Overview

- Eastern Maine Healthcare Systems & EMHC
- Patient Centered Medical Homes
- Affordable Care Act Health Homes
- Innovation - Community Care Teams
- Role of Home Care and Hospice
Eastern Maine Healthcare Systems (EMHS)

EMHS Mission

• The mission of EMHS is to maintain and improve the health and well-being of the people of Maine through a well-organized network of local health care providers who together offer high quality, cost-effective services to their communities
• EMHS serves two-thirds of Maine’s geography
• Strong Culture of Health Information Technology

EMHS Members

• 8 Hospitals
  – Tertiary Trauma Center
  – Psychiatric Hospital
  – General & Critical Access Hospitals
• 8 Nursing Facilities
• 1 Continuing Care Retirement Community
• Emergency Transportation (Ground & Air)
• Pharmacy
• Physician Practices
• HomeCare & Hospice (Eastern Maine HomeCare & VNA Home Health Hospice)
EMHS Innovation

- 2010-2013 one of 17 National Beacon Communities advancing Health Information Technology to improve quality and lower the cost of care
- Participant CMMI Patient Centered Medical Home Multi Payer Demonstration Project
- Affordable Care Act Health Home Participant
- Original CMS Pioneer Accountable Care Organization
OH MY, I am an independent provider.

Will this presentation apply to me???

YES!!!!
Patient Centered Medical Homes

“A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”

*American Academy Pediatrics*

Patient Centered Medical Homes History

- 1967 - American Academy of Pediatrics Introduces term “Medical Home”
- 1978 – International Conference on Primary Health Care adopts first international declaration of primary care role in promoting health, support also provided by the World Health Organization
- 1996 – IOM publishes Primary Care: America’s Health in a New Era
- 2002 – Future of Family Medicine project is launched and chronic care model is born
- 2005 – Researcher Dr. Barbara Starfield publishes “Contribution of Primary Care to Health Systems and Health
- 2008 – NCQA and JCAHO launch medical home accreditation
- 2010 – Affordable Care Act includes numerous provisions for enhancing primary care and medical homes
- 2010- CMMI Multi-Payer Advanced Primary Care Practice Demonstration Project
PCMH Provider Perspective

http://www.youtube.com/watch?v=2J5ImY8yvtA

Traditional Primary Care & PCMH

**Primary Care**
- Fee for Service Drives Productivity
- Focus on physician role in patient care
- Patient individual health status
- Care Coordination external to focus on acute needs of the patient

**PCMH**
- Accountable for Patient Outcomes
- Physician is a member of the health care team
- Health status of population served by the practice
- Coordination of Care is integrated
- Patients are engaged in their care
- Technology is an essential tool
Medical Home Demonstration Projects

- In 2011 CMS Center for Innovation creates “Multi-Payer Advanced Primary Care” (MAPCP) demonstration Project
- Eight States Selected to Participate
  - Maine
  - Rhode Island
  - Vermont
  - New York
  - Pennsylvania
  - North Carolina
  - Minnesota
  - Michigan

Purpose of the Demonstration Project

- To evaluate advanced primary care when supported by Medicare, Medicaid and Private Health Plans:
  - Reduce variation, utilization and expenditures
  - Improve safety and effectiveness of care
  - Increase beneficiaries participation in decision making
  - Increase availability and delivery of evidence based care
CMMI Multi-payer Demonstration Project Model

- Under this demonstration program, Medicare will participate in existing State multi-payer health reform initiatives that currently include participation from both Medicaid and private health plans.
- The demonstration program will pay a monthly care management fee for beneficiaries receiving primary care from APC practices. The care management fee is intended to cover care coordination, improved access, patient education and other services to support chronically ill patients.
- Additionally, each participating State will have mechanisms to offer APC practices community support and linkages to State health promotion and disease prevention initiatives.

Maine CMMI Demo Medical Home Payment

- PCMH Participants Must be NCQA Accredited
- Medicare, MaineCare and Commercial Insurers provide PCMH’s with additional payment
- Medicare Payments – Demonstration Project
  - $7 pmpm to providers,
  - $3 pmpm for community-based care teams
- Maine projections to achieve budget-neutrality (i.e. to reach $10 pmpm savings):
  - 6-7% decrease in inpatient admissions
  - 5% decrease in ED visits
  - 5% decrease in specialty consultations, imaging
NCQA PCMH Designation

- **Enhanced Access & Continuity**: Accommodate patient needs with access and advice during and after hours, give patients and their families information about the medical home and provide team based care
- **Identify and Manage Patient Populations**: Collect and use data for patient management
- **Plan and Manage Care**: Use evidence-based guidelines for preventive, acute and chronic care management including medication management
- **Provide Self-Care Support and Community Resources**: Assist patients and families in self care management with information tools and resources
- **Track and Coordinate Care**: Track and coordinate tests, referrals and transitions in care
- **Measure and Improve Performance**: Use performance and patient experience data for continuous quality improvement

Maine PCMH Core Expectations

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local community resources
9. Commitment to waste reduction
10. Patient-centered HIT
CMMI Multi-payer Demonstration Project Model Extended

- September 24th CMS announced that the demonstration project would be extended for two years for six participating states (Maine, Michigan, North Carolina, New York, Rhode Island and Vermont)
- CMS commented that the extension is to help bridge the gap between the end of the pilot and the start date for the new chronic care management fee codes
- Extension focused on states with community care teams that would not be eligible to bill under the new chronic care codes.
National Opportunity Health Homes - 2013

- Included in the Affordable Care Act
- CMS will provide 90/10 match for Health Home services to eligible members for eight quarters
- CMS must approve Medicaid “State Plan Amendment”
- Health Homes may serve individuals with:
  - Two or more chronic conditions
  - One chronic condition and who are at risk for another (Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval)
  - One serious and persistent mental health condition
  - Dual eligible beneficiaries cannot be excluded from Health Home services

Required Health Home services include:
- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings
- Individual and family support
- Referral to community and social support services
- Use of health information technology (HIT)
- Prevention and treatment of mental illness and substance abuse disorders
- Coordination of and access to preventive services, chronic disease management, and long-term care supports
Health Home Providers

States have flexibility, eligible providers include:

- **A designated provider**: May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider.

- **A team of health professionals**: May include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and can be free-standing, virtual, hospital-based, or a community mental health center.

- **A health team**: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractic's, licensed complementary and alternative practitioners.

States with Approved Health Home Plans

- Alabama
- Idaho
- Iowa
- Maine
- Maryland
- Missouri
- New York
- North Carolina
- Ohio
- Oregon
- Rhode Island
- South Dakota
Maine PCMH & Health Home Project – Community Care Teams

- 2012 Quality Counts added Community Care Teams to the PCMH project. CCTs will also support Health Homes
- CCTs based on Camden Coalition & Dr. Jeffrey Brenner work “hot spotting”
- Community Care Teams must be:
  - Multi-disciplinary, community-based, practice-integrated care teams
  - Support patients & practices in Pilot sites, help patients overcome barriers to care, improve outcomes
  - Key element of cost-reduction strategy, targeting high-cost patients to reduce avoidable costs (ED use, admits)

Community Care Teams

- The primary goal of the CCT is to provide support for the most complex, high risk, high need and/or high cost patients served by the PCMH and MaineCare Health Home Pilot Sites
- Current Maine CCT Programs
  - Eastern Maine HomeCare
  - PCHC
  - MaineHealth
  - MaineGeneral
  - Androscoggin Home Care & Hospice
  - DFD Russell
  - Hancock County Regional Team – Coastal Care
  - Community Partners (Newport FM & Reddy Ctr)
- 2013 New Teams: AMHC, CHANS & EMHC/VNA Home Health Hospice
EMHC Community Care Team

- Team serves designated Patient Centered Medical Homes and Health Homes – Functions as an extension of the primary care practice.
- Goal to provide high cost high utilization patients in the PCMH with community support and services to reduce the cost of care and improve outcomes.
- Team led by LCSW, staff include home care RN, SW, SW interns.
- CCT staff document in the PCMH/HH Medical Record
- Real time notification from HealthInfoNet when CCT patients are in the emergency room
- Community Partners include Area Agency on Aging, Local Healthy Maine Partnerships, Public Health.

43 Practices Served in 4 Regions
Priority Patients for CCT

- Frequent ED Utilization
  (>3 vs. in 6 mos., > 5 vs. in 12 mos.)

- Multiple Hospital Admissions
  (>3 in 6 mos. or > 5 in 12 mos.)

- Patients identified as high-risk or high-cost using payer or health plan data

- CCT Risk Stratification Criteria

EMHC CCT Risk Stratification

- Patients with 3 ED visits w/in 6 months or 3 hospitalizations in 12 months.
- Transitions of Care
- History of medication non-compliance
- 2 or more chronic illnesses
- 1 chronic illness with comorbid mental/behavioral health diagnosis
- Barriers to care
- Additional criteria for pediatrics: multiple children with needs, new diagnosis, change in family structure
EMHC CCT

- Over 2000 Patients Served- Variety of Challenges
  - Behavioral Health
  - Substance Abuse and Dependence w/o Resources for Detox
  - Domestic Violence
  - ER High Utilization
  - Asthma
  - Medication Compliance Including Access & Rationing
  - Senior Housing & Supports
  - Inadequate Food Resources
  - Isolation
  - Pediatric/Family Resources
  - Transportation

Primary Referral Reasons – All Payers
Eastern Maine HomeCare – Community Care Team

• Our Story

Other States with Community Care Teams

- Alabama
- Minnesota
- Montana
- New York
- North Carolina
- Oklahoma
- Vermont

Source: Commonwealth Fund Report May 2013
PCMH National Success

- PCMH Studies Continue to Demonstrate Impressive Results Improvement

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<th>Care Redefinition</th>
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Source: Patient Centered Primary Care Collaborative Annual Update January 2014

Opportunity for Home Care

- October 2013 - VNAA Case Study Innovative Models for Home Health and Hospice
  - Mediation Reconciliation and Care Coordination
  - In Home “Nurse Call Button” access to centralized call center
  - HomeCare Telehealth
  - Integrating Physician Home Visits with VNA Care
  - Coordination with Hospital ED for Referrals to Home Care
  - Integrated Care Model (ICM) Train the Trainer Program
  - Regular Primary Care and Nurse Practitioner Visits at Home
  - Same Day Home Care Joint Replacement Program
  - Nursing Intervention and Patient Teaching to Prevent Surgical Site Infections

Source: Patient Centered Primary Care Collaborative Annual Update January 2014
Hospice

• Hospice functions as the end of life patient centered service in the home
  – Interdisciplinary Team
  – Coordinated Care
  – Community Based
  – Patient & Family Engagement

Opportunity – Health Information Exchange

• Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient’s vital medical information electronically—improving the speed, quality, safety and cost of patient care.

• Appropriate, timely sharing of vital patient information can better inform decision making at the point of care and allow providers to
  – Avoid readmissions
  – Avoid medication errors
  – Improve diagnoses
  – Decrease duplicate testing
ONC Evaluation of State HIE’s

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Opportunity Chronic Care Management

- 2015 Medicare Physician Fee Schedule includes payment for chronic care management, approximately $42 for the CCM code, no more than once per month for qualified patient
- CCM Services include development and revision of the plan of care, communication with other professionals and medication management
- CMS proposes that practices use electronic health record, HIT or information exchange platform
- Other CCM requirements include
  - Access to care management services 24/7
  - Continuity of Care
  - Care management for chronic conditions
  - Creation of a patient centered care plan document
  - Management of care transitions

Opportunities

- Care Coordination & Care Management Certification
  - Independent Certification
  - Academic Certification
  - NCQA Accreditation
Final Thoughts

• Data, Data, Data – Home Care and Hospice Providers need to track data demonstrating impact
• Technology – Technology is a major tool driving transformation in health care
• Scalability – Population health management requires scalability of home care and hospice interventions

Rapid pace transformational change is occurring in health care. No matter where we are going, we can’t go back.
THANK YOU!

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