

UOP, LLC

UOP's Implementation Plan for PCMH Patient Provider Partnership Initiative Capabilities / Tasks

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WHAT IS A PATIENT-CENTERED MEDICAL HOME?

A patient-centered medical home is an approach to providing comprehensive primary care for people of all ages and medical conditions. It is a way for a physician-led medical practice, chosen by the patient, to integrate health care services for that patient who confronts a complex and confusing health care system.

(American Academy of Family Physicians)

Principles

- The primary care physicians in the group practice are 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
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level

Capabilities/Tasks for BCBSM PC-MH and ECBR PGIP Initiatives

- Patient Provider Partnership Initiative (CCP-08-02)
- Patient Registry Initiative (CF-08-01)
- Performance Reporting Initiative (IC-08-03)
- Individual Care Management Initiative (CCP-08-04)
- Extended Access Initiative (CCP-08-03)
- Test Results tracking & Follow – up Initiatives (CCP-08-05)
- Evidence Based Care Initiative (CCP-08-01)

UOP'S Implementation Plan for the Patient Provider Partnership Initiative Component

- All participating group practices in UOP informed of the PCMH program
- Training on Planned Care Visits provided to participating group practices
- BCBSM documentation on PCMH mailed to all group practices
- Power point presentation shared with physician offices.
- On site visits to physician offices initiated by the marketing representative of UOP. Copies of patient provider agreement, sample document forms and other educational material hand delivered to the practices.
- Periodic Evaluation of participating group practices by an onsite UOP staff evaluator.

The Patient-Doctor Partnership

The health and wellness of our patients is a top concern of this office. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, *your doctor*, and you, *my patient*, work together. This concept is called the Patient Centered Medical Home.

Patient Responsibilities:

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms, and other important information about your health
- Tell your doctor about any changes in your health and wellbeing
- Take all of your medicine and follow your doctor's advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call your doctor *first* with all problems, unless it is a medical emergency
- End every visit with a clear understanding of your doctor's expectations, treatment goals, and future plans

Doctor Responsibilities:

- Explain diseases, treatments, and results in an easy-to-understand way
- Listen to my patients' feelings and questions; help them make decisions about their care
- Keep treatments, discussions, and records private
- Provide 24 hour access to medical care and same day appointments, whenever possible
- Provide instructions on how to meet your health care needs when the office is not open
- To care for you to the best of my abilities based on my understanding of current medical methods available
- Give my patients clear directions about medicines and other treatments
- Send my patients to trusted experts, if needed
- End every visit with clear instructions about expectations, treatment goals, and future plans

The patient is asked to read this document, or it is read to her/him by the physician's staff as they enroll in the program, and a copy is placed in their medical record, with the initial contact date recorded. This document would ideally be reviewed annually with the patient.

This agreement would be re-emphasized more often to the patients who are not in compliance.

Planned and Group Visits

These are an integral part of Care Management protocols. Instead of waiting until something goes wrong, patients with chronic conditions have regular planned visits that help them stay in control of their condition. Plus, group visits provide the opportunity for patients to receive services in a support environment that also motivates them to achieve better health outcomes. With the help of the Care Manager and a patient information system, staff track, monitor and follow-up on the health goals and outcomes of patients who are receiving care. Planned Care allows for more assistance and time for clinicians to work with individual patients on their customized treatment plan and any problems that arise along the way. Planned care visits can be provided 1:1 or in Group/Shared Medical Appointment Format.

Action Steps

Assign Team Roles and Responsibilities

Identify the logistical and clinical tasks necessary for the preparation and execution of the visit. For example, the following questions might need to be addressed: Who is going to call the patient to schedule the visit? Who will room the patient? If the patient has diabetes, who will remove her/his shoes and socks? Who will examine the feet? Who will prepare the patient encounter form for use during the visit: All tasks need to be delegated to specific team members so that nothing is left to chance.

Roles in Team Care

<u>Role:</u>	Primary Care Provider	Primary Care Nursing Staff	Medical Specialist	Clinical Care Manager	Resource Coordinator	Clerical Staff

Call a Patient In For a Visit

Develop a script for the call, and decide which team member will make the call. Set the tone and expectations for the issues addressed in the visit. Here is a sample script you can adapt to your setting:

"Hello Ms. Smith. This is Karen calling from Dr. Brown's office. He is interested in making sure all of his patients with chronic conditions are receiving the best possible care. He has asked me to have you come in for visit to discuss your (insert condition here). If you have other health concerns, we may have to address those at a future visit. By focusing on just your (condition here) both you and he can better manage your health.

Can we set up a time that is convenient for you? When you come, please bring all your current medications (and anything else pertinent to the condition). Thank you. We will call you a day before the visit to make sure you are still able to come."

If you choose to mail an invitation to patients, be sure to track respondents. Typically, less than 50% of patients respond to a letter. You will need to plan an alternative method of contacting non-responders.

Deliver Clinical Care and Self-Management Support

In preparation for the visit, print an encounter form from your registry or pull the chart in advance so that you can review the patient's care to date. Document what clinical care needs to be done during the visit.

Example of Patient Encounter Form for Collecting Registry Data at Time of Visit (same form can be used as template for automated Patient Summary form for use during next visit – Diabetes example)

Patient Summary Sheet

<p>Date: Patient ID #: Patient Name: Patient Age: Primary Phone: Alternate Phone : Primary Practitioner:</p>	<table border="1"> <thead> <tr> <th>Vital Signs</th> <th>Last Visit</th> <th>Today</th> </tr> </thead> <tbody> <tr> <td>Weight (Lbs.)</td> <td></td> <td></td> </tr> <tr> <td>Height (Inches):</td> <td></td> <td></td> </tr> <tr> <td>Blood Pressure:</td> <td></td> <td></td> </tr> <tr> <td>Body Mass Index:</td> <td></td> <td></td> </tr> <tr> <td>Vital Signs Date:</td> <td></td> <td></td> </tr> <tr> <td>Smoking Status:</td> <td></td> <td></td> </tr> </tbody> </table>	Vital Signs	Last Visit	Today	Weight (Lbs.)			Height (Inches):			Blood Pressure:			Body Mass Index:			Vital Signs Date:			Smoking Status:		
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<p>Priority Registry Health Risk Factors</p>	<p>Working Notes</p>																					
<p>1. CAD/CVD Risk Family History of PREMATURE CAD? Most Recent Lab Values Total Chol.: _____ HDL: _____ TC/HDL: _____ Date: _____ LDL: _____ Date: _____ TG: _____ Date: _____ Baseline LDL Aspirin/day?</p>																						

Example of Patient Encounter Form for Collecting Registry Data at Time of Visit (same form can be used as template for automated Patient Summary form for use during next visit – Diabetes example)

Patient Summary Sheet

Priority Registry Health Risk Factors	Working Notes
<p>2. Kidney Risks Albuminuria/Creat. Ratio Date: <i>Serum Creatinine</i> Date:</p>	
<p>3. Retinal Screening Latest Eye Exam: Left Eye: Right Eye:</p>	
<p>4. Foot Risk Status Date of Last Foot Exam: High Risk Foot?</p>	

The Acute Care Visit and Planned Care

Regardless of how much you plan, patients still arrive unexpectedly with acute exacerbations. Assuming that your patient is stable, use this opportunity to provide all or some of their routine chronic care. You can then fold them into the planned care visit schedule. To take advantage of this opportunity, try the following:

Get As Much Done As You Can

- Consider developing standing orders for these kinds of visits
- Make sure the team knows their roles and responsibilities around the standing orders
- Find or develop a tool to keep track of what you've done and still need to do (encounter form)
- Introduce the concept of self-management to the patient and discuss how you would like them to start having planned visits with your team, and why
- Schedule their first planned care visit!

American Diabetes Association

Channel Guide

Online Tools



Rate your Plate

Plan your meal -- learn what will raise your blood sugar levels the most.

Exercise

Do you know what you can do in your life to increase your activity level?

The Basics



#1 Type 1 Diabetes

People with type 1 diabetes don't make any insulin. Learn more about type 1 diabetes to cope with it.

#2 Type 2 Diabetes

People with type 2 diabetes don't make enough insulin or it doesn't work well. You can find a way to care for it.

#3 Eating



Food is the hardest part of caring for diabetes. Work with your dietitian to include your favorites and still keep your blood sugar on track.

#21 Are You Ready To Lose Weight?

You can lose weight and keep it off, even if you've never done it before.

Rate your Plate

Plan your meal -- learn what will raise your blood sugar levels the most.

Meal Planning with Diabetes

American Diabetes Association

Channel Guide

Keep Your
Blood Sugar
on Track



#4 Factors Affecting Blood Sugar

Keeping your blood in your target range most of the time can help keep you healthy. Lots of things make blood sugar rise or fall.

#5 Checking Your Blood Sugar

Checking your blood sugar and keeping track of the results help you know what's going on with your blood sugar.

Your
Diabetes Care



#6 You and Your Diabetes Care Team

Diabetes care is mainly up to you, but your health care team is important, too.

#12 Treating Type 2 Diabetes for Life

Things change. Changing your treatment plan can help you reach your blood sugar goals.

Living Well



#7 Changing Habits

Making changes in your life is a matter of trying and learning. And to reach your goals, you need a plan.

#8 Emotions

Diabetes raises your risk for serious depression. Serious depression is a medical problem. Don't put off asking for help.

#11 Type 2 Diabetes and Exercise

Exercise helps in a lot of ways and you don't have to spend hours exercising to look and feel better.

Determine How to Meet Regularly

Until new roles are well integrated into the normal work flow, many practices have team huddles for 5-10 minutes in the morning to review the schedule and identify chronic care patients coming in that day for an acute care visit. Decide how best to meet as a team to manage these patients. Determine the best intervals and timing for these meetings, and stick to them. The brief get-togethers help the team stay focused on practice redesign and create a spirit of “one for all”.

Use of the UOP Disease Registry for PC-MH Patients

- Efforts are underway to create the required field in the existing UOP electronic disease registry for chronic diseases to identify PC-MH patients
- Verification of log-on ID and passwords for all of the participating physicians in the practice group
- Expansion of the disease registry ongoing

Clinical Guidelines

Use of Michigan Quality Improvement Guidelines (MQIC) is recommended

Useful Web Sites for Patient Education Materials

www.americanheart.org

www.diabetes.org

www.lungusa.org

Enter Name of Group Practice Unit
Name of Practice Unit Rep and Title Providing Info
Practice Unit Contact Phone #
Practice Unit Contact FAX #
of PGIP Physicians in Practice Unit

Definitions of Capabilities/Tasks for PC-MH and ECBR PGIP Initiatives

Patient Provider Partnership Initiative (CCP-08-02): Capabilities/Tasks

		Y	N	Onsite UOP Eval Comments	GP Sign-off	Date
1.1	Practice unit is prepared to implement patient-provider agreement or other documented patient communication process - Documents and patient education tools are developed that explain PC-MH concepts, and outline patient and provider rights and responsibilities - Staff has been educated/trained on pt-prov partnership concepts and patient communication process - Data field has been created in patient registry to identify PC-MH patients					
1.2	Practice unit is using a systematic approach to provide patient education and outreach on PC-MH - Process of reaching out to patients, including patients who do not visit practice regularly, and providing information about PC-MH and patient-provider partnership is underway					
1.3	Total number of patients in practice as of:					
1.4	Patient-provider agreement or other documented patient communication process is implemented for at least 10% of patients					
1.5	Implemented for at least 30% of patients					
1.6	Implemented for at least 50% of patients					
1.7	Implemented for at least 60% of patients					
1.8	Implemented for at least 80% of patients					
1.9	Implemented for at least 90% of patients					

THE BOTTOM LINE

It is hoped that Care delivered by primary care physicians in a Patient-Centered Medical Home will be consistently associated with better outcomes, reduced mortality, fewer preventable hospital admissions for patients with chronic diseases, lower utilization, and improved patient compliance with recommended care.

Bibliography

- American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA)
- Dartmouth Atlas of Health Care, variation among states in the management of severe chronic illness, 2006
- Blue Cross Blue Shield of Michigan, 2008 PGIP reference materials
- “Developed by Improving Chronic Illness Care. ICIC is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health’s MacColl Institute for Healthcare Innovation”.
- Michigan Quality Improvement Guidelines, 2006