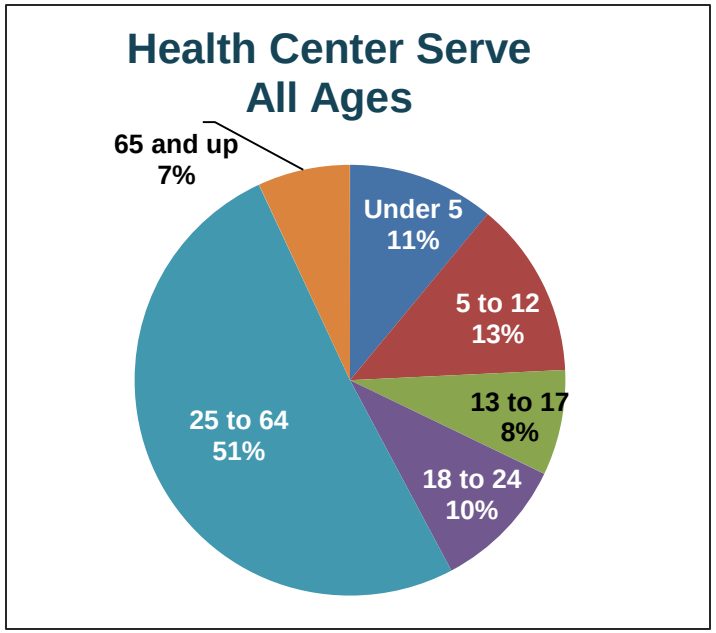
U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Primary Health Care

Health Center Program Overview
Calendar Year 2011

20.2 Million Patients

- 93% Below 200% Poverty
- 36% Uninsured
- 62% Racial/Ethnic Minorities
- 1,087,000 Homeless Individuals
- 863,000 Farmworkers
- 188,000 Residents of Public Housing





80 Million Patient Visits

- 1,128 Grantees
- 8,500+ Service Sites

Over 138,000 Staff

- 9,937 Physicians
- 6,934 NPs, PA, & CNMs

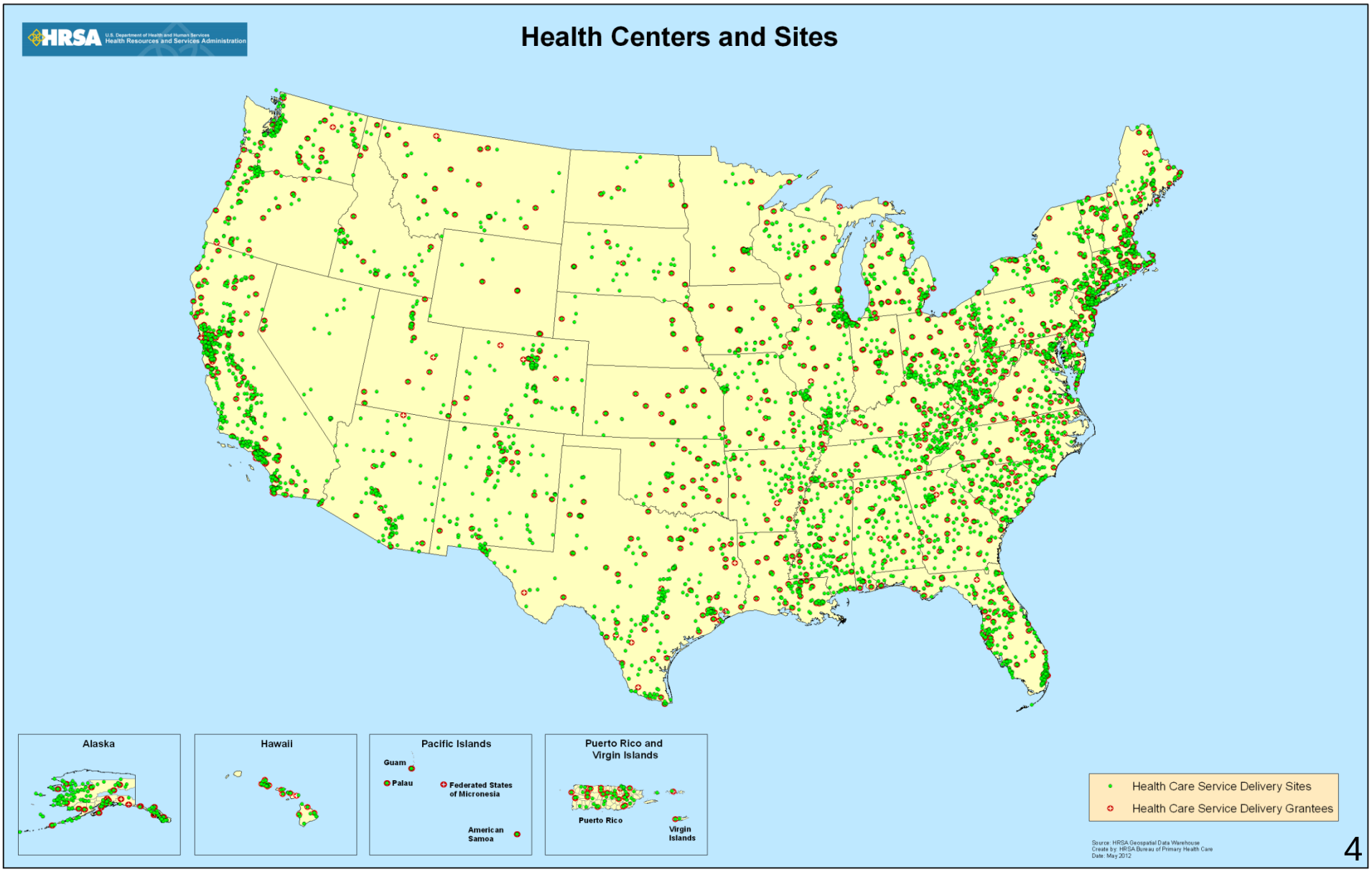
Source: Uniform Data System, 2011, Service Sites: HRSA Electronic Handbooks

Health Center Program: Fundamental Principles

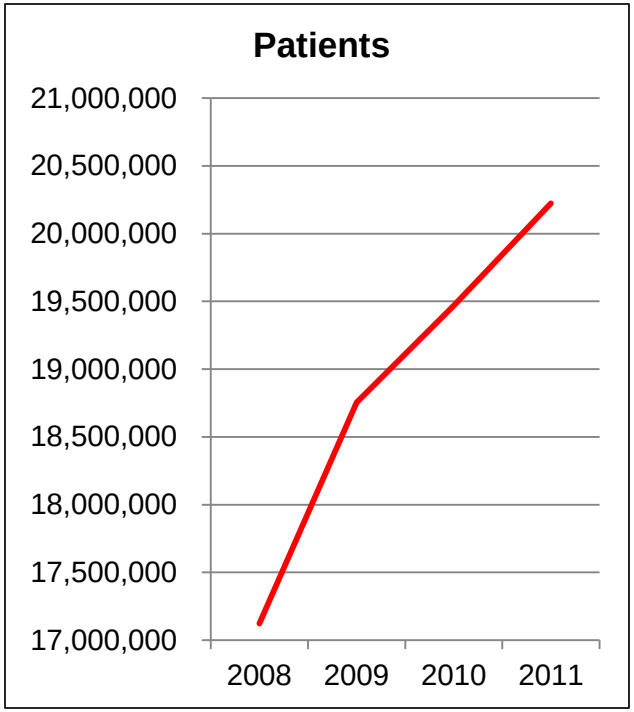
Health Center Program Requirements:
http://www.bphc.hrsa.gov/about/requirements.htm

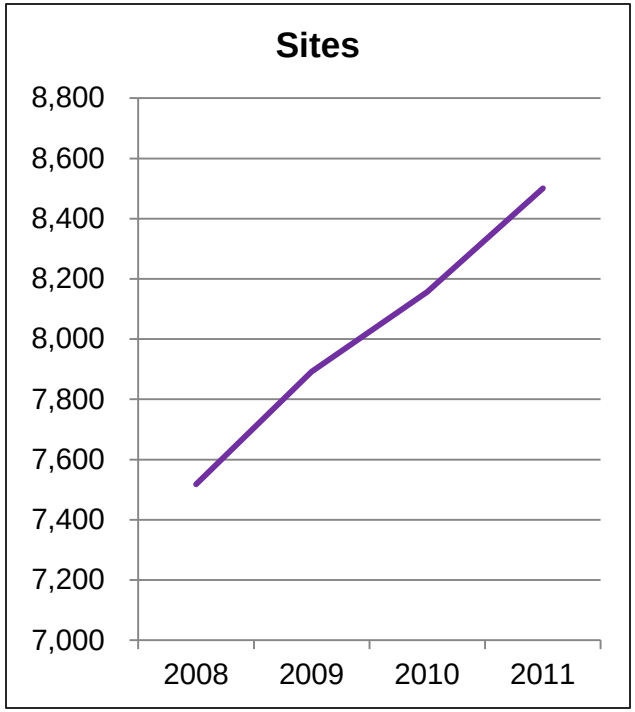
- Private non-profit or public agency that must serve **a high need community or population**, i.e. medically underserved areas (MUA) or medically underserved populations (MUP);
- **Governed by a community board** of which a majority (at least 51%) are health center patients who represent the population served;
- Provide **comprehensive primary care** services as well as enabling/supportive services such as education, translation and transportation that promote access to health care;
- Services are **available to all** with fees adjusted based upon ability to pay;
- Establish **linkages and collaborative arrangements** with other community providers to maximize resources and efficiencies in service delivery systems;
- Meet other **performance and accountability requirements** regarding administrative, clinical, and financial operations.

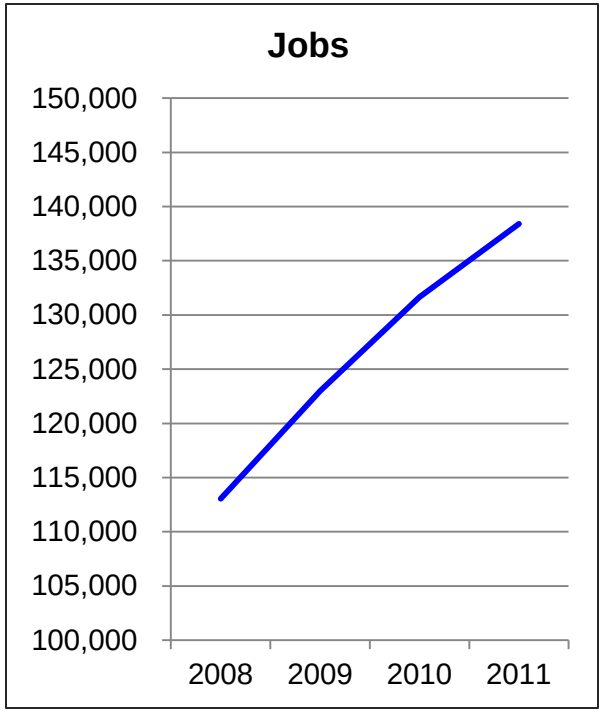
Health Center Program National Presence



Health Center Program Growth: National Impact 2008 - 2011





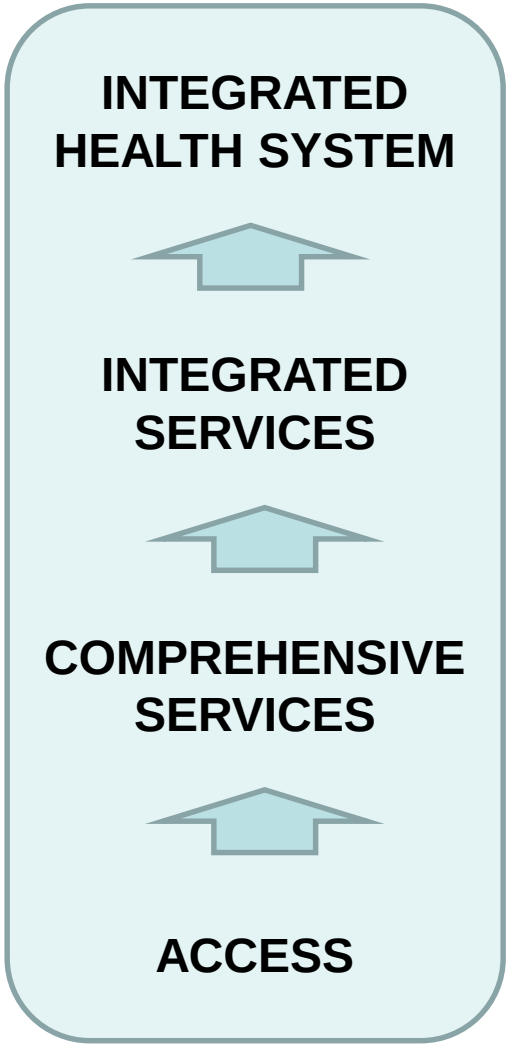


	2008	2009	2010	2011	Growth from 2008-2011 (% Increase)
Patients	17,122,535	18,753,858	19,469,467	20,224,757	3,102,222 (18.1%)
Sites	7,518	7,892	8,156	8,501	983 (13.1%)
Jobs	113,059	123,012	131,660	138,403	25,344 (22.4%)

Source: Uniform Data System, 2008-2011 and HRSA Electronic Handbooks

BPHC Quality Strategy

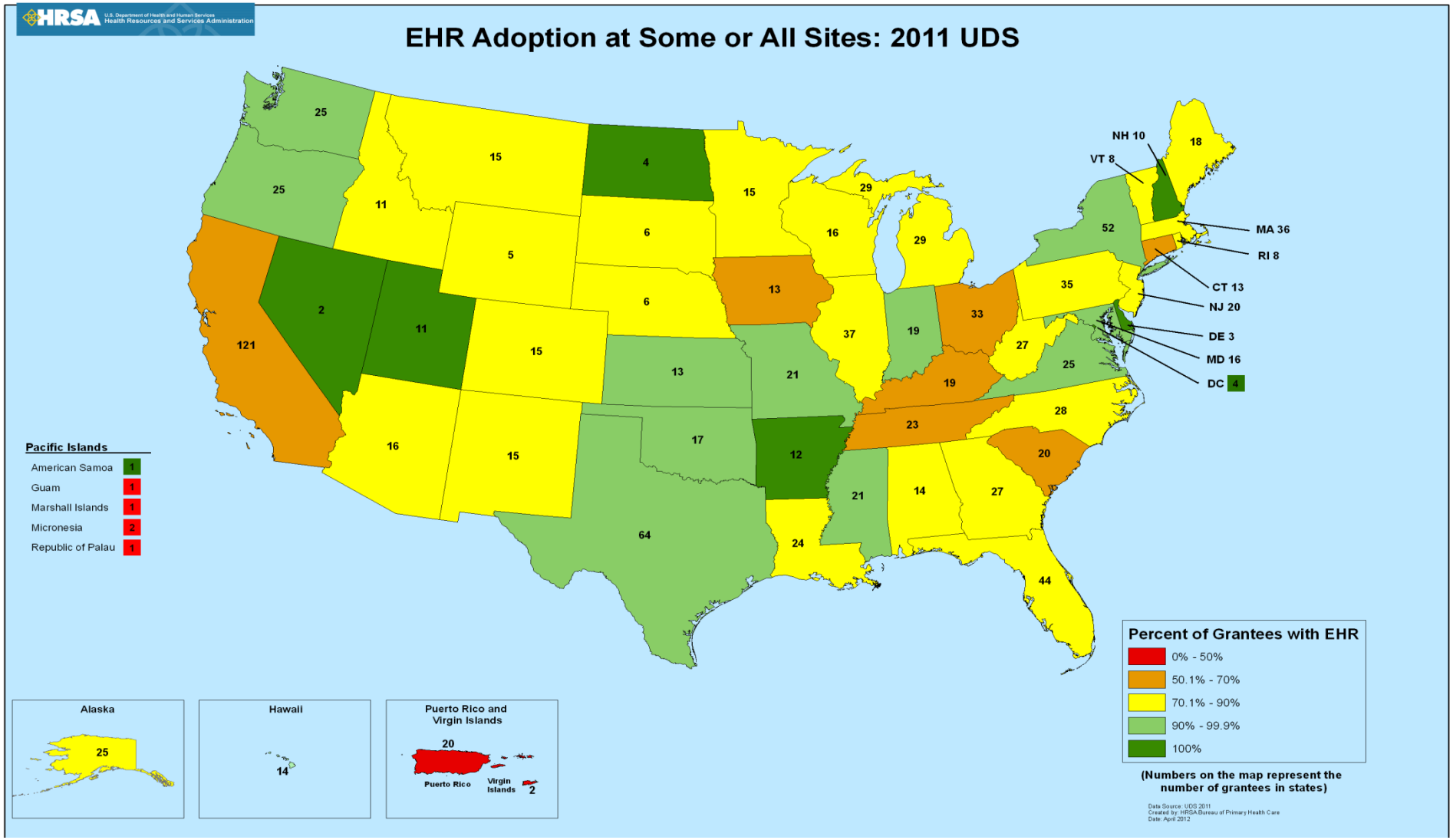
Better Care • Healthy People & Communities • Affordable Care



Priorities & Goals

1. Implementation of QA/QI Systems
   All Health Centers fully implement their QA/QI plans
2. Adoption and Meaningful Use of EHRs
   All Health Centers implement EHRs across all sites & providers
3. Patient Centered Medical Home Recognition
   All Health Centers receive PCMH recognition
4. Improving Clinical Outcomes
   All Health Centers meet/exceed HP2020 goals on at least one UDS clinical measure
5. Workforce/Team-Based Care
   All Health Centers are employers/providers of choice and support team-based care

EHR Adoption in 2011



Source: Uniform Data System, 2011

The Patient Centered Medical Home

- BPHC Quality Strategy Priority Goal 3: Patient Centered Medical Home Recognition
  - All Health Centers receive PCMH recognition
- HHS Priority Recognition Goal
  - Goal: 25% of grantees recognized by 9/30/2013
  - Goal: 13% of grantees recognized by 9/30/2012
- HRSA investments in the patient centered medical home
  - Patient-Centered Medical Health Home Initiative
  - Accreditation Initiative
  - PCMH Supplemental funds
  - Partnership with the CMS Primary Care Demonstration

Why Patient Centered Medical Home?

- Demonstrates the quality of care provided in health centers and provides opportunity for continuous quality improvement.
- Positions health centers for the changing health care landscape.
- Investment in the health center workforce through reduced staff turnover and improved recruitment.
- Transforms patient care to help health centers achieve the three part aim of: better care, better health and communities, and affordable care.

Key Elements of Patient Centered Medical Homes

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

PCMH1: Enhance Access and Continuity

A. Access During Office Hours**
B. After-Hours Access
C. Electronic Access
D. Continuity
E. Medical Home Responsibilities
F. Culturally and Linguistically Appropriate Services
G. Practice Team

PCMH2: Identify and Manage Patient Populations

A. Patient Information
B. Clinical Data
C. Comprehensive Health Assessment
D. Use Data for Population Management**

PCMH3: Plan and Manage Care

A. Implement Evidence-Based Guidelines
B. Identify High-Risk Patients
C. Care Management**
D. Manage Medications
E. Use Electronic Prescribing

PCMH4: Provide Self-Care Support and Community Resources

A. Support Self-Care Process**
B. Provide Referrals to Community Resources

PCMH5: Track and Coordinate Care

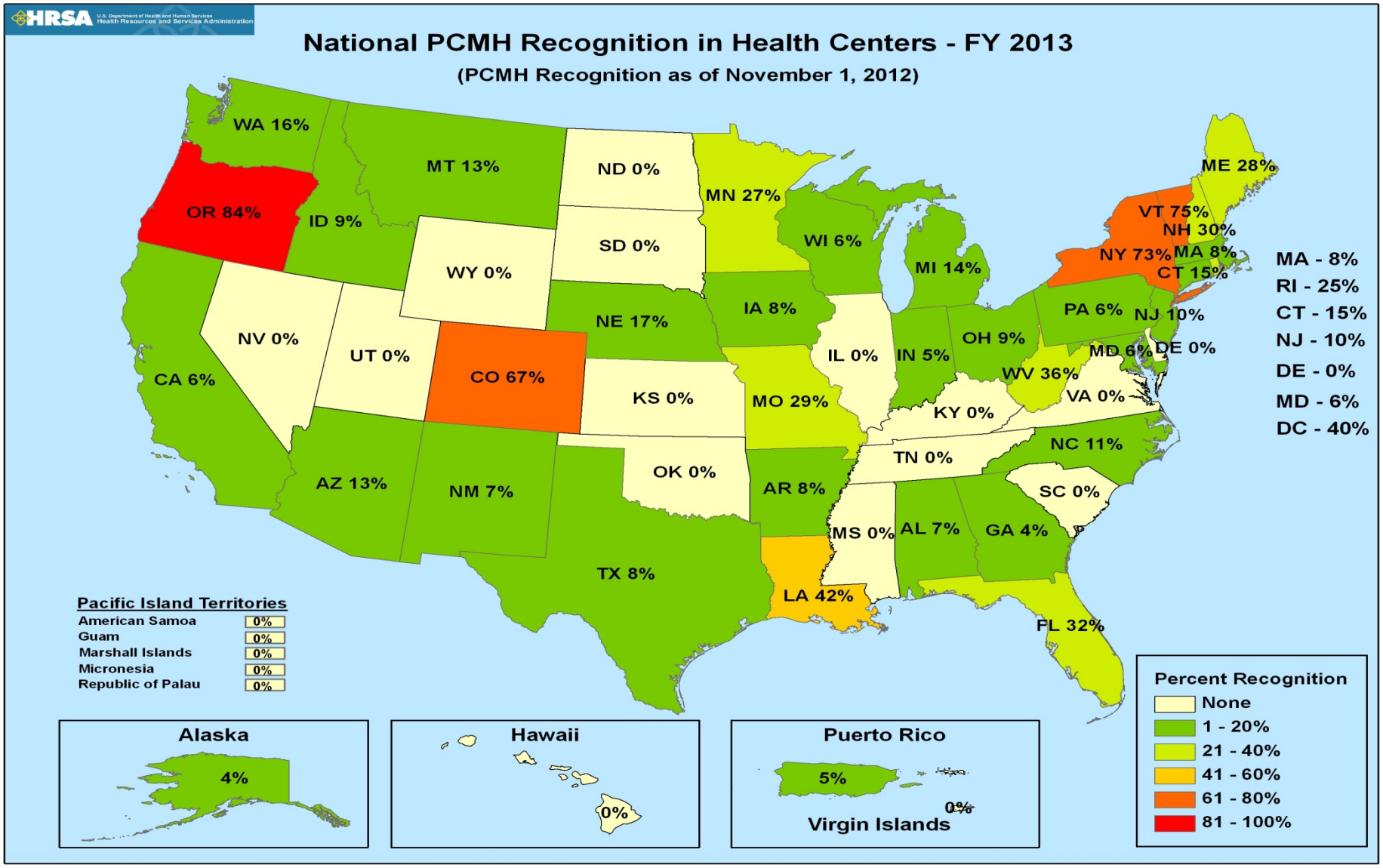
A. Test Tracking and Follow-Up
B. Referral Tracking and Follow-Up**
C. Coordinate with Facilities/Care Transitions

PCMH6: Measure and Improve Performance

A. Measure Performance
B. Measure Patient/Family Experience
C. Implement Continuously Quality Improvement**
D. Demonstrate Continuous Quality Improvement
E. Report Performance
F. Report Data Externally

**Must Pass Elements

National PCMH Recognition in Health Centers



Many Paths to PCMH

- Many entities across the country are embracing the PCMH model:
  - Private Payers: Blue Cross Blue Shield, United Health Care, etc.
  - States: Oregon & Minnesota
- HRSA supports 2 initiatives to assist grantees with the survey costs and assistance in achieving PCMH recognition.
  - The Accreditation Initiative: The **Accreditation Association for Ambulatory Health Care** & The Joint Commission
  - The Patient Centered Medical Health Home Initiative: **National Committee for Quality Assurance**

Practice Transformation

- Practice transformation is a process that takes time
  - Experience from HRSA PCMHHI: 12-18 months to transform practice

- Before you begin complete a Readiness Assessment
  - Many available online for free
    - PCDC, Safety Net Medical Health Home Initiative, etc.

- Assemble a multi-disciplinary PCMH Team
  - Staff that understand the clinical and operational systems

Source: Hudson Headwaters Journey to PCMH Recognition – Cyndi Nassivera-Cordes, VP Clinical Quality

Practice Transformation

- Develop a work plan
  - Establish purpose, goals, and objectives of your transformation efforts.
  - Regular Meetings: Workgroup, staff, team huddles, staff orientation
  - COMMUNICATE to staff and patients

- Learn from your peers
  - Talk to grantees who are going through the process
  - Talk to grantees who have achieved recognition

Source: Hudson Headwaters Journey to PCMH Recognition – Cyndi Nassivera-Cordes, VP Clinical Quality

Practice Transformation: Tips From Grantees

- "Spend some time understanding the standards. Review the standards and do an evaluation of your readiness before beginning the process."
- "Use your partners and colleagues in the Health Center world who have done this for advice."
- "You can get recognized without an EMR but it makes it a lot harder. Work on implementing your EMR first."
- "Build a solid multi-disciplinary team, (nursing, caremanagement, human resources rep. etc.), that has protected time to meet on a regular basis."

Source: Hudson Headwaters Journey to PCMH Recognition – Cyndi Nassivera-Cordes, VP Clinical Quality

PCMH Resources

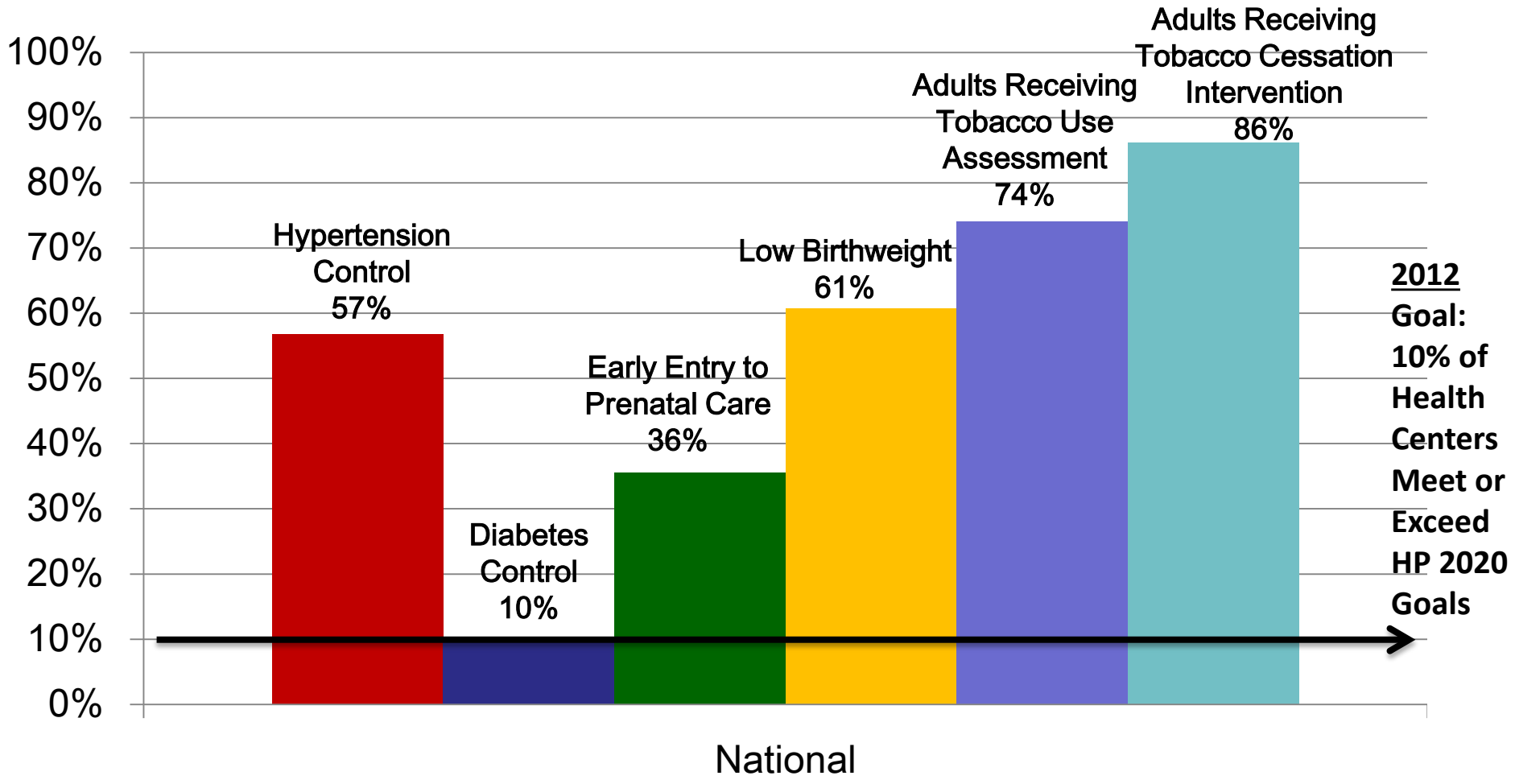
- PCMH Readiness Assessment Tools
  - Primary Care Development Corporation (PCDC): http://www.pcdc.org/resources/patient-centered-medical-home/pcdc-pcmh/ncqa-2011-medical-home.html
  - PCMH Assessment (PCMH-A) from the Safety Net Medical Home Initiative: http://www.safetynetmedicalhome.org/practice-transformation/assessment
  - Medical Home Implementation Quotient Assessment (MHIQ) from TransforMED: http://www.transformed.com/userLogin.cfm
- PCMH Change Concepts: http://www.safetynetmedicalhome.org/change-concepts
- Patient-Centered Primary Care Collaborative (PCPCC): http://www.pcpcc.net/content/pcmh-outcome-evidence-quality

PCMH Resources

- Agency for Healthcare Research and Quality (AHRQ) PCMH Resource Center: http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483
  - Clinical Practice Guidelines: http://www.ahrq.gov/clinic/cpgsix.htm
  - US Preventive Services Task Force: http://www.uspreventiveservicestaskforce.org/tools.htm
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS patient experience survey): https://www.cahps.ahrq.gov/default.asp
  - Innovations Exchange: http://www.innovations.ahrq.gov/
  - Patient Health Literacy Toolkit: http://www.ahrq.gov/qual/literacy/

Percent of Health Centers Meeting or Exceeding Healthy People 2020 Goals

UDS 2011



Source: 2011 UDS and Healthy People 2020

Grantee Summary Report

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

	GRANTEE	ADJUSTED QUARTILE RANKING [5]
QUALITY OF CARE/HEALTH OUTCOMES		
Prenatal		
% Having First Prenatal Visit in 1st Trimester	73.96%	2
% Low and Very Low Birth Weight	7.93%	3
Preventive Screening & Immunizations		
% of Women with Pap Tests	61.89%	2
% of Children and Adolescents with BMI Percentile and Counseling on Nutrition and Physical Activity Documented	9.14%	4
% of Adults who Received Weight Screening and Follow up if Appropriate	23.59%	3
% of Adults Assessed for Tobacco Use	49.55%	4
% of Tobacco Users who Received Cessation Advice and/or Medication	13.21%	4
% of Asthmatics Treated with Appropriate Pharmacological Intervention	65.88%	3
% of Two year Olds Immunized [4]	13.39%	4
Chronic Disease Management		
% Hypertensive Patients with Blood Pressure < 140/90	59.65%	3
% Diabetic Patients with HbA1c <= 9	70.59%	2

'-' - Data Cannot be Calculated

[2] Hypertensive adults as a percent of estimated adult medical patients of ages 18-85.

[3] Diabetic adults as a percent of estimated adult medical patients of ages 18-75.

[4] Measure was revised in 2011 and is not comparable to calendar year 2010 and prior.

[5] Grantee adjusted quartile results from a statistical model adjusting for special populations, uninsured and minority patients, and EHR use. Clinical performance for each measure is ranked from Quartile 1, highest 25% of reporting grantees, to Quartile 4, lowest 25% of reporting grantees.

UDS Web Tools

UDS Website:

http://www.hrsa.gov/data-statistics/health-center-data/index.html.

- Data analysis tools
- Data download functionality

- UDS Grantee/State/National Summaries
- Health Center Trend Reports
- State and National Roll-up Reports
- Reporting and Training Resources

UDS Mapper: www.udsmapper.org

- HRSA has developed a mapping and support tool driven primarily from data within the UDS
- Webinar trainings on using Mapper functionality available: http://www.udsmapper.org/webinars.cfm

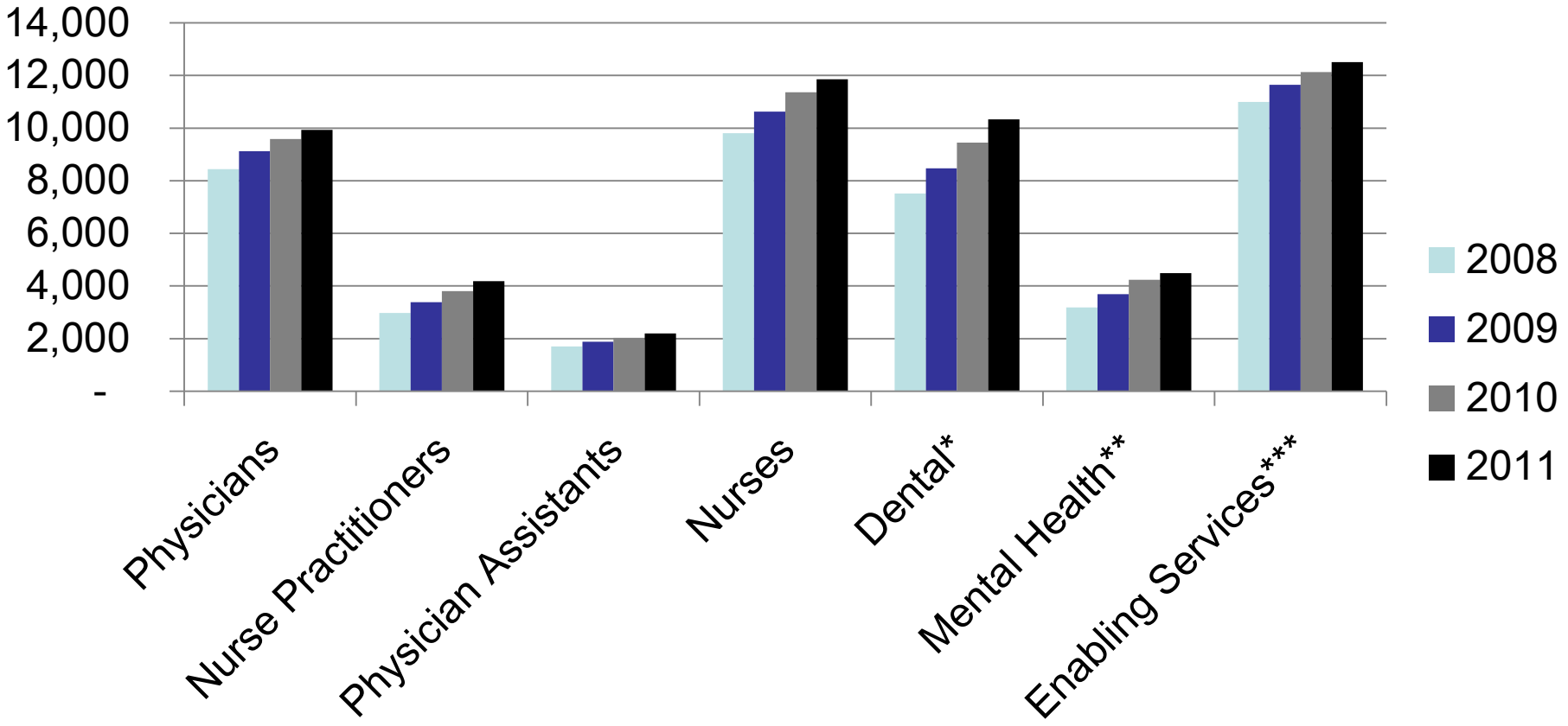
Health Center Program Workforce Calendar Year 2011

Total Staff		138,403
Physicians		9,936
Family/General P.	5,034	
Internal Med	1,607	
Pediatrics	2,010	
Ob/Gyn	979	
Other MD/DO	306	
Nurse Practitioners		4,186
Physician Assistants		2,194
Certified Nurse Midwives		553
Nurses		11,854
Other Med		17,711
Lab/X-ray		2,778
Dental		10,338
Dentists	3,096	
Hygienists	1,285	
Assistants	5,957	

Source: Uniform Data System, 2011 Data

Mental Health		4,486
Psychiatrists	401	
Clinical Psychologists	403	
Clinical Social Workers	1,394	
Other Licensed MH	1,006	
Other MH	1,282	
Substance Abuse		874
Pharmacy		2,999
Vision		298
Ophthalmologists	30	
Optometrists	134	
Other Vision Care Staff	134	
Other Professional		977
Program Enabling Services (Case Managers, Education, Outreach, Transport, etc.)		12,504
Other Program/Services		4,256
Patient Support Staff		23,596
Management and Support Staff		13,875
Fiscal and Billing Staff		9,261
IT Staff		2,180
Facility Staff		3,547

Health Center Program Workforce Key Trends 2008 - 2011



Source: Uniform Data System 2008-2010.

* Dental includes Dentists, Dental Hygienists, and Dental Assistants

** Mental Health includes Psychiatrists, Clinical Psychologists, Clinical Social Workers, and Other Licensed/Non-licensed Mental Health providers.

*** Enabling Services includes Case Managers, Health Education, Outreach, Transportation, etc.

Health Center Program: Veterans Hiring Initiative

- HRSA has partnered with the National Association of Community Health Centers (NACHC) in assisting health centers in hiring an average on one veteran per grantee site over the next three years with the goal of hiring 8,000 veterans.

- In a recent sample survey, 10% of 2012 newly-hired employees in health centers were veterans.

- Veteran hires in health centers included family physicians, nurses, physician assistants, dentists, psychologists, and community health workers, case managers and patient support staff.