PCMH
An entire team to call YOUR OWN
Ann Arbor Family Practice
Dr. Steven Thiry M.D.
Wynda Carter R.N.
Sue Saxton R.N, Practice Manager
The path to PCMH

- In the beginning............... 
- The Electronic Medical Record
- PGIP
- PCMH roll- out
What is IHA?

- 150 Physicians
- 37 APN/PA
- 30 Sites
- 250,000 Active Patients
- 22,000 New Patients in 2008
- 488,000 Patient Visits in 2008
- 2,652 Deliveries
- 700 Employees
What is IHA?

- 5 divisions including Internal Medicine, Family Medicine, Pediatrics, OB/GYN, and Surgery
- After Hours
- Ancillary Services – CT, General Ultrasound, General Radiology
- Specialty Services – Maternal-Fetal Medicine, Pediatric and Adult Neurology, Dermatologic Surgery, General Surgery
- Hospitalist Services at SJMH, Saline, and Chelsea for adult patients
IHA’s Network of Care

Ann Arbor/Ypsilanti
- Ann Arbor Family Practice
- Ann Arbor OB/GYN Associates*
- Arbor Park Bone Density Associates in Gynecology and Obstetrics*
- Boyd Gillard Institute of Aesthetic and Dermatologic Surgery
- Child Health Associates - Ann Arbor
- Huron Valley CT Center
- IHA After Hours Care
- IHA Family Practice
- IHA Maternal-Fetal Medicine
- IHA Ultrasound
- IHA West Arbor Obstetrics and Gynecology
- IHA Menon, Miller & Midwives
- Office Procedure Center of IHA
- Pediatric Healthcare Associates - Ann Arbor/Ypsilanti
- Primary Pediatrics
- Walker Gynecology Practice of IHA

Brighton
- Associates in Gynecology and Obstetrics*
- Genoa Ultrasound
- Brighton Family Care Specialists
- IHA Bone Density - Genoa
- IHA Livingston Pediatrics
- IHA Menon, Miller & Midwives*
- IHA Family Pharmacy
- Pamela Davies, MD - Brighton Obstetrics and Gynecology

Canton
- Associates in Internal Medicine - Cherry Hill
- Canton Obstetrics and Gynecology
- IHA Radiology and Cherry Hill Bone Density
- Pediatric Healthcare Associates - Canton

Chelsea
- Associates in Gynecology and Obstetrics*
- Chelsea Internal Medicine
- Chelsea Pediatrics
- Chelsea Surgical Associates

Clinton
- Okey Family Practice

Milan
- Milan Family Practice

Pinckney
- Pinckney Family Care

Plymouth
- Ann Arbor OB/GYN Associates*
- Child Health Associates - Plymouth
- IHA Plymouth Internal Medicine

*Multiple Locations
Where do we start?

- Select Offices to Pilot
  - Cherry Hill Internal Medicine
  - Okey Family Practice
  - Plymouth Internal Medicine
  - CHA-Plymouth
  - Ann Arbor Family Practice
What are IHA’s *tools* for building our Patient-Centered Medical Homes?

- Extended Access
- Test Tracking
- Patient Registry
- ePrescribing
- Care Management
- Patient Provider Partnership
- Performance Reporting
Patient Satisfaction at IHA

“Getting through to the Office”

<table>
<thead>
<tr>
<th>Survey Period</th>
<th>IHA Overall</th>
<th>AMGA Norm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Excellent)</td>
<td>(Excellent)</td>
</tr>
<tr>
<td>Spring 2005</td>
<td>33%</td>
<td>39%</td>
</tr>
<tr>
<td>Spring 2006</td>
<td>38%</td>
<td>42%</td>
</tr>
<tr>
<td>Spring 2007</td>
<td>38%</td>
<td>45%</td>
</tr>
<tr>
<td>Fall 2007</td>
<td>41%</td>
<td>45%</td>
</tr>
<tr>
<td>Spring 2008</td>
<td>44%</td>
<td>44%</td>
</tr>
<tr>
<td>Fall 2008</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>Spring 2009</td>
<td>47%</td>
<td>44%</td>
</tr>
</tbody>
</table>
Each metric has a scale of 1-5 with 5 being “best” access.  The total any office can achieve is 60 starting with June (55 prior).

<table>
<thead>
<tr>
<th></th>
<th>June 07</th>
<th>Sept 07</th>
<th>Dec. 07</th>
<th>Mar. 08</th>
<th>June 08</th>
<th>Difference between June 07 and June 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of offices answering phones during lunch</td>
<td>38%</td>
<td>48%</td>
<td>55%</td>
<td>87%</td>
<td>97%</td>
<td>59%</td>
</tr>
<tr>
<td>Percent of offices that have a live person answer phones</td>
<td>31%</td>
<td>41%</td>
<td>52%</td>
<td>43%</td>
<td>45%</td>
<td>14%</td>
</tr>
<tr>
<td>Percent of offices that have started Advanced Access</td>
<td>45%</td>
<td>55%</td>
<td>55%</td>
<td>67%</td>
<td>84%</td>
<td>39%</td>
</tr>
<tr>
<td>Percent of offices only have 3 days or less for 3PE</td>
<td>28%</td>
<td>34%</td>
<td>41%</td>
<td>47%</td>
<td>55%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Total increase from June 07-June 08: 11.22

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>June 2007</td>
<td>27.59</td>
</tr>
<tr>
<td>July</td>
<td>28.48</td>
</tr>
<tr>
<td>August</td>
<td>29.34</td>
</tr>
<tr>
<td>September</td>
<td>29.52</td>
</tr>
<tr>
<td>October</td>
<td>31.45</td>
</tr>
<tr>
<td>November</td>
<td>31.07</td>
</tr>
<tr>
<td>December</td>
<td>31.34</td>
</tr>
<tr>
<td>January 2008</td>
<td>31.62</td>
</tr>
<tr>
<td>February</td>
<td>33.28</td>
</tr>
<tr>
<td>March</td>
<td>34.07</td>
</tr>
<tr>
<td>April</td>
<td>35.57</td>
</tr>
<tr>
<td>May</td>
<td>36.63</td>
</tr>
<tr>
<td>June</td>
<td>38.81</td>
</tr>
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</table>
IHA ER Utilization Trends

<table>
<thead>
<tr>
<th>Jan 08</th>
<th>Feb 08</th>
<th>Mar 08</th>
<th>Apr 08</th>
<th>May 08</th>
<th>June 08</th>
<th>July 08</th>
<th>Aug 08</th>
<th>Sept 08</th>
<th>Oct 08</th>
<th>Nov 08</th>
<th>Dec 08</th>
<th>Jan 09</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP ER Rate/1000</td>
<td>180</td>
<td>216</td>
<td>185</td>
<td>149</td>
<td>167</td>
<td>159</td>
<td>142</td>
<td>141</td>
<td>163</td>
<td>171</td>
<td>166</td>
<td>152</td>
</tr>
<tr>
<td>Priority ER Rate/1000</td>
<td>217.51</td>
<td>224.48</td>
<td>223.84</td>
<td>208.28</td>
<td>203.11</td>
<td>197.3</td>
<td>182.39</td>
<td>190.17</td>
<td>220.9</td>
<td>191.65</td>
<td>171.12</td>
<td>163.05</td>
</tr>
</tbody>
</table>
Barriers to getting started......

• **Resources, resources, resources**
  – Project Manager
  – Training – IHA University
  – The SE Michigan and National Economy
    • Decreased Visits in 2008

• System interfaces with multiple institutions

• EMR vendor limitations
Thinking in a New Way… LEAN

- Registry Function
- Test Tracking
- Development of Internal Coaches
- Roles and Responsibilities
- Care Coordination: Learning Collaborative with HVPA and U of M
Identifying Teams
An entire healthcare team to call your own.

IHA is transforming the way it delivers care with the Patient-Centered Medical Home.

Our team approach to providing medical care and wellness is centered on you, the patient, and includes a medical assistant, nurse, nurse practitioner, dietitian and physician.

Our team is transforming the traditional “doctor’s office” into a Patient-Centered Medical Home by partnering with you to create a plan of care. The plan encompasses both your goals for maintaining health habits, as well as the desired lifestyle changes that will put you on the road to greater wellness.

We not only want to care for you when you are ill, but also partner with you on scheduling regular check-ups and testing and preventive screenings. With open and regular communication, since no decisions are made without you, we are creating a trusted and valued partnership.

Our goal is to be accessible, reliable and so thorough that IHA becomes your “healthcare” home away from home.
Planned Care: The Chronic Care Model

Chronic Condition Visit

Recall

Run registry

Pre-call

Task

Recall

f/u appt scheduled

Planned care follow-up: phone/face to face
Recommendations for Planned Care: Complicated Diabetes

• Newly diagnosed
• BP >130/80 on two consecutive visits
• A1C > 8.0
• Co-morbidity associated with diagnosis: CAD, CHF, CVA, PVOD
• Depression
• LDL >100
• Change in medications
• Recent hospitalization
PEACHFARM

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Pneumovax Given anytime</td>
</tr>
<tr>
<td>F</td>
<td>Eye Exam Once a year</td>
</tr>
<tr>
<td>A</td>
<td>A1C Every 3 mo. if &lt; or equal 7.0, every 6 mo. if &lt; 7.0</td>
</tr>
<tr>
<td>C</td>
<td>Cholesterol LDL below 100</td>
</tr>
<tr>
<td>H</td>
<td>Hypertension Goal BP 130-80</td>
</tr>
<tr>
<td>F</td>
<td>Test Inspect at every visit</td>
</tr>
<tr>
<td>A</td>
<td>Aspirin</td>
</tr>
<tr>
<td>R</td>
<td>Remove Tobacco Provide smoking education</td>
</tr>
<tr>
<td>M</td>
<td>Microalbumin Check every 6 months</td>
</tr>
</tbody>
</table>
Healthy Changes Action Plan

Name: [ ] [ ] Plan Date: 06/08/2009

I have agreed that to improve my health I will: (from DM flowsheet)

My specific goal for next month is:

The steps I will take to achieve my goal are:

How Much: [ ] When: [ ] How Often: [ ]

Things that could make it difficult to achieve my goal include:

My plans for overcoming these difficulties include:

Support / resources I will need to achieve my goal include:

This is my rating on how sure I will be able to complete my action plan: [ ] on a scale from 0 (unsure) to 10 (very sure).

Save Action Plan

☑ Implement chronic disease management

Needs RN PCV follow up: [ ]

Submit F/U appt [ ]

☑ f up submitted
The Future State

- Program Manager
- Learning Collaborative
- Build infrastructure
- Develop and track desired metrics
- Collaboration between Medical Management and I.T.
- Align compensation structure
- Align management incentives
Introducing
IHA’s Patient Portal

Coming in September

IHA is making a big change to serve you better...

Always striving to enhance patient care, we are preparing to launch our new IHA Patient Portal. In order to streamline the registration process for our patients, we will be asking for an e-mail address at your visit.

- We only need one e-mail per patient
- If the patient is a minor child, we will need the e-mail of the person responsible for care of the child or the guarantor

With the new IHA Patient Portal, patients will have the ability to do the following online:
- Request appointments, prescription refills & referrals
- View, manage and update health histories
- View online statements
- Update personal profiles
- Complete pre-visit forms
- Receive and review documents

24 Frank Lloyd Wright Drive • Ann Arbor, MI • 48106 • www.ihacares.com
It’s kind of fun to do the impossible!

Walt Disney
AAFP and the PCMH

- Our primary goal is to provide the best possible care to every patient.
  - It is a transformation.
- Some changes will be noticeable as we build our medical home.
  - It will require a commitment to change.
Getting Started

• Choose/identify the “Office Leads”

Process committee should include representatives from:

• Clerical (Phones, check in/out, file rm.)
• Clinical (MA’s, Nurses)
• Provider
• Practice Manager

**WHY?**

This group will facilitate evaluation and change in office policy and procedures. They will function as the “go to” people for the staff.
Committee Evaluation Meetings

• Start the **LEAN** process
• Evaluate/Map the present office process for a patient.
• Take each step from first contact by phone through checking out at the end of the visit. (*Your* process)

**WHY?**

You will get a clearer picture of the patient experience and how the staff response affects each step.
• Evaluate/Map the future office process. Define *Step by Step* what the “ideal” process should be.
• Choose **one or two goals each week to change**.
• Each committee member reports back at weekly meetings, how the changes affected that area and suggest change if needed.
• Committee continues to add changes until FUTURE office process goals are met.
• Keep in mind some goals are more easily met than others. Flexibility and patience are key to a successful change.
Increase Efficiencies and Decrease Errors

Make the Right Thing the Easy Thing

Same Way
Every Time
No Double Work
Processes Identified for Change

• **Phones**: operator takes live calls.

• Answering menu activated for pt only if all operators are on another call.

• Answering menu changed. Choices made clearer. Decreased number of choices.

• **Clerical/front office:**
  All pt. insurance confirmed prior to visit (decrease wait time at check in).

• Check-in/check out consolidated in one area.

• Planned care patients identified at check in by EMR alert and flagged for MA and provider.
• **MA rooming the patient:** Standardized rooming protocol.

• **Provider visit:**
  - Interruption policy
  - Standardized equipment supplies for each exam room
  - Preferred specialist list for referrals in each exam room

* Improved overall cycle time.
Processes Identified for Change cont.

- **Planned Care Visits**
  - Diabetic patients only
  - Develop protocol
  - Expand role of the office RN
    - Billable planned care follow-up phone call and nurse only office visit (T-code billing)

- **Template in EMR for provider and nursing.**
Planned Care Follow-Up

Date: 03/19/2009  Time: 9:52 AM
Name: 
DOB: 03/29/1966  Age: 41 Year
Insurance: Midwest Health Plan

Chronic Condition Goals from visit on: 02/18/2009
Select condition being discussed

- Asthma
- CAD
- CHF
- DM Diabetes Uncomp Type II 250.01
- HTN

PCP: Mark Zawisa MD

Actions this Visit
(PCV Follow up )

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Condition</th>
<th>Notes</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/19/2009</td>
<td>10:40 AM</td>
<td>Diabetes</td>
<td>3/19/09 9:53AM Post visit follow up: Discussed self care goals for Diabetes on visit date 02/18/2009. The patient stated he was not taking his medications and was not checking his blood sugar. He has been depressed and has not been working on his goals. The patient walked outside for approximately 30 minutes a couple of times when the discussion of the goals started.</td>
<td>Frances Pachota</td>
</tr>
</tbody>
</table>

DME
Future Orders
Lab Master
Disease Management
Check Out

Submit to Superbill

AADE Goal Orders

<table>
<thead>
<tr>
<th>Date</th>
<th>Category</th>
<th>Review</th>
<th>Goal Set</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/18/2009</td>
<td>Healthy Eating</td>
<td></td>
<td>Make better food choices</td>
<td>Mark Zawisa MD</td>
</tr>
<tr>
<td>02/18/2009</td>
<td>Self manage goals</td>
<td></td>
<td>Eat less, get a little more activity</td>
<td>Mark Zawisa MD</td>
</tr>
</tbody>
</table>
Patient Education

- Informational bulletin board designed and displayed in the lobby.
- Handouts- informational brochure-
  *IHA patient centered medical home.*
- Protocol-discusses with all patients PCMH done by clinical/provider staff.
- Document in EMR.
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PATIENT CENTERED MEDICAL HOME FLOW SHEET

1. Patient makes appointment
   - Appointment triggered by:
     - Recall
     - Registry Review
     - Provider Request

2. Patient checks in
   - Patient Given by Reception:
     - Patient Agreement Brochure
     - DM Questionnaire (if applicable)
   - Patient roomed by M.A.

3. MA documents in DM Flow Template:
   - Patient Agreement Given
   - DM Binder Given

4. Patient Visit with Provider:
   - Discuss Patient/Provider Agreement
   - Initiate Planned Care (Per protocol or Provider Request)
   - Healthy Changes Action Plan Completed/DM Flow Template (Copy given to Patient)

5. Patient Checks Out:
   - Follow Up Scheduled
     - Per Provider / OV / Phone Call
     - Per Planned Care Protocol
       - Phone follow-up call if Planned Care Patient.
     - Nurse OV per Provider
Implementing the Plan

• **Staff Education:**
  - Updates and process changes discussed at monthly meetings, on alternating weeks.
  - Clerical only
  - Clinical only
  - Providers only
  - All staff meeting

• **PCMH competency**
  - Each staff member reviews an online power point presentation.
    “IHA and the PCMH”
  - Assessment test to validate competency
• PCMH office LEAD process committee
  Weekly meetings
• Ongoing evaluation, maintenance and implementation of office processes
Predictors of Success

• We’re aligned with our mission/vision
  – IHA exists to meet community needs by providing personalized, high-quality health and medical services to every patient. We strive to achieve unparalleled patient satisfaction with our clinical quality, service, accessibility and value.
• There’s been an articulated need for change
• We have the commitment of Leadership
• We have an effective transition team
• Failure brings consequences
ASK US HOW IT’S GOING

NEXT YEAR…