Hudson Headwaters' Journey to Patient Centered Medical Home Recognition

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February 9, 2012

Initial Steps

Identify PCMH Project Leader	Determine who “owns” your PCMH initiatives including the application and survey processes.
Educate Yourself	http://www.ncqa.org PPC-PCMH Standards and Guidelines can be obtained at no charge on the NCQA Website. NCQA trainings are highly recommended. Links to additional Resources also available through NCQA website including: American Academy of Family Physicians **Joint Principles of the Patient-Centered Medical Home** **"Road to Recognition - Your Guide to the NCQA Medical Home"** American Academy of Pediatrics **AAP and the Medical Home Model** American College of Physicians **Understanding and Running a Patient-Centered Medical Home** http://www.transformed.com/transformed.cfm TransforMED was awarded the initial National Demonstration Project for PCMH (2006). Offer several tools/services including the DeltaExchange. Conduct annual PCMH Conference with MGMA. Subsidiary of AAFP.

Initial Steps

Determine where you currently stand	•Conduct a Baseline Practice Assessment to determine your practice's current PCMH score •Complete a Change Readiness Survey to determine your practices readiness to implement change
Assemble a PCMH Team	Team will differ by Practice but recommend in addition to the PCMH Project Leader you include: • Provider Champion(s) • IT staff/EMR Superuser(s) • Staff that understand clinical and/or operational systems • Input from all levels whenever possible • Our Team included 3 Physicians, our full athena Support Team, VP of Operations, Director of Nursing, Director of Front Office Staff, Performance Improvement Manager, Health Center Lead Nurse and Health Center Front Office Manager
Have a Work Plan	The Plan should include your goals and objectives, specific steps to achieve them, the timeline for achievement and the accountable party. Communicate key aspects of the Plan to EVERYONE including your patients (e-mails/brochures/ website/face-to-face meetings)
Reach Out to Others	•Talk to other practices that have gone through the transformation process and achieved NCQA Recognition. • Consider hiring a consultant • Insurers are your friend

Medical Home standards focus on the entire primary care delivery process

Enhance Access and Continuity	The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.
Identify and Manage Patient Populations	The practice systematically records patient information and uses it for population management to support patient care.
Plan and Manage Care	The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines.
Provide Self-Care Support and Community Resources	The practice acts to improve patients' ability to manage their health by providing a self care plan, tools, educational resources and ongoing support.
Track and Coordinate Care	The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.
Measure and Improve Performance	The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

Enhance Access and Continuity

Access During Office Hours	•Reviewed and Revised our policies and set standards related to appointment scheduling, timely response to calls for clinical advice and documenting clinical advice. • Established Triage Nurse for Sameday appointment requests • Provider Scheduling/Care Team Development
After Hours Access	* Reviewed After Hours Call Policies * Implemented Guidelines to document calls in the patient's medical record
Electronic Access	Implemented athena Communicator (Developed brochure/ Conducted Patient Mailing/ Revised check-out process to include providing patient with pin number to access their personal information)
Continuity	Determined means to capture patient's PCMH Provider information then set up monthly report to monitor whether patients were being scheduled with that provider or a member of his/her Care Team
Cultural and Linguistically Appropriate Services	Contracted with Language Translation Service, pay based on use, receive monthly use reports
Care Team	Determined Health Center/Care Team plus established Medical Home Team: Care Management Team that included Nursing and non-nursing staff, 2 CDE (1RD, 1RN), 2 Patient Navigators, 2 Transition Care RNs. Used delegation authority and standing orders

Identify and Manage Patient Populations

Patient Information	Fields available in Electronic system. Ran Reports from athenaCollector to ensure we were capturing patient demographic information appropriately
Clinical Data	Searchable fields are available in Electronic Medical Record. Ran reports to ensure the provider/team is documenting
Comprehensive Health Assessment	•Trained Nursing staff to obtain key aspects of Social and Family History. • Built Depression Screens/Cage Questionnaire and Smoking Questionnaire into Social History Templates. • Use of age-appropriate Social History Templates and Templates that automatically include orders for screenings/Immunizations/ anticipatory guidance
Data for Population Management	• Ticklers used for patients we see for preventive services/chronic care • Quality Management Reports used for outreach for patients by Patient Navigators (pap/mammo/colon cancer screening) or Care Management Team (chronic conditions) • Reminder Calls used for multiple purposes • Reports from Report Builder available to manage patients on specific medications – used to identify patients with formulary change

Plan and Manage Care

Implement Evidenced-Based Guidelines	• Determined the conditions that were important to our patients through report of top 20 diagnosis by frequency and cost • Adopted evidenced-based guidelines and related quality indicators • Embedded guidelines into our day-to-day operations through Flow Sheets, Quality Measures, Templates and Order Sets •Purchased UptoDate and linked to athena
Identify High Risk Patients	• Care Management Program established levels of patient outreach – education, coaching, care management • Identified patients through Quality Management Reports and Pre-visit Planning •Establishing Provider referral process
Care Management	•Pre-visit planning done by Care Management • Referral to Care Management • Developed Nursing HPI Templates to assess barriers • Summary of Visit/Flowsheet/Medication List provided to patient at Check-out and on Portal • No-Show process includes automated calls to patient and ability to reschedule
Medication Management	• Starts at Check-in. Patient receives medication list and asked to reconcile then Provider reviews during Encounter • Medication Reconciliation is key aspect of Transition Care Program after hospitalization • OTC/Herbal/Supplements use obtained for all patients by Nursing during Intake
E-Prescribing	99% of all prescriptions e-prescribed. Integrated system with safety and efficiency alerts

Provide Self-Care Support and Community Resources

Support Self-Care Process	•Developed Community Resource Handout and Self-Management Tools • Patient outreach incorporated into Care Management Program • Use of Flowsheets, Templates and Order Sets in Electronic Medical Records to document Self-Management Support activities •Use of Clinical Summaries •Patient Portal
Provide Referrals to Community Resources	• Resource List created in searchable database • Mental Health services imbedded in the Health Center • Collaborated with community entities to offer health education and support groups (Pre-Diabetes Program/Chronic Condition Support Group) •Collaborated with other community providers on non-medical supports

Track and Coordinate Care

Test Tracking and Follow-up	• Electronic Medical Record designed to track lab/imaging tests until results are available • Established process for working " Follow-up" Bucket and "Lab/Imaging" results • Interfaces built with key labs and radiologist • Use Reminder Calls to notify patients and pushed labs to the Patient Portal
Referral Tracking	• Electronic Medical Record has key elements you need, including "Note to Provider" field, "Referral alarms", electronic fax to specialist of key data (trackable) • Centralized Service
Coordinate With Facilities and Care Transitions	• Developed Collaborations with key hospital Case Management/Discharge Staff and obtained access to the hospital's electronic record • Collaborated with other Community provider, Public Health, Office for the Aging, Independent Living Center, Skilled Nursing Facilities •Developed Transition Care Program based on Eric Coleman Model.
Health Information Exchange	• Interface developed between athena and RHIO (HIXNY •Data exchange underway •Consenting process underway

Measure and Improve Performance

Quality Measures/Meaningful Use	•Established based on HEDIS measures •Incorporated into patient's encounter •Different members of the Care Team empowered to address
Provider Dashboards	• Disseminated Monthly •Reviewed by Lead Provider
Data Warehouses	• Claims data-TREO • Clinical Quality data from HIXNY to Quality Data Warehouse

Parting Thoughts

Recognize There Will be Failures	•There is Never Enough Time, Staff, Money……. Learn to Accept that Quality Improvement is a Continuous Process • Not everyone will make the transition • You don't know what you don't know until you measure • Change will take longer than you think – Plan accordingly
Celebrate Victories	•Change can be Difficult, Foster a Positive Transformation •Let Staff Know When Milestones have been Achieved and Celebrate
Communicate, Communicate, Communicate	•Use any means possible to keep staff and patients informed •Every site/practice needs a Medical Home Cheerleader •StoryBoards/Brochures/Website(s)/Meetings