Medical Home DIY! Self-Guided Practice Transformation

Jeff Halbstein-Harris, Patient/Advocate

Collette Carver, Sentara Healthcare

Suzanne Berman, Plateau Pediatrics

C.J. Peek, University of Minnesota

PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

Medical Home DIY! Self-Guided Practice Transformation

Description: Many tools and resources have been developed to assist primary care practitioners in leading their own quality improvement efforts.

This session will include a panel of **providers** and **experts** who will each describe how they acquired the necessary skills to lead their staff in transforming the practice into a **patient-centered** medical home (PCMH).

Patient-Centered Primary Care COLLABORATIVE

Defining the medical home

The medical home is an *approach* to primary care that is:

Patient-Centered
Supports patients in managing decisions and care plans.

Comprehensive
Whole-person care provided by a team

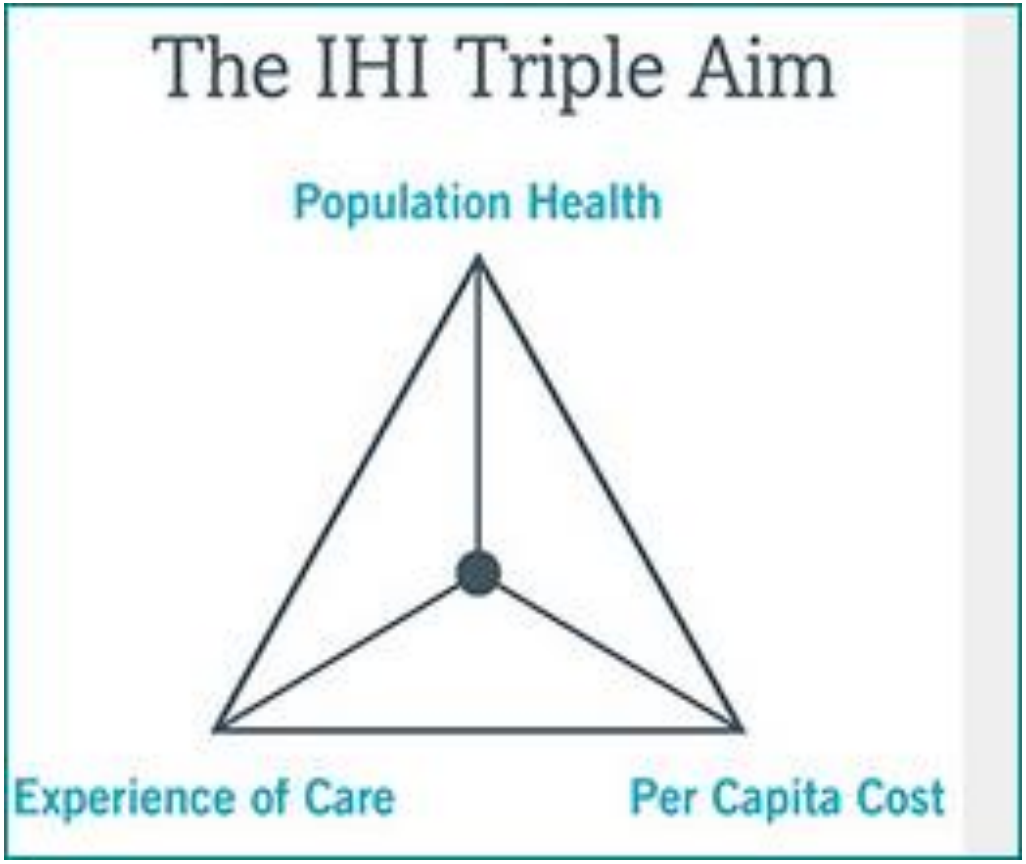
Coordinated
Care is organized across the 'medical neighborhood'

Committed to quality and safety
Maximizes use of health IT, decision support and other tools

Accessible
Care is delivered with short waiting times, 24/7 access and extended in-person hours.

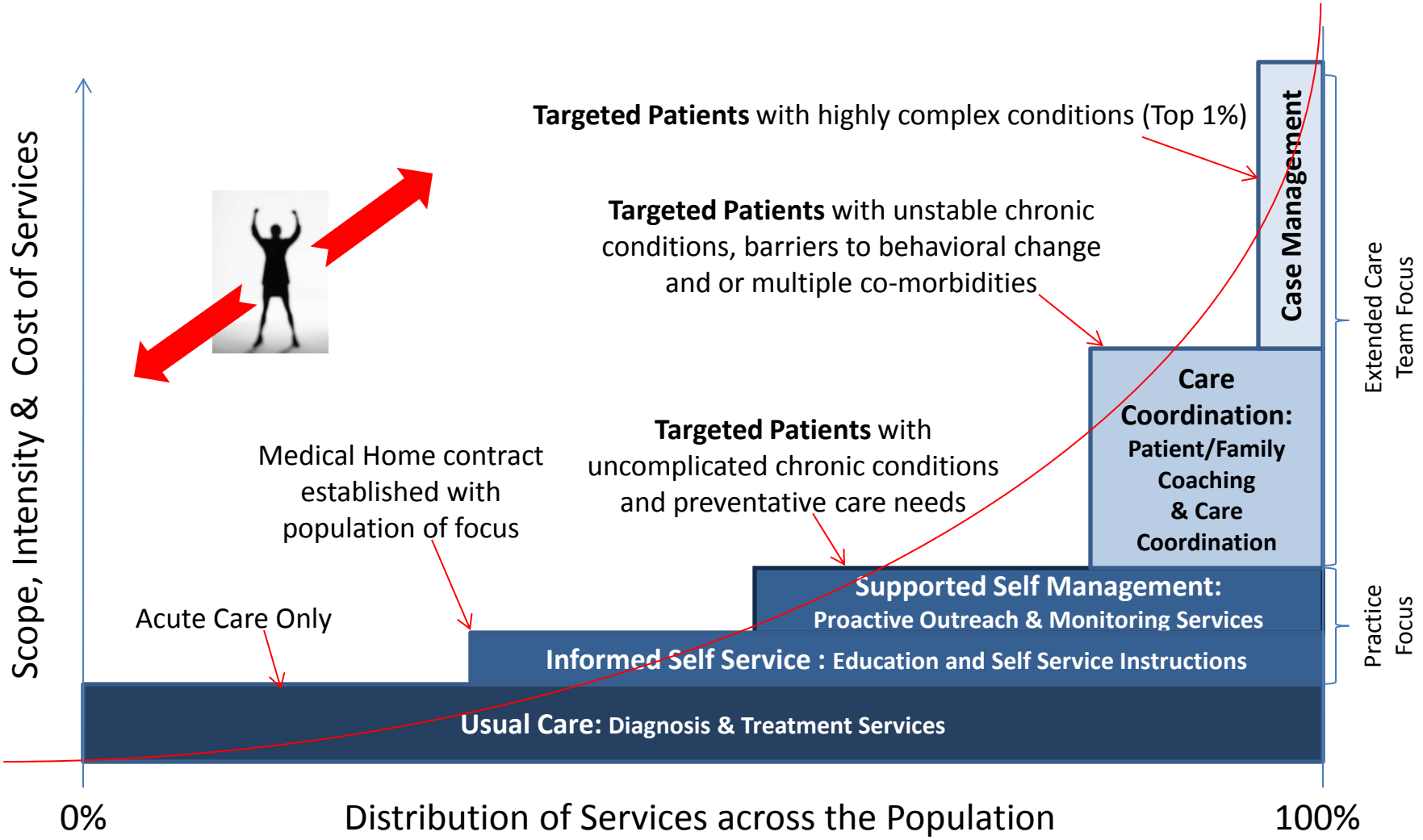
 Source: www.ahrq.gov

National demand for healthcare transformation.



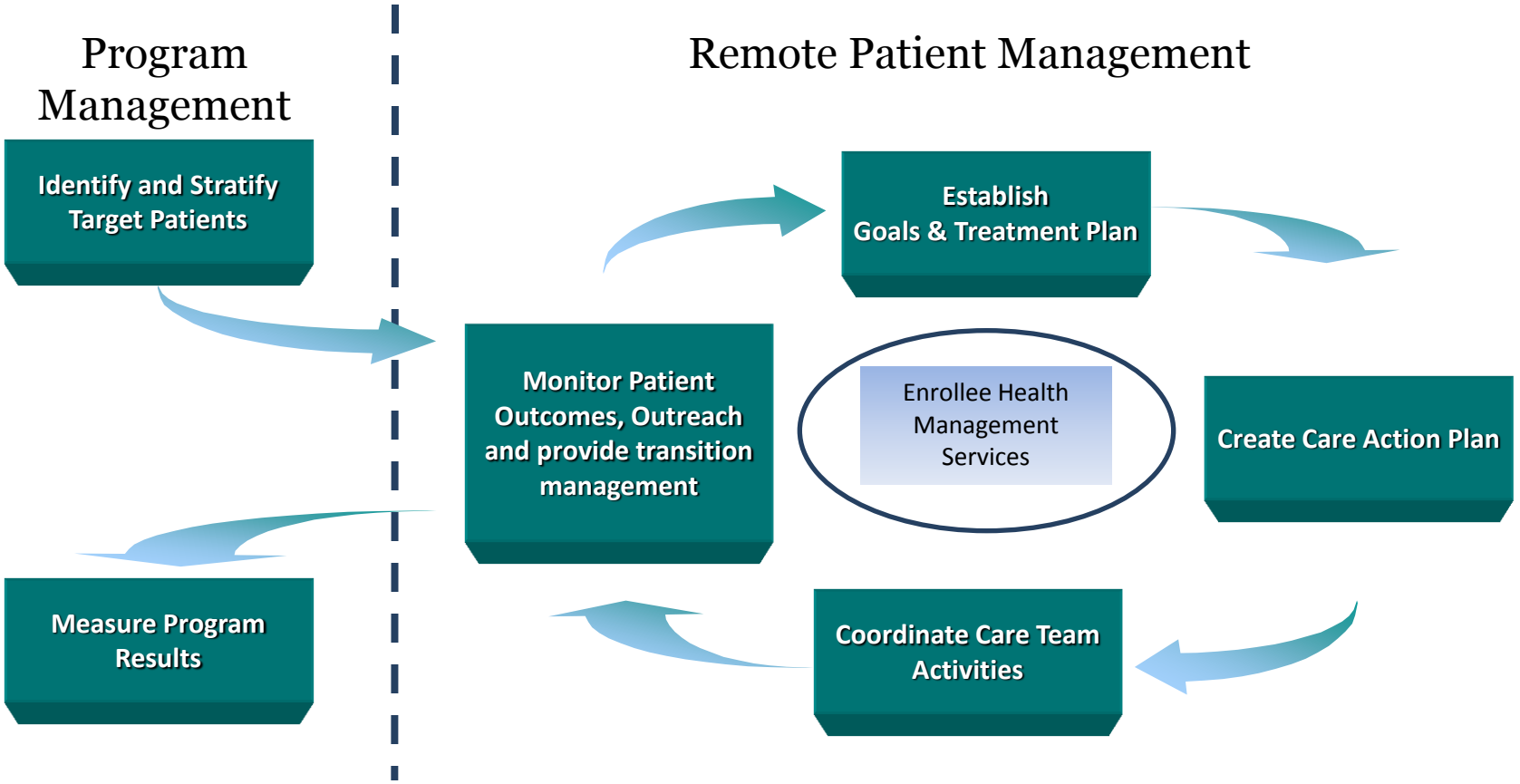
PCMH Population Stratification

Formerly within domain of payer, now within scope of care for PCMH



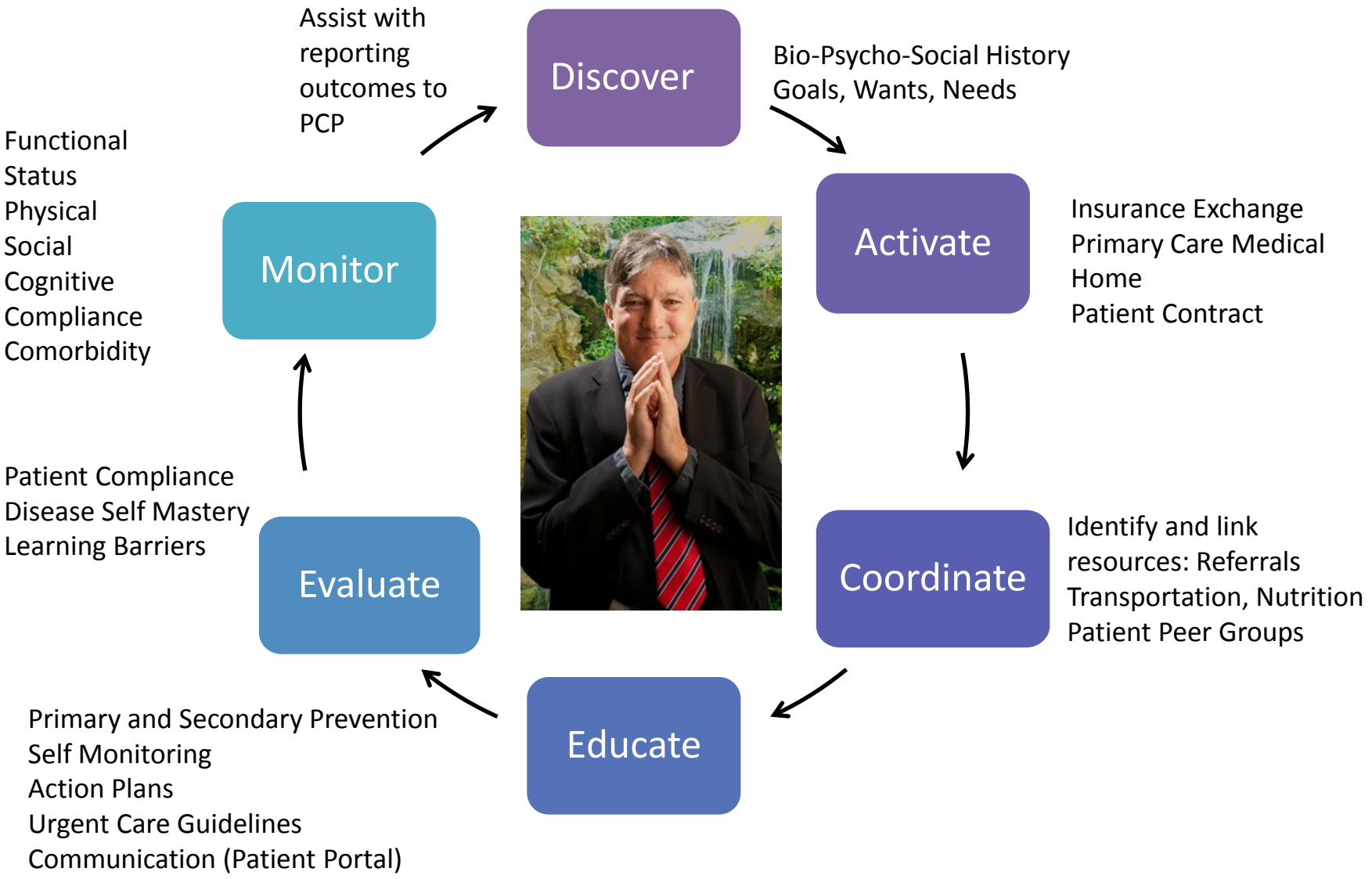
Population Management

A new practice skill set



Fully engaging our patients

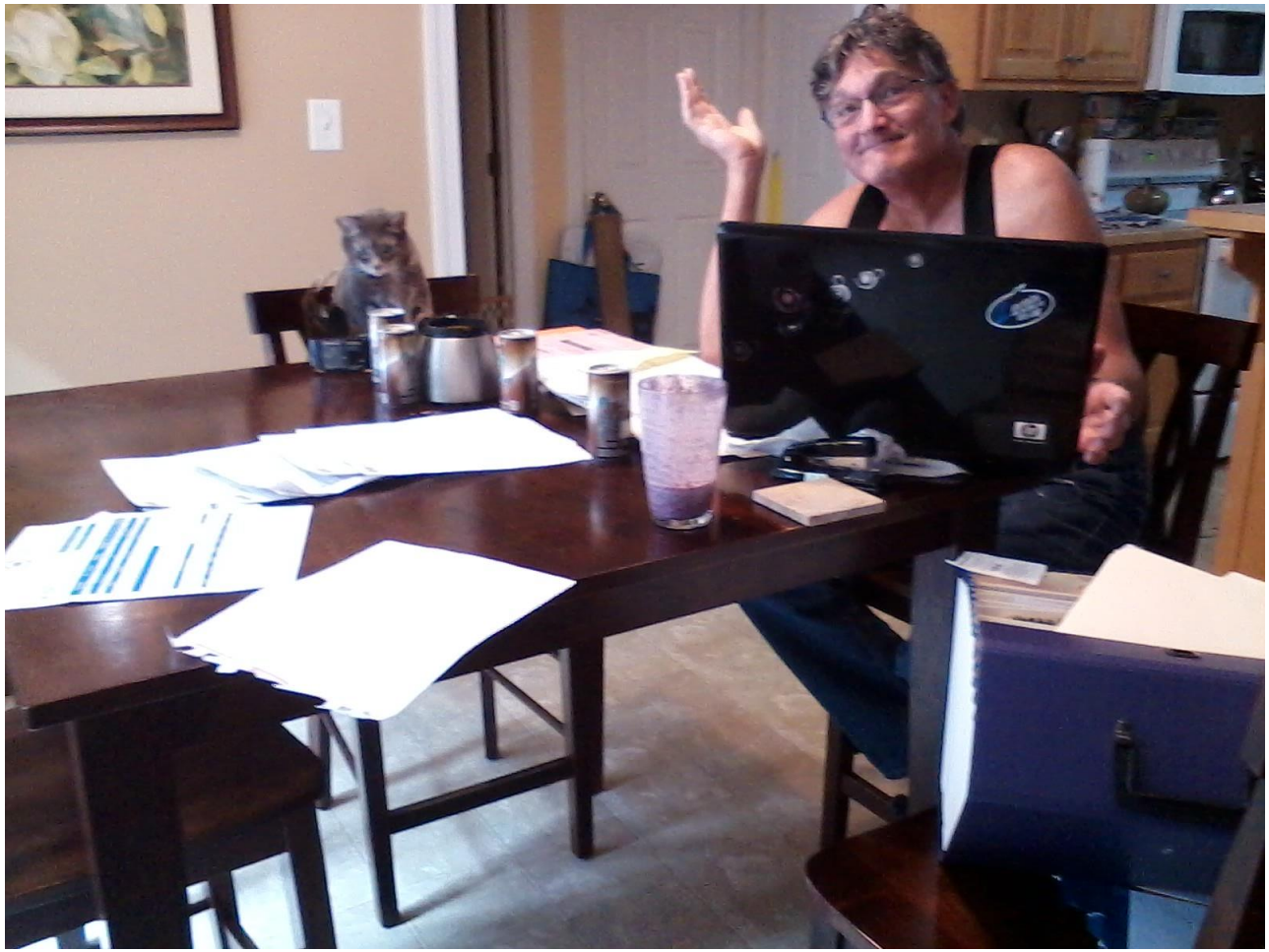
How much should we expect from the consumer?



A patient's perspective

- **Me:** 58 y/o male
- **5 physicians**
- **3 chronic conditions** (diabetes, Hepatitis C, RSD)
- Comorbidity's: Retinopathy, autonomic neuropathy
- Behavioral Health: PTSD, Chronic Depression
- Onset dates: Diabetes age 10, Hepatitis age 24, RSD age 55, retinopathy age 49, neuropathy age 55, PTSD age 33, chronic depression age 33.
- Meds = 7
- **Technology** includes CAGM
- **Functional status:** Retired SSDI due to RSD and autonomic neuropathy. Able to work at desk for periods up to 3 hours, able to drive for up to 3 hours
- **Social Status:** Married 20 years, no children.
- Education: BS Economics , AS Respiratory Therapy; RCVT, RPFT
- Former occupation: Director of High Risk Case Management; Director of Clinical Informatics Director of Cardio-Pulmonary Rehabilitation
- Recent Losses: Occupation and Avocational activity (Private Pilot)
- **Goals:** Control CD process and part time work in field of passion

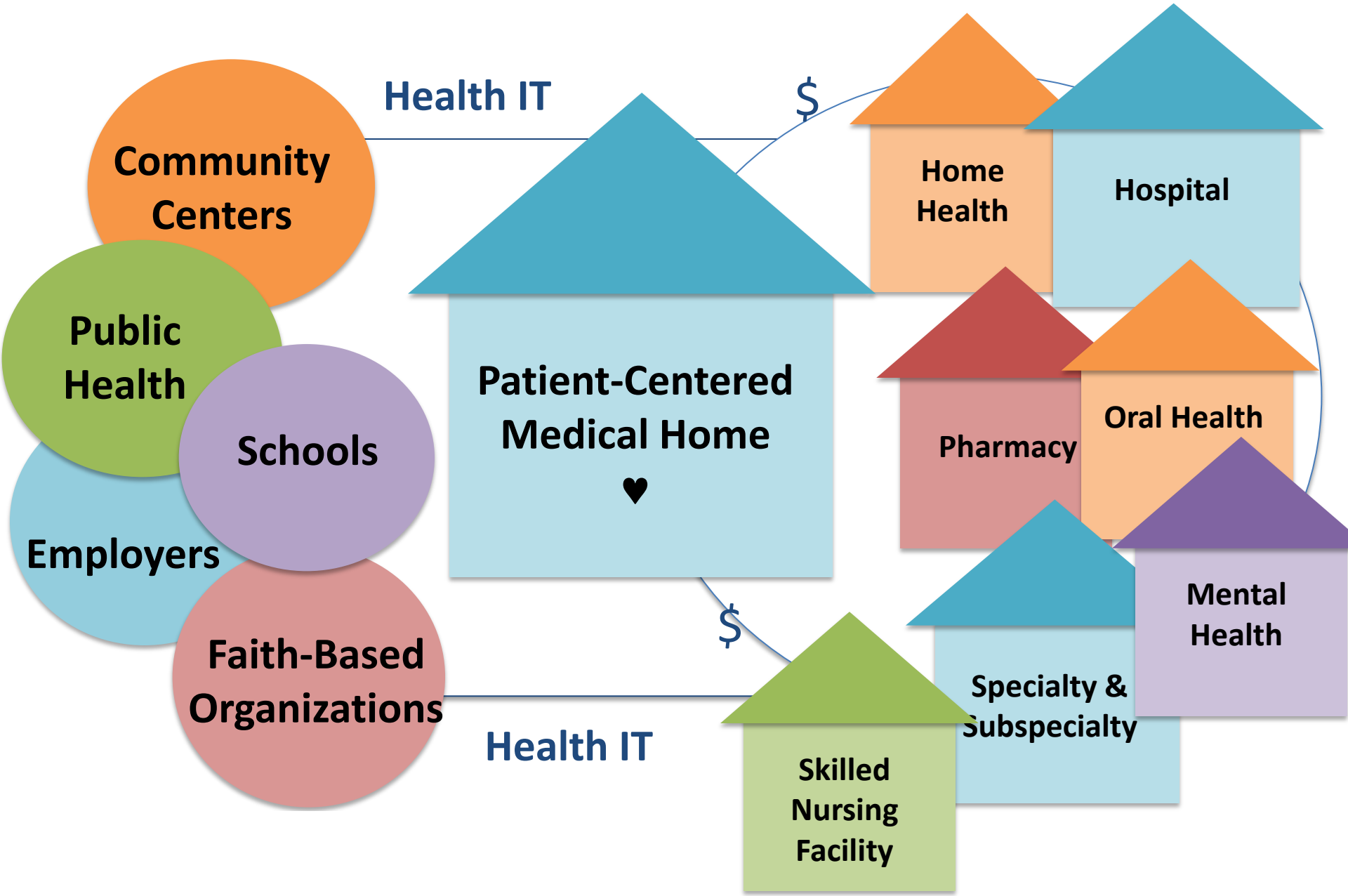
Sorting, distributing, analyzing, paying, communicating, why the heck won't my records synchronize?



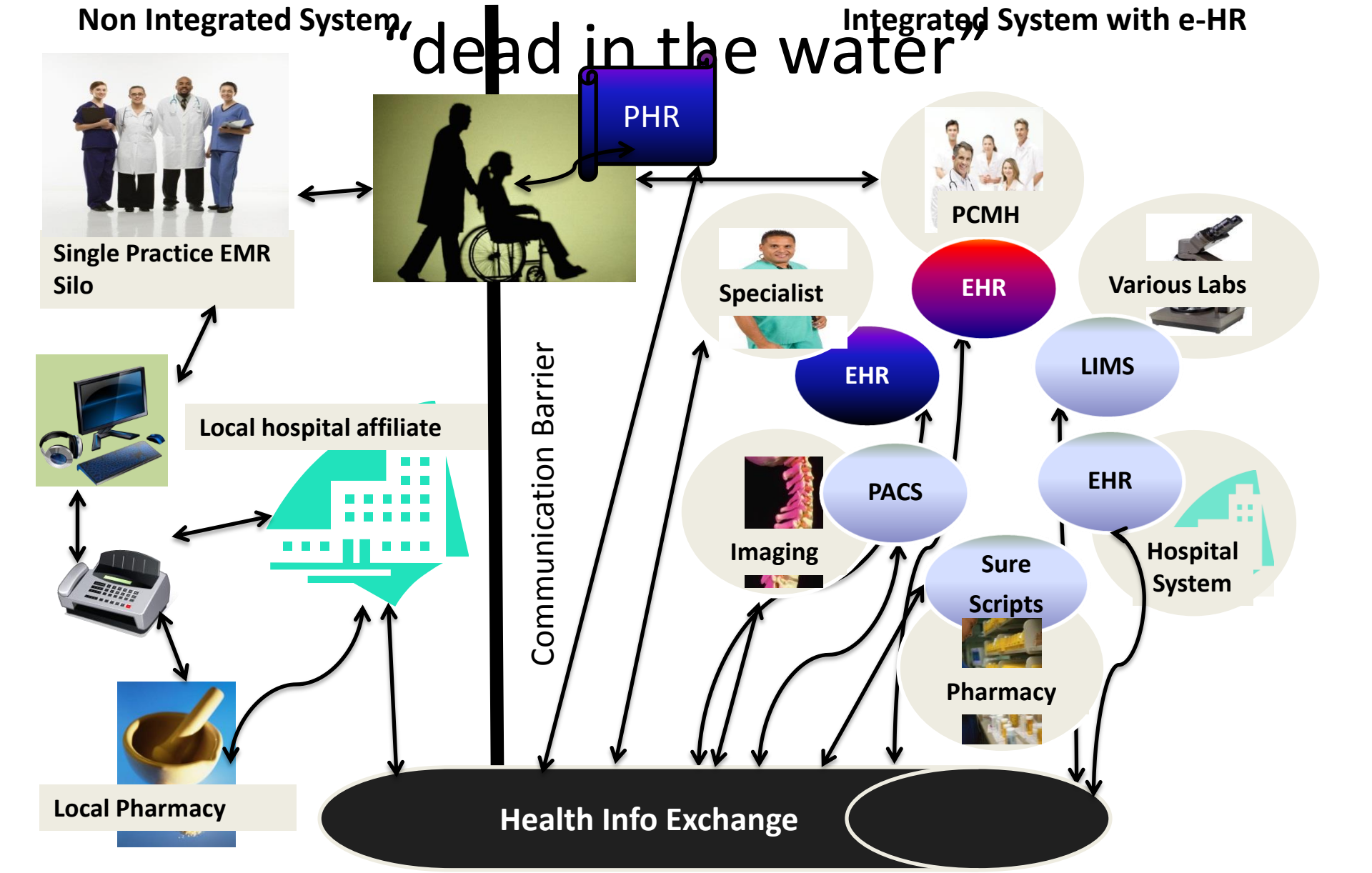
2 hours later , 3 Starbucks, one fruit smoothie, 8 units of Apidra

How much more can we take!

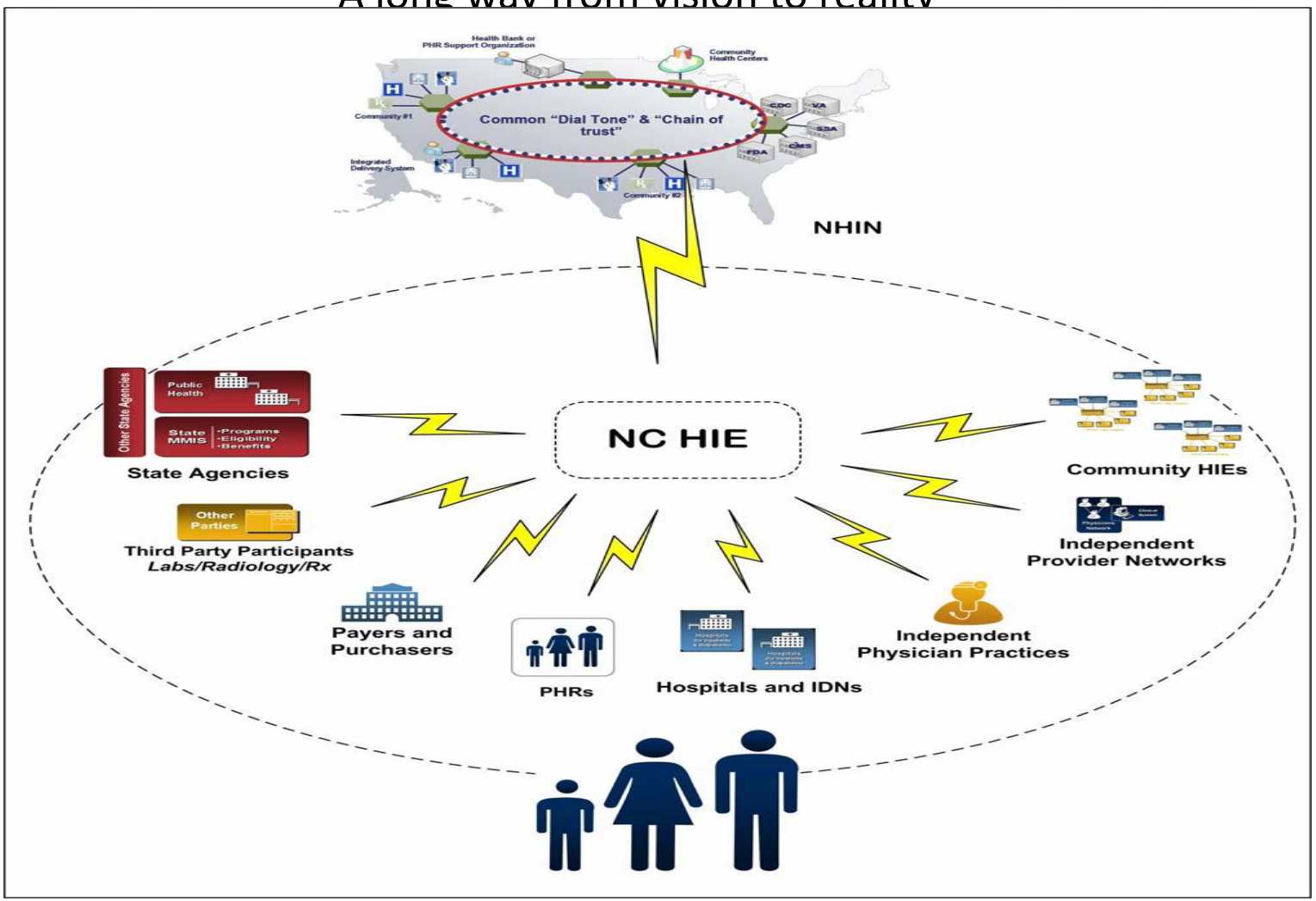
PCMH at ♥ of "Medical Neighborhood"



Without data interchange we are "dead in the water"



NCHICA Proposes Architecture
A long way from vision to reality



Stopping the revolving door

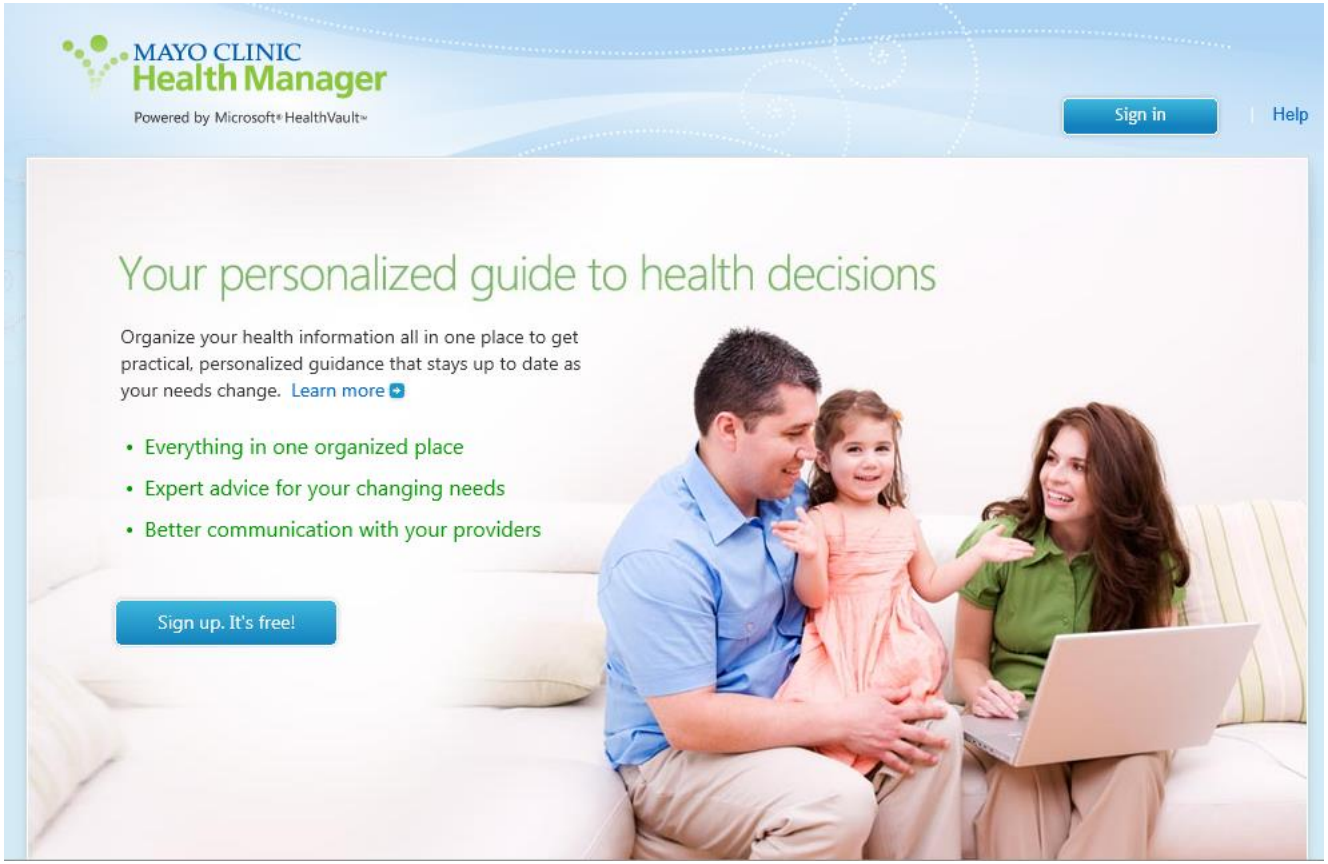
"Go to the people, live with them, learn from them....
Start with what they know, build with what they have...."
Lao Tzu

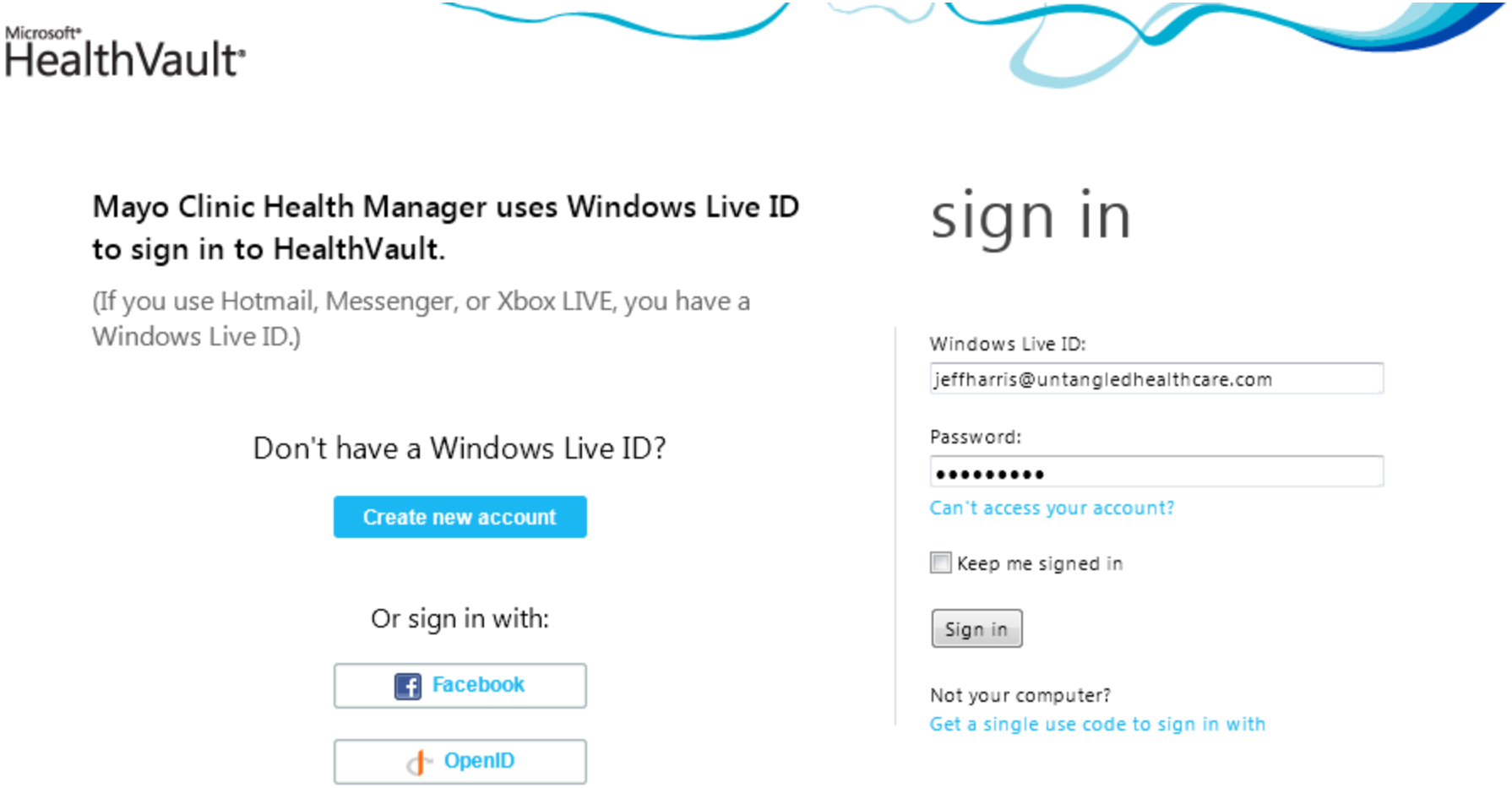
After ten years work with 3000 pulmonary and cardiac disease patients I learned some very simple lessons:

- **We are an interdisciplinary workforce, our patients count on our ability and desire to share our treatment plans and assessments**
- **We may have individual treatment plans by sub-specialty or episode of care but we all share in the development of a "Life-Plan" engaging patients and families in their own self-defined "Plan of Care"**
- **Self mastery starts with understanding how the system works, who the cast of actors are and everyone's responsibility.**

Preparing for a trip

My PHR


MAYO CLINIC
Health Manager
Powered by Microsoft® HealthVault™
Sign in
Help
Your personalized guide to health decisions
Organize your health information all in one place to get practical, personalized guidance that stays up to date as your needs change. Learn more
• Everything in one organized place
• Expert advice for your changing needs
• Better communication with your providers
Sign up. It's free!


Microsoft HealthVault
Mayo Clinic Health Manager uses Windows Live ID to sign in to HealthVault.
(If you use Hotmail, Messenger, or Xbox LIVE, you have a Windows Live ID.)
Don't have a Windows Live ID?
Create new account
Or sign in with:
Facebook
OpenID
sign in
Windows Live ID:
jeffharris@untangledhealthcare.com
Password:
Can't access your account?
Keep me signed in
Sign in
Not your computer?
Get a single use code to sign in with
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How I connected my system

- Located physician with knowledge of health data interchange and motivation to heal
- Located surgeons who would treat me as equal
- Located tools online that worked and were interoperable
- Created my own accounts {HealthVault, Connected to

- Connected to CVS, SPINN secure Communication and LabCorp

RALEIGH ENDOCRINE ASSOCIATES

The quality of your care is the measure of our success.

Blue Ridge Center II
2709 Blue Ridge Road, Suite 320
Raleigh, NC 27607

www.raleighendocrine.com
portal@raleighendocrine.com
(919) 876-7692

Available on the App Store

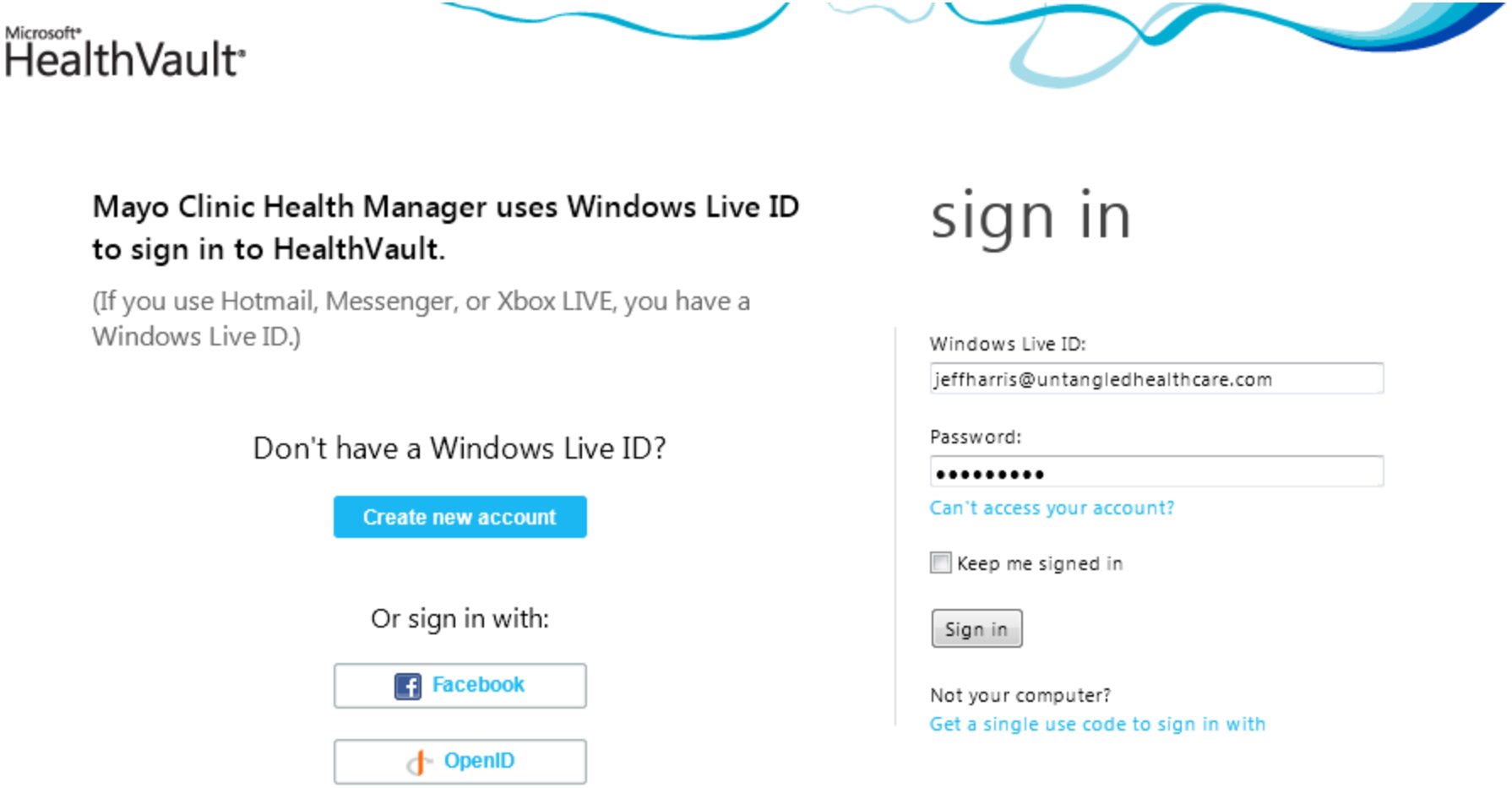
GET IT ON Google play

Log In

Select your account login method or Go Back.

FMH

Help | Español


Microsoft HealthVault
Mayo Clinic Health Manager uses Windows Live ID to sign in to HealthVault.
(If you use Hotmail, Messenger, or Xbox LIVE, you have a Windows Live ID.)
Don't have a Windows Live ID?
Create new account
Or sign in with:
Facebook
OpenID
sign in
Windows Live ID:
jeffharris@untangledhealthcare.com
Password:
Can't access your account?
Keep me signed in
Sign in
Not your computer?
Get a single use code to sign in with
©2011 Microsoft | Terms | Privacy
Help Center | Feedback

My Family

Mayo Clinic Health Manager helps you organize, manage and understand your family's health, and offers personalized guidance to help you make the right decisions at the right time.

Get a quick update on each family member here. For details, just click a person's name.

Add a family member

Alex Brother

Next appointment
None upcoming

Action items
Answer Starter Questions for more personalized action items

Other recommendations
View all

Carol

Next appointment
None upcoming

Action items
Answer Starter Questions for more personalized action items

Other recommendations
View all

Jeffrey

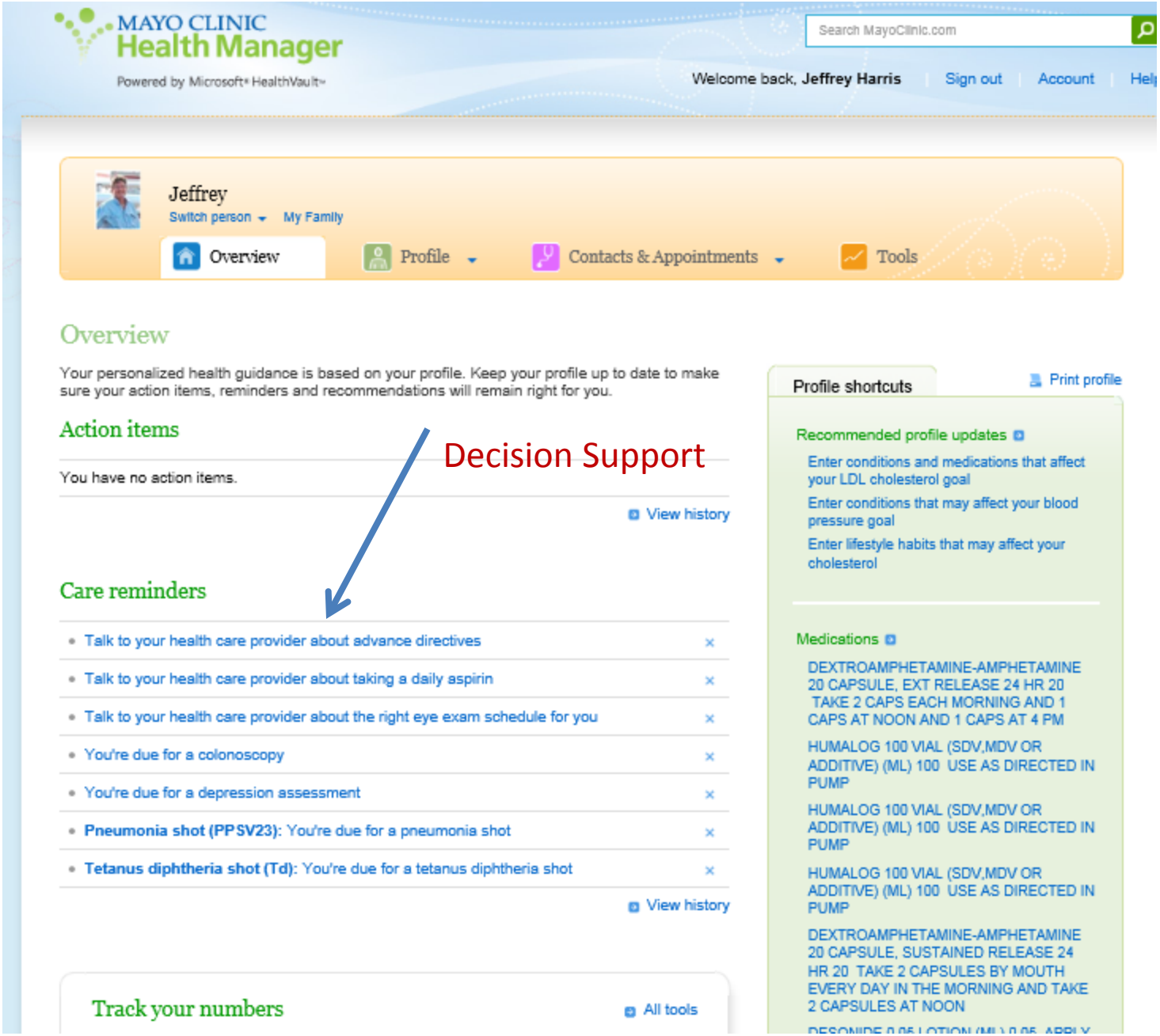
Next appointment
None upcoming

Action items
No action items

Other recommendations
View all

Mayo Clinic Health Manager uses Microsoft HealthVault to store your data Learn more.

Tell others about Mayo Clinic Health Manager


MAYO CLINIC
Health Manager
Powered by Microsoft® HealthVault™
Search MayoClinic.com
Welcome back, Jeffrey Harris
Sign out
Account
Jeffrey
Switch person
My Family
Overview
Profile
Contacts & Appointments
Tools
Overview
Your personalized health guidance is based on your profile. Keep your profile up to date to make sure your action items, reminders and recommendations will remain right for you.
Action items
You have no action items.
View history
Decision Support
Care reminders
Talk to your health care provider about advance directives
Talk to your health care provider about taking a daily aspirin
Talk to your health care provider about the right eye exam schedule for you
You're due for a colonoscopy
You're due for a depression assessment
Pneumonia shot (PPSV23): You're due for a pneumonia shot
Tetanus diphtheria shot (Td): You're due for a tetanus diphtheria shot
View history
Track your numbers
All tools
Profile shortcuts
Print profile
Recommended profile updates
Enter conditions and medications that affect your LDL cholesterol goal
Enter conditions that may affect your blood pressure goal
Enter lifestyle habits that may affect your cholesterol
Medications
DEXTROAMPHETAMINE-AMPHETAMINE 20 CAPSULE, EXT RELEASE 24 HR 20 TAKE 2 CAPS EACH MORNING AND 1 CAPS AT NOON AND 1 CAPS AT 4 PM
HUMALOG 100 VIAL (SDV,MDV OR ADDITIVE) (ML) 100 USE AS DIRECTED IN PUMP
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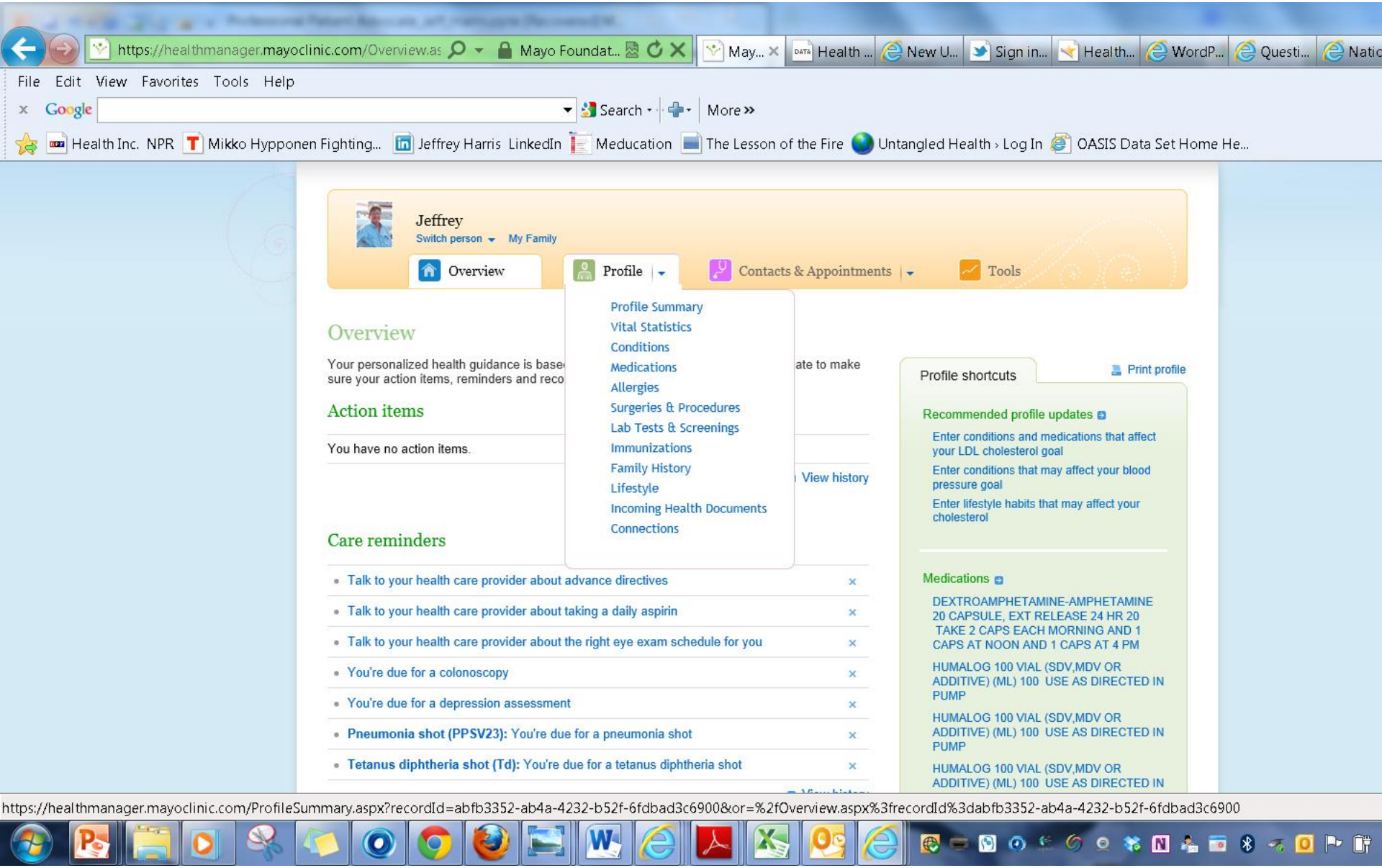
https://healthmanager.mayoclinic.com/Overview.as
Mayo Foundat...
File Edit View Favorites Tools Help
Google
Search
More »
Health Inc. NPR
Mikko Hypponen Fighting...
Jeffrey Harris LinkedIn
Meducation
The Lesson of the Fire
Untangled Health › Log In
OASIS Data Set Home He...
Jeffrey
Switch person
My Family
Overview
Profile
Contacts & Appointments
Tools
Profile Summary
Vital Statistics
Conditions
Medications
Allergies
Surgeries & Procedures
Lab Tests & Screenings
Immunizations
Family History
Lifestyle
Incoming Health Documents
Connections
Overview
Your personalized health guidance is base
ate to make
sure your action items, reminders and reco
Action items
You have no action items.
View history
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Pneumonia shot (PPSV23): You're due for a pneumonia shot
Tetanus diphtheria shot (Td): You're due for a tetanus diphtheria shot
Profile shortcuts
Print profile
Recommended profile updates
Enter conditions and medications that affect your LDL cholesterol goal
Enter conditions that may affect your blood pressure goal
Enter lifestyle habits that may affect your cholesterol
Medications
DEXTROAMPHETAMINE-AMPHETAMINE 20 CAPSULE, EXT RELEASE 24 HR 20 TAKE 2 CAPS EACH MORNING AND 1 CAPS AT NOON AND 1 CAPS AT 4 PM
HUMALOG 100 VIAL (SDV,MDV OR ADDITIVE) (ML) 100 USE AS DIRECTED IN PUMP
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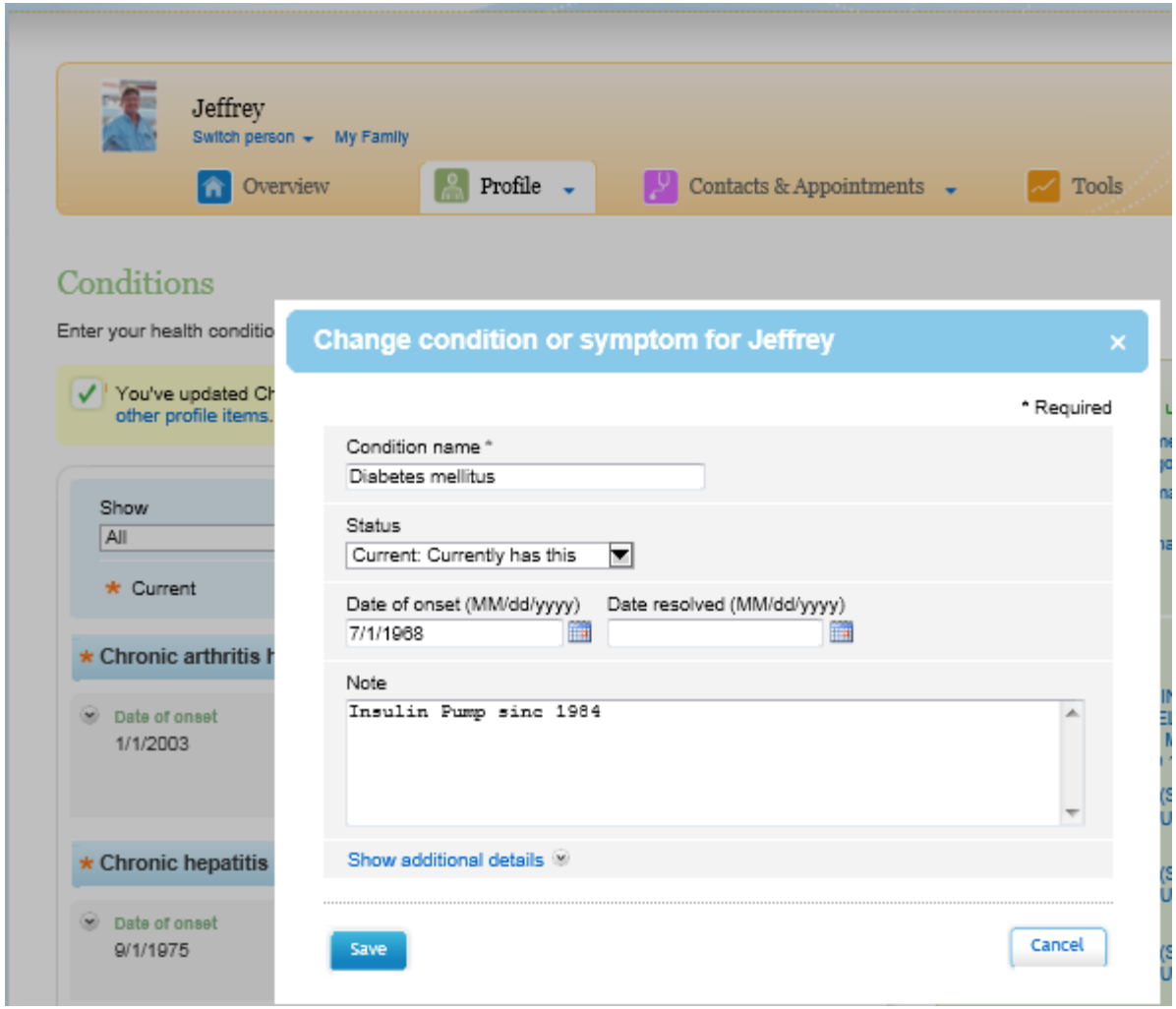
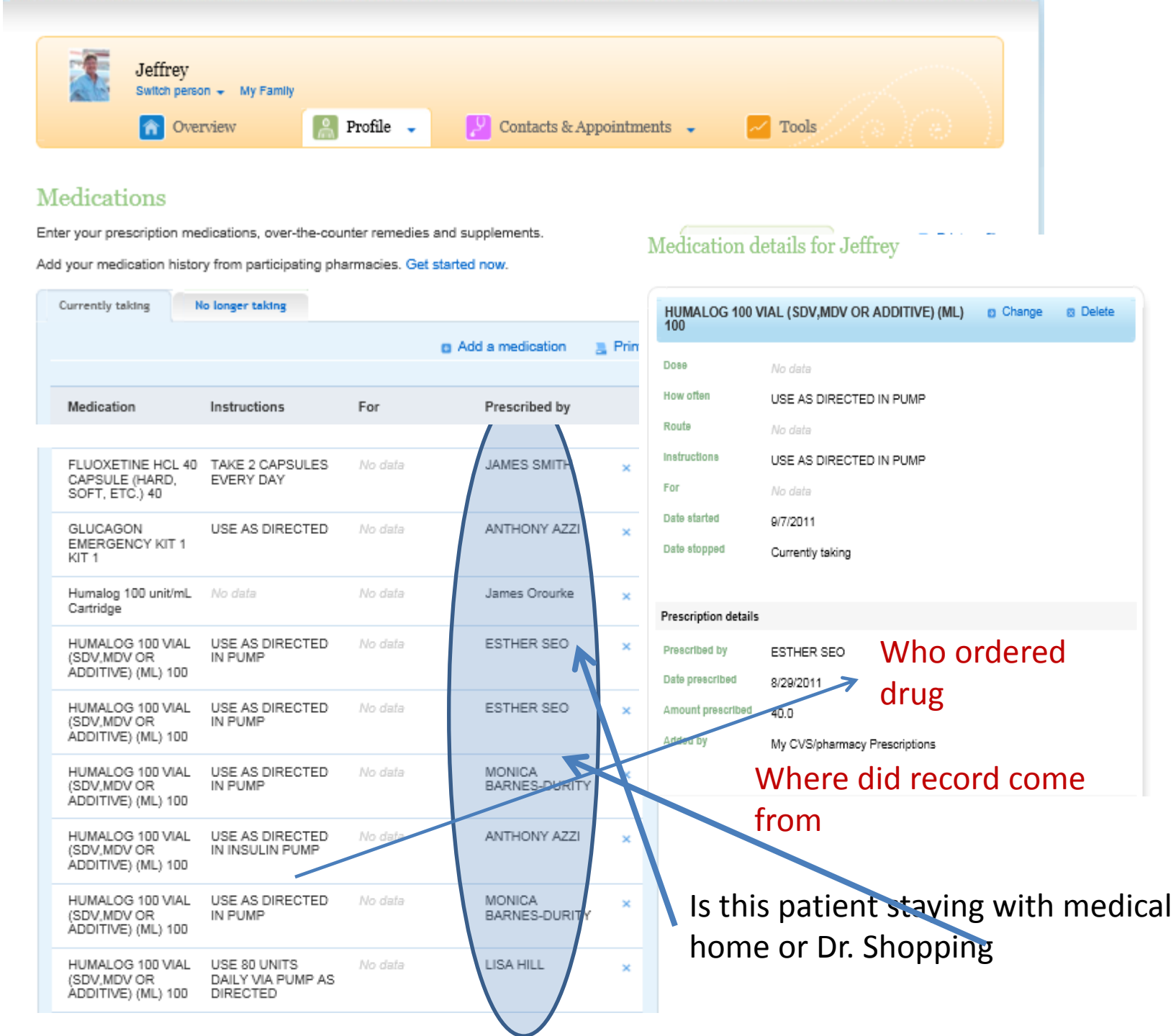
https://healthmanager.mayoclinic.com/ProfileSummary.aspx?recordId=abfb3352-ab4a-4232-b52f-6fdbad3c6900&or=%2fOverview.aspx%3frecordId%3dabfb3352-ab4a-4232-b52f-6fdbad3c6900

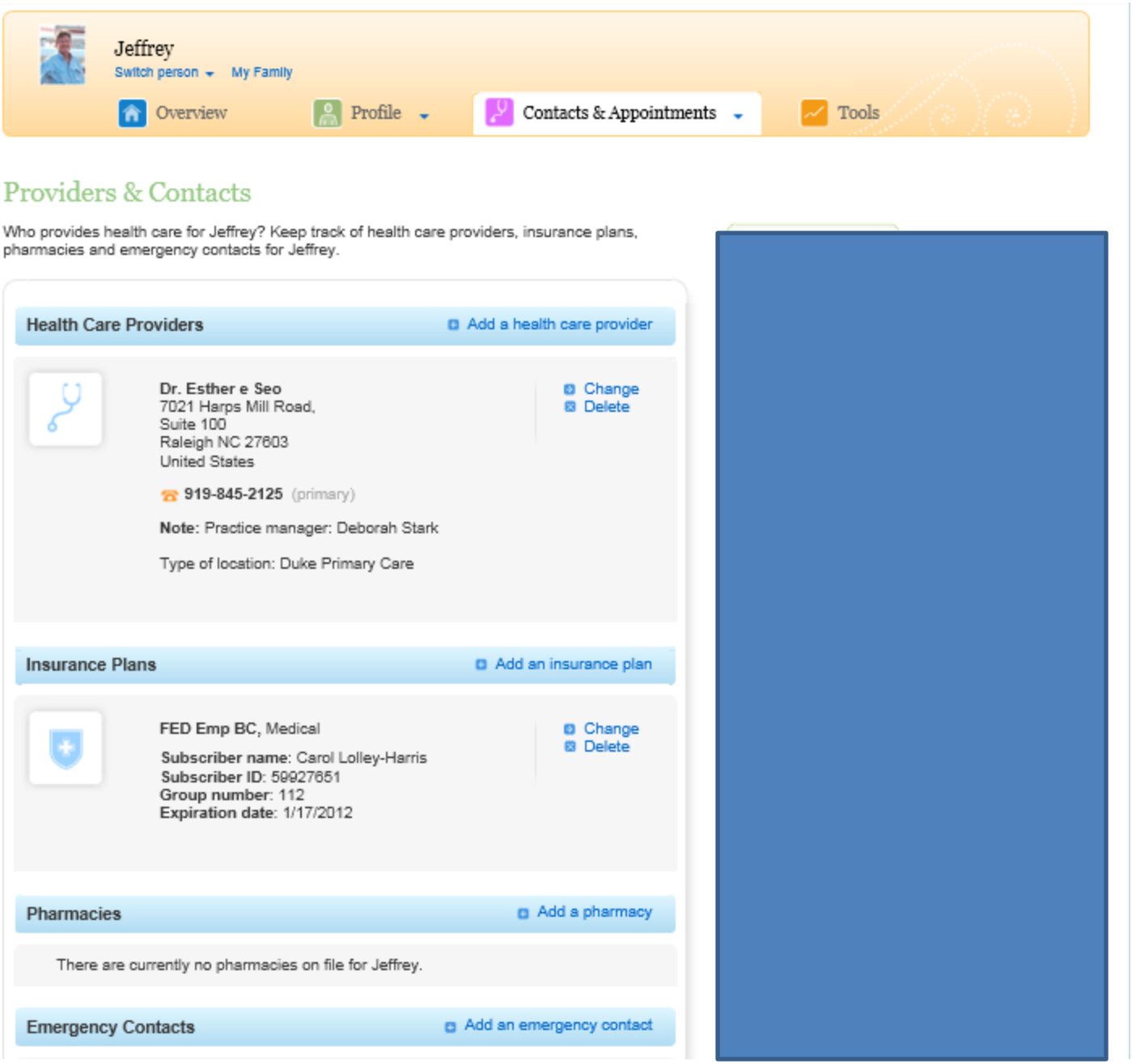
Details of record source



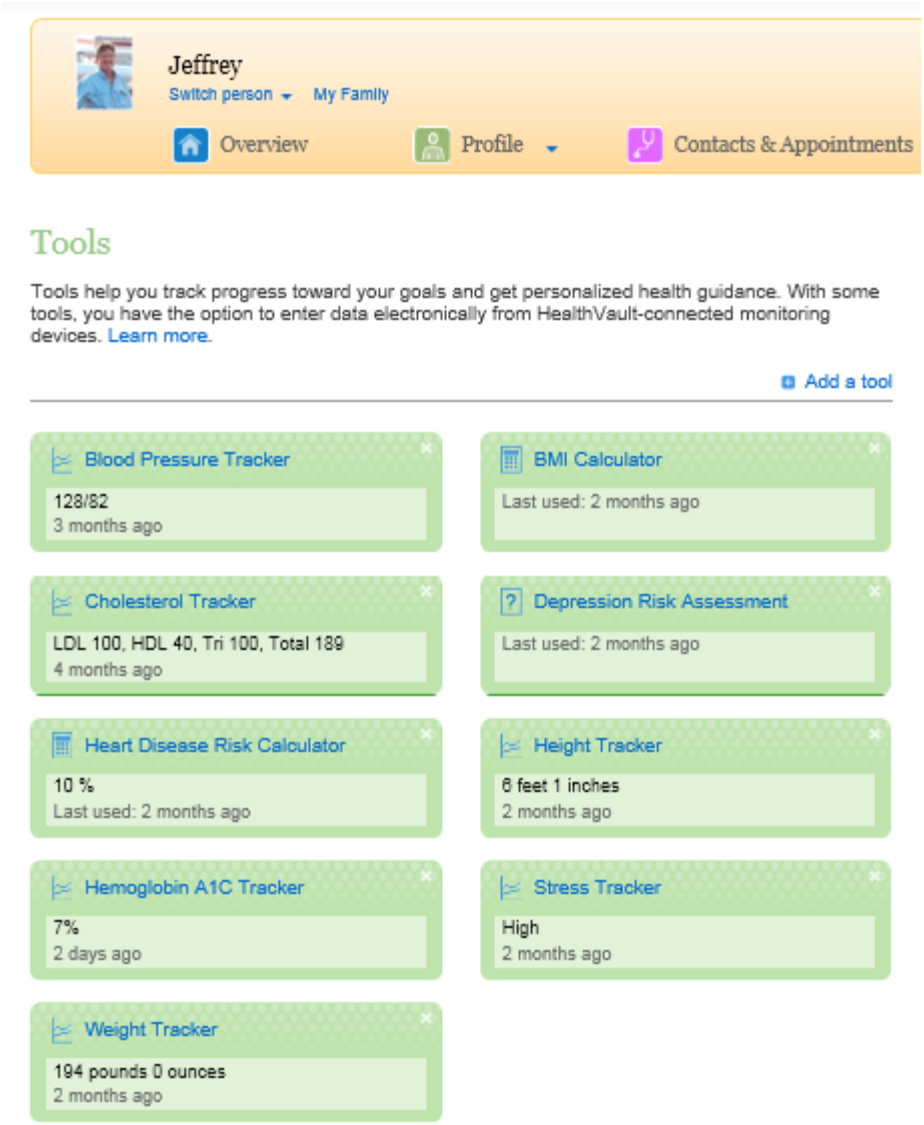
Medication Reconciliation



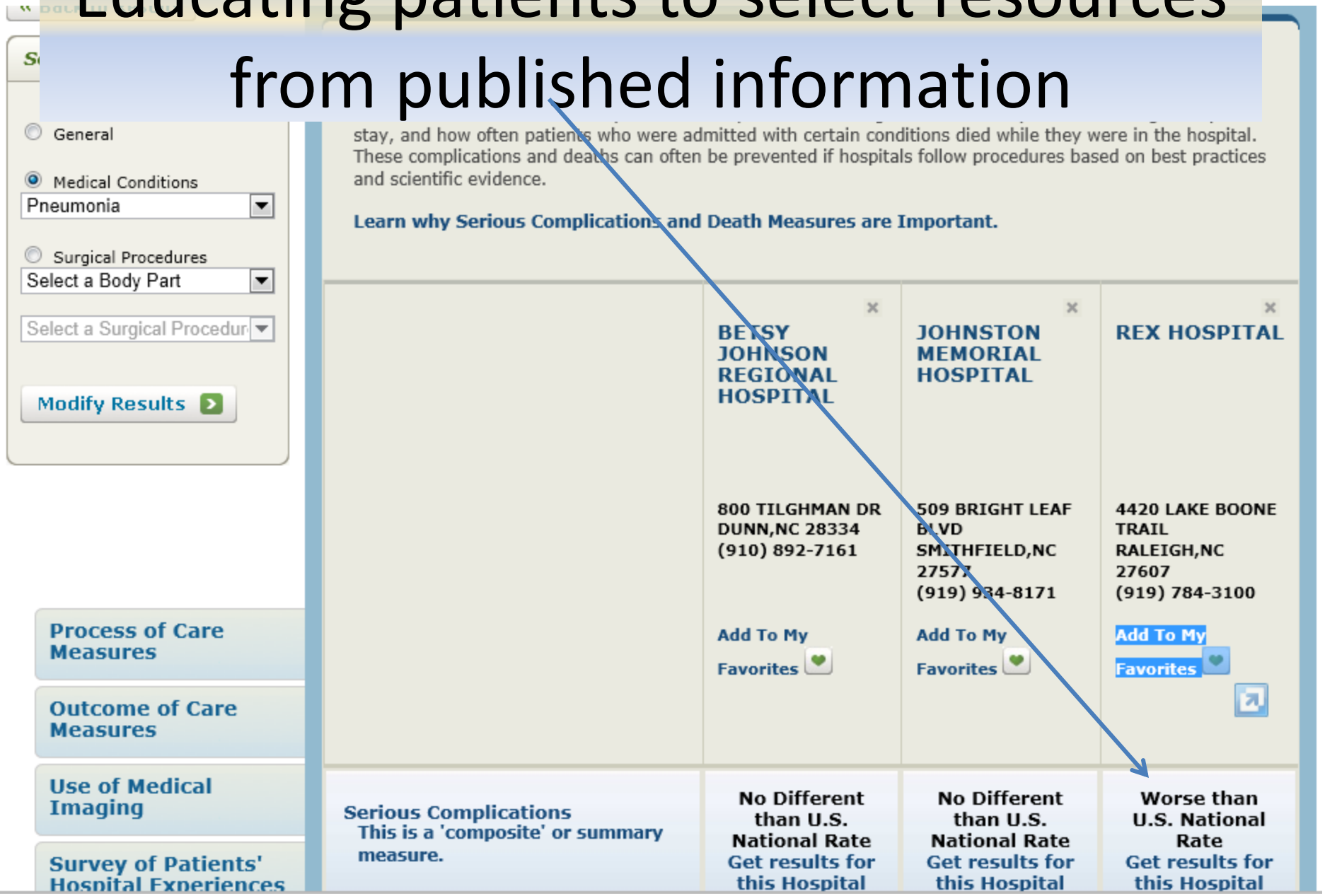
Providers and Contacts



Monitoring

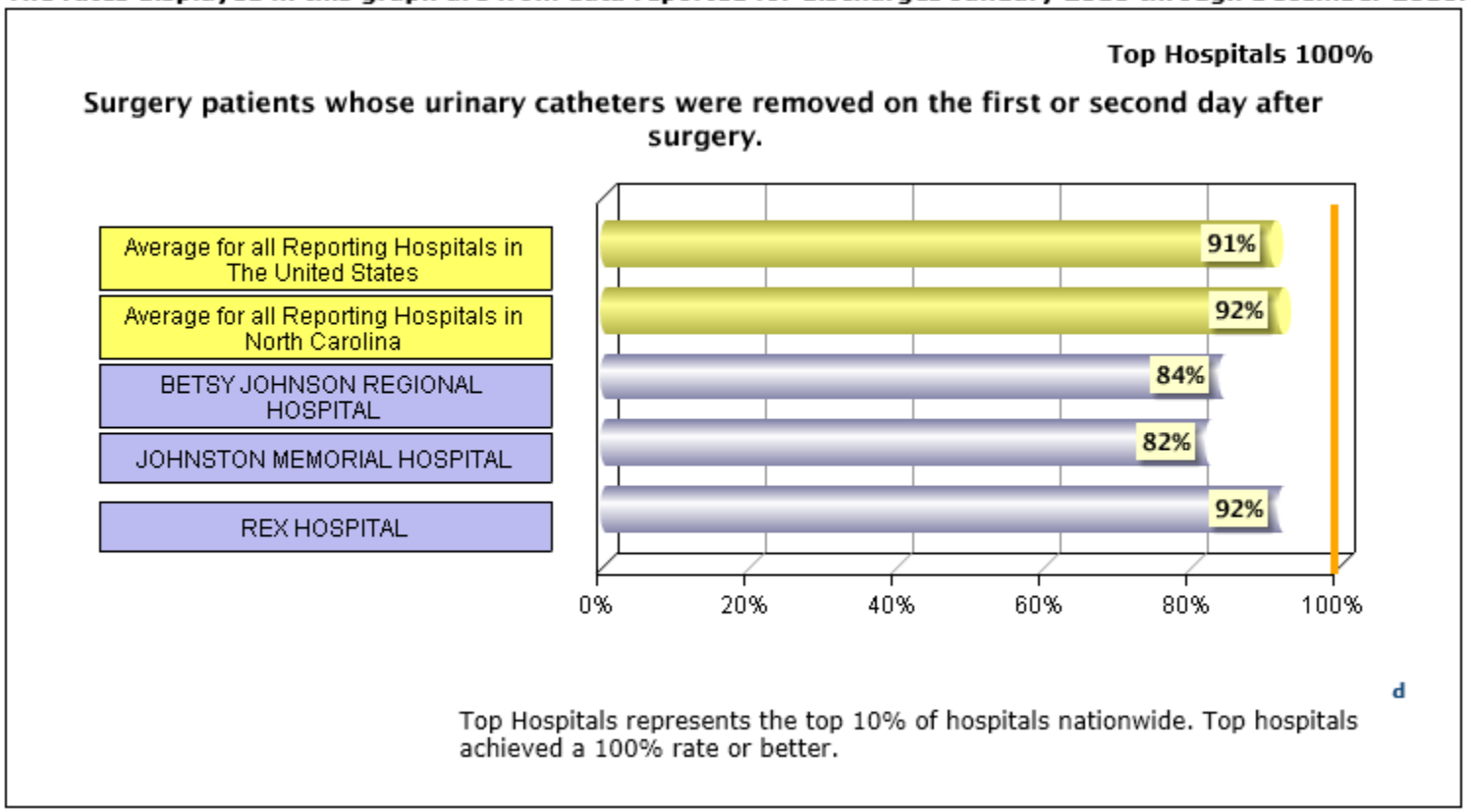

Jeffrey
Switch person
My Family
Overview
Profile
Contacts & Appointments
Tools
Tools help you track progress toward your goals and get personalized health guidance. With some tools, you have the option to enter data electronically from HealthVault-connected monitoring devices. Learn more.
Add a tool
Blood Pressure Tracker
128/82
3 months ago
BMI Calculator
Last used: 2 months ago
Cholesterol Tracker
LDL 100, HDL 40, Tri 100, Total 189
4 months ago
Depression Risk Assessment
Last used: 2 months ago
Heart Disease Risk Calculator
10 %
Last used: 2 months ago
Height Tracker
6 feet 1 inches
2 months ago
Hemoglobin A1C Tracker
7%
2 days ago
Stress Tracker
High
2 months ago
Weight Tracker
194 pounds 0 ounces
2 months ago

Educating patients to select resources from published information



Using process measures to make decisions when choosing providers

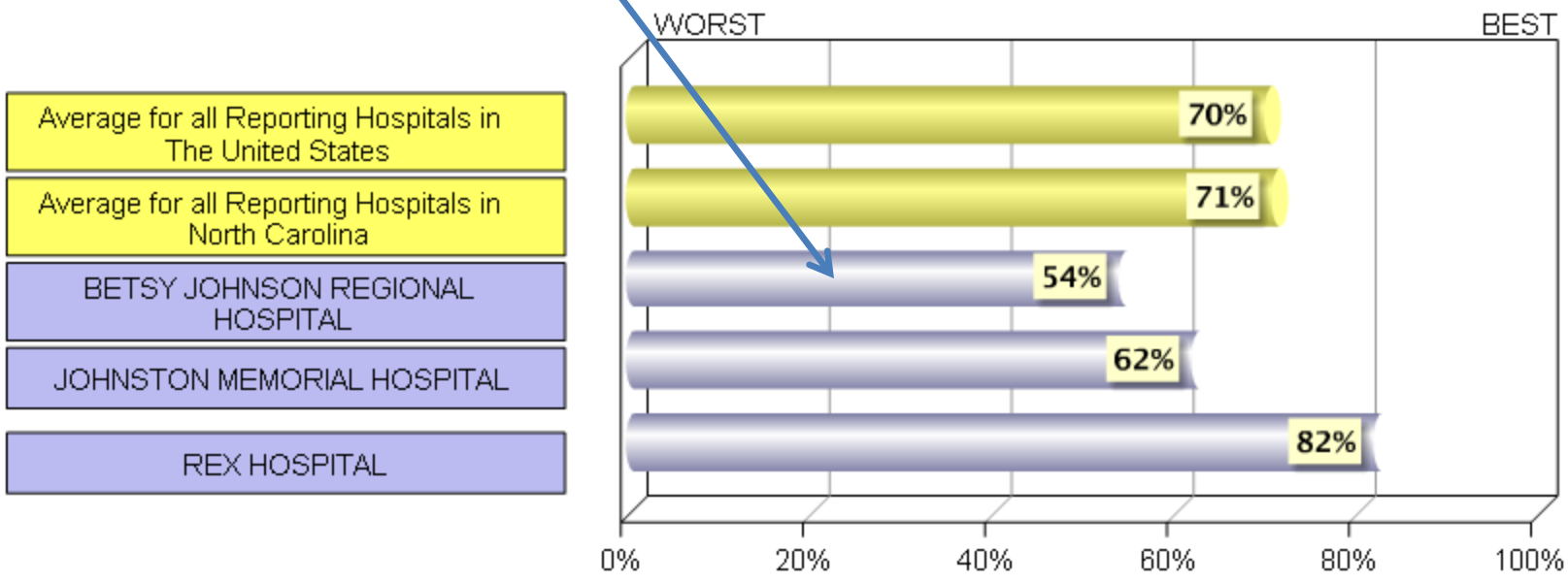
The rates displayed in this graph are from data reported for discharges January 2010 through December 2010.



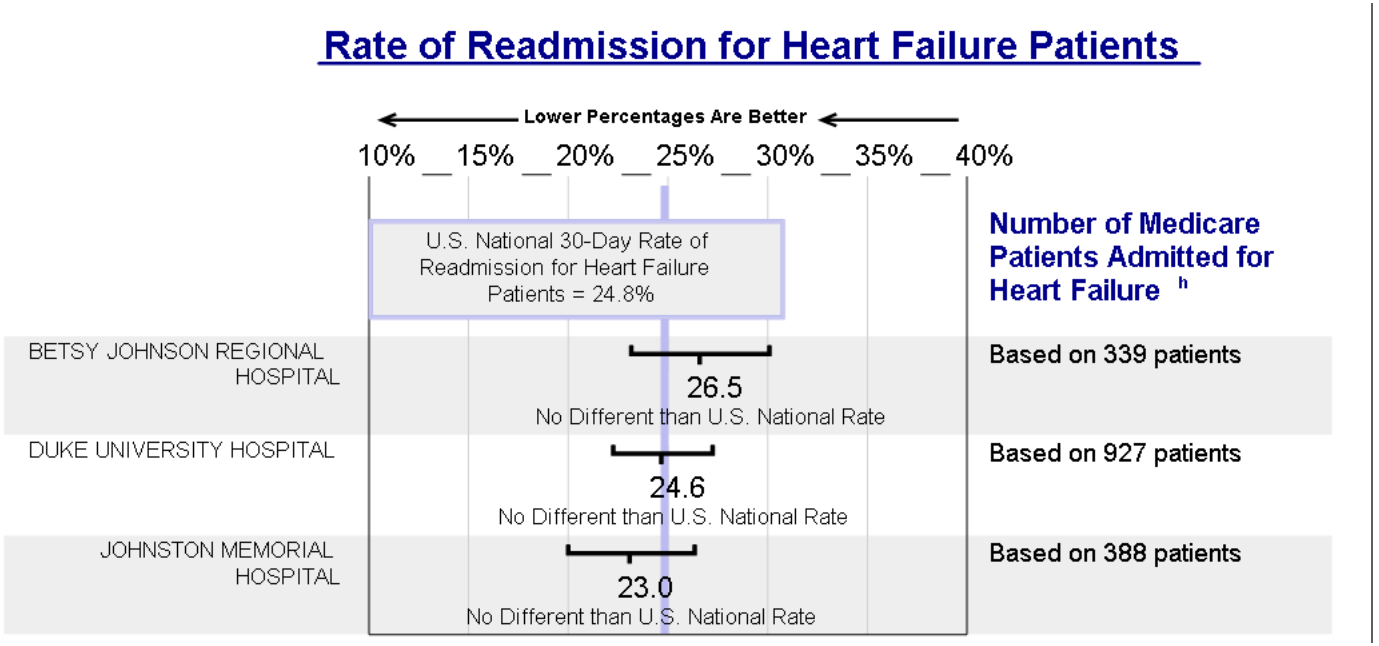
Why Wouldn’t Patients Recommend

Bars below tell the percent of patients who reported YES, they would definitely recommend the hospital.

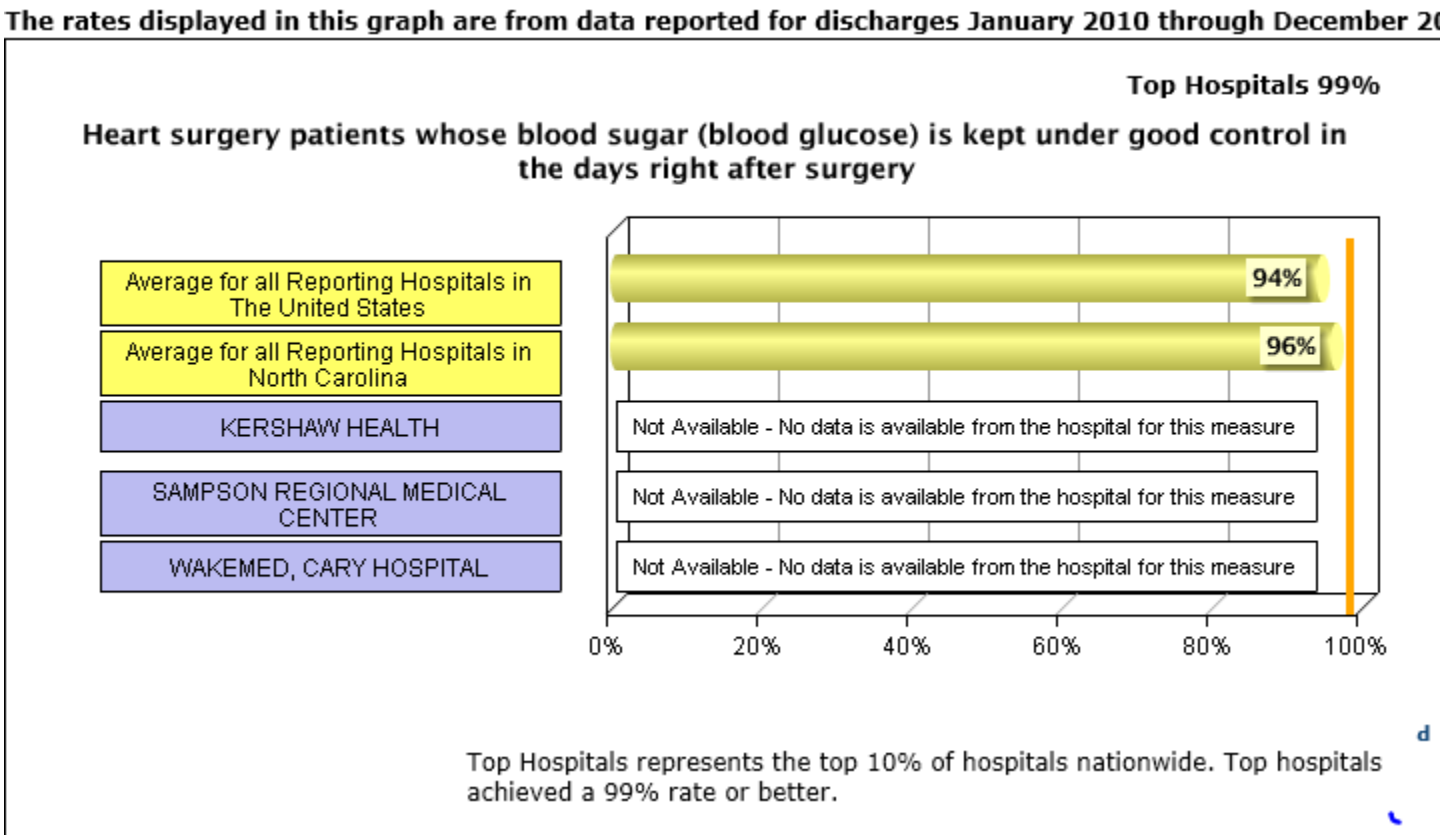
Would patients recommend the hospital to friends and family?



If patients are readmitted is that the hospital issue or does it say something about the supporting community?

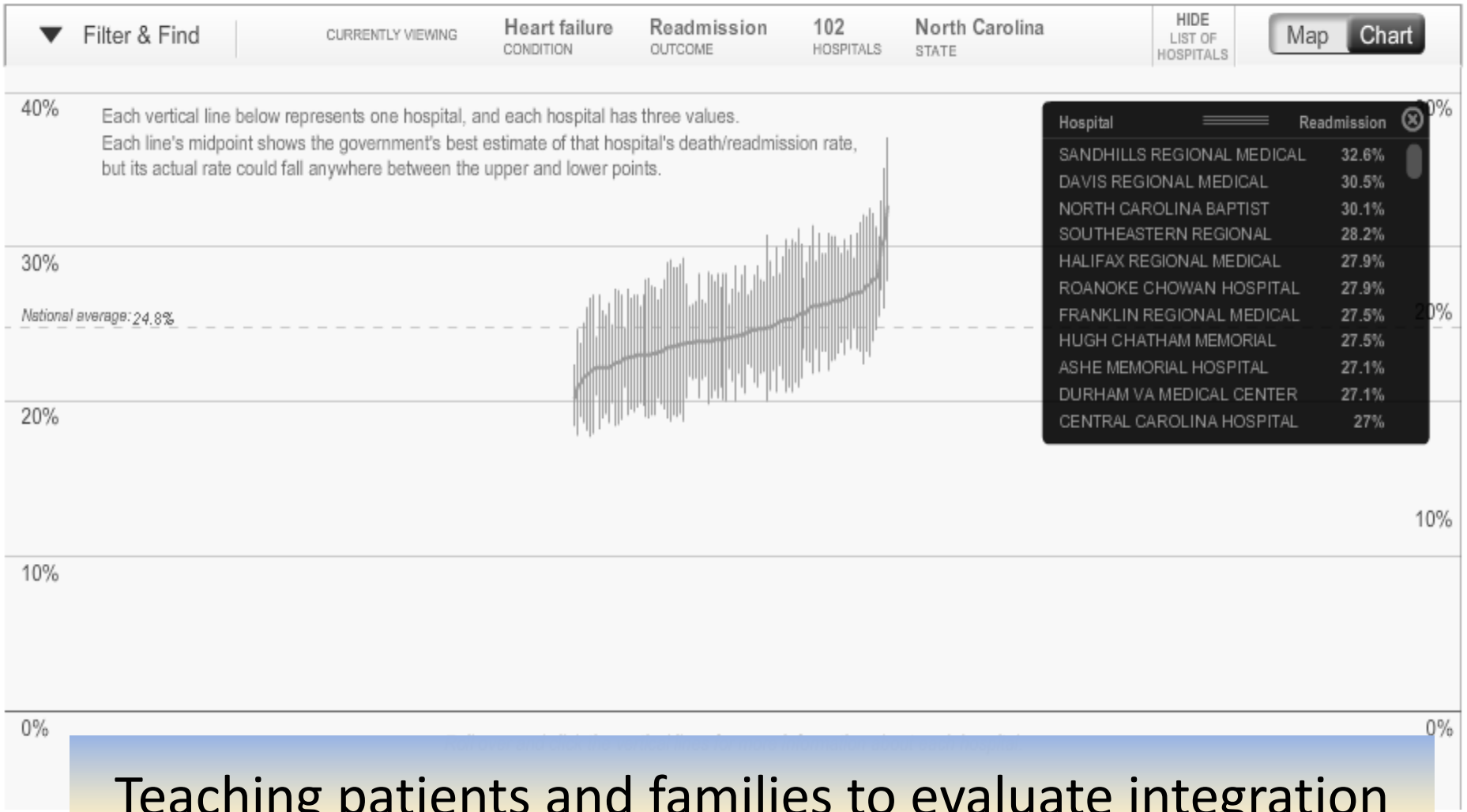


Would you go somewhere with no reported data?



Compare hospitals on heart attack, heart failure and pneumonia

Check hospitals' death and readmission rates for heart attack, heart failure and pnuemonia. Select a condition, outcome and state from the menus.



Teaching patients and families to evaluate integration based on hospital readmission rates

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PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

Sentara Medical Group Care Model

Guiding Principles

Patient-Centered
Data Driven Decision Making
Standardization
Practice at Highest Level of Clinical License

Aim

Improve the health of our patients
Deliver clinical and service excellence that is cost effective and promotes an optimal experience for all.

Patient-Centered Medical Homes
Primary Care Teams

- Standardization of patient experience
- Same Day Appointments
- 7 day hospital follow up
- EMR
- Patient EMR Portal
- Evidenced based guidelines
- Best practice alerts

Care Management
RN/Social Worker/Pharm D

- Hospital follow up
- Transitional contact after facility care
- Disease Management
- High Risk population management
- Managing psychosocial barriers
- Behavioral Health Integration
- Utilization analysis
- Coding optimization

Population Management
RN/ LPN/MA/Secretaries

- Preventive Care Telephonic Outreach
- Preventive Care and Screening Registries
- Health Maintenance review
- Chronic Disease Registries
- At Risk and Full Risk Patient populations with Payers

Integration between PCP, Specialty and Community Partners
Specialists/PCPs/Hospitalists/CSB/Community Health Centers

- Clinically Integrated Network with community providers
- Hospitalists and PCP communication
- Specialist and PCP care agreements
- Health Plan collaborations

Supporting programs: Leadership and Professional Development, Safety and Regulatory, Quality Committee, IT and Analytics, Health System

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PATIENT-CENTERED PRIMARY CARE:
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DIY Medical Home Transformation

SUZANNE BERMAN, MD, FAAP

Transformation takes time

No consultant can come in and do an "instant makeover" to PCMH-ify your practice.

Assemble your team

Team Leads:

- **Project manager (lead)**: to assign, track, and check pieces for completion. Needs to 1) be OCD and 2) have nag power.
- **Provider (lead**)– to write/approve the clinical decision-making pieces, to provide input for clinical protocols, and to champion provider workflow changes
- **Administrator (lead)** – to write/approve policies and procedures (clinical and nonclinical) and to champion front desk, clinical staff, and back office workflow changes.

Assemble your team

Team Supports:

- **Nonclinical and clinical staff (support)** – to provide feedback on current practices and proposed changes
- **Patient/parent representatives (support)** – to provide feedback on current practices and proposed changes
- **Computer geek (support)** – to prepare and analyze data for reporting. Needs familiarity with Excel, screen captures, PDF creation, etc.
- **Wordsmith (support)** – to proofread others' materials; to draft protocols and/or find good ones to borrow on the Internet.

Assemble your tools

- **Web-based project management tool**
  - Dividing projects up into smaller tasks
  - Assigning people to tasks
  - Letting team members provide status reports
  - Collaborative document writing
  - Scheduling meetings and deadlines
  - Sending reminders
- **Spreadsheet software**
- **Screen capture and screen capture editor** – essential for documention of computer-based workflow

Protected time

- Non-administrators MUST have protected time to work on transformation.
- Even if they have some "interstitial downtime," most staff have difficulty working on transformation in 5- and 10-minute pieces.
- If you want transformation to be a priority, schedule (paid) blocks of time for each staff member to work on their pieces.
- To prevent "playing" during protected time, use very short deadlines with frequent small deliverables; make it an active meeting/discussion with the transformation leader, rather than a self-paced activity.

Getting started is the hardest part

PICKING THE FIRST PROCESS TO IMPROVE CAN BE OVERWHELMING!

Your first change: choose something with $$$ benefit

- **Huddles:** reduce overtime
- **Better lab, x-ray, and referral tracking**: reduce overtime
- **Recall:** more remunerative schedule saturation
- **Same day appointments:** fewer no-shows
- **Team engagement:** better employee morale and lower turnover

Your second change: what bugs you?

- Find a common annoyance in your practice that all staff can rally around
  - Taming the telephone or fax?
  - Message tracking?
  - Patient wait times?
- Avoid "picking on" one department

Other longer-term or more expensive transformations: do later

- Extending evening/weekend hours
- Hiring, training, and implementing a care coordinator
- Formal comanagement agreements
- Hospital and ER tracking/coordination
- Empanelment matching
- Culturally and linguistically appropriate teaching

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PATIENT-CENTERED PRIMARY CARE:
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Integrating Behavioral Health with PCMH Practices: An overview of Why, What, How

C. J. Peek, PhD

Professor, Dept. of Family Medicine and Community Health
University of Minnesota Medical School
cjpeek@umn.edu

Patient Centered Primary Care Collaborative (PCPCC)

Panel: Medical Home DIY--Self-Guided Practice Transformation

November 13, 2014 Washington, DC

UNIVERSITY OF MINNESOTA
Medical School

Patient-Centered Primary Care COLLABORATIVE

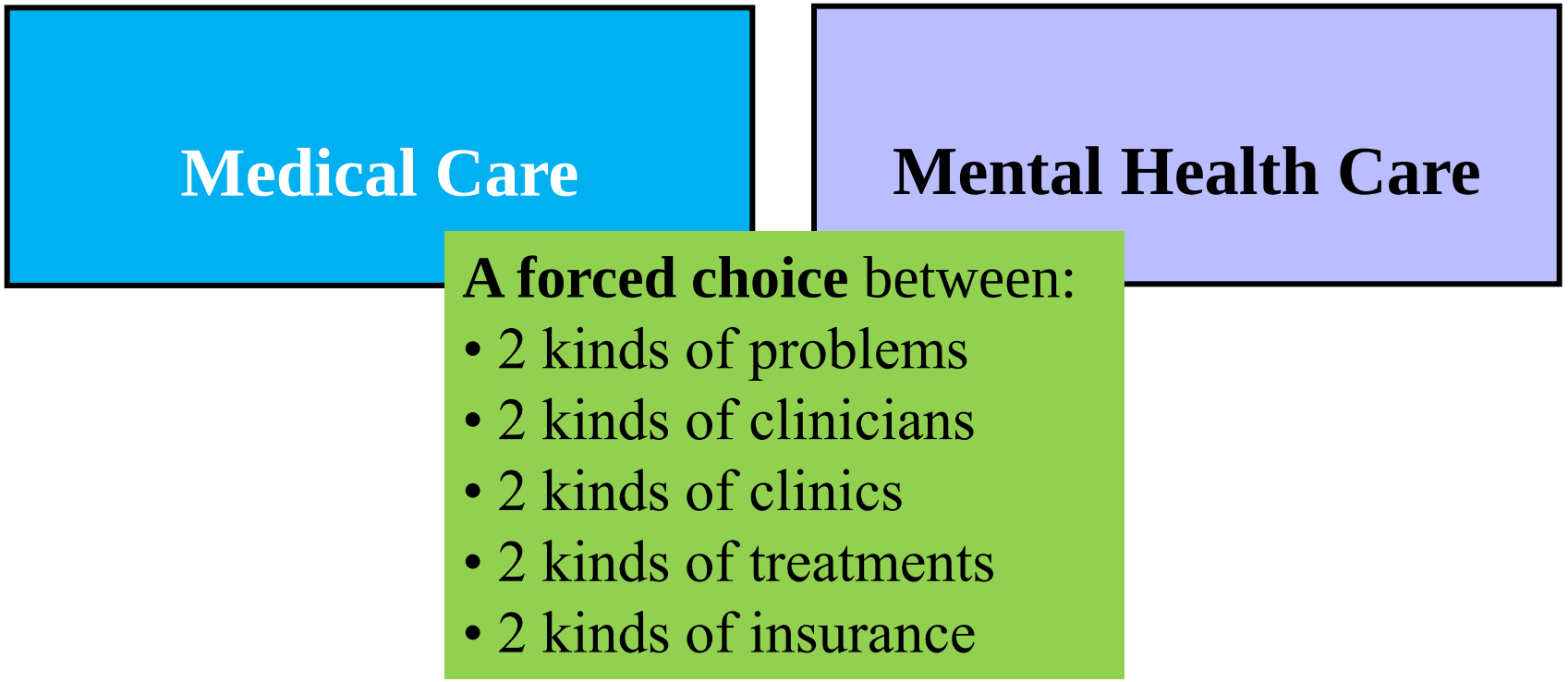
Why should BH be part of the PCMH?

PCPCC slide decks

http://www.pcpcc.org/resource/behavioral-health-integration-pcmh

	PCPCC slide contents
Prevalence and burden	Prevalence of BH, burden of illness, primary care as de-factor MH system, behavioral factors in medical illnesses
Unmet needs	Untreated persons, challenge of access; problems of separate and parallel systems
Cost	Increased health cost with BH co-occurrence; lower cost when BH treated—ROI; increased employee costs
Outcomes	Improved MH outcomes; improved physical health outcomes
Experience	Improved patient and provider satisfaction

A legacy of separate and parallel systems



Integrated behavioral health leads to a better match of clinical services to the realities that patients and their clinicians face daily.

Original Source: CJ Peek 1996

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What is integrated BH?
AHRQ Lexicon functional definition

"What": (An ordinary two-sentence definition)

"How" functions:

1. A practice team tailored to the needs of each patient and situation (3 sub-clauses)
2. With a shared population and mission
3. Using a systematic clinical approach (6 sub-clauses)

"Supported by" functions:

4. Supported by 1) reliable office processes, 2) leadership alignment, and 3) sustainable business model
5. Ongoing QI and measurement of effectiveness (2 sub-clauses)
6. With a community or population expecting that BH and PC will be appropriately integrated as a standard of care

Example—plain old glossary (AHRQ 2013)

Illustration: A family tree of related terms used in behavioral health and primary care integration
See glossary for details and additional definitions

Patient-Centered Care
"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"—or "nothing about me without me" (Berwick, 2011).

Integrated Care
Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. "Altitudes" of integration: 1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

Coordinated Care
The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care" (AHRQ, 2007).

Shared Care
Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

Collaborative Care
A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

Co-located Care
BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

Integrated Primary Care or Primary Care Behavioral Health
Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

Behavioral Health Care
An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Patient-Centered Medical Home
An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

Mental Health Care
Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

Substance Abuse Care
Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

Primary Care
Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

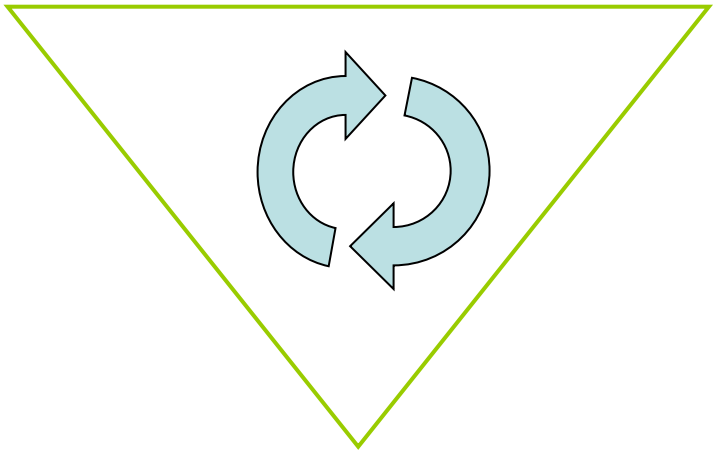
Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

integrationacademy.ahrq.gov/sites/ default/files/Lexicon.pdf

Scope of Integrated BH

Condition-Centered and Person-Centered

Integrated care for MH conditions
- Depress / anxiety
- Substance abuse
- ADHD
- Other



Integrated care for Medical conditions
- Diabetes / BP / obesity
- Heart disease
- Childhood chronic illness
- Stress-linked phys sx

CJ Peek & Mac Baird, 2010; PCPCC 2014

Integrated care for Persons: Social and care complexity
- Distress, distraction & readiness to engage in care
- Social safety, support & participation
- Understanding own health situation / health literacy
- Health behavior change
- Organization of care / relationships in health system

Questions to ask early on with your consultant "hat" on

Who is your population—who do you serve? What are the BH aspect of their needs? How well are those needs met?

One way to get at that:

"Who feels what kind of pain when it comes to the BH aspect of doing your job in your PCMH?"

What initial target for BH integration to start with?

Significant to the practice; can actually get it going

What financial arrangement at first? What payment or business models will you use to stay in business at first?

See this panel's Berman and Carver presentations!

Only a *sample* of resources for action

AHRQ Integration Academy integrationacademy.ahrq.gov	Lit repository; lexicon (definitions); Atlas of integration measures; soon on-line community, “playbook”
Center for Integrated Health Solutions (CIHS) www.integration.samhsa.gov	Frameworks and models; guides and articles on financing, workforce, clinical, administrative
AIMS Center—Advancing Innovative MH Solutions; U of Washington; aims.uw.edu	Implementation guides, resource library, research; pieces on teams, roles, workflows, financing, examples
PCPCC Behavioral Healh SIG pcpcc.org/resource/behavioral-health-integration-pcmh	Slide decks; monthly phone calls or presentations on topics suggested by members
Center for Integrated Primary Care. www.umassmed.edu/cipc/	Training, literature, websites, reports, videos,
Collaborative Family Healthcare Association: www.cfha.net	Membership organization, journal, conferences, webinars, listserv, blog

References

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Medical Home DIY! Self-Guided Practice Transformation

Jeff Halbstein-Harris, Patient/Advocate

Collette Carver, Sentara Healthcare

Suzanne Berman, Plateau Pediatrics

C.J. Peek, University of Minnesota

PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY