The Office of the National Coordinator for Health Information Technology

Medical Home Overview

May 6, 2014 | Noon-1:00pm EST

Paul Klintworth, Medical Home Lead
Office of the National Coordinator for Health IT
U.S. Department of Health & Human Services

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Meaningful Use as a Building Block

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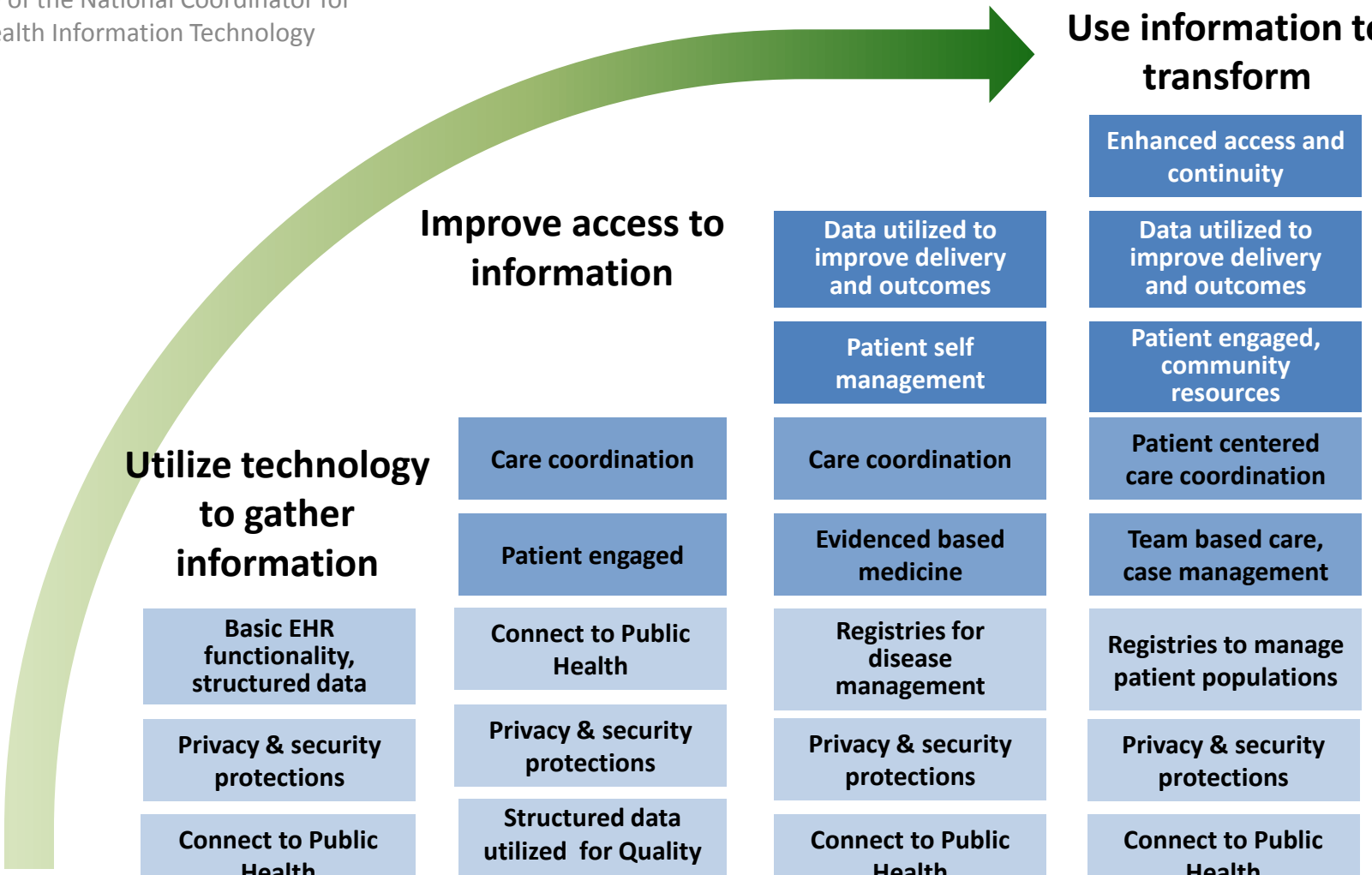

Public-Private Alignment for Care Delivery Transformation

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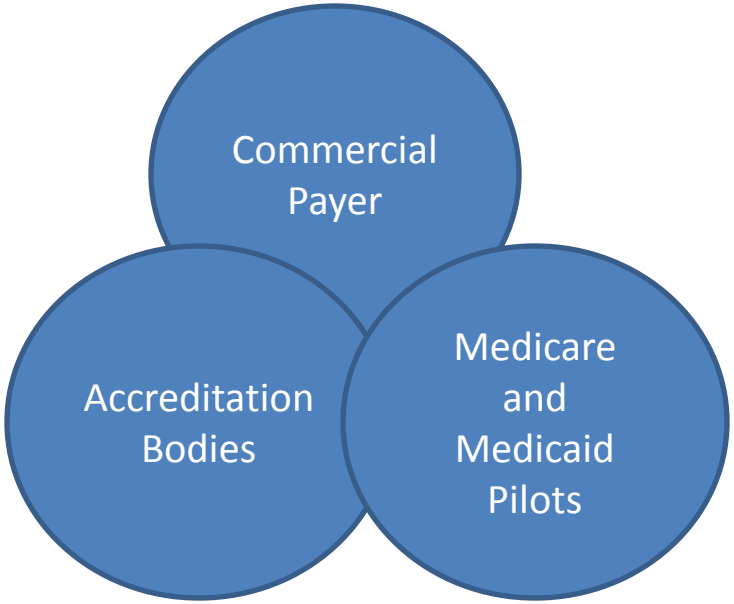
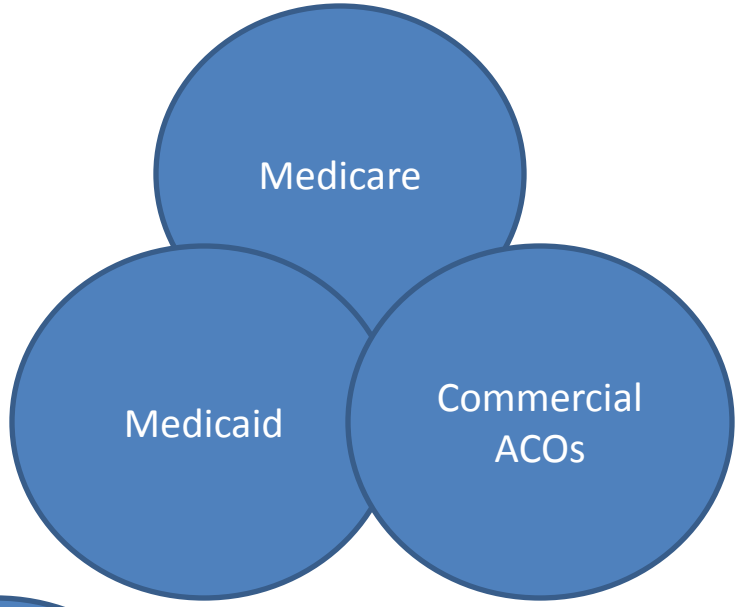
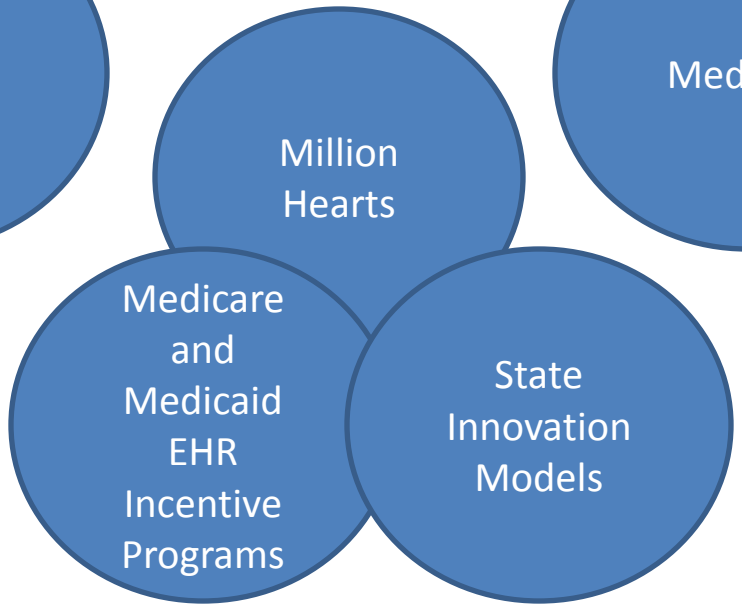
Care Delivery Improvement Through Medical Home



New Payment Model Through Accountable Care



Population Health Awareness



Medical Home Neighborhood Across the Health Care Continuum

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Lab Companies

Home Health

Nursing Homes

Hospitals

Public Health Agencies

EMS

Physician Practices

Pharmacies

Behavioral Health Providers

Schools

Community Health Centers

Patients and Caregivers

Skill Demands to Support Care Delivery Transformation

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Care Delivery

- Health Information Exchange
- Privacy and Security

Payment Models

- Consumer Engagement
- Data Aggregation, Analysis, and Reporting

Population Health

- Risk Stratification
- Practice Workflow Redesign

Medical Home Framework

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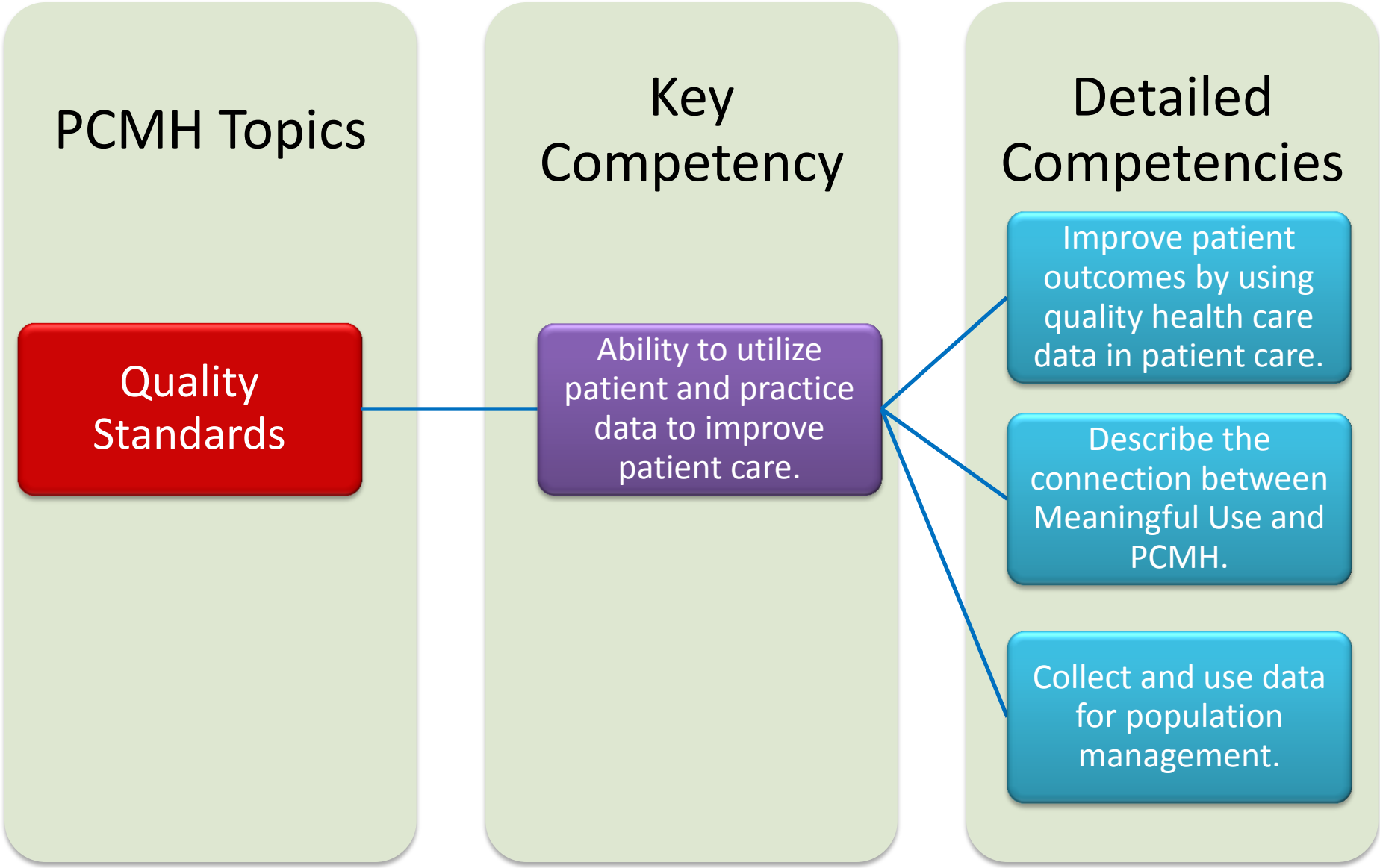

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Medical Home is essential to care coordination, aligning Health IT use, care quality, and participation in value-based health care programs.

Comprehensive Support Beyond the EHR Implementation

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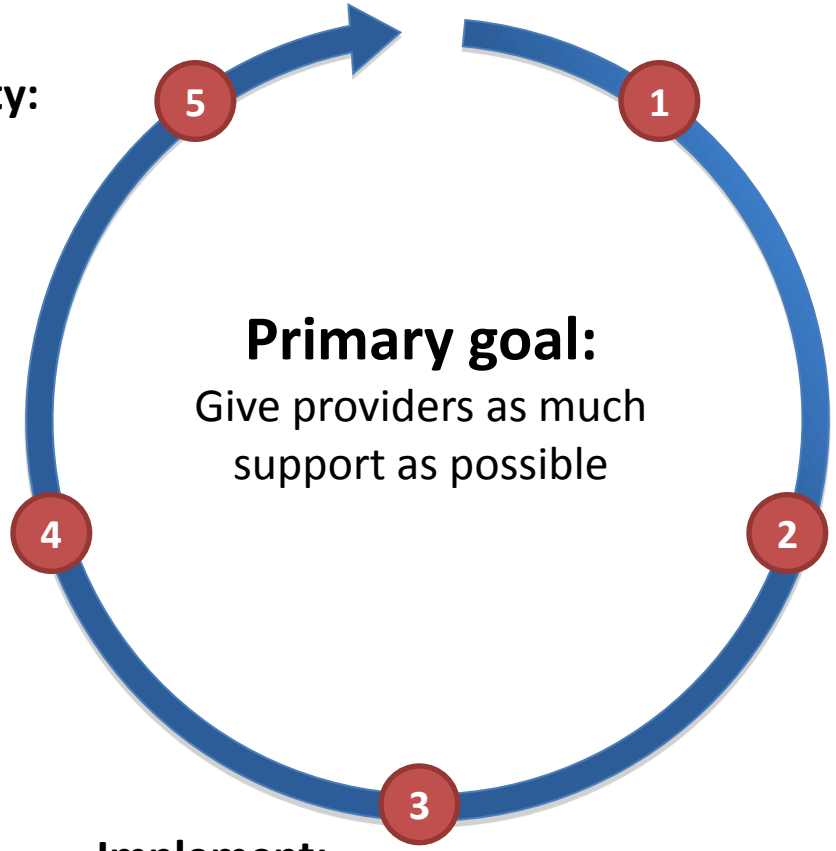

Improve Care Quality:

- Assess ACO, PCMH models
- Prepare for future pay for performance
- Empower patients in their own health care

Plan:

- Conduct readiness assessment
- Identify tools needed for change (i.e. EHR system, workflow changes, etc)

Operate & Maintain:

- Continuous quality improvement
- MU Stages 1,2,3

Transition:

- Redesign practice workflow
- Perform HIT education & training

Implement:

- Provide technical assistance
- Partner with local stakeholders, HIEs

Medical Home, *patient centered (not inclusive)*

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National Accreditation | Certification | Recognition Programs / Initiatives

Accreditation Organizations (AOs)

AAAHC - Accr Assc for Ambulatory Health Care
- ❖ Accreditation and Certification

The Joint Commission
- ❖ Accreditation with Certification

NCQA – National Comm. for Quality Assurance
- ❖ Recognition, Certification, Accreditation

URAC
- ❖ Accreditation Achievement

State Initiatives

MD (Maryland Multi-payer "SB 855 Mandate"
Oregon Patient Centered Primary Care Home

Payer Programs

Humana – Star Rewards Program (4-stages)
BCBS – varies by State (CareFirst)
Geisinger Health Innovation Model
Cigna
Unite HealthCare (UHC)
BCBS – WellMark
WellPoint
Aetna for Oncology
Medicare Comprehensive Primary Care

62 Regional Extension Centers (RECs) Cover 100% of the USA

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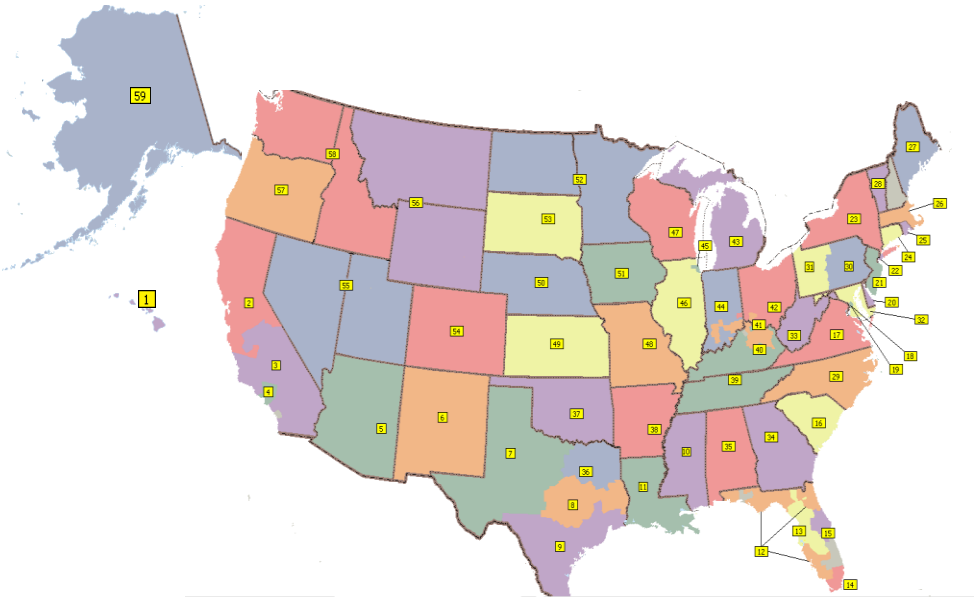
Initial Program Goal

100,000 priority primary care providers achieve meaningful use (MU) by 2014

Every REC:

- Has a defined service area and specific number of providers
- Provides unbiased, practical support throughout process
- Serves as two-way pipeline to federal and local resources



Approach differs by REC:

- Independent operations
- Affiliation with QIOs and universities
- Partnership with other HHS grantees (HCIA, Beacon, ACO, CPC, HCCNs, QIOs, HIE)
- Variety of hospital and payer partnerships

Medical Home Community of Practice
36 RECs of 62 active across 36 States

"The Medical Home Community of Practice (CoP) is a collaborative membership of Regional Extension Centers (RECs) supporting provider practices effective use of health IT to become patient-centered medical homes. In response to payer, state, and federal initiatives related to the medical home, the CoP is driving provider practices to attain medical home recognition/accreditation using Meaningful Use (MU) functionality.

Additionally, the Medical Home CoP provides an innovative forum leveraging expertise in Meaningful Use, EHRs and HIEs, and clinical expertise in care delivery transformation to share, discuss, and develop tools and resources supporting provider practices to become and subsequently 'live' as a patient centered medical home. "

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Regional Extension Center
Louisiana Health Information Technology Resource Center (LHIT) of the Louisiana Health Care Quality Forum (LHCQF)

PCMH Practice Transformation - REC Practice Engagement Model

1 - Practice Assessment

- Determine Practice PCMH recognition/certification/accreditation program
- Determine Practice Goal, i.e. Tier 3 NCQA PCMH Recognition

2 - Facilitation

- In-practice REC support of enabled health IT optimization
- Partnering in support of assisting with recognition requirements attainment
- Submission to Recognition/Certification/Accrediting organization, i.e. NCQA

3 - Coaching

- Clinical Health Coach work with 9 to 10 practices helping the practice to live the principles after having received medical home recognition (On-going through 2015)

Partners

150 Practices
Louisiana State Medicaid
ONC Regional Extension Center Program

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Regional Extension Center
Wisconsin Health Information Technology Extension Center (WHITEC)
REC partnered with a national organization to offer medical home expertise to Wisconsin providers. Embedded in-practice REC staff serving as coach and liaison across six practices.

Partners
Six (6) Pilot Practices
National Medical Home Organization
ONC Regional Extension Center Program: 1,800+ Providers enrolled the REC

Regional Extension Center
Rhode Island Quality Institute (RIQI)
REC engaged a State Payor who incentivized practice enrollment in the State HIE to facilitate secure A/D/T and DSM patient transitions of care information alerts.

Partners
National Payer
State Health Information Exchange
ONC Regional Extension Center enrolled Practices: 1,000+ Providers enrolled

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Thank you

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"The implementation of Patient-Centered Team Based Care, supported by health IT, brings about many challenges for new workers and incumbents, alike. Both groups will find interpersonal dynamics to be an unexpected focus and new technologies will emerge that will have to be learned and integrated into their workflows. On the job success will likely stem from a work environment with a ***consistent understanding of the transformation process, visible leadership and support****, and* ***established outcomes that can be measured against contextual factors during delivery of care.*** *"*

Mohla, C., Reed, C., Keesey, P., McKenzie, H., Damico, D., & Sital, S. Agency for Healthcare Research and Quality, (2013). *Readying the health it workforce for patient-centered team based care: Understanding training needs* (ARRA NRC D2 HITECH) http://healthit.gov/sites/default/files/summer_workforce_meeting_paper_508.pdf