

From Philosophy to Reality: Making Our House a Home



Department of Family Medicine
University of Michigan Health System

~ Objectives ~

- **Share our PCMH implementation experiences**
 - Describe our vision for a “personal health home”
 - Discuss strategies for change management
 - Describe ways to influence patient perceptions
- **Illustrate population management strategies**
 - Describe our patient risk stratification model
 - Demonstrate potential uses of T-codes
 - Discuss incorporating a registry into daily practice

UMHS Family Medicine: Our Clinical Environment

- Five clinical sites
- 140,000 annual visits
- 55 clinical/research faculty, 30 residents
- Provide full spectrum care, including obstetrics
- The challenge of academic medicine
 - Support clinical, educational, research missions
 - Demonstrate model that attracts students to primary care
- Initial clinic model (2005)
 - Practiced as individuals, no true team-based care
 - Challenges with continuity, coverage for absences
 - Population management not well developed

Putting the Pieces Together: Every Home Needs a Blueprint



UMHS Family Medicine

~ New Model Vision ~

- To have clinical quality as the defining feature of all aspects of clinical operations
- To establish consistent clinical operations standards
- To bring patient satisfaction to the highest levels
- To markedly improve patient access
- To enhance and improve chronic care and case management
- To markedly improve faculty morale and satisfaction
- To fully integrate resident and medical student education with daily clinical practice, focus on resident continuity experience
- To enhance integration of practice-based research at all sites

Focused, Phased Approach To Implementation

- **Phase 1:** Team development, role definition
- **Phase 2:** Point-of-care population management
- **Phase 3:** Population management and care coordination, access improvement



Patient Care Teams: Structure and Functions

- Foundation for PCMH, involve entire office in care
- Include on-site faculty, residents, NP/PA, RN, MA, LPN, front staff
- Provide coverage for daily patient issues, urgent care, phone calls, refills, labs when not available
- Teach residents a PCMH group practice model
- Team leader - facilitates coverage, leads meetings
 - Monthly team meeting time carved out of patient care
 - Discuss both clinic operations and patient management
 - Review registry reports, identify focus areas

Define and Expand Team Member Roles: Examples

- **Nurse Practitioners/Physician Assistants**
 - Involved in care coordination, access improvement
- **Registered Nurses**
 - More formalized role in care coordination
- **Licensed Practical Nurses**
 - Renew prescriptions based on delegation protocol
- **Medical Assistants**
 - Assist with chronic/preventive care during visits
- **Outpatient Office Assistants**
 - Call patients who need follow up appointments/testing

New Role: Population Health Coordinator

■ Rationale:

- On-site accountability for overseeing population management

■ Functions:

- Coordinate report distribution and patient mailings
- Maintain list of high-risk patients managed by RNs/NPs
- Monitor team progress with chronic care call lists
- Act as site point person for registry reports/requests

■ Position level:

- Medical Assistant, LPN or front office staff

■ Time commitment:

- Eight hours per week (0.2 FTE) per health center

The Role of a Registry: With the Right Tools...

- **Must be fully integrated into clinic operations**
- **Must contain validated, up-to-date information**
- **Our registry: Cielo Clinic**
 - Integrates with existing EHR
 - Point-of-care (POC) prompts based on a comprehensive set of coded, clinician-verified diagnoses
 - POC prompts flexible, easily customizable
 - Generation of online call lists, patient letters, performance reports, patient panel information
 - www.cielomedolutions.com

Incorporating Registry Use Into Daily Practice

- **Current Cielo Compliance Rate**
 - 96% form return rate, 94% prompt action rate
 - How did we do this??
- **Strategies for encouraging use**
 - Make it EASY to manage prompts at each visit
 - Train MAs and RNs to assist with prompts as part of normal routine daily operations
 - Monthly email of team compliance to members
 - Include Cielo compliance in clinical incentive program (\$1/RVU for > 90% return rate)

Managing Change



Strategies for Engaging Physicians and Staff

- **Personalize PCMH concepts to meet our needs**
- **Give people control over their environment**
 - Annual faculty/staff retreats to define model components
 - Staff participation in creating their job descriptions
 - Sharing of successes across practices
- **Anticipate, understand and address barriers**
- **Discuss changes in multiple venues**
 - New Model Implementation Team - meets monthly
 - Review/discuss all new registry prompts and reports
 - Frequent email communication to faculty and staff

Medical Home Pilot Projects (Encourage Innovation!)

- **Team approach to care**
 - Multiple team-based pilots at various clinical sites
 - Include clinic flow, registry management, patient outreach
- **Patient population management**
 - Develop/pilot new patient POC reminders/processes
 - Involve RNs in chronic care management – each site with initial focus area, share knowledge and best practices
- **Access improvement**
 - 20 minute visit model – piloted at two sites
 - Group visits – piloted at three sites
 - Electronic visits (RelayHealth) – piloted at two sites
 - Modified open access – piloted at one site



Engaging Patients and Families




Introducing the Team Concept To Patients

TEAM COVERAGE
Our goal is to have you see your primary healthcare provider whenever possible. In this person's absence, however, you will be seen by another member of your team, who will be aware of and ready to respond to your needs. Through regular team meetings, all members of the team will be kept informed of your needs and the status of your care.

PATIENT ASSIGNMENTS TO TEAMS
You will be assigned to the team on which your current provider is a member. You will not need or be asked to change providers as a result of the new team structure. If you should decide to change providers at any time, you would then receive care from the team on which the new provider is a member.

APPOINTMENTS AND SCHEDULES
When you call for an appointment, you only need to indicate the name of your primary care provider and we will schedule you with this person whenever possible. If this person is not available to meet your schedule, you will be offered the option of seeing another provider on your team or another professional at our site, if this is the only remaining option.



Briarwood Family Medicine
OUR COMMITMENT:
TO BE YOUR
'PERSONAL HEALTH HOME'

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Briarwood Family Medicine
ENHANCING PATIENT CARE
THROUGH A TOTAL TEAM APPROACH

**New Model For Us,
Same Great Care For You**

Team Two

DEPARTMENT OF FAMILY MEDICINE





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Team Two

			
Dr. Amy Bohn	Dr. Phillip Rodgers	Kelly Lingenfeller, MA	Christina Stewart, MA

Cross-Team Providers

			
Dr. David Serlin	Margaret (Peggy) Miodonski, NP	Susan Doyle, PA	Luanne Altman, MA


		
Patty Coughlin, RN	Heather Moore, MA	Linda Warzyniec, MA

New Model For Us

Same Great Care For You

Family Medicine Newsletter: Introduce PCMH Concepts

Winter
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University of Michigan
Health System 2009



IN THIS ISSUE

P2 Handwashing
Cold and Flu

P3 Dry Skin

Plus!

P4 Briarwood
Providers
Meet our new
Medical Director
Lab Hours

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Specialty complementary and
alternative medicine service.
Located within the
Briarwood Family Medicine
Building.

If you have any comments
or suggestions for future
publications regarding our
newsletter, please feel
free to contact Melissa :
melcraw@umich.edu
Please put "BFM
Newsletter" in your subject
line or phone (734)998-
7390.

Thank you!

Briarwood Family Medicine

A quarterly newsletter from our medical home to yours....

Introducing Your Michigan Medical Home

A Medical Home is the foundation for a trusting partnership between a physician led health care team and an informed patient. It is a health care setting that provides patients with timely, well organized care and enhanced access to providers. At Briarwood Family Medicine, your health care team consists of physicians, nurses, medical assistants, nurse practitioners, physician assistants, and call center specialists. Your team has been designed to meet the broad scope of your healthcare needs and provide you with a "personal health home". We also partner with specialists to coordinate your care. In future months, we will be focusing on the following areas as part of our ongoing goal to provide you and your family with the best health care possible. Your feedback and comments are welcome and encouraged!

Joint Principles of the Patient-Centered Medical Home*

- **Personal Relationship:** Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Team Approach:** The personal physician leads a team of individuals at the practice level who collectively take responsibility for ongoing patient care.
- **Comprehensive Care:** The personal physician is responsible for providing for all the patient's health care needs at all stages of life or taking responsibility for appropriately arranging care with other qualified professionals.
- **Care Coordination:** Care is coordinated and integrated across all domains of the health care system, facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they want it.
- **Quality and Safety:** Quality and safety are hallmarks of the medical home. This includes using electronic medical records and technology to provide decision-support for evidence-based treatments and patient and physician involvement in continuous quality improvement.
- **Expanded Access:** Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, physicians and practice staff.

*Issued in 2007 by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association

- Quarterly publication
- Four pages, 50% common to all sites, 50% site-specific
- Distributed in clinic, link on Web sites
- Explains PCMH concepts, introduces new features, solicits feedback
- Seasonal articles (allergies, bike safety, "common cold")
- Education on caring for chronic conditions (DM, etc.)

PCMH Patient-Provider Partnership (Child and Adult Versions)



Auto Print Patient Name
Site

Please join us as we build your Michigan Medical Home together

A **Medical Home** is a trusting partnership between a doctor-led health care team and an informed patient and caregiver. We ask you to choose a doctor who will work with you and your child/dependent to take part in their care and set goals to manage their health.

Being part of the Michigan Medical Home means we will:

- › take care of short term illness and long term chronic diseases
- › ask about your goals to improve the health of your child
- › listen to you and your child and address any concerns
- › help your child stay healthy by giving you information about their health and medical conditions in a way you can understand
- › respond promptly to your calls, questions and concerns
- › have a nurse or doctor on call after hours for urgent calls
- › remind you when vaccines and screening tests are due
- › notify you of test results in a timely manner
- › help coordinate care with specialty doctors if necessary

Having a Medical Home means we trust you to:

- › learn about your child's medical problems
- › follow the care plan that is agreed upon as best you can
- › tell us about all medications and supplements your child is taking
- › let us know when other doctors are involved in your child's care and ask them to send us a report when you see them
- › keep appointments as scheduled, or call to reschedule or cancel
- › call if you do not receive test results within 2 weeks
- › use the "after hours" line only for issues that can't wait until the next work day
- › call the office for minor problems instead of going to the Emergency Room, so someone who knows your child's history can care for them
- › learn about your insurance so you know what it covers or work with us to help develop a payment plan
- › pay your share of the visit fee at the time of the visit
- › give us your feedback so that we can improve our services

The University of Michigan Health System's list of Patient Rights and Responsibilities provides more information about what you can expect from us, and what we ask of you as our patient. Visit www.med.umich.edu/quality/toolkit/riprights.htm or ask for a copy at any of our locations.

For more on the "Medical Home" initiative, both at UMHS and nationwide, please ask your doctor or visit www.med.umich.edu/medicalhome.



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Being part of the Michigan Medical Home means we will:

- › take care of short term illness and long term chronic diseases
- › discuss your goals and how you would like to improve your health
- › listen to you and address your concerns
- › help you stay healthy by providing information about your health and medical conditions in a way you can understand
- › respond promptly to your calls, questions and concerns
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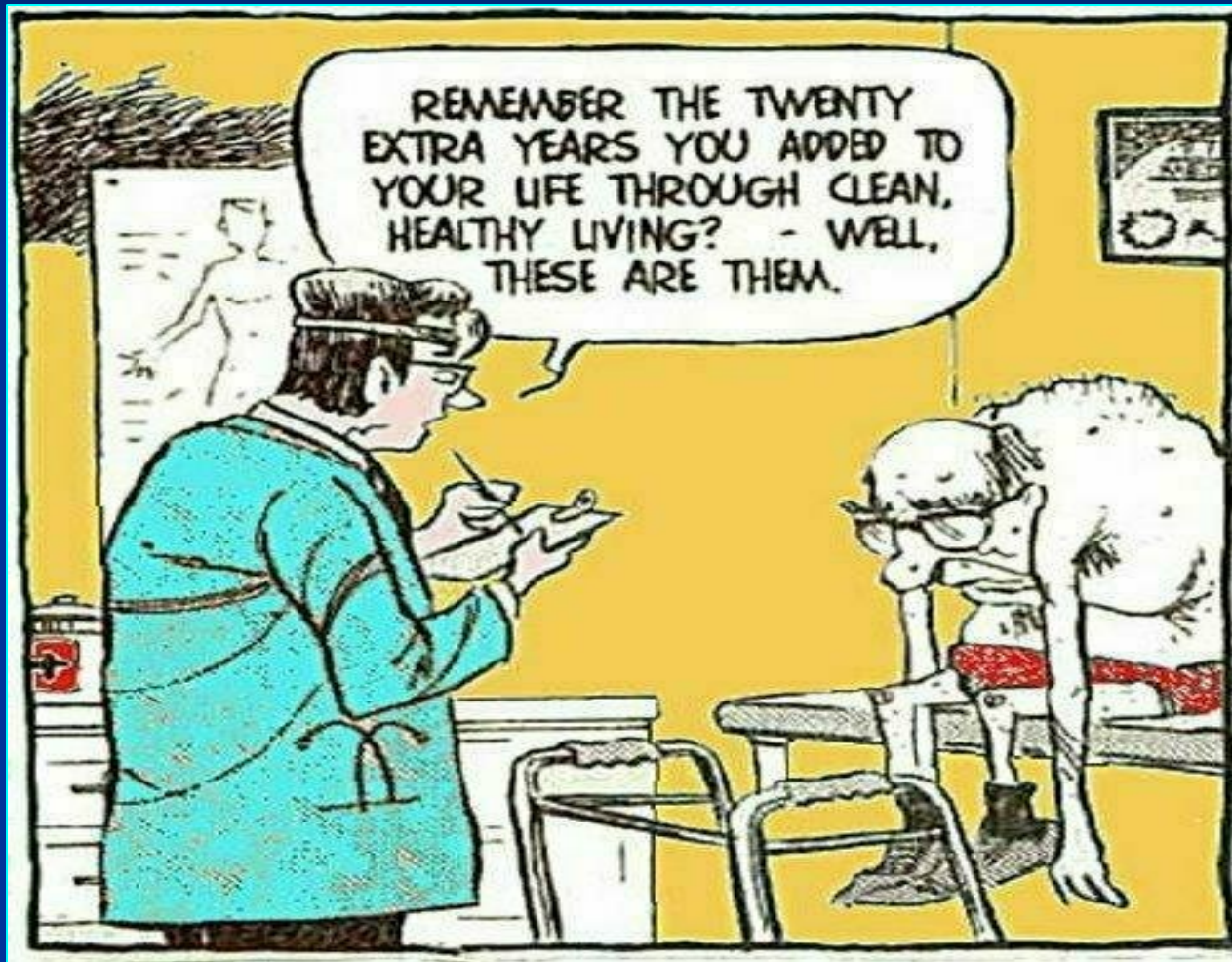
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Lean Project: Understanding Patient Preferences

- BCBSM-sponsored, in design phase
- Question to be answered: **How do our patients prefer to receive information and services to help them manage their health?**
- Incorporating patient input
 - Survey on patient preferences (through Cielo, coded for age, chronic conditions)
 - Patient participation in Lean workshop
 - Development of patient focus group

Managing Population Health



Our Philosophy: Stratify Risk, Maximize Health of ALL Patients

■ Tier 1

- Healthy patients, no chronic conditions
- Goal: Keep them healthy!

■ Tier 2

- Patients with one or more chronic, stable conditions
- Goal: Self-management, improve intermediate outcomes, prevent long-term complications from disease

■ Tier 3

- Patients with multiple co-morbidities, “high risk”
- Goal: Focused intense interventions to minimize complications and unnecessary utilization, maximize function and quality of life

Patient Population Report

- Defines patients assigned to a provider, team and/or clinic
- Defines profiles by patient age, gender, chronic conditions, visit frequency
- Facilitates decisions on panel closures, resource distribution, etc.

Patient Population Report for All Patients 2007-08-05 - 2008-08-04		
For Site: All Team All Provider All		
Total Patients	5792	
Patient Visits		
1-2	3851	66.49%
3-4	977	16.87%
>=5	517	8.93%
0	447	7.72%
Gender		
Female	3610	62.33%
Male	2171	37.48%
Age		
0-18	846	14.61%
19-29	867	14.97%
30-49	1951	33.68%
50-64	1327	22.91%
65-84	690	11.91%
Over 84	111	1.92%
>50	2128	36.74%
>65	801	13.83%
Conditions		
Diabetes Type I	4	0.07%
Diabetes Type II	302	5.21%
CHF	13	0.22%
CAD	136	2.35%
Asthma Persistent	14	0.24%
Depression	149	2.57%

Point-of-Care Patient Management Form

- Cielo form printed for routine and urgent care visits
- Prompts based on coded diagnoses, patient demographics, services performed
- Medical Assistants address many prompts before physician sees patient (flu vaccine, mammogram referral, etc.)

Encounter Form

PCP: Timothy D. Morris, MS Not a Family Medicine Patient

Name	ID #	Age	Gen.	Site	Provider	Date	Time
Doe, Jane	98765-432-1	61 Y	F	DSF	99999: Timothy D. Morris, MS (Test)	2009-01-15	08:00

Patient Needs	Previously Performed	Done	Ordered	Declined	Not Cand.	Excused	Not Addr.
Flu Vaccine (if done elsewhere, enter in CareWeb)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DM2 or CAD - annual fasting lipid profile	_____	<input type="checkbox"/>	<input type="checkbox"/>	2007-03-15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Cancer Screen (circle type DONE) FOBT, Fln.Sig., BE, Colonoscopy	_____	<input type="checkbox"/>	2006-12-19	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annual Diabetic Eye Exam	_____	<input type="checkbox"/>	2007-03-15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DM no A1C in six months	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PAP Smear - Low Risk (circle if High Risk)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screening Mammogram	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult Pneumovax for Chronic Illness	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consider pneumovax due to persistent asthma	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Chronic Problems (write in changes)	Last Addressed	Addressed?
Visit for Periodic Health Examination : (V70.0)	None	<input type="checkbox"/>
Hypertension : (401.9)	2006-10-23	<input type="checkbox"/>
Asthma (persistent) (Persistent = rescue inhaler > 2x/wk or night symptoms > 1x/mo) : (493.10)	2008-12-27	<input type="checkbox"/>
Diabetes Mellitus Type 2 : (250.00) (add new problems here)	2008-01-04	<input type="checkbox"/>

Recent Acute Problems (write in changes)	Last Seen	Addressed?
(add new problems here)		

987654321 Doe, Jane 2009-01-15 1

Point-of-Care Prompts: Services Due

■ Preventive care

- Mammograms
- Pap tests
- Colon cancer screening
- PSA screening
- Flu vaccines
- Pneumovax
- HPV vaccine
- Pediatric lead screening
- Prenatal care prompts
- Smoking cessation

■ Chronic care

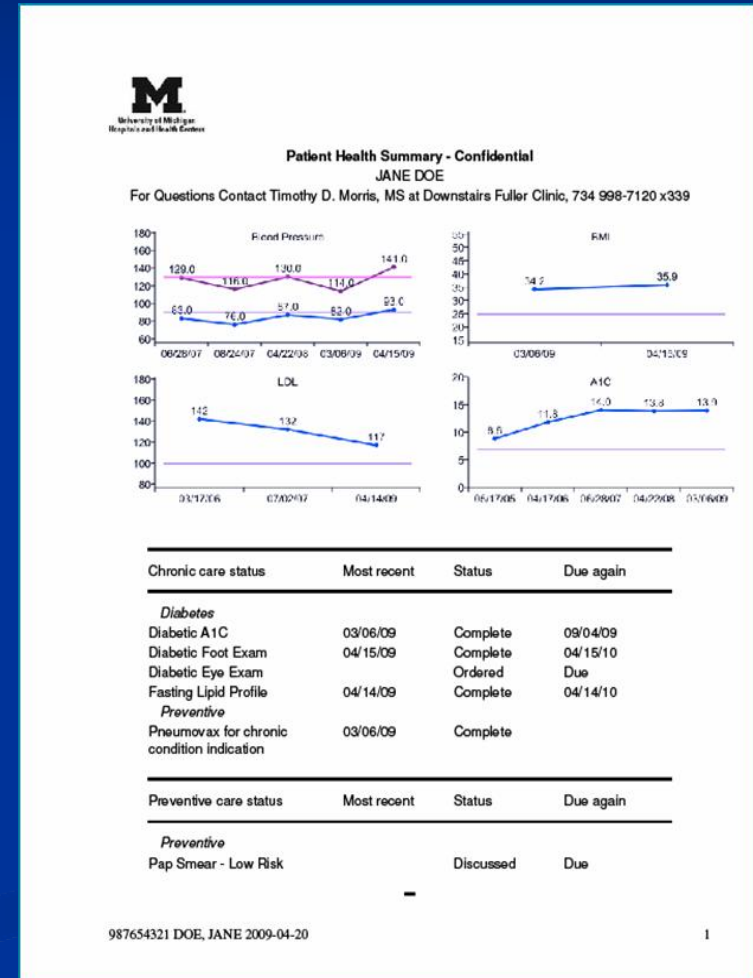
- Diabetes: A1c, LDL, foot exam, UMA, eye exam
- Asthma: action plan, inhaled steroid
- CAD: beta blocker, ASA, LDL
- CHF: LVEF, ACE/beta blocker if EF < 40
- HTN: BP out of range
- Chronic pain/narcotic use

Point-of-Care: Patient Management Options

- Customized, automated printing by Cielo forms generator based on patient characteristics
- Limited only by our imagination!
- Examples:
 - Pre-populated referrals, lab forms for services due
 - Patient education materials (HPV vaccine, hypertension, etc.) based on diagnosis
 - Patient surveys and study enrollment materials based on patient demographics and/or diagnosis
 - Screening tools (PHQ-9, SF-12) based on diagnosis
 - Personalized patient health information

Patient Health Summary Report

- Printed at each visit for patients with chronic conditions
- “Personalized health plan” provides education opportunity
- Reviewed with patient by provider or RN
- Reminds patients when services are due, taken home for their records



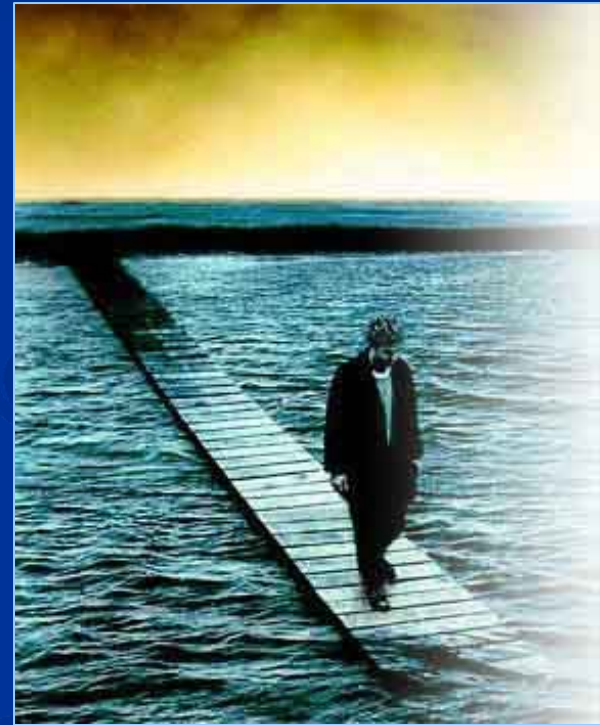
Integrating Chronic Care Into Daily Workflow: Asthma

- POC prompt for annual asthma action plan, if due
- After office visit, provider puts out flag for RN
- RN performs asthma education (then, or in scheduled visit another day)
 - Reviews asthma action plan, symptom triggers
 - Provides peak flow meter
 - Documents in EHR



Integrating Chronic Care into Daily Workflow: Depression

- PHQ-9 form pre-printed for patients with a diagnosis of depression, includes previous three PHQ-9 scores
- Medical Assistant gives form to patient in exam room
- Physician reviews completed form with patient during visit
- Saves time AND improves quality of care
- Planned: also use PHQ-9 to screen patients at high risk



Integrating Chronic Care into Daily Workflow: Chronic Pain Management

- Facilitates a consistent approach to managing high-liability controlled substances across health centers
- Based on UMHS Chronic Pain Management guideline
- Point-of-care prompts triggered by Cielo diagnosis of “Chronic Opioid Therapy”
- Includes point-of-care prompts for:
 - annual controlled substance agreement update
 - annual MAPS report
 - random urine drug screens
- Pain management questionnaire prints at every visit

Using Patient Call Lists

- Cielo call lists generated for services due for any specified population, such as:
 - High-risk children due for lead screening
 - Women due for mammograms
 - Diabetic patients due for labs, other testing
- Teams/sites identify focus areas, try pilot projects
- Plan: Standardize approach based on pilot results

Cielo Clinic Sample Call List

Services Call List
FSC-1 Provider: 999
1/7/2008

ID	Name	Address	Date
1027	1027 General Practitioner		
1028	1028 General Practitioner		
1029	1029 General Practitioner		
1030	1030 General Practitioner		
1031	1031 General Practitioner		
1032	1032 General Practitioner		
1033	1033 General Practitioner		
1034	1034 General Practitioner		
1035	1035 General Practitioner		
1036	1036 General Practitioner		
1037	1037 General Practitioner		
1038	1038 General Practitioner		
1039	1039 General Practitioner		
1040	1040 General Practitioner		
1041	1041 General Practitioner		
1042	1042 General Practitioner		
1043	1043 General Practitioner		
1044	1044 General Practitioner		
1045	1045 General Practitioner		
1046	1046 General Practitioner		
1047	1047 General Practitioner		
1048	1048 General Practitioner		
1049	1049 General Practitioner		
1050	1050 General Practitioner		

Cielo Clinic
MedSolutions

Cielo Clinic™ 1.8.5 Sample Call List
© Copyright 2006-2008 Cielo MedSolutions™
734.627.1000 www.cielomed.com

UMHS Experience with T-codes

- Currently being piloted by health center RNs
- Enhances ability to maximize registry use
- Matches tasks with team members' skills/training
- Initial skepticism replaced with enthusiasm!
 - RNs appreciate ability to contribute to practice revenue
 - Allows reimbursement for what we've done "for free"
 - Provides incentive to develop new team member roles
 - Ability to enhance RN career satisfaction – "I finally feel like I'm doing more of what I was trained to do"
- Funds more RN support for population management

Use of T-codes for Chronic Care Management

■ Diabetes/CAD

- Physician/RN identify registry patients, RN educates on diet, exercise, glucose/lipid management, BP control
- RN adjusts medications based on physician protocols

■ Hypertension

- Loan BP monitors for two weeks, schedule RN visit to review results, educate on medications/lifestyle changes

■ Asthma

- RNs provide asthma teaching, create Asthma Action Plan (after provider visit or through asthma call list review)

Results: Quality Indicators

Change in base over 12 months

- Asthma: Action Plan – 53% increase
- Diabetes: Self-mgmt goal – 60% increase
- Diabetes: BP < 135/80 – 7% improvement
- Diabetes: LDL < 100 – 8% improvement
- Diabetes: Number of indicators above UMHS average – 30% increase

(Anticipate additional improvements once T-codes are fully implemented at all health centers)

Identifying “High Risk” Patients

- Subset of patients that may benefit from higher intensity care coordination
- No perfect model for identifying patients at risk
- Initial stratification process proposed
 - Includes patients with the following characteristics: multiple (>4) co-morbidities, elderly plus dementia, frequent ED use and/or hospitalizations, SF-12 score (Dorr, OHSU)
 - Data sources: Cielo registry, Health System Data Warehouse (ED, hospital utilization), Cielo forms generator (SF-12)
 - Patient lists reviewed and validated by team members

Managing “High Risk” Patients

- Growing body of literature suggests that care coordination can be effectively performed within practices, with collaboration of entire care team
- Increased PCP costs require new funding models
 - Cost of PMPM or T-code payment to PCP office could be offset by reduced costs for ED, specialty, inpatient use
- Our initial work with this patient population
 - Physician/NP pilot to co-manage high risk patients
 - Evaluating various care coordination models (Examples: Guided Care, Care Management Plus)
 - Training RNs for expanded role in care coordination

Summary: Lessons Learned

- Change must be gradual and carefully planned
 - Involve physicians and staff early in the process
 - Seek input often (and act on it!)
 - Never lose sight of the vision
- Go slow - don't underestimate how long things take
- Consistent, frequent communication is critical
- Understand what patients want and what works (surveys, literature review)
- Above all, always do what's right for the patient
- Questions? jskratek@umich.edu



Whether you think you can or whether you think you can't,
you're right.

- *Henry Ford*

Appendix:
Teamwork in Chronic
Care

Diabetes and CAD Management

- MD/RN identify patients from registry or MD referral
- Identify focus areas (i.e. LDL, A1c, diet, BP)
- RN contacts patient, reviews:
 - Medications
 - Diet, exercise
 - Self-management goals
 - Glucose monitoring
- RN adjusts medications based on physician protocol
- RN schedules f/u labs, visits



Hyperlipidemia Management

- Provider receives abnormal cholesterol result electronically
- Sends lab to RN with order to provide lifestyle and/or medication counseling
- RN contacts patient, reviews cholesterol results, discusses diet and exercise
- RN adjusts medications based on physician protocol, if applicable
- RN schedules f/u labs



Hypertension Management (1)

- Physician/RN review Cielo diabetes call list and identify patients with BP out of range
- Review patient record and develop management plan
- RN contacts patient and sets up initial visit for patient education, review of medication regimen, etc.
- RN communicates with physician through EHR or in person, schedules f/u visits as appropriate



Hypertension Management (2)

- Trained MAs in correct technique for monitoring and recording BP reading
- Purchased 7-10 BP monitors for each practice to loan
- If elevated BP noted at office visit, provider places sticker on checkout form
- Staff dispense BP monitor and demonstrate its use
- Patient records BP at home for two weeks
- Patient schedules RN visit for education and follow-up based on RN/physician collaboration

