

Welcome

Good afternoon. Welcome to the second webinar in the series that we have planned for you. You recently received an email announcing these webinars with a schedule through the end of the year. Today Susan Maxsween and I will be discussing the Patient Centered Medical Home. We will be giving you an overview of the components of PCMH according to BCBSM PGIP's PCMH designation program and NCQA accreditation. For some of you this might be a review while others it will be new information. Please feel free to ask questions during the presentation by using the chat option in the right hand of the screen.

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Primary Care physicians are best positioned to focus on the needs of the patient, coordinate, and collaborate appropriate care, work in a team environment, promote wellness and manage chronic diseases. The PCMH Model directly empowers the patient to take responsibility for his or her wellness and well-being. The Patient Centered Medical Home provides an framework, a common language, and the opportunity for change. The medical home is a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. Is this any different than what you have been doing? This is the 21st Century Model of Medicine. The physician-led care team is responsible for providing all the patient's health care needs, and, when needed, arranges for appropriate care with other qualified physicians.

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Key Elements Include:

Personal physician with patient centered care - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – where the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. Team based, patient centered, a high performing practice.

Use of advanced information systems – the use of EMR's/registry systems is crucial for a fully functioning medical home - to monitor and share information with patients and providers to coordinate care, provide timely reminders for providers and patients, identify relevant populations for proactive care and facilitate individual patient care planning. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Healthcare Information Technology – Registry or EMR

Purpose – enable providers to take care of their patients proactively and in a population-based fashion. Example, who are the uncontrolled diabetics in the practice and they should have a vigorous, proactive approach to managing those patients.

The marketplace is demanding population-based care that will lead to higher quality and lower cost.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. Care coordination is a key aspect
Care is provided in a community context

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).

Redesigned or Transformed practices – looking to improve the process and delivery of care

Medical Home designation -Payment appropriately recognizes the added value provided to patients who have

Elimination of access barriers

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Focus is on quality and safety. Evidence Based Guidelines that are used in daily practice are corner posts to Quality of care and quality and safety are hallmarks of the patient centered medical home.

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❖ PCMH is not a new concept. It has been evolving since the late 1960s.

Patient Centered Medical Home was started in 1967 with the American Academy of Pediatrics for children with special healthcare needs. In 1990 Dr. Wagner included some elements of the Chronic Care Model, and then in 2007 extended the model beyond care for chronic health problems and a Patient Centered Medical Home Joint Principals Statement was developed that included measurement of quality indicators and enhanced technology working with an Informed Activated Patient and a Prepared Proactive Practice Team. By implementing the Chronic Care Model the physician can improve the timeliness of care provided to patients, improve office workflow, and improve patient outcomes.

In 2008 the National Committee for Quality Assurance developed a PCMH Recognition Program.

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This is a model that is recognized by the: American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association published a Joint Principals statement in Feb. 2007

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Now many payers are developing recognition programs, BCBSM with the PGIP PCMH program, Priority Health who accepts NCQA accreditation. BCBSM Designated PCMH Practices in the PGIP program - This designation occurs annually. Two PCMH Assessments throughout the calendar year. Priority Health accepts NCQA accreditation

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The PCMH Model fits into the Wagner Chronic Care Model:

The Chronic Care Model (CCM) identifies the essential elements of a health care system that **encourage high-quality chronic disease care**. Evidence-based change concepts under each element, in combination, foster productive **interactions between informed patients who take an active part in their care and providers with resources and expertise**.

The Chronic Care Model includes six essential elements of a health care system that when integrated encourage high-quality chronic disease care:

Community Resources - Mobilize community resources to meet needs of patients, such as the United Way 211 program

- Encourage patients to participate in effective community programs
- Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
- Advocate for policies to improve patient care

Self-Management Support - **Empower and prepare patients to manage their health and health care**

- Emphasize the patient's central role in managing their health
- Use effective **self-management support strategies that include assessment, goal-setting, action planning, problem-solving, and follow-up**
- **Organize internal and community resources to provide ongoing self-management support to patients**

Health System - **Create a culture**, organization and mechanisms **that promote safe, high quality care**

- Visibility support improvement at all levels of the organization, beginning with the senior leader
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of errors and quality problems to improve care
- Provide incentives based on quality of care
- Develop agreements that facilitate care coordination within and across organizations

Delivery system design - Assure the **delivery of effective, efficient clinical care and self-management support**

- Define roles and distribute tasks among team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services for complex patients
- Ensure regular follow-up by the care team
- Give care that patients understand and that fits with their cultural background

Decision Support – Promote clinical care that is consistent with scientific evidence and patient preferences

- Embed **evidence-based guidelines into daily clinical practice**
- **Share evidence-based guidelines and information with patients to encourage their participation**
- Use proven provider education methods

- Integrate specialist expertise and primary care

Clinical Information Systems – Organize patient and population data to facilitate efficient and effective care

- **Provide timely reminders for providers and patients**
 - **Identify relevant subpopulations for proactive care**
 - Facilitate individual patient care planning
 - Share information with patients and providers to coordinate care
 - Monitor information with patients and providers to coordinate care
 - Being Proactive Not Reactive with an Informed Patient with the provider and a team that can educate and help the patient manage their conditions will ultimately improve outcomes.
- All of these elements are required in the initiatives for BCBSM PCMH and NCQA
- **By implementing the Chronic Care Model in the physician office setting physicians can improve the timeliness of care provided to patients, improve office workflow and improve patient outcomes.**

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Increased patient and family/care –giver satisfaction –patient satisfaction surveys that are conducted can measure patient satisfaction as well as provide opportunities to improve patient care and patient satisfaction.

More efficient use of limited resources – Coordinating care and working with specialists as necessary. Improved communication with specialists for referrals only and not ongoing management. This will help to reduce **redundant testing, unnecessary or redundant referrals and unnecessary procedures.**

Improved quality – Through **evidenced based care measures** patients are followed up in the ongoing management of their chronic disease. Example, A1c for diabetes

- Reduced health disparities among patient treatment – will close the gap so that all patients receive the same care no matter the race, ethnicity, or socioeconomic status
- Improved professional satisfaction and staff satisfaction

Improved professional satisfaction -Ultimately looking at practice transformation. How we look at processes (using standards) and how we can improve the processes and build a change team.

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- ❖ Presently, there are two popular approaches to obtaining PCMH designation:
 1. BCBSM’s PGIP Program
 2. NCQA PPC-PCMH™ Accreditation
- ❖ Still no national “recipe” for PCMH. Rather a number of multi-year demonstration programs are underway throughout the country.

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The BCBS PCMH Initiative is a three to five year process. There are 13 Domains of Function and each of them has a set of capabilities or tasks that must be completed for that Initiative

A benchmark for this year is to have over 60 capabilities in place.

The Interpretative Guidelines give you the description of how a capability might be considered completed or not. For example it doesn’t matter what initiatives you want to work on or which ones are reported for the year – just looking for a continual progression of meeting the capabilities for the Initiatives.

Patient/Provider Agreement – a document that describes the partnership showing the provider and patient’s responsibility that each patient receives

Extended access – Patients have a 24 hour access to a clinical decision maker and have access to non-ED after hours provider for urgent care’s needs for at least 8 – 12 after hours per week

Patient Tracking and registry - Provide timely reminders for providers and patients

- Identify relevant subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with patients and providers to coordinate care
- Monitor information with patients and providers to coordinate care

Performance reporting/follow up –allow tracking and comparison of results at a specific point in time across the population of patients with diabetes and other chronic diseases.

Test tracking and follow up – a process for ensuring patients receive normal and abnormal results

Individual care management – A systematic approach is in place using evidence-based care guidelines with action plan development and self management goal setting

E-prescribing- electronic prescription

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Preventive Services – systematic approach following preventive care guidelines in place using appointment tracking & reminder systems to provide preventive services – annual physicals, immunizations, colonoscopy's, mammograms,

Linkage to Community Services – Systematic approach in place for educating patients about community resources and assessing/discussing need for referral. The community resource is United Way's 2-1-1

Self Management Support – Patient directed plan to empower the patient to manage their health care

Patient Web Portal – ability for practices to communicate with a patient through a secure website to schedule appointments, send alerts, participate in E-visits – electronic visits

Coordination of Care – Systematically track care coordination from discharge from the hospital and flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue

Specialist Referral Process – Systematic process for each phase of the referral process through the scheduling and follow up of results

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- **Generic Use** – Encourage the use of high quality, cost effective, generic drugs as alternatives to brand name prescriptions when generic use is considered clinically appropriate by the physician
- **ED Visit Rate** - Reduce the emergency department use for primary care sensitive conditions
- **Low Tech and High Tech radiology use** - Reduce the utilization PMPM for radiology procedures; Increase compliance with prior authorization through AIM for high tech procedures; Increase the use of the web-based authorization tool; and Lower the overall radiology cost PMPM.
- **Evidence Based Care Report** - Improve health outcomes through adherence to PGIP evidence based guidelines; Reduce gaps in care;
- **Preventive measures** – Adult mammogram and pap; peds immunizations for 2 months & 13 months, and well visit 15 months & 36 months
- The 2009 data was used for the 50% quality/use score for PCMH

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50%_Quality Use – 50% PCMH capabilities - Provides a weighted score to determine designation

Slide 14

Patient Centered Medical Home?

Practices will improve pt care – fine tune the good work that practices are already doing

Take advantage of the incentive payments that reward pt.-centered medical homes

Increase the value of their practice, Build a team for changes

Slide 17: Path to PCMH

Assess your readiness to start down the path

Review the BCSM PCMH Capabilities requirements

Educate your staff

REMEMBER

1. PCMH education is needed for all practice staff, including physicians, support and care team.
2. PCMH education for staff should be kept on file and be readily accessible
3. Engage your staff in the journey by asking them to help you in implementing the PCMH capabilities and change processes
4. Review the JPA website for resources available to you
5. Call JPA for assistance
6. You need to start on this path. Starting is successful. With the ultimate goal of becoming a designated PCMH