Advanced Health Care Homes: Creating Through Partnerships

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Key Features of Health Reform

- *Individual Mandate:* purchase coverage or pay penalty, with income-based subsidies up to 400% of poverty ($41,000/$88,000) to make coverage affordable
- *Employer Contribution:* offer coverage or pay penalty
- *Medicaid Expansion:* all individuals up to 133% of poverty (major new group: adults)
- *Health Insurance Exchanges:* marketplace for consumers, with competing plans
- *Insurance market reforms,* to end discrimination
- *Workforce Training Reforms*, especially Primary Care
- *Payment System Reforms*, especially Integrated Care

Health Reform: What Might It Mean for You?

- **You will face increasing pressure to integrate with other providers both vertically and horizontally**
  - Vertically: to coordinate patient care through various levels to assure continuity and full sharing of clinical data/information with all members of the health care team
  - Horizontally: to coordinate service delivery across a level of care (eg, primary care) to better match capacity and demand at various sites, share full information, and link patients with needed enabling services

Health Reform: What Might It Mean for You?

- **These pressures will include financial / payment incentives and penalties (eg, medical homes & accountable care organizations)**
- **<u>The greatest challenges will be how to plan for this expansion and how to achieve integrated care while maintaining your autonomy and mission focus</u>**
  - How to respond to competition from Managed Care Organizations?
  - How to work with partners/sister organizations to ensure success?

Crucial Value of Primary Care in Health Reform

- *Entry point* into health care system
- Focus on *whole individual* (not organs, systems)
- Treat *most common* conditions and *prevent* ill health
- Have *continuing relationship* with individuals in care
- *Manage and coordinate* all care for individual (referral, diagnostics, specialty/inpatient care)
- Address individual needs in context of *family* and *community* (relationship/stressors, nutrition, environment, occupation, violence, epidemics, etc.)

Result: more primary care leads to <u>better access</u>, <u>better health outcomes</u>, and <u>LOWER COSTS</u>

Characteristics of the Patient Centered Medical Home

- In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association – the leading primary care physician organizations- released the Joint Principles of the Patient-Centered Medical Home. In this document they state the characteristics of the Patient Centered Medical Home:
  - **Personal Relationship**: Each Patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Characteristics of the Patient Centered Medical Home

- **Team Approach:** The Personal Physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing patient care.

- **Comprehensive:** The personal physician is responsible for providing for all the patient's health care needs at all stages of life or taking responsibility for appropriately arranging care with other qualified professionals.

Characteristics of the Patient Centered Medical Home

- **Coordination:** Care is coordinated and integrated across the domains of the health care system, facilitated by registries, information technology, health information exchange and other means to assure that patient get the indicated care when and where they want it.

- **Quality and Safety**: Quality and Safety are hallmarks of the medical home. This includes using electronic medical records and technology to provide decision-support for evidence-based treatments and patient and physician involvement in continuous quality improvement.

Characteristics of the Patient Centered Medical Home

- **Expanded Access**: Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, physicians, and practice staff.
- **Added Value**: Payment that appropriately recognizes the added value provided to patients who have Patient-Centered Medical Home.

Advanced Health Care Homes

- Meet medical home criteria but include oral and mental health as services.
- Meet meaningful use criteria – certified EHR, 15 core measures and 5 from menu set, as well as 3 quality core measures and 3 additional ones from a set of 38 (stage one).

Focus of Quality

- Advanced healthcare homes require collaboration with more entities.
  - Advanced Health Care Homes (AHCHs) provide personal, team-oriented, comprehensive, coordinated, high-quality, safe care while creating expanded access, in a culturally competent manner, adding value to the care at each step.
  - Creating these AHCHs requires close collaboration and the development of partnerships among many organizations. Each organization provides specific skills and performs specific tasks. The care is integrated, comprehensive and coordinated.

Focus of Quality

- IT systems are in place that are integrated, allow for data exchange, and support the needs of the advanced health care home.
- EMR meaningful use, movement from process measures to outcome measures.
- More coordination of care both vertically and horizontally.
- Greater integration of care including behavioral health.

Growth – Stepping up

- Staff training
- Infrastructure funding
- Increased accountability and scrutiny
- More complex organizations and organizational structures
- Greater legal/compliance complexities

Advanced Health Care Homes - GCHC

Attributes

Personal

Team

Comprehensive

Coordination

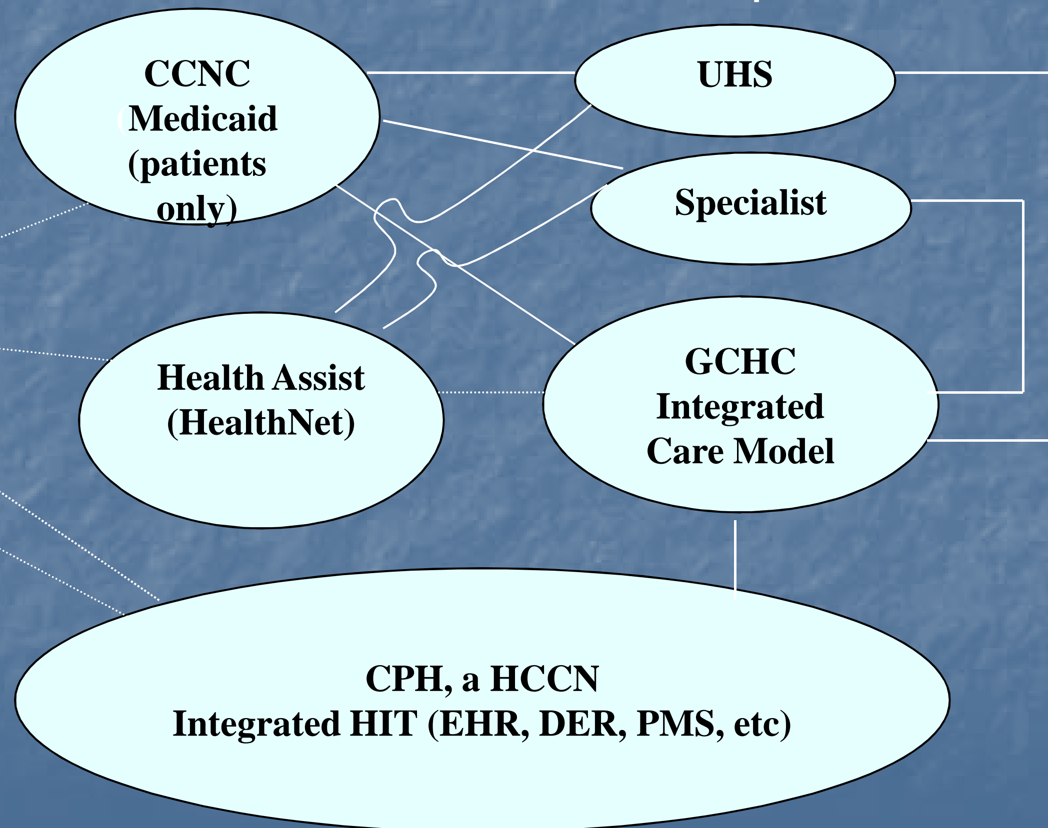
Quality & Safety

Expanded Access

Cultural competency

Added Value

Partnerships



GCHC Major Partnership

- Community Partners HealthNet
- East Carolina University
- Pitt County Memorial Hospital
- CCP of Eastern NC
- Health Assist (Greene & Pitt)
- Greene & Pitt County Health Departments
- Office of Rural Health & Community Care
- NCCHCA, NACHC

Community Partners HealthNet

- Health center controlled network, 501(c)3, formed in 1999
- Delivers integrated EHR, PMS, and DER using a centralized ASP model
- Clinical Data Warehouse
- HIPAA/HITECH/Security
- Disaster Recovery Site
- High level staffing

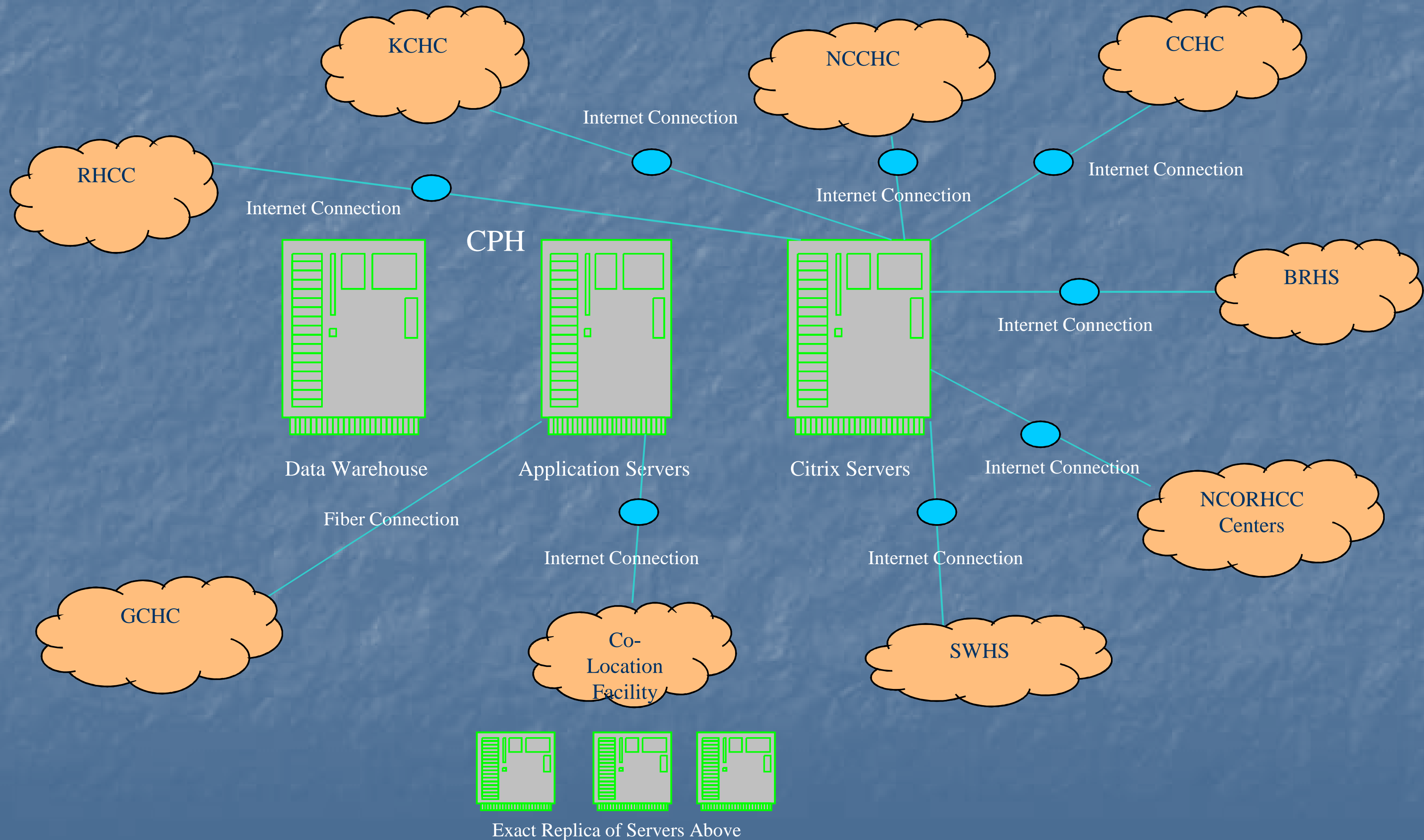
Networks – Strengths

- Collaboration on HIE/NHIN
- Data mining/standardized outcomes measurement, facilitating quality discussions among health centers
- Meaningful/use as the bar keeps moving up
- Economies of scale, higher levels of expertise, enterprise level solutions
- Close communication with PCAs and ORHCC

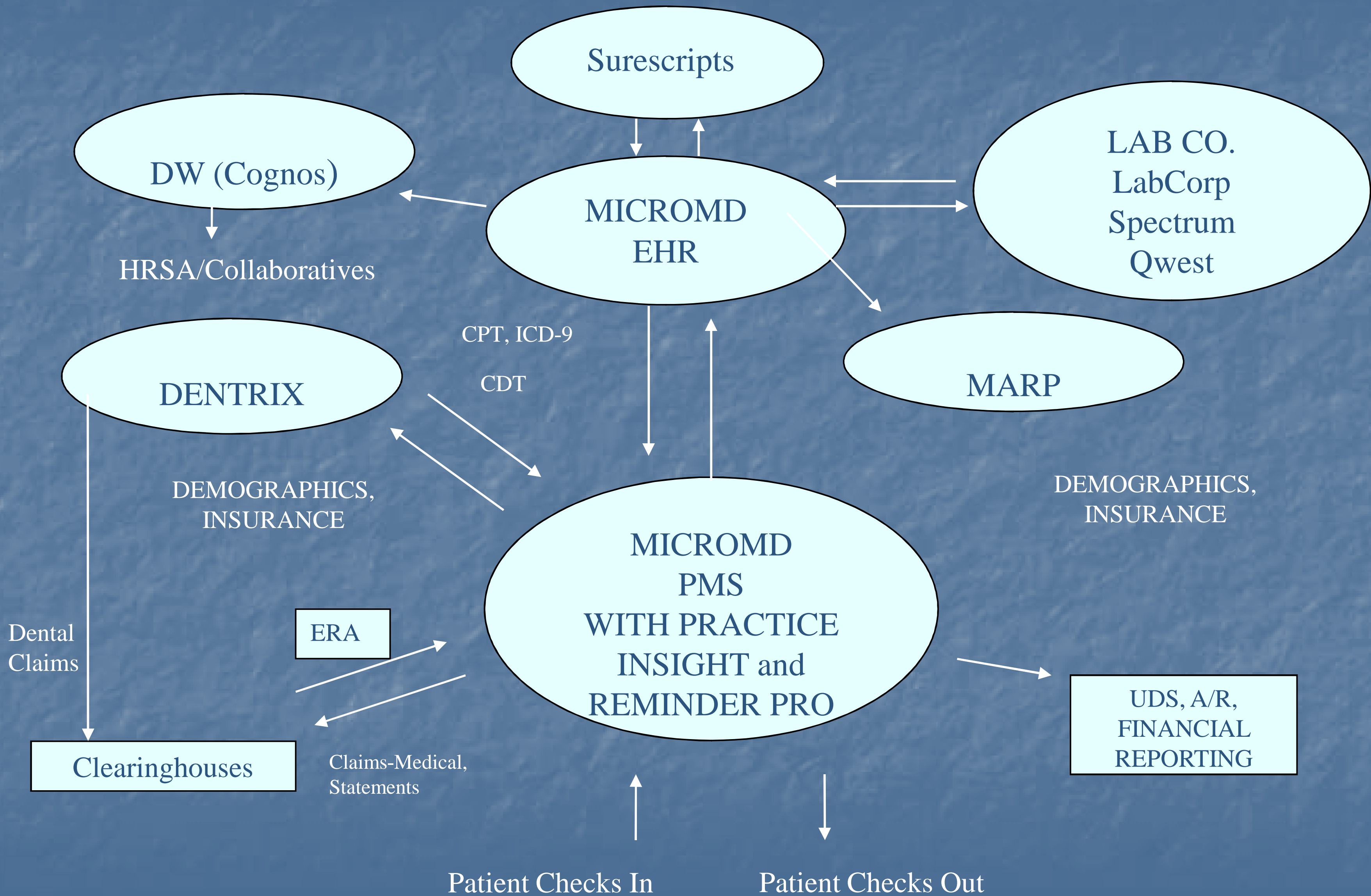
Networks – Strengths

- Work with state agencies and regional entities on demonstrations and other projects through business arrangements (accountable care organizations, etc.)
- IT workforce development and funding for it
- Assist health centers with business efficiencies, IT, billing, managed/accountable care organizations, and portions of advanced health care home.

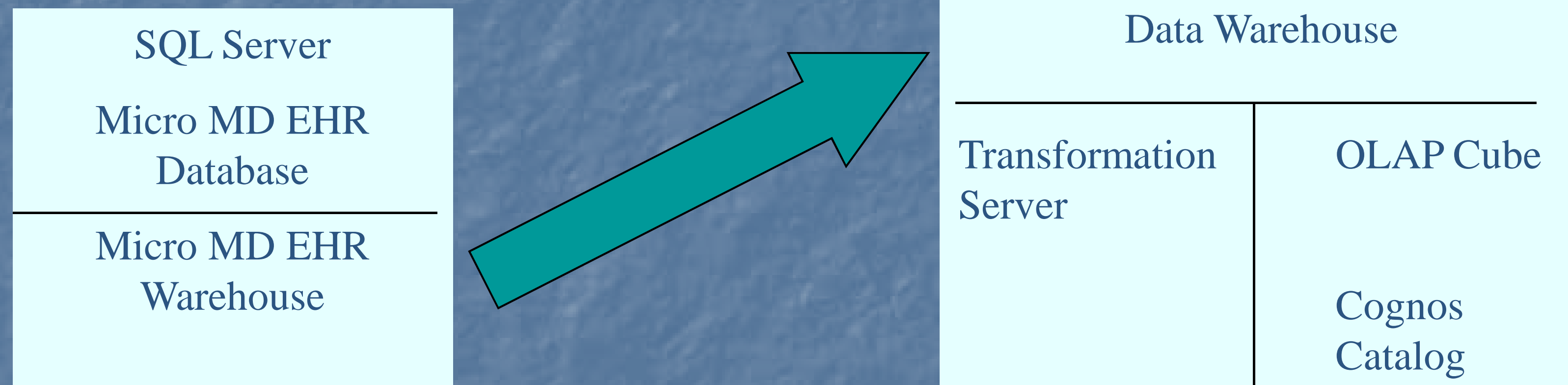
CPH Network Schematic



CPH Integrated Applications



Simplified Design of Data Transfer/Transformation



Creates views, groupings, and events

Community Partners HealthNet has already added additional functionality to Micro MD EHR to create views, groupings (e.g. diabetics, CVD, etc.) and events (e.g. 2 BPs in last year). The data is exported to the transformation server in the data warehouse, which populates the new database. A Cognos catalog is used to access the data and used to write the reports.

Community Partners
HealthNet
Date: 9/28/06

HbAlc Test Range For Diabetes Patients Last Year

GCHC

Race: BLA	Total number who had HbA1c test: 268	
HbA1c test result range: 7.0 or less	Number of patients: 153	Percentage: 57.09%
HbA1c test result range: 7.0-7.9	Number of patients: 85	Percentage: 31.72%
HbA1c test result range: 8.0-8.9	Number of patients: 42	Percentage: 15.67%
HbA1c test result range: 9.0-9.9	Number of patients: 29	Percentage: 10.82%
HbA1c test result range: 9.9 or more	Number of patients: 42	Percentage: 15.67%
Race: HIS	Total number who had HbA1c test: 125	
HbA1c test result range: 7.0 or less	Number of patients: 55	Percentage: 44.00%
HbA1c test result range: 7.0-7.9	Number of patients: 27	Percentage: 21.60%
HbA1c test result range: 8.0-8.9	Number of patients: 21	Percentage: 16.80%
HbA1c test result range: 9.0-9.9	Number of patients: 24	Percentage: 19.20%
HbA1c test result range: 9.9 or more	Number of patients: 39	Percentage: 31.20%
Race: WHI	Total number who had HbA1c test: 120	
HbA1c test result range: 7.0 or less	Number of patients: 68	Percentage: 56.67%
HbA1c test result range: 7.0-7.9	Number of patients: 37	Percentage: 30.83%
HbA1c test result range: 8.0-8.9	Number of patients: 21	Percentage: 17.50%
HbA1c test result range: 9.0-9.9	Number of patients: 8	Percentage: 6.67%
HbA1c test result range: 9.9 or more	Number of patients: 14	Percentage: 11.67%

Lessons Learned

Well done is better than well said.

Benjamin Franklin

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