Clinical Update

Raj Krishnamurthy
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DSTI: Delivery System Transformation Initiative

- Joint state and federal funding via CMS for $628 million to safety net hospitals over 3 years
- First authorized in December ‘11 under MA Medicaid waiver
- BMC share is $103 million per year for 3 years
- But...there is a catch...
DSTI Requirements

• Development of a fully integrated delivery system, such as converting primary care practices into Patient Centered Medical Homes, integrating physical and behavioral health care, and developing integrated networks of providers linked by electronic health records.
  – GIM and Family Medicine Practices will become NCQA Certified Medical Homes

• Implementation of innovative care models to improve quality of care and health outcomes, such as building electronic chronic disease registries, implementing new care management programs for patients with complex conditions, and better coordinating care when patients leave the hospital to prevent readmissions.
  – Patient Support Center in GIM Primary Care to manage populations
  – Diabetes Rapid follow up from ER Care to avoid admissions
  – Simulation Center to improve team based care

• Development of capabilities necessary to implement alternative payment models, such as building the infrastructure to become an Accountable Care Organization (ACO), piloting alternative payment models for low-income patients, and enhancing systems to monitor providers’ performance on health care quality and costs.
  – ACO Development for BMC, FPF and associated CHCs

• Population-focused health outcome improvements, projects aimed at collecting and reporting key measures that will allow the Commonwealth to track and assess the impact of the transformation initiatives on patients’ health and system costs over time.
  – Reporting on Common Measure Sets on quality and patient safety
Patient Centered Medical Home

• Goal: LEVEL 1 National Committee for Quality Assurance (NCQA) certification as PCMH

• GIM and Family Medicine and eventually Pediatrics PC Practices

• Using MAeHC as Consultants to the process
  – Company launched September 2004
    • Non-profit registered in the Commonwealth of Massachusetts
  – Backed by broad array of 34 non-profit MA health care stakeholders
  – Work in areas of PCMH, implementation of electronic medical records, Meaningful Use, HIE development and training, process and workflow redesign
PCMH: Access

• Processes already existed
  – Same day access
  – Telephone Response time and documentation
  – On Call response time and documentation

• Now the practice has monitored the effectiveness of the processes in meeting patient care needs and practice standards

• The practice has written guidelines to document processes, help set expectations and use as for training future team members.
PCMH: Manage Populations

• Collecting and reporting demographic and clinical information (problem list, med list, allergies, smoking status, language, PCP)
• Preventative Services
  • Overdue Mammogram
  • Overdue Pap
  • Overdue Influenza
• Chronic Care Services
  • Overdue A1C
  • Overdue LDL
  • Following up to ED or inpatient discharge
• Patients not seen by the practice in > 18 months
PCMH: Chronic Diseases

• Adopted Evidence Based Guidelines (EBG) for care of chronic diseases
  – Diabetes
  – Hypertension
  – Smoking Cessation
• EBGs documents the practice’s patient identification process, goals for care, treatment guidelines and clinical measures
• Developed templates for documenting patient care plans, self-management goals and barriers to care.
PCMH: Care Coordination

- Lab, referral and imaging test tracking
- Follow up to discharge process
- Case Management position
- Continued work on Referral loop closure and pre-visit planning
PCMH: Measure and Improve Performance

• Report analysis by practice and provider semi-annually
• Goals assessed and performance monitored over time

1. Preventative Care Measures
   – Percentage of patients with a mammogram in the past two years
   – Percentage of patients > 80 years of age with an influenza vaccine

2. Chronic Care Measures
   – Percentage of patients with an A1C > 9.0
   – Percentage of patients with an LDL < 100

3. Patient Experience Data
   – Percent of patients alerted to wait time and appointment delay information
2011 PCMH tasks can follow patient flow

- High-Risk Patients
- Office Hours
- After-Hours Access
- Practice Team
- Cultural & Linguistic Population Mgt
- Continuity of care
- PCMH Responsibilities
- Patient Information
- Clinical Data
- Health Assessment
- Medication Mgt
- EB Guidelines
- eRX
- Care Management
- Self-Care Process
- Community Resources
- Referral Tracking
- Test Tracking
- Care Transitions
- Electronic Access
- Measure Performance
- Patient/Family Experience
- Quality Improvement
- Report Performance
- Report Data

Indicates a Must Pass element

Pre-Visit ➔ Registration ➔ Patient Intake ➔ Provider Visit ➔ Check-Out ➔ Post Visit
It takes a village to raise a Medical Home...

Responsibilities fall across all staff levels to meet the PCMH Recognition

- **Practice Support Center**
  - Reminding patients to schedule their Influenza vaccine, return calls in 2 hours, booking same day appointments, provider continuity
- **Front Desk and Referral Staff**
  - Sending preventative care letters, test and referral tracking, use of interpreter services
- **Practice Managers**
  - Report analysis and distribution, Patient Access, policy
- **MA/Pas**
  - Pre-visit planning, entering clinical data
- **Nursing**
  - Telephone response, clinical advice, population management, high-risk patients, post discharge follow up
- **Provider**
  - eRX, medication management, referrals to community resources and education
  - Self-management goals, barriers to care, care plan documentation
Next Steps

• Chart Review of DM, HTN and smoking patients
  – Care plans and updated goals
  – Barriers to care in meeting goals or taking prescribed medications
  – Self-management goals and support
  – Referrals, use of community resources for self-management and patient education

• Continue to update templates based upon provider feedback. Feedback sessions have occurred along with Family Medicine and changes will be in effect in the next few weeks based upon provider input. Continued feedback will drive best practices and more edits to the verbiage in templates and quick text.

• Complete Application documentation and submission

• Begin process of monitoring and evaluating goals for selected measures and sharing information with providers and staff

• Continue discussion of areas such as referral tracking and pre-visit planning.