The Transformational Journey as a Medical Home

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The Transformational Journey as a Medical Home

What I Will Talk About Today:

- Who we are
- Why we did this
- How we did this
- Where we are now
- Where we want to be

Medical Home Journey

Who We
Are

Department of Family and Community Medicine

Department of Family and Community Medicine

- **30 Faculty, 27 Residents, 6 Fellows, 5 NPs, 1 Social Worker (Integrated)**
- **Main Clinical/Teaching/Research on the Campus of TJU in Center City Philadelphia**
- **Geriatrics Division (off campus)**
- **Sports Medicine (on site)**
- **40% HMO, 27%Medicaid HMO, 12% PPO, 10% Medicare**

Department of Family and Community Medicine

- **All Socioeconomic, Ethnic, Gender and Age Groups plus special populations:**
  - **Homeless**
  - **Refugee**
  - **Gay/Lesbian/Transgender**
  - **University of the Arts/Pennsylvania Academy of Fine Arts/ Curtis School of Music**
  - **Philadelphia Phillies**

Department of Family and Community Medicine

- **80,000 patient visits, including outpatient procedures**
- **Active Inpatient Service at TJUH including 100+ deliveries**
- **Nursing Homes**
- **Other Community Activities**

Department of Family and Community Medicine

- **Great Leadership**
  - **Encouragement of and support for new ideas**
  - **Follow Through**
  - **Results Oriented**

- **Great Colleagues**
  - **Supportive**
  - **Critical Thinkers**
  - **Team Players**

- **Great Presence**
  - **Local, State, National Level**

Department of Family and Community Medicine

- **Mission: Excellence in**
  - **Clinical Care**
  - **Education**
  - **Research**

Medical Home Journey

Why We Did This

PCMH: Why We Did This

- **Clinical Care**
  - **HEDIS scores not the best in the area**
  - **Patient satisfaction not the best, either**
  - **Records a mess**
  - **Access an issue across the board**
- **Education**
  - **Teach Practice Management**
  - **Top Residency programs in the country**
    - **Challenges with continuity and numbers**
  - **Highest ranked Medical Student rotation**
    - **Challenges to show that we are not overworked**
- **Research**
  - **Needed to have an atmosphere to do this better**

Medical Home Journey

How We
Did This

PCMH: How We Did This

- **Strengths:**
  - **Innovative/First Adopter Department**
  - **Leadership**
  - **Collaborators**
  - **“Can Do” Attitude**
  - **Pride of Ownership**
  - **Luck**

PCMH: How We Did This

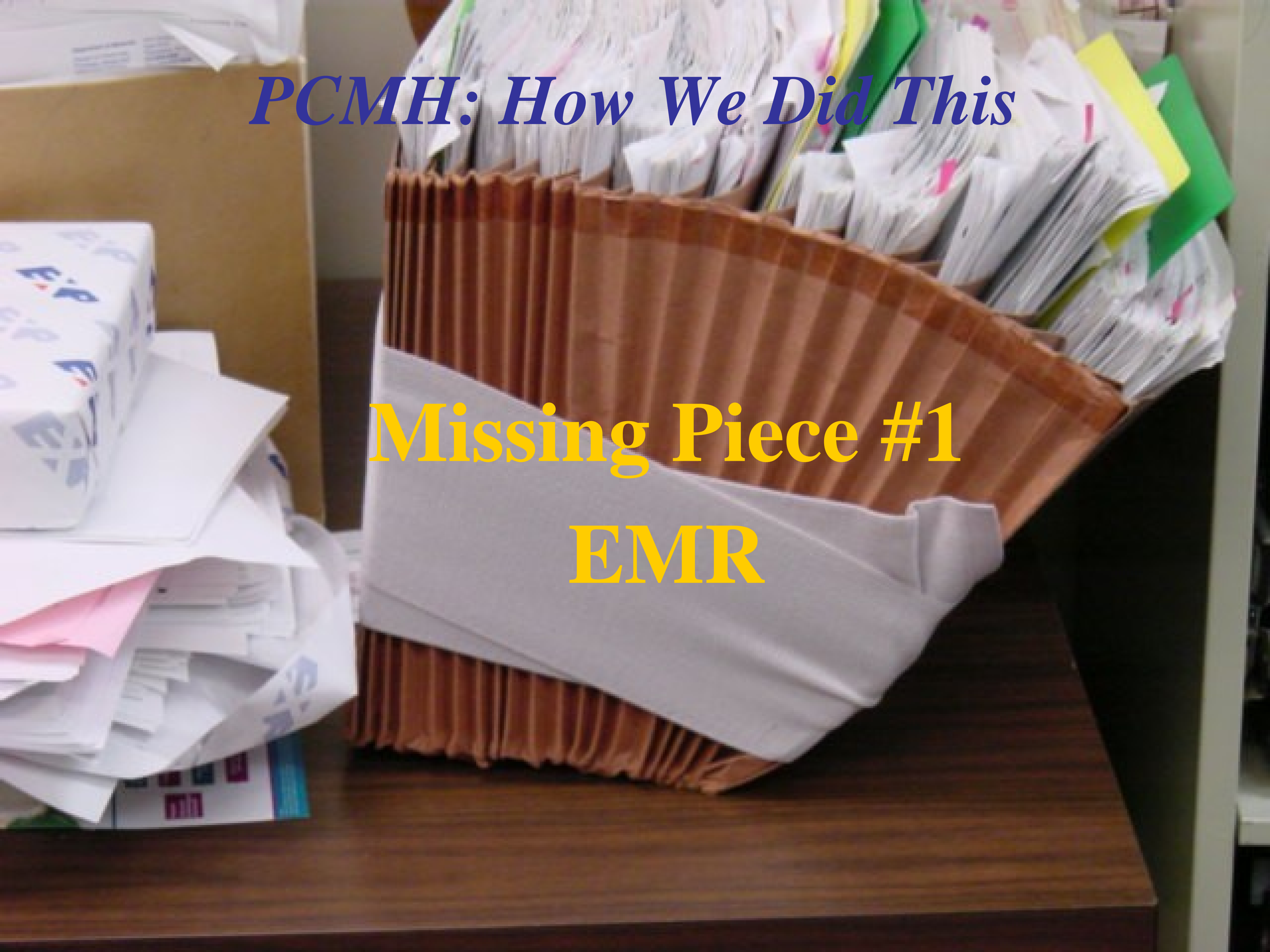
- **Started With Practice Improvement**
  - **Committees**
  - **Data**
  - **Culture Change**
  - **In-House Advice/Collaboration**
    - **Hypertension Improvement with Jefferson University Physicians Clinical Care Committee**
  - **Literature**

PCMH: How We Did This

- **Outside Advice from Thought Leaders**
  - **Institute for Healthcare Improvement**
    - **Open Access Scheduling**
      - **July, 2002**
      - **Became a National Model for Academic Family Medicine**
      - **Others came to us for advice**
      - **Exchanged Best Practices**
    - **Group Visits**
    - **Team Approach to Patient Care**
    - **But, still No Plan**

PCMH: How We Did This

- **Future of Family Medicine Project (2004)**
  - **Clinical 5-year Strategic Plan based on the "New Model of Care" (2005)**
    - **Building Blocks in Place**
    - **Two Critical Pieces Missing:**


PCMH: How We Did This
Missing Piece #1
EMR

PCMH: How We Did This

Missing Piece # 2

Money

PCMH: How We Did This

- **Medical Home Strategic Plan**
  - **EMR: We Got Involved**
    - **Promoted concept to TJU**
    - **Committee Service**
    - **Implementation Team Service**
    - **Alpha/Beta Site**

PCMH: How We Did This

- **Medical Home Strategic Plan**
  - **Money**
    - **TransforMed**
    - **Preparing Physicians For Practice (P4P)**
    - **Grants**
    - **Donations**
    - **Involvement and sharing ideas opens doors to other opportunities: Pennsylvania Chronic Care Initiative**

PCMH: How We Did This

- **Pennsylvania Chronic Care Initiative**
  - **Governor Edward Rendell Creates the Office of Health Care Reform in 2003**
    - **Insure All Pennsylvanians**
    - **Chronic Care Reform**

Pennsylvania Chronic Care Initiative

- **Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission (Commission) Created by Executive Order in 2007**

- **Richard Wender, MD and George Valko, MD serve on subcommittees (Steering and Practice Redesign)**

Pennsylvania Chronic Care Initiative

- **Why Chronic Disease Care?**
  - **Increasing Levels of Chronic Diseases**
  - **Associated Costs Out of Control**
  - **Not Well Cared For at a Primary Care Level**
  - **Pennsylvania One of the Worst States**

Pennsylvania Chronic Care Initiative

- **Why Reimbursement Redesign?**
  - **Patients with Primary Care Physicians (PCPs) have lower costs but PCPs are declining in numbers**
    - **Lower reimbursements compared to non-PCP peers**
    - **Low satisfaction**
    - **Failing to attract new graduates**

Pennsylvania Chronic Care Initiative

- **The Commission developed a Strategic Plan to improve the quality of care and reduce avoidable illnesses and their attendant costs**

- **The Strategic Plan is based on a model which is an integration of the Wagner Chronic Care Model and the Patient Centered Medical Home**

Pennsylvania Chronic Care Initiative

- **Evaluation of the program by the Commission will utilize standardized measure sets and performance goals for diabetes and asthma**
  - **These measures are based on national measures as defined by AQA/NQF and NCQA/HEDIS**
  - **Reviewed at the highest levels of the Government**

Pennsylvania Chronic Care Initiative

- **Incentives for the reimbursement redesign is based on the following:**
  - **Participation in the Learning Collaborative**
  - **Transform the practice by implementing the Chronic Care Model**
  - ***Achieve NCQA Level (1,2,or 3) Recognition within 1 year***

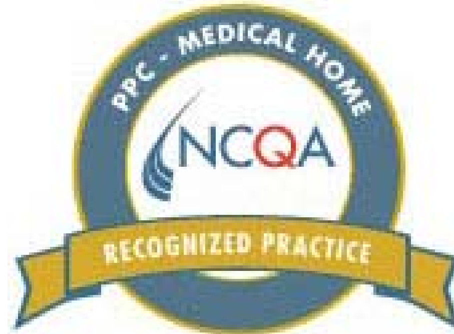
NCQA Recognition

- **NCQA along with the AAP, AAFP, ACP and AOA developed standards to assess if a practice is functioning as a medical home**

NCQA Recognition

- **PPC-PCMH Standards:**
  - **PPC1: Access and Communication**
  - **PPC2: Patient Tracking and Registry Functions**
  - **PPC3: Care Management**
  - **PPC4: Patient Self-Management and Support**
  - **PPC5: Electronic Prescribing**
  - **PPC6: Test Tracking**
  - **PPC7: Referral Tracking**
  - **PPC8: Performance Reporting and Improvement**
  - **PPC9: Advanced Electronic Communication**

NCQA Recognition



NCQA Recognition does not guarantee provision of quality care

That's the work of the Medical Home

Medical Home Journey

Where
We Are
Now

PCMH: Where We Are Now

- **TEAM**
  - **Victor Diaz, MD, Director of Quality Improvement, Assistant Med Director**
  - **Karen James, RN, Nurse Coordinator**
  - **Amy Lopez, Medical Assistant**
  - **Brooke Salzman, MD, Physician, Coordinator for resident curriculum in chronic disease**
  - **Amy Miller, Pharm.D**
  - **Mona Sarfaty, MD, Physician, Research Coordinator**
  - **Beth Frankhouser, Office Staff**
  - **Anthony Amoroso, Director of Operations**
  - **George Valko, MD, Medical Director**
  - **Ave Dougherty, RN, Nurse Coordinator**
  - **Anna Czerobski, Medical Assistant**
  - **Nancy Brisbon, MD, Physician**
  - **Gail Hoffman, RN, Nurse Coordinator**
  - **Janis Bonat, CRNP, Nurse Practitioner**
  - **Makady Rinn, Medical Assistant**
  - **Kathy Hilbert, RN, Quality Improvement Coordinator**

PCMH: Where We Are Now

- **Implementation of Joint Principles of the PCMH**
  - **Personal Physician**
  - **Physician Directed Medical Practice**
  - **Whole Person Orientation**
  - **Care is Coordinated and Integrated**
  - **Quality and Safety are Hallmarks**
  - **Enhanced Access**
  - **Payment**

Joint Principles PCMH

- **Personal Physician**
  - **Patients are strongly encouraged to choose a personal physician in the practice, and assigned one if they have not identified a physician**
  - **EMR easily identifies PCP (patient-centric EMR)**

Joint Principles PCMH

- **Physician Directed Medical Practice**
  - **Practice redesign: Physician-led clinical care teams were created within the larger practice to provide continuity of care not only with clinicians, but nurses and medical assistants as well.**
  - **Staff Relations Task Force: performed focus groups and designed strategies to improve communication between and among different professionals at JFMA**

Joint Principles PCMH

- **Whole Person Orientation**
  - **Integration of mental health services, smoking cessation programs, fitness programs, clinical pharmacist, and pain management program**
  - **Self-Management Support**
  - **Patient Satisfaction Task Force: focuses on improving the friendliness and hospitality of the practice**

Joint Principles PCMH

- **Care is coordinated/integrated**
  - **Integration of multiple health services at JFMA**
  - **Utilization of patient registries to track process and health outcomes, and facilitate care**
  - **Utilization of electronic health records and electronic prescribing to consolidate patient records and facilitate care**

Joint Principles PCMH

- Quality and Safety are Hallmarks
  - Quality Improvement Task force
  - Resident Quality Improvement in Chronic Disease Curriculum with HRSA
  - Utilization of patient registries to track quality of care relating to diabetes
  - Using insurance programs/registries to track data and design outreach
  - Cancer Screening Task Force: Coordinates tracking and outreach for cancer screening
  - Vaccine Task Force: Coordinates tracking and outreach for vaccinations

Joint Principles PCMH

- **Enhanced Access**
  - **Open Access Scheduling**
  - **Private, direct phone lines to schedule colon cancer screening for DFCM patients with GI and Colorectal**
  - **Group Visits**
  - **24/7 Phone Access**
  - **Encourage Use of Personal Voice Mail**

Joint Principles PCMH

- **Payment**
  - **Participation in the SEPA Chronic Care Learning Collaborative, which combines practice redesign with reimbursement redesign**
  - **DISH—utilization of group visit model to obtain payment for self-management support**
  - **Participation in multiple pay for performance programs with various insurers**

Medical Home Journey

Where
We Want
To Be

PCMH: Where We Want To Be

- **Spread Plan**
  - **Aim is to spread the implementation of the chronic care model to the remainder of the practice clinicians**
    - **Improve Quality Indicators**
    - **Include all chronic conditions**
    - **Include screenings and immunizations**
  - **Improvement plan for measures not at goal**

PCMH: Where We Want To Be

- **Future:**
  - **Meaningful Use**
    - **Well on the way with PCMH and EMR**
  - **Advanced/Proactive Patient Communication**
    - **Patient Portal**
    - **Patient Health Record**
    - **Social Media**
  - **Education**

Transformational Journey to a Patient-Centered Medical Home

What I Talked About Today:

What we wanted – to be the best

Took an Honest Look at Ourselves

Change Has to Happen – Manage Change

Learned from Others – but Adapted to Us

Leadership and Teamwork Carry the Day

Keep up with the Literature/Thought Leaders

Share Your Work With Others

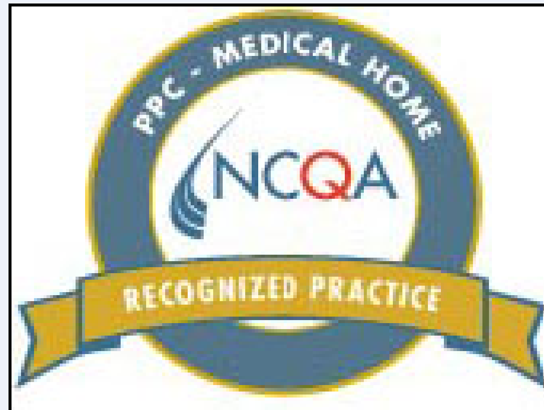
Be Alert for Opportunities

Constant Quality Improvement

Department of Family and Community Medicine

Jefferson Family Medicine Associates

Level 3



Questions?