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.

Community Collaborative Approach

- 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

Consumer Engagement – Txt4health

- 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

Chronic Care Management

- 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

GNO Health Care Delivery Safety Net System

- 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 Community Provider Profile

- 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

- 12-month intensive CCBC-sponsored Practice Coaching on Chronic Care Management for participating practices;
- All 13 PCMH recognized sites up for renewal in 2012;
- 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

PCMH Mapping Project

- 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)
  - AHRQ Study Clinical Decision Support Participation

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

NCQA PCMH-driven practice change

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Re-assess health IT impact on PCMH workflow efficiency

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

Access & Communication	Lab & Referral Tracking; eRx	Care Management	Performance Reporting

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EMR workflow inefficiency

- 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

Electronic medical record end-user workgroup

- 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

External pressure from national initiatives

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- **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

Standard 1: Enhance Access and Communication	Pt
A. Access During Office Hours	4
B. After Hours Access	4
C. Electronic Access	2
D. Continuity	2
E. Medical Home Responsibilities	2
F. Culturally Linguistically Appropriate Services	2
G. Practice Team	4
	20

Standard 2: Identify and Manage Patient Populations	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. Use Data for Population Management	4
	16

Standard 3: Evidence-Based Guidelines	Pts
A. Identify High Risk Patients	4
B. Care Management	3
C. Manage Medications	4
D. Use Electronic Prescribing	3
	3
	17

Standard 4: Provide Self-Care Support & Community Resources	Pts
A. Support Self-Care Processes	6
B. Provide Referrals to Community Resources	3
	9

Standard 5: Track & Coordinate Care	Pts
A. Test Tracking and Follow Up	6
B. Referral Tracking and Follow Up	6
C. Coordinate with Facilities/Care Transitions	6
	18

Standard 6: Measure and Improve Performance	Pts
A. Measure Performance	4
B. Measure Patient/Family Experience	4
C. Implement Continuous Quality Improvement	4
D. Demonstrate Continuous Quality Improvement	3
E. Report Performance	3
F. Report Data Externally	2
	20

- "…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

How We Started

- 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

How we started

- 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

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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)
PCMH 1: Enhance Access and Continuity						
1A: Access During Office Hours MUST PASS	The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:					
	1. Providing same-day appointments (CRITICAL)	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 documentng calls/secure messaging in Medical Record	Yes	Yes	Chart	Unknown

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Crosswalk EMR-PCMH Worksheet

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

Community provider engagement

- **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

Key system enhancements

- 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

PCMH Toolkit

- 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

Next steps

- 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