Expanding PCMH: Beyond the Practice to the Community

Project Leader
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The MMC Physician-Hospital Organization is located at 110 Free Street, Portland, Maine. We serve providers and practice staff in 7 hospital service areas including Midcoast Hospital, Miles Memorial Hospital, St. Andrews Hospital, Maine Medical Center, Penobscot Bay Medical Center, Southern Maine Medical Center, Stephens Memorial Hospital and Waldo County General Hospital. We serve 1,027 members, 293 of whom are primary care providers and 734 specialty providers.

The goal of our project was threefold; 1) expand care management services to support Patient Centered Medical Home (PCMH) practices, 2) develop a spread methodology for PCMH transformation, and 3) develop a risk stratification process to identify high risk patients to ensure patients in need are connected with the supports available to them thereby improving the coordination of care and decreasing readmission rates.

Key project components:
1. PCMH Spread
   - Several interdisciplinary workgroups were formed or connected with to focus on key areas of PCMH transformation:
     - Southern Maine Medical Center (SMMC) PCMH Steering Committee – Develops strategy, assesses progress and develops system wide goals and communication plan. Long term goal is to achieve level 3 NCQA PCMH for all primary care practices.
     - PCMH Leadership Team (practice based) – Guides transformation work within a practice team. Teams formed at each of the four targeted practices to meet bi-monthly. Educational focus for teams in 2011 included communication and improvement skills with a specific focus on improving access for patients and how the care team delivers care to patients.
     - Biddeford Internal Medicine, a Maine PCMH Pilot participant, has several subgroups continuing to meet: Access, Patient Experience, Roles and Responsibilities, Pharmacy, Behavioral Health Integration, Community Resources and Care Management. All subgroups are guided by the PCMH Leadership team.
     - Care Management/Care Transitions workgroup – Develops and oversees workflows to transition patients from hospital to home or rehab facility (as needed) and back to the PCP within 72 hours of discharge. The workgroup will assess progress and adjust workflows as needed.
   - Practice Assessment tools identified and implemented providing valuable feedback
     - PCMH Practice Assessment
     - AHRQ Patient Culture of Safety Survey
     - Patient Experience Survey
   - All PCMH Leadership teams participated in PCMH Collaborative Learning Sessions. Content of sessions included PCMH principles, organizational goals for the next 3 years, as well as improvement skills and how to use them to transform a practice culture into the PCMH model of care.
2. Transformation of the PHO Care Management model
   - Care Managers were cross trained in the Eric Coleman Care Transitions Intervention Model
   - Care Manager role was expanded to include any patient deemed to be high risk, regardless of diagnosis
   - New workflow established providing practice based care management support to extend into the hospital on a daily basis and to rehab facilities as needed
     - All inpatients receive contact from practice RN Care Manager. Care Transitions Intervention offered to anyone at risk for readmission
     - Follow up phone call to all patients seen in the ED and offered care management services if deemed appropriate

3. Risk Stratification: “At Risk” population identified as: 1) hospital admission/discharge; 2) Skilled Nursing Facility; 3) ED visits.

Performance Measure Results:

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1) % “At Risk” patients enrolled in care management (Biddeford IM)</td>
<td>Identification of patients “at risk” under development</td>
<td>Identification of patients “at risk” under development</td>
<td>Patients initially identified: 1) hospital discharges; 2) Skilled Nsg Facilities; 3) ED visits</td>
<td>0%</td>
<td>96%</td>
<td>50-75%</td>
</tr>
<tr>
<td>2) % appropriate patients with medication reconciliation (within 72 hrs post discharge) (Biddeford IM)</td>
<td>84%</td>
<td>91%</td>
<td>91%</td>
<td>82%</td>
<td>92%</td>
<td>80-100%</td>
</tr>
<tr>
<td>3) % patients seen by PCP within 7 days post discharge</td>
<td>60%</td>
<td>81%</td>
<td>77%</td>
<td>87%</td>
<td>86%</td>
<td>90-100%</td>
</tr>
<tr>
<td>4) % practices with PCMH leadership team (4 practices total)</td>
<td>25%</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>5) % practices completing PCMH gap analysis (4 practices total)</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>6) Electronic Risk Stratification Process in Place</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
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</table>
Other Outcomes:

- All four targeted practices earned Level 1 NCQA PCMH recognition
- Patient Experience with Care Management/Care Transitions (actual survey attached)

<table>
<thead>
<tr>
<th>Confidence: Managing Health</th>
<th>Understands Meds</th>
<th>Aware of Med S/Es</th>
<th>Confidence: ask PCP</th>
<th>Knowledge of Symptoms</th>
<th>Satisfaction with service</th>
<th>Recommend service to others</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENOM</td>
<td>81</td>
<td>82</td>
<td>80</td>
<td>80</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td># of '4' ratings</td>
<td>54</td>
<td>60</td>
<td>53</td>
<td>59</td>
<td>58</td>
</tr>
<tr>
<td>% rating a '4'</td>
<td>66.7%</td>
<td>73.2%</td>
<td>66.3%</td>
<td>73.8%</td>
<td>69.9%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Agree &amp; Strongly Agree</td>
<td># of '3' &amp; '4' ratings</td>
<td>80</td>
<td>79</td>
<td>76</td>
<td>79</td>
<td>80</td>
</tr>
<tr>
<td>% rating a '3' &amp; '4'</td>
<td>98.8%</td>
<td>96.3%</td>
<td>95.0%</td>
<td>98.8%</td>
<td>96.4%</td>
<td>97.6%</td>
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Goals not achieved:

- Risk Stratification - Our goal was to create an electronic risk stratification report the SMMC, PrimeCare Biddeford IM practice could use that would pull together hospital admission/discharge data with their EMR patient data. Unfortunately due to limitations of the EMR system and the planned movement to a new EMR system in the near future we were unable to achieve this. However, the practice and PHO collaborative team worked together to establish target populations and prioritization of care management referral/activity.

- The AHRQ Medical Office Survey for Culture of Patient Safety will not be re-administered until the fall of 2012. Each practice team is in the process of creating an action plan based on the results of the first survey.

Lessons Learned:

**1. Key Ingredients for Success**

**Leadership** is a key component of transforming a practice to a PCMH, from senior level in the organization to the practice level. Need to be able to connect this work back to the strategic plan of the organization or practice while demonstrating the urgency to change through the patients eyes. Having a core interdisciplinary team in the practice that is a champion of change is incredibly valuable.

**Improvement Coaching** is essential. Team development is critical to being able to transform a practice and create sustainable change. The coach can teach ways to do improvement work using the IHI model for improvement along with other methods and tools; however without a high functioning **interdisciplinary team** these are simply tools.

**Sense of Ownership** by the teams to transform to a PCMH. They must be the ones to develop and create the change. Sustainable improvement must be done locally by the front line teams

**Efficient Systems** whether they are electronic or manual, need to be able to remove waste and **standardize** work with a focus on the experience of the patient.
Using Data as the impetus for change as well as the meter to determine if the change is an improvement or just a change. Using data to help move teams beyond the perception of “we already do all of this, why do we need to change…”

2. Care Management/Care Transitions

Communication workflows are more effective when created using a patient centered approach. Ensuring practice and hospital teams work together to create processes that work for both environments provides the best possible care for patients and is the most efficient way to collaborate. Embedding the care manager into the practice team is a critical success factor.

3. Needs from the System

1. A provider payment model that allows providers and their team time to do the work to transform their practice without losing personal revenue.

2. IT Infrastructure
   a. Timely information flow between patient, PCP, hospital, specialist, nursing homes, Community Care Team, etc.
   b. Ability to run reports locally by practice
      i. Clinical measures
      ii. Admissions, discharges, ED visits
   c. Develop and support patient portal

3. Develop and support robust Community Care Team(s) in each community to support patients in the practices
   a. Nurse care managers
   b. MAs for chronic condition support
   c. Care Navigators
   d. Behavioral health
      i. Psychiatrist
      ii. NPs for medical management
      iii. LCSWs and LSWs for counseling services
   e. Pharmacist
   f. Community resource partnerships

4. Community based Learning Sessions for teams
   a. Leadership – learn how to engage and lead others in this work
   b. Quality Improvement tools
   c. Engaging patients
   d. Providing care as a team – how do providers learn to let go and how does the team step up to function at the top of their license?
   e. Advanced access

Extending and sustaining achievements:

Risk Stratification

To support PHO primary care practices in identifying patients at high risk, the PHO will provide data analysis and risk stratification using a methodology which has proven to be effective and is consistent with industry standards. The following factors will be included as part of risk stratification and patient identification methodology:

- frequent hospitalizations (two or more in past year)
- frequent visits to ED for urgent or emergent care (two or more in prior six months)
- high resource use (e.g. frequent provider visits, multiple pharmacy use)
- multiple co-morbidities, including behavioral health and/or substance abuse
- complex medication management
- barriers to medication adherence
- poor health literacy
- high risk psychosocial status (inadequate social and/or financial support system)
- advanced age, with frailty and risk for falls
- other patients with high risk/high needs as identified by the practice or patients.

The PHO will continue to work toward creating a centralized position and process for ensuring at risk patients are connected with care management support and community resources.

**PCMH**

HPHC grant funds allowed the MMC PHO to assist SMMC in developing a PCMH Spread model that provided valuable lessons to use for the broader PHO/MaineHealth PCMH Spread.

“One of the biggest challenges in doing quality improvement work in healthcare is finding the time to be able to outline goals and provide educational sessions that allow practices the time to learn, do team-building exercises and really come to consensus on areas they want to focus their quality improvement work. MMC-PHO and the Harvard Pilgrim grant gave us an opportunity for our teams to work closely with our Practice Improvement coach to develop curriculums that would support practices in the transformation to become a Patient Centered Medical Home.”  **Karen Waycott, Quality Manager, SMMC PrimeCare Physician Services**

In collaboration with MaineHealth, the PHO developed a PCMH Learning Collaborative model to be implemented in 2012. Each Learning Collaborative will meet three times over a six month period. Our first Learning Session will be May 23, 2012. We anticipate enrolling 30 practices over 18 months.

Kris Scrutchfield, Practice Improvement Advisor will continue assisting SMMC, PrimeCare to transform all of its primary care practices to Patient Centered Medical Homes.

The MMC PHO is committed to expanding our ability to provide practice coaching. Our experience has clearly demonstrated that coaching support is a critical factor in transformation success. In addition, our Practice Improvement Advisors will be training additional coaches to work directly with PCMH teams throughout our Learning Collaborative.

**Care Management/Care Transitions**

We will continue to assess and adjust our Care Management and Care Transitions work as we move toward becoming an Accountable Care Organization.

"PCMH is not building a screen porch on the back of your house. It's tearing it down and rebuilding”  
**Ed Wagner**