

The Medical Home — Where Do We Stand?

As the debate about investing more in primary care heats up in Washington, DC, and across the nation, the conversation often includes a discussion about the medical home. In Massachusetts, the Commonwealth's Executive Office of Health and Human Services (EOHHS) recently requested information to help it develop a statewide patient-centered medical home initiative. EOHHS plans to implement a variety of infrastructure changes to help a selected number of primary care practices across the Commonwealth transform into patient-centered medical homes. If the initiative proves effective at the demonstration sites, EOHHS intends to roll out the model more broadly in the future.

In the fall 2008 issue of *Primary Care News*, we described our plans to begin to assess our primary care practices for their "medical home readiness" using the published *National Committee for Quality Assurance (NCQA) guidelines*. At this time, we have surveyed 30 internal medicine, family medicine and pediatric practices across the system. Those surveyed represent many practice sizes and types, including private and Community Medical Group offices, as well as hospital-based practices

and community health centers.

Each practice completed a self-assessment interview using the NCQA Physician Practice Connections – Patient-centered Medical Home (PPC-PCMH) Standards tool. There are nine standards covering the following:

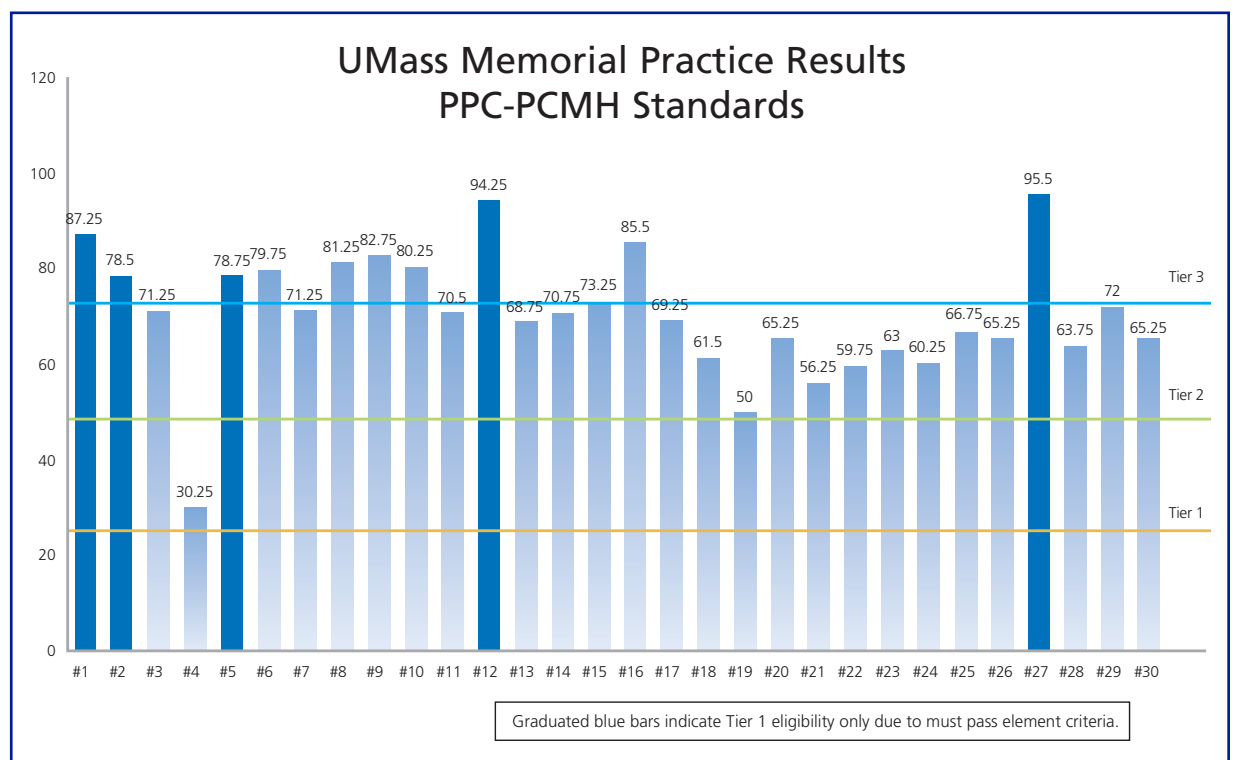
- Access and communication
- Patient tracking and registries
- Care management
- Patient self-management support
- E-prescribing
- Testing
- Referral tracking
- Performance and improvement
- Advanced electronic communications

Within these standards, there are a total of

30 elements, 10 of which are must pass elements. The survey scoring is based on a total of 100 with each element having a scoring range recognizing that not every practice will adopt or will have fully implemented all elements within a standard. The scores are then ranked by tiers (see graph):

- Tier 1 is the minimum qualification for recognition by NCQA. A Tier 1 rank indicates a practice has scored at least 50 percent on five must pass elements and the total score is between 25 and 49.
- Tier 2 indicates a practice has scored at least 50 percent on 10 of 10 must pass elements and has a score of 50 to 74.
- Tier 3 indicates a practice has scored at least 50 percent on 10 of 10 must pass elements and has a score of 75 or more.

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The majority of our self-assessment scores fall within the Tier 2 range for points, however, we do not score at 50 percent or more on the 10 must pass elements which results in a Tier 1 ranking for a number of the practices.

One area of strength identified is the adoption of evidence-based guidelines demonstrated by use of charting tools, flow sheets and progress note templates for well child visits, chronic disease care and risk-based assessments. We also do well in the area of patient self-management, including

interpreter services as needed, use of self-management tools and support, such as asthma action plans, blood sugar logs, written treatment plans, and referrals to self-management resources such as the Diabetes Education Center or behavioral health services. Other areas of strength include our electronic systems for registration and scheduling, electronic health record, e-prescribing, test results and imaging results. Must pass elements that need some additional work include written policies and procedures for some of the smaller practice sites,

generation of population-based data and measures, and performance reporting on clinical or service performance across practices.

As we continue with our self assessment of medical home readiness, we are beginning to learn about exemplary work processes identified by practices that are patient-centered, efficient and help practices deliver high-quality care. We are identifying ways to share these successes with others who may be interested in learning more about these approaches to care delivery for their own practice.



Practice Improvement Corner **Diabetes Collaborative**

The “pilot wave” of the Office for Primary Care Diabetes Collaborative (OPC-DC) held its third and final learning session on May 5. During April, the leaders from each participating practice reported back on their experience.

One hundred percent of respondents indicated that they had changed how they care for patients with diabetes, that these changes represented improvement, and that if given the opportunity, they would participate in such a collaborative again.

The following OPC-DC activities and components were reported to be of high value or indispensable by more than 75 percent of respondents:

- Patient registry
- Data reports
- Monthly patient newsletters
- Web site for clinicians
- Web site for patients
- Site visits from the OPC-DC Core Leadership Team liaison
- Learning sessions
- Provision of monofilaments
- Nurse-to-nurse learning sessions

Eighty-one percent of participants who included a patient advisor on their “change team” reported that this was valuable or very valuable.

These practices will now seek to sustain the gains over time. The OPC-DC team will continue to lend some support, but its efforts will be more focused on Wave 2, scheduled to begin work in June. Practices that adopt the changes promoted through the OPC-DC will find that they have accomplished many of the elements required for qualification as patient-centered medical homes.

For more information about the work of the Diabetes Collaborative, contact Ron Adler, MD, at ronald.adler@umassmemorial.org or visit www.umassmemorial.org/opc.

“We were able to develop a clearer picture of how we were doing with diabetes care in our practice and get everyone on the team working together to improve care. The enhanced role of nursing in our practice is something that we have struggled with in the past, and this time it really worked.”
– OPC-DC participant

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Welcome New Colleagues!



Safdar Medina, MD

Pediatrics

Tri-River Family Health Center, Uxbridge

Medical School: Indiana School of Medicine

Residency: Hasbro Children's Hospital



Kathleen Sweeney, MD

Family Medicine

Community Health Connections, Fitchburg

Medical School: University of Rochester School of Medicine

Residency: UMass Memorial/UMass Medical School

The Office for Primary Care welcomes new members to our Advisory Committee and thanks to departing members.

Three new medical students — John Ducey, Elizabeth Herrup and Jonathan Klaucke, all members of the Class of 2012 — join the Advisory Committee for the 2009 – 2010 academic year.

Eric Dickson, MD, MHCM, senior medical director of the UMass Memorial Medical Group, and George Maxted, MD, associate medical director at Family Health Center, are also new members.

We offer thanks to Rachel Rosenberg and Zheni Stavre, both Class of 2011, for serving as our first medical student representatives to the Advisory Committee, as well as to Michele Streeter and Matt Collins as they complete their service.

A Must Read

Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

Testimony before the United States Senate Finance Committee (March 2009)

By Fitzhugh Mullan, MD, Murdock Head Professor of Medicine and Health Policy, Professor of Pediatrics, George Washington University

Link to: <http://finance.senate.gov/hearings/testimony/2009test/031209fintest.pdf>

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