Patient-Centered Best Practices

October 23, 2014
Diabetes Best Practices Report and Guide

PCMH Best Practices in the Care of Diabetes

Case Studies from Maryland

Patient-Centered Techniques for Succeeding with Diabetes

What is it that high-performing patient-centered medical homes do to achieve good outcomes with their diabetic patients?

Discern Health asked that question of five primary care practices in a statewide multi-payer patient-centered medical home program in Maryland. Diabetic outcome data from the five practices ranked highly among the 52 practices between 2011 and 2013.

This tool summarizes techniques that those successful practices used. All of the five practices were PCMH-recognized as patient-centered medical homes (PCMHs) as of 2011. In-depth interviews with the staff of each practice showed that they all went beyond NCQA FOM standards to implement patient-centered care in depth. The six areas described in this Guide summarize the cultural characteristics and the techniques they used, including:

- The key concept at work in each subject area
- The specific actions to which practices attribute their success in diabetes care

If you would like help in transforming your practice to a patient-centered medical home, consider local resources. There are many active programs now—your state, your medical association, or one of your payers may offer assistance and possible incentives.
Discern Health PCMH Best Practices Case Studies in Diabetes

1. Chose practices based on outcomes:
   • Diabetes measures
   • Related measures

2. Diversified for 5 practices

3. Interviewed teams in depth: How do you get good outcomes?

4. Found each practice had a unique culture

5. Found all 5 cited 6 similar methods
Criteria for selecting practices to interview

Primary selection criteria:
1) High performance in diabetes quality measures
2) High performance in diabetes-related quality measures

Secondary selection criteria:
1) NCQA Ranking (Special notice taken of Level III practices)
2) Shared savings performance
3) Size
4) Independent or large group practice
5) Geography
6) Urban/rural

Preferred: wide representation among top performers.
Measures To Identify Best Performing Practices

1) Core Diabetes Measures in 2011 and 2012
   a) HbA1c Control
   b) HbA1c Poor Control
   c) Diabetes BP control

2) Related Measures 2012
   Measures that strongly correlated to good performance in Core Measures:
   a) IVD LDL<100
   b) Tobacco intervention
   c) Weight screening and follow-up ages 18-64

Practices ranked for each measure and averaged to obtain a comprehensive rank.
Best PCMH Practices Findings

1. Follow-up
   Continually mine data or follow up with future appointments
   - NCQA only requires once-a-year population management

2. Customized Plans
   Tailor goals to each patient’s lifestyle and interests
   - NCQA requires this for identified Care Management patients

3. Care Management
   Identify, organize, and assign this function
   - NCQA requires care planning, self-management support, overcoming barriers, reconciling meds
Discern Best PCMH Practices

Findings

4. Great Use of IT

Use your EHR to its maximum capability

- NCQA requires some Meaningful-Use-like reports
- NCQA requires assessment of record completeness

5. Comprehensiveness

Work with the whole person; consider sub-specialists carefully

- NCQA requires actively incorporating behavioral health and actively managing referrals

6. TLC

Constantly attend to Teamwork, Leadership, Communication

- NCQA requires team roles, team communication about patients, including the patient on the team
Two Top Practices

Mountain Laurel Medical Center (Oakland)

Johnston Family Medicine (Westminster)
Compassionate care in your community
Open to everyone in the community regardless of a person’s ability to pay, socioeconomic or insurance status
Offers a sliding fee discount to people who qualify based on income.
Located in Garrett County, the westernmost county of the state of Maryland bordering West Virginia and Pennsylvania.

A private non-profit health care organization that meets certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act) and receive funds under the Health Center Program (Section 330 of the Public Health Service Act).

Funded and operational in 2006 as a new health center to provide comprehensive primary health care services as well as supportive services (education, translation and transportation, etc.) that promote access to health care.

Governed by a community board composed of a majority (51% or more) of health center patients who represent the population served.
- **Support and management** are provided by a competent staff of 38 including (3) family physicians, (2) nurse practitioners and (3) P.A.’s

- **A culture built on** patient centeredness and quality driven care

- **Early adopter of Patient Centered Medical Home** model of care, NCQA Level III recognized

- **Expansion including a satellite office** in the Grantsville, MD area in 2014
Johnston Family Medicine

41 Magna Way
Suite 100
Westminster, MD
21157
410.751.6684

- Virtual Office Visit
- Previsit Interview
- Health Forms & Practice Policies
- Pay My Bill Online
- Webview Patient Portal
- JFM Wellness Center

We continually strive to meet the often-missed needs of the evolving, active family.
Our Speakers

- Beth Little Terry
  - CEO, Mountain Laurel Medical Center, since 2007
  - Formerly COO of an Alaska Community Health Center, and Director of a Florida Medicaid Program

- Kimberly Johnston, MD
  - Physician and Owner, Johnston Family Medicine, since 2000
  - University of Maryland Medical School, Internship, and Residency
Questions for Beth Little Terry and Kim Johnston MD

1. What is your practice’s “brand,” a short statement about your culture.
2. How do you do the basic blocking and tackling, i.e., making sure diabetics come in every 3 – 6 months? (This is often called population management.)
3. What’s your position on getting lab work done ahead of the visit, and how do you handle that?
4. How does your practice carry out care management? How do you define the function, and who does it?
5. Give us an example of engaging a patient with diabetes. The patient delivers most of her own health care—how do you customize goals with the patient?
6. Both your practices offer direct counseling and help with lifestyle change. Can you describe what you do, and how it interacts with chronic care management for patients?

7. Now I want to ask about your practice’s development as a PCMH. What was the key to making the transformation?

8. What was most difficult about becoming a PCMH? How did you interact with the Maryland Multi-Payer PCMH Pilot, and what support did you get to help in the transformation?

9. Your two practices are similar in having NPs and Pas carry their own panel of patients with chronic illness. Can you tell me how that works?
10. Your two practices both have excellent clinical outcomes, yet are different in your levels of NCQA Recognition. Can you tell us your rationale for seeking a Level 3, or staying at a Level 2?
Thank you!
Linda K Shelton, Partner, Discern Health
lshelton@discernhealth.com
(410) 542-4470 ext. 117