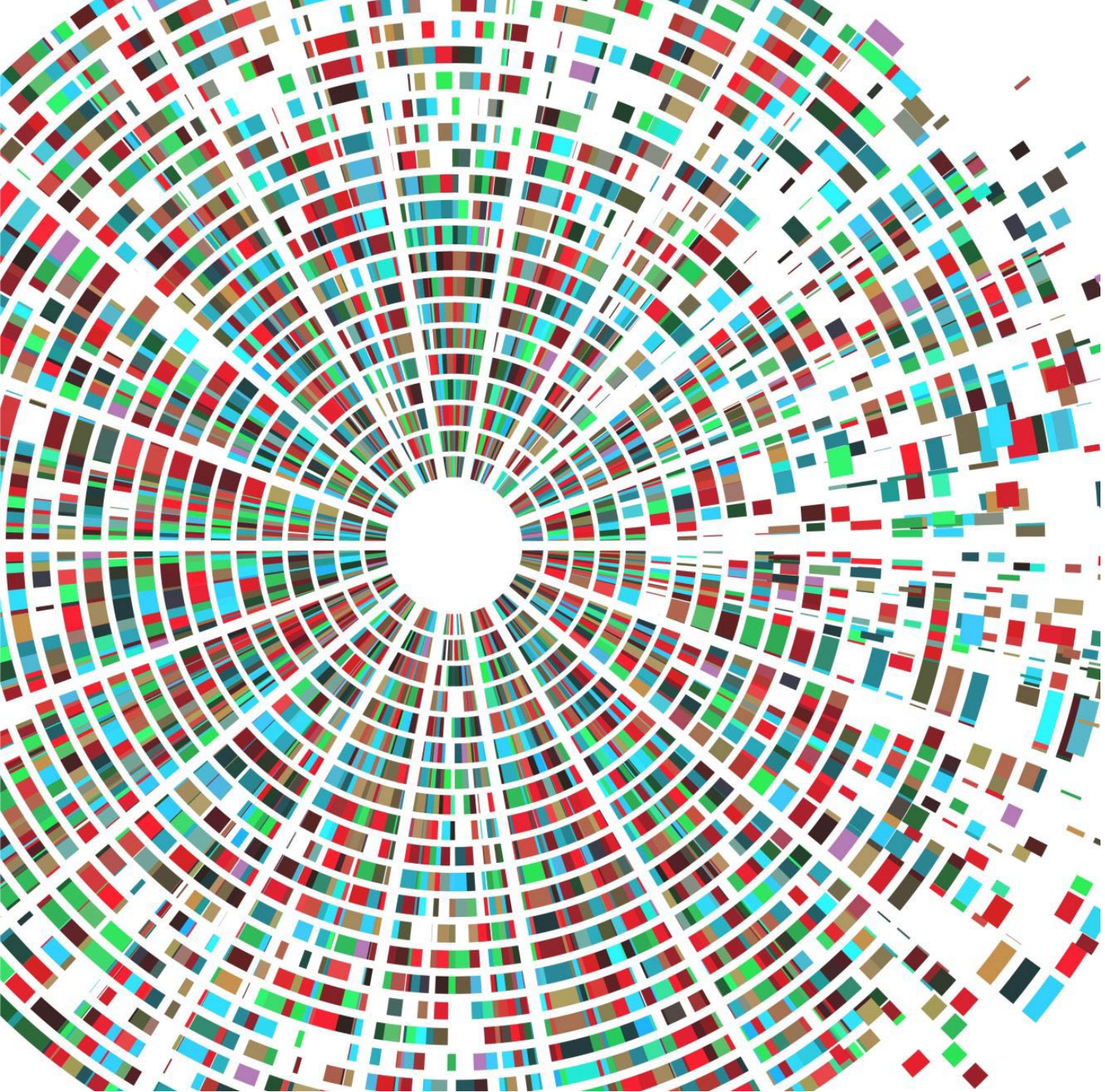

Best Practices to Kick off 2021

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PCMH Annual Education

- **Required annually for each capability in place for appropriate staff:**
- Patient-Centered Medical Home Model 1.1
- Chronic Care Model 4.1
- Practice Transformation Concepts 4.1
- Test Tracking Policy and Procedures 6.8
- Preventive Services/Health Promotion 9.8
- Community Resources 10.4
- Self-Management Support Concepts (4 Concepts) 11.1
- Self-Management training by Care Manager for appropriate staff 11.8
- Care Coordination Processes 13.7
- Specialist Pre-Consultation and Referral Process 14.8

- **NPO shared NMMPs education process in December.**
- Great for the current climate (COVID)
- Can include other annual Educations
- Checklist style for each Employee (on next slide)

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PCMH Annual Education

<Practice Name>

<Year>

Employee Education Checklist: *Required Annually and Upon Hire*

Topic	Location of Training	Instructions	Date Completed	Initials
Active Shooter Preparedness	https://www.youtube.com/watch?v=5VcSweiU2D0&feature=player_embedded	View Homeland Security Run, Hide, Fight video		
CMS Fraud and Abuse		Read both documents, parts 1 and 2		
Standard Operating Guidelines		Read all clinical or office based on position, plus all administrative (Compliance, HIPAA Privacy, Test Tracking policy and Procedures 6.8, Specialist Consultation and Referral process 14.8 ...)		
Fire Safety Plan		Read plan, hard copy also available in Practice Manager's Office		
Hand Hygiene	https://www.cdc.gov/handhygiene/index.html	Review all hand washing information on the CDC website		
IT Security Awareness		Review SafetyNet presentation		
Notice of Privacy Practices		Read document, hard copy also available in Practice Manager's Office		
OSHA General Industry Standards		Review presentation on: hazards, PPE, infectious disease, exposure control, universal precautions		
Patient-Centered Medical Home and Neighbor Models	p:\community resource guide.pdf	Review current PCMH interpretive guidelines (PCMH Overview) 1.1 in the Education folder and community resources 10.4 using the link		
Written Hazard Communication Plan		Read hazard plan including SDS sheets, hard copy also available in Practice Manager's Office		
Can add any other yearly education including other PCMH annual education Capabilities the practice has in place; These may include: 4.1, 9.8, 11.1, 11.8, and or 13.7. Check the practice capability sheet.				

Employee Name:_____

Position: _____

Training listed on this form must be completed annually and submitted to Supervisor by **12/31 of the current year**. For new hires, training must be completed **within 2 weeks of hire**.

Last Updated XX/XX/XXXX

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Keeping an Annual Agenda

- **One practice reports**: I keep a calendar to make sure reports are run throughout the year. I think the reports are a good indication of services and preventative care and help with the overall efforts to provide comprehensive care to our patient population while also taking into account the individual and specific needs and circumstance of each patient.

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- Reports are one PCMH task to be completed each year what about but not limited to:
- N/D report for PCMH conversation
- Pat Sat Survey or Care Manager Survey
- PCMH Education

Performance Reporting

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- Who views this information and what is the process?
- Can the process be improved upon?
- Performance reporting can be added to the Annual Agenda
- **Most importantly! What happens with this information and how is it used?**
- Integrate into huddles
- Integrate into staff or team meetings
- Make specific goals
- Share with providers; especially provider specific reports

Hospital follow-up Calls- ADT/MED Rec

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- **Why are these calls important?**
  - Helps lower non-emergent ED visits
  - Provide opportunity to educate on when to go to the ER vs Urgent Care
  - Provide opportunity to education on after hours. Call us first!
  - Provide opportunity to increase Care Management case load and billing opportunities
  - Provide opportunity to educated patients in general and help them receive needed care
  - Information
  - Education
  - Set up Follow-up visit
  - Determine SDOH needs. Perhaps a need isn't being met that is causing frequents ED visits.
- **Introduction to Team Based Care for Medial Assistance**

Care Management: TCM/TOC calls

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- **Follow-up with patients for 4 weeks not just two touches**
  - Follow-up with patients even if they won't be seeing their PCP
  - This is great practice for elective joint surgery or bladder surgery
    - Depression after surgery is a risk with these types of surgery
    - This can also be adopted into hip replacements, knee replacements, shoulder replacement etc.
    - Helps improve patient outcomes and lower rates or readmissions

Care Management: Provider Engagement

- **Share Success stories**
- How often do you communicate with your Care Managers?
- Ask for a success story each month
- Send it out to the office and providers or share in staff huddle or staff meeting making sure its somewhere the providers can hear!
- Can this work for other areas you want to increase provider engagement?
- High performing practices have high provider engagement!

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Care Management: Motivational Interviewing

- **Motivation Interviewing can greatly impact the success of Care Management**
- **Many Care Managers report forgetting to utilize MI these reasons can be:**
- Being busy
- Frustration with the Care Manager Relationship
- Focusing on the provider goal
- Getting comfortable in a Care Management patient relationship
- **Is there way the office can help them remember or encourage the use!?**
- Hang a flyer in the workstation, reminders in huddles or staff meetings
- **Is the practice interested in receiving a flyer such as this?**

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Advanced Care Planning

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- **How is this occurring/ What is the process?**
- Focus on the Conversation rather than the paperwork
- **What is the Target Population: Start with one and move on to another**
- Healthy patient
- Newly diagnosed terminal disease
- Seriously ill but stable
- Last phase of life
- **Develop the process**

COVID Related Best Practice: Telehealth

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- **Telehealth suggestions and success**
- Have a telehealth superuser/s to assist with technical difficulties for patients or staff
- Create a flow to ensure follow-up testing, appointments and other services to not get missed. Some providers message the MA or FOH directly after a visit
- Use telehealth with snowbirds! *Keep in mind: Providers need to be licenses in other states: there is working on this topic being done*
- Helps separate sick patients from the healthy
- Helps keep up on gaps in care and needed services
- Can be great for Behavior Issue appointments (mental health) or Medication follow-ups
- Adopt telehealth AWVs
- Patients like them! Good for patient satisfaction and delivery of care
- Teenagers seem more willing to discuss their issues and breach topics than in the office setting

Planned Visit

- **A strong Planned Visit can positively affect most other Best Practice suggestions in this PP**
- Do you think your practice utilizes them to the utmost benefit?
- What are the barriers
- **Some practice's**
- Use check sheets (similar to the next page)
- Use the EMR to check for needed services
- Have templates for certain chronic condition visits
- A staff member to follow-up about needed services prior to the visit
- **Consider**
- Offloading tasks
- Does it make sense to have an employee/s whos main roll is planned visits and filling gaps in care

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Planned Visit Checklist

- **From 2020 GPRO Lessons Learned**

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Visit Checklist

Patient Name:		**DOB:**

(Services that still need to be completed are circled)

Annual CPE	HbA1c: Completed	Depression Screen
AWV	HbA1c: Controlled (< 8 and/or ≤ 9)	Documented Depression Follow-Up Plan
Well-Child Exam	Lipid Panel	Follow-Up PHQ-9
	Microalbumin/Creatinine	Fall Risk Screen
Calculated BMI	Serum Creatinine and K+	Tobacco Use Assessment
Nutrition Counseling	Retinal Eye Exam	Tobacco Cessation Counseling
Exercise Counseling	DM Foot Exam	
		Chlamydia Screen
Controlled BP (<140/90)	PFT (Spirometry)	Colorectal Cancer Screen
		Mammogram
Influenza Immunization: Administration and/or documentation		Pap Smear
Pneumococcal Vaccination: Administration and/or documentation		
Childhood Immunizations: Combo 10		
Adolescent Immunizations: Combo 3		

Notes	

Visit Checklist

Patient Name:		**DOB:**

Last, Patients Want Convivence

- Telehealth
- **Able to call during lunch**
- Expanded Hours
- **Portal Capability for refills, scheduling,**
- On-call provider availability
- **Low wait times or communication about wait times**
- Collaboration of Care
- **Good communication from their Providers and Health care staff**
- Any Other Ideas? What do you like as a patient?

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If the practice has any questions or needs assistance about implementing any of the best practices discussed in this PowerPoint please reach out to Rachael Smart rsmart@npoinc.org, Sharon Lassila slassila@npoinc.org, or Kris Elliott kelliot@npoin.org

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