Implementation of PCMH
Children’s Health Quality Coalition
1/24/2014
Mark Mandell, M.D.
CMO
Partners Community Health Care
Partners Pediatrics

Service Locations

- Partners Pediatric practices encompasses ~ 220 Pediatricians in 45 practices
- There are ~85 acute inpatient Pediatric beds across Partners, and 12 specialty outpatient sites north, south, and west of the city.

Outpatient Specialty sites

- Nashua, NH
- Lowell
- Emerson
- Danvers
- Salem
- Lexington
- Waltham
- Newton
- Framingham
- Leominster
- Foxboro
- Sandwich

- PCHI Pediatric Practices
- Over 12 different MassGeneral for Children (MGfC) specialty practice sites
- 4 Partners hospitals
Implementation of PCMH

- Four Partners Pediatric practices were part of the CHIPRA Medical Home Initiative
  - Pediatric Associates of Greater Salem
  - Patriot Pediatrics
  - MGH Chelsea
  - MGH Revere

- Implementation in each of the practices took place within the larger context of Partners network level implementation of PCMH in all primary care practices

- Implementation of Patient Centered Medical Home was a major strategic initiative of Partner’s Population Health Management to improve patient care and experience, and to succeed in risk based contracts

- Process initiated for all Primary Care Practices in 2011

- Initial goals were around achieving NCQA recognition
Partners in Care, the PHS Patient-Centered Medical Home (PCMH) initiative, aims to transform our entire system of primary care practices to a team-based model enabling people to work at the top of their license. The initiative will be driven by quality improvement and supported by information technology. We will build vibrant and healthy practices, empowering the teams to deliver coordinated, comprehensive care to all of our patients. We will move the entire population towards a better state of health.
Objectives / Working Principles

- We are taking a modular approach
- We are focused on building the right infrastructure
  - ‘Building Blocks’ to lay the foundations
- Practice needs will vary; There is not a ‘one size fits all model’
- The system must support practices by providing training, metrics, analytics, financial support and enabling IT solutions
- Our system will continue to learn and improve and iterate
- Process needed to align and coordinate with other system initiatives
- System remains committed to meeting NCQA recognition but want to be thoughtful about the pace of that process
- We recognized the need for culture change
Roadmap for Success: PCMH Building Blocks

- **Quality**
  - High Risk Chronic Cond
  - Test & Referral Tracking

- **Improvement**
  - Care Management
  - Population Mgmt Tool

- **Team-Based Care**
- **Practice Redesign w/Lean**

- **Virginia Mason Production System**
  - (Flow)

- **EMR**
- **Patient Portal**

- **Access**

- **Tools**
- **Structure**
- **Capacity**

- **Better Patient Care**

- ✔ More consistent, sustainable results
- ✔ Within network many pieces already there
- ✔ Physician champions
- ✔ Resources, incentives can move us forward
Medical Home Programs and Services

General Education
- Newsletter to inform network about the initiative
- Knowledge-Sharing dinners to facilitate networking and best practices

Medical Home Coach
- Advise on the realities of PCMH
- Assist RSO leadership in developing a local strategy
- Coach practices going through the implementation

Practice Redesign Workshops
- Practice redesign session for care team
- Foundational concepts to build efficiencies, improve care
- Based on lean model developed by Virginia Mason

Lean Collaborative
- Formal follow-on program to practice redesign
- Practice teams utilize tools to solve specific problems
- Access to network process improvement experts

MA/CA Academy
- Support for team-based care approach of PCMH
- Consistent level of enhanced expertise
- Elevated clinical assistant involvement

NCQA Collaborative
- Advanced practices preparing for NCQA recognition
- Development of documentation and policies
- Assessment of value/feasibility for network
### Primed Status Measures

Primed Status is a framework to measure evolution toward comprehensive, patient-centered, team-based care. These foundational elements are designed to position practices so that they are ‘Primed’ for further advances including NCQA Patient-Centered Medical Home (PCMH) Recognition.

<table>
<thead>
<tr>
<th>Building Block</th>
<th>Overview</th>
<th>Focus</th>
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</thead>
</table>
| Team-Based Care      | Ensure adequate clinical staff resources with everyone working collaboratively and effectively to the top of their license | - Physicians and dedicated clinical staff working together in a 1:1 ratio  
- Standard work for MA, Nurse, Admin staff, huddle |
| Practice Redesign    | Create and sustain a model for the care team to evolve the practice towards team-based, patient-centered care | - AHRQ Survey on practice culture  
- 30% of physicians and 30% of associated staff trained in process improvement methodology  
- Average time from appt to visit note |
| EHR                  | Use technology effectively to care for patients                          | - Stage 1 Meaningful Use criteria  
- **NCQA***/ self-management must-pass measure |
| Patient Portal       | Utilize a secure, interactive, electronic platform to increase access to care teams | - Practice has achieved a tipping point of member enrollment |
| High Risk – infrastructure | Improve access, coordination, and monitoring to manage care across the continuum for the most medically complex, vulnerable High Risk (HR) patients | - HR patients assigned to Care Manager (CM)  
- RN CM staffed at a ratio of 1:200 for adult (Pedi 1:150) tracked at an RSO level |
| High Risk – process  | Establish criteria and systematic processes to manage care for HR patients | - **NCQA***/ care management must-pass measure |
| Chronic Conditions | - Depression | - Self-assessment; Standard work including screening, treatment, psych support and outcomes reporting with at least x% of patients screened |
| Pop Mgmt             | Integrate tool(s) into workflow (e.g. registries, analytics)            | - **NCQA***/ pop mgmt must-pass measure |
| Test and Referral Tracking | Incorporate tools to track tests and referrals to create closed loop system | - **NCQA***/ referral tracking must-pass measure |
| Access               | Create the capacity to provide the right care at the right time in the right place | - **NCQA***/ access must-pass measure |
| Quality Improvement  | Improve patient outcomes in key conditions                               | - **NCQA***/ quality improvement must-pass measure |

- 2013 existing metrics
- 2014 new metrics
* Complete 3 must-pass measures as of Q3 including care management
**Primed Status** is a framework to measure evolution toward comprehensive, patient-centered, team-based care. These foundational elements are designed to position practices so that they are ‘Primed’ for further advances including NCQA Patient-Centered Medical Home (PCMH) Recognition.

**Partners in Care Phase 2** will be established as our measure of PCMH. It will include NCQA level 3 recognition as well as other components (e.g. panel size, access).
Critical factors for PCMH Success

- Training
- Best Practices
- Leadership
- Healthy Culture
Implementation at Pediatric Associates of Greater Salem 2010-2013

- **Education**
  - Initial staff meetings to inform staff about PCMH and CHIPRA initiative
  - Practice retreat held April 2013 to introduce concepts of Partners strategy, team based care, lean process improvement to entire practice staff

- **Medical Home Team**
  - Weekly meetings of team consisting of lead physician, PTF, Executive leader, Nursing Team lead, office manager, NP, SW, 2 parent advisors
  - Created Parent advisory group meeting Quarterly - “PAG at PAGS”

- **Practice Redesign**
  - 3 day Practice redesign sessions attended by 10/14 physician with clinical assistant for care team
  - Foundational concepts to build efficiencies, improve care
  - Based on lean model developed by Virginia Mason

- **Team based approach**
  - Care teams consisting of 2 physicians, each with RN or LPN and Medical secretary, 1 MA, 1 NP
  - Provide continuity of care, take phone calls in flow, provide post ER/inpatient follow up calls, provide urgent access for team’s patients

- **Standard Work**
  - Unique teams created to create standard work for rooming, pre-visit assessment, preauthorizations, check in, huddles, referral tracking, etc.
  - Piloted, revised as needed and implemented across the practice
  - Need to develop process to audit compliance

- **Care Management**
  - RN hired to provide care management for all high risk patients.
  - Partners now providing additional care manager for high risk patients for patient s in commercial contracts
Factors Unique to Pediatrics
Expanding the Medical Home

Presentation to the Child Health Quality Coalition
Dan Slater
January 27, 2014
The Pediatric Medical Home

PROTECT

Quality

Relationship

Support

FOUNDATION
HVMA Chelmsford Pediatrics: Our aim and team

• **Our Medical home will create a place for all children where health care services and resources are easily available, family centered, compassionate and culturally sensitive.**

• **Our team members:**
  
  Kim Tresch, MD, Pediatric Champion  
  Melissa Chartier, Parent Partner  
  Margi Byrnes, Administrator  
  Nicky Nault, Parent Partner  
  Sally Faggella, RN Nurse Leader  
  Denise St. Amand, LPN  
  Bobbie Goldman, DPH Care Coordination  
  Claudia Scott, Med Secretary II  
  Laura Lee, MD, Department Chief
Learnings from our CHIPRA Experience

Already in Place at HVMA

• Strong Leadership
  Commitment to Care Improvement
  – Data Management
  – PDSA cycles part of culture

• High functioning EMR
  – Priority Diagnoses
  – Rosters
  – Commitment to improve tools

New to our Practice

• Designated Care-Coordinator

• Specific standard work
  – To identify and Manage at risk populations
  – To support transitions of Care

• Parent Focus Groups

• Community Interface
Care Planning and Care Coordination
Developments

- Team designed a multi purpose care plan in collaboration with the Pediatrics Association of Greater Salem. Our EHR populates many of the fields and includes drop down lists for ease of documentation.
- Care plan is continuously revised
- A “medically complex patient” roster was developed to allow for proactive care of children with special needs. 160 children are on the registry
- The ‘medically complex patient” diagnosis was converted to a “priority diagnosis” that automatically populates our schedule when a patient from the registry is booked.
- A staff member has been designated point person for care coordination issues and is working closely with the DPH Care Coordinator.
- Providing a DPH resource book to parents and staff
December 12, 2013

Dear Margi Byrnes:

We are writing this letter in recognition of Claudia Scott who has been phenomenal in terms of recognizing the complexity of our special needs child. She has been extremely helpful in getting services to meet the needs of our unique family. We realize that it has been a very long and tedious process and we deeply appreciate her presence through every challenging roadblock and look forward to our collaboration in the very near future.

We would like to extend our thanks for Medical Home Program, as it is brilliantly implemented and it works beautifully. It makes our lives so much easier medically and it makes it so much easier to care for Special Needs Child. Please continue to implement and sufficiently fund this Program throughout other locations.

With Deepest Thanks

Very truly Yours,
Care Coordination Plans

Impact:

From a Parent Partner...

- The Medical Home and care plans...you can’t have one without the other.

- When we travel we have a copy; our ER has everything in place that’s accurate.

- At 3AM 'What’s your name?' could be a tough question! This helps!

- I don’t think pediatricians know how much of a difference it makes for us, to make our lives a little easier.
Identifying our At-Risk Population

• Standard work developed through *PDSA*
• “Medically Complex Patient” Diagnosis
• Who are Children with special health care needs?
  – Children with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount not usually required by children. - *Maternal and Children Health Bureau*
# Care Improvement: Standard Work

**Standard Work Sheet**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Key Point</th>
<th>Who</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient presents to department in person or by phone and clinician or staff identifies them as medically or psychosocially complex</td>
<td>Patient Identification</td>
<td>All Staff</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Diagnosis “Medically complex Pediatric patient” PRG in JMS is added to the problem list</td>
<td>Triggers Priority Diagnosis</td>
<td>All Staff</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Overview is completed with relevant data including diagnoses, specialists, contact information, treatment plans. Does not need to restate information already present under specific diagnoses elsewhere in the problem list</td>
<td>Provides Basic information for clinicians and staff caring for complex patients. Allows for identification of key participants in care and any important elements of intervention/care</td>
<td>Nurse/ APC/ MD</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Rosters provided to chiefs monthly to evaluate engagement of department/ clinicians</td>
<td>Establish Roster, encourage engagement. Evaluate for defects in process</td>
<td>Central Page/ Chief</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Roster reviewed by PCP quarterly to remove inappropriate entries</td>
<td>Maintain integrity of List</td>
<td>PCP</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>When patient is on schedule, CMPLX will appear in priority diagnosis column. MA/MS reviews problem list prior to visit to assure visit is set up to meet patient's special needs</td>
<td>Provide patient-centric high quality care</td>
<td>MA/MS</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Ultimately care coordination document will be developed for patients’ record</td>
<td>Complete medical home documentation to assure that patients care is clearly communicated to all involved and is optimal</td>
<td>TEAM</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>2014: Case Management Nurse participation in roster reviews and care</td>
<td>Provide thorough high value patient centered care to this high risk population.</td>
<td>Central Page/ Case Manag/ PCPs</td>
<td></td>
</tr>
</tbody>
</table>
# Roster
By Diagnosis and Cost

<table>
<thead>
<tr>
<th>ISSITE</th>
<th>PCPNAME</th>
<th>MRN</th>
<th>DX_NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHE</td>
<td>DELIKAT, JENNIFER MD</td>
<td>1</td>
<td>ADHD, predominantly inattentive type</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Asthma</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Body mass index between 19-24, adult</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ehlers-Danlos syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Exotropia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Herpes simplex</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MEDICALLY COMPLEX PEDIATRIC PATIENT (NOT DX, FOR PROB LIST ONLY)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mitral valve atresia, congenital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mitral valve insufficiency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Acne</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CEREBRAL PALSY, QUADRIPLEGIC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>FAT NECROSIS OF SKIN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hypercalcemia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hypoglycemia, neonatal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MEDICALLY COMPLEX PEDIATRIC PATIENT (NOT DX, FOR PROB LIST ONLY)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Obesity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ORAL MOTOR DYSFUNCTION</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rhinitis, allergic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Seizure disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>ADHD, predominantly hyperactive-impulsive or combined</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Adjustment disorder with mixed emotional features</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Asthma</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Charcot-Marie-Tooth disease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ISSITE</th>
<th>PCPNAME</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHE</td>
<td>JIANG, KEYI MD</td>
<td>$466,660</td>
</tr>
<tr>
<td></td>
<td>DELIKAT, JENNIFER MD</td>
<td>$154,566</td>
</tr>
<tr>
<td></td>
<td>DELIKAT, JENNIFER MD</td>
<td>$140,986</td>
</tr>
<tr>
<td></td>
<td>MELO, LORNA MD</td>
<td>$129,025</td>
</tr>
<tr>
<td></td>
<td>RAMANATHAN, CHANDRA MD</td>
<td>$128,426</td>
</tr>
<tr>
<td></td>
<td>SALOMON, DAVID MD</td>
<td>$114,097</td>
</tr>
<tr>
<td></td>
<td>LEE, LAURA MD</td>
<td>$94,979</td>
</tr>
<tr>
<td></td>
<td>LEE, LAURA MD</td>
<td>$77,243</td>
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<tr>
<td></td>
<td>SALOMON, DAVID MD</td>
<td>$72,676</td>
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<tr>
<td></td>
<td>RAMANATHAN, CHANDRA MD</td>
<td>$57,619</td>
</tr>
<tr>
<td></td>
<td>DELIKAT, JENNIFER MD</td>
<td>$57,518</td>
</tr>
<tr>
<td></td>
<td>SALOMON, DAVID MD</td>
<td>$54,123</td>
</tr>
<tr>
<td></td>
<td>DELIKAT, JENNIFER MD</td>
<td>$51,207</td>
</tr>
<tr>
<td></td>
<td>LEE, LAURA MD</td>
<td>$50,372</td>
</tr>
</tbody>
</table>
Develop Family Participation

- Coordination of care office created in the waiting room for team or parent meetings with speaker phone and voicemail options.
- 2 Parent-Partners joined the team. Both parent-partners have children with special needs.
- Increased MY HEALTH (EHR portal) from 16.6% baseline to 56% currently.
- Parent focus Group identified many things to work on: the importance of staff knowing their child’s unique needs; being prepared for the visit from the point of booking; knowing who is best served being roomed immediately and not having to wait.
- Joint telephone conference with parent, PCP, Children’s Hospital Boston specialist (Neuro), PACT team, MASSTART Nurse, and DPH Care Coordinator done
- Patient Voice on numerous “RIEs” (Rapid Improvement Events)
List of Measures for CHIPRA per NICHQ

- **Preschool Wellness Assessment (24-30 months):** Well visits, immunizations, developmental screening including screening for autism spectrum disorders, and oral health assessment.
- **Preventive Services (choose one)**
  - **Adolescents Wellness Assessment (ages 13-20):** Well visits, immunizations, developmental screening, preventive dental care, healthy weight assessment, assessment of sexual activity, and Chlamydia screening (for those who are sexually active).
  - **School Age Wellness Assessment (ages 5-12):** Well visits, immunizations, developmental screening, preventive dental care, and healthy weight assessment.
- **Referrals for Developmental or Behavioral Concerns (all ages):** Percentage of children who screen positive for developmental or behavioral concerns who are referred for follow up to a mental health provider, developmental specialist, or community provider such as Early Intervention.
- **Chronic Care Management (choose one)**
  - **Asthma Care:** Percentage of the five components of asthma care documented in medical record for patients diagnosed with asthma: controller medication prescription for persistent asthmatics, follow up in primary care, assessment of control, influenza vaccine administration, and creation of a written asthma action plan.
  - **ADHD:** Percentage of the six components of ADHD diagnosis and follow up for children diagnosed with ADHD: assessment of symptoms using a validated instrument, evaluation for co-existing conditions, family involvement in treatment goals and decisions, creation of a written ADHD management plan, and follow up care.
  - **Care Plans:** Creation and semi-annual updating of care plans for all children with chronic conditions or special health care needs. For children aged 14 and older, the care plan should include a Transition Plan from pediatric to adult systems of care.
  - **Medication Safety:** Medication reconciliation and documentation of medication allergies.
  - **Efficiency Measures:** Emergency room visits and ambulatory sensitive hospitalizations.
Engaging leadership

- Administrator brought Atrius CEO to Chelmsford to discuss CHIPRA
- HVMA Pediatric Specialty Chief receives regular updates on Medical Home development
- Met with Epic Pedi team to talk about smart sets including more NICHQ components and spread.
- Central investment in clinical staffing to support access and population management
- Budgetary imperative to diminish cost of care perfectly aligned with proactive focus on preventing ER visits, hospitalizations and unnecessary utilization by medically complex patients
Community collaboration

- Developed closer relationship with DCF due to more frequent and proactive calls to them to discuss patients.
- DPH Care coordinator has presented at two early intervention staff programs the Medical Home concept and worked to create linkage to care coordination at our office.
- Relationship with Massachusetts Technology Assistance Resource team (MASSTART) and Children Hospital Boston Pediatrics Advance Care Team (PACT) developed and utilized in a phone conference with a parent.
- Resource Fair at the Chelmsford Site brought numerous agencies to the site.
Next Steps:

• Develop a workflow to begin the transition of 20+ year old patients to adult care
• Test and then operationalize the Team Roster Review Process
• Demonstrate ROI for care coordinator and spread to other Atrius practices
• Increase use of telephone conferences with school and specialty care
• Spread the use of Parent Parents and develop parent/patient advisory boards
Experiences with Medical Home Implementation

Angela Leigh Beeler, MD
Interim Division Director, General Pediatrics
UMass Medical School, UMass Memorial Health Care
UMass Memorial Health Care

Pediatric Primary Care – facility based in Worcester, 7800 patients, 4.5 FTE MD + 2.0 FTE NP

+ South County Pediatrics – community based in Webster, 2900 patients, 1.5 FTE MD + 1.6 FTE NP

= Division of General Pediatrics

UMMHC also owns 2 community based pediatric practices and has many more private groups in their contracting network.
Lessons Learned

• Staff are more flexible than I imagined
• Money is an important driver
• Not every family cares about this
• What are the important measures?
Ways in which CHIPRA Coalition Helped

• Outside pressure is a catalyst for change
• Sharing the struggles, learning from others success
My Dream Coalition Work

• Unified set of measures
• Standardized insurance benefits package that supports the measures
• Figure out what a meaningful care plan is, and how to easily keep it updated
• Centralized care management for the most medically complex patients, support for patient coaching for socially complex patients
• Help families understand what Medical Home is and how it can help them