

*FQHC:
The Model for Quality
&
The Patient-Centered Medical
Home*

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The “Rules”

- ⇒ **ASK QUESTIONS** – *your time is valuable*
- ⇒ **What do YOU want from this session?**

Whooo is here?



- FQHC staff
- FQHC providers
- FQHC Senior Leadership
- FQHC Board Members
- State Stakeholders



Objectives

Participants will be able to:

- Identify FQHCs requirements for Quality
- Define the relationship between Quality, Meaningful Use, and PCMH
- Describe the role of meaningful use
- Describe the role of PCMH

*“I saw the angel
in the marble and
carved
until I set him
free.”*

Michelangelo



**Meaningful
Use**

PCMH

Risk Mgmt

**Quality
Mgmt**

Conceptual Framework

- Quality Management adopts a number of management principles used to guide organizations towards improved performance. The principles cover:
 - Customer focus,
 - Leadership,
 - Involvement of staff.
 - Process approach,
 - System approach to management,
 - continual improvement,
 - data-driven approach to decision making and
 - mutually beneficial supplier relationships

Conceptual Framework

- ❑ PCMH is the best vision currently available for a sustainable model to deliver high value healthcare at an affordable cost
- ❑ An EMR, used correctly (meaningful use), becomes the information management infrastructure for powering the workflows required in a PCMH
- ❑ Meaningful Use is simply an operational definition of the information management requirements for supporting PCMH

Quality Management



Quality is:

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

As defined by the Institute of Medicine (IOM)

Continuous Quality Improvement (CQI)

Is the ongoing

☐ **monitoring, [auditing]**

☐ **evaluation, [assessment] and**

☐ **improvement of processes and systems.**

It is a **patient-driven** philosophy and process that focuses on **preventing problems** and **maximizing quality of care.**

What is Integrated Quality ?

- ❏ Combining aspects and functions of activities related to quality into a system that addresses the whole, to improve communication and focus on key aspects across the continuum of the organization

Quality Management Program

Rationale for integration:

- Practical – most organizations are ‘compact’
- Enhanced Communication- with a common flow of information
- Overlap of functions – limited time
- Enhanced rapid cycle PDSA
- Compacts/ consolidates related activities (performance measurement, system performance, QI projects, required measures for compliance and/or clinical measures)

Key Functions of Quality Management

- Policies & Procedures
- Medical Record
- Clinical Protocols
- Tracking Systems
- Trend identification that impact systems and processes
- Quality Improvement Plan
- Credentialing
- Peer Review
- Privileging
- Compliance
- Safety
- Risk Management

Origin of Required Functions for FQHC Quality Program

HRSA's Expectations for Quality Programs

- PIN 98-23 & (42 CFR 51c.303(c)(1-2))
- FTCA
- UDS – Improved Clinical Outcomes

Medicaid & Medicare

Accreditation organization/ Joint Commission

Contractual relationships – managed care

HRSA Expectations of Quality

Health centers **must** have:

- ❑ An ongoing Quality Program
 - To ensure continuous performance improvement
 - Effective clinical and administrative leadership to support Quality Program
 - Policies and procedures to guide the delivery of health care services and the quality program
 - Quality Committee – interdisciplinary supported by leadership

HRSA Expectations of Quality

Health centers **must** have:

- ❑ An ongoing Quality Program
 - Quality studies addressing utilization of appropriate specialty referral, prescribing, hospital – inpatient and ER use
 - Use of data to monitor performance with benchmarking and trending overtime
 - Process for communicating quality activities and results to
 - Management
 - Board
 - Staff

PIN 98-23 & (42 CFR 51c.303(c)(1-2))

HRSA Expectations of Quality

Health centers **must** have:

- ❑ Have a system and process [written policy] to utilize data to monitor performance to:
 - compare to internal and external benchmarks,
 - tracking trends over time
 - With identified trends leading to documented improvements
- ❑ method [written process] for periodic re-assessment of performance (*Quality Plan, Work Plan & Calendar*)

HRSA Expectations of Quality

Health centers **must** have:

- ❑ Have the capacity to measure performance using **standard performance measures** and **accepted scientific approaches** [methodology]. (*Model for Improvement*)
- ❑ In analyzing performance data, health centers should compare their results with other comparable providers at the state and national level [BENCHMARK], and set realistic goals for improvement.

HRSA Expectations of Quality -

HRSA/BPHC PIN 98-23

- Health centers must have written policies and procedures which address at least the following elements:
 - hours of operation;
 - patient referral and tracking systems;
 - the use of clinical protocols;
 - risk management procedures;
 - procedures for assessing patient satisfaction;
 - consumer bill of rights; and
 - patient grievance procedures.

FTCA Requirements of Quality

- ❑ Quality Programs will conduct periodic assessments.

Assessments shall be:

- Conducted by physicians or other licensed health professional under supervision of physicians
- Based on the systematic collection and evaluation of patient records
- Identify and document the necessity for change in the provision of services, and
- Result in the institution of such change, whenever warranted

FTCA Requirements of Quality

- ❑ Quality Committee – “focus of responsibility” to support the QI Program
- ❑ QI identified trends impact systems and processes documented
- ❑ Written & approved Quality Improvement Plan

Expectations of Quality Joint Commission

1. Set Priorities
2. Priority to high volume, high-risk, problem-prone processes
3. Reprioritize performance improvement activities
4. Organization-wide performance improvement

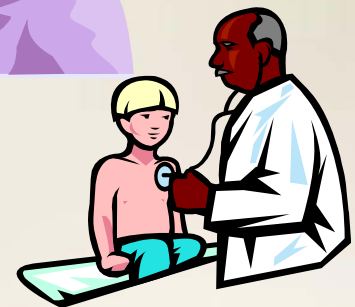
*LD.04.04.01 Leadership Managing Safety & Quality Elements of Performance/
Ambulatory Standards*

Meaningful Use

Meaningful Use (MU)

All of the many things
that computers need to
do to **store, organize
and manage
information** in a way
that supports people in
the enterprise of
healthcare

Jeff Hummel, MD, Qualis Health



Meaningful Use As A Series Of Steps

- Step 1: Practice Management System:
 - demographics, privacy, insurance eligibility & claims submission
- Step 2: Clinical laboratory results reporting
- Step 3: Discrete data entry
 - CPOE, eRx, Med & Allergy Lists, Med Reconciliation,
 - Problem List
 - VS, smoking status
- Step 4: Start using the data
 - Decision support tools & Med-med/allergy/formulary checks
 - Lists of Pts by condition
 - Pt reminders & Pt clinical visit summaries
- Step 5: Start sharing information
 - Pt copies and access to info, and care transition summaries
 - quality reporting & feeding immunization registries
 - Syndromic surveillance
- Step 6: Exchange key data summary with other entities

Patient Centered Medical Home

What is the PCMH?

A PCMH puts patients at the center of the health care system, and provides primary care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”

(American Academy of Pediatrics)

Joint Principles of the PCMH

Adopted by AAFP, ACP, AAP, AOA:

- Personal Physician
- Physician Directed Medical Practice
- Whole Person Orientation
- Care is Coordinated and Integrated
- Quality and Safety are Hallmarks
- Enhanced Access
- Payment Reform

Bridges To Excellence[®] - NCQA

Physicians who receive BTE recognition pass a performance assessment program administered by the National Committee for Quality Assurance (NCQA) and other similar assessment organizations. The BTE initiative consists of programs designed to promote and reward physicians for improving the quality of patient care:

- Cardiac Care Recognition
- Diabetes Care Recognition
- Spine Care Recognition
- Physician Office Recognition
- BTE Medical Home

<https://www.healthgrades.com/content/bte>

Bridges To Excellence[®] - NCQA

BTE offers three levels of Recognition through its approved Performance Assessment Organization. Higher Recognition levels require physicians to meet higher thresholds in performance measure areas.

- Level 1 Recognition recognizes physicians and practices at or above the 50th percentile nationally.
- Level 2 Recognition recognizes physicians and practices at or above the 75th percentile nationally.
- Level 3 Recognition recognizes physicians and practices at or above the 90th percentile nationally

Overview of NCQA PPC-PCMH Recognition Program

- ❑ 9 standards, 7 of which contain “must-pass” elements
- ❑ 30 elements, 10 of which are “must-pass”
- ❑ Each element contains a series of factors upon which your final score will be based

PPC-PCMH Content and Scoring

Standard 1: Access and Communication A. Has written standards for patient access and patient communication** B. Uses data to show it meets its standards for patient access and communication**	Pts 4 5 9	Standard 5: Electronic Prescribing A. Uses electronic system to write prescriptions B. Has electronic prescription writer with safety checks C. Has electronic prescription writer with cost checks	Pts 3 3 2 8
Standard 2: Patient Tracking and Registry Functions A. Uses data system for basic patient information (mostly non-clinical data) B. Has clinical data system with clinical data in searchable data fields C. Uses the clinical data system D. Uses paper or electronic-based charting tools to organize clinical information** E. Uses data to identify important diagnoses and conditions in practice** F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	Pts 2 3 3 6 4 3 21	Standard 6: Test Tracking A. Tracks tests and identifies abnormal results systematically** B. Uses electronic systems to order and retrieve tests and flag duplicate tests	Pts 7 6 13
Standard 3: Care Management A. Adopts and implements evidence-based guidelines for three conditions ** B. Generates reminders about preventive services for clinicians C. Uses non-physician staff to manage patient care D. Conducts care management, including care plans, assessing progress, addressing barriers E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	Pts 3 4 3 5 5 20	Standard 7: Referral Tracking A. Tracks referrals using paper-based or electronic system**	PT 4 4
Standard 4: Patient Self-Management Support A. Assesses language preference and other communication barriers B. Actively supports patient self-management**	Pts 2 4 6	Standard 8: Performance Reporting and Improvement A. Measures clinical and/or service performance by physician or across the practice** B. Survey of patients' care experience C. Reports performance across the practice or by physician ** D. Sets goals and takes action to improve performance E. Produces reports using standardized measures F. Transmits reports with standardized measures electronically to external entities	Pts 3 3 3 3 2 1 15
Standard 9: Advanced Electronic Communications A. Availability of Interactive Website B. Electronic Patient Identification C. Electronic Care Management Support	Pts 1 2 1 4		

**** Must Pass Elements**

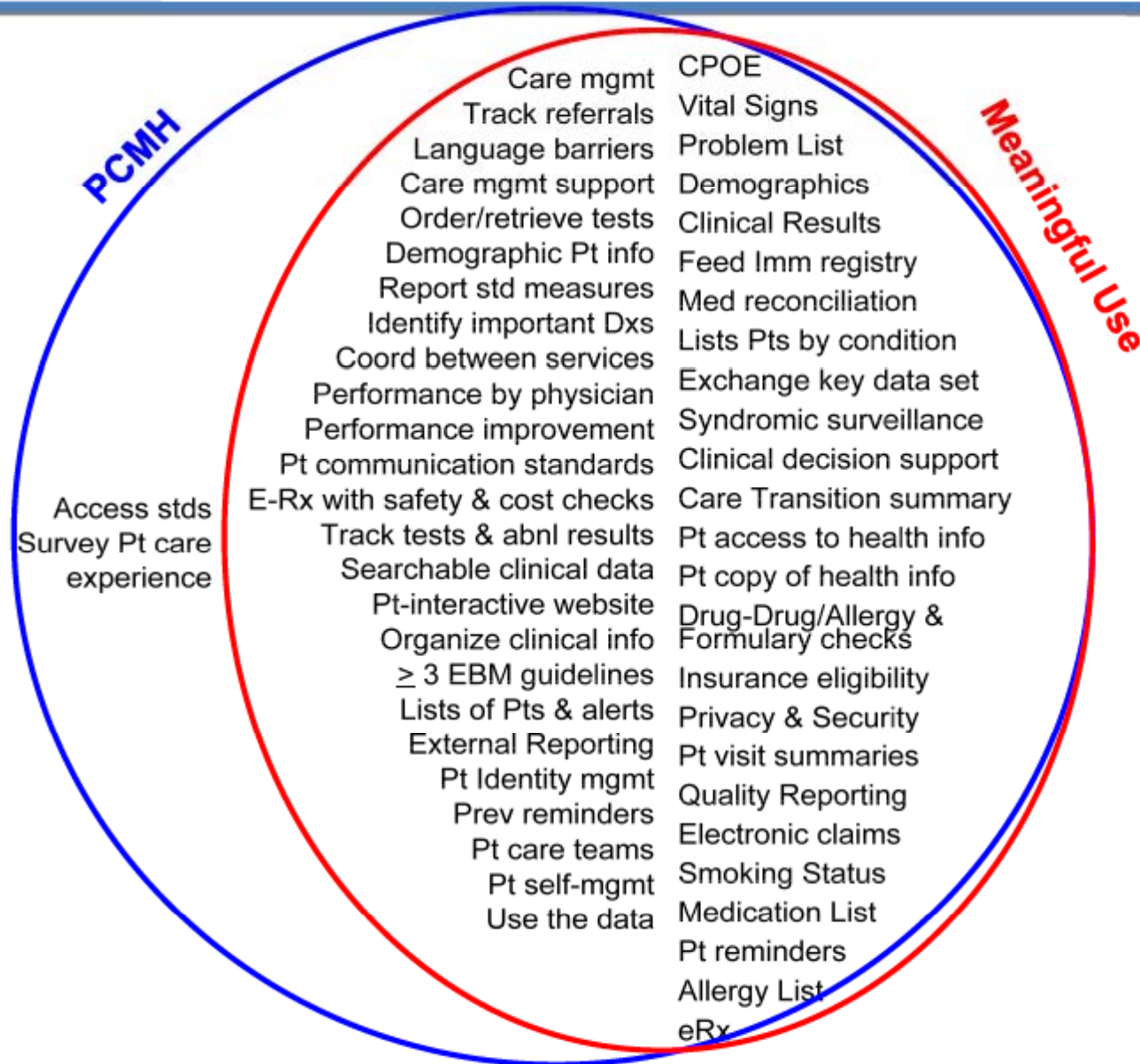
Measures of Success for Patient Centered Health Home Efforts

Commitment to organizational/system redesign to improve/enhance:

- Patient-Centered Care
- Patient Care Coordination- Both Internal and External
- Patient and Staff Satisfaction
- Clinical Outcomes
- Quality improvement
- Patient Safety
- Care that is efficient and effective
- Community Partnerships and Linkages
- Access to Specialty Care
- Opportunity to Capitalize on Revenue

Relationships

High Degree of Overlap



PCMH-MU Relationship

PCMH

- ❑ All of the many things that people need to do in order to assure high quality patient- centric care in a sustainable manner and at a cost that is affordable to society

MU

- ❑ *All of the many things that computers need to do to store, organize and manage information in a way that supports people in the enterprise of healthcare*

Jeff Hummel, MD, Qualis Health



Lessons From the Field

Lessons from the Field:

How has the PCHH Process Changed the Organization?

- Formalized policies and procedures
- Training for staff on EMR documentation
- Enhanced corporate compliance
- Revamping of Quality Improvement Program/Plan of the CHC
- Assisting in the enhancement of partnerships with hospitals and community mental health centers to improve access to care coordination and specialty care.

Five Strategies for States

- Forming Key Partnerships
- Defining and Recognizing a Medical Home
- Reimbursement Strategies
- Support for Changing Practices
- Measuring Results

Common Challenges, Barriers, and Competing Priorities

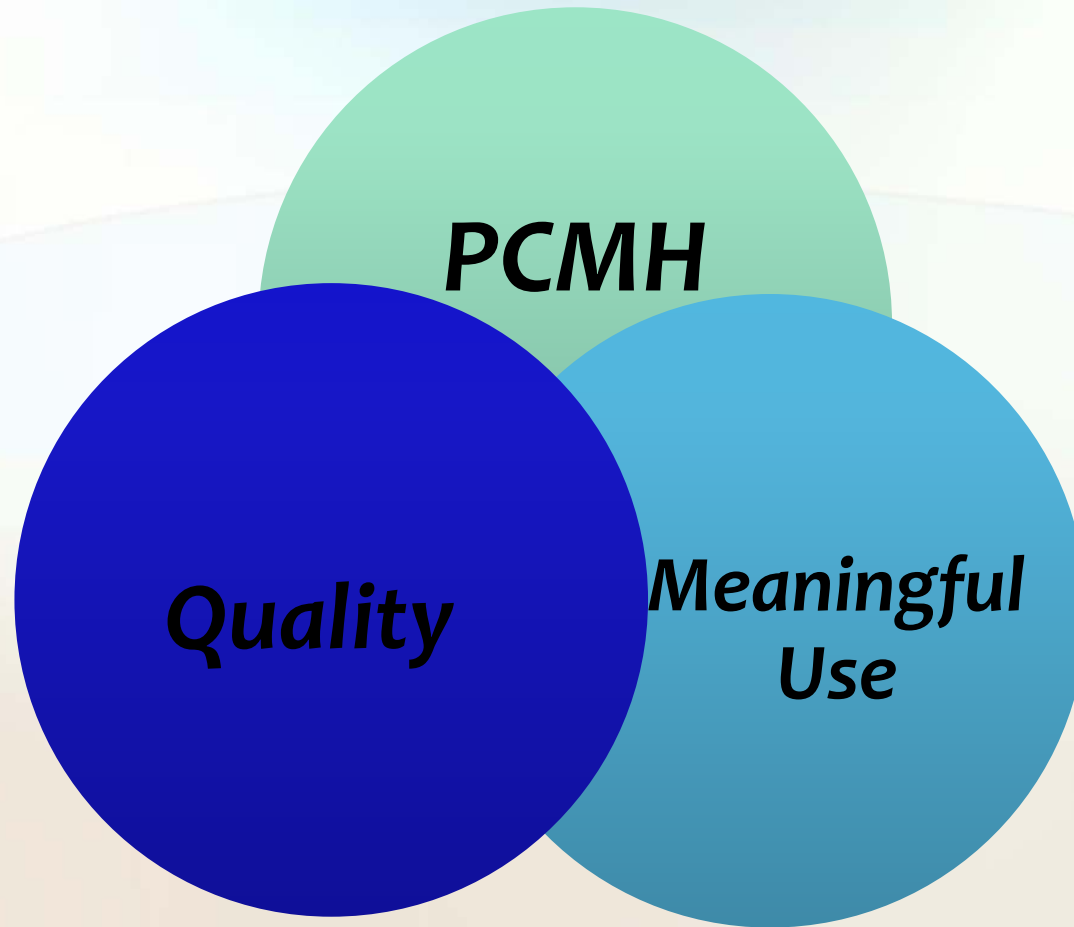
- Staff Shortage and Turnover
- Buy-In of all staff regarding importance of quality improvement
- Balance productivity demands with efficient and effective Patient-Centered Care
- Managing Change
- Maintaining High Functioning Teams
- Current Economic Climate
- Coordinating patient care with other providers in the community

Summary

The PCHH process is beneficial to the organization and provides an excellent review of the following functions:

- Quality Improvement Programs
- Care Coordination- Both internal and external
- Community Linkages and access to specialty care
- Policies and procedures
- Corporate compliance
- Data extraction/reporting
- Meaningful Use of EMR

Relationships



More Information - Quality

- ❑ **Quality Program Development GAPHC Quality Manuals** (*templates for Quality Plan and policies and procedures to support HRSA-FTCA- accreditation compliant quality program for FQHCs*) www.gaphc.org
see quality
- ❑ **NACHC** free downloads quality, risk & clinical publications
<http://iweb.nachc.com/Purchase/SearchCatalog.aspx>
- ❑ **National Quality Center** excellent resource
<http://nationalqualitycenter.org/index.cfm/22>
- ❑ **HRSA** <http://www.hrsa.gov/qualityimprovement/>

More Information PCMH

- ❑ **American Academy of Family Practice PCMH Checklist:**

http://www.aafp.org/online/etc/medialib/aafp_org/documents/membership/pcmh/checklist.Par.0001.File.tmp/PCMHChecklist.pdf

- ❑ **Patient-Centered Primary Care Collaborative:**

www.pcpcc.net/content/patient-centered-medical-home

- ❑ **Center for Medical Home Improvement:**

www.medicalhomeimprovement.org/index.html

- ❑ **Commonwealth Fund:**

www.commonwealthfund.org/Topics/Patient-Centered-Care.aspx

- ❑ **National Committee for Quality Assurance**

www.ncqa.org/tabid/631/Default.aspx

More Information PCMH

- ❑ **Primary Care Development Corporation of New York: How to Manual**

www.pcdcny.org/index.cfm?organization_id=128§ion_id=2047&page_id=8777

- ❑ **American College of Physicians:**

http://www.acponline.org/running_practice/pcmh/

- ❑ **Improving Chronic Care PCMH**

http://www.improvingchroniccare.org/index.php?p=Patient-Centered_Medical_Home&s=224

- ❑ **Qualis Health** <http://qhmedicalhome.org/index.cfm>

- ❑ **TransforMEDSM:** <http://www.transformed.com/>

More Information

FTCA <http://bphc.hrsa.gov/ftca/>

Federal Law FQHCs

http://www.access.gpo.gov/nara/cfr/waisidx_08/42cfr51c_08.html

CDN Learning Opportunities

<http://www.cdnetwork.org/NewCDN/index.aspx>

More Information

- ❑ NQHC – Measuring Quality Improving health Care
 - <http://www.ncqa.org/tabid/60/Default.aspx>
- ❑ HEDIS – National Committee for Quality Assurance
 - <http://www.ncqa.org/tabid/60/Default.aspx>
- ❑ UDS – Uniform Data Set
 - <http://bphc.hrsa.gov/uds/>
- ❑ OPR – Office of Performance Review
 - <http://www.hrsa.gov/performance/performancereview/>

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