PCMH: What Does this Mean for FM Residents?

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Objectives

- List the Joint Principles of the PCMH
- Describe multiple components of health information technology in PCMH
- Discuss quality and safety benefits of the PCMH
- Formulate ideas how PCMH can be implemented within the Family Medicine residency program of attendees

2007 Joint Principles of the PCMH

- Personal physician
- Physician-directed practice
- Whole person orientation
- Coordinated and integrated care
- Quality and safety
- Enhanced access
- Payment reform

Family Medicine

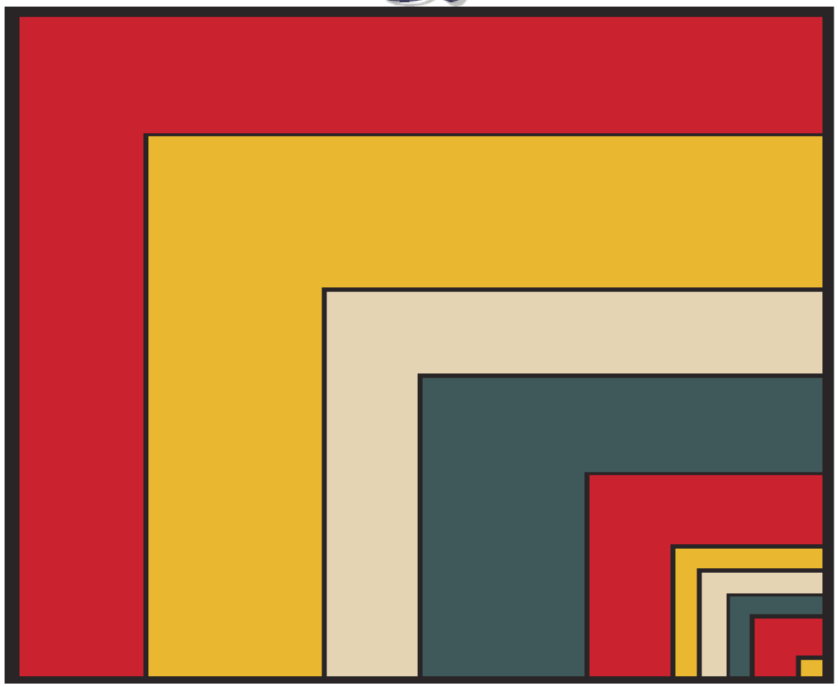
- Family Physicians Bring Value and Access for the U.S.
- Family Medicine is a specialty of complexity and relationships
- The Patient Centered Medical Home (PCMH)
- Challenges and Opportunities
- Optimism for the Future

Equity effects of primary care

- Improves self-rated health
- Reduces disparities
- Reduces effects of income inequality
- Reduces:
  - All-cause mortality
  - Cause specific mortality: Asthma, pneumonia, CAD, emphysema

Starfield B et al. Milbank Quar 2005;83:457-502

Ecology of Medical Care - 1996



Each box contains a subgroup of the biggest box of 1000 persons. This figure includes children and reconfirms that most of the problems most people have most of the time would escape detection, analysis, and response by health care efforts restricted to hospitals and academic health centers.

Source - Green et al, *N Engl J Med* 2001;344:2021-25 (An update of classic 1961 study: White KL et al. The ecology of medical care. *N Engl J Med* 1961;265:885-92.)

Time Requirements

- 10.6 hrs/day – chronic conditions[1]
- 7.4 hrs/day – preventive services[2]
- Patient agenda?
- Acute care?
- Administrative issues?

1. **Ostbye T. Ann Famed Med 2005; 3:209-214.**
2. **Yarnall KHS. AJPH 2003;43:635-641.**
3. **Bodenheimer T. NEJM 2006:355:861-864.**

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

Slide from Daniel Duffy, MD School of Community Medicine Tulsa Oklahoma

Medical Home: NCQA Definition

- NCQA definition of a medical home:
  - Each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.
  - 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

Medical Home: NCQA *cont.*

- PPC-PCMH has 3 levels of recognition and measures:
  - Access/communication
  - Patient tracking/registry functions
  - Care management
  - Patient self-management support
  - E-prescribing
  - Test/referral tracking
  - Performance reporting
  - "Advanced" electronic communication

PCMH: Integral to the Residency Care Experience

- Make it a PRIORITY
- Part of the Culture
- Taught at Every Venue
  - Orientation
  - Inpatient
  - Outpatient
- Systems Supporting PCMH

Permanente Medical Groups in California

Departments of Family Medicine & Family Medicine Residencies

PRACTICE ORGANIZATION

- Financial Management
- Practice Development
- Practice Data
- Customer Engagement

HEALTH INFORMATION TECHNOLOGY

- E-prescribing
- Population Registry
- Clinical Decision Support tools
- Connection
- Experimental care delivery

QUALITY MEASURES

- Registries
- Referrals
- Patient Safety Alerts
- Patient Reminders
- Care Plan

PATIENT EXPERIENCE

- Open/Advance Access scheduling
- Patient portal
- Patient self management
- Communication

Practice Organization

Financial Management

- Budget and forecast management in conjunction with Kaiser Health Plan
- Coding education with certified physician coders
- Inpatient rounding with utilization managers
- Drug, Lab and Radiology utilization action teams

Practice Development

- Manager and leadership off-sites/training
- Department/unit based teams (UBT)
- SCPMG university
- New Employee Orientation (NEO)

Practice Data

- Access date: Bonding rate, Adjusted utilization, Leakage reports
- People Pulse survey: Labor Management Partnership (LMP)

Customer Engagement

- KP Ambassador program

Quality Measures

Registries

- Permanente Online Interactive Network Tools (POINT)
- Clinical Strategic Goal (CSG)
- Care gaps: granular down to individual/clinic performance

Referrals

- e-Referral and eConsult

Patient Safety Alerts

- Labs: duplicate future order alert
- Meds: interaction alert
- Allergies: built into HealthConnect

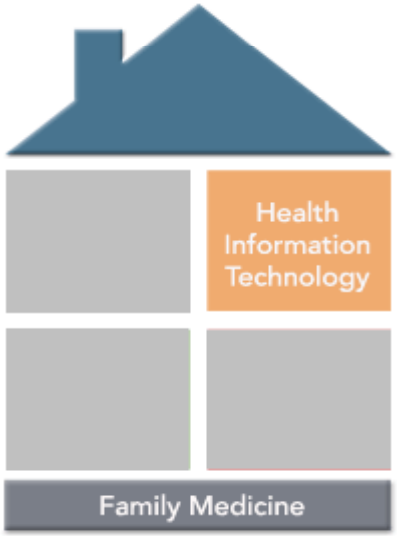
Practice Reminders

- Best Practice Alerts
- Health Maintenance Alerts

Care Plan

- Problem/medication list
- After Visit Summary: patient information at check-out

Health Information Technology



E-prescribing

- Integrated within HealthConnect and linked to all pharmacies in each region (NCAL or SCAL)
- Formulary substitution alert
- Weight based dosing built in for certain medications

Population Registry

- Population Care Management (Proactive office encounter)

Clinical Decision Support tools

- On-line clinical library
- Medication look up directly linked from HealthConnect
- Clinical practice guidelines built into referral templates
- PACS/IMIS, Visible light, MUSE – interfaced systems

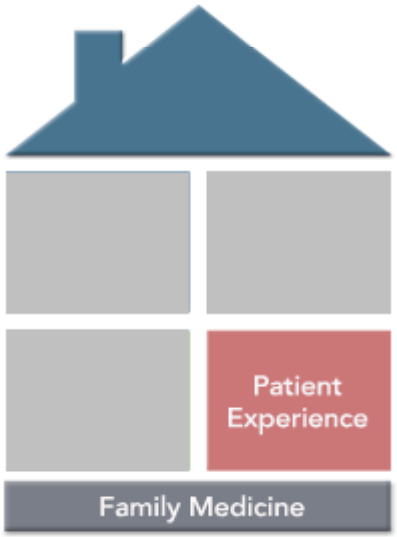
Connection

- Internet/intranet access in ambulatory and inpatient areas
- Data extraction via Clarity reports

Experimental care delivery

- Garfield Center
- Office of the Future

Patient Experience



Open/Advance Access scheduling

- Same day appointments
- Clinic start on time reporting
- Access departments – standardization of appointment types

Patient portal: KP.org

- Personal medical records review
- Patient emails
- Online appointment direct booking
- Prescription refill requests
- Online health information

Patient self management

- KP On-Call
- Motivational interviewing pilot "DM insulin new start"
- Group visits

Communication

- Language concordance program
- Onsite interpreter
- Spanish/Chinese/Vietnamese Centers of excellence
- Patient satisfaction surveys (ASQ, METEOR, MAPPS/MPS)

USE OF PATIENT-CENTERED MEDICAL HOME COMPONENTS BY FAMILY PHYSICIANS

Electronic medical records	49.2%
Chronic disease management	46.8%
Extended office hours	42.4%
Web-based information for patients	35.7%
E-prescribing	31.7%
Open-access scheduling	28.9%
Team approach	22.1%
E-mail with patients	21.0%
Registries or patient tracking systems	20.7%
Performance management of processes or clinical recommendations	20.4%
Electronic performance measurement reporting	20.0%
Self-care management support	13.4%
Outcomes analyses	11.3%
Online appointments	10.2%
Patient population management	9.8%

Source: AAFP Practice Profile I Survey, July 2008.

Meaningful Use:
An Overview From 36,000 Feet

MU Objectives Overview

- 15 core objectives – providers, 14 – hospitals
- 10 menu objectives
- Most objectives have provider and hospital objectives
- Functionality / workflow used to fulfill objectives must be certified

CORE REQUIREMENTS

- Medication orders submitted electronic (Computer Provided Order Entry – CPOE)
- Implement drug/drug and allergy/drug check
- 30% of all patients (lab and radiology in stage 2 – threshold then 60%)
- Enabled

CORE REQUIREMENTS

- Generate/transmit prescriptions electronically
- Maintain up to date problem list
- Maintain active medication list

- More than 40% of patients
- More than 80% of all patients (at least one dx or "none")
- More than 80% of all patients
  (At least one entry)

CORE REQUIREMENTS

Maintain active medication allergy list	More than 80% of patients
Smoking status – over 13 y/o - structured field	More than 50% of patients

CORE REQUIREMENTS

- Implement one designed decision support rule
  - Track compliance
- Report ambulatory clinical quality measure to CMS
- Track compliance

CORE REQUIREMENTS

- Demographics recorded – structured
  - **Preferred language**
  - **Gender**
  - **Race**
  - **Ethnicity**
  - **Date of birth**

- More than 50%

- Record vital signs
  - **Height – structured**
  - **Weight – structured**
  - **BP – structured**
  - **BMI**
  - **Growth Charts 2-20**
    - **Including BMI**

- More than 50%

CORE REQUIREMENTS

- Provide patients with electronic copy of health information upon request
  - Diagnostic test results
  - Problem list
  - Medication list
  - Medication allergies
- Provide clinical summaries for patients for each office visit

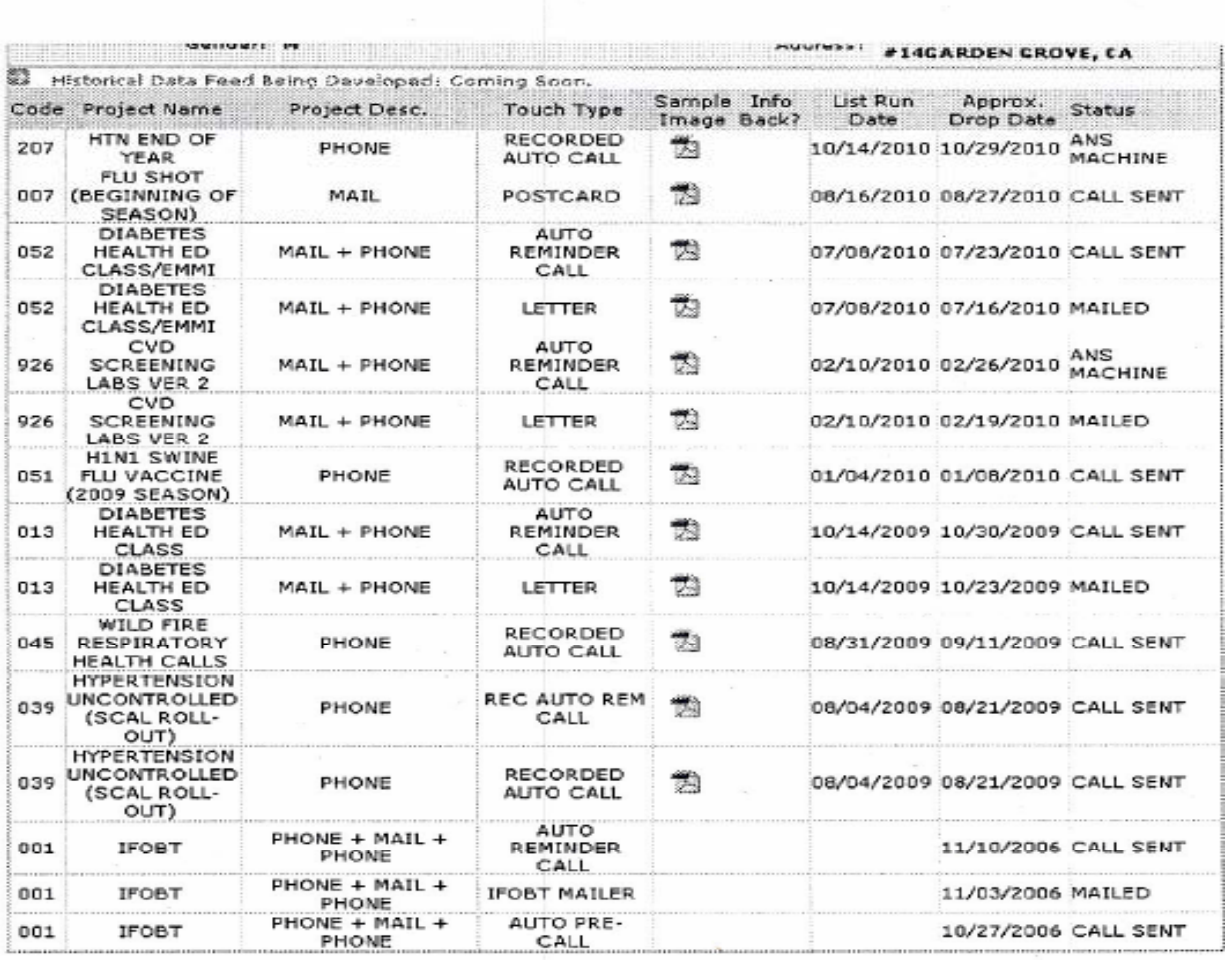
- More than 50% within 3 business days

- More than 50% with 5 business days

CORE REQUIREMENTS

- Capability to exchange key clinical information among providers electronically
- Privacy and Security - Protect electronic health information
- One test and confirmation
- Security risk analysis

Care Gap Reports



Historical Data Feed Being Developed: Coming Soon.

Code	Project Name	Project Desc.	Touch Type	Sample Image	Info Back?	List Run Date	Approx. Drop Date	Status
207	HTN END OF YEAR	PHONE	RECORDED AUTO CALL			10/14/2010	10/29/2010	ANS MACHINE
007	FLU SHOT (BEGINNING OF SEASON)	MAIL	POSTCARD			08/16/2010	08/27/2010	CALL SENT
052	DIABETES HEALTH ED CLASS/EMMI	MAIL + PHONE	AUTO REMINDER CALL			07/08/2010	07/23/2010	CALL SENT
052	DIABETES HEALTH ED CLASS/EMMI	MAIL + PHONE	LETTER			07/08/2010	07/16/2010	MAILED
926	CVD SCREENING LABS VER 2	MAIL + PHONE	AUTO REMINDER CALL			02/10/2010	02/26/2010	ANS MACHINE
926	CVD SCREENING LABS VER 2	MAIL + PHONE	LETTER			02/10/2010	02/19/2010	MAILED
051	H1N1 SWINE FLU VACCINE (2009 SEASON)	PHONE	RECORDED AUTO CALL			01/04/2010	01/08/2010	CALL SENT
013	DIABETES HEALTH ED CLASS	MAIL + PHONE	AUTO REMINDER CALL			10/14/2009	10/30/2009	CALL SENT
013	DIABETES HEALTH ED CLASS	MAIL + PHONE	LETTER			10/14/2009	10/23/2009	MAILED
045	WILD FIRE RESPIRATORY HEALTH CALLS	PHONE	RECORDED AUTO CALL			08/31/2009	09/11/2009	CALL SENT
039	HYPERTENSION UNCONTROLLED (SCAL ROLL-OUT)	PHONE	REC AUTO REM CALL			08/04/2009	08/21/2009	CALL SENT
039	HYPERTENSION UNCONTROLLED (SCAL ROLL-OUT)	PHONE	RECORDED AUTO CALL			08/04/2009	08/21/2009	CALL SENT
001	IFOBT	PHONE + MAIL + PHONE	AUTO REMINDER CALL				11/10/2006	CALL SENT
001	IFOBT	PHONE + MAIL + PHONE	IFOBT MAILER				11/03/2006	MAILED
001	IFOBT	PHONE + MAIL + PHONE	AUTO PRE-CALL				10/27/2006	CALL SENT

Language: **ENGLISH**

Missing Care Gaps

- Pneumovax Immunizations Due
- Hypertensive
- Diabetic
- A1C Due
- DM Retinal Photo Due
- DM Missing Annual Monofilament Foot Exam
- DM Health Education Class Needed

Recommendations

Care Gaps Due	Actions to Be Taken
Pneumovax Immunizations Due	• Pend order for immunization through POE or BPA SmartSet • Administer vaccine per scope of practice and document in HealthConnect and KITS
Hypertensive	• Take BP (Repeat if above or equal to 140/90 for uncomplicated HTN or above or equal to 130/80 for members with Diabetes or Chronic Kidney Disease) • If elevated, repeat BP, document in New Set of Vitals and review Best Practice Alert • Ask member if they brought home BP readings (if so give to provider)
Diabetic	• Check BP (if BP is greater than or equal to130/80, repeat and notify provider) • Set out the meds the patient brought or the medication list out for the provider to review • Get meter from patient and download SMBG numbers or ask patient for their log book and give to provider • If member does not have a meter, Pend order for Lifescan OneTouch Ultra2 meter start-up kit through POE SmartSet and inform provider patient has not been monitoring • If member does not have a meter, schedule member into either Health Ed class, Nurse Clinic, or other local procedure for meter class.
A1C, Lab Screening Due	• A1C: Orders Loaded, Confirm un-resulted order(s) exist in Chart Review Lab Tab before sending member to lab
DM Retinal Photo due	• Arrange appointment to have a photo of the retina taken
DM Annual Monofilament Foot Exam	• Prepare patient for monofilament foot exam and stage order and screening dx for provider using POE SmartSet
Diabetes Health Education Class Needed	• Refer member to health education diabetes class

Outcomes

- Patient care and safety improvements
- Access improvements
- Improved patient satisfaction
- Cost savings

Outcomes

2010 CSG Imperatives and Benchmarks

	Period 2 2010	Period 3 2010	Internal Target	External Benchmark
Cancer Screening				
Breast Cancer Screening	88.6	88.8	90.0	90
Cervical Cancer Screening	85.5	85.6	88.0	87
Colorectal Cancer Screening	72.9	72.6	77.0	79
Chronic Conditions				
Comprehensive Diabetes Care				
HbA1C ≤ 9.0%	78.9	79.5	81.0	81
HbA1C < 8.0%*	65.8	66.5	—	—
HbA1C Testing	94.0	93.9	94.0	94
Lipid Control (< 100 mg/dL)	63.8	64.2	65.0	65
Cardiovascular LDL-C Control (< 100 mg/dL)	75.7	75.7	78.0	77
Controlling High Blood Pressure (Ages 18–85)	83.5	84.5	86.0	88

Pugno's Pearls for a Positive Perspective

- Behave in an optimistic manner and you will indeed feel optimistic
- Avoid negative people – they are energy vampires and "suck energy"
- Learn something positive (and useful) from every failure
- Look at the avocado – God has a sense of humor. It's ok to laugh at yourself once in awhile
  - Pugno. JABFM. January 2009

Pugno's Pearls for a Positive Perspective

- Try always to do what's right, not just what's expedient. Even if you fail – you were on the "high road"
- Always tell the truth – it's much easier than remembering the lie
- Remember – success favors the well prepared. "Life is filled with golden opportunities, carefully disguised as irresolvable problems"

It's the Relationship!
We Make a Difference!!!

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