



PCMH WEBINAR
SETTING THE FOUNDATION

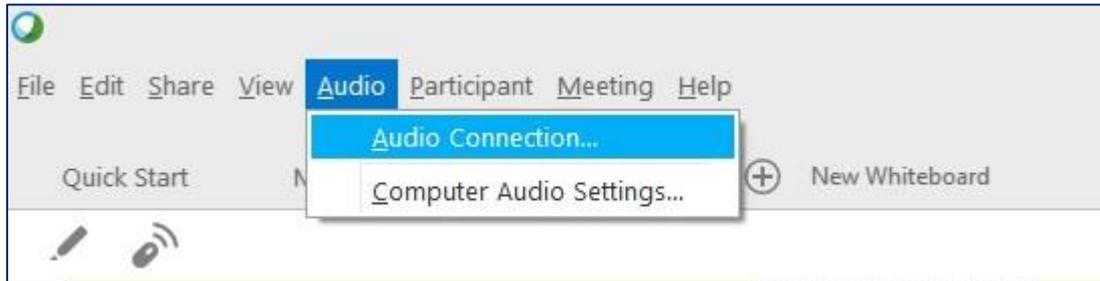
SEP 6 2017





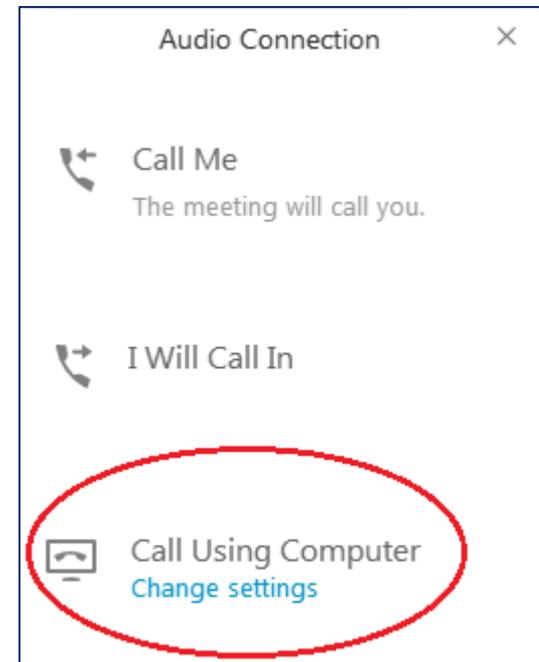
WELCOME!

Audio Connections



If you are not hearing any sound, please select “call using your computer” from Audio tab

NOTE: If you are hearing an echo, try lowering the volume on your computer or wearing headphones



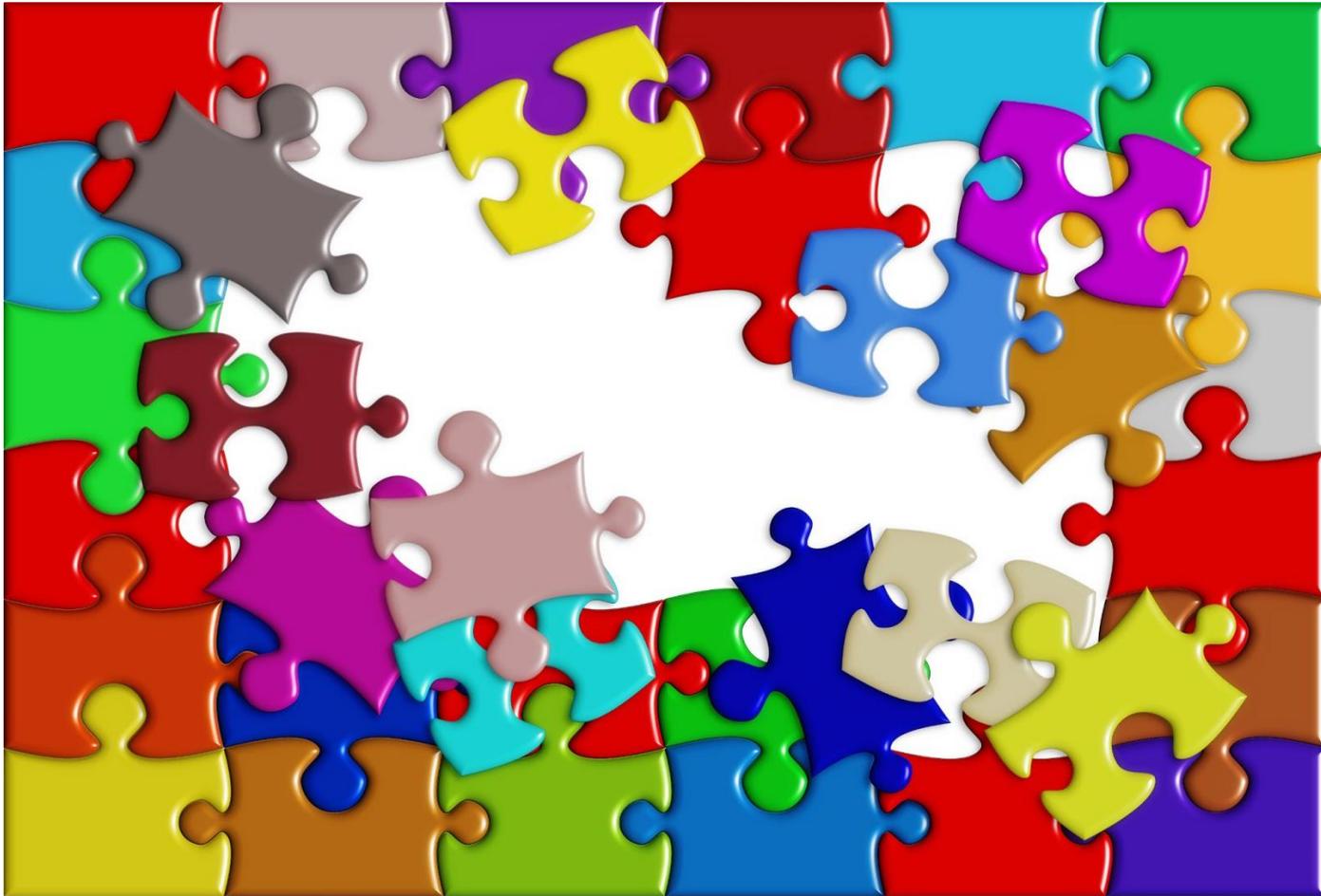
Setting the Foundation

Today's Agenda:

(11:30 a.m.-12:30 p.m.)

- Introduction to the webinar
- The shifting healthcare environment
- Review of the NCQA PCMH 2017 Guidelines
- Setting the Foundation for PCMH
 - Clinician Lead
 - Involving staff (and patients) in QI
 - Team-Based Care
 - Patient Satisfaction Survey
 - Facilitated Discussion
 - Best Practices, Challenges and Novel Ideas

Introduction to the Webinar Series



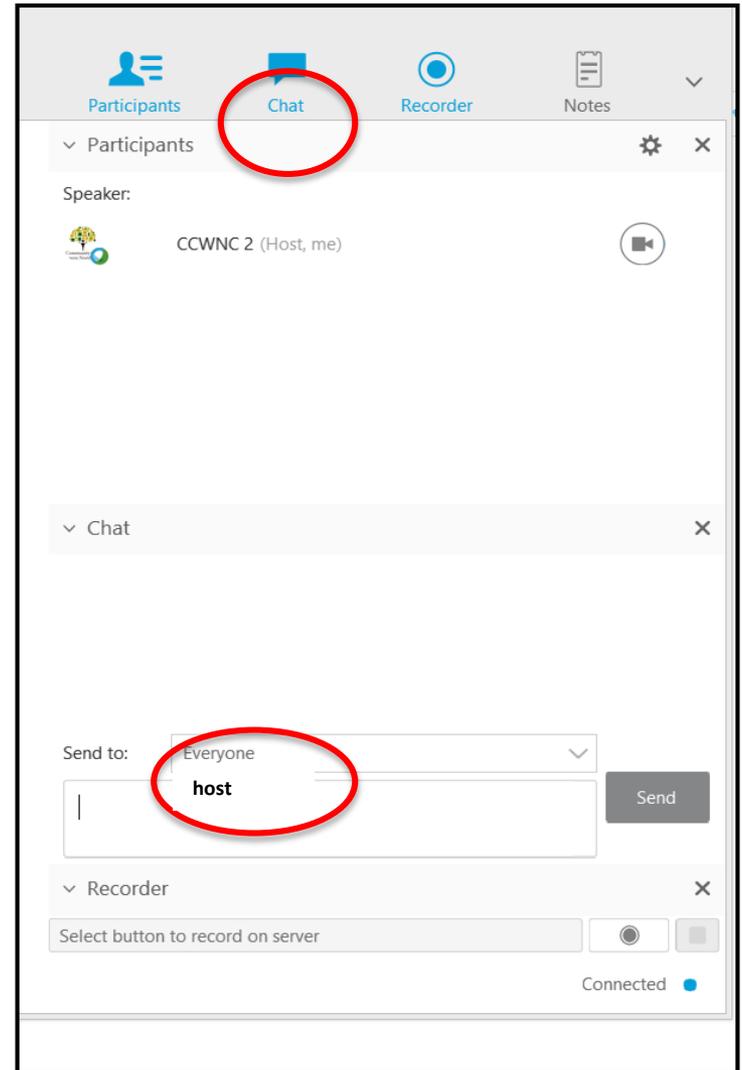
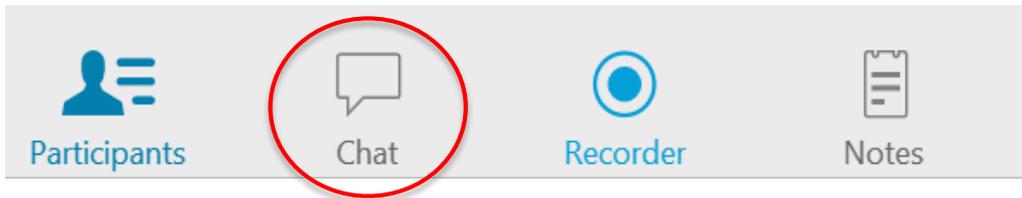
Introduction to the Webinar Series

Chat box during the presentation:

- Send to the Host
 - BEST PRACTICES
 - CHALLENGES
 - NOVEL IDEAS
 - QUESTIONS

Example:

- “NOVEL IDEA – STRUCTURED COMMUNICATION: My practice meets at the end of the day, rather than in the morning”



Shifting Healthcare Environment

Patient-Centered Medical Home

“The PCMH is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.”

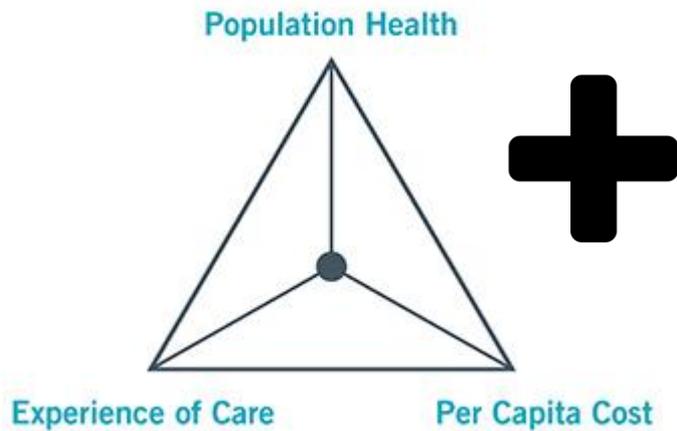
*Joint Principles of the PCMH, March 2007, AAFP, AAP, ACP, AOA

Shifting Healthcare Environment



The Shifting Healthcare Environment

The IHI Triple Aim



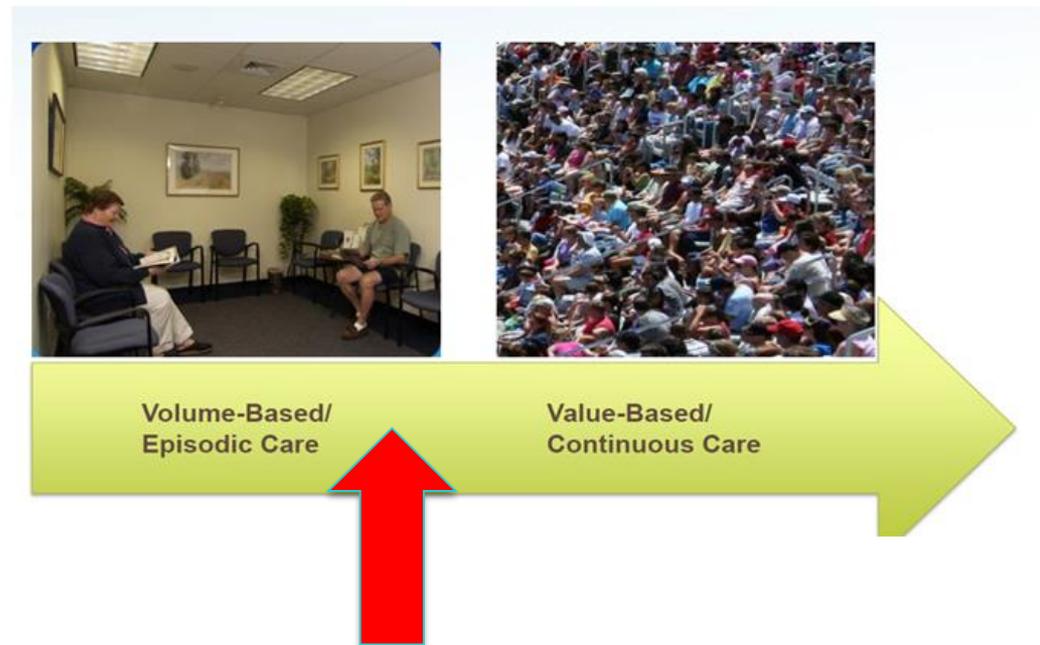
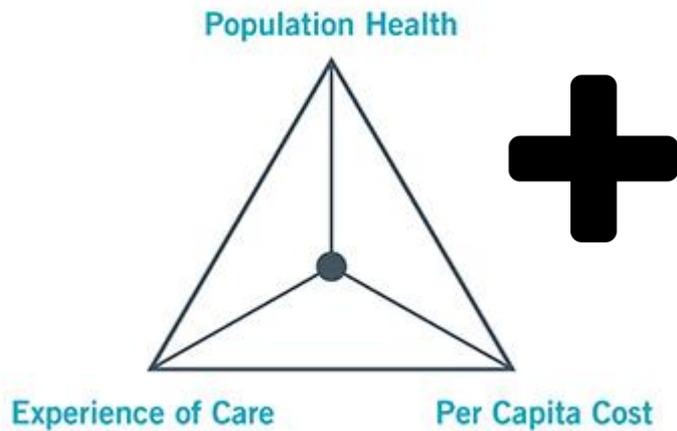
Volume-Based/
Episodic Care



Value-Based/
Continuous Care

The Shifting Healthcare Environment

The IHI Triple Aim



The Shifting Healthcare Environment

Current Model =

Fee-for-Service/episodic Care



- The Primary Care Provider (PCP) office waiting room is filled with *patients who are sick*
- The Provider *treats the patients illness*
- The Patient returns to the PCP when they have another acute (and likely, related) episode*
- The Provider gets paid each time they see the patient – *Is the patient any healthier?*

Future Model =

Pay-for-Performance/Continuous Care



- The PCP office room is filled with *patients who are due for routine and preventive services*
- The Provider follows evidence-based guidelines and *develops a goal-oriented care plan with the patient*
- The Patient returns to the PCP when they are due for their next Routine or Preventive care visit*
- The Provider gets paid when the data from the practice's Electronic Health Record (EMR) shows that *their patient populations are getting healthier*

NCQA PCMH 2017

- New Language (from 2011 and 2014)
 - Concepts (previously Standards) : 6 overarching categories
 - Team-Based Care and Practice Organization (TC)
 - Knowing and Managing your Patients (KM)
 - Patient-Centered Access and Continuity (AC)
 - Care Management and Support (CM)
 - Care Coordination and Care Transitions (CC)
 - Performance Measurement and Quality Improvement (QI)
 - Competencies (previously Elements): sub-sections
 - Criteria (previously Factors): this is where the meat is!
 - 40 Core Criteria and 60 Elective Criteria points
 - Must complete ALL 40 Core Criteria and receive 25 elective points

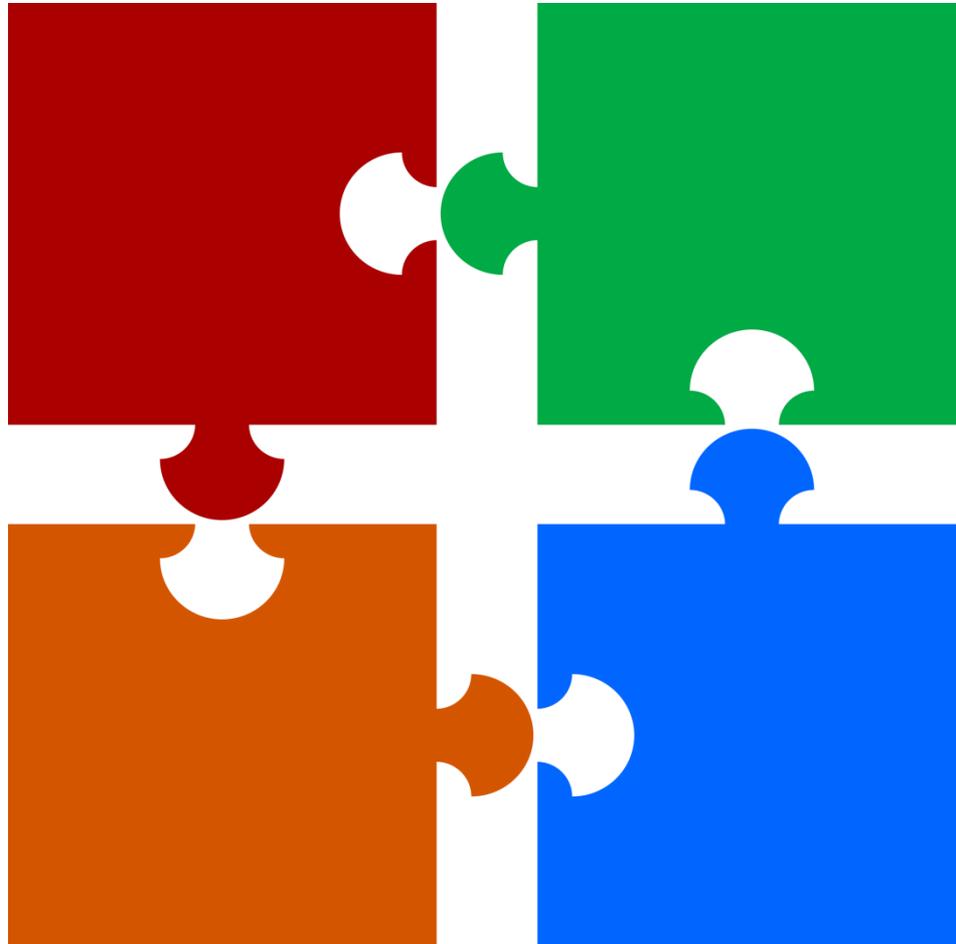


New Online Platform - QPASS

NCQA PCMH 2017

- NCQA website:
 - <http://www.ncqa.org>
- NCQA 2011 and 2014 recognized practices:
 - <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-redesign>

Setting the Foundation



Setting the Foundation

PCMH 2017 Guidelines for Today's Agenda

- TC1 (Core): Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.
- TC2 (Core): Defines practice organizational structure and staff responsibilities/skills to support PCMH functions.
- TC4 (2): Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.
- TC6 (Core): Has regular patient care team meetings or a structured communication process focused on individual patient care.
- TC7 (Core): Involves care team staff in the practice's performance evaluation and quality improvement activities
- AC10 (Core): Helps patients/families/caregivers select or change a personal clinician.
- Q15 (Core): Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.

Setting the Foundation

PCMH 2017 Guidelines for Today's Agenda cont.

- QI 16 (1): Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice.
- QI 17 (2): Involves patient/family/caregiver in quality improvement activities.
- QI 04 (Core): Monitors patient experience through:
 - **A. Quantitative data:** The practice conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:
 - i. Access ii. Communication iii. Coordination iv. Whole person care, Self-management
 - **B. Qualitative data:** The practice obtains feedback from patients/families/caregivers through qualitative means

Clinician Lead

TC1 (Core): Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.

Effective Team Leaders:

- Organize the team
- Articulate clear goals
- Make decisions through collective input of members
- Empower members to speak up and challenge, when appropriate
- Actively promote and facilitate good teamwork
- Skillful at conflict resolution



TeamSTEPPS

PCMH Coordinator

TC1 (Core): Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.



Involve Staff in QI

TC7 (Core): Involves care team staff in the practice's performance evaluation and quality improvement activities



“A chain is only as strong as its weakest link.”

TeamSTEPPS

Involve Staff in QI

1. Team–Based Care:
 - Structured Communication (such as Huddles and Debriefs)
 - Pre-visit Planning
 - Standing Orders
2. Sharing Data with Staff
 - Process for gathering feedback
 - Process for *implementing* feedback
3. Organizational Charts and Job Descriptions
4. Culture

Team-Based Care: Structured Communication

TC6 (Core): Has regular patient care team meetings or a structured communication process focused on individual patient care.



Team-Based Care: Structured Communication

- Pre-Visit Planning
- Standing Orders
- Debriefs

TeamSTEPPS



Sharing Data with Staff

QI 15 (Core): Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.

Some questions to consider when sharing data:

- Is the data engaging and relevant to staff?
 - Remember that not all staff are clinical!
- Is the data correct?
- Do staff understand the data?
- Do staff feel their feedback is valued and important to the practice?
- Is the feedback reviewed regularly?
- Is there a process to implement feedback?

Sharing Data with Staff

QI 15 (Core): Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.

How small practices can get staff engaged in QI:

- Practices who successfully create change are motivated by what interests them rather than by incentives
- Small practices should focus on 1-2 things for as many as 2-3 years in order to create real change = patience
- Physician buy-in is key!!
- Small practices have limited capacity to undertake change
- Small practices value help reaching specific goals

“QI in small office settings” Wolfson, 2009, BMS Family Practice

“Support and Strategies for change among small PCMH practices” S. Cholle, 2013, Annals of Family Medicine

Organizational Chart and Job Descriptions

TC2 (Core): Defines practice organizational structure and staff responsibilities/skills to support PCMH functions.

Shared Mental Model?



Organizational Chart and Job Descriptions

TC2 (Core): Defines practice organizational structure and staff responsibilities/skills to support PCMH functions.

Things to consider:

- Update and share with staff regularly
 - Allow staff to participate in it's development!
- In addition to job roles, Job Descriptions need to include:
 - Each staff member's role in QI, providing feedback and being part of a team
 - Each staff members role as part of Patient Centered Medical Home
 - Consider their roles in Care Coordination, Population Management & Self-Care
- The org chart should outline:
 - How team based care works at your practice
 - Who leads and sustains team-based care

Culture

Staff Quality Service Survey (Mark the appropriate response to the following questions)	1. Not at all	2. To a small extent	3. To a moderate extent	4. To a great extent	5. To a very great extent
Our organization is totally committed to the idea of creating satisfied patients.					
Rather than having to undo mistakes, we aim to "do things right the first time."					
Patient's complaints are regularly analyzed in order to identify quality problems.					
We treat other staff members with respect.					
Staff is supported with resources that are sufficient for doing the job well.					
Staff at all levels is involved in making decisions about some aspects of their work.					
We study the best practices to get ideas about how we might do things better.					
We work to continuously improve our outcomes and services.					
When problems with quality are identified, we take action to solve them.					
As a Staff member, I feel quality is important.					
As a Staff member, I am committed to improve our quality.					

- Sustained QI requires the intrinsic MOTIVATION of clinicians and practice staff
- A practice with a positive attitude toward change will be more ready to engage
- AHRQ “Engaging Primary Care Practices in Quality Improvement”, 2015

Involving Patients in QI

QI 04 (Core): Monitors patient experience through:

B. Qualitative data: The practice obtains feedback from patients/families/caregivers through qualitative means

QI 17 (2): Involves patient/family/caregiver in quality improvement activities.

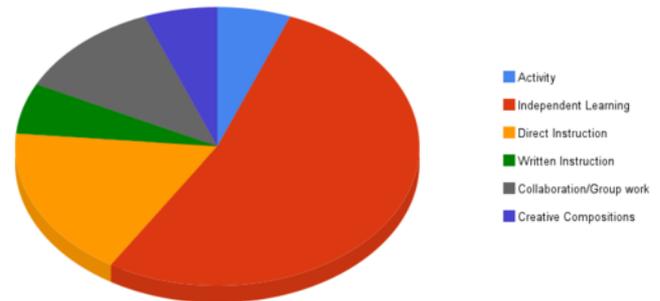
TC4 (2): Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.

QI 16 (1): Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice.



Patient Satisfaction Survey

- **QI 04 (Core): Monitors patient experience through:**
 - **A. Quantitative data:** The practice conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:
 - i. Access
 - ii. Communication
 - iii. Coordination
 - iv. Whole person care, Self-management support and comprehensiveness



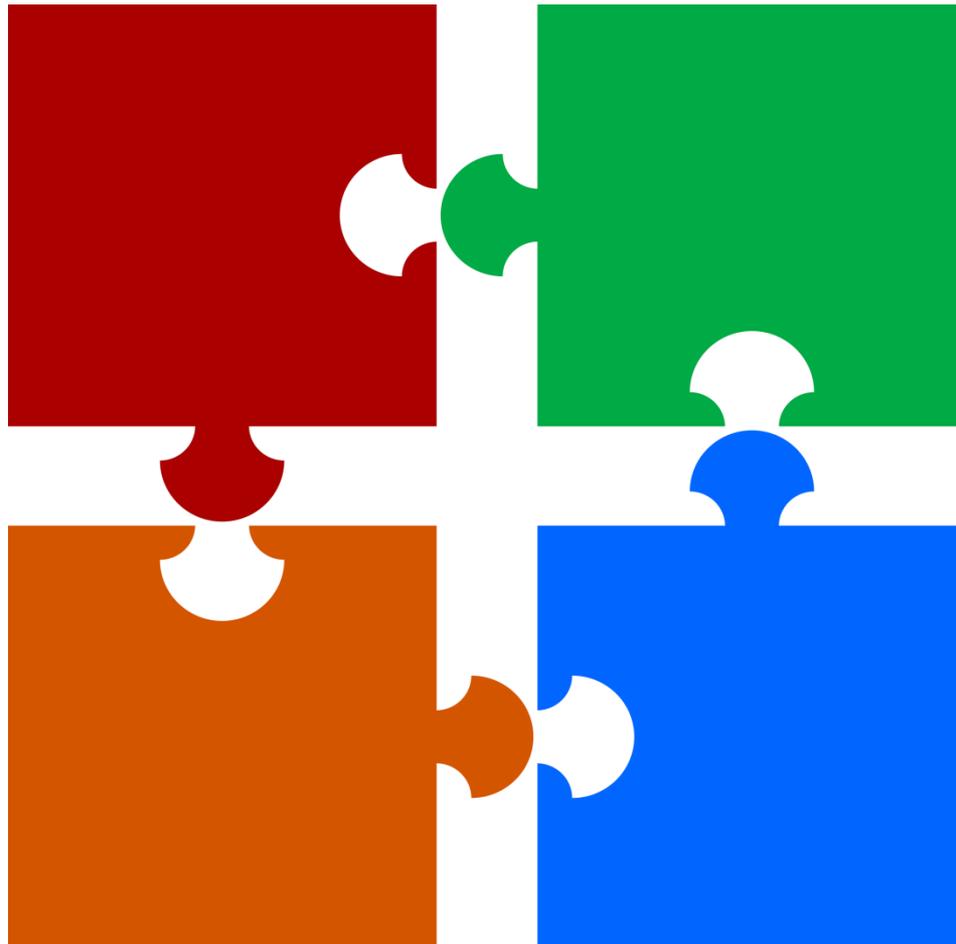
Patient Satisfaction Survey

- QI 04 (Core): Monitors patient experience through:
 - **A. Quantitative data:** The practice conducts a survey....
- Things to consider:
 - What questions will you ask?
 - How long should the survey should be (CAHPS is 66 questions!)
 - Which demographic questions should you ask
 - How will you survey patients?
 - electronically, by paper, both?
 - via email, on the website, at the office
 - Who will you survey?
 - All patients who come in to the office within a period of time?
 - all patients whose email addresses you have? Only those seen in the office in the last 4 months?

Patient Satisfaction Survey

- QI 04 (Core): Monitors patient experience through:
 - **A. Quantitative data:** The practice conducts a survey....
- Things to consider:
 - How often will you survey?
 - After every office visit?
 - Quarterly? Annually? Every Tuesday morning....
 - How will you analyze the data?
 - Paper surveys require a lot of manual data entry
 - We often recommend Survey Monkey or its equivalent because it will do the analysis for you!

Setting the Foundation

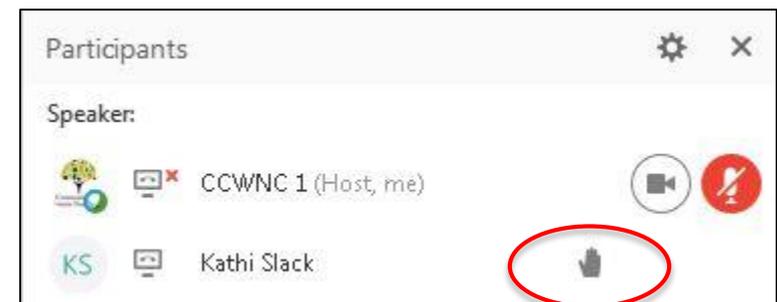


Discussion

- BEST PRACTICES
- CHALLENGES
- NOVEL IDEAS
- QUESTIONS

HOUSEKEEPING

- The host will read comments from the chat box
- Please raise your hand to engage in discussion – we will unmute you when we call your name.
- Please lower your hand when you are finished speaking



Schedule of Upcoming Sessions

	Objective
1	Introduction to the Webinar Setting the foundation Sep 6th
2	Population Health Management: Stratification Part 1 - Risk Oct
3	Population Health Management: Stratification Part 2 - Access and Community Resources Nov
4	Population Health Management: Action! Part 1 - Data and Goal-Setting Dec
5	Population Health Management: Action! Part 2 – Process Improvement Jan
6	Evidence Based Care and Access to Care Feb
7	Behavioral Health and Medication Management Mar
8	Closing the Loop and Closing remarks Apr

Next Session

Population Health Management: Stratification Part 1 – Risk

(Insert date & time)

(Presenter names?)

If you haven't already registered, please do!

For questions/comments please
contact me:

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