



# Patient-Provider Partnership

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## Patient-Provider Partnership

**Overview:** The goal of the Patient-Provider Partnership initiative is to expand physician and patient awareness of the patient-centered medical home (PCMH) model, and strengthen the bond between patients and their care-giving team.

**These Blue Cross Blue Shield of Michigan criteria pertain to the patient-provider partnership initiative:**

Criteria

Met 

- 1.1 Practice unit has developed PCMH-related patient communication tools, has trained staff, and is prepared to implement patient-provider partnership with each established patient, which may consist of a signed agreement or other documented patient communication process to establish patient-provider partnership
- 1.2 Process of reaching out to established patients is underway, and practice unit is using a systematic approach to inform patients about PCMH, including patients who do not visit the practice regularly
- 1.3 Patient-provider agreement or other documented patient communication process is implemented and documented for at least **10%** of current patients
- 1.4 Patient-provider agreement or other documented patient communication process is implemented and documented for at least **30%** of current patients
- 1.5 Patient-provider agreement or other documented patient communication process is implemented and documented for at least **50%** of current patients
- 1.6 Patient-provider agreement or other documented patient communication process is implemented and documented for at least **60%** of current patients
- 1.7 Patient-provider agreement or other documented patient communication process is implemented and documented for at least **80%** of current patients
- 1.8 Patient-provider agreement or other documented patient communication process is implemented and documented for at least **90%** of current patients

## **1.0 Patient-Provider Partnership**

### **1.1**

***Practice unit has developed PCMH-related patient communication tools, has trained staff, and is prepared to implement patient-provider partnership with each established patient, which may consist of a signed agreement or other documented patient communication process to establish patient-provider partnership***

#### **Guidelines:**

- Patient communication process must include a conversation between the patient and a member of the clinical practice unit team. In extenuating circumstances, well-trained Medical Assistants who are highly engaged with patient care may be considered a member of the clinical practice unit team.
- The patient-provider partnership must only be established one time per patient.
- Documentation may consist of note in medical record, sticker placed on front of the chart, indicator in patient registry, patient log, or similar system that can be used to identify the percent of patients with whom the partnership has been discussed.
- Documents and patient education tools are developed that explain PCMH concepts and outline patient and provider roles and responsibilities.
- Practice unit team members and all appropriate staff are educated/trained on patient-provider partnership concepts and patient communication processes
- Process has been established for patients to receive PCMH information, and for practitioner to have conversation with patients about PCMH patient-provider partnership.
- Mechanism and process has been developed to document establishment of patient-provider partnership in medical record or patient registry.

### **1.2**

***Process of reaching out to established patients is underway, and practice unit is using a systematic approach to inform patients about PCMH, including patients who do not visit the practice regularly***

#### **Guidelines:**

- Established patients are defined as, at a minimum, all patients within the practice (regardless of insurance coverage) who were seen within the past 12 months.
- Outreach may consist of distribution of material at time of visit
  - o Outreach may also (but is not required to) include mailings, emails, websites, telephone outreach, or other electronic means, providing the mechanism incorporates an active “push” function to communicate with patients, including those who do not visit the practice regularly
    - Mass mailings do not meet the requirements for 1.3 through 1.8
    - Outreach materials should explain the PCMH concept and patient-provider partnership
    - For any reference to a practice having “BCBSM Designation status” please reference BCBSM’s recommended language for communications to patients from PCMH-Designated practices

### 1.3

***Patient-provider agreement or other documented patient communication process is implemented and documented for at least 10% of current patients***

Guidelines:

- “Current” patients are defined as patients who the practice unit considers to be active in the practice (e.g., practices may define “current” as seen within the past 12 months or 24 months)
- Establishment of patient-provider partnership *must* include conversation between patient and a member of the practice unit clinical team
  - o In extenuating circumstances, well-trained Medical Assistants who are highly engaged with patient care may be considered a member of the clinical practice unit team.
  - o Conversation should preferably take place in person, but may take place over phone in extenuating circumstances, for a limited number of patients
  - o Other team members may begin the conversation, or follow-up after physician conversation with more detailed discussion/information, but a clinical team member must participate in at least part of the patient-provider partnership conversation
- Conversation may be documented in medical record, patient registry, or other type of list.
- Practice must also have mechanism to track percent of patients that have established partnership, and be able to provide data during site visit showing denominator (total number of “current” patients in the practice) and numerator (total number of patients with whom conversations have been held and partnerships established at any point in the past, who are in the denominator).

### 1.4

***Patient-provider agreement or other documented patient communication process is implemented and documented for at least 30% of current patients***

Guidelines:

- Reference 1.3

### 1.5

***Patient-provider agreement or other documented patient communication process is implemented and documented for at least 50% of current patients***

Guidelines:

- Reference 1.3

### 1.6

***Patient-provider agreement or other documented patient communication process is implemented and documented for at least 60% of current patients***

Guidelines:

- Reference 1.3



**1.7**

***Patient-provider agreement or other documented patient communication process is implemented and documented for at least 80% of current patients***









**1.8**

***Patient-provider agreement or other documented patient communication process is implemented and documented for at least 90% of current patients***


Guidelines:

- Reference 1.3

## Establishing the Patient-Provider Partnership

1. Educate your staff on the Patient-Centered Medical Home (PCMH) concepts and process (Initiative 1.1)
  - Hold staff training sessions
  - Develop scripts for front desk and clinical staff
  -  Laminate scripts and/or make pocket versions of scripts
  - Review monthly how many partnerships are established, get feedback from staff
2. Educate your patients on the PCMH concept (Initiative 1.1)
  - Develop PCMH patient brochures, handouts and/or letters (samples are in the binder). Explain PCMH concepts and outline the patient and provider roles and responsibilities
  -  Add brochures and handouts to your web site if you have one
  -  Add signage around the office, on the front door and in the waiting rooms. Get creative - some offices have used a digital picture frame to promote PCMH
  - Current patients are defined as those seen within the last 12 months
  - Reach out to patients who do not visit the practice regularly by mail or phone
3. Establish the patient-provider partnership with the patient (Initiative 1.1 and 1.2)
  - Establish the partnership with a conversation between the patient's primary practitioner and the patient. This is mandatory
  -  Place signage in exam rooms to promote conversation
  - The conversation should take place in person but may take place over the phone if necessary
4. Document the patient communication process (Initiative 1.3)
  - Document the conversation in the medical record, patient registry, or other list
  -  Give patients a brochure/letter upon check in and document it
  -  Some offices have created an ICD V code that staff enter in the patient registry
  - Place a sticker on the front of the chart
  -  Create a stamp that says "PCMH" and stamp the outside of the chart when the patient has received the document/brochure after checking in for their appointment
  -  Write in the chart the date the patient received the document/brochure

5. Track your results (Initiative 1.3 to 1.8)

- Track the percent of patients who have established a partnership. Numerator is the number of partnerships currently established. Denominator is the number of patients seen by your practice in the last 12 months
- Keep a daily tab of the percentage
-  Offer incentives to staff to reach certain milestones, i.e. an extra hour for lunch when 10 percent of patients are documented, movie tickets when 30 percent are documented etc.



Denotes best practice ideas



<Date>

Dear <Patient name>,

You may notice that our office is doing some things differently these days. We think you will like the changes. We have organized our office into a Medical Home.

We are providing some documentation on what this means for you. Please take a look and feel free to discuss this with your doctor.

Sincerely,

<Dr. Name>



## Welcome to your Medical Home

Your health and wellness is a top concern of our office. To give you the best care, doctors and patients must work together. This idea is called the Patient Centered Medical Home. We will work with you to manage your health care needs.

### As your Medical Home, 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 giving you easy to understand information
- Respond promptly to your calls, questions and concerns
- Have a doctor on call after hours for your urgent needs
- Remind you when vaccines and tests are due
- Notify you of test results in a timely manner
- Help coordinate care with specialty doctors if needed

### As your Medical Home, we trust you to:

- Follow the care plan that is agreed upon as best you can
- Tell us about all medications and over the counter supplements you are taking
- Let us know when you see other health care providers and ask them to send us a report about your care
- Keep your appointments or call to reschedule or cancel
- Call if you do not receive your 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 before going to the Emergency Room if possible so someone who knows your history can care for you
- 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 when you are seen in the office
- Give us feedback to help us improve our services



## **Patient Rights and Responsibilities**

### **Patient rights**

1. High quality, medical care, without discrimination, that is compassionate and respects personal dignity, values and beliefs.
2. Participate in and make decisions about their care and pain management, including refusing care to the extent permitted by law. Care providers (doctor, nurse, etc.) will explain the medical consequences of refusing recommended treatment.
3. Have illness, treatment, pain, alternatives and outcomes be explained in an understandable manner, with interpretation services as needed.
4. Treatments, communications and medical records kept private to the extent permitted by law.
5. Access to medical records in a reasonable timeframe, to the extent permitted by law.
6. Full information regarding charges; counseling on the availability of known financial resources for health care.
7. Access to an advocacy or protective service agencies and a right to be free from abuse.
8. Forum for having concerns and complaints addressed; and guarantee that sharing concerns and complaints will not compromise access to care, treatment and services.

### **Patient responsibilities**

1. Partner with the provider/medical home staff in establishing collaborative relationship to address patient's personal health and health behavior issues.
2. Keep scheduled appointments or cancel in advance if at all possible
3. Contact provider first for all medical issues, other than emergencies perceived to be life-threatening or with potential to permanently impair health status
4. Reports changes in condition or symptoms, and keep medical record up to date, including information on all over-the-counter medications and dietary supplements (such as vitamins, herbal supplements)
5. Share concerns and questions, needs and priorities
6. Identify personal life goals and establish care management plans, including clearly identified self-management goals and responsibilities
7. Take the medicine prescribed
8. Read information from provider, and ask questions if help or clarification is needed
9. Meet financial obligations

## Principles of Patient-Centered Medical Home

1. Each patient has an ongoing relationship with a **personal physician** trained to provide first contact, continuous and comprehensive care.
2. **Physician directed** - the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients, using a planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
3. **Whole-person orientation** - patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
4. The goal of the physician and the team is to assure that patients get the indicated care when and where they need and want it in a **culturally and linguistically appropriate** manner.
5. **Care is coordinated and integrated** - the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals, for all stages of life: acute care; chronic care; preventive services; and end of life care. Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).
6. **Quality and safety** - evidence-based medicine and clinical decision-support tools guide decision making.
7. **Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
8. **Information technology** is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
9. Physicians in the practice accept **accountability for continuous quality improvement** through voluntary engagement in performance measurement and improvement.

*As part of our Patient-Centered Medical Home(PCMH) orientation, we will ask you to acknowledge your agreement to the enclosed and we will acknowledge our agreement to you. Our goal has been to provide excellent care for you.*

*We desire to get better and better.*

*We appreciate the opportunity to provide you with medical services. The information that follows is designed to answer the questions most frequently asked by our patients. We want you to know our policies and methods of practice. If you have any questions, please ask us.*



**OFFICE NAME**  
**ADDRESS**  
**PHONE**  
**FAX**  
**WEBSITE**

PCMH

PCMH

PCMH

PCMH

PCMH

PCMH

PCMH

**Welcome To Our Practice**  
*A Patient-Centered Medical Home*

PHYSICIAN NAME  
PHYSICIAN NAME  
PHYSICIAN NAME  
PHYSICIAN NAME  
PHYSICIAN NAME

**PRACTICE NAME HERE**



PATIENT-CENTERED MEDICAL HOME

Right for our office. Right for you.



## WHAT ARE YOUR OPTIONS?

Helping you make the right choices.



**A Patient-Centered Medical Home (PCMH) is a trusting partnership between a doctor led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program.**

### PRACTICE HOURS

Monday, Tuesday, Thursday:  
9:00 AM until 7:00 PM

Wednesday, Friday:  
9:00 AM until 5:00 PM

Saturday:  
9:00 AM until Noon

Additional hours are available most days

### URGENT CARE

We strive to accommodate patients who need more urgent care. Please call us to see if we can see you or guide your care. Often we might guide you to care that serves you well. Emergency care is safer if we can guide the Emergency Department about your health situation.

### INSURANCE

**PARTICIPATION** We participate in many health plans. Some health plans are better for preventative care than others; some health plans offer more choices. We reviews health plans with your interests in mind.

### LAB TEST RESULTS

Please try to use laboratories and other test facilities we use regularly to ensure better communication. We strive to get test results to patients. Please call if you haven't heard from us a week after test were done.

# HELPING YOU MAKE THE RIGHT CHOICES.

#### We will:

- Ask what your goal is, or what you want to do to improve your health
- Ask you to help us plan your care, and to let us know if you think you can follow the plan
- Create written copies of care plans for more complex illnesses
- Have the care team members doing more and/or different parts of care
- Remind you when tests are due so that you can receive the best quality care
- Ask you to have blood tests done before your visit so that the doctor has the results at your visit
- Explore methods to care for you better; including ways to help you care for yourself.



#### We trust you, our patient, to:

- Tell us what you know about your health and illnesses
- Tell us about your needs and concerns
- Take part in planning your care
- Follow the care plan that is agreed upon-or let us know why you cannot so that we can try to help, or change the plan
- Tell us what medications you are taking and ask for a refill at your office visit when you need one
- Let us know when you see other doctors and what medications they put you on or change
- Ask other doctors to send us a report about your care when you see them
- Seek our advice before you see other physicians. We may be able to care for you and we know about the strengths of various specialists.
- Learn about wellness and how to prevent disease
- Learn about your insurance so you know what it covers
- Respect us as individuals and partners in your care
- Keep your appointments as scheduled, or call and let us know when you cannot
- Pay your share of the visit fee when you are seen in the office
- Give us feedback so we can improve our services (We may survey you in the future to understand this better.)

#### We will continue to:

- Provide you with a care team who will know you and your family
- Respect you as an individual-we will not make judgments based on race, religion, sex, age, disability, etc.
- Respect your privacy-your medical information will not be shared with anyone unless you give us permission or it is required by law
- Provide care given by a team of people led by your physician
- Give the care you need when you need it
- Give care that meets your needs and fits with your goals and values
- Give care that is based on quality and safety
- Have a doctor on call 24 hours a day and 7 days a week
- Take care of short illness, long term disease and give
- Advice to help you stay healthy
- Tell you about your health and illnesses in a way you can understand
- To improve your care we are using technology-like our Electronic Health Record and we will strive to continuously improve



Call us today for an appointment

(XXX) XXX-XXX

**As we build your Medical Home you will notice some changes in the way we provide care, but many things will stay the same.**

# Brochure Print Request

Contact Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Shipping Address  
(If Different Than Billing): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description: \_\_\_\_\_

Request Completion Date: \_\_\_\_\_

Quantity Needed: \_\_\_\_\_

Estimate Needed (Please Circle): Yes / No

Color: Y/N

B&W: Y/N

**Price Guide:** Print Color both sides no bleeds

Stock: 80# dull coated text

Flat size: 17x11

Folded size: 8.5x11

File supplied by customer

\*Qty 100: \$47.62

\*Qty 500: \$238.11

\*Qty 1,000: \$476.22

\*Qty 2,000: \$930.22

\*Estimates are guides and not a guaranteed cost quote.

Brochures are also available to suit audiences with the majority or a variety of ethnicities. Please choose which best suits your practices audience:

- Asian
- Middle Eastern
- African American
- Caucasian
- Variety of backgrounds

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Production Use Only:**

Order Received By: \_\_\_\_\_

Date Order Received: \_\_\_\_\_

Details/Comments: \_\_\_\_\_

Date of Client Approval: \_\_\_\_\_

# Patient-Centered Medical Home

Tool 1-7 Initiative 1.1



# What is a Patient-Centered Medical Home (PCMH)?

- A health care setting that provides care that is respectful of, and responsive to individual patient preferences, needs and values, and ensures that patient values guide all clinical decisions
- Provides patients with access to a single point-of-care that addresses a patient's full range of health care needs
- Provides patients with additional hours of access and methods of access to care.
- Coordinates care across specialties and community based services



# Background

- Initially introduced by American Academy of Pediatrics (AAP) in 1967
- American College of Physicians (ACP) and American Academy of Family Physicians (AAFP) expanded concept to include care of adults
- Developed by AAP, ACP, AAFP, and the American Osteopathic Association in response to request by several large employers
  - Employers are demanding a more effective and efficient model of health care delivery
- Created “*Joint Principles*” which were adopted and endorsed in February 2007
- All health plans and many large employers actively engaged in testing and implementing the model
  - Including Medicare, Medicaid, and BCBSM



# The personal physician directs care

- Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care
- The personal physician leads a multi-disciplinary team of health care professionals who collectively take responsibility for the ongoing care of patients.
- Physician becomes more of a coach than with traditional health care delivery – coordinating care for both wellness and illness



# Includes the whole person

## - care is coordinated/integrated

- The personal physician is responsible for providing all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals for all stages of life: acute care, chronic care, preventive services, and end-of-life care
- Care is coordinated across all elements of the health care system (e.g. sub-specialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g. family, public and private community-based services)



# Hallmark of medical home - quality and safety

- Evidence-based medicine and clinical decision-making support tools guide decision making
- Evidence-based medicine uses evidence from science to assess which tests or procedures should be done relevant to the risks and benefits of treatment (including lack of treatment). Evidence-based medicine is the conscientious use of current best evidence in making decisions about the care of individual patients.



# Hallmark of medical home - quality and safety

- Care is facilitated by registries, health information exchanges/technologies, etc., to assure patients get the care they need and want in a culturally appropriate manner
- Patients actively participate in decision-making— feedback is sought to ensure patient’s expectations are met
- Patients and families participate in quality improvement activities at the practice level



# Patients have more access to care

- Enhanced access to care is available through systems such as
  - Open scheduling,
  - Expanded hours
  - New technology options (e-mail, e-visits, phone visits)
  - Group visits
  - Planned visits

More access and better communication between patients and their personal physician and staff fosters a more engaged patient



# The role of Information Technology

- Support adoption and use of health IT for quality improvement
- Reflect the value of physician and non-physician staff patient-centered care management work that falls outside the face-to-face visit
- Support provision of enhanced communication access such as secure e-mail and telephone consultation
- Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting



# American Academy of Family Physicians - PCMH Endorsement

<http://www.aafp.org/online/etc/medialib/aafp.org/media/video/patctrmedhomevid.html>



# The Vision for Restoring Primary Care

- Primary care physicians fulfill a commitment to a patient population, actively coordinate care, offer patients better access, and deliver consistent care based on access to patient-specific information at the point-of-service
- The office visit becomes a productive interaction between an informed, activated patient and a proactive, prepared health care team



# Medical homes improve care

- By following patients to sub-specialists for better information sharing, coordinated transitions and feedback
- By following up on chronic illness and reducing hospitalizations
- By reducing redundancies in testing and procedures
- Through the appropriate application of evidence-based guidelines where such guidelines exist
- By direct collaboration with disease management entities or by providing such care support directly
- With health IT that supports population management, clinical decision support and health information exchange



# New Paradigm

## Today's Care

**My patients are those who make appointments to see me**

Patients' chief complaints or reasons for visit determines care

Care is determined by today's problem and time available today

Care varies by scheduled time and memory or skill of the doctor

Patients are responsible for coordinating their own care

I know I deliver high quality care because I am well trained

Acute care is delivered in the next available appointment and walk-ins

It is up to the patient to tell us what happened to him/her

Clinic operations center on meeting the doctor's needs

## Medical Home Care

**Our patients are those who are registered in our Medical Home**

We systematically assess all our patients' health needs to plan care

Care is determined by a proactive plan to meet patient needs without visits

Care is standardized according to evidence-based guidelines

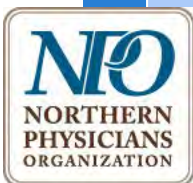
A prepared team of professionals coordinates all patients' care

We measure our quality and make rapid changes to improve it

Acute care is delivered by open access and non-visit contacts

We track tests and consultations, and follow-up after ED and hospital

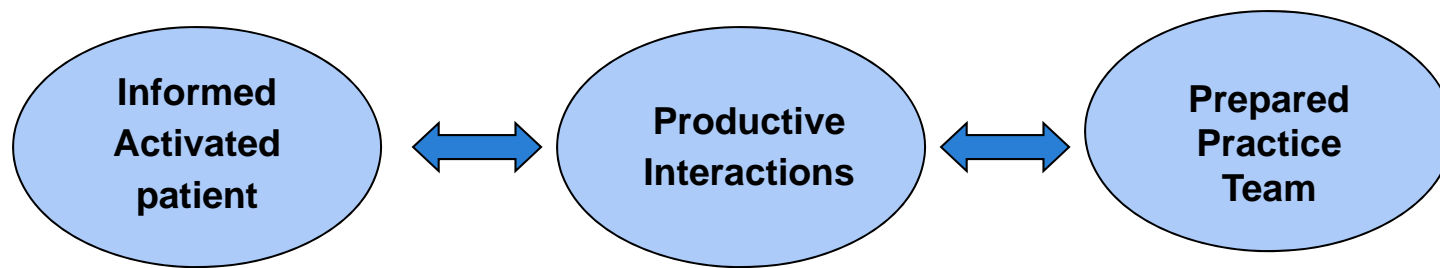
A multidisciplinary team works at the top of our licenses to serve patients



# Mrs. C in the Old System

- Mrs. C is a 68 year old woman with cough and shortness of breath and risk factors for Type II diabetes
- Calls her primary care physician
- Hospitalized – CHF
- Discharged
- Sees general practitioner
- Hospitalized – CHF and diabetes
- Home, confused and scared

# Essential Elements of Good Chronic Illness Care



# What Characterizes a Prepared Practice Team?

- At the time of the visit, they have the patient information, decision support, people, equipment and time required to deliver evidence-based clinical management and self-management support

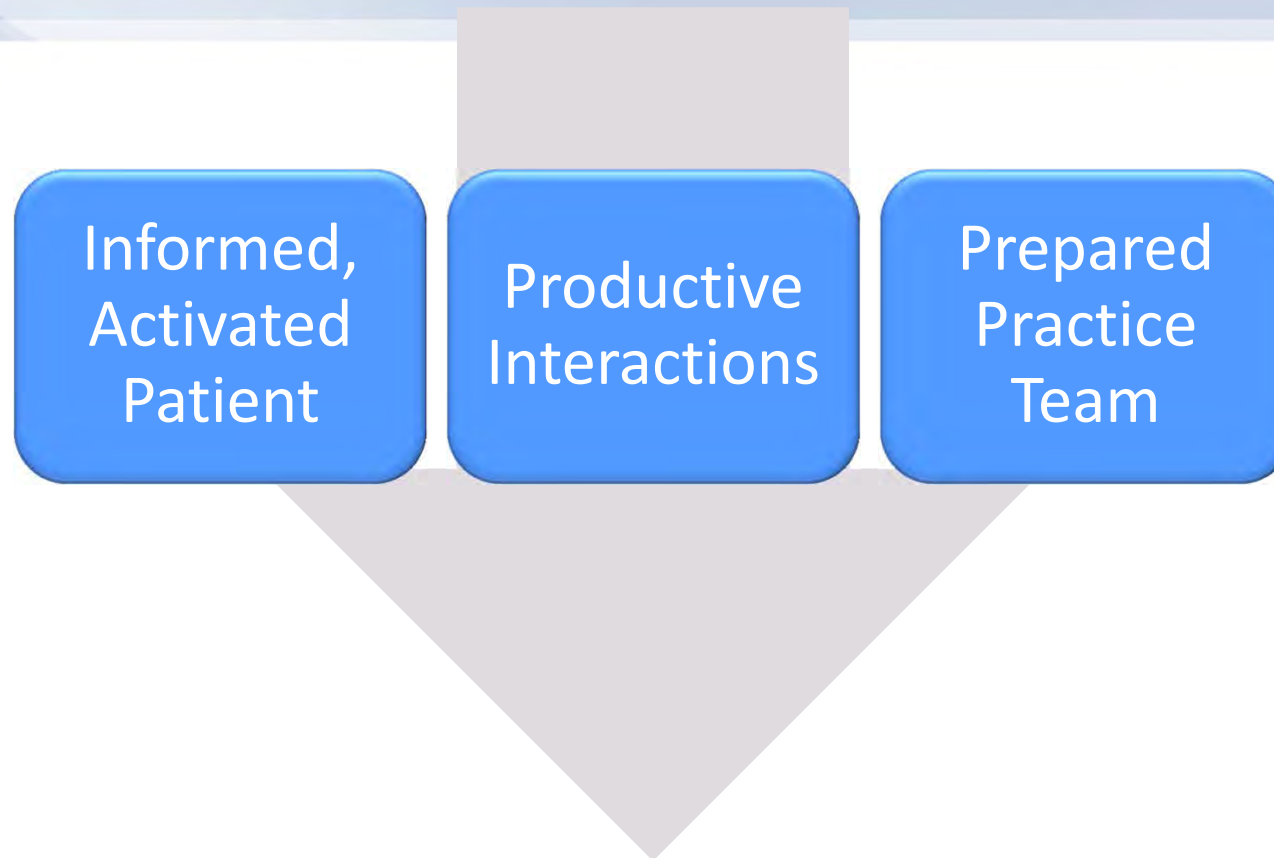


# What Characterizes an Informed, Activated Patient?

- Patient understands the disease process, and realizes his/her role as the daily self manager. Family and caregivers are engaged in the patient's self-management. The provider is viewed as a guide on the side, not the sage on the stage!



# What is a Productive Interaction?



- Assessment of self management skills and confidence as well as clinical status
- Tailoring of clinical management by stepped protocol
- Collaborative goal setting and problem solving resulting in a shared care plan
- Active, sustained follow-up

# Mrs. C in the New System

- Hospitalized – CHF
- Discharged with follow-up
- Family practice team sees her – adds to registry
- Clinical care and self-management support delivered – Shared Care Plan created
- Screened for risks – Diabetes discovered early
- Scheduled for planned chronic care visits
- Shared Treatment Plan amended
- IT enables all aspects of care
- Home, scared but confident she is part of a proactive, prepared team



# Key Benefits

- Increased patient and family/care-giver satisfaction
- Improved quality
- More efficient use of limited resources
- Reduced health disparities
- Improved professional satisfaction
- Reduction in unnecessary ED visits, inpatient admissions, inappropriate specialist referral, reduced duplication in diagnostic imaging studies and lab work, etc.
- And many more!



Everyone needs a place to call home.....



**Everyone  
should have  
a Medical  
Home**





