

Patient-Centered Primary Care Collaborative of Central Ohio

Q4 Learning Session

December 2, 2011

www.accesshealthcolumbus.org

Please save the following dates for 2012 learning sessions (7:30-10:30AM):

- *Friday, February 24*
- *Friday, May 11*
- *Friday, August 3*
- *Friday, December 7*

Coordinated by:



Lead Support



Columbus Medical Association Foundation

Major Support



Additional Support



Strategic Partners:



Agenda

- ***Welcome & Briefing on National, State, and Local Improvement Activities***
 - Jeff Biehl, President, Access HealthColumbus

- ***Keynote: Patient-Centered Medical Home – sharing lessons learned on building a foundation of accountable and coordinated care***
 - Thomas Graf, MD, Associate Chief Medical Officer, Geisinger Health System (Courtesy of Merck & Co., Inc.)

- ***Serving Patients in a Shared Medical Appointment (Group Visit) at the Chalmers P. Wylie VA Ambulatory Care Center***
 - Edward Bope MD, Chief of Primary Care Columbus VA, OSU Assistant Dean for VA Medical Students
 - Sreedevi Nemali MD, Lead Primary Care Physician
 - Colleen Mc Sweeney B. S. N., RN Care Manager

- ***Medicare Federally Qualified Health Center Advanced Primary Care Practice Demonstration***
 - Dana Vallangeon, MD, CEO, Lower Lights Christian Health Center

- ***Raising the Bar on Patient-Centered Medical Home National Standards***
 - Donna Hedrick, RN, BSN, CDE, Access HealthColumbus Consultant

Briefing on National, State, and Local Improvement Activities

National

- Centers for Medicare and Medicaid Innovation (CMMI)
– Comprehensive Primary Care Initiative
- National Patient-Centered Primary Care Collaborative
- learning on payment reform

State

- Medicaid Health Homes
- Ohio Patient-Centered Primary Care Collaborative

Local

(updates on work coordinated by Access HealthColumbus)

- 2011 Project Updates
- 2012 Project Plan

Practice and Payment Redesign through the CPC initiative

Supportive Multipayer Environment

Enhanced, accountable payment

Continuous improvement
driven by data

Optimal use of health IT

Comprehensive primary care
functions:

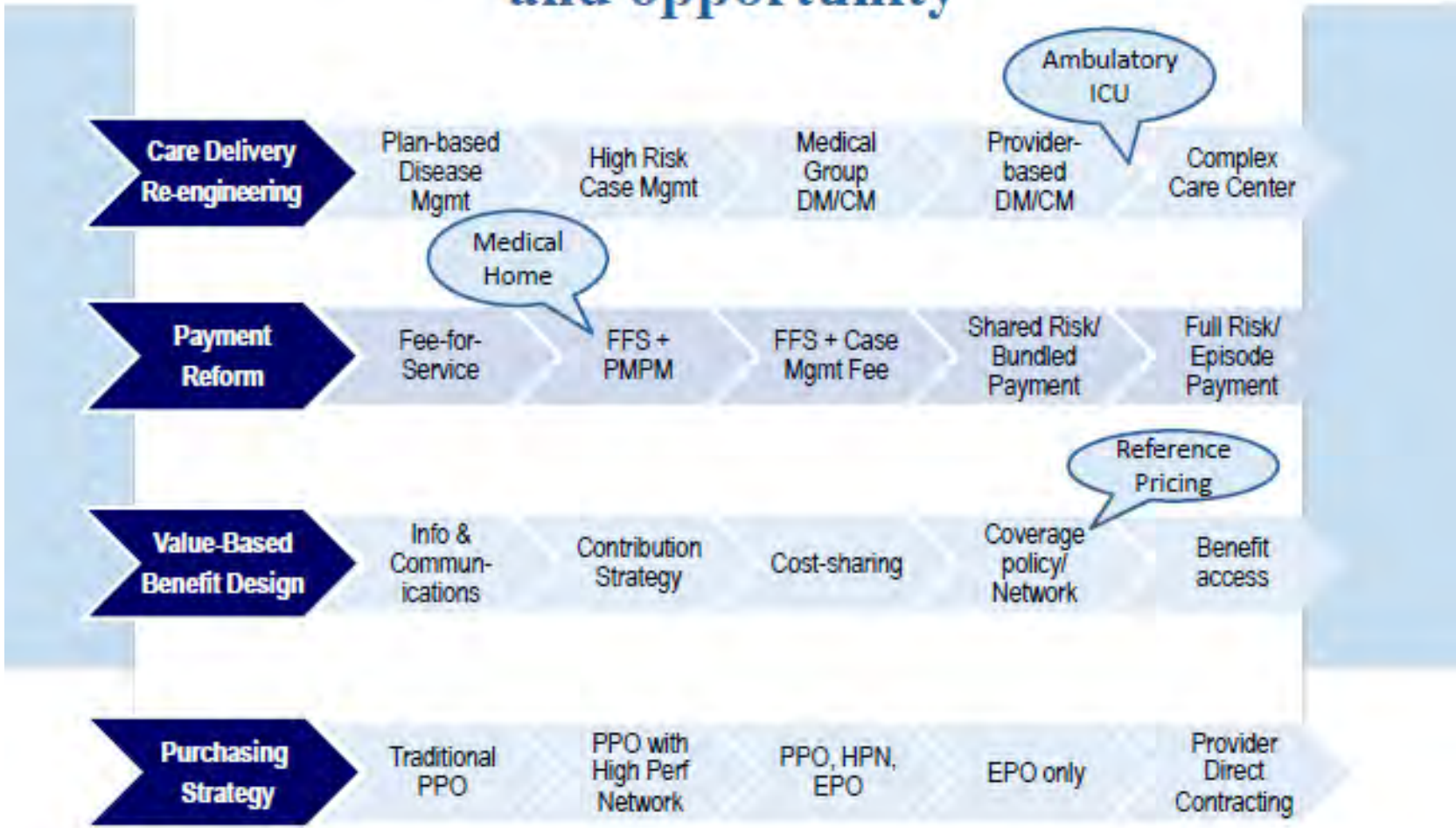
- Risk-stratified care management
- Access and continuity
- Planned care for chronic conditions and preventive care
- Patient and caregiver engagement
- Coordination of care across the medical neighborhood

Comprehensive
primary care

Aim:
*Better health,
Better care,
Lower cost*

National: Payment Reform

No single model for ACOs – a continuum of risk and opportunity



State: Medicaid Health Homes

- **State of Ohio is finalizing a 2012 care coordination project focused on serious and persistent mental illness (SPMI) Medicaid beneficiaries**
- **Opportunity for mental health care organizations to partner with physical health care providers**
- **Over a two-year period, enhanced reimbursements will be matched 90/10 by federal government**

State: Ohio Patient-Centered Primary Care Collaborative

Purpose

The Ohio Patient-Centered Primary Care Collaborative (PCPCC) is a coalition of primary care providers, insurers, employers, consumer advocates, government officials and public health professionals. They are joining together to create a more effective and efficient model of healthcare delivery in Ohio.

Coordinating Council

Jeff Biehl, Co-Chair

Richard Shonk, MD, Co-Chair

Kenneth Bertka, MD

Randal Cebul, MD

Angela Dawson

Cathy Levine

Candace Novak

Craig Osterhues

Dan Paoletti

Dianne Radigan

Richard Snow, MD

Craig Thiele, MD

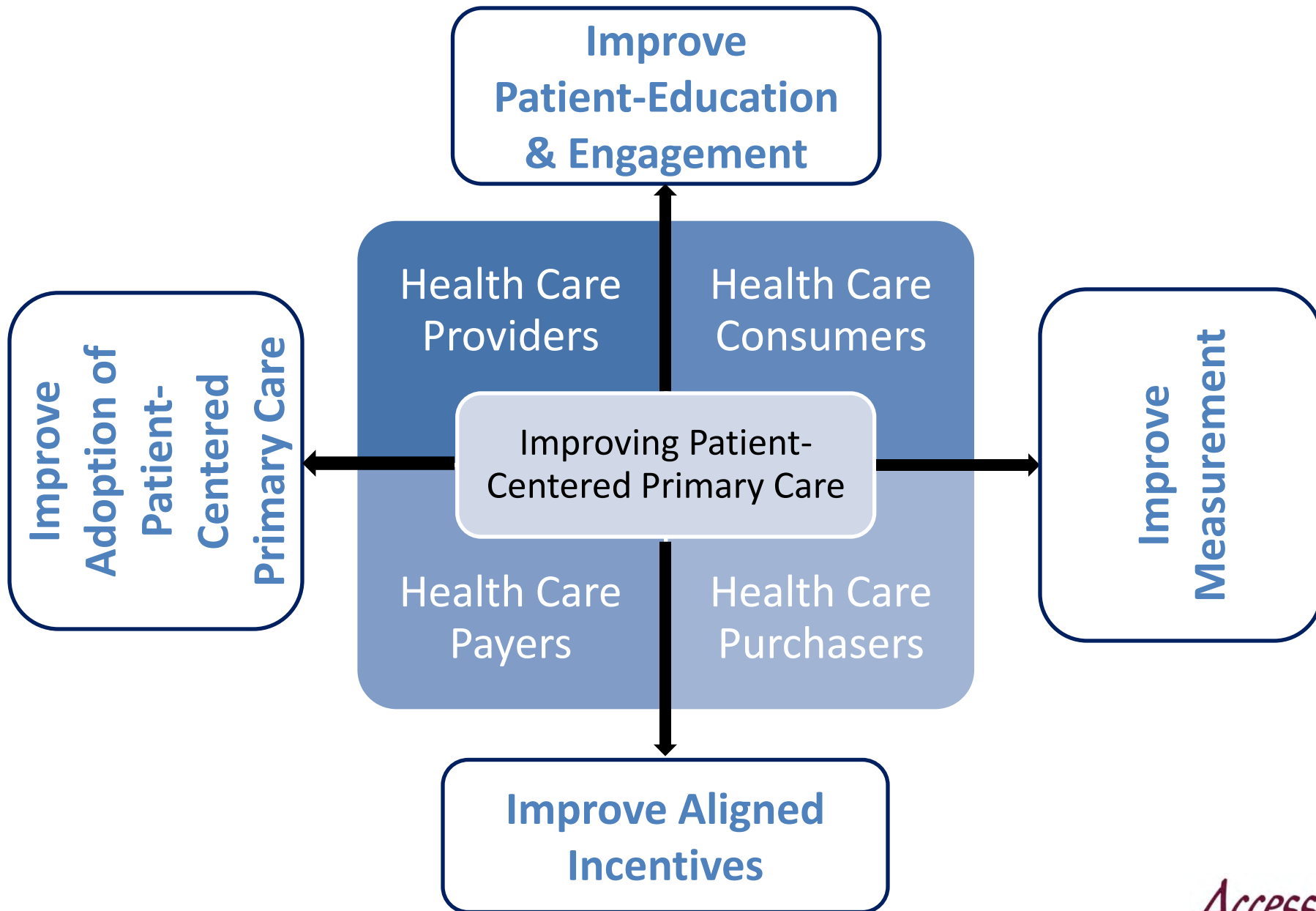
Christina Williams

J William Wulf, MD

Ted Wymyslo, MD

(ex officio)

Collaborative Approach for Improving Patient-Centered Primary Care



2010 Wave: Patient-Centered Medical Homes in Central Ohio

Central Ohio Primary Care,

3 *Central Ohio Medicine*



3 *American Health Network Hilliard*

OSU Family Practice at Gahanna **3**

OSU Thomas E. Rardin Family Practice **3**

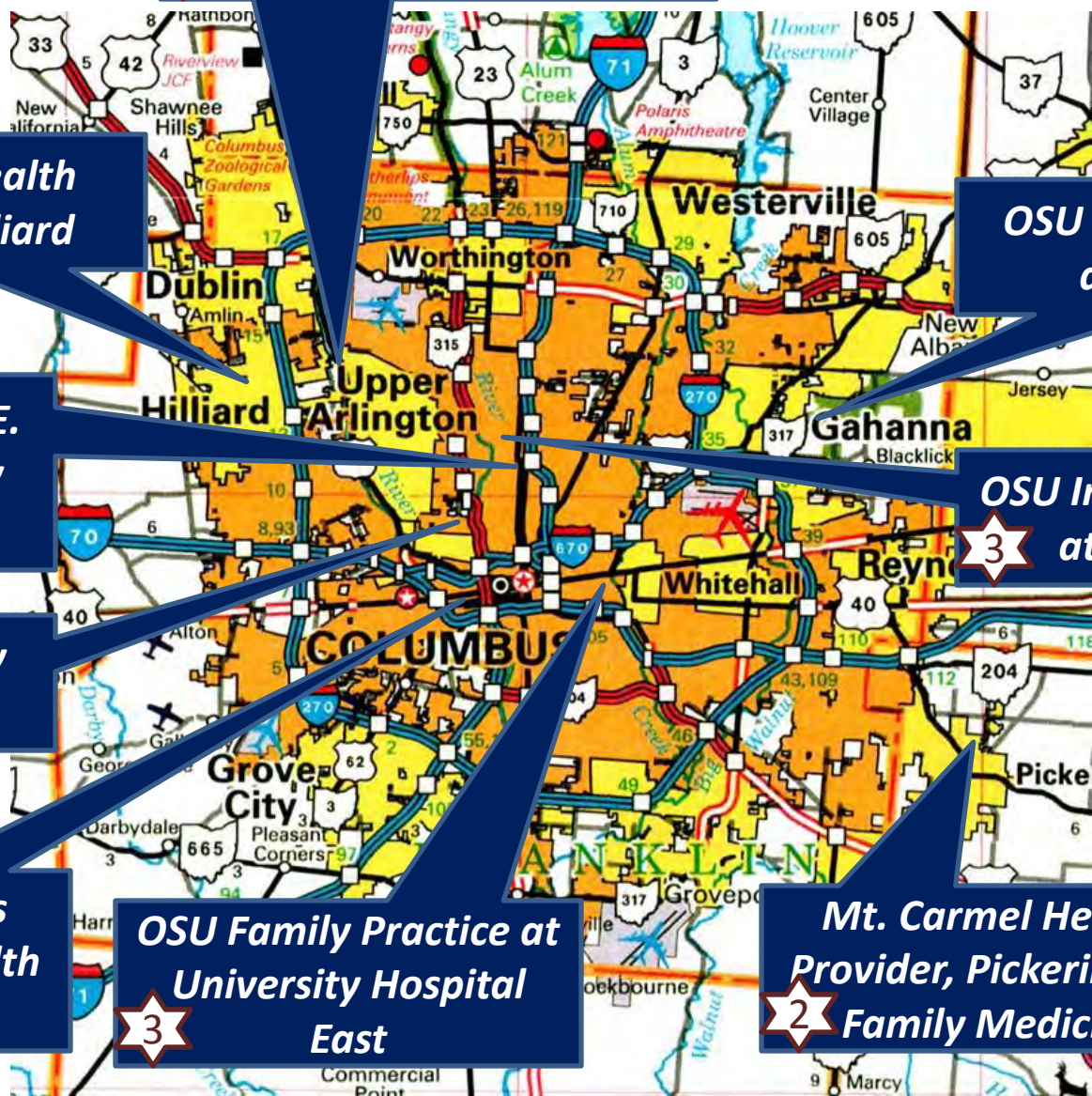
OSU Internal Medicine at Morehouse **3**

3 *Village Family Medicine*

Lower Lights Christian Health Center **2**

OSU Family Practice at University Hospital East **3**

Mt. Carmel Health Provider, Pickerington Family Medicine **2**



2011 Wave: Patient-Centered Medical Homes in Central Ohio

**OSU Internal Medicine
at Stoneridge/Dublin**

**OSU CarePoint Lewis
Center Primary Care**

**St. Stephen's
Health Center**

**Hand in Hand
Pediatrics Dublin**

**Rivers Edge Pediatrics
Dublin & Westerville**

**Columbus Northeast
Health Center**

**OSU Family Practice
at Upper Arlington**

**East Central Health
Center**

**Central Ohio Primary
Care, Northwest
Family Physicians**

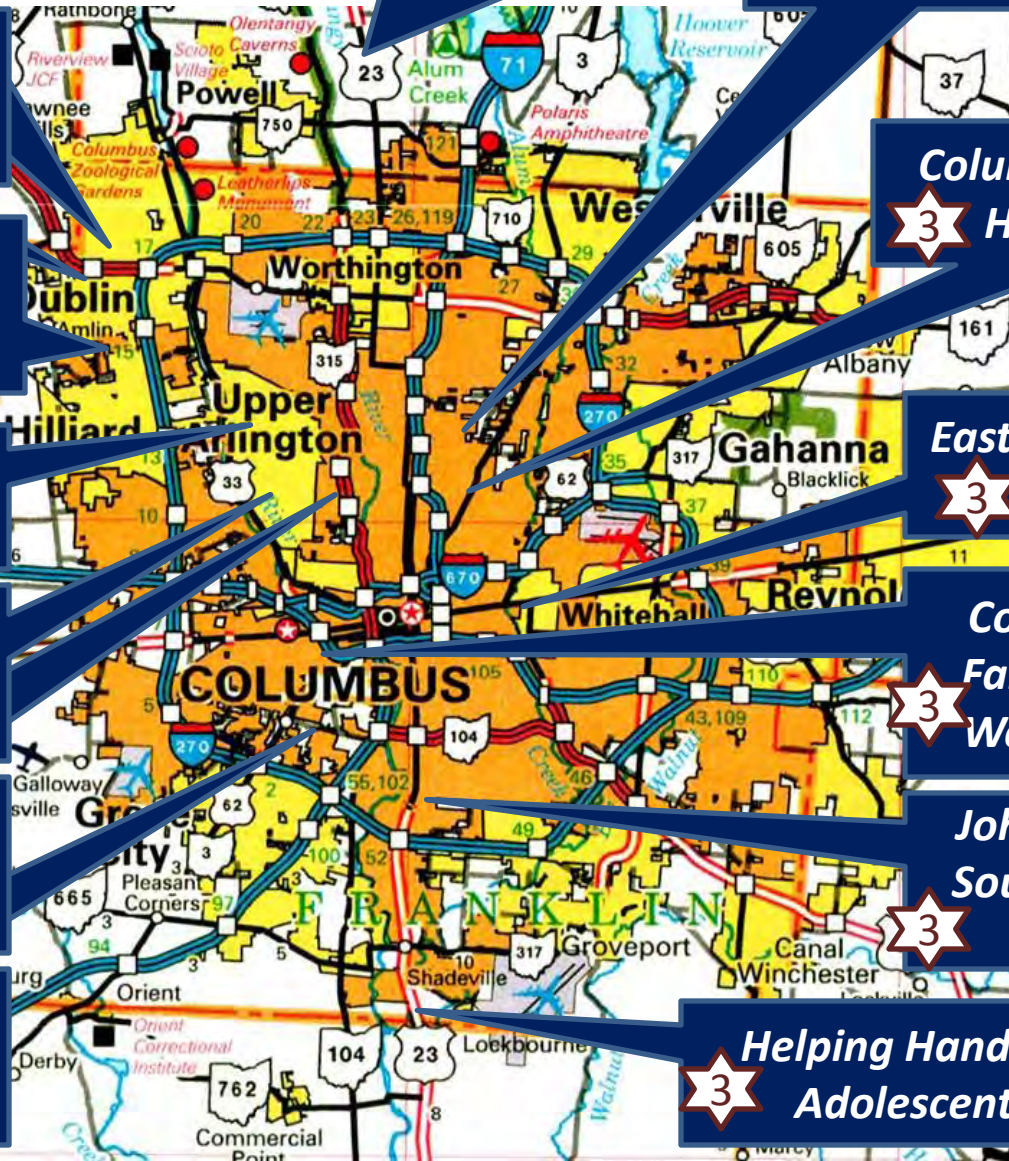
**Columbus West
Family Health &
Wellness Center**

**Central Ohio Primary
Care, Riverside
Pediatrics**

**John R. Maloney
Southside Health
Center**

**OSU Internal
Medicine & Pediatrics
- Grandview**

**Helping Hands Pediatric &
Adolescent Medicine**

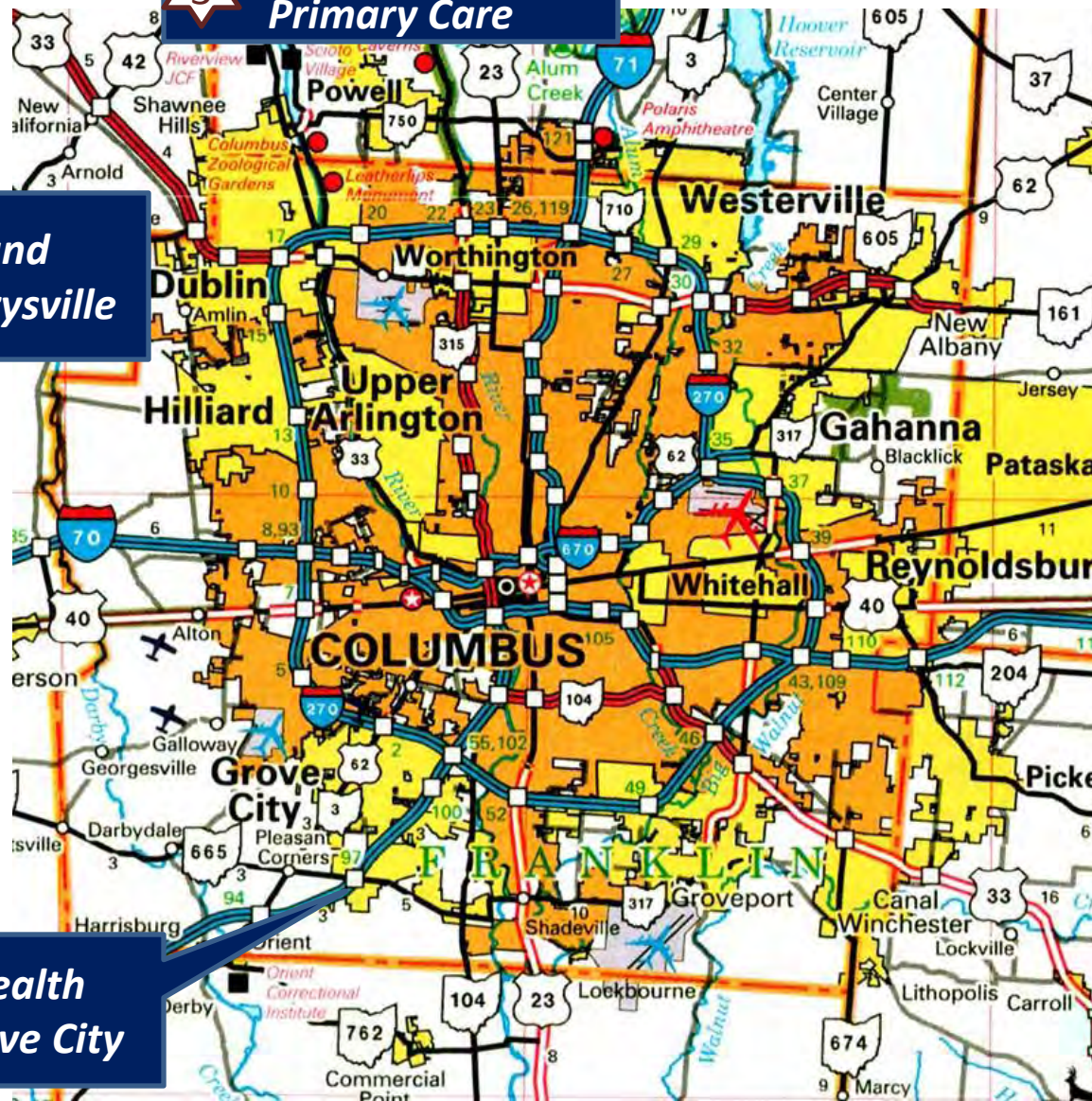


2011 Wave: Patient-Centered Medical Homes in Central Ohio

**Central Ohio Primary
Care, Marysville
Primary Care**

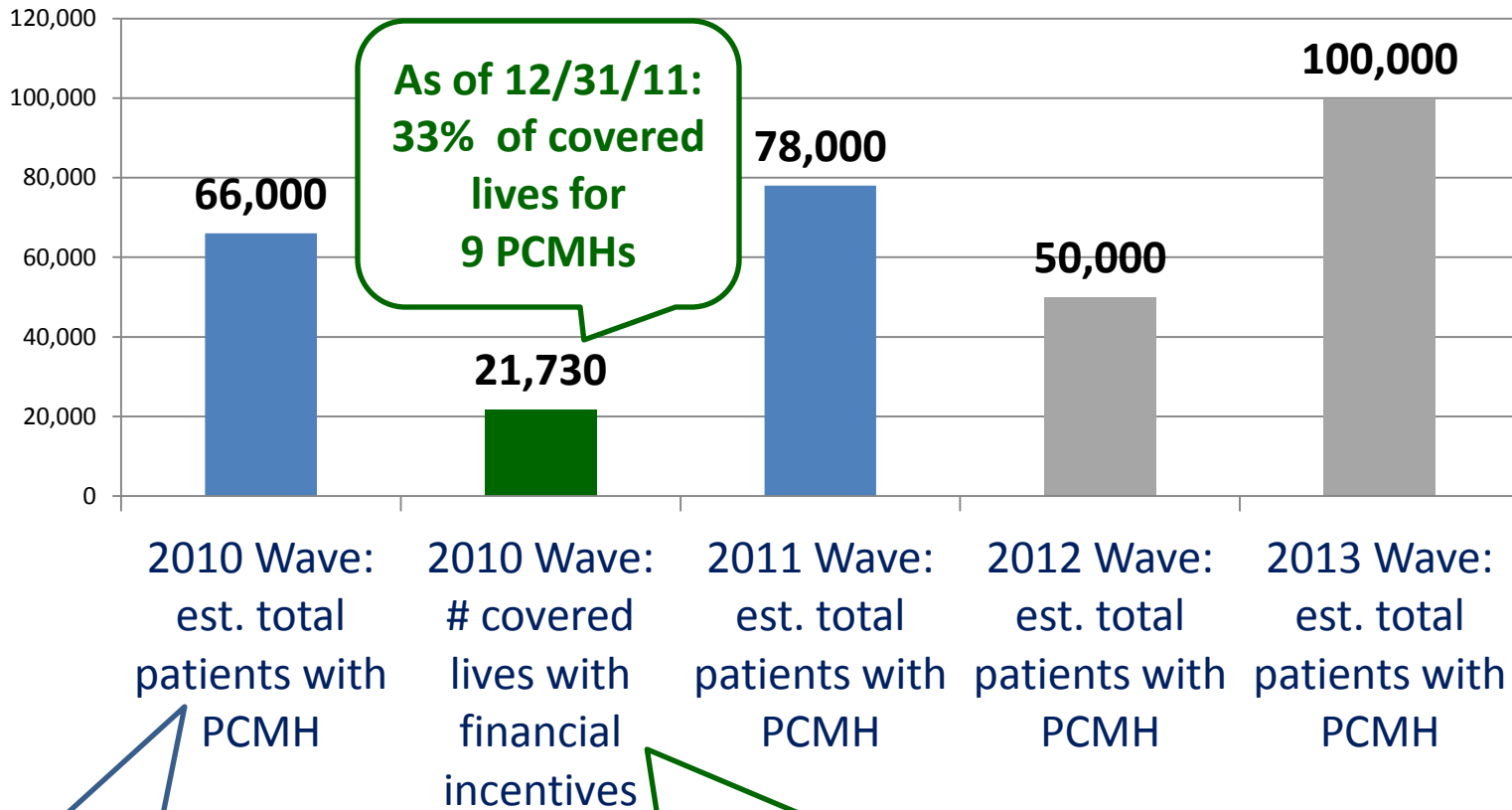
3

**Hand in Hand
Pediatrics Marysville**



**Pickaway Health
Services – Grove City**

**Patient-Centered Medical Homes (PCMH) Spread in Central Ohio
(based on activities coordinated by Access HealthColumbus)
Financial Incentives Monitor (as of November 2011)**



**As of 12/31/11:
33% of covered
lives for
9 PCMHs**

**PCMHs providing
team-based
accountable and
coordinated care
(data from 9 PCMHs)**

**Purchasers (health plans and employers)
providing incentives to enable
patient-centered medical homes to
achieve quality and cost objectives
(data from 6 health plans)**

Participating Health Plans & Employers

These purchasers have committed to provide financial incentives to recognized patient-centered medical homes in central Ohio starting in 2011:

- ✓ Anthem Blue Cross & Blue Shield
- ✓ Aetna
- ✓ Franklin County Cooperative Health Benefits Program
- ✓ Humana
- ✓ Medical Mutual of Ohio
- ✓ MediGold
- ✓ Partners for Kids
- ✓ The Ohio State University
- ✓ The Ohio State University Health Plan
- ✓ UnitedHealthcare

We anticipate additional health plans and self-insured employers will be joining our collaborative effort in 2012

Patient-Centered Medical Home Improvement Dashboard

- **Access Measures**
 - **Capacity to Schedule Same Day Appointments**
 - **Continuity of Care with Personal Physician**
- **Patient Experience**
- **Provider and Staff Job Satisfaction**
- **Diabetes Patient Self-Health Management**
- **Diabetes Management Screenings**
- **Diabetes Management Testing Outcomes**
- **Utilization Outcome Measures**
 - **Emergency Department Visits**
 - **Hospitalizations**
 - **Re-Hospitalizations**
 - **Prescriptions Filled by Generics**



WHY are we coordinating the Collaborative?

To improve patient-centered primary care as the foundation of health care delivery to achieve better care, better health, and better value in our community

Projects to Improve:	2012 Measures of Success
Adoption of patient-centered primary care, starting with the patient-centered medical home (PCMH) model	<ul style="list-style-type: none"> <input type="checkbox"/> 25,000 (existing and new) patients receive care from new PCMHs (national recognition by Q1, 2013) <input type="checkbox"/> at least 2 primary care organizations implement a strategy for spreading PCMHs utilizing their internal resources to serve an additional 25,000 (existing and new) patients <input type="checkbox"/> host at least 3 multi-stakeholder learning sessions
Patient education and engagement	<ul style="list-style-type: none"> <input type="checkbox"/> at least 2 primary care practices implement patient-family advisory councils
Aligned Incentives	<ul style="list-style-type: none"> <input type="checkbox"/> at least 4 additional purchasers (health plans and/or self-insured employers) implement financial incentives for PCMHs <input type="checkbox"/> at least 10 employers participate in learning series focused on implementing value-based benefits (implement in 2013)
Measurement	<ul style="list-style-type: none"> <input type="checkbox"/> compile and release at two Improvement Dashboards with data from PCMHs and purchasers <input type="checkbox"/> at least 4 primary care practices implement projects to improve: a) access to care or b) care coordination or c) patient self-management

**Keynote: Patient-Centered Medical Home –
sharing lessons learned on building a foundation
of accountable and coordinated care**

**Thomas Graf, MD, Associate Chief Medical Officer,
Geisinger Health System**

(Courtesy of Merck & Co., Inc.)

***Serving Patients in a Shared Medical Appointment
(Group Visit) at the
Chalmers P. Wylie VA Ambulatory Care Center***

**Edward Bope MD, Chief of Primary Care Columbus VA,
OSU Assistant Dean for VA Medical Students**

Sreedevi Nemali MD, Lead Primary Care Physician

Colleen Mc Sweeney B. S. N., RN Care Manager

Shared Medical Appointments

The group visit has been talked about in the medical home literature as an efficient method to see a group of patients in one time slot. In the VA these visits are called Shared Medical Appointments (SMAs) and are used for groups of 10-12 with a similar condition e.g. diabetes or hypertension. It is hard to imagine how a group visit can be effective and personal without experiencing one.



***Medicare Federally Qualified Health Center
Advanced Primary Care Practice Demonstration***

**Dana Vallangeon, MD, CEO,
Lower Lights Christian Health Center**

National: Medicare FQHC Advanced Primary Care Practice Demonstration

➤ *What is the FQHC Advanced Primary Care Practice Demonstration?*

The initiative is designed to evaluate the impact of the advanced primary care practice (APCP) model, also known as the patient-centered medical home (PCMH), on improving health, improving quality of care, and lowering the cost of care provided to Medicare beneficiaries served by Federally Qualified Health Centers (FQHCs). Created by the Affordable Care Act, it will pay an estimated \$42 million over three years to 500 FQHCs to coordinate care for almost 200,000 Medicare beneficiaries.

➤ Lower Lights Christian Health Center located in Franklinton was one of 20 Ohio FQHCs to participate in the project

➤ For more information please visit www.fqhcmedicalhome.com

***Raising the Bar on Patient-Centered Medical Home
National Standards***

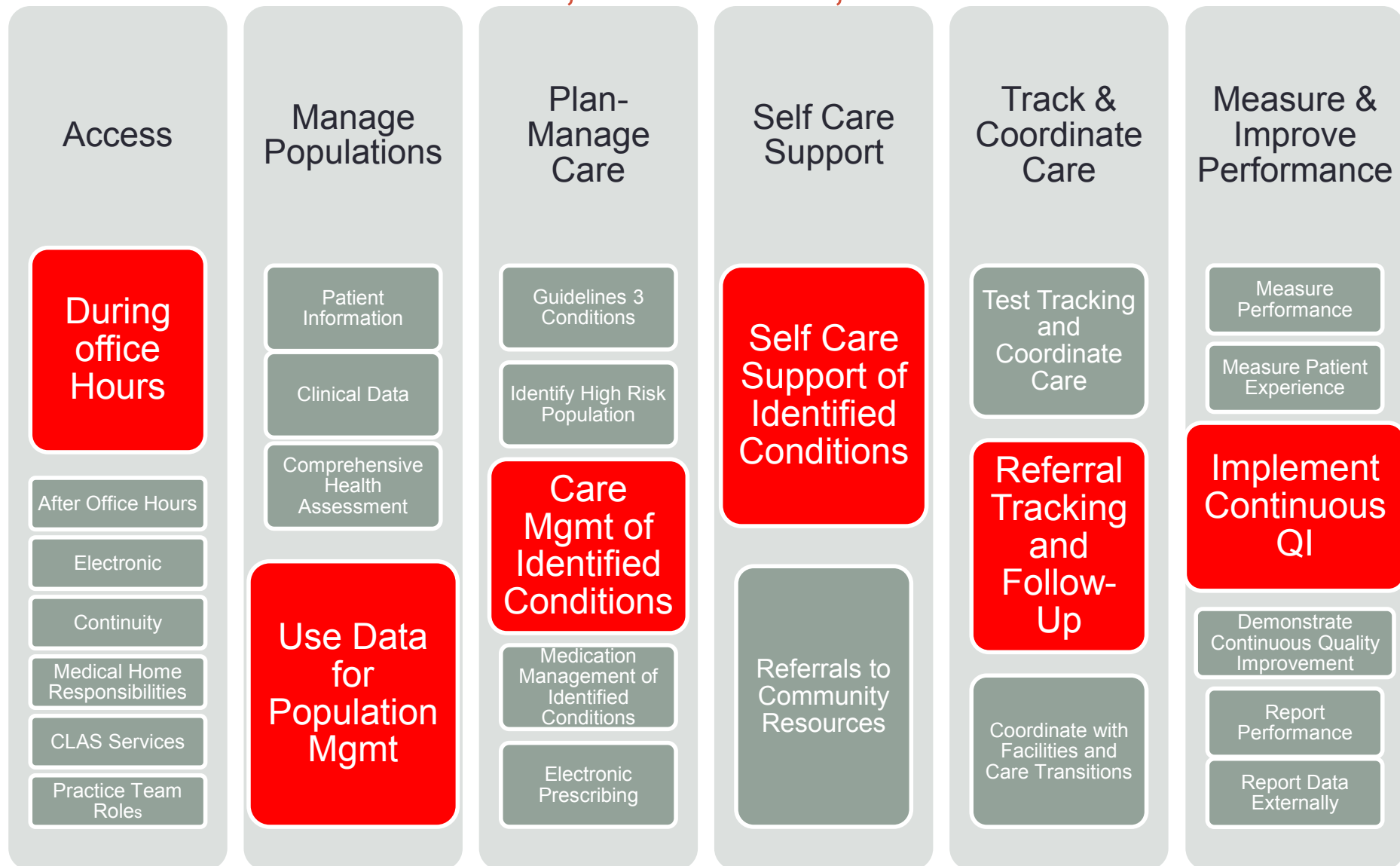
**Donna Hedrick, RN, BSN, CDE
Access HealthColumbus Consultant**

UPDATED PATIENT CENTERED MEDICAL HOME RECOGNITION

National Committee for Quality Assurance (NCQA)
2011 Standards Overview
www.ncqa.org

NCQA PCMH 2011 Standards

6 Standards, 27 Elements, 150 Factors



PCMH Scoring

6 standards = 100 points

6 Must Pass elements

Must Pass elements require a $\geq 50\%$ performance level to pass

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	85 - 100	6 of 6
Level 2	60 - 84	6 of 6
Level 1	35 - 59	6 of 6
Not Recognized	0 - 34	< 6

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 “Must Pass” Elements are not Recognized.

Practice Eligibility

- Practice
 - One of more clinicians provide care at a single geographic location
 - Physicians, (Physician Assistants, Nurse Practitioners-with their own panel of patients)
 - Internal Medicine, Family Practice, Pediatrics
- Multisite groups with more than 3 locations
 - Practice care team follows same procedures
 - Medical records are available and shared
 - Same systems and procedures for clinical and administrative functions

Other Medical Home Recognition & Accreditation Programs

- **URAC (formerly the Utilization Review Accreditation Commission)**
- **Joint Commission**
- **Accreditation Association for Ambulatory Health Care (AAAHC)**

Funding from the following public-private partners supports our collaborative work in the community!

Lead Supporter



Columbus Medical
Association Foundation

Major Supporters



Additional Supporters

100%
Access HealthColumbus
Board & Staff

Individual &
Corporate
Donations