PATIENT-CENTERED MEDICAL HOMES:
PROGRESS, NOT PERFECTION

JONATHAN GRIFFIN, MD, MHA

MMA PHYSICIAN LEADERSHIP
EFFECTIVENESS PROGRAM
JANUARY 16, 2015
WHY PATIENT CENTERED MEDICAL HOME

VISION
for change

FRAMEWORK
for change

Patient Centered Medical Home Creates

OPPORTUNITY
for change

COMMON LANGUAGE
for change
PCMH CREATES VISION FOR CHANGE
### Yesterday’s Care vs. Medical Home Care

<table>
<thead>
<tr>
<th>Yesterday’s Care</th>
<th>Medical Home Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those who make appointments to see me</td>
<td>Our patients are those who are registered in our medical home</td>
</tr>
<tr>
<td>Patients’ chief complaints or reasons for visit determines care</td>
<td>We systematically assess all our patients’ health needs to plan care</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today</td>
<td>Care is determined by a proactive plan to meet patient needs without visits</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory or skill of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates all patients’ care</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained</td>
<td>We measure our quality and make rapid changes to improve it</td>
</tr>
<tr>
<td>Acute care is delivered in the next available appointment and walk-ins</td>
<td>Acute care is delivered by open access and non-visit contacts</td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them</td>
<td>We track tests &amp; consultations, and follow-up after ED &amp; hospital</td>
</tr>
<tr>
<td>Clinic operations center on meeting the doctor’s needs</td>
<td>A multidisciplinary team works at the top of our licenses to serve patients</td>
</tr>
</tbody>
</table>

Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma
<table>
<thead>
<tr>
<th>Yesterday’s Care</th>
<th>Medical Home Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care is delivered to individual patients</td>
<td>Care is delivered to individuals and to clinical populations</td>
</tr>
<tr>
<td>Quality is assumed by an absence of errors</td>
<td>Quality is measured and continually improved, care is monitored against national or regional benchmarks</td>
</tr>
<tr>
<td>The team is organized to make things flow smoothly for providers</td>
<td>Everyone on the team has a role in making care flow smoothly for patients</td>
</tr>
<tr>
<td>Primary care treats medical problems and refers out everything else</td>
<td>Primary care treats the whole person and coordinates all services that impact health</td>
</tr>
<tr>
<td>Patients make appointments when something is wrong and the provider treats the complaint</td>
<td>The provider and team proactively partner with a panel of patients over time</td>
</tr>
<tr>
<td>Out of sight, out of mind</td>
<td>Anticipate and respond to needs for prevention, acute, chronic and palliative care</td>
</tr>
</tbody>
</table>

Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma
DON’T MISTAKE ACTIVITY FOR ACHIEVEMENT

Increased access does not ensure increased quality of communication

Quality of interaction = real achievement
  • Patient trust
  • Behavior change
  • Outcomes
  • Satisfaction

Understanding where the patient is coming from
  • Social relationships
  • Living situation
  • Quality of life
  • Goals
  • Beliefs
  • Understanding and beliefs about health, disease, medications
PCMH CREATES A FRAMEWORK FOR CHANGE
Section 5. Standards for patient-centered medical homes. (1) The commissioner shall, in consultation with the stakeholder council of interested parties, set standards from the list provided in subsection (2).

(2) Standards may be set for one or more of the following or for other topics determined by the commissioner in consultation with stakeholders:

(a) payment methods used by health plans to pay patient-centered medical homes for services associated with the coordination of covered health care services;

(b) bonuses, fee-based incentives, bundled fees, or other incentives that a health plan may use to pay a patient-centered medical home based on the savings from reduced health care expenditures associated with improved health outcomes and care coordination by qualified individuals attributed to the participation in the patient-centered medical homes;

(c) a uniform set of health care quality and performance measures that include prevention services; and

(d) a uniform set of measures related to cost and medical usage.

(3) A patient-centered medical home must meet the standards in this section in full or in part by providing proof to the commissioner that it has been accredited by a nationally recognized accrediting organization.
Patient-Centered Medical Homes

Upcoming Meetings:

Payer Subcommittee
July 10th, 9:00 - 10:00am

Quality Metrics Subcommittee
July 10th, 10:00 - 11:00am

PCMH Stakeholder Council
July 16th, 1:00 - 3:00pm

All meetings are held at the CSI Office
840 Helena Ave.
Helena, Montana

Call-in information for all meetings: (712) 432-1212
Access Code: 236-818-235

Commissioner Lindeen has approved three national accrediting agencies for inclusion in the Montana PCMH Program. The National Committee for Quality Assurance (NCQA), The Accreditation Agency for Ambulatory Health Care (AAAHC), and The Joint Commission met all the necessary criteria to become a recognized accrediting organization for Montana's PCMH program.

View lists of medical practices Commissioner Lindeen recently qualified and provisionally qualified for the Montana PCMH Program here:

- 2014 Qualified PCMHs
- 2014 Provisionally Qualified PCMHs

More Information on Patient-Centered Medical Homes:

- 2014 Stakeholder Council Meetings
- Resources for Practice Transformation
- General Resources
- PCMH Across the Country
- 2011-2013 Advisory Council Archived Meetings
- Early History of the Montana PCMH Initiative
PCMH 2014
(6 standards/27 elements/100 points)

1) Patient-Centered Access (10)
   A) *Patient-Centered Appointment Access
   B) 24/7 Access to Clinical Advice
   C) Electronic Access

2) Team-Based Care (12)
   A) Continuity
   B) Medical Home Responsibilities
   C) Culturally and Linguistically Appropriate Services
   D) *The Practice Team

3) Population Health Management (20)
   A) Patient Information
   B) Clinical Data
   C) Comprehensive Health Assessment
   D) *Use Data for Population Management
   E) Implement Evidence-Based Decision Support

4) Care Management and Support (20)
   A) Identify Patients for Care Management
   B) *Care Planning and Self-Care Support
   C) Medication Management
   D) Use Electronic Prescribing
   E) Support Self-Care & Shared Decision Making

5) Care Coordination and Care Transitions (18)
   A) Test Tracking and Follow-Up
   B) *Referral Tracking and Follow-Up
   C) Coordinate Care Transitions

6) Performance Measurement and Quality Improvement (20)
   A) Measure Clinical Quality Performance
   Measure Resource Use and Care Coordination
   A) Measure Patient/Family Experience
   B) *Implement Continuous Quality Improvement
   C) Demonstrate Continuous Quality Improvement
   D) Report Performance
   E) Use Certified EHR Technology

* Must-pass
Patient-Centered Medical Home

Begin the journey towards a successful PCMH practice.

ACP has gathered a comprehensive collection of information, resources and demonstration projects to assist you in planning for a complete Patient-Centered Medical Home.

Understanding the PCMH

A Patient-Centered Medical Home is a team-based model of care led by a primary physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

Costs, Benefits & Incentives

Learn about the costs to implement a Patient-Centered Medical Home in your practice and the benefits and incentives that will make the process worth the effort.

PCMH in Action

Access profiles of current Patient-Centered Medical Home demonstrations in action across the U.S. The purpose of these demos is to test the model and measure its effect, particularly in terms of quality improvement and cost savings.
PCMH CREATES OPPORTUNITY FOR CHANGE
I have an idea... let's all have a big group hug!!!
Medical Home Activity
States with medical home activity for Medicaid/CHIP since 2006

- None
- Medical home activity, no payments to medical homes
- Payments to medical homes underway

[Map of the United States showing states' medical home activity levels]
Multi-Payer Medical Home Initiatives
States with an active role in a multi-payer medical home initiative

- None
- Multi-payer planning activity underway
- Multi-payer payments to medical homes underway

Map showing states with active involvement in multi-payer medical home initiatives.
PCMH is the fastest-growing delivery system innovation
35,677 PCMH clinicians have earned NCQA Recognition

[Map of the United States showing states colored according to the number of PCMH recognitions earned.]

NCQA
Measuring quality. Improving health care.

PCMH 2014

As of 2/28/14
PCMH CREATES COMMON LANGUAGE FOR CHANGE
PCMH COMMON LANGUAGE

Access to care: the ease with which a patient can initiate an interaction for any health problem with a clinician, such as through same-day appointments, clinicians answering patient emails, etc.

Patient engagement and self-management: the practice counsels patients to adopt healthier behaviors or learn how to better manage a chronic condition

Team-based care: the primary care physician works with an interdisciplinary team to manage the patient’s care, including collaboratively developing a treatment plan

Comprehensiveness of care: the breadth of services the practice offers, to address any health problem at any given stage of a patient’s life

Continuity of care: policies that specify that patients are to be seen by the same clinician over time

Coordination of care: interacting with other providers – e.g., specialists and hospitals – to coordinate all care delivered to the patient, including care transitions

Care plan: developing an individualized treatment plan for a patient, basing this care plan on an individualized health risk assessment of the patient, etc.
PCMH COMMON LANGUAGE

Population management: use of a registry to proactively manage care for patients with a given chronic condition

Evidence-based care: use of evidence-based care guidelines, clinical decision support, etc.

Quality measurement: quality is measured in some way

Quality improvement: required to engage in quality improvement projects and/or set performance targets based on quality measure data collected

Community resources: referrals to social services

Medical records: specific types of information that should be recorded in patients’ medical records

Health IT: when questions explicitly require the use of an electronic system, like electronic health records (EHRs), e-prescribing, an electronic patient registry, etc.

Evidence-based care: very basic care processes that all clinicians should already engage in, such as physician speaks to the patient about his/her health problems and concerns
**PCMH COMMON LANGUAGE**

**Business practices:** the financial and organizational management of the practice, such as having a business plan, analyzing the percentage of submitted claims that went unpaid, etc.

**Presence of policies:** requiring a policy on after-hours care for patients, but not requiring that policy to provide patients with in-person access to care after-hours, sets standards for continuous quality improvement work.

**Empanelment/Attribution:** appropriately matching patients with specific primary care physicians and organizations with implications in quality reporting and health plan PCMH payments.

**Compact between practice and patients:** requiring practices to execute a written PCMH agreement and/or have a conversation and document it in a patient’s medical record in which the practice commits to provide certain services – such as care coordination – and the patient agrees to some basic responsibilities

**Culturally competent communication:** the practice provides information at an appropriate reading level for patients and in multiple languages; the practice makes available translation services, etc.

**Patient Centered Communication:** implementing techniques such as motivational interviewing, cognitive behavioral therapy, activation and commitment therapy, etc. into everyday clinical interactions either through brief provider interventions or specialty behavioral health visits.
PATIENT CENTERED MEDICAL HOME (PCMH)

A PROCESS
NOT AN EVENT

At both state and organizational levels
HOW DOES A PRACTICE BECOME A MEDICAL HOME?

“Change is hard enough; transformation to a PCMH requires epic whole-practice reimagination and redesign.”

“The magnitude of stress and burden from the unrelenting, continual change required to implement components of the [PCMH] model was immense.”

PCMH Critical Design Elements

Making a business case

- Reforming payment
- Engaging providers
- Defining the medical home
- Supporting practice transformation
- Health data management & exchange
- Evaluating impact
Alaska Native Medical Center, Anchorage, AK
- 50% fewer urgent care and emergency room (ER) visits
- 53% fewer hospital admissions
- 65% reduction in specialist utilization

Capital Health Plan, Tallahassee, FL
- 40% fewer inpatient stays
- 37% fewer ER visits
- 18% lower health care claims costs

Geisinger Health System, Danville, PA
- 25% fewer hospital admissions
- 50% fewer hospital readmissions
- 7% lower cumulative total spending

Group Health of Washington, Seattle, WA
- 15% fewer inpatient stays
- 15% fewer hospital readmissions
- Estimated costs savings of $15 million (2009-10)
- 18 - 65% improvements in medication management

HealthPartners, Bloomington, MN
- 39% fewer ER visits
- 40% fewer hospital readmissions
- Reduced appointment wait time from 26 days to 1 day

Horizon Blue Cross Blue Shield of New Jersey
- 25% fewer hospital readmissions
- 21% fewer inpatient admissions
- 31% increase in self-management of blood sugar

Maryland CareFirst Blue Cross Blue Shield
- 4.2% reduction in patients' overall health care costs
- Estimated cost savings of $40 million (2011)

Vermont Medicaid
- 31% fewer ER visits
- 21% reduction in inpatient services
- 22% lower per member per month costs (2008-10)

http://www.pcpcc.org/content/results-evidence
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PATIENT CENTERED PRIMARY CARE COLLABORATIVE – OCT 2012
REV
IMPROVED PATIENT EXPERIENCE
REDUCED CLINICIAN BURNOUT
REDUCED HOSPITALIZATION RATES
REDUCED ER VISITS
INCREASED SAVINGS PER PATIENT
HIGHER QUALITY OF CARE
REDUCED COST OF CARE
PCMH LOWERS COSTS IN PENNSYLVANIA

August 5th 2013

44% reduction in hospital costs

21% reduction in overall medical costs.

160 PCMH practices Pennsylvania from 2008 to 12

Number of patients with poorly controlled diabetes declined by 45%.

Jeffrey Bendix  modernmedicine.com/
PCMH LOWERS UTILIZATION IN MICHIGAN

August 11th 2013

- 19.1% lower rate of adult hospitalization.
- 8.8% lower rate of adult ER visits.
- 17.7% lower rate ER visits (children under age 17)
- 7.3% lower rate of adult high-tech radiology usage VS non-PCMH designated PCPs

3,017 Physicians

Medical home physicians help patients avoid ERs and admissions by evening hour appointments, weekend and same-day appointments
Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care

Mark W. Friedberg, MD, MPP1,2,3; Eric C. Schneider, MD, MSc1,2,3,4; Meredith B. Rosenthal, PhD4; Kevin G. Volpp, MD, PhD5,6,7,8,9; Rachel M. Werner, MD, PhD5,7

[+] Author Affiliations


Main Outcomes and Measures Practice structural capabilities; performance on 11 quality measures for diabetes, asthma, and preventive care; utilization of hospital, emergency department, and ambulatory care; standardized costs of care.

Results Pilot practices successfully achieved NCQA recognition and adopted new structural capabilities such as registries to identify patients overdue for chronic disease services. Pilot participation was associated with statistically significantly greater performance improvement, relative to comparison practices, on 1 of 11 investigated quality measures: nephropathy screening in diabetes (adjusted performance of 82.7% vs 71.7% by year 3, P < .001). Pilot participation was not associated with statistically significant changes in utilization or costs of care. Pilot practices accumulated average bonuses of $92 000 per primary care physician during the 3-year intervention.

Conclusions and Relevance A multipayer medical home pilot, in which participating practices adopted new structural capabilities and received NCQA certification, was associated with limited improvements in quality and was not associated with reductions in utilization of hospital, emergency department, or ambulatory care services or total costs over 3 years. These findings suggest that medical home interventions may need further refinement.
PCMH Critical Design Elements

- Making a business case
- Reforming payment
  - Engaging providers
  - Defining the medical home
  - Supporting practice transformation
- Health data management & exchange
- Evaluating impact
ECONOMIC INCENTIVES

SIGNIFICANTLY INFLUENCE HEALTHCARE IN BACKWARD AND COMPLETELY UNINTENDED WAYS.

“What’s the use you learning to do right when it’s troublesome to do right and ain’t no trouble to do wrong, and the wages is just the same.”
Healthcare transformation will require a step change in thinking and execution.

Meaningful change in clinical delivery includes the development of robust information systems, primary care platforms, adherence to clinical pathways, integrated networks, and reductions in variability.
In this scenario, the planning approach considers the inflection point inside of the planning horizon and increases the slope of the transition - aligning the strategic plan and market imperatives.
Managing Through the Payment Tipping Point
PCMH Driving Care Delivery Efficiency

Strategies
Operate close to capacity
Maximize per unit care delivery
Understand care delivery costs

Processes
Employ rigorous QI techniques (LEAN, Six Sigma)
Manage activity-based costing (ABC) systems
Identify & eliminate waste from value chain

Realize Financial Benefit From PCMH Based Care Model

Maximize Operating Margins

Data Analysis Capabilities
Forecast & measure financial margins for services across settings
Identify drivers of cost
Compare outcomes and cost data to local standards

External Realities
Downward pressure of FFS schedules
Rising charity care
Tougher contracts with commercial payers
Penalties for readmissions
More financial risk for HC organizations

Declining reimbursement challenges providers to make ends meet - this will only intensify
MONTANA PATIENT CENTERED MEDICAL HOME PROGRAM

• Legislation passed 2013 (SB-84)
• Anti-trust protections
• Consistent standards
• Multi-stakeholder involvement

AN ACT ESTABLISHING STANDARDS FOR PATIENT-CENTERED MEDICAL HOMES; PROVIDING THAT PATIENT-CENTERED MEDICAL HOMES HAVE A STATE PURPOSE THAT PROVIDES STATE ACTION IMMUNITY ON ANTICOMPETITION CONCERNS; ALLOWING THE USE OF PATIENT-CENTERED MEDICAL
WHAT DO NEW REIMBURSEMENT MODELS LOOK LIKE?

Fee-for-service hybrid models
Reimbursement rates declining

Quality care incentivized
Pay for performance
Value-based purchasing

Reduced cost of care incentivized
Shared savings models

Penalties for low quality
Providers assume more risk

Bundled payments
Steerage
Exclusivity

Capitated models
APPROACHES TO PCMH PAYMENTS

1. Fee-for-service (FFS) with discrete new codes
2. FFS with higher payment levels
3. FFS with lump sum payments
4. FFS with PMPM fee
5. FFS with PMPM fee and with P4P
6. FFS with PMPY payment
7. FFS with PMPM fee and shared savings
8. FFS with PMPY payment and shared savings
9. FFS with at risk PMPM (per member per month) payment and shared savings
10. Comprehensive payment with P4P (pay for performance)
11. Grants
PAYMENT REFORM REQUIRES MORE THAN ONE METHOD. ADJUSTMENTS IN PROGRESS.

“fee for health”
“fee for value”
“fee for outcome”
“fee for process”
“fee for patient service”
“fee for satisfaction”

Mix it up!
*Numbers based on educated assumptions for demonstration purposes and are not precisely representative of the Montana healthcare market.
PCMH - PAYMENT REFORM

Rationale:
• Infrastructure support
• Incentive alignment

Payers want to see:
• ROI
• Decreased costs
• Reduced utilization

Ready, set, you go first
IN DEVELOPING OUR OWN STATE AND ORGANIZATIONAL MEDICAL HOMES, PHYSICIANS MUST BE AT THE TABLE WITH HEALTH PLANS HELPING GUIDE THE PROCESS OF PAYMENT REFORM.

IT IS OUR RESPONSIBILITY TO BE ENGAGED AND TO ADVOCATE FOR OUR PATIENTS AND OUR PROFESSION.
PCMH Critical Design Elements

- Making a business case
- Reforming payment
- Engaging providers
- Defining the medical home
- Supporting practice transformation
- Health data management & exchange
- Evaluating impact
THE VALUE OF PHYSICIAN LEADERSHIP AT EVERY LEVEL OF THE HEALTHCARE SYSTEM

INTERFACE PROFESSIONALS

THE SOLE OF THE BUSINESS

MATTERS OF TRUST

RESPECTED CHANGE AGENTS

MULTIDISCIPLINARY TEAMS

TRANSITIONAL HURDLES

ADJUSTING TO AMBIGUITY

POWER OF INFLUENCE

NEW INTELLIGENCE NEEDED

INNOVATIONS IN EDUCATION
PCMH Critical Design Elements

Making a business case
Reforming payment
Engaging providers

Defining the medical home
Supporting practice transformation
Health data management & exchange
Evaluating impact
St. Peter's Medical Home Program

Design Elements

- Strategic Framework
- Leadership Model
- Data Management Model
- Operational Model
- Payment Model
- Workforce Model
- Service Delivery Model
St. Peter’s Strategic Framework and Pillars of Excellence

Vision:
To be the best place in the region to receive patient care, to practice medicine, and to work.

Values:
- Safety
- Service
- Respect
- Accountability

Goals:
- Strengthen Our Foundation
- Create Systems of Care
- Move Up Stream to Manage Health

Service
- Patient Centered
- Access
- Satisfaction
- Education
- Engagement

Quality
- Chronic disease management
- Preventive care
- Care Coordination
- Documentation

Growth
- Building a practice
- Scheduling
- Retention & loyalty

Financial
- Productivity
- Practice expenses

People
- Provider engagement & attendance
- Provider satisfaction survey
- Provider rounding
- Provider coaching

High Priority Strategies
- Culture of Service Excellence, Quality & Safety
- Patient-Centered Delivery Model
- Develop Key Service Lines
- Cost Management
Engaged & organized
Physician leadership

St. Peter's Medical Home Program

Design Elements

- Strategic Framework
- Leadership Model
- Data Management Model
- Operational Model
- Payment Model
- Service Delivery Model
- Workforce Model
St. Peter’s Provider Performance Leadership Team

Provider Performance Leadership Team Areas of Oversight
- Provider recruitment, interviewing and selection
- Provider orientation, training, on-boarding
- Diagnose & address provider sentiment
- Performance measurement & monitoring
- Provider and care team education, training
- Provider and care team recognition

Executive Committee
- Executive Committee Chair
- Finance Committee Chair
- Operations Committee Chair
- Quality Committee Chair
- Provider Coach

Provider Performance Leadership Team
- CEO
- COO
- VP Finance
- VP Medical Affairs
- VP Medical Homes & Innovation

Best Practices Workgroup
- Patient-centered interactions
- Expanded team roles
- New care team members
- New service lines
St. Peter's Medical Home Program

Design Elements

- Provider
- Nurse
- MA/LPN
- Behavioral Health
- Care Manager
- Clinical pharmacist
- Social worker

Strategic Framework
Service Delivery Model
Leadership Model
Data Management Model
Workforce Model
Operational Model
Payment Model
• Continuous quality improvement
• Patient-centered interactions
• Organized, evidence based care
• Continuous and team-based healing relationships
• Enhanced access
• Population management
• Care coordination
St. Peter's Medical Home Program

Design Elements

- Strategic Framework
- Leadership Model
- Data Management Model
- Operational Model
- Payment Model
- Service Delivery Model
- Workforce Model

- Data capture & aggregation
- Data integrity
- Reporting capabilities
- Dashboards
- Sustainability model for all programs
- Creativity with payment models
- Active negotiations with health plans
<table>
<thead>
<tr>
<th>2014 Service Delivery Lines</th>
<th>Strategic Alignment</th>
<th>Workforce Model</th>
<th>Operational Model</th>
<th>Data Management Model</th>
<th>Payment Model</th>
<th>Leadership Model</th>
</tr>
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<tbody>
<tr>
<td><strong>Clinical Assistant Program</strong></td>
<td>Enhance team-based structure. Engage patients.</td>
<td>RN team lead. Two MA/LPNs per provider.</td>
<td>Primary care clinical protocols.</td>
<td>EHR templates. Clinical decision support tools.</td>
<td>Increased fee-for-service productivity. PCMH contracts.</td>
<td>Care team leadership. Best practices workgroup.</td>
</tr>
<tr>
<td><strong>Clinical Research Program</strong></td>
<td>Diversify service lines.</td>
<td>RN site coordinator.</td>
<td>Governed by trial protocol</td>
<td>Specialized analytics.</td>
<td>Industry sponsorship.</td>
<td>Site management organization.</td>
</tr>
<tr>
<td><strong>Referrals Management Program</strong></td>
<td>Coordinate care.</td>
<td>Care teams.</td>
<td>Consultation protocols for initiating and tracking</td>
<td>EHR referrals module.</td>
<td>PCMH contracts.</td>
<td>Performance leadership team.</td>
</tr>
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PCMH Critical Design Elements

Making a business case
Reforming payment
Engaging providers
Defining the medical home

Supporting practice transformation

Health data management & exchange
Evaluating impact
TO BUILD A PATIENT CENTERED MEDICAL HOME
(state & local levels)
PRACTICE REDESIGN
STRATEGIES LINKED TO RESULTS

• Pre-visit checklists
• Team huddles
• Using HIT to flag charts, build lists and use alerts in scheduling
• Bundling prevention with other visits
• Make it easy for the patient; reduce need to arrange multiple visits
• Standing orders/protocols - prevention services
• Create targeted quality improvement teams; for example; the Colorectal Health Team
• Streamline and improve process efficiency
• New workflows embedded in protocols, policies and new staff oriented to improved flows.
• New roles; navigators, population/panel management, health coaches.
• Regular, visible reporting of QI
• Transparent improvement cycles
• “working the register” aka “scrubbing the list.”
• New process for communication of lab results=standardized response to A1C abnormalities.
• Improving access/continuity of team.
SUCCESSFUL STRATEGIES

Focus on real-life needs of patients – nonclinical factors

- Transportation
- Social relationships

Care outreach, in the home, in the community

Physician engagement and change leadership

Protocols for specific conditions

Risk stratification – focused services and resources

- Complex care coordination
- Chronic disease management
PCMH Critical Design Elements

Making a business case
Reforming payment
Engaging providers
Defining the medical home
Supporting practice transformation
Health data management & exchange
Evaluating impact
Delivery Model: Traditional -> Medical Home -> Integrated Network

CoordiCare © 2013
PROACTIVE OUTCOMES AND PERFORMANCE IMPROVEMENT THROUGH METRICS AND REPORTING

1. Evidence & Guideline-Based Clinical Decision Support (CDS)
2. Care Team & Provider Quality Reports
3. MU, PQRS, PCMH, Metrics Reports
4. Goal-Directed Outreach Population Management
5. Care Gap Analysis Outcomes Improvements
6. Operational & Financial Performance Improvement
7. Patient Population Data
8. Patient Specific Data
9. Provider Specific Data
10. Quality Data Subsets
11. Provider Reports
12. Evidence & Guideline-Based Clinical Decision Support (CDS)
13. Care Team & Provider Quality Reports
14. MU, PQRS, PCMH, Metrics Reports
15. EHR Incentive Payments & Medical Home Status

- Patient Specific Data
- Provider Specific Data
- Quality Data Subsets
- Evidence & Guideline-Based Clinical Decision Support (CDS)
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- Goal-Directed Outreach Population Management
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- Operational & Financial Performance Improvement
- Patient Population Data
- Provider Reports
- EHR Incentive Payments & Medical Home Status
MULTIPLE DEFINITIONS OF SUCCESS

• Improved chronic disease process and outcomes measures
  • Need to allow 4 years to see differences
• Improved ability to capture data in EHR systems
• Workflow redesign to improve care of specific patient conditions or episodes of care
• Workflow redesign of comprehensive care planning (preventive care plus multiple chronic conditions management)
• Enhanced patient service – manifest through experience reports, loyalty, retention
• Improved primary care team morale, quality of work life
• Increased primary care payment/revenue

• Patient engagement – behavior change – quality of life
A WORK IN PROGRESS

THANK YOU!

Jonathan Griffin, MD, MHA
Family Physician
VP of Medical Homes and Innovation
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Chair, Montana State PCMH Advisory Council