Project Option 2.1.1 Enhance/Expand Medical Homes:  **NHC Medical Home Expansion**

**Unique Project ID:** 138951211.2.4

**Performing Provider Name/TPI:** The El Paso County Hospital District d/b/a/ University Medical Center of El Paso (UMC) / TPI: 138951211

**Project Description:**

***This project will increase coordination of patient’s care in a medical home environment and increase patient loyalty to their medical home. The project will seek to obtain Medical Home Certification for each of the Neighborhood Health Center sites, and create a patient registry.***

Target Zip Codes: 79907, 79927, 79849, 79838, 79928, 79912, 79922, 79932, 79936, 79935.

**Goals and Relationship to Regional Goals:**

Project Goals: The medical home model will be fully implemented in the UMC neighborhood health centers, which will result in better coordination of care, greater access, and enhanced quality of patient care. Development of a patient registry including layered reporting of performance measures and decision support so that cost, access and quality are measurable and improvement can be demonstrated.

This project meets the following regional goals: This project meets the regional goal of providing services on the full healthcare continuum. Allowing patients to have a central location to access primary and specialty care will reduce unnecessary ED admissions and provide primary care in a clinic setting that is utilized by uninsured and indigent populations. This project will assist in getting patients assigned to a medical home as a resource to access the much-needed primary and specialty care support that is in short-supply throughout the region.

**Challenges:**

The challenges involve philosophical changes to the practice; expand staff and staff roles and implementing the requirements to acquire Medical Home Certification for all NHC sites. Creating a shared patient registry among the clinics will require coordination and training for the staff at the NHCs as well as integration with the existing EMR system.

**5-Year Expected *Outcome for Provider and Patients:***

We expect that the Neighborhood Health Centers will achieve patient centered medical home NCQA recognition helping to document better care coordination and better health outcomes for the patients they serve.

**Starting Point/Baseline:**

The Neighborhood Health Centers are just beginning the implementation of the patient centered medical home model. The baseline will be zero from program inception.

**Rationale:**

Region 15 has identified expansion of Primary care as its first priority in its community needs, designating it as CN.1, and secondary care as its second priority, CN.2, as shown below. Increasing patients’ assignment to a medical home will improve not only access to primary care, but also provide long-term health care outcomes due the patients’ continuous access to preventative and ambulatory care. This project will serve the community by getting patients access to care in the right place, right setting, reducing inappropriate ED admission, and cost avoidance of inpatient treatment for care that is better served in an ambulatory setting.

Federal, state, and health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. In addition, the PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform. PCMH development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. These projects all are focused on the concepts of the PCMH model; yet, they take different shapes for different providers.[[1]](#footnote-1)

This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The projects associated with Medical Homes establish a foundation for transforming the primary care landscape in Texas by emphasizing enhanced chronic disease management through team-based care.

**Project Components: 2.1.1 Develop, implement, and evaluate action plans to enhance / eliminate gaps in the development of various aspects of PCMH standards:**

The establishing a new primary care medical home will accomplish the following core project components (a-d):

1. Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs’ NCQA PCMH readiness.
   * During DY2, UMC will perform a gap analysis to determine readiness.
2. Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
   * During DY2, UMC will perform a feasibility study to determine readiness.
3. Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.
   * During DY 2 and DY 3, UMC will conduct educational sessions to inform physicians, staff, and leadership of the rationale and vision of PCMH.
4. Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.
   * CQI Milestone: P-8 Participate in at least biweekly interactions with other HP to promote collaborative learning around shared or similar projects.

**Unique community need identification numbers the project addresses:**

* CN.1
* CN.2
* CN.4

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**

**The Neighborhood Health Centers are currently providing reactive patient care instead of proactive planned care. Patient’s may or may not see the same provider at their next visit. The project will provide for a patient centered medical home and patient empanelment to help patients better manage their health. A registry system will be established to help insure each patient receives the care they need. Medical Home certification will be achieved to help insure UMC-NHC is providing outstanding quality care.**

**Related Category 3 Outcome Measures:**

OD-11 Addressing Health Disparities in Minority Populations

IT-3.12 Select any other category 3 outcome and target specific minority population.

* Patients discharged from UMC with a diagnosis of diabetes to the UMC NHC Medical Home

**Reasons/rationale for selecting the outcome measures:**

This outcome measure was chosen to measure the comprehensiveness in providing primary care through the lens of the patient. Patient satisfaction with timeliness and access to information will help determine whether there is adequate access to care in the community.

**Relationship to other Projects:** UMC has several other projects dedicated to improving the outcomes for marginalized populations with diabetes, including 138951211.2.1: the Salvation Army and 138951211.2.2: Rescue Mission.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**

Performing Providers, IGT entities, and the Anchor for Region 15 have held consistent monthly meetings throughout the development of the Waiver. As noted by HHSC and CMS, meeting and discussing Waiver successes and challenges facilitates open communication and collaboration among the Region 15 participants. Meetings, calls, and webinars represent a way to share ideas, experiences, and work together to solve regional healthcare delivery issues and continue to work to address Region 15’s community needs.  UMC, as the Region 15 Anchor anticipates continuing to facilitate a monthly meeting, and potentially breaking into workgroup Learning Collaboratives that meet more frequently to address specific DSRIP project areas that are common to Region 15, as determined to be necessary by the Performing Providers and IGT entities. UMC will continue to maintain the Region 15 website, which has updated information from HHSC, regional projects listed by Performing Provider, contact information for each participant, and minutes, notes and slides from each meeting for those parties that were unable to attend in-person.

Region 15 participants look forward to the opportunity to gather annually with Performing Providers and IGT entities state-wide to share experiences and challenges in implementing DSRIP projects, but also recognize the importance of continuing ongoing regional interactions to effectuate change locally. Through the use of both state-wide and regional Learning Collaborative components, Region 15 is confident that it will be successful in improving the local healthcare delivery system for the low-income and indigent population.

**Project Valuation**

In determining the value of this project, UMC considered the extent to which Patient Centered Medical Home transforms primary care from being reactive and unplanned to systematic planned care meeting each patient’s needs. It is well documented to significantly improve patient health outcomes while being cost effective in a systems approach to care. Multiple studies have shown that increased access to planned, proactive primary care and support staff and greater involvement of the patient in making their own health care decisions improve total health care costs. This project will focus on achieving the Waiver goal of improving outcomes while curbing overall healthcare costs while supporting the development of a coordinated care delivery system and improving the healthcare infrastructure.

| 138951211.2.4 | ***2.1.1*** | | 138951211.2.4.a-d | ***Medical Home Enhancement and Expansion – NHC*** | | |
| --- | --- | --- | --- | --- | --- | --- |
| ***University Medical Center of El Paso*** | | | | | *138951211* | |
| ***Related Category 3 Outcome Measure(s):*** OD-11 Addressing Health Disparities in Minority Populations | IT-3.12 Select any other outcome and target specific minority population | | 138951211.3.12 | Addressing Health Disparities in Minority Populations | | |
| **Year 2**  **(10/1/2012 – 9/30/2013)** | | **Year 3**  **(10/1/2013 – 9/30/2014)** | | **Year 4**  **(10/1/2014 – 9/30/2015)** | | **Year 5**  **(10/1/2015 – 9/30/2016)** |
| **Milestone 1**  **P-1** Implement the medical home model in primary care clinic at two sites (Ysleta and Fabens)  Metric  **P-1.1** Increase number of primary care clinics using the medical home model.  **Numerator:** Number of primary care clinics using the medical home model. Goal:2  **Denominator**: Total number of primary care clinics = 4  Data Source  Documentation of the increased number of primary care clinics using the medical home model  Milestone 1 Estimated Incentive Payment: $961,708  **Milestone 2**  **P-3** Reorganize staff into primary care teams responsible for the coordination of primary care at Ysleta and Fabens  Metric  **P-3.1** Document Primary Care Teams  Numerator: Number of staff organized into care teams. Goal: 50% or 24  Denominator: Total number of staff=48  Data Source  Documentation of staff assignment into care teams  Milestone 2 Estimated Incentive Payment *(maximum amount)*: $961,708  **Milestone 3**  **CQI: P-12** Participate in at least biweekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects  Metric  **P-12.1** Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in  Data Source  Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in.  Milestone 3 Estimated Incentive Payment *(maximum amount)*: $961,708 | | **Milestone 4**  **P-1** Implement the medical home model in primary care clinic at two sites (East and Crossroads)  Metric  **P-1.1** Increase number of primary care clinics using the medical home model.  **Numerator:** Number of primary care clinics using the medical home model. Goal: 4  **Denominator**: Total number of primary care clinics = 4  Data Source  Documentation of the increased number of primary care clinics using the medical home model  Milestone 4 Estimated Incentive Payment: $1,049,172  **Milestone 5**  **P-3** Reorganize staff into primary care teams responsible for the coordination of primary care at East and Crossroads  Metric  **P-3.1** Document Primary Care Teams  Numerator: Number of staff organized into care teams. Goal: 9  Denominator: Total number of staff=18  Data Source  Documentation of staff assignment into care teams  Milestone 5 Estimated Incentive Payment *(maximum amount)*: $1,049,172  **Milestone 6**  **CQI: P-12** Participate in at least biweekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects  Metric  **P-12.1** Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in  Data Source  Number of bi weekly meetings, conference calls or webinars organized by the RHP that the provider participated in.  Milestone 6 Estimated Incentive Payment: $1,049,172 | | **Milestone 7**  **I-18** Obtain Medical Home recognition by a nationally recognized agency for NHC sites.  Metric  **I-18.1** Medical Home recognition / accreditation  **Numerator:** number of sites or clinics receiving recognition / accreditation. Goal: 2  **Denominator:** Total number of sites or clinics eligible for recognition= 4  Data Source  Documentation of Medical Home recognition / accreditation from a nationally recognized agency  Milestone 7 Estimated Incentive Payment: $3,156,666 | | **Milestone 8**  **I-13** New patients assigned to medical homes receive their first appointment in a timely manner  Metric  **I-13.1** Improve number of new patients assigned to medical home that are contacted for their first patient visit within 60-120 days.  **Numerator:** number of new patients contacted within specified day. Goal: 300  **Denominator:** Total number of new patients=600  Data Source  Scheduling systems, registry, EMR, etc.  Milestone 8 Estimated Incentive Payment: $2,607,680 |
| Year 2 Estimated Milestone Bundle Amount: $2,885,124 | | Year 3 Estimated Milestone Bundle Amount: $3,147,516 | | Year 4 Estimated Milestone Bundle Amount: $3,156,666 | | Year 5 Estimated Milestone Bundle Amount: $2,607,680 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5)****:***$11,796,986 | | | | | | |

93655

1. <http://www.pcpcc.net/content/pcmh-vision-reality> [↑](#footnote-ref-1)