Patient Centered Medical Home

The First Step on the Journey to Better Medical Practice and Patient Outcomes

Overall Picture of Patient Centered Medical Home Concept

- "The patient brings into the office a unique understanding about his or her own personal and health issues. No one knows about it more than he or she does. The doctor brings into the office a carefully developed body of expert knowledge. The basic notion is that the two get together with their own expertise and negotiate a shared plan and understanding…if you get to know people over time…you can fill in the blanks and complete a rather organized review that gives you a good picture of the patient above and beyond the purely biomedical or even psychosocial issues." – Dr. Tom Delbanco An Expert Interview with Tom Delbanco, MD, Medscape Psychiatry & Mental Health. 2005.

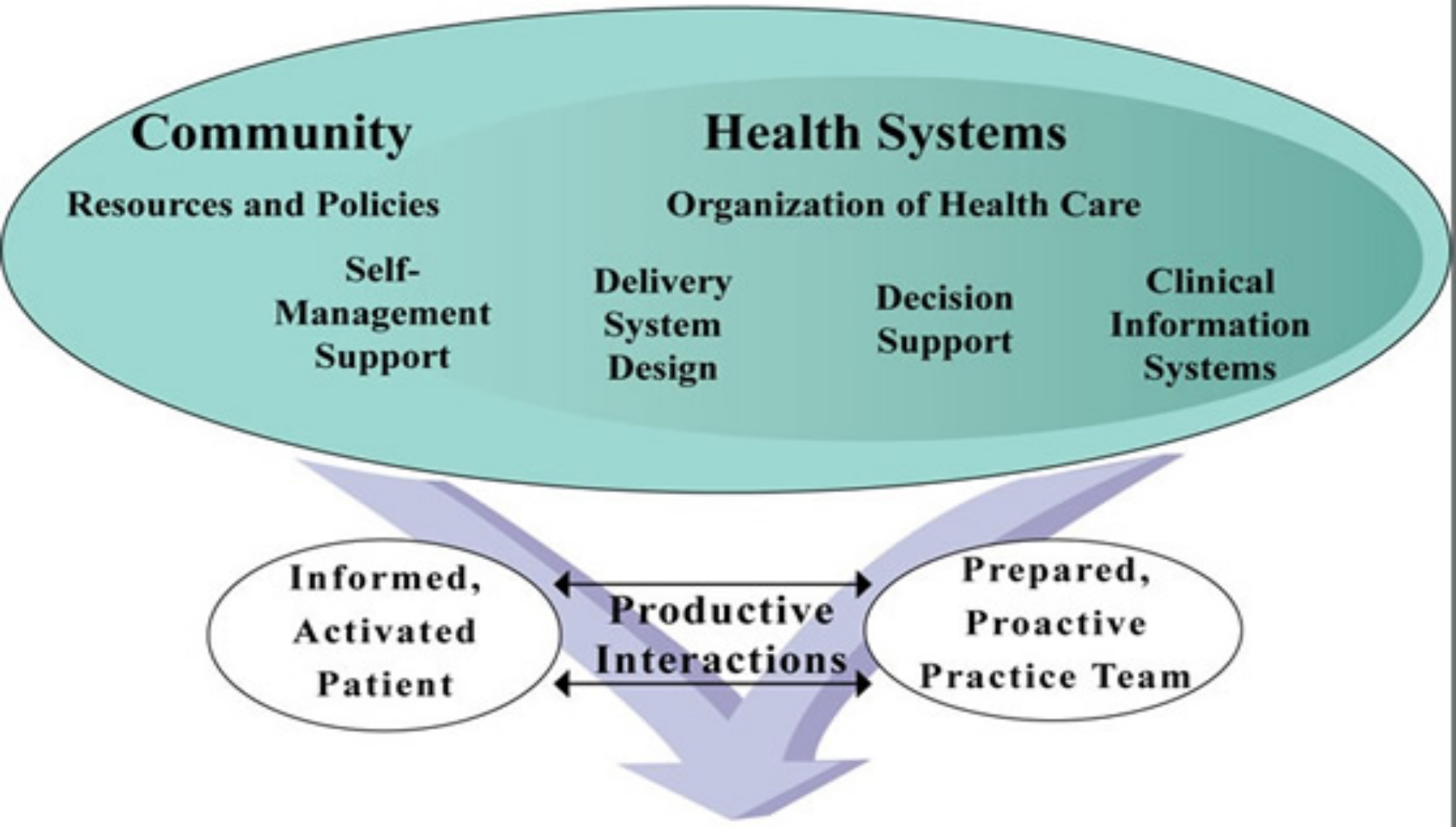
What is a Patient Centered Medical Home?

- New Model for the Delivery of Primary Care Practice
- Focuses on Strong Patient-Physician Relationships
- Patient Empowerment
- Physician Serves as Care Coordinator
- Comprehensive Approach to Healthcare
- Prevention and Wellness Goals
- Physician Directed Practice Team Approach

History of PCMH

- 1960's: American Academy of Pediatrics adopts similar model to treat the special healthcare needs of very ill children
- 1970's: WHO more closely examines primary care and the concept of medical home. Defines health as not merely the absence of disease
- 1990's: Ed Wagner's: Chronic Care Model
- 2007: Patient Centered Medical Home Joint Principles Statement
- 2008: Many health plans and employers implementing model in pilot studies
- 2009: 1st year of BCBSM PCMH designations – resulting in 299 practice units = 1,272 physicians
- 2014: 6th year of BCBSM PCMH designations- resulting in 1,422 practice units = 4,022 physicians

The Chronic Care Model



Improved Outcomes

Practice Transformation Concepts

- Plan, Do, Study, Act (PDSA) Cycles
- Team Huddles
- Keep an open mind
- Try new ways of doing things
- Learn from the feedback you receive
- Stay positive
- Offer your ideas

Joint Principles of PCMH

- Enhanced Access
- Whole Person Orientation
- Coordination of Care
- Personal Physician
- Safety and Quality
- Physician Directed Practice Team
- Payment System

Professional Organizations Adopting PCMH: Joint Principles

- American Academy of Family Practice
- American College of Physicians
- American Osteopathic Association
- American Academy of Pediatrics

Specialty Organizations Endorsing PCMH: Joint Principles

- American Academy of Hospice and Palliative Care
- American College of Cardiology
- American Academy of Neurology
- Society for Adolescent Medicine
- Society of Critical Care Medicine

Joint Principles Continued

- Enhanced Access:

- Improve access to healthcare by:

  -Increase same day/sick appointment time slots

  -Patient has 24/7 access to physician either in the office or via phone after hours

  - Developing an Urgent Care partnership

- Whole Person Orientation:

-Serve as the patient's main hub for all their care with PCP deciding and guiding patient to appropriate specialist

PCMH Joint Principles Continued

- Coordination of Care:

-PCP has active relationships and contacts in the community for patient care:

-Urgent Care Designation

-ER Designation

-Specialists

-PT/OT

-PCP has process in place to ensure receives information regarding the follow up care the patient received

Joint Principles Continued:

- Personal Physician:

  -Strong patient-physician relationship

  -Starting point for all of patient's medical care

  -It is who the patient trusts and desires to see because he/she is known by the physician and understood

Joint Principles…

- Safety and Quality:
- Evidence based medical practice
- Enhanced by implementation of test tracking methods (ex. Flow sheets, Lab/Diagnostic Logs, etc)
- Improved chronic disease management through electronic disease registry with access to performance reports
- More efficient office flow methods
- Better communication through technology applications:
  - -E-Prescribing
  - -EMR/EHR
  - -Disease Registry
- Improved Patient Outcomes

Joint Principles…

- Physician Directed Practice Team:

  -All staff members are involved in creating a “warm and welcoming home” for patients

  -Staff actively engaged in creating more efficient office practices and participate with physician in chronic disease management

Joint Principles…

- Payment System:

  - The overall goal is to become designated as a certified Patient Centered Medical Home through Blue Cross Blue Shield of Michigan

  -This certification will increase your reimbursement of office visits from BCBSM by at least 10%

  -NEW in 2012 and continued for 2014 physician's participating in PGIP with a benchmark PHO/PO could earn an additional 10% uplift from BCBSM.

General Summary
PCMH Concept

- "The rationale for the benefits for primary care for health has been found in:
    1. Greater Access to Needed Services
    2. Better Quality of Care
    3. A Greater Focus on Prevention
    4. Early Management of Health Problems
    5. The Cumulative Effect of the Main Primary Care Delivery Characteristics
    6. The Role of Primary Care in Reducing Unnecessary and Potentially Harmful Specialist Care

Where the primary care team functions as a 'navigator' through secondary and tertiary care and other sectors, it can be a strategy for achieving cost-effectiveness."

-DeMaeseneer J,et al. World Health Organization

Why PCMH Now?

- **The demand for primary care physicians is increasing**
- **Nearly 1 in 2 Americans (133 million) has a chronic condition**
  Chronic Care in America: A 21st Century Challenge, a study of the Robert Wood Johnson Foundation & Partnership for Solutions: Johns Hopkins University, Baltimore, MD for the Robert Wood Johnson Foundation (September 2004 Update). "Chronic Conditions: Making the Case for Ongoing Care".
- **By 2020, about 157 million Americans will be afflicted by chronic illnesses,** *according to the U.S. Department of Health and Human Services.*
- **That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million.**
  Chronic Care in America: A 21st Century Challenge, a study of the Robert Wood Johnson Foundation & Partnership for Solutions: Johns Hopkins University, Baltimore, MD for the Robert Wood Johnson Foundation (September 2004 Update). "Chronic Conditions: Making the Case for Ongoing Care".

PCMH Is Making A Difference

Comparing PCMH Designated and Non Designated Practices

- Emergency department visits were **9.9%** lower
- Primary care-sensitive emergency department visits were **11.8%** lower
- Ambulatory care sensitive inpatient discharge were **27.5%** lower
- High-tech radiology services were **8.7%** lower
- High-tech radiology standard cost PMPM was **6.8%** lower
- Low-tech radiology services were **9.4%** lower
- Low-tech radiology standard cost PMPM was **8.5%** lower
- Generic dispensing rate was **1.9%** higher

Provided from BCBSM PCMH Results July 2014

PCMH is Catching On

- MiPCT (Michigan Primary Care Transformation)

  - Michigan is 1 of 8 states chosen to participate in the CMS (Centers for Medicare & Medicaid Services) Demonstration Project.

  2014 is the third year of the multi-payer study of the PCMH model in primary care practices.

- More Third Party Payers

  Offer P4P (Pay for Performance) programs, incorporating PCMH concepts/initiatives:

  - McLaren Health Plan
  - Health Plus
  - United Health
  - Priority Health

Quick Breakdown of Requirements for PCMH designation

1. Patient – Physician Partnership
2. Patient Registry
3. Performance Reporting
4. Individual Care Management
5. Extended Access
6. Test Tracking
7. Electronic Prescribing
8. Preventive Services
17. Linkage to Community Resources
19. Self Management Support
21. Patient Portal
23. Coordination of Care
25. Specialist Referral Process

Test Tracking and Follow Up Requirements

- Practice has policy in place requiring tracking and follow up for all test results, which require follow-up, with identified timeframes for notifying patients of results
- Systematic approach and identified timeframes are in place for tracking tests until the results have been received
- Process is in place for ensuring patient contact details are kept up to date
- Mechanism is in place for patients to obtain information about normal tests
- Systematic approach is used to inform patients about abnormal test results
- Systematic approach is used to ensure that patients with abnormal results receive the recommended follow up care within defined timeframes
- Systematic approach is used to document all test tracking steps (phone calls, letters, etc.) in the patient's medical record

Linkage to Community Services

- Review of community resources for your geographic area has been conducted
- Maintain a community resource database
- You have partnerships with appropriate agencies and organizations in the community
- All members of the practice team have received training on referring patients to community resources and know their role in the process
- Systematic approach is in place to educate patients about community resources
- Systematic approach is in place for referring patients to community resources
- Systematic approach is in place for tracking referrals of high risk patients to community resources made by the practice and every effort is made to ensure the patients complete the referral activity
- Systematic approach is in place for conducting follow up with high risk patients regarding any indicated next steps as an outcome of their referral to a community based program or agency.

Advanced Initiative - Care Coordination

- For every patient with a chronic illness a mechanism is established for being notified of each patient admit and discharge, or other type of encounter, at facilities with which our physician has admitting privileges or other ongoing relationships.
- Practice has a process in place for exchanging necessary medical records and discussing continued care arrangements with other providers, including facilities, for all patients with a chronic illness.
- Approach is in place to systematically track care coordination activities for each patient with a chronic illness.
- Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for all patients with a chronic illness.

Specialist Referral Process

- Procedures are in place to guide each phase of the specialist referral process including desired timeframes for appointment and information exchange for preferred or high volume specialists
- Procedures are in place to guide each phase of the specialist referral process including desired timeframes for appointment and information exchange when patients are referred to other key specialists
- Directory is maintained listing specialists to whom patients are routinely referred
- Practice has developed specialist referral materials supportive of process and individual patient needs
- Practice routinely makes specialist appointments on behalf of patients
- Process is in place to determine whether or not patients completed the specialist referral in a timely manner, reasons they did not seek care if applicable, additional sub-specialists visits that occurred, specialist recommendations, and whether patients received recommended services
- Practice staff is trained on all aspects of the specialist referral process
- Practice regularly evaluates patient satisfaction with most commonly used specialists, to ensure physicians are referring patients to specialists that meet their standards for patient centered care

Self Management Requirements

- Formally trained and educated staff on self management concepts including; motivational interviewing, problem solving techniques, health literacy, use of teach back process and follow up.
- Self management is offered to ALL patients.
- Office incorporates self management goal sheets utilizing the S.M.A.R.T. goal format.
- Self management is part of our planned chronic disease visits.
- Office recruits patients for the Stanford Chronic Disease Self Management Workshop.
  - MPP has Master Trained Leaders in the Stanford Chronic Disease Self Management program which allows us to train Leaders for your practice.
- Office conducts systematic follow up with patients.
- Office conducts self management surveys after goal setting is completed.

How Does Self Management Support Provide Value?

- Increased health care professional satisfaction
- Increased patient satisfaction
  - Patient's have a more active role in managing their care/partnership with health care team.
  - Focus is on well care versus sick care
  - Better health outcomes
  - Patient becomes a self-advocate
- Increased patient engagement and accountability
- An effective tool for managing chronic disease
- Improved outcomes and performance measurement

Source: http://www.mipcc.org/tools-and-more/self-management-support-toolkit/introduction

What will MPP Provide?

- Interactive Staff Training
  - PCMH, chronic care model, practice transformation
  - Self Management Support
  - Self Management Workshop – Leader
- Personal Guidance
  - Champion Meetings
  - Best Practice Concepts
  - Lean Thinking
  - Feedback
  - Assistance with e-scribe/ patient registry
- PCMH Tool Kit
  - Easy to Follow Guide
  - Resource Tools
  - Templates
    - Policy and Procedures
    - Log Sheets
    - Forms
    - Letters
    - Worksheets
- Mock Site Visits
  - Preparation Tools
  - Mock Staff Interviewing
  - Site walkthrough
  - Evidence Binder Review

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- **Blue Cross Blue Shield of Michigan designates record number of physician practices to nation's largest patient-centered medical home program http://news.bcbsm.com/news/2012/news_2012-08-06-09260.shtml**