

# Crescent City Beacon Community: Innovative Solutions for Using HIT to Implement the NCQA PCMH Model

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# Crescent City Beacon Community: Overview

CCBC is focused on reducing the burden of diabetes and cardiovascular disease in the Greater New Orleans area by accomplishing the following goals:

- Reduce healthcare costs by improving transitions of care (TOC) between hospitals and primary care practices.
- Improve chronic care management (CCM) through patient-centered medical homes, enabled by HIT.
- Test innovative technologies and strategies to engage patients and the public in health care process.

- Statewide hospital providers
- Community health centers (including FQHCs)
- School-based health centers
- LA Department of Health & Hospitals
- LAHIE & REC (Regional Extension Center)
- BlueCross BlueShield of LA
- Local & state public officials
- Community Advisory Groups (GNOHIE, txt4health)

# Transitions of Care Use Cases

- **Health information exchange with central data repository**
  - Care coordination
  - Population management
  - Community-wide registries
  - Data analytics
- **ED/Inpatient Notification**
  - Notification to the patient's PCP
  - Transmission of relevant clinical information from the ED/Inpatient setting to the PCP.
- **Electronic Specialty Care Referral**
  - Electronic transmission of referral requests/documentation by PCP
  - Appointment confirmations from specialist to PCP electronically
  - Specialty consult summaries electronically sent to PCP's EMR system

- Text messaging campaign “txt4health” for diabetes risk awareness
- Based on text4baby national campaign concept
- Three main components:
  - Risk awareness for diabetes
  - Personal goal-setting (weight, physical activity)
  - Connecting patients to appropriate resources (clinical, educational, support)
- Evaluate effectiveness for national spread



- Clinical Quality Improvement Workgroup
- Quality Improvement subaward funding
- Clinical seminar series
- Centralized registry and care management capacity through health information exchange
- Practice coaching in partnership with PCDC
- EMR Optimization for PCMH role; working with vendors for reporting and NCQA certification

# Clinical Transformation Efforts

- Greater New Orleans Area
  - Poor Health Outcomes
  - Large uninsured population
- Health Care Delivery System
  - Prior to Hurricane Katrina
    - Hospital based emergency department care (public hospital system)
  - Post-Hurricane Katrina
    - Participated in large federal program to stabilize and expand primary care
    - Federal 1115 Waiver in place of federal grant, expanded primary care access for uninsured to Medicaid demonstration
    - Quality incentivized and monitored by Payors
    - Anticipated in 2014
      - Third of population to be covered by Medicaid or exchange





- CCBC Provider Profile
  - 18 primary care practices; 12 organizations
  - 58,000 patients; avg. 3,000
  - 79 providers; avg. 2-5 provider/practice
- Types of Sites
  - FQHCs
  - Academic Medical Center Community Based Practices
  - Grassroots
- NCQA PCMH Recognized
  - 13 Practices recognized under 2008 standards

# Facilitating Factors for Project

- All 13 PCMH recognized sites up for renewal in 2012;
- 12-month intensive CCBC-sponsored Practice Coaching on Chronic Care Management for participating practices;
- 2011 NCQA PCMH Standards increased population based reporting;
- Meaningful Use 1 product enhancement workflows challenging to use; concerns for MU 2 ;
- Vendor interested in PCMH, Beacon alignment
- Local Superuser already engaged with vendor

- One dominant EMR vendor for community-based primary care providers in region
  - SuccessEHS (13 practices, 52,000 lives)
  - Allscripts (3 practices, 3,500 lives)
  - Aprima (1 practice, 1,500 lives)
- Pre-Beacon relationship to SuccessEHS
  - EMR implementation in FQHCs post-K (2006-2007)
  - Convened SuccessEHS Users Group (2008-2009)

# PCMH Mapping Project: System Enhancements to Improve EMR Workflow

# Pilot site for PCMH Mapping Project



Initially adopted an  
EMR in 2006

Tier 3 NCQA PCMH  
under 2008 standards

Switched to  
SuccessEHS 2010

AHRQ e-  
Recommendation pilot  
site 2010-2011

Tier 3 NCQA PCMH  
under 2011 standards

## Re-assess health IT impact on PCMH workflow efficiency

Diagram existing processes, identify deficiencies relevant to PCMH standards, and revise workflow to maximize adherence

**Telephones  
Scheduling  
Registration**

Access & Communication

**Interoperability  
Task Organizer**

Lab & Referral Tracking; eRx

**Clinical  
Decision Support  
& Patient  
Registry**

Care Management

**Reporting Tool**

Performance Reporting



- Multi-step work-arounds within each respective system revealed software deficiencies
- End-users of the same EMR vendor created different workflows
- End-users of the same EMR vendor mastered use of different parts of the system → knowledge and skills gap

- Objectives
  - Determine best practices under the current system limitations
  - Share workflow analyses with EMR vendor
  - Make formal recommendations for system redesign
- Challenges
  - Workgroup consensus prioritization of requests to vendor
  - EMR vendor response time suboptimal



- **Beacon Community Programs**
  - Build and strengthen HIT infrastructure and exchange capabilities to improve care coordination, improve quality of care and slow growth of health care spending
- **HIT for Economic & Clinical Health Act (HiTech)**
  - Adopt certified technology
    - Meaningful use - capture, move and report data
  - **NCQA revises PCMH standards to align with meaningful use standards**

# 2011 NCQA medical home standards

<p>Standard 1: Enhance Access and Communication</p> <p><b>A. Access During Office Hours</b>            B. After Hours Access            C. Electronic Access            D. Continuity            E. Medical Home Responsibilities            F. Culturally Linguistically Appropriate Services            G. Practice Team</p>	<p>Pts</p> <p>4 4 2 2 2 2 4</p> <p>20</p>	<p>Standard 4: Provide Self-Care Support &amp; Community Resources</p> <p><b>A. Support Self-Care Processes</b>            B. Provide Referrals to Community Resources</p>	<p>Pts</p> <p>6 3</p> <p>9</p>
<p>Standard 2: Identify and Manage Patient Populations</p> <p>A. Patient Information            B. Clinical Data            C. Comprehensive Health Assessment  <b>D. Use Data for Population Management</b></p>	<p>Pts</p> <p>3 4 4 4</p> <p>16</p>	<p>Standard 5: Track &amp; Coordinate Care</p> <p>A. Test Tracking and Follow Up  <b>B. Referral Tracking and Follow Up</b>            C. Coordinate with Facilities/Care Transitions</p>	<p>Pts</p> <p>6 6 6</p> <p>18</p>
<p>Standard 3: Evidence-Based Guidelines</p> <p>A. Identify High Risk Patients  <b>B. Care Management</b>            C. Manage Medications            D. Use Electronic Prescribing</p>	<p>Pts</p> <p>4 3 4 3 3</p> <p>17</p>	<p>Standard 6: Measure and Improve Performance</p> <p>A. Measure Performance            B. Measure Patient/Family Experience  <b>C. Implement Continuous Quality Improvement</b>            D. Demonstrate Continuous Quality Improvement            E. Report Performance            F. Report Data Externally</p>	<p>Pts</p> <p>4 4 4</p> <p>3</p> <p>3 2</p> <p>20</p>

- “...health IT *per se* is unlikely to lead to better care. But health IT built, implemented, and used in “meaningful ways” is very likely to result in better care.”

Peter Blausch, Health Affairs Blog, Feb 11, 2011

# Electronic medical record end-user workgroup task revisions

- Use *Crescent City Beacon Community Initiative* as platform for unified customer voice
- Realign suggestions for EMR product redesign/upgrade with NCQA PCMH & meaningful use workflow
- Develop a toolkit to instruct other clients on how to use the new system updates to facilitate adherence to PCMH standards

- Assigned Project Team (July 2011)
  - Community Superuser Lead
  - LPHI Chronic Care Management Project Team
  - Vendor Team
    - Project Facilitator / Director of Client Services
    - Project Manager / System Architect
    - Project Coordinator / Account Manager
    - Product Management / Manager Project Management
    - Clinical Product Management
    - Senior Report Builder
    - Clinical Consultant
    - Government Affairs

- Created NCQA 2011 Worksheet by standard, element, factor
  - Definitions (*highlighted Renewal, MU, Must Pass, Critical Factor*)
  - Reporting requirements (policy, lists, reports)
  - Current EMR workflow (modules, functionality)
  - Reviewed system capacity
    - To collect info required
    - To report



# Mapping PCMH standards to EMR features

PCMH 2011 Standards and Elements	Clinical Protocol Required	EMR Functionality Required for PCMH	EMR Functionality Exists	EHS Module Name	Extractable and Reportable on population basis (% of patients)	
<b>PCMH 1: Enhance Access and Continuity</b>						
<b>1A: Access</b>	The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:					
<b>During Office Hours MUST PASS</b>	1. Providing same-day appointments <b>(CRITICAL)</b>	Same Day Appointment Protocol	Yes	Yes	Scheduling	Unknown
	2. Providing timely clinical advice by telephone during office hours	Patient Call Protocols During Office Hours	Yes?	Yes	Clinical Console - Telephone Log	
	3. Providing timely clinical advice by secure electronic messages during office hours	Policy on Electronic Messaging during office hours	Yes	Unknown (Patient Portal?)	Unknown	Unknown
	4. Documenting clinical advice in the patient medical record.	Policy for documenting calls/secure messaging in Medical Record	Yes	Yes	Chart	Unknown



- For each standard, element, factor
  - Tested system capacity
  - Identified workflow challenges
  - Developed recommended system enhancements
  - Developed list of standardized reports



- **2 Day Kick-Off Meeting Attendees (August 2011)**
  - Community provider representation
    - Clinical and practice management superusers
    - Care Team Members
  - LPHI Chronic Care Management Project Team
  - Senior Vendor Team
- **Review and provide feedback on** vendor suggested system enhancements
- **Weekly Project Calls**
  - Full project team +/- advanced superusers
  - Refine request, clarifications, testing functionality

- First round of enhancements released (Dec. 2011)
  - Organize data display
    - Order tracking details
  - Capture data in reportable format
    - Response times to medical calls
  - Reduce steps to document data
    - Care management templates linked to care plan forms
  - Build standardized reports

- Reviews requirements for documenting adherence to NCQA PCMH standards
- Provides instruction to standardize use of existing features and system enhancements to implement PCMH standards and capture data for reporting
- Report templates imported into customer database
- Sample policies and procedures from NCQA PCMH recognized customers

- Beta testing system enhancements
  - Examine experience of customers
    - Typical vs. advanced end users
    - Impact on workflow for different care team members
- Piloting PCMH toolkit
  - CCBC partners undergoing NCQA PCMH recognition process