PRIMARY CARE DEVELOPMENT CORPORATION

Leatherstocking PCMH Learning Collaborative – Session 3

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Primary Care Development Corporation
December 3, 2015

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NCQA PCMH 2014 Standards

Scoring

1: Enhance Access and Continuity	Pts
A. *Patient-Centered Appointment Access	4.5
B. 24/7 Access to Clinical Advice	3.5
C. Electronic Access	2
	10

2: Team-Based Care	Pts
A. Continuity	3
B. Medical Home Responsibilities	2.5
C. Culturally and Linguistically Appropriate Services (CLAS)	2.5
D. *The Practice Team	4
	12

3: Population Health Management	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. *Use Data for Population Management	5
E. Implement Evidence-Based Decision-Support	4
	20

4: Plan and Manage Care	Pts
A. Identify Patients for Care Management	4
B. *Care Planning and Self-Care Support	4
C. Medication Management	4
D. Use Electronic Prescribing	3
E. Support Self-Care and Shared Decision-Making	5
	20

5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. *Referral Tracking and Follow-Up	6
C. Coordinate Care Transitions	6
	18

6: Measure and Improve Performance	Pts
A. Measure Clinical Quality Performance	3
B. Measure Resource Use and Care Coordination	3
	4
C. Measure Patient/Family Experience	4
D. *Implement Continuous Quality Improvement	3
	3
E. Demonstrate Continuous Quality Improvement	0
	20
F. Report Performance	
G. Use Certified EHR Technology	

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Step 1

PCMH GOALS

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1. Team Care Goals for PCMH

The practice:

- Allows patients to **select their PCP/Team** and **measure continuity** with the provider/care team
- **Educates** patients on their patient centered services
- Identifies and defines the **roles and structure of the patient care team**
- Has organized **internal communication** platforms
  - meetings/huddles
- Provides **trainings** to the care team related to:
  - supporting patient self management
  - managing patient populations, and
  - coordinating care for patients

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Step 2

ACTION ITEMS TO REACH GOALS

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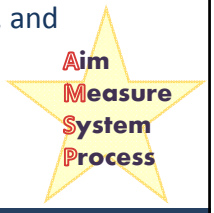
2. Actions Items to Reach Goals

A. Establish and monitor relationships between the patient and the care team

B. Develop materials and processes to educate patients on patient-centered services

C. Develop processes for providing culturally and linguistically appropriate services

D. Identify and define the roles and structure of the patient care team including regular communication, training, and involvement in QI activities



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2. Actions Items to Reach Goals

Part A – Empanelment: Establishing Patient-Care Team Relationships

- One of the core elements of the PCMH is that the patient has a relationship with a personal physician or a practice team
- To accomplish this, individual patients must be assigned to individual primary care providers (PCP) and/or care team
- Patients choose their PCP based on preferences
- Assignment is the basis for population health management and continuity of care
  - Every assigned patient receives optimal care, whether he/she regularly comes in for visits or not

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How Does Empanelment Support Care Optimization?

- **Creates accountability** – the PCP/team is responsible for meeting the acute, chronic, and preventive needs of assigned patients
- **Enables measurement** – the performance of the PCP/team can be assessed across a population of assigned patients
- **Prevents burnout** – makes explicit the number and risk characteristics of the group of assigned

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Keys to Panel Management

Ability to provide access that is culturally and linguistically appropriate

- ✓ Same Day
- ✓ Open Access
- ✓ Electronic Access
- ✓ Phone Access

Ability to provide continuity between the patient and PCP/Care Team

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Keys to Panel Management

Ability to provide Team Based Care

Having a registry system and care planning process that includes panel management

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Part A: Empanelment Policy

[redacted]

SUBJECT: Patient Selection of Primary Care Physician

NUMBER:

OWNER: [redacted]

EFFECTIVE DATE: 1/12 **REVISED DATE:** **SUPERSEDES:**

Factor 1: Annotated policy highlights how the practice communicates to patients that they have the ability to choose and change PCP

I. **POLICY**
[redacted] Center for Child Health and Resiliency Billing Representatives will notify patients of the Primary Care Physician Selection Process

II. **PURPOSE**
To ensure that patients are aware of the selection process

III. **PROCEDURE**

PCMH 2A1

1. Upon registration, patients are provided with information on how to select a PCP and are given a list of providers available at our site and updated within the registration system.
2. When choosing a PCP, the patient will have the option of selecting one provider for the whole family or an independent provider for each member. Our staff consists of physicians, nurse practitioners and certified nurse midwives.
3. When selected, the PCP's name and telephone number will appear on the patient's insurance card.

PCMH 2A1

4. Patients can change their PCP at any time by consulting with the Billing Representative for assistance or by accessing Website of your Insurance Plan.

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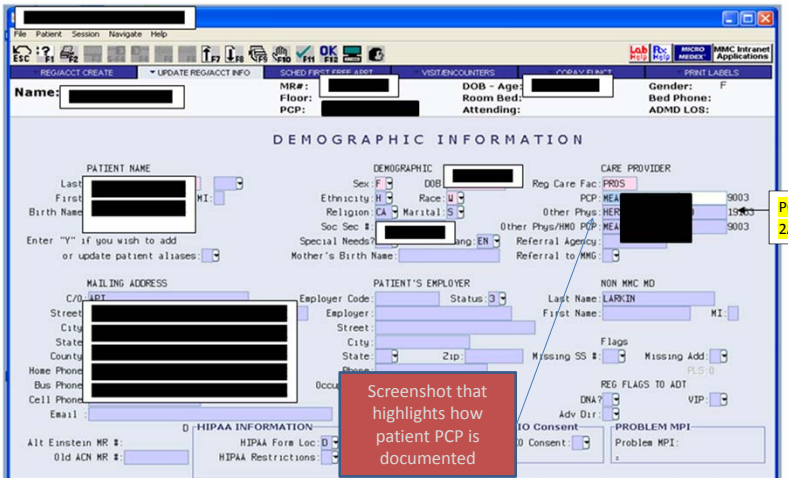
Part A: Documenting PCP/Team



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Part A: Monitoring Continuity

Visits with PCP Report
October 1st 2014- October 31st 2014

Provider	Not PCP	PCP Visit	Total	Percent of visits with PCP
Pa	12	237	249	95%
M	3	54	57	95%
W	38	289	327	88%
Ka	12	62	74	84%
Tr	19	60	79	76%
Ba	39	103	142	73%
Pe	5	11	16	69%
Ak	70	153	223	69%
Le	7	7	14	50%
Ha	5	4	9	44%
Bh	23	18	41	44%
Ng	41	28	69	41%
Ar	29	17	46	37%
Su	47	12	59	20%
Ku	203	21	224	9%

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2. Actions Items to Reach Goals

Part B: Develop materials educate patients on their patient centered services

PCMH 2B Factors 1-4

[redacted] *Internal Medicine Division*

[redacted]

Inpatient and outpatient services, from adult primary care aimed at wellness, prevention and health maintenance, to highly sophisticated subspecialty care. Lead by a cadre of highly qualified and experienced Board-certified physicians, the Internal Medicine services at Wyckoff include not only high quality medical care, but also medical student training, post graduate medical education and research.

For more information about our programs, contact or arrange an appointment to our Primary Care Medical Clinic or any of our subspecialty services, call [redacted]

DID YOU KNOW ...

When scheduling an appointment at our Medicine Clinic you will be given an appointment with your PCP to maintain continuity of your care.

If you prefer to see some one else just lets us know and we will help you arrange care with another primary care provider.

Our Medicine Clinic is staffed with Attending Physicians along with medical resident physicians (Care Teams) You will be given the name of the providers on your care team when you schedule an appointment with us.

[redacted] Medicine Clinic: Your Patient Centered Medical Home

Internal Medicine Division:

Allergy/ Immunology
Cardiology
Dermatology
Endocrinology
Gastroenterology
Geriatrics / Gerontology
Hematology
HIV
Infectious Diseases
Nephrology
Neurology / Designated Stroke Center
Medical Oncology
Physical Medicine & Rehab
Pulmonary Medicine

[redacted] Medical Clinic is your partner in care so during relevant visits we will ask you if there is a change in your medical history or you've been treated by another provider. We are happy that you have entrusted us with your health care needs.

How to reach us...

Same day/ walk in & scheduled appointments available during our clinic hours:

Monday	9-4:00 PM
Tuesday	8:30-6 PM
Wednesday	9-4:00 PM
Thursday	1-4:00 PM
Friday	9-4:00 PM

When the office is closed you can call us at 7[redacted] We will connect you with a provider to get your concerns addressed.

Patient Centered Support for Screenings, Exams and Referrals

[redacted] will help you stay on track of all of your medical screenings, exams, immunizations and your scheduled appointments. We will assess your progress towards your medical goals and provide you with the most current evidence based care and self-management support so you feel confident about managing your health at home. If you need a referral to a specialty provider we will help coordinate your care across multiple settings.

We will help you coordinate all of your medical needs!

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2. Actions Items to Reach Goals

Part B: Establish process to educate patients on patient centered services

Memorandum

To: [redacted] Staff

From: [redacted]

Date: 8/02/13

Re: [redacted] PCMH Outpatient Clinic Brochures

The [redacted] Center has a new PCMH/Outpatient clinic brochure highlighting how our Medical clinic provides patient centered services to our community.

All staff shall read the brochure and help our patients understand what to expect in a patient centered medical

The pamphlets will be posted throughout the clinic and mandatorily distributed at registration for all new patients.

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2. Actions Items to Reach Goals

Part C: Sample Interpretation Policy

PURPOSE: In respect for the dignity of every person, Our Town Medical provides interpretation services to non- or limited-English speaking persons to afford such persons an equal opportunity to benefit from the services provided in the clinic and to assure safety and quality in their care.

POLICY:

Our Town ensures that persons with limited English proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of Our Town is to ensure meaningful communication with LEP patients and their authorized representatives regarding their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to: waivers of rights, consent to treatment forms, financial and insurance benefit forms, health information, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the use of an interpreter.

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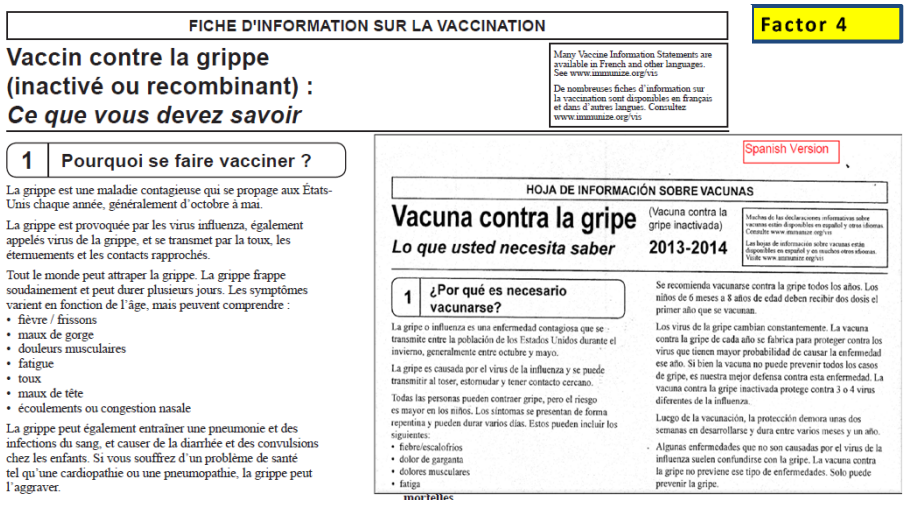
2. Actions Items to Reach Goals

Part C: Materials in Languages other than English

Factor 4



FICHE D'INFORMATION SUR LA VACCINATION

Vaccin contre la grippe (inactivé ou recombinant) :
Ce que vous devez savoir

Many Vaccine Information Statements are available in French and other languages. See www.immunize.org/vis

De nombreuses fiches d'information sur la vaccination sont disponibles en français et dans d'autres langues. Consultez www.immunize.org/vis

1 Pourquoi se faire vacciner ?

La grippe est une maladie contagieuse qui se propage aux États-Unis chaque année, généralement d'octobre à mai.

La grippe est provoquée par les virus influenza, également appelés virus de la grippe, et se transmet par la toux, les éternuements et les contacts rapprochés.

Tout le monde peut attraper la grippe. La grippe frappe soudainement et peut durer plusieurs jours. Les symptômes varient en fonction de l'âge, mais peuvent comprendre :

- fièvre / frissons
- maux de gorge
- douleurs musculaires
- fatigue
- toux
- maux de tête
- écoulements ou congestion nasale

La grippe peut également entraîner une pneumonie et des infections du sang, et causer de la diarrhée et des convulsions chez les enfants. Si vous souffrez d'un problème de santé tel qu'une cardiopathie ou une pneumopathie, la grippe peut l'aggraver.

Spanish Version

HOJA DE INFORMACIÓN SOBRE VACUNAS

Vacuna contra la grippe (Vacuna contra la gripe inactivada)
Lo que usted necesita saber **2013-2014**

Muchas de las declaraciones informativas sobre vacunas están disponibles en español y otros idiomas. Consulte www.immunize.org/vis

Las hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 ¿Por qué es necesario vacunarse?

La gripe o influenza es una enfermedad contagiosa que se transmite entre la población de los Estados Unidos durante el invierno, generalmente entre octubre y mayo.

La gripe es causada por el virus de la influenza y se puede transmitir al toser, estornudar y tener contacto cercano.

Todas las personas pueden contraer gripe, pero el riesgo es mayor en los niños. Los síntomas se presentan de forma repentina y pueden durar varios días. Estos pueden incluir los siguientes:

- fiebre/escalofríos
- dolor de garganta
- dolores musculares
- fatiga

mortales

Se recomienda vacunarse contra la gripe todos los años. Los niños de 6 meses a 8 años de edad deben recibir dos dosis el primer año que se vacunan.

Los virus de la gripe cambian constantemente. La vacuna contra la gripe de cada año se fabrica para proteger contra los virus que tienen mayor probabilidad de causar la enfermedad ese año. Si bien la vacuna no puede prevenir todos los casos de gripe, es nuestra mejor defensa contra esta enfermedad. La vacuna contra la gripe inactivada protege contra 3 o 4 virus diferentes de la influenza.

Luego de la vacunación, la protección demora unas dos semanas en desarrollarse y dura entre varios meses y un año.

Algunas enfermedades que no son causadas por el virus de la influenza suelen confundirse con la gripe. La vacuna contra la gripe no previene ese tipo de enfermedades. Solo puede prevenir la gripe.

2. Actions Items to Reach Goals

Part D: Team-Based Care

Team-based health care *is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.*

Institute of Medicine, Core Principles & Values of Effective Team-Based Health Care, 2012

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Principles of Team-Based Care

2) Clear roles

- There are clear expectations for each team member's functions, responsibilities, and accountabilities
- This makes the team more efficient and often make it possible for the team to take advantage of the division of labor, thereby
  - Can accomplish more than the sum of its parts

- Time, space, and support for team education and training, including opportunities to practice the skills and hone the values that support teamwork.
- Facilitate communication among team members regarding their roles and responsibilities.

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Establish clear roles

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Defining Team Member Roles

Task/Activity →

Team Role ↓

	# 1 -PCMH Team Huddles	#2 - Depression Screening Adolescents and Adults	#3 Preventive Care Reminders	# 4 Chronic Care Reminders
Provider	Lead Daily Medical Home Team Huddles	For patients who respond positively to Depression Screening tool, PHQ-2 conducted by the LPN/AOAII,conduct further Depression Screening using tool PHQ-9 in EPIC. Based on results of PHQ-9 provide appropriate intervention/referral which	Provider, look in EPIC for pended orders to complete overdue preventive care. Review and approve as appropriate.	Provider, look in EPIC for pe complete overdue care for conditions. Review and ap
RN	Participate in Daily Work Team Huddles	Provide patient with follow-up phone [illegible] as requested by provider. Document phone call in EPIC.	Work with high risk patients referred by provider to aid compliance, improve outcomes	Work with high risk patient to aid compliance, improve
LPN	Participate in Daily Work Team Huddles	Include Screening for Depression during Patient Intake on specified patients 1x/yr. Provide patient with Mental Health Resource information as requested by provider and record in EPIC that resource was given.	Working from a list provided, once patient has arrived for visit and they are listed as being overdue for our one or more of our 3 specified preventive care measures, pend orders in EPIC for the provider to review and sign, for the overdue care. This activity requires no patient assessment.	Working from a list provide arrived for visit and they ar overdue for our one or mor chronic care measures, HgA orders in EPIC for the provid for the overdue care. This a patient assessment.
	# 1 -PCMH Team Huddles	#2 - Depression Screening Adolescents and Adults	#3 Preventive Care Reminders	# 4 Chronic Care Reminders
AOA II Clinical	Participate in Daily Work Team Huddles. Assigned AOA documents Huddle on PCMH Team Huddle Form. Retain forms in date order in 3 Ring Binder for NCQA audit and application submission.	Include Screening for Depression during Patient Intake on specified patients 1x/yr	Working from a list provided, once patient has arrived for visit and they are listed as being overdue for our one or more of our 3 specified preventive care measures, pend orders in EPIC for the provider to review and sign, for the overdue care. This activity requires no patient assessment.	Working from a list provide arrived for visit and they ar overdue for our one or mor chronic care measures, HgA orders in EPIC for the provid for the overdue care. This a patient assessment.
Lab or Rad Tech	Participate in Daily Work Team Huddles	Be aware patients being screened.	Carry out any orders for overdue lab work.	Carry out any orders for ove

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Principles of Team-Based Care

3) Effective communication

- The team prioritizes and continuously refines its communication skills.
- It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.

- Dedicated time and space for communication
- Ensure that team members are trained in shared communication expectations and techniques.

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Daily Huddle Standing Agenda

THE ENTIRE HUDDLE SHOULD TAKE NO MORE THAN 15 MINUTES. THE M
KEEPERS TO ENSURE WE DON'T RUN OVER.

I.	**Informal Head Count** (< 1 minute)	
	Confirm if significant participants are not present so they can be updated upon arrival	
II.	**Review staff and clinic coverage** (1-2 minutes)	
	Which team members are absent/working today	
	Identify/report any missing supplies (such as vaccines)	
III.	**Case Reviews** (approximately 10 minutes)	
	Which patients are being seen by someone other than their PCP/why?	
	Any unexpected appointments? Identify reason for visit (such as ER follow up, acute visits, etc.)	
	Who called overnight? Why? Will he/she be coming today?	
	Indicate complex cases and possible solutions (may be medically complex, behaviorally complex, use of interpreter/language link or other)	
	Identify patient-specific factors that might affect flow	

Daily Huddle Standing Agenda

THE ENTIRE HUDDLE SHOULD TAKE NO MORE THAN 15 MINUTES. THE MAs AT THE HUDDLE WILL BE TIME-KEEPERS TO ENSURE WE DON'T RUN OVER.

			Patients
I.	**Informal Head Count** (< 1 minute)		
	Confirm if significant participants are not present so they can be updated upon arrival [redacted]	TEAM	
II.	**Review staff and clinic coverage** (1-2 minutes)		
	Which team members are absent/working today [redacted]	TEAM	
	Identify/report any missing supplies (such as vaccines) none	MA	
III.	**Case Reviews** (approximately 10 minutes)		
	Which patients are being seen by someone other than their PCP/why? none	RN	
	Any unexpected appointments? Identify reason for visit (such as ER follow up, acute visits, etc.)	RN	
	Who called overnight? Why? Will he/she be coming today? [redacted] - Dr G. (Envision)	MA	
	Indicate complex cases and possible solutions (may be medically complex, behaviorally complex, use of interpreter/language link or other) none	TEAM	
	Identify patient-specific factors that might affect flow none	TEAM	
	Indicate who needs to see Case Management and Behavioral Medicine none	TEAM	
	Discuss adherence issues (medication, appointments, treatment plan) ✓	TEAM	
IV.	**Review overall schedule** (approximately 2 minutes)		
	Who has opening and when (same day and cancellations)	MA	

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Using Embedded Order Sets

PCMH 2D4 Example 1

Standing Orders for New HIV Patients aged <40

The following standing orders are imbedded in the EMR as an order set so that PCP providers and nurses can draw appropriate labs on HIV patients in advance of their appointment with the part-time HIV specialist employed by Heritage Health and Housing, Inc. Both sets of standing orders are found under order sets when you click on the treatment and then OS for order sets. The nurse or PCP is notified by the HIV care coordinator that the patient is due for these labs.

Primary care providers are instructed to order the following labs for patients greater than age 40 that are newly diagnosed with HIV.

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Written Standing Orders

PCMH 2D4, Example 2

PCMH2D4: Standing orders at the practice for preapproved testing protocols

OUR TOWN MEDICAL

Standing Orders

These standing orders are approved by the medical director and providers of Our Town Medical Appropriate staff Medical Assistants (MA's), and/or, Licensed Practical Nurses (LPN's) and/or Registered Nurses (RN's) who have been appropriately trained with documented competencies may initiate these orders.

Urine Analysis

PCMH 2D4: Standing orders for preapproved urine analysis for pregnant women and patients with the listed symptoms

Appropriate Staff: MA's, LPN's and RN's

Order: Pregnant women

Appropriate staff is authorized to obtain a routine UA on all pregnant women

Order: All patients

Appropriate staff is authorized to obtain a UA on patients with the following:

Patient presents with one or more of following symptoms:

- Pain or burning with urination
- Frequent or urgent need to urinate
- Cloudy urine
- Blood in the urine
- Foul or strong urine odor
- Need to urinate at night

Patient may also complain of:

- Pressure in lower pelvis
- Fever
- Chills
- Lower back or flank pain

Documentation: Appropriate staff will indicate on the encounter the UA was performed

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Principles of Team-Based Care

2) Mutual trust: Team members earn each others' trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

- Create opportunities for team members to get to know each other on a personal level.
- Embed the personal values that support high-functioning team-based care into training and hiring processes
  - "Hire for attitude, train for skill."
- Develop resources and skills among team members for effective communication, including conflict resolution

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Principles of Team-Based Care

4) Shared goals: The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.

- Provide time, space, and support for information exchange between team members
- Create and maintain a written plan of care that is accessible and updatable by all team members.

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PCMH 1G Factor 4 &6 Managed Care

10/2013- Training [redacted] - Demystifying Managed Care – highlights both population management and care coordination.

Demystifying Managed Care

[redacted]

Role of States in Monitoring Performance

- Monitor MCO performance in meeting CMS program standards and requirements:
  - Monitoring population management and special needs; access and availability of services
  - Ongoing reporting requirements
  - Quality management oversight
  - Annual review process
  - External quality monitoring

Agenda

- Community Care introduction
- About Community Care
  - Goals and objectives
- MCO critical functions
- Innovation highlights
- Current Planning in New York
- Clinical Home Models for Adults and Children

Role of MCO's

- Provide general managed care operations on behalf of the state
- Provide clinical oversight and leadership of care management activities
- Ensure quality care to those with complex needs
- Enhance the efficacy of the clinical service system

Establish shared goals via Group Trainings

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Providing Correct Documentation

BE A REVIEWER:
What do you think?

How to Deal with Rude/Angry Patients

- Try your best to avoid getting angry with patients that are already angry/dissatisfied.
- Do not let angry patients taint your idea of the office. Do not accept their assumption that the practice is inefficient because of their one unhappy experience.
- Continue apologizing for the inconvenience.
- Call the patient later that day, or the following business day if you have sorted out their problems. By this time, they may cool off and will apologize to you.
- Do not take personal offense to people's rudeness. We do not know what their situation is or why they are angry.
- Do not deliberately act cold or rude to someone even if they have been rude to you in the past.
- Always keep cool, professional and polite. Stay detached but also show the patient you care about their situation. Reiterate to them that you are trying to help them in every way you can.
- Always make eye contact and make an effort to look interested in their problems.

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Our Town Medical Center | 2013

Name of Agency: Our Town Medical Center
Purpose of Meeting: Monthly Continuous Quality Improvement Meeting
Date/Time: August 7, 2013 - Start Time: 8:30 AM End Time: 9:15 AM
Chair: R. Moore, MD
Attendance: Kimmie M., Deborah J., Maria K., Maia B.
Absent: Karla S., Alan S., Dane D.

All staff including members of the care team.

Topic	Discussion/Action	Person Responsible
1. **Call to Order:** called to order the CQI meeting of Our Town on August 7, 2013, in the waiting room area.		R. Moore, MD
2. **Purpose of Today's meeting**	It was discussed why the CQI meeting has now made a clinic wide meeting so that all staff would be included and that we would be discussing physician dashboard for meaningful, PCMH, and incident reporting/medical errors	R. Moore, MD
2. **UDS Data**	Reviewed UDS 2011-2012 Data Today's focus was on current status and goals for the practice around each measure. Areas for improvement were prioritized and interventions were agreed on. Areas for improvement are: Immunization, 0-2 yrs (Number of children who have received required vaccines who had their 2nd birthday during measurement year (on or prior to 31 December) 2012 = 81.04%	R. Moore, MD 6E2: UDS data across the practice

PCMH 2D 8 &9, 6E 1 & 2– Our Town holds a monthly meeting with all staff including all members of the interdisciplinary care team. During these meetings, communication includes technological, clinical, and quality improvement updates. Additionally, performance data is shared by clinician and across the practice. Specifically, the practice considers provider specific Meaningful Use data and practice specific UDS data.

Involvement of Care Team in QI activities

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Contact:
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www.pcdc.org