1. Enhance/Expand Medical Homes

- Project Goal: ~~Establish a "home base" for patients, where patients have a health care team that is tailored to the patient's health care needs, coordinates the patient's care, and proactively provides preventive, primary, routine and chronic care, so that patients may see their health improve, rely less on costly emergency department (ED) visits, incur fewer avoidable hospital stays, and report a greater patient experience of care.~~ The goal of projects under this heading is to expand or enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model. The PCMH provides a primary care "home base" for patients. Under this model, patients are assigned a health care team who tailors services to a patient's unique health care needs, effectively coordinates the patient's care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care. Federal, state, and health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. In addition, the PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform. PCMH development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. These projects all are focused on the concepts of the PCMH model; yet, they take different shapes for different providers

- Project Options:
  - ~~Enhance medical homes~~
  - ~~Establish/expand medical homes~~
  - ~~Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license~~[1]
  - ~~Empanel patients who would most benefit from medical homes~~
  - ~~Actively manage medical home patient panels~~
  - ~~The team will be responsible for contacting patients to receive their initial health assessment~~
  - Develop and implement action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.
  - Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs' NCQA PCMH readiness.
  - Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status

[1] ~~Providers who operate at the top of their license are being maximally utilized so that (1) the overall capacity of the primary care team is optimized and (2) the patient receives optimal care from the most appropriate team member.~~

Comment [MD1]: In general, the project goal descriptions are very minimal. Suggest expanding this description. For example (I tried to incorporate your words into this more robust description):

The goal of projects under this heading is to expand or enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model. The PCMH provides a primary care "home base" for patients. Under this model, patients are assigned a health care team who tailors services to a patient's unique health care needs, effectively coordinates the patient's care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care. Federal, state, and health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. In addition, the PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform.

PCMH development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction.

These projects all are focused on the concepts of the PCMH model; yet, they take different shapes for different providers. …

Comment [jw2]: Language included

Comment [MD3]: Suggest that the project options be a bit more specific in the way they are laid out. To note, many of the measures identified below would follow this anyway. For example:
oDevelop and implement action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.
oUtilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs' NCQA PCMH readiness.
oConduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
oConduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.
oCollaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients.
oImprove data exchange between hospitals and affiliated medical home sites.
oDevelop best practices plan to eliminate gaps in the readiness assessment.
oRestructure staffing into multidisciplinary care teams that manage a panel of patients where … [1]

Comment [jw4]: Language included

DRAFT

- Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.
- Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients.
- Improve data exchange between hospitals and affiliated medical home sites.
- Develop best practices plan to eliminate gaps in the readiness assessment.
- Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license.
- Implement other evidence based project to develop or enhance Patient-Centered Medical Home Models -in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on, at minimum, all of the improvement metrics listed under ~~measure~~Milestone viii.

- Key ~~Measure~~Milestones:
  - **Process ~~Measure~~Milestones:**
    - i. ~~Measure~~Milestone: Implement the medical home model in primary care clinics
      1. Metric: Increase number of primary care clinics using medical home model
         a. Numerator: Number of primary care clinics using medical home model
         b. Denominator: Total number of primary care clinics
         c. Rationale/Evidence: NAPH found that nearly 40% of programs could offer either anecdotal or quantitative evidence of reduced ED usage—attributed to the redirection of primary care-seeking patients from the ED to a medical home.[2] In addition to reductions in ED utilization, the medical home model has helped improve the delivery and quality of primary care and reduce costs.

    - ii. ~~Measure~~Milestone: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, theirpersonal physician, and practice staff. [3]
      1. Metric: Performing Provider policies on medical home
         a. Numerator: 0 if no documentation is provided, 1 if documentation is provided.
         ~~a. Documentation of Performing Provider policies on medical home~~
         b. Denominator: NA

Comment [C5]: Need more of a narrative in the beginning about what these policies and procedures may be, as well as how they enhance access by patients specifically.

Comment [jw6]: Included language around access domain of PCMH from AAFP

[2] NAPH Research Brief February 2010 *Safety Net Medical Homes Establish "Medical Homes"*

[3] http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf

~~b.~~c. Data Source: Performing Provider's "Policies and Procedures" documents

d. Rationale/Evidence: Operationalizing the work as part of the "Policies and Procedures" for an organization will make the work the "norm" or expectation for the organization and its employees.

iii. ~~Measure~~Milestone: Reorganize staff into primary care teams responsible for the coordination of patient care . Teams can be designed in a variety of ways depending on the size and needs of the patient population and the resources of the practice. Ideally, primary care practices should be structured to respond to all common problems for which their patients seek care. Most successful practices are organized around an accountable clinician (usually a physician or advanced registered nurse practitioner or physician assistant) and a medical assistant dyad who interact continuously throughout the day. Other team members are usually responsible for providing self-management support (e.g., nurse or clinical pharmacist, or health educator) or arranging other resources (e.g., social worker). Regardless of team composition, care must be taken to keep the team size relatively small (fewer than five to seven members) because team functioning breaks down as teams grow. Other clinic staff members, including billing staff, receptionists, computer technicians, and laboratory personnel, complement the primary care teams. Each of these staff members can play important roles in engendering strong trusting relationships between patients and their care team.[4]

Comment [C7]: Would like to see in the narrative what a "team" should be. Assigning roles and responsibilities is a key part of that, but there should be an explanation (to guide the providers) of what makes a team a team.

Comment [CMMI/PfP8]: How will you determine how big and what skill sets need to be provided on the team? This needs to be included as well.

Comment [jw9]: Included language around team based care from Safety Net initiative (Qualis + Commonwealth+ MacColl).

1. Metric: Primary care team
   a. Numerator: Number of staff organized into care teams
   b. Denominator: Total number of staff
   ~~b.~~c. Data Source: Documentation of staff assignments into care teams
   d. Rationale/Evidence: "Primary care physicians are expected to provide acute, chronic, and preventive care to their patients while building meaningful relationships with those patients, and managing multiple diagnoses according to a host of evidence-based guidelines. A research study estimates that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients plus an additional 10.6 hours to adequately manage this panel's chronic conditions.[5] It is clear that primary care physicians in

[4] Safety Net Medical Home Initiative. Coleman K, Reid R, Continuous and Team-Based Healing Relationships Implementation Guide: Improving Patient Care Through Teams. 1st ed. Burton T, ed. Seattle, WA: The MacColl Center for Health Care Innovation at the Group Health Institute and Qualis Health; December 2010. http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Team-Based-Care.pdf

[5] Yarnell, K.S., K.I. Pollak, T. Ostbye, K.M. Krause, J.L. Michener. "Primary Care: is there enough time for prevention?" American Journal of Public Health 2003: 93:635-41; and Ostbye, T.,K.S Yarnal, K.M. Krause, K.I. Pollak, M. Gradison, J.L. Michener. "Is there time for management of patients with chronic diseases in primary c are?" Annals of Family Medicine 2005; 3:209-14.

DRAFT

the 15-minute visit can no longer do what their patients expect and deserve."

iv. ~~Measure~~Milestone: Expand and redefine the roles and responsibilities of primary care team members.[6]

1. Metric: Expanded primary care team member roles
   a. Numerator: 0 if no documentation is provided, 1 if documentation is provided.
   ~~a.~~b. Demominator: ~~Documentation of roles/responsibilities~~NA
   ~~b.~~c. Data Source: Revised job descriptions and documentation of established orientation and internal trainings for expanded roles and responsibilities beyond the basic education programs completed prior to hire.
   d. Rationale/Evidence: "Primary care physicians are expected to provide acute, chronic, and preventive care to their patients while building meaningful relationships with those patients, and managing multiple diagnoses according to a host of evidence-based guidelines. A research study estimates that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients plus an additional 10.6 hours to adequately manage this panel's chronic conditions.[7] It is clear that primary care physicians in the 15-minute visit can no longer do what their patients expect and deserve." Additionally, "basic medical assistant (MA) education programs do not adequately prepare individuals for the roles that MAs are increasingly asked to perform in community clinics. While most MAs are adequately trained in basic clinical skills such as taking and recording vital signs, most MA programs offer little preparation in areas such as patient care coordination or the use of the health information technology in patient management."[8]

DRAFT

[6] Safety Net Medical Home Initiative. Coleman K. Redefining Staff Roles – Where to Start. Seattle, WA: The MacColl Center for Health Care Innovation at Group Health Research Institute and Qualis Health; February 2012. http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Supplement-Team-Based-Care.pdf

[7] Yarnell, K.S., K.I. Pollak, T. Ostbye, K.M. Krause, J.L. Michener. "Primary Care: is there enough time for prevention?" American Journal of Public Health 2003: 93:635-41; and Ostbye, T.,K.S Yarnal, K.M. Krause, K.I. Pollak, M. Gradison, J.L. Michener. "Is there time for management of patients with chronic diseases in primary c are?" Annals of Family Medicine 2005; 3:209-14.

[8] S. Chapman, M. Chan, T. Bates, "Medical Assistants in Community Clinics: Perspectives on Innovation in Role Development" Research Brief, Center for the Health Professions at UCSF, June 2010.

v. ~~Measure~~Milestone: Determine the appropriate panel size[9] for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Empanelment should be based on the following principles: Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis; Assess practice supply and demand, and balance patient load accordingly; Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need. 10.

1. Metric: Determine Panel size[11]

   a. ~~Number of patients assigned to a provider care team, by provider FTE. For part-time providers or residents who are assigned a dedicated panel, list the true panel size with percentage FTE.~~ Numerator: 0 if no documentation is provided, 1 if documentation is provided.

   ~~a.~~b. Denominator: NA

   ~~b.~~c. Data Source: Panel size determination tool, ~~and ppanel by provider,~~ patient registry, -EHR, or needs assessment tool to assess appropriate panel size based on patient needs (as determined by the clinic) for proactive panel management

   ~~c.~~d. Rationale/Evidence: Panel size analysis could support panel management decisions as clinics approach population management.[12] "At the heart of the Patient Centered Medical Home model is the relationship between a patient and a provider and his/her practice team. All the activities of an effective patient centered medical home should strengthen and reinforce the primacy of that relationship, and its accountability for the patient's care. The positive impacts of seeing the same provider on patient experience, clinical care, and outcomes have been unequivocally demonstrated by research and practice."[13]

Comment [C10]: I don't see how this metric gets at the appropriate size – how do you determine what is appropriate for the particular patient population? This metric is just a count of patients per FTE – doesn't really help you determine appropriateness.

Comment [jw11]: Addressed by including citation for panel size determination tool, which uses encounter volume, appointment availability and average visits per patient per year.

DRAFT

[9] Measure panel size by the number of patients assigned to a provider care team, by provider FTE. For part-time providers or residents who are assigned a dedicated panel, list the true panel size with percentage FTE. Panel size analysis could support panel management decisions as clinics approach population management.

[10] http://www.safetynetmedicalhome.org/change-concepts/empanelment

[11] See Determining Perfect Panel Size excel tool found at http://www.safetynetmedicalhome.org/change-concepts/empanelment

[12] *Safety Net Medical Home Initiative*. Coleman CF, Phillips KE, eds. Empanelment Implementation Guide: Establishing Patient-Provdier Relationships. 1st ed. Seattle, WA: The MacColl Institiute for Healthcare Innovation at the Group Health Research Institute and Qualis Health, March 2010.

[13] Safety Net Medical Home Initiative. Coleman CF, Phillips KE, eds. Empanelment Implementation Guide: Establishing Patient-Provider Relationships. 1st ed. Seattle, WA: The MacColl Institute for Healthcare Innovation at the Group Health Research Institute and Qualis Health, March 2010; Saulz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. Ann Fam Med. 2005;3(2):159-66; and Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair, CE, McKendry R. Continuity of Care: a Multidisciplinary Review. BMJ, 2003;327(7425):1219-21.

vi. ~~Measure~~Milestone: Establish criteria for medical home assignment

1. Metric: Medical home assignment criteria

a. Numerator: 0 if no documentation is provided, 1 if documentation is provided.

—Denominator: NA

~~a.~~b. ~~Submission of medical home assignment criteria, such as patients with specified chronic conditions;[14] patients who have had multiple visits to a clinic; high-risk patients; patients needing care management; high utilizers of health care services;[15] and patients with particular socio-economic, linguistic, and physical needs[16]~~

~~b.~~c. Data Source: Submission of medical home assignment criteria, such as patients with specified chronic conditions;[17] patients who have had multiple visits to a clinic; high-risk patients; patients needing care management; high utilizers of health care services;[18] and patients with particular socio-economic, linguistic, and physical needs[19]
Performing Provider policies and procedures or other similar documents

d. Rationale/Evidence: With limited resources, it may behoove some organizations to focus their work on medical homes within a subset of patients. Also, some of these higher risk patients are the highest utilizers of health care resources and dollars. Focusing on these cohorts should result in reduced health care costs. At Carolinas Medical Center in Charlotte, NC, interventions targeting high-risk patients who utilized the hospital's medical home resulted in an 80% decrease in hospitalizations and ED visits for the intervention group.[20]

vii. ~~Measure~~Milestone: Track the assignment of patients to the designated care team

1. Metric: Tracking medical home patients

~~[14] Such as: Diabetes, hypertension, chronic heart failure, obesity, asthma, post-secondary stroke, community-acquired pneumonia (CAP), HIV/AIDS, chronic pain, and depression.~~

~~[15] Such as patients who have presented in the ED, been admitted to the hospital, or visited specialty clinics multiple times.~~

~~[16] Such as seniors and persons with disabilities, homeless people, and immigrants.~~

[17] Such as: Diabetes, hypertension, chronic heart failure, obesity, asthma, post-secondary stroke, community-acquired pneumonia (CAP), HIV/AIDS, chronic pain, and depression.

[18] Such as patients who have presented in the ED, been admitted to the hospital, or visited specialty clinics multiple times.

[19] Such as seniors and persons with disabilities, homeless people, and immigrants.

[20] Wade, KE, Furney, SL,Hall, MN (2009) Impact of Community –Based Patient-Centered Medical Homes on Appropriate Health Care Utilization at Carolinas Medical Center. NC Med J, 70(4), 341-345.

DRAFT

a. Numerator: 0 if no documentation is provided, 1 if documentation is provided.

Denominator: NA

a.b. Submission of tracking report

b. Data Source: Submission of tracking report.

c. Can be tracked through the practice management system, EHR, or other documentation as designated by Performing Provider

d. Rationale/Evidence: Review panel status (open/closed) and panel fill rates on a monthly basis for equity to be able to adjust to changing environment (e.g., patient preference, extended provider leave).

viii. MeasureMilestone: Develop or utilize evidence based training materials for medical homes based upon the model change concepts. [21]

1. Metric: Documentation of staff training materials.

a. Numerator: 0 if no documentation is provided, 1 if documentation is provided.

b. Denominator: NA

c. Data Source: Training materials.

d. Rationale/Evidence: PCMH model change concepts are widely supported as the means to achieve meaningful and sustainable PCMH practice transformation.

Comment [C12]: Need more information

Comment [jw13]: Language and citation included around PCMH change concepts.

viii. ix. MeasureMilestone: Train medical home personnel on PCMH change concepts.

1. Metric: Number of medical home personnel trained

a. Numerator: 0 if no documentation is provided, 1 if documentation is provided.

b. Denominator: NA

c. Data Source: Training records and HR documents

d. Rationale/Evidence: PCMH model change concepts are widely supported as the means to achieve meaningful and sustainable PCMH practice transformation.

Comment [C14]: Trained for what?

Comment [jw15]: Included reference to PCMH model change concepts (heavily supported as the means to achieve meaningful and sustainable PCMH practice transformation.

ix. x. MeasureMilestone: Expand and document interaction types between patient and healthcare team beyond one-to-one visits to include group visits, telephone visits, and other interaction types

1. Metric: Documentation of interaction types and expansion of use

2. Percent of hospitalized patients who have clinical, telephonic or face-to-face follow-up interaction with the care team within 2 days of discharge during the measurement month at sites with implemented complex care management.

Comment [C16]: Before this metric, you should have one that identifies the different interaction types that should be made available and for which types of patients (which patients would most benefit from particular interaction types, such as group visits).

[21] http://www.qhmedicalhome.org/pcmh-qualis-health/change-concepts

DRAFT

3. Percent of patients who have been seen in the Emergency Room with a documented chronic illness problem, who have clinical telephonic or face-to-face follow-up interaction with the care team within 2 days of ER visit during the measurement month at sites with implemented complex care management.

x.

xi.

xii. xi. MeasureMilestone: Identify current utilization rates of preventive services and iimplement a system to improve rates among targeted populationprevention services (must select at least one metric):

1. Metric: Implement a patient paper-based or electronic tool to measure registry that captures prevention preventive services utilization.
   a. Numerator: Number of patients overdue for preventive services.
   b. Denominator: Total number of patients in the registry
   Data Source: Patient registry or .EHR
   c.
   a. Rationale/Evidence: Relationship-centered aspects of PCMH are more highly correlated with preventive services delivery in community primary care practices than are information technology capabilities. [22]

2. Metric: Implement a recall system and /processes that allow staff to report which patients are overdue for which for targeted preventiveion services and track when and how patients were notified on their needed services.
   a. Numerator: 0 if no documentation is provided, 1 if documentation is provided.
   b. Denominator: NA
   c. Data Source: Documentation of recall report
   d. Rationale/Evidence: The goal of this measure is to make evidence-based care routine. This is accomplished through both planned interactions initiated by the practice, and through point-of-care reminders which help ensure that every interaction is informed by the clinical needs and wishes of the patient. This means that the availability of up-to-date patient information is key, as well as the care team's ability to review patient data before the visit and communicate via team

Comment [C17]: This is good, but needs more specificity.

Comment [jw18]: Added language to reflect identify preventive service gaps, and implement system to get patients in to receive said services.

DRAFT

[22] http://annfammed.org/content/8/2/108.full.pdf+html

huddles or other formats to work efficiently as a unit and maximize the value of each interaction.

3. Metric: Develop prevention services education management and outreach program
    a. Numerator: 0 if no documentation is provided, 1 if documentation is provided.
    b. Denominator: NA
    c. Data Source: Program documentation, including policies and procedures
    ~~b.~~ Rationale/Evidence: Educating patients about the benefits and availability of preventive services is critical to patient-centered care and patient wellness. Additionally, having processes in place that define targeted populations and outreach activities will promote wellness as a culture within the patient panel practice at large.
    d.

- **Improvement ~~Measure~~Milestones:**
    i. ~~Measure~~Milestone: Based on criteria, improve the number of ~~assign~~ eligible patients[23] that are assigned to the medical homes.
        1. Metric: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the Performing Provider
            a. Numerator: Number of eligible patients assigned to a medical home
            b. Denominator: Total number of eligible patients
            c. Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider
            d. Rationale/Evidence: Murray M, Davies M, Boushon B, Panel Size: How Many Patients Can One Doctor Manage? *Fam Pract Manag.* 2007 Apr;14(4):44-51

    ii. ~~Measure~~Milestone: New patients assigned to medical homes receive their first appointment in a timely manner

[23] Many patients seen at safety net hospitals seek only episodic care and would not avail themselves of a medical home. Eligibility for medical home is determined for each plan, according to unique confluence of patient populations and delivery system structure, using criteria such as 1-2 primary care visits within 12-24 months, frequent utilization of emergency services, and/or identified medical needs such as chronic conditions.

1. Metric: Improve ~~N~~number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days
    a. Numerator: Number of new patients contacted within specified days
    b. Denominator: Total number of new patients
    c. Data Source: Practice management or scheduling systems, registry, EHR, or other documentation as designated by Performing Provider
    d. Rationale/Evidence: It is important to get new patients into the medical home in a timely manner.

iii. ~~Measure~~Milestone: Patient access to medical home
    1. Metric: Third Next-Available Appointment
        a. Numerator: The length of time in calendar days between the day an existing patient makes a request for an appointment with a provider/care team, and the third available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as an average of the providers in a given clinic. It will be reported for the most recent month. The ultimate improvement target over time would be seven calendar days (lower is better), but depending on the Performing Provider's starting point, that may not be possible within five years.
        b. Denominator: NA
        ~~b.~~c. Data Source: Practice management or scheduling systems
        d. Rationale/Evidence: This measure is an industry standard of patients' access to care. Under principles of PCMH open access, this should be same day. [24]
        ~~For example, the IHI definition white paper on whole system measures cite this metric.~~

iv. ~~Measure~~Milestone: Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes
    1. Metric: Usual source of care

Comment [C19]: As written, these 2 measures are really process measures – they aren't set up to show improvement.

Comment [jw20]: addressed

Comment [CMMI/PfP21]: What is the goal for time to appt? Need to set an aim.

Comment [jw22]: This should be same day to be in accordance with PCMH principles of open access. Language and citation included

[24] Safety Net Medical Home Initiative. Moore LG, Powell J. Enhanced Access Implementation Guide: Providing the Care Patients Need, When They Need It. 1st ed. Burton T, ed. Seattle, WA: Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute; December 2010. http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Enhanced-Access.pdf

DRAFT

a. Numerator: Number of medical home patients that are able to identify their medical home as their usual source of care
b. Denominator: Total number of medical home patients
c. Data Source: Patient survey
d. Rationale/Evidence: The medical home should be seen by the patient as the patient's "home base" or usual source of care, and this measures the success of the medical home in providing ongoing, organized care for the patient and educating the patient about medical home services.

v. ~~Measure~~Milestone: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home

Comment [CMMI/PfP23]: By what percent?

Comment [jw24]: TBD by baseline and RHP plans

1. Metric: Percent of primary care visits at medical home
   a. Numerator: Number of enrolled patients' primary care visits with medical home primary care provider/team
   b. Denominator: Total number of enrolled patients' primary care visits within the Performing Provider
   c. Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider
   d. Rationale/Evidence: Patients know the professionals on their care team and establish trusting, ongoing relationships to reinforce continuity of care. Medical home model should enhance continuity.

vi. ~~Measure~~Milestone: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care

Comment [C25]: Shouldn't the measure be the number who actually received the preventive service? That would be a much more meaningful measure and could be in addition to this measure.

Comment [jw26]: Yes, added patients receiving preventive service, but left reminder messages here so that providers are able to accurately reflect effects of process changes (ie. Implementing reminder system and registry).

1. Metric: ~~Patient appointment reminders~~Reminders for patient preventive services
   a. Numerator: For select specific preventive service (e.g., pneumococcal vaccine for diabetics), the number of patients in the registry needing the preventive service and who have been contacted to come in for service
   b. Denominator: Total number of patients in the registry needing the preventive service
   c. Data Source: Registry, or other documentation as designated by Performing Provider
   d. Rationale/Evidence: Panel manager (or staff on care team) identifies patients who have process or outcome care gaps and contacts them to come in for services. This approach has been used with good effect in state and federal health disparities collaboratives. The care team assesses the patient's overall

DRAFT

health and co-develops a health care plan with the patient, including health goals, ongoing management, and future visits.

2. Metric: Number of patients receiving preventive services as indicated by standards of care (e.g., annual wellness exam, vision screening, mammograms, ect.)
    a. Numerator: For select specific preventive service , the number of patients in the registry that are up to date on the preventive service.
    b. Denominator: Total number of patients in the registry needing the preventive service
    c. Data Source: Registry, or other documentation as designated by Performing Provider
    d. Rationale/Evidence: Panel manager (or staff on care team) identifies patients who have process or outcome care gaps and contacts them to come in for services. This approach has been used with good effect in state and federal health disparities collaboratives. The care team assesses the patient's overall health and co-develops a health care plan with the patient, including health goals, ongoing management, and future visits.

vii. ~~Measure~~Milestone: Obtain medical home recognition by a nationally recognized agency (e.g., NCQA)
    1. Metric: Medical home recognition/accreditation
        a. Numerator: 0 if no documentation is provided, 1 if documentation is provided.
        b. Denominator: NA
        c. Data Source: Documentation of recognition/accreditation from Nationally recognized agency (e.g., NCQA)
        d. Rationale/Evidence: ~~Currently, there is no single medical home recognition body that has taken into account an updated definition for the medical home that includes safety net clinics/practices, but likely in the near future, there may be one. At that point, it will become~~It is important to validate the medical home service being provided by seeking and receiving recognition/accreditation.[25] Some safety net sites that have

Comment [jw27]: Qualis, Commonwealth and MacColl developed a model/change concepts that focuses on Safety Net providers and CMMI currently has FQHC demonstration project going on which uses NCQA, but my understanding is there is no recognizing/accrediting entity specifically for Safety Net. That being said, I believe NCQA uses language that is inclusive of safety net providers.

Comment [RN28]: Hasn't this changed since California submitted its original plan??

Comment [jw29]: Included language and citation about relevance of NCQA in Safety net providers. Article addresses benefits AND challenges.

[25] http://www.safetynetmedicalhome.org/practice-transformation/recognition

DRAFT

attained NCQA accreditation "reported that they have become far more sophisticated as a result of the application effort and have invested in quality improvement efforts that might otherwise have gone unrealized".[26]

viii. ~~Measure~~Milestone: Develop or expand principles of medical home and patient centered care using innovative project option.

1. Metric: Increase percentage of target population reached.
    a. Numerator: Number of individuals of target population reached by the innovative project.
    b. Denominator: Number of individuals in the target population.
    c. Data Source: Documentation of target population reached, as designated in the project plan.
    d. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching it targeted population.

Comment [jw30]: Measures specific for innovative project option.

2. Metric: Increased number of patient centered visits.
    a. Numerator: Total number of visits for reporting period
    b. Denominator: NA
    c. Data Source: Registry, EHR, claims or other Performing Provider source
    d. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care.
3. Metric: Documentation of increased number of unique patients that receive education around clinic's adoption of patient centered principles and are empanelled into the medical home. Demonstrate improvement over prior reporting period (baseline for DY2).
    a. Numerator: Total number of unique patients that receive education about patient centered clinic services and are assigned to the medical home.
    b. Denominator: NA
    c. Data Source: Registry, EHR, claims or other Performing Provider source
    ~~a.~~d. Rationale/Evidence: Patient education around medical home principles and the clinic's commitment to this model is integral to successful transformation.

[26] http://content.healthaffairs.org/content/21/5/284.full.pdf+html

DRAFT

Page 1: [1] Comment [MD3]	Maria Durham	7/24/2012 3:43:00 PM

Suggest that the project options be a bit more specific in the way they are laid out. To note, many of the measures identified below would follow this anyway. For example:

- Develop and implement action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.
- Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs' NCQA PCMH readiness.
- Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
- Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.
- Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients.
- Improve data exchange between hospitals and affiliated medical home sites.
- Develop best practices plan to eliminate gaps in the readiness assessment.
- Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license.
- Establish or expand or enhance patient-centered medical homes.
- Apply for Patient-Centered Medical Home recognition by a nationally recognized organization such as NCQA.
- Empanel patients who would most benefit from medical homes.
- Actively manage medical home patient panels.
- Contact patients to receive initial health assessment