

BUT WE ALREADY DO THAT!

THE RURAL REALITY OF PATIENT CENTERED MEDICAL HOMES

COLORADO RURAL HEALTH CENTER
The State Office of Rural Health

What we'll talk about...

- Define patient centered medical home (PCMH)
- The landscape of PCMH
- PCMH standards
- The PCMH connection to rural clinics
- How SORHs can plug in to the PCMH movement
- A brief link between PCMH and accountable care organizations (ACOs)

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Alphabet Soup?

REC?

PPACA?

PCMH?

P4P?

ACOs?

CCM?

MU?

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Credit for this slide: Julie Schilz, Colorado Beacon Consortium

Patient Centered Medical Home

A **Patient-Centered Medical Home** (PCMH) is not so much a place as it is a concept.

PCMH is:

- partnerships between individual patients, their personal care providers, and the patient’s family.
- a way of coordinating all health services in a quality, cost-effective and accessible manner
- team-centered care

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Patient Centered Medical Home

The **Patient-Centered Medical Home** encompasses five functions and attributes:

- Patient-centered
- Comprehensive care
- Coordinated care
- Continuous access
- A systems-based approach to quality and safety

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A brief background on PCMH

1964-AAP defines Medical Home for Children with Special Needs

1998—Chronic Care Model first published by Ed Wagner, MD

2001—Institute of Medicine publishes *Crossing the Quality Chasm Report* including a recommendation for “10 Simple Rules for the 21st Century Health Care System”

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More PCMH background

2007– The four national primary care societies (AAFP, AAP, ACP and the ASOM) agree on the “Seven Joint Principles of the Patient-Centered Medical Home” and the first version of the NCQA PPC-PCMH Recognition Program™ made publically available

2010– US Federal Government awards millions of dollars to competing states under the American Recovery and Reinvestment Act to support health care achievement of health information technology “meaningful use” and state health information exchange. **ALSO** PPCAC was signed.

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Patient-Centered Medical Home

Overview of Pilot Activity and Planning Discussions

○ Multi-Payer pilot discussions/activity
 ■ Identified pilot activity
 □ No identified pilot activity – 5 States

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PCMH Landscape

National Demonstration Pilots

Federal Participation

Recognition Programs

- NCQA PPC-PCMH
 - Over 15,000 practices recognized nationally
 - Enhanced version being rolled out 2011
- Medical Home Index

Colorado PCMH Landscape

Colorado Initiatives

- System of Care Grant
- Colorado Medical Home Initiative
- Safety-Net Medical Home Initiative
- Colorado Multi-Stakeholder PCMH Pilot
- Colorado Family Medicine Residency PCMH Program
- Colorado Medicaid Accountable Care Communities

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CRHC and PCMH

Why we got involved

CRHC's Programs Division

- CAH
- Emergency Preparedness
- RHC

Why CRHC chose NCQA

- Part of our grant requirement
- National "gold" standard
- Starting to be recognized by private payers
- Medicare pilot programs and links to QAPI

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PCMH: The Rural Connection

What rural facilities do well:

MANY THINGS!

What rural facilities don't do well:

DOCUMENT WHAT THEY DO!

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PCMH Exists in Rural America

PCMH is a community based model of health care. Rural communities are often used to community based provision of many services; PCMH is another method of provision of health care services that will involve the whole community.

Many rural health care providers are used to the patient centered model of care by necessity; coordination of care, with specialists and others related to health care is something that is already done because of geography and location of services.

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PCMH Exists in Rural America

Rural health care providers and communities are very resourceful and creative in obtaining needed health services, something that will ease creation of medical homes in those practices communities.

Rural health care providers are often by necessity already serving as medical homes (as best they can), and recognition could improve their ability to receive additional compensation and/or resources.

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PCMH Exists in Rural America

PCMH guides uses tools that will improve provider/patient communication and patient's abilities to self-manage chronic diseases over long distances.

Newer health care providers are being trained in the medical home model. Practices and communities that are willing to embrace the medical home model of care will find it easier to recruit and retain health care providers.

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"NORMAL" CARE	MEDICAL HOME CARE
My patients are those who make appointments to see me	Our patients are those who are registered in our medical home
Patients' chief complaints or reasons for visit determines care	We systematically assess all our patients' health needs to plan care
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet patient needs without visits
Care varies by scheduled time and memory or skill of the doctor	Care is standardized according to evidence-based guidelines
Patients are responsible for coordinating their own care	A prepared team of professionals coordinates all patients' care
I know I deliver high quality care because I'm well trained	We measure our quality and make rapid changes to improve it
Acute care is delivered in the next available appointment and walk-ins	Acute care is delivered by open access and non-visit contacts
It's up to the patient to tell us what happened to them	We track tests & consultations, and follow-up after ED & hospital
Clinic operations center on meeting the doctor's needs	A multidisciplinary team works at the top of our licenses to serve patients

Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma

What SORHs can do

Many of our facilities don't know where to start...

SORHs are the best resource!

Who else knows what exists in rural health care?

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<i>PCMH Needs in Rural America</i>	SORHs AND PCMH
<p>PCMH requires implementation of technologies that may not be readily available in rural communities without significant investment, both on the part of medical providers and the community as a whole (communication, hardware, software).</p> <p>Many of the services that are essential to the creation of medical homes are not available in rural areas, and could require significant investment of resources that might preclude the establishment of medical homes.</p>	

<i>PCMH Needs in Rural America</i>	SORHs AND PCMH
<p>Some rural practitioners are reluctant to work toward PCMH recognition because they see it as a potential grab by urban providers of rural patients or adding required services that they won't be reimbursed for providing.</p> <p>Resistance to medical home models, and potential shifts of payment for care, may force some health care providers to choose to leave the industry, leaving communities without health care providers.</p>	

<i>What SORHs can do</i>	SORHs AND PCMH
Be a resource	
Be a sponsor	
Be a supporter	
Be a connector	

Significant PCMH Wins in Rural Colorado

2009:

- First RHC in Colorado to report clinical data (Eads Medical Clinic)

2010:

- First RHC in Colorado to receive NCQA PCMH Level 1 recognition (Spanish Peaks Family Clinic in Walsenburg)
- Three RHCs reporting clinical data

2011:

- First independent RHC will apply for NCQA recognition (Rocky Ford Family Health Center)
- Seven RHCs reporting clinical data

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PCMH and ACOs


Accountable Care Organizations are looking to partner with facilities that can demonstrate the ability to provide quality outcomes and cost savings.

Designation as a PCMH is the best way a rural facility can demonstrate the ability to best fit into the ACO model.

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PCMH and ACOs

The Spanish Peaks argument...



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Contact Information	SORHS AND PCMH
Matt Guy Executive Director Southeastern Colorado Area Health Education Center 719.544.7833 matt.guy@secahec.org (formerly CRHC Quality Improvement Coach in SE Colorado)	
Michelle Mills Director of Programs Colorado Rural Health Center 800.851.6782 mm@coruralhealth.org	
