

Health Neighborhoods

Complex Care Committee

Council on Medical Assistance Program Oversight

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Qualidigm: Our Vision and Mission

OUR VISION... *quality health care for all.*

OUR MISSION... *advancing the quality, safety and cost effectiveness of health care.*



What is a Medical Home?

- Enhanced access to care
- Care continuity
- Practice-based team care
- Comprehensive care
- Coordinated care
- Population management
- Patient self-management
- Health Info Technology
- Evidence-based care
- Care plans
- Patient-centered care
- Shared decision-making
- Cultural competency
- Patient feedback
- New payment systems
- Quality measurement and improvement

Why is PCMH Recognition Important?

- Becoming a condition of participation for many payers
- Viewed as a building block for Accountable Care Organizations (ACO)
- Overlaps with EHR Meaningful Use criteria
- Endorsed by patients, business, policy makers, specialty societies



Who is the National Committee for Quality Assurance (NCQA)?

- Largest PCMH accrediting organization in the nation
- Private, not-for-profit organization
- Recognized symbol of quality
- Widely-adopted evaluation model



When is a practice ready for PCMH?

- Electronic Health Record (EHR)
- Computer system with:
 - Email
 - Microsoft Office
 - Internet Explorer
 - Adobe Acrobat Reader
- Clinician/staff experienced with computer programs
- Time commitment-a minimum of **4 hours** per week for 6 months between lead MD and office manager



How does the practice proceed?

- Purchase survey tool license
- Obtain online application materials
- Assess compliance with standards
- Pay application fee
- Submit online application, practice information, and agreements

Qualidigm Model (NCQA PCMH)

- Conducts a needs assessment of the practice
- Provides a customized plan or roadmap for the practice
- Conducts three on-site meetings over six months
- Provides technical assistance via webinars, conference calls and email
- Assists with selection of conditions and measures
- Provides templates of Policies & Procedures and clinical performance reports
- Reviews NCQA standards and required documentation
- Assists with NCQA submission process

Results to Date

- First group: 19 practices, 105 clinicians
 - Currently 16 of 19 practices are recognized at Level 3
 - 1 practice is recognized at level 2
 - 1 practice is recognized at level 1
 - 1 practice still working
- Second group
 - Results ongoing
- Third and fourth group
 - Recruitment in progress

Testimonial

“Qualidigm promised to facilitate our quest for Level 3 recognition as a Patient-Centered Medical Home, and they did. They were our coach and mentors as we proceeded with the project over a period of months, and their guidance was invaluable. I recommend them to any practice that wishes to achieve this recognition.”

*-- Jeff Hyman, Practice Administrator
New Milford Medical Group*

Qualidigm: NCQA Sponsoring Organization

- Recently received this recognition due to our successes for encouraging clinicians to adopt proven practices for improving care

Lessons Learned

- Expense and time commitment are challenging to small practices
- Will likely need assistance from outside source
- The practice itself need to transform its processes and systems to truly be a PCMH practice

A Story: CT's Communities of Care

(Transitions of Care)

- 2010 – 2012 Qualidigm/CHA formed partnership to reduce heart failure readmissions
- CHA Collaborative
 - 25 hospitals
 - Hospital-focused
- Qualidigm Communities of Care
 - Providers across the continuum
 - 13 hospitals, 67 NHs, 35 HHAs
 - Interactive workshops, individual training and support
 - Laying the groundwork for Health Neighborhoods concept



Strategic Approach to Communities

- Interactive workshops, individual training and support for each community
- Group training/sharing – all communities together
- Laying the groundwork for Health Neighborhoods concept

Community Development

- Relationship building
- Shared purpose
- Culture of no blame
- Availability of/and collection of data
 - needs assessment/environmental scan
 - root cause analysis
 - 30-day readmission rate



Challenges to Community Building

- Varying levels of knowledge/experience
- Culture change
- Communication
- Willingness to share

Challenges to Care Transitions

- Consistency of information
- Communication across providers/patient/family
- Care coordination
- Patient/person/family education
- Identification of high risk individuals
- Medication issues
- End of Life care

Community Interventions

- Performance assessment and feedback
- Enhanced communication between/across settings
- Timely post hospitalization physician visits
- Standardized patient/family education
- Emergency care plans
- Medication reconciliation
- Palliative/Hospice care

Qualidigm Support

- General education and technical support across communities
- One-on-one and group technical support for each community



Successes: Transfer of Information Committee

- Convened a committee of representatives from across the healthcare continuum
- Developed a set of data elements determined to provide safe transition between healthcare settings
- Reviewed by DSS and DPH
- Currently being utilized by communities and incorporated into EHRs when available

Successes: Patient and Provider Education Committee

- Input from consumers and community providers from across the continuum
- Collaboration with education and quality improvement consultants
- Developed videos and written materials related to patients with heart failure

What is Heart Talk?

- Educational videos for licensed staff, non-licensed staff and patients/families/caretakers
 - Patient Education booklet
- Standardized for use in all care settings
- Funded by CMS
- Goal: reduce preventable hospital readmissions for patients with HF

Available in English, Spanish and Polish

Why Develop the Videos?

- Connecticut is a small state, opportunity for large impact
- Patients make multiple stops along the continuum within the state
- Same message, different terms



How Can Heart Talk be Accessed?



Qualidigm's Heart Talk Video Series

Download FREE evidence-based educational videos for nurses, nursing assistants, patients, families and caregivers at www.HeartTalk.org



Impact

- 14 Communities established and thriving
- Implementation of evidence-based practices
- Standardization of processes
- Improved communication
- Peer-to-peer sharing and mentoring
- 8.3% relative improvement in 30-day readmission among patients with heart failure

Broadening the Community Focus

- Feb 2012 - broadened initiative to address preventable hospital readmissions of all patients across the state.
- CT Community-Based Care Transitions Program (CCTP) Proposals
- Align with CHA Health Engagement Network (HEN)
- Other related initiatives

Care Transitions Leadership Academy

- Care Transitions and Community Building
- Data, Collection, Analysis and Interpretation
- Interventions and Strategies
- Palliative Care

Upcoming Workshops:

November 7th – Hospice Care

January 24th – Motivational Interviewing

Institute of Medicine Report

- “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America”
- Ten Recommendations
 1. The Digital Infrastructure
 2. The Data Utility
 3. Clinical Decision Support
 4. Patient-Centered Care
 5. Community Links
 6. Care Continuity
 7. Optimized Operations
 8. Financial Incentives
 9. Performance Transparency
 10. Broad Leadership

“No one individual, organization, or sector alone can affect the scope and scale of transformative change necessary for a true learning system. Rather, leadership from all sectors working in concert will be required.”

– Harvey V. Fineberg, M.D., Ph.D.

Sustainability

- Communities/Health Neighborhoods will thrive, meet and exceed expectations if there is:
 - A shared purpose
 - Seamless communication
 - Continuous nurturing
 - Focus on person-centeredness



Lessons Learned

- Focus on person-centeredness
- Passion among providers and social service organizations
- Peer-to-Peer learning and sharing is essential
- Communication is key
- CT is a small state

If you want to go fast, go alone. If you want to go far, go together.

proverb

African



Thank you

Contact Us

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