

Vice President, Clinical Services,

The Compliance Team





Population Health Series Turbo Charge Your Patient Engagement: Six Easy Steps to PCMH

Learning Outcomes

When you have completed this course, you should be able to:

- Provide a deeper understanding of the team-based approach for successful implementation
- Position your practice as Provider of Choice for the primary and secondary markets
- Integrate processes that enable improved patient and employee satisfaction
- Identify methods to support revenue growth
- Create a robust practice that improves the overall patient-provider relationship





The PCMH Model

- Patient-Centered Care
 - Coordinated Care
 - Accessible Services
 - Quality and Safety





- Puts patients first
- Make primary care more accessible
- Improves patient outcomes
- Improves staff satisfaction
- Improves patient satisfaction
- Mitigates health disparities





- With greater access, patients seek healthcare services earlier in their illness
- Patients spend less un-budgeted time and money when treated early in an illness
- Even short-term illness greatly impacts the financial circumstances of rural American families





With increased access, patient caregivers are also less impacted.

Consider the time and financial impact of the caregivers of pediatric, disabled, and elderly patients.











- Every \$1.00 increase in Primary care spending equals \$13.00 in savings
- This study provides another piece of evidence supporting the hypothesis that PCMH can lead to lower cost of care.
- Nevertheless, this study shows a consistent pattern, suggesting a robust cost saving across all the cost categories. Study shows the PCMH impact on each of the three main components of the total cost: acute inpatient, outpatient, and professional costs. (Geisinger Study)
- Primary care is a great investment for a high-performing health care system. Research demonstrates that greater use of primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality. (Milbank Memorial Fund)





PCMH Defined

Improving "the quality, effectiveness, and efficiency of the care" practices "deliver while responding to each patient's unique needs and preferences".







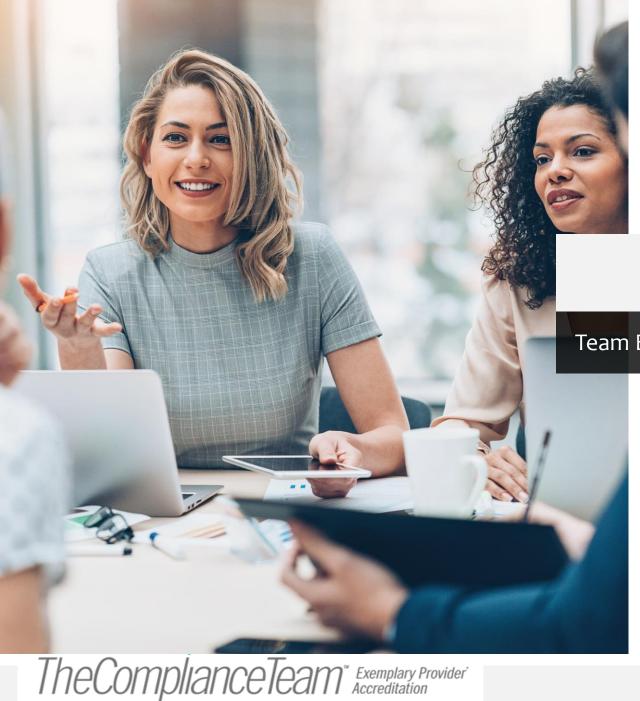
The PCMH ACTION Model











Align

Team Based / Comprehensive Care

- Team can be provider, a nurse, and a MA or any combination
- Written work-flow for team members
- Comprehensive Care Coordination
 - Follow up on labs/diagnostics
 - Communicates routinely
 - Facilitates care between providers
- Huddles











We Assess Our Community Resources:



Community Resources should be used to engage with the patient population (Service area)

- ☐ Church programs
- ☐ Health services
 - ☐ Home Health/Hospice
 - ☐ Therapy
 - ☐ Behavior health
- Volunteers
- ☐ Meals/Food Resources
- ☐ Organizations (Lions, Rotary etc.)
- ☐ Care takers/home makers/housekeeping
- ☐ Social services









Chronic Care Management/Care Management

Coordinated / Patient-Centered

- Care Coordinator
 - RN, LPN, MA depending on state/practice
 - Dedicated responsibilities, no saturation of 'other duties"
- Disease Management
- Care plans
- Self-Management Resources



Understanding
CHRONIC CARE
MANAGMENT

CARE COORDINATOR: ROLES AND REQUIREMENTS

Standard Daily CCM Job Duties

- Enroll patients complete paperwork
- Call patients at home per schedule
- Take/return pt. calls (24/7 access)
- Provide for identified needs (refills, etc.)
- Set up pt. in portals activate feeds
- Review pt. results data answers
- Review after hours call logs f/u
- Update/consult with PCP
- Educate or f/u with pt. based on info review or care transitions
- Attend huddles/team meetings
- Speak with inpatient/hosp. staff
- Review ADT/visit logs
- Share CCD/pt. info healthcare settings
- Set up services/equipment for needs
- Update tracking/EHR/care plan/etc.
- Notify billing to bill CCM claims
- Organize all aspects of <u>CCM</u> program



The CCM Care Coordinator

Key points:

- General supervision
- Clinical staff member required
 - 20 minutes of activities
 - Care plan development
 - Patient medical instruction
 - Medical care items

Non-clinical Staff:

- Member of the care team (CHW)
- Perform non-clinical activities
 - Paperwork
 - Organization of services
 - Transfer of information
 - Other non-medical care items

AMA defines clinical staff as: "A person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service."

The CCM Care Coordinator

- Finding out
- "What Matter Most to the Patient" is KEY.

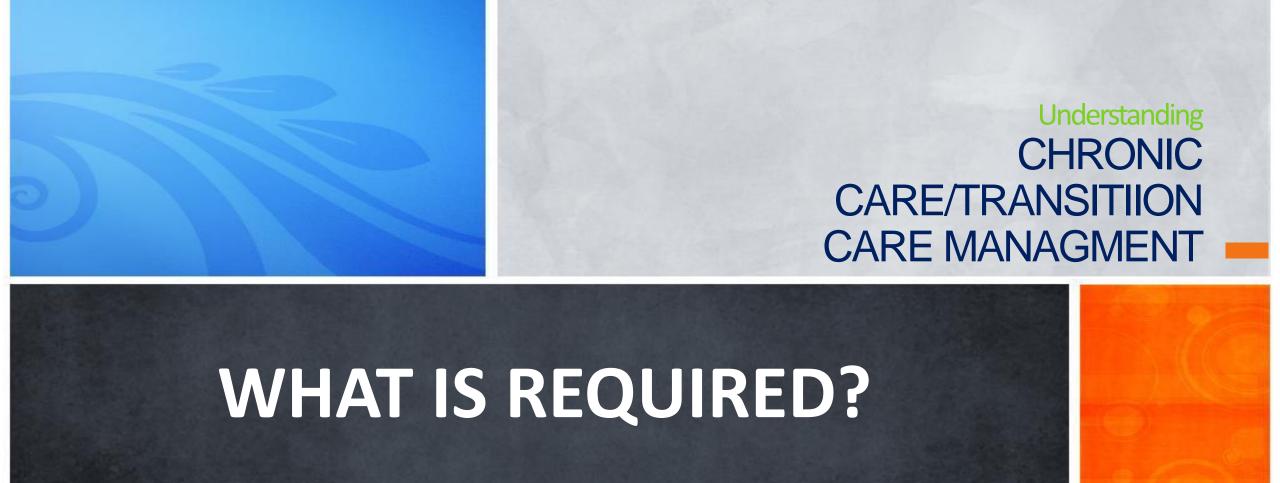




Patient would like to....
But is unable to do this due to...

- Walk a flight of stairs
- Play on the floor with grandchildren
- Drive a car





Requirement: ENHANCED COMMUNICATION POSSIBILITIES

CMS Expectation:

CCM patient will have ability to communicate with care team/Provider in an enhanced manner, and not just by telephone.





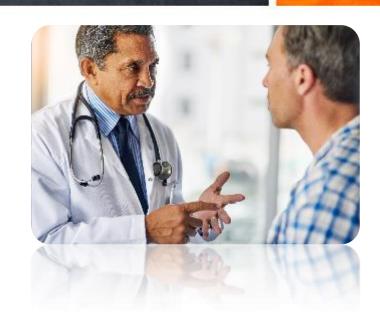
Simple Interpretation (2 parts):

- 1. CCM patient can communicate with care team & Provider by telephone
- **2**. CCM patient can also communicate via one of the following options:
 - Secure Email
 - Patient Portal
 - Secure Texting
 - Other Electronic Program w/messaging

Requirement: SUCCESSIVE ROUTINE APPOINTMENTS

CMS Expectation:

CCM patient will be ensured continuity of care with a designated member of the care team, with whom the patient will have timely access and be able to schedule successive routine appointments





- Key Word = Routine (not urgent needs)
- Patient assigned a Primary Care Provider (PCP)
- Patient scheduled with that same assigned PCP for all current/future <u>routine</u> appointments
- Care team makes sure patient has access to assigned PCP for all routine needs – and within a suitable time frame

Requirement: CERTIFIED ELECTRONIC HEALTH RECORD

CMS Expectation:

CCM program utilizes or has access to utilize a CMS certified EHR that meets current CMS standards as of December 31st the prior year, for the purpose of recording CMS required patient information





- The use of an EHR is required
- But only required to do the following inside EHR:
 - Record patient demographics problem list medication list allergy list
 - Retain <u>copies</u> of pt. Care Plans
- Current service year (1/1/17 present):
 - Follow latest CMS standard that was in place as of the date 12/31/16
 - Standards created 1/1/17 or later will not apply until the following service year (1/1/18)

Requirement: PATIENT CENTERED CARE PLAN

CMS Expectation:

CCM team will be responsible for electronically creating a patient-centered comprehensive care plan for each CCM patient that contains specific information required per CMS regulation



- Final care plan copy created electronically (Not hand written)
- Care plan = collection of various papers (assessments, logs, worksheets, etc.)
- Patient Centered-Comprehensive means it should contain/address the following:
 - Physical, mental, cognitive, psychosocial, functional, & environmental <u>needs</u>
 - Problem list with symptom management interventions & treatment goals
 - Identify who is responsible for each intervention or treatment
 - Inventory of community resources/support available & already in place
 - Medications and medication management
 - Coordination of care transitions, referrals, outside services/agencies
- Available to others outside practice (Printed copy, electronic access, secure email)

Requirement: PATIENT 24/7 ACCESSTO CARE

CMS Expectation:

CCM patient will have the ability to access qualified healthcare professionals 24 hours a day/7 days a week to address their urgent needs – healthcare professional from patient's practice setting available for consultation when necessary





- Practice setting has process to allow patient's to contact healthcare professionals regardless of the time or day or the day of the week
- Pertains to urgent patient needs only non urgent needs addressed per usual process during normal business hours
- Healthcare Professional from patient's practice is reachable to discuss patient's urgent need and provide insight into patient's current plan of treatment – when necessary

Requirement: PROCESS FORTRANSITIONS IN CARE

CMS Expectation:

Practice setting will manage all patient care transitions (Hospitalization, ER, referrals, domicile change, etc.), and during transitions will share CCD/pertinent patient information with all healthcare providers involved in patient's care in a timely manner





- Goal = promote communication & collaboration between healthcare providers/settings
- Care team follows pt. through care transition process to make sure all patient needs met
- Pt. information shared with each healthcare setting:
 - CCD = Continuity of Care Document (demographics, med list, problem list, allergies, care plan or plan of care summary)
 - Timely = reasonable for optimal treatment of pt.

Requirement: 20 MINUTES NON-FACE-TO-FACE

CMS Expectation:

Care Team will accumulate 20 minutes or more of non-face-to-face activities with each CCM enrolled patient per calendar month to be able to bill for CCM services that month





- CCM is billed once per calendar month:
 - Calendar month = 1st thru 30th/31st (Jan,Feb,...)
 - Bill once reach 20 min. of activities or more
- Appropriate activities & time to include can vary:
 - Time counts for staff time only not pt. time
 - Activities related to/address chronic conditions
 - Phone calls, data review, referrals, service set-up
 - Face-to-face time ok if not counted in billed visit
 - Can count any Care Team members time

TCM PROCESS

- 1) Patient admitted as inpatient to hospital
- 2) Patient discharged to home (day 1)
- 3) 2 business day follow up call to patient
 - Business day mirrors typical clinic hours of business
 - Performed by hospital or clinic staff
- 4) Face to face appointment (7 or 14 day) with Provider
- 5) Medication Reconciliation performed
 - On or before 7 or 14 day face to face visit
- 6) Follow patient for 30 day TCM window
- 7) Bill for TCM once 30 day window closed
 - Readmission restarts 30d window & can't bill 1st episode



Provider Who Performs Face to Face Must Have

"Established Relationship with Patient"







Team Based Care

Everyone trained in PCMH

Review of roles/responsibilities

Care Coordination

Huddles

Ongoing Learning

Workflow redesign





Training team members

- Staff Training
 - Communication skills
 - Motivational Interviewing
 - Active listening
 - Self-management training
 - Workflow redesign
 - The MacColl Center for Health Care Innovation (http://improvingprimarycare.org/)
 - The Cambridge Health Alliance
 (http://www.integration.samhsa.gov/workforce/teammembers/Cambridge_Health_Alliance_TeamBased_Care_Toolkit.pdf)
 AHRQ's TeamSTEPPS for Primary Care
 (http://www.ahrq.gov/professionals/education/curriculumtools/teamstepps/primarycare/)
 - The Safety Net Medical Home Initiative (http://www.safetynetmedicalhome.org/changeconcepts/continuous-team-based-healing-relationships)

- Patient Awareness/Engagement
 - PCMH model of care
 - Meet cultural preferences
 - Engaged in shared decision making
 - Invaluable partner in their care
 - Goal setting
 - Feedback/Surveys









Innovation

Workflow Redesign

Best Practices

New Models of Care Delivery

RHIhub PCMH Models

https://www.ruralhealthinfo.org/toolkits/care-coordination/2/patient-centered-medical-home-model

AHRQ www.pcmh.ahrq.gov



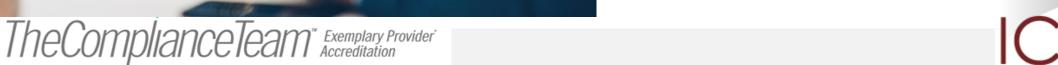




Obstacles

Change Management

Provider Engagement
Patient Engagement
Staff Engagement
Lean and Workflow





Lean Principles

Process and Customer

Process

- 1. Engage the <u>people</u> who work in the <u>process</u> to improve the process
- 2. Focus on creating value from the <u>customer's</u> perspective
- 3. Bring measurable and sustained improvement

Customers: WHAT are their requirements?

Customers judge value on:

- Speed How quickly do I receive it once I request it
- Accuracy The information is correct and responded to my request
- Understandable The information is easy to read and understand
- Convenience It is convenient for me to get it, I can get it when I want it (and not when you are willing to give it to me)





The Eight Forms of Waste

"DOWNTIME"



Work that contains errors, rework, mistakes, or lacks something that is necessary



Overproduction is to produce a product or service before the costumer wants it or to produce more than the customer ordered.



3. Waiting

Idle time created when material, information, people, or equipment is not ready. Waiting occurs when a person or machine must wait to do assigned work.





5. Transportation

Transportation waste occurs when materials, documents, supplies, etc. are unnecessarily moved from one location to another



6. Inventory

More supplies, material, or work on hand than is currently needed



7. Motion

Any unnecessary movement of a person that does not add value to the product or service is considered waste.



8. Excess Processing

Processing waste is any operation or process step that does not add value from the customer's view (or <u>over-processing</u> beyond the customer's specifications).









Numbers

Quality and Safety

Patient Outcomes
Employee Satisfaction
Patient Satisfaction



The Compliance Team Exemplary Provider Accreditation

Quality and Safety

Quality

- Improved preventive care
- Improved patient outcomes
- Reduced hospitalizations/readmissions
- Decreased ER utilization
- Improved communication

Safety

- Improved patient adherence
- Improved provider accessibility
- Stronger provider/patient relationships
- Personalized care
- Team approach





Clearly it's a journey, not a destination!













