

Michigan Primary Care Association
Patient-Centered Medical Home and Meaningful Use
Clinical Quality Assessment Final Report
March, 2011

The Clinical Quality Team (CQT) at the Michigan Primary Care Association (MPCA) conducted an assessment of Michigan Community Health Centers (CHCs) to understand how to best support performance improvement in the delivery of quality health care within the health centers. The focus of this report is on CHC readiness to become designated as a Patient-Centered Medical Home (PCMH) and to achieve Meaningful Use (MU), and to identify the ways in which the CQT can best support the centers in these endeavors.

METHODOLOGY

The assessment process included the following components,

- A survey conducted by interview of key informants in Michigan CHCs
- Data on health center information systems from the Virtual Community Health Center (Virtual CHC)
- Data on all Michigan CHCs regarding PCMH designation/recognition status

The survey was designed by the CQT and employed a one hour interview with key informants at each health center who are familiar with the needs and capacities of the CHC as it relates to readiness to become designated as a PCMH and achieve MU of the Electronic Health Record (EHR). Some interviews were conducted between the CQT members and a key contact from the health center. In other cases, there were multiple individuals from the CHCs that participated in the interview. Key informants were selected by the health center when queried by formal letter (and telephone contacts) as to the best person(s) in the organization to respond to these areas of focus. Individuals interviewed at the CHCs include the following,

- Quality Improvement Directors
- Patient Management Specialists
- Directors of Nursing
- Chief Medical Officers
- Clinical Affairs Directors
- Chief Operating Officers and Directors of Operations
- Chief Executive Officers
- Risk Managers
- Staff Development Specialists
- An Administrative Fellow

A letter of introduction was sent to each of the centers indicating the purpose of the survey. When surveyed, each health center was assured that data would be used by MPCA staff for improving support services. Health centers were assured of the confidentiality of data of individual sites. A follow-up letter was sent to each health center after the survey was conducted. A standard process was developed and discussed among the CQT for inter-rater uniformity.

The response rate for the survey is 64.7 % (22/34). Twenty-two of the thirty-four health centers were interviewed, with additional interviews currently scheduled for health centers that have not yet participated. Also, data regarding designation status of PCMH has been collected on all thirty-four of the health centers.

TOP STRATEGIC PRIORITIES FOR MICHIGAN CHCs

The health centers were asked to identify their three top strategic priorities for the coming year. The following list enumerates the five most frequently named strategic priorities that were identified by health centers.

1. EHR and Registry selection/implementation and achieving Meaningful Use of EHR
2. Improve the quality of patient care
3. PCMH designation
4. Improve efficiency and productivity of clinical services
5. Improve integrated delivery, in particular, better integration of behavioral health

PATIENT-CENTERED MEDICAL HOME

The PCMH, defined in the *Joint Principles of the Patient-Centered Medical Home*¹ is a new model of care that has been adopted by professional academies and is being championed as the transformative model that will build primary care infrastructure, improve quality of care, and control health care costs.

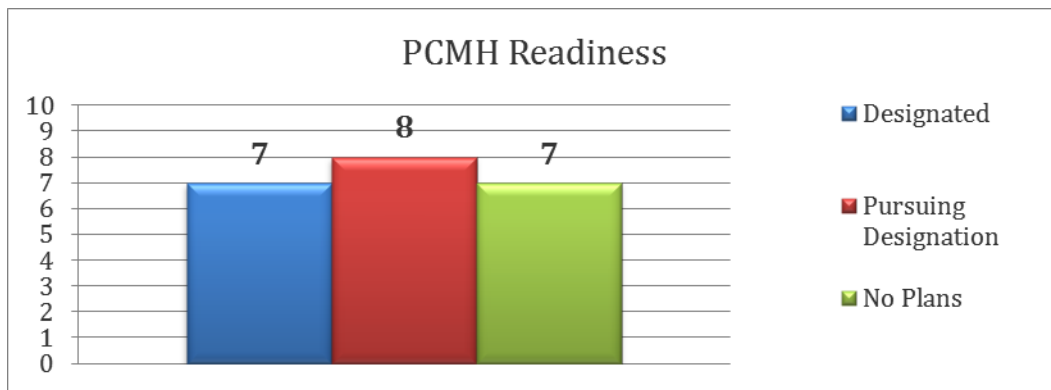
In the PCMH model, every patient has a medical home for first contact with the health care delivery system and an ongoing relationship with a trusted health care team. It is *patient-centered*, meeting the needs of the whole person by addressing physical and behavioral needs of the patient in a culturally sensitive manner. The PCMH encourages patients to become engaged in their health and health care. Practice teams coordinate comprehensive care across the health system with links to community resources. The PCMH emphasizes expanded access, health information systems, continuous quality improvement, safety and reliability, and payment reforms that create sustainable funding for the enhanced services. Practices become designated as a PCMH through an accrediting body, such as the

National Committee on Quality Assurance (NCQA) or Blue Cross Blue Shield of Michigan (BCBSM) by way of a rigorous review in which the health centers must demonstrate PCMH capabilities.

Readiness for PCMH Designation

The survey results provide data on readiness to become designated as a PCMH among those health centers that were surveyed. Figure I, below, depicts *readiness for PCMH designation* with three defined categories, 1) those health centers that are currently designated, 2) those health centers that are pursuing designation, and 3) those health centers that have no plans to become designated at this time.

FIGURE I

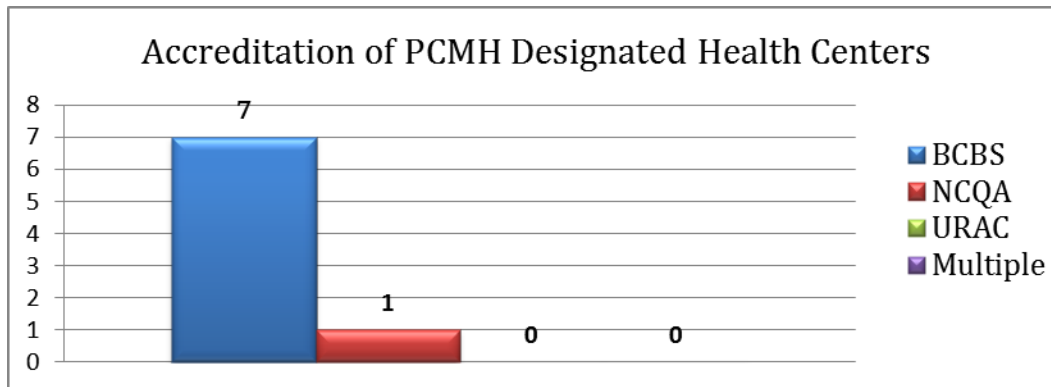


Health centers that were surveyed are evenly divided in readiness between those that are designated, those that are pursuing designation, and those that have not made plans. Seven of the health centers that were surveyed are currently designated by BCBSM or recognized as a PCMH by NCQA. (An eighth CHC is designated, but was not yet surveyed, so was not included in the data shown in Figure I, above.) Table I, below, enumerates the eight centers which are currently designated and the accreditation body to which they are designated or recognized. Figure II, below, illustrates that most Michigan CHCs are designated through BCBSM.

TABLE I

Health Center	Accreditation
1. Alcona Health Centers	BCBSM
2. Baldwin Family Health Care	BCBSM
3. Cherry Street Health Services	BCBSM
4. East Jordon Family Health Center	BCBSM
5. Hackley Community Care Center	NCQA Level 3
6. Health Delivery, Inc.	BCBSM
7. Mid-Michigan Health Services	BCBSM
8. Sterling Area Health Center	BCBSM

FIGURE II



PCMH Capacity

CHCs, by design, provide greater access to health care delivery to those who have limited access to health care due to economic, cultural, or geographical factors. All CHCs that were surveyed offer increased access for patients through expanded hours: early morning, evening, weekend, and walk-in clinics. Some centers are expanding capitol, exploring open scheduling for timely access, and/or testing new staffing models that optimize the skills of clinicians and increase patient flow.

CHCs report varying capacity for team-based care for better primary and secondary prevention, and chronic disease management. A few centers have explored new models of care such as Group Visits, and

report varying degrees of success. Overall, self-management support programs are in the early stages of development. AmeriCorps Patient and Community Navigators are utilized in some health centers for advancing the principles of the PCMH to engage patients in their health and healthcare, to educate patients about health issues, and link patients to community services.

Behavioral health integration is an important priority for health centers. Although many centers have made great strides in integrating medical and behavioral services, most informants report that their CHC has been challenged by improving integration of behavioral services.

The quality of care coordination across the health system varies among the health centers. Referrals to specialists are often problematic. In addition, some communities have difficulty linking patients with needed community services, such as an effective tobacco treatment program. Formal predictive modeling is not currently employed in health centers to identify the medically or socially complex patient who would benefit from more intensive care coordination services. Moreover, most health centers that were surveyed have not developed structured processes for transition care post-emergency department visit, and/or post-hospitalization.

Optimizing information systems through health information technology (HIT) has been a priority for most health centers. Many of the centers have implemented new systems in the past several years. There is varying capacity in using electronic information systems, such as use of registries for population management or ability to create performance reports for process improvement and demonstrating outcomes. Most CHC informants indicated a substantial lack of staff and/or technical expertise to optimize HIT.

All of the health centers are engaged in activities to improve the quality of care delivered, and two thirds of those surveyed are either pursuing PCMH designation or are already designated.

Challenges to Building and Maintaining PCMH Capabilities

Informants report the following challenges to becoming designated or maintaining designation status,

- Lack of information or understanding of the PCMH model (and report that they need a step-by-step guide through the process)
- Educating the organization as a whole about the PCMH
- EMR implementation is difficult and they need upgrades to achieve PCMH capabilities

- Need a better registry product for population management (or the need to better utilize a registry to maximize its function)
- Need a designated person to coordinate the change process, but have limited staff
- Need greater staffing capacity to collect and analyze data and to produce performance reports
- Need greater self-management capacity (staff training and structured processes)
- Consider PMCH to be a lot of work with no incentives for the center
- Recent growth challenges further system change

PCMH Topics of Interest

PCMH topics that health centers identified as priorities include the following,

- Assistance with implementing and optimizing the function of EMR
- Improving performance reporting for process improvement and for demonstrating outcomes
- Optimal use of registries for population health management
- Improving chronic disease management
- Behavioral health integration and coordination of behavioral health services
- Leadership training for executive staff and clinicians (as a foundation for improving clinical performance and achieving PCMH designation and MU)
- Engaging patients in improving their health and partnering to manage chronic disease
- Improving primary and secondary preventive services
- New staffing models that increase access to care

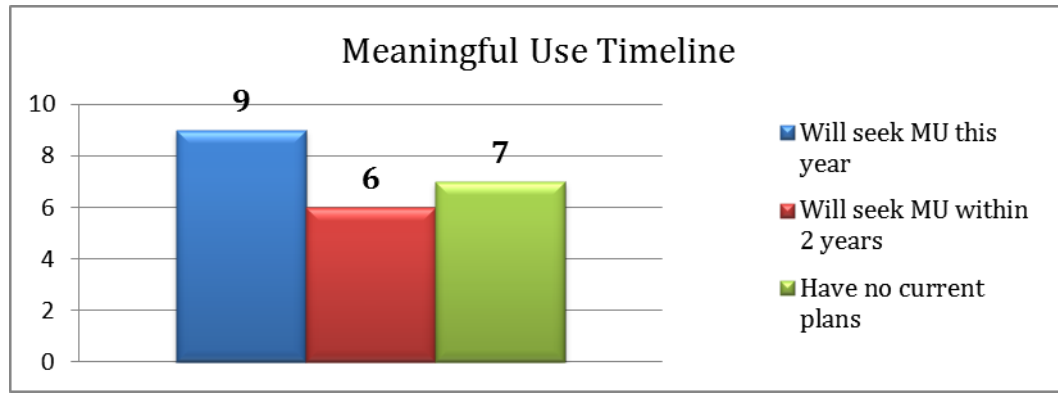
MEANINGFUL USE

In 2012, the Centers for Medicare and Medicaid (CMS) will offer incentives to eligible providers that can demonstrate MU of EHR by meeting a set of requirements set forth by CMS. As discussed previously, the health center priority which is identified with greatest frequency is “implementing EHR and achieving Meaningful Use.” There is a financial incentive for adopting MU of EMR in the coming years, which according to many of the CHC informants, has influenced the commitment to immediate implementation.

Readiness for PCMH Designation

As shown in Figure III, nine of the health centers that were surveyed expect to achieve MU within one year and fifteen health centers, more than two thirds, expect to achieve MU within two years.

FIGURE III

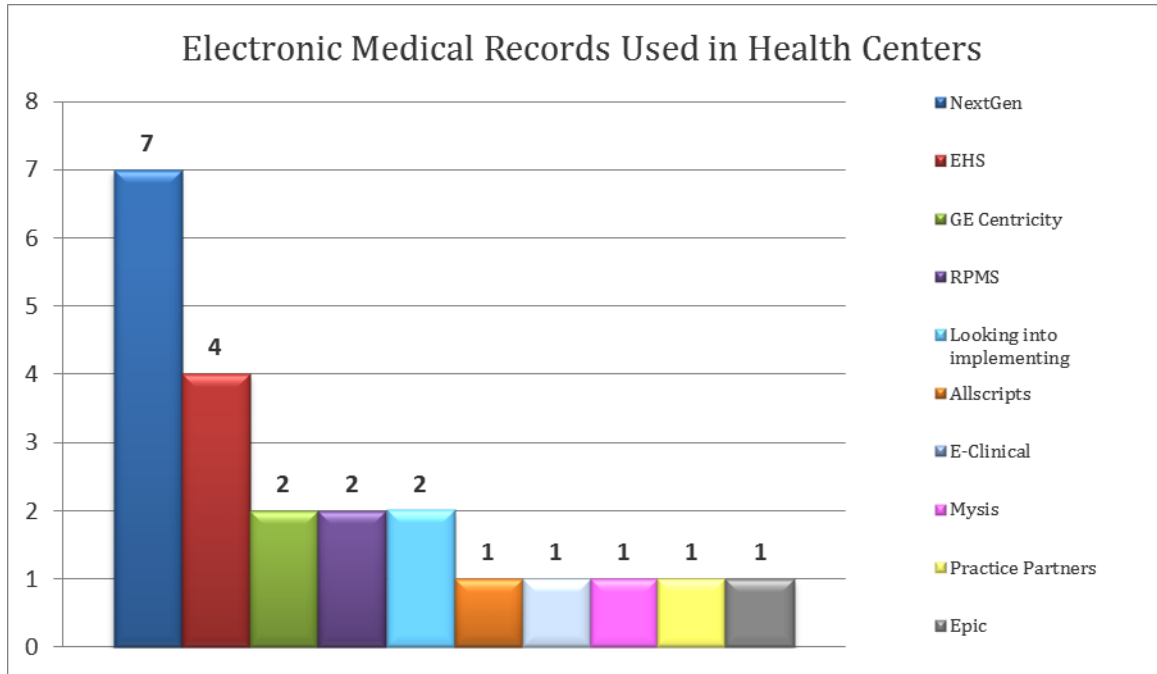


Meaningful Use Capacity

Figure IV, below, illustrates that CHCs have implemented many different EMR systems, and the most commonly used systems are NexGen and Electronic Health System (EHS). In addition, health centers use many different registry products, including Cielo, EHS, Patient Electronic Care System (PECS), WellCentive, and Resource and Patient Management System (RPMS). Some CHCs do not have registry capability, and as a result, population management is a difficult and laborious process. Most health centers are not using the registry to its full capability. Improving registry capability was cited as a common concern among many of the health centers.

Health centers report that they have received technical assistance from information technology vendors. However, for the most part, the informants report that the health centers have not been satisfied with the level of support. Some centers have received technical assistance from Michigan Center for Effective IT Adoption (M-CEITA) with variable levels of satisfaction. A few centers have received support from Virtual CHC at MPCA.

FIGURE IV



Challenges to Achieving Meaningful Use

- Financial: Very expensive products and processes; may not be financially worth it
- Operational: Difficult to implement requirements. EMR implementation is difficult, upgrades are needed to achieve MU
- Staff: Limited staff for activities involved in achieving MU
- Administrative: The MU application is detailed and takes a long time to prepare

PREFERRED METHODS OF CLINICAL SUPPORT SERVICES

Health centers' preferred methods for performance improvement and achieving designation of PCMH and MU of clinical support varied among those surveyed. The following is a list of preferred methods of assistance for improving performance and readiness for designation of PCMH and achieving MU,

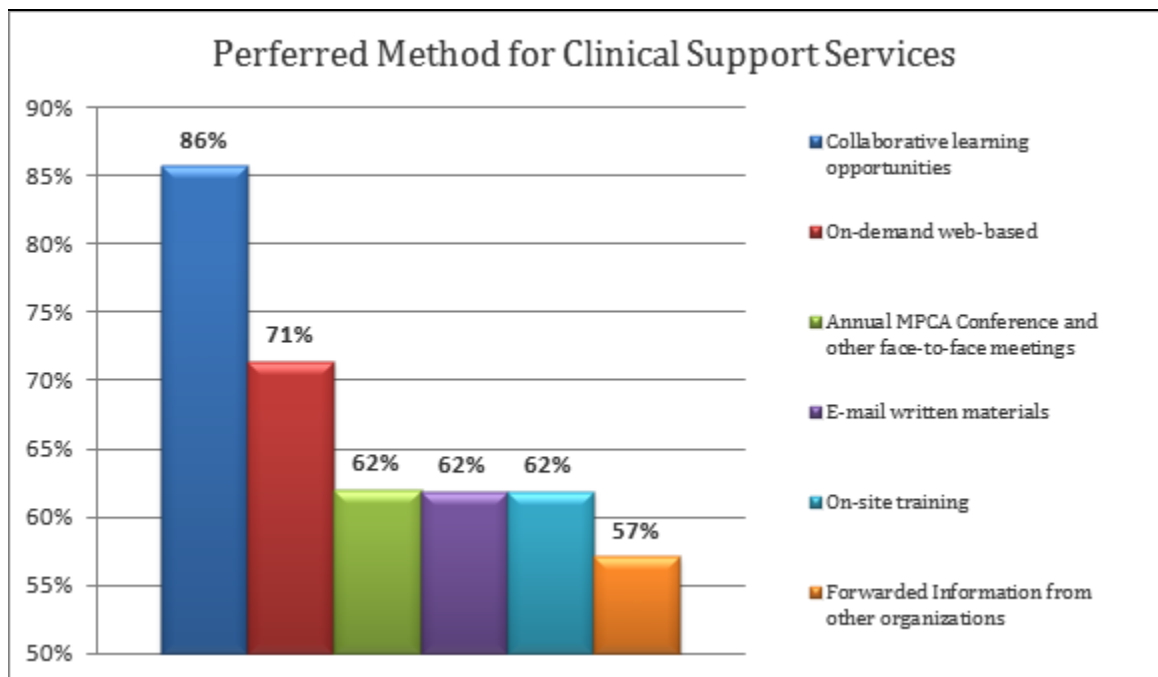
1. Collaborative learning (e.g., learning collaboratives, networks, mentoring programs)
2. On-demand, web-based programs
3. Live web-based programs
4. Annual meetings with relevant clinical topics
5. EMR and/or registry User Groups to work through problems with implementing EHR
6. Greater CHC-specific training, educational programs, and technical assistance

7. Technical assistance support: on-site training is a valuable method for accelerating performance improvement

As noted in Figure V, below, collaborative learning opportunities are deemed the most valuable clinical support option that the CQT at MPCA can offer. The MPCA Annual Conference was considered valuable, but according to some of the informants, face-to-face conferences are too difficult to attend (for reasons of limited time or too great a distance to travel). On the other hand, on-demand programs that are located in a web-based, centralized location are highly preferred so that relevant information is available at the convenience of the clinician.

Written materials from MPCA and other organizations are never mentioned as the preferred option for clinical support, but were included by most CHCs as an important source of information in a broad range of support services. Many informants reported a need for individualized technical assistance, including on-site assistance. In this regard, many CHCs report that they seek out technical assistance from organizations within their community, such as health systems or health plans, but these are not tailored to the CHCs, leaving many questions and concerns unanswered.

FIGURE V

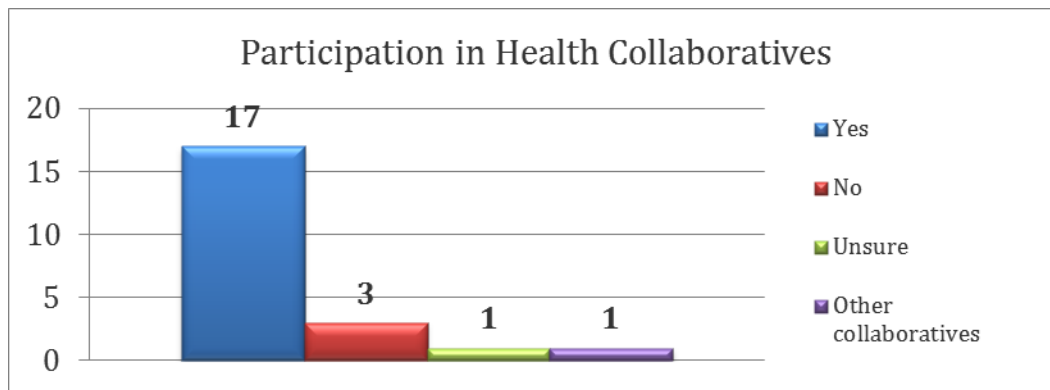


Experience with Collaboratives

As discussed above, the most preferred method of clinical support assistance for PCMH and achieving MU is through collaborative learning opportunities. Many respondents indicated that they had benefitted from working with health centers on the Health Disparities Collaboratives (HDCs) and wanted to become engaged again in collaborative learning.

The health center informants were asked whether their health center has participated in an HDC. Figure VI, below, depicts past or present involvement in collaboratives among Michigan health centers. More than three quarters of the health centers have been involved in HDCs. One health center is currently involved in a collaborative, which is a partnership between the Indian Health Services and the Institute for Healthcare Improvement (IHI). One informant was unsure about past involvement in collaboratives. Only three health centers indicated that they have had no prior experience with collaboratives.

FIGURE VI



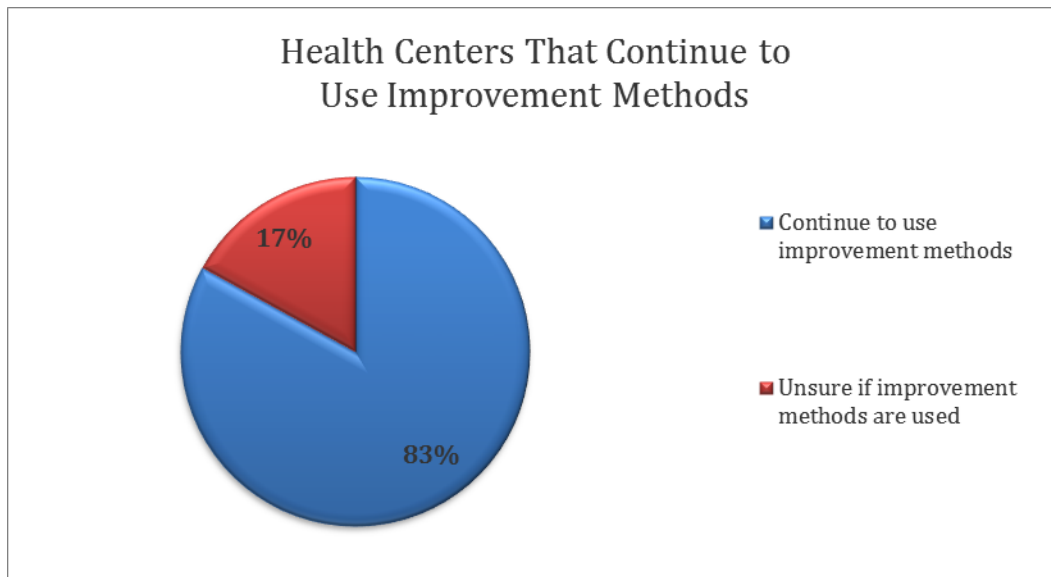
Key informants were asked whether current staff had participated in the HDCs. As shown below in Figure VII, of the 18 health centers that reported participation in collaboratives, fifteen, or more than 80%, have at least one member of the staff that has been involved with the collaboratives. As such, the knowledge and skills of this improvement methodology are embedded in the organizational memory.

Key informants were asked whether processes from the collaboratives are currently implemented in health center. As shown in Figure VIII, more than eighty percent of health centers that participated in the HDCs continue to incorporate the process improvement methods that they learned, such as PDSA cycles. This data suggest that a foundation for process improvement has been laid for accelerating change processes.

FIGURE VII



FIGURE VIII



DISCUSSION

Most health centers are working toward PCMH designation and they are engaged in improving health information systems through EMR implementation to achieve MU in the next two years. All health centers that were surveyed relayed a strong commitment to improving clinical performance. Those health centers that have no plans to become designated as PCMH or achieve MU may become more engaged in the process through training and collaborative learning opportunities, which help them to improve their performance. In this way, these health centers can build PCMH capability over time in a way that is in alignment with their immediate strategic priorities.

Understanding the barriers to achieving PCMH and MU provides insights into how to assist health centers in performance improvement. Many health centers report that they lack basic knowledge about how to operationalize the principles of the PCMH and to achieve MU. They request educational opportunities that provide clear guidance in a step-by-step manner to help them get started. Others, especially those that are already designated as PCMHs, report the need for individualized technical assistance and collaborative learning opportunities to make continuous improvements. In particular, they express a need to optimize electronic information systems and to redesign work flow for better primary and secondary prevention, as well as chronic disease management.

The data highlights varying levels of readiness and capacity among the CHCs for performance improvement, and informs the strategic planning process of the need to offer clinical support services that *meet the health centers where they are*. Programs offered through self-paced modules for PCMH and MU allow health centers to build their knowledge sequentially. Training opportunities that are available in a variety of topics allow health centers to select areas of interest to fill gaps in knowledge in PCMH and MU. When on-demand programs are offered in a web-based, centralized information center, the busy clinician can access needed information in one location, when it is convenient. Technical assistance, on the other hand, requires personnel resources. To offer technical assistance, the CQT must identify additional resources to build capacity at MPCA and/or develop partnerships with external stakeholders that have the technical expertise.

The MPCA Annual Conference is a valued educational asset, providing opportunities for face-to-face meetings, during which time important professional connections are made for collaboration and networking. Many CHCs report that the conference content is excellent; however, because conferences

are difficult to attend, they request archived webcasts and materials to be made available after the conference.

Learning collaboratives are reported to be the preferred method for learning how to operationalize the PCMH and achieve MU. They offer opportunities to work with other CHCs to bring out and resolve problems with performance improvement and to share lessons learned. In addition to learning collaboratives, many of the CHCs report an interest in building clinical networks, for example, HIT User Groups that address common problems that CHCs experience with implementing EHRs and registries.

Valuable information has been gathered through the assessment process about how to meet the needs for clinical support services in Michigan CHCs. As such, the CHCs will be reassessed for their readiness and PCMH and MU capability as part of an annual evaluation to monitor progress and provide data to inform strategic planning in the future. It is anticipated that there will be more CHCs that are designated as PCMHs in the next twelve months and some of the health centers will achieve MU of EHR.

CONCLUSION

In summary, Michigan CHCs are committed to performance improvement, PCMH designation, and achieving MU. They also desire to be supported through clinical quality services at MPCA. The *Technical Assistance Cooperative Agreement Work Plan* reflects a data-driven approach to strategic planning with a focus on collaborative learning opportunities and on-demand, web-based programs and educational materials that meet health centers where they are in performance improvement, PCMH designation process, and achieving MU of EHR. In addition, clinical sessions at the Annual Conference can provide valuable content in face-to-face meetings, during which time CHCs can learn about PCMH and MU topics and develop and deepen professional connections that from the basis of working together to improve clinical performance and achieve PCMH designation and MU.

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1. American College of Physicians. "Joint Principles of a Patient-Centered Medical Home." Available at: <http://www.acponline.org/pressroom/pcmh.htm>. Accessed on June 1, 2008.