Novello Physicians Organization

Patient-Centered Medical Home (PCMH) Primer for Primary Care

To be used with BCBSM Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor Interpretive Guidelines

2023 - 2024

What to expect from the PCMH Primer for Primary Care?

- The primer will be used to facilitate the PCP's practice manager's learning about Patient Centered Medical Home (PCMH).
- PCMH-N is the Patient Centered Medical Home-Neighborhood with the Specialist Practice. A Specialist Primer is used to facilitate learning for the Specialist Practice.
- As the primer is worked through, it will be apparent how PCMH and the PCMH-N share goals.

Schedule and Study Layout

- The NPO PCMH Contact will assign sections of the primer to the learner for independent study. A face-to-face or virtual meeting will be scheduled with the PCMH Contact to go over the assigned section.
    - It is the learner's responsibility to complete the assigned section prior to the meeting. It is ok to work ahead!
    - The learner is encouraged to write questions down along the way and may email or call the PCMH contact with questions. The PCMH Contact will respond right away with an answer or let the learner know the question requires more time to research and will be on the agenda for the next scheduled meeting.
    - During the meeting, the PCMH contact will have a conversation with the learner to ask and answer questions to determine understanding, and ask to see examples of things like handouts, registry reports, performance reports and training documents laid out throughout the Primer.
    - Upon meeting end, new independent study will be assigned and next meeting scheduled.
    - The cycle repeats until completion.

What Tools will be Needed to Work in Conjunction with The Primer?

It is essential that the BCBSM Physician Group Incentive Program (PGIP) PCMH and PCMH-N **Interpretive Guidelines** and **Domain Capability Self-Assessment PDF** documents are used in conjunction with the Primer. Using only the Primer will result in missing important information.

To further understand and acquire more information throughout the Primer please note:

- **Green underlined text with page numbers** indicates the need to refer to the **Interpretive Guidelines-Redline Version.**
- **Purple underlined text** indicates the need to refer to the **BCBSM Domain Capability Self-Assessment Document**.
- **Agenda Check:** In order to foster an effective PCMH practice, each practice adapts their own way of organizing PCMH tasks. A calendar template is provided on Page 2.
    - Throughout the primer there will be prompts: **Agenda Check** which flag the reviewer to assess the practice's current processes and their organization by ensuring the in-place status capability is in use by all practice members involved.
    - This is a great opportunity to create and improve the practice processes. to ensure a strong PCMH practice.
    - The practice already has a great organized system that flows well? That is great! Instead, observe that system to ensure tasks are going as planned while considering any areas for improvement.
        - This activity is for the learner and practice to use if they choose. NPO will not dictate when the practice performs certain PCMH tasks. The agenda should be flexible. Although certain tasks are required at set schedules, certain reports will be generated based on need and what makes sense at the time. It is the practice's responsibility to ensure PCMH tasks are completed.

Bookmarking/Hyperlinks

- Bookmarking/Hyperlinks are used throughout the primer to refer you back to certain instructions.
- To utilize, hover over link, press control and click.
- The document will need to be used electronically to utilize the bookmarking/hyperlinks.
- If you are using a printed version and can't figure out what to resort back to, reach-out to your PCMH contact.

Yearly Calendar

January	February	March	April	May	June
July	**August**	**September**	**October**	**November**	**December**

Patient Centered Medical Home (PCMH) Primer for Primary Care: PCMH General Overview

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Considering PCMH:

Exercise 1: There is no need to look anything up; this exercise is to prep the PCMH mindset and determine a baseline of PCMH knowledge.

- What do you think of when you hear PCMH?
- What do you know about PCMH?
- What is the purpose of PCMH?

PCMH Definition: What is PCMH? Why PCMH?

Definition of PCMH from BCBSM Interpretive Guidelines: Pg. 4

The Patient-Centered Medical Home (PCMH) is a care delivery model in which patient treatment is coordinated through primary care physicians to ensure patients receive the necessary care when and where they need it, in a manner they can understand.

Definition of PCMH-N from BCBSM Interpretive Guidelines: Pg. 4

The PCMH-Neighbor model enables specialists and sub-specialists, including behavioral health providers, to collaborate and coordinate with primary care physicians to create highly functioning systems of care.

Exercise 2: **Refer to Pg. 4-6 and READ** the goals of the PCMH/PCMH-N model. Why do we need "Interpretive Guidelines?"

How NPO fits into the practice PCMH:

The providers at the practice are members of Novello Physicians Organization (NPO). To be able to participate in BCBSM PGIP incentives including programs such as PCMH, providers need to belong to a Physician Organization. **NPO's mission**: Healthcare leadership via an organization of successful, independent physicians. **NPO's vision**: To be the engine that drives successful, high quality, cost effective healthcare by putting physicians and partners in the driver seat to inspire wellness.

NPO advocates for practices with payers, helps support PCMH and PCMH-N, assists with improving efficiencies in the practice administration and management, and provides forums for peer support and educational support. NPO operates with integrity and transparency. NPO helps physicians earn all revenue to which they are entitled.

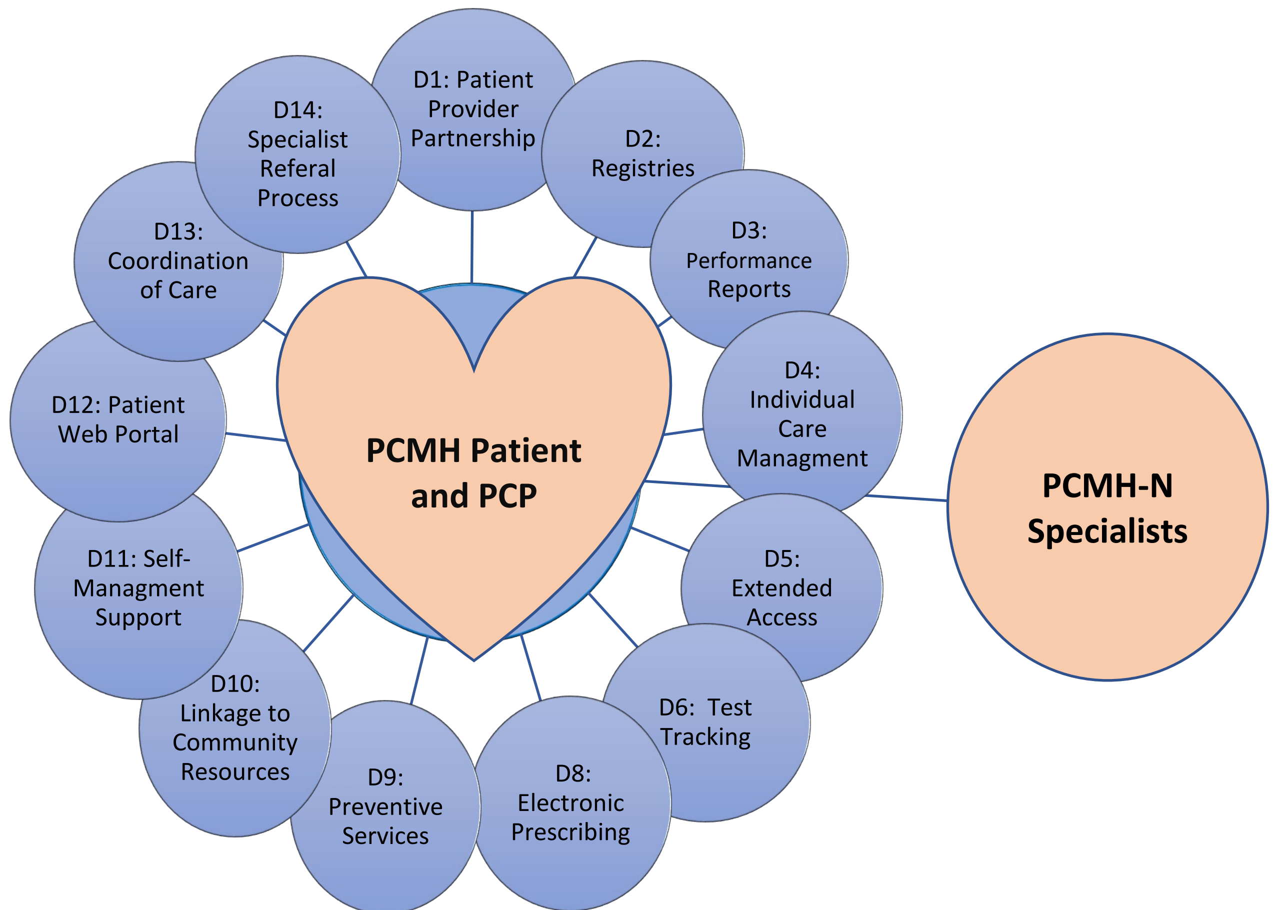
NPO works with practices to determine which PCMH and PCMH-N capabilities are in place and reports those to BCBSM so that the PCP practice can earn BCBSM PCMH designation and the specialist practice is considered an engaged member of the PCMH-N.

What PCMH Means to the Practice:

PCMH drives the functionality of the practice and is the foundation of all policies, procedures and workflows, ultimately improving patient lives. Implementing PCMH Domains and Capabilities will improve workflow processes and provide the foundation to improve the health of populations, enhance the experience of care for individuals, reduce the per capita cost of health care and attain joy in work, also known as the Quadruple Aim. PCMH is part (PGIP), a collection of quality-based initiatives that improve patient care in Michigan, providing opportunities to improve health care quality, reduce healthcare costs and together, improve the practice Quality Scores. High Performing/improved quality scores and low cost of care provide Value Based Reimbursement (VBR) payment or similar incentive payments each year for PCPs and Specialists across multiple payers.

The PCMH/PCMH-N model, when implemented effectively, can provide high quality care and lower health care costs:

Exercise 3: Review the diagram below. Note the PCP and Patient is at the center of all Domains that circle and support the PCP and Patient at heart. Specialists are connected to the PCMH as a neighbor and are considered in the Patient-Centered Medical Home-Neighborhood (PCMH-N).



Consider how each Domain complements the others, collectively working together to drive the practice's functionality and workflows as well as provide better quality of care and better experience for the patient.

PCMH Layout:

PCMH is made up of 14 Domains and several Capabilities. Thinking of an outline, the Domain would be the main heading and the Capabilities would be each bullet point under the heading. **Refer to interpretive guidelines Pg. 9, "Capability Overview" chart.**

What is it and How to Utilize the Capability Sheet: BCBSM Domain Capability Self-Assessment Document

NPO provides a BCBSM Domain Capability Self-Assessment document personalized to each practice. The capability sheet serves as a form of communication between NPO and the practice. It paints a picture of the practice's PCMH program by documenting capabilities as fully in place, not in place, and it also includes notes.

The note section is where the NPO PCMH contact will communicate needs or action items with the practice. Each practice is unique in that they have different capabilities in place. The BCBSM Domain Capability Self-Assessment Document records the practice capabilities. NPO ensures the practice has the appropriate capabilities *in place* and

in use by all appropriate members of the practice unit team on a routine and systematic basis. NPO then reports to BCBSM the capabilities in place at each practice.

BCBSM adds new capabilities and retires capabilities no longer relevant each year. Healthcare is constantly changing; continuous improvement is necessary to maintain high-quality, low-cost performance. Continuous improvement may not be accomplished by adding as many capabilities as possible to increase their number. Careful evaluation should occur to make sure new capabilities bring value. It's ok to move some capabilities to "not in place" if they no longer fit the practice's workflows or goals. It is important to make sure that the capabilities in place add value to the practice and not just create busy work. Please be mindful that full demonstration will be required to report a capability as *"in place". BCBSM will not accept that the practice has "the ability" to put the capability in place*; the capability must actually be in use. Capabilities the practice would like to report in place cannot be reported if the practice has not developed a process and the capability is not yet *in* use.

PCMH Domain/Capability Requirements:
Some capabilities require written process, staff and new staff education or both. Others require reports or surveys depending what the practice has marked fully in place.

Exercise 5: Please **review the practice capability sheet** for which processes require written processes/training. A key to this can be found at the top of the capability sheet. Look for the blue, pink, and green headings

PCMH General Overview Summary: Why PCMH?

The PCMH/PCMH-N delivery model treats the patient by coordinating and collaborating care to meet the patient's needs through high functioning systems of care. When the practice has PCMH/PCMH-N well embedded within its workflow, a more positive patient experience is achieved and higher quality of evidenced-based care and low-cost healthcare should be achieved. **INTERPRETIVE GUIDELINES MUST BE USED ALONGSIDE THIS PRIMER.** The Interpretive Guidelines and BCBSM Domain Capability Self-Assessment document are important tools to ensure the practice is meeting the intent and requirements of each capability that is in place. Consider and assess your practice's yearly PCMH agenda while working through this primer. Never hesitate to reach out to NPO with questions or concerns. At the end of each Domain the section *Wrapping it Up with The Why* will explain the importance of each Domain and appropriately connect each previously learned Domain, explaining its effects; rather like the song *Twelve Days of Christmas;* this section will expand as more related content is added.

PCMH questions contact information

- Rachael Smart, NPO – Manager of Quality , rsmart@npoinc.org
- Kris Elliott, NPO – Director of Operations , kelliott@npoinc.org

Patient Centered Medical Home (PCMH) Primer: Domain 1: Patient-Provider Partnership

Goal:

Build provider care team and patient awareness of, and active engagement with, the PCMH model, clearly define provider and patient responsibilities, and strengthen the provider-patient relationship.

Getting primed for Domain 1:

Exercise 1:

1. **Locate the practice's PCMH Capability Sheet**
2. **Locate the Interpretive Guidelines Pgs. 10-14**

a. Make sure both documents are the current year. If the current year is not found, contact one of the PCMH contacts. Contact information: PCMH Contact

3. Read the specified pages of the Interpretive Guidelines alongside the capability sheet, focusing on the capabilities the practice has fully in place.
4. Talk to the team: What do staff members know about PCMH? Can each staff member involved in the process discuss PCMH talking points: what they say to the patient? What is the process for educating patients about PCMH? Who is involved? Who is responsible for this conversation? Is the process working? How do you document the conversation?

    a. 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 PCMH Conversation and PCMH Brochure/handout:

The PCMH Conversation and PCMH Brochure/handout go hand-in-hand. BCBSM encourages the practice front office staff to use something like a laminated brochure and to focus on a few revolving points for conversation. They provide the patient an understanding of what PCMH is and how the provider and staff have worked hard to put processes in place to ensure the patient receives the right care at the right time. It builds the relationship between the patient, provider and practice. The PCMH conversation is required by a member of the clinical practice team; it is not enough to simply hand the patient the brochure/handout. The Brochure has practice-specific information about the PCMH capabilities the practice offers and provides expectations for the patient-provider relationship. An MA or front office staff may provide the brochure/handout but a clinical practice member must have the conversation. Refer to the previous PCMH diagram. Each circle is a PCMH Domain. The knowledge gained as staff are educated about PCMH Domains will help develop talking points that the patient can understand.

Examples: You are the Patient (P), the Care (C) is centered around you and the practice name_______) is your Medical (M) Home (H).

Please keep in mind the following depends on what capabilities the practice has in place and should be explained in terms the patient can understand. The examples below may need to be described in more detail for patient understanding.

As your medical home we:

- Keep you up-to-date on preventive services and remind you when you’re due
- Offer patient satisfaction surveys because we want to ensure we are providing optimal care
- Provide reminders for your appointments
- Offer planned visits
- Offer extended access through the afterhours service the practice provides. Please call us when you require care after our practices operating hours so that we can help ensure you receive the most appropriate care
- Track all your procedures and tests
- Assess your needs and help you get the resources you need
- Help educate and support you to learn self-management skills for illness and chronic disease
- Offer a patient portal where you can view labs, request medication etc.
- Help coordinate care with your referral specialists until a consultation report is received

Exercise 2: Find the practice's PCMH Brochure/handouts or any materials used to review with your PCMH contact.

Reports:

Domain 1: **Refer to Pg. 9-14** to ensure intent is being met for capabilities in place

1. **1.2:** A list of patients who are not regularly seen or getting close to inactivation. This list is used to provide outreach.
    a. **About:** "Current" patients are defined as patients who the practice considers to be active in the practice. **Example:** Practices may define "current" as seen within the past 24 months or past 36 months, as examples. Outreach helps ensure patients are not missed, patients are receiving preventive health care and helps keep the practice's patient list current. Outreach helps identify patients who have moved and/or are seeing a new provider and gives opportunity for PCMH conversation.
    b. **Example:** Practice considers their "current" patients as those seen in the last 24 months. After this 24-month period the practice chooses to inactivate patients if the patient has not been seen. However, proof of outreach should be documented before the patient is inactivated. The practice may run a report to determine what patients are nearing the 24-month period and provide outreach.
    c. **Examples for working the list**: Some practices generate the list every January and/or June showing patients not seen in the last year or last two years. The timing of generating the report and process for outreach is entirely up to the practice. **Outreach Process Examples:**
        i. Provide outreach to a certain number of patients a day, week, month etc.
        ii. Outreach to all people in January with a January birthday
        iii. Provide outreach to all patients on the list as quickly as possible and repeat in a few months
2. **1.3-1.8:** Patient-provider partnership documented communication process
    a. Depending on what capabilities the practice has in place, the % of patients who have had the PCMH conversation will need to be shown.
    b. **Example*: Current patients***: Patients seen in the last **24 months**:
        - Determine the number of patients seen in the past **2 years or (24 months)**
        - Example: 01/01/2018 – 12/31/2019 How many patients? This will be **the denominator**.
        - Determine the total of the denominator patients who have received a PCMH conversation. This will be **the numerator.**
        - Numerator/Denominator = % of patients who had the PCMH conversation.

Exercise 3:

1. Find where the practice keeps the reports for **1.2** and **1.3-1.8**
2. Assess for the following:
    a. Have these been completed in the last calendar year?
    b. How are these **r**egistry reports being worked? Being worked definition: how is the practice providing outreach to patients on these lists? Are they calling patients, sending letters, or a combination of both?
    c. What is the practice's process for running the registry reports?
        i. What time, or times, of year are they run? Does this make sense?
        ii. Who is responsible for running the registry report?
        iii. Who is responsible for working the registry report?
        iv. Do you feel there should be any changes to the current process?
            1. **Agenda Check**

3. If running the registry report is your responsibility, is there someone in your practice who can help you figure out the steps? If so, set some time up with them.
4. If the reports are not your responsibility, schedule time to learn the process and put the process in writing or delegate this task if not already delegated.
    a. **Why is it suggested to write the process out?** Changes can occur, employees leave or get different positions, and the person responsible for the reports may be gone, leaving the rest of the staff to figure it out.

Exercise 4: Refer to pages: 10-14Go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it Up with The Why

Successful performance of Domain One lays the foundation for all other PCMH Domains by building a strong patient-provider relationship and educating the patient about PCMH, expectations of the patient-provider relationship, and how it benefits the patients. A strong provider-patient relationship within the practice sets the foundation for success!

Write Down any questions or thoughts you have for your PCMH contact for Domain 1

Patient Centered Medical Home (PCMH) Primer: Domain 2: Patient Registry

Goal:

Enable providers to manage their patients both at the population level and at point of care through use of comprehensive patient registry.

What is a Patient Registry?

A patient registry can be generated using most Electronic Medical Record (EMR) programs or the practice may have another way. The patient registry is a generated list of patients based on certain criteria. For example: In Domain 1, a report was generated for patients that have not been regularly seen or have not had the PCMH conversation; this is considered a registry. The registry promotes actionable data for improving patient care and provides insight on where patients have gaps in care; from there outreach can be provided. The registries are unique to each practice based on the capabilities in place. Registries must be “all-payer,” including all patients from all the insurance the practice accepts, including self-pay. Contact NPO for information about Health Focus and how it can assist the practice with Patient Registries.

Evidence-Based Care (EBC) Guidelines:

Each practice uses EBC guidelines. EBC guidelines are developed statements to assist the providers and patients to make appropriate health care delivery decisions. Many practices use Healthcare Effectiveness Data and Information Set (HEDIS), American Family Physician (AFP), or U.S. Preventive Services Task Force (USPSTF) guidelines, as examples. Registry generation is based off EBC guidelines and aligns with quality measures. For example, MQIC guidelines state that people with diabetes should have an A1c checked every 3-6 months. A registry may be run for patients who have not had an A1c in the last 3-6 months.

Exercise 1: Find out what Evidenced-Based Care Guidelines the practice follows and know how to locate them.

Gaps in Care:

A gap in care is a discrepancy based on recommended care related to EBC guidelines. For example, patients older than 50 should have a colorectal cancer screening test. If a patient is older than 50 and hasn’t had colorectal cancer screening test, it is considered a gap in care. Registries help determine gaps in care and outreach helps to fill them.

Getting Primed for Domain 2:

Exercise 2:

1. **Locate the office's PCMH Capability Sheet**
2. **Locate the Interpretive Guidelines Pg. 14-28**
3. Read the selected pages of the interpretive guidelines alongside the capability sheet focusing on the capabilities the practice has in place.

Exercise 3:

5. Find where the practice keeps the registry reports for the capabilities in place
6. Assess for the following:
    a. Have they been completed at least once in the last calendar year?
    b. How are these registry reports being worked? "Being worked" meaning can be found: Being_Worked_Definition
    c. What is the practice's process for running the registry reports?
        i. What time, or times, of year are they run? Does this make sense?
        ii. Who is responsible for running the registry report?
        iii. Who is responsible for working the registry report?
        iv. Do you feel there should be any changes to the current process?
            1. **Agenda Check**

    d. **Exercise 4:** Follow exercise 3, number 3 & 4 from Domain One: Repeat_Exercise

Exercise 5: **Refer to pages 14-28** Go through each of the PCMH Validation Notes for Site Visits for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it Up with The Why

Domain two is very important as it provides the practice information of patients requiring outreach for existing gaps in care to specific patients related to specific quality measures. The registry facilitates the practice in providing optimal care to the patients while filling gaps in care, which ultimately helps with quality incentive scores and related incentive performance across multiple payers and lower health care costs. Outreach for these measures will aid in keeping the reports from Domain 1 shorter, which equals less busy work for the practice and an improved patient-provider relationship!

Write Down any questions or thoughts you have for your PCMH contact for Domain 2

Patient Centered Medical Home (PCMH) Primer: Domain 3: Performance Reporting

Goal

Generate all-patient/payer reports enabling POs and providers to monitor their population level performance over time, close gaps in care, and improve patient outcomes.

What is a Performance Report?

Performance reports assist the practice in developing awareness of their standing with certain health care quality measures. These measures can be compared to years prior, quarterly, per physician, and/or compared to other practices within the PO, in order to track efforts to fulfill gaps in care and to meet quality incentive

measurements. **Example:** The practice runs a performance report in March to find the % of patients who had an A1c in the past current calendar year by provider. Performance % may be low for the calendar year because it's only three months into the year. The report is generated again in June; hopefully, the performance % has increased meaning more patients have had their diabetic exams. If the performance % is not what the practice expects, a registry report/list can be generated in order to start reaching out to patients, fill gaps in care, and increase performance levels. It may be found that some provider's performance is higher than others indicating opportunity of sharing of processes with those whose performance is lower. Some practices choose to have quarterly meetings with their physicians in order to discuss results and act as needed. Contact NPO for information about Health Focus how it can assist the practice with Performance Reports.

Getting Primed for Domain 3:

Exercise 1:

1. **Locate the practice capability sheet**
2. **Locate Interpretive Guidelines Pg. 28-39**
3. Read the selected pages of the Interpretive Guidelines alongside the capability sheet focusing on the capabilities the practice has in place.

Exercise 2:

1. Locate where the practice keeps their performance reports for the capabilities in place
2. Assess for the following:
    a. Have they been run in the last calendar year?
    b. How are these performance reports being utilized and what is the process?
        i. What time, or times, of year are performance reports generated? Does this make sense?
        ii. Who is responsible for generating the performance report?
        iii. How is the data communicated to the providers?
        iv. Do you feel there should be any changes to the current process?
            1. **Agenda_Check**

Exercise 3: Follow exercise 3, number 3 & 4 from Domain One: Repeat_Exercise

Exercise 4: **Refer to pages: 28-39** and go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it Up with The Why

Performance reports are an influential piece of PCMH, providing an overview of the practice's standing related to quality incentive measurements, guiding decisions to, facilitate high-quality scores for the practice positively affecting payer incentives, and high-quality patient care. If the performance report indicates a need for action because of a low performance score, a registry (Domain 2) is generated with patients' names related to the issue. Then, these patients are provided outreach with PMCH language (Domain 1) to close gaps in care and increase performance. Win, win, win!

Write Down any questions or thoughts you have for your PCMH contact for Domain 3

Patient Centered Medical Home (PCMH) Primer: Domain 4: Individual Care Management

Goal

Patients receive organized, planned care that empowers them to take greater responsibility for their health.

What is Care Management?

A team-based approach that is centered around the patient to improve need for medical services by enhancing coordination of care and support systems, assisting patients more effectively in managing their health conditions.

Why Care Management:

Care Management helps improve the patient's health care experience, fostering a healthier population and community, causing reduced health care costs. Provider Delivered Care Management (PDCM):

Blue Cross Blue Shield of Michigan Care Management Fun Facts:

- PDCM providers had a 5.1 percent lower rate of ED visits for adults and a 3.6 percent lower rate of ED visits for the pediatric population compared to their PCMH-only peers.
- PDCM providers had a 7.2 percent lower rate of ED visits for conditions that could have been managed in the primary care setting for adults and a 5.8 percent lower rate of such visits for the pediatric population compared to their PCMH-only peers.
- In addition, despite the complexity of evaluating the PDCM program at a member level, results of an internal analysis from 2018 showed consistent positive findings for the commercial population with an estimated four percent savings equating to a $17 - $23 PMPM on engaged members!!!!!!

What is Provider Delivered Care Management (PDCM):

PDCM is a complementary component of PCMH, emphasizing Team Based Care. PDCM practices provide care management. Care Management (CM) is provided by a team led by the physician who works collaboratively with trained Care Managers. Trained Care Managers may be, but are not limited to: pharmacists, nurses, nutritionists, social workers, or certified diabetes educators. Trained Care Managers can bill multiple care management codes for their patient encounters that directly affect payment. When a practice has a strong PDCM program, they should see correlation in yearly revenue from incentive performance across multiple payers.

Exercise 1: Stu Rockafellow is an NPO-employed Pharmacist trained as a Care Manager. He works directly within some NPO practices. Please watch the following video to see how Stu's role as well as other team members work together to meet patient needs: https://www.youtube.com/watch?v=gVOHtaBAsXQ

Planned Visits:

Planned visits are a main component of Domain 4. Planned visits can be any type of visit but are specifically helpful for varying chronic conditions and for closing gaps in care. It is good practice to chart prep prior to each scheduled visit if possible. Ask NPO for an updated checklist for chart prep to assist in meeting quality incentive measures. A planned visit is as it sounds: a scheduled series of events, with practice members each having designated functions, during the patient's appointment; for visits to run smoothly, ensuring nothing is missed. Some preparation may take place before or after the visit in order to check off the most needed health services of gaps in care. The planned visit process paints a picture of each team member's role in the planned visit. Team members include but are not limited to: Front office staff, Medical Assistants, Nurses, APPs, Care Managers, or Pharmacists. When done effectively, planned visits create a more positive patient experience, can shorten registry reports which lessens patient outreach, and improve performance reports. Also, they can help to reduce unnecessary visits – for example, a patient scheduled to come back to discuss lab or referral results, but patient comes in and provider learns test/referral not completed, so patient must come back again later.

Getting Primed for Domain 4:

Exercise 1:

3. **Locate the practice capability sheet**
4. **Locate Interpretive Guidelines Pg. 39-56**
5. Read the selected pages of the interpretive guidelines alongside the capability sheet focusing on the capabilities the practice has in place.

Exercise 2:

1. **Locate the practice capability sheet:** if the practice has 4.1, 4.8, or 4.14 marked fully in place; these capabilities require written materials or new and current staff training, signified by the highlighted pink or blue.
2. Complete the following for each fully in place capability:
    a. 4.1- What is the practice's process for educating new and current staff yearly about PCMH, PCMH-N, and Chronic Care Model?
        i. Where and how is the training documented?
        ii. Have you been trained on these concepts?
        iii. What materials are used and where are they?
        iv. Who completes the training?
            1. **Agenda_Check**
    b. 4.8 and 4.14 - Find the practice's written process for planned visits. The process may be separate or combine both 4.8 and 4.14.
        i. When was the process last updated?
            1. **Suggested:** It is good to review processes at least 1x a year. Pass the documents around to current staff having them pencil in any changes noticed to the workflow or discuss a process at a staff meeting with all in attendance Make sure the changes and the policy are updated! This review is also good practice as a process breakdown may be discovered.
                a. **Agenda_Check**
        ii. Could this written process be used as a training tool for new staff? This is not a requirement but is suggested as it provides meaningful use for the practice. This does not need to be a long process; make it easy, use flowcharts or whatever works best for the practice.
    a. 4.4 - Patient Satisfaction Survey- What is the practice's process? Find the last survey, or last few surveys, completed to discuss with the PCMH contact. The practice will pick an issue found from the survey to work on. Trending data is viewed to see how improvement efforts are working.

Exercise 3: **Refer to pages: 39-57** and go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it Up with The Why

Individual Care Management requires all team members in the patient home or practice to participate. The team-based approach becomes apparent through CM services and planned visits that are centered around the patient, fostering a more positive patient experience and higher quality of care. Planned visits combined with care management (Domain 4) can shorten registry reports (Domain 2) which lessens patient outreach (Domain 1) and improved performance reports (Domain 3). Through this combination, the patient population and community served receives better health care and education to help the patient take greater responsibility over their own health care and health choices, helping lower health care costs. This high quality of care can create more revenue for the practice to continue their efforts. See how all the parts are coming together!?

Write Down any questions or thoughts you have for your PCMH contact for Domain 4

Patient Centered Medical Home (PCMH) Primer: Domain 5: Extended Access

Goal

All patients have timely access to health services that are patient-centered and culturally sensitive and are delivered in the most appropriate and least intensive setting based on the patient's needs. Practice must be routinely referring non-emergent patient's after-hours care, whether located at the practice site or another urgent care center (specialist practices that always send patient to ED do not meet the criteria for having after-hours care capabilities in place).

Exercise 1:

1. **Locate the practice capability sheet**
2. **Locate the Interpretive Guidelines Pg. 56-65**
3. Read the selected pages of the interpretive guidelines alongside the capability sheet focusing on the capabilities the practice has fully in place.

Exercise 2:

1. **Locate the practice capability sheet:** if the practice has 5.7, 5.8, 5.13, 5.14, 5.15 or 5.16 marked fully in place; these capabilities require a documented training tool/flowchart/process/policy/form and/or education signified by highlighted pink, blue or green.
2. Complete the following for each fully in place capability:
   a. When was the process last updated?
   b. Could this written process be used as a training tool for new staff? This is not a requirement but is suggested as it provides meaningful use for the practice.
   c. Has staff received education over the proper capabilities in the proper timeline? Please check the Interpretive Guidelines Pg. 63-65 as some education is required annually and some bi-annually.
      i. **Suggested:** It is good to review processes at least 1x a year. Refer to: Suggested reasoning.
      ii. Agenda Check

Exercise 4: Listen to the practices after-hours answering message with the mindset of being a patient with an urgent concern and listen for the following:

- Do you receive 24-hour access information quickly and easily?
- Is the information easily understood?
- **From the practice perspective:**
  How does the Physician receive the after-hours patient contact request? What if the Physician is unavailable?

Exercise 5: **Refer to pages: 57-67** and go through each of the PCMH Validation Notes for site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it Up with They Why

Extended Access provides higher quality of care for the patient, keeping their continuum of care with the PCP practice and directly impacts health care cost by keeping non-emergent issues out of the ED. It is required that the PCP has a 24-hour phone access for clinical decision making/triaging for patient concerns. This is also required for the PCMH-N (specialists) as an agreement between the NPO PCPs and Specialists.

It is essential that patients are frequently reminded and educated about the practice's extended access and what constitutes an emergency. Some practices will provide this information, along with the on-call number, on a business card during each discharge. Some have posters; some remind patients at check-out. All patients should be called after the PCP is notified of an ED visit in order to educate on extended access, assess needs and to determine if a follow up appointment is needed. If certain patients are frequently utilizing the ED, Care Management follow up may be appropriate to help find the root of the problem and again provide education (Domain 4). When patients are educated properly on the practice's extended access and utilize it appropriately, the patient-provider relationship can be strengthened (Domain 1).

The better the patient-provider relationship, the more likely the practice will be able to close gaps in care, creating shorter registry reports (Domain 2) in return improving performance reports (Domain 3). Refer to: BCBSM_Fun_Facts for a reminder how keeping patients out the ED affects health care spending. This also positively affects the practice's incentive performance across multiple payers while creating higher quality care for the patients! Yay to better outcomes!

Write Down any questions or thoughts you have for your PCMH contact for Domain 5

Patient Centered Medical Home (PCMH) Primer: Domain 6: Test Result Tracking & Follow-up

Goal:

Practice uses a standardized tracking system to ensure needed tests are received, results are communicated in a timely manner, and follow-up care is received

Getting Primed for Domain 6:

Exercise 1:

1. **Locate the practice capability sheet**
2. **Locate the Interpretive Guidelines Pg. 65-70**
3. Read the selected pages of the interpretive guidelines alongside the capability sheet, focusing on the capabilities the practice has fully in place.

Exercise 2:

1. **Locate the practice capability sheet:** if the practice has 6.1 and or 6.8 marked fully in place; these capabilities require a documented training tool/flowchart/procedure/policy/form and or current and new staff education
2. Complete the following for each fully in place capability:
    a. 6.8- What is the practice's process for educating new and current staff yearly to ensure adherence to the test-tracking procedures?
        i. Where and how is the training documented?
        ii. Have you been trained on these concepts?
        iii. What materials are used and where are they?
        iv. Who completes the training?
            1. **Agenda_Check**
    b. 6.1- Find the practice's written process for test tracking.
        i. When was the process last updated?

ii. Could this written process be used as a training tool for new staff? This is not a requirement but is suggested as it provides meaningful use for the practice.
    1. **Suggested:** It is good to review processes at least 1x a year. Refer to: Suggested for reasoning.
    2. **Agenda_Check**

Exercise 3: **Refer to pages: 65-70** and go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes? If there are concerns write them down to discuss with your PCMH contact.

Wrapping it Up with The Why

Test Tracking and follow-up helps ensure ordered services do not fall through the cracks and that all patients are notified of their test results, normal and abnormal. **Example**: the tracking includes team members following the course of ordered services including, but not limited to,: service is ordered, service result is pending, patient did not show or cancelled, result is available, patient is notified of results or notified to reschedule or be reminded of pending services, and the information is moved into the appropriate place in the EMR. Ordered services may be but are not limited to: labs, pulmonary function tests, colonoscopies, mammograms and specialist appointments. Informing patients of all test results in an appropriate timeframe helps build the provider-patient relationship by building trust (Domain 1), closing gaps in care (Domain 2) and by improving performance reports (Domain 3). Care Management may also become apparent for those with labs out of range such as a high A1c or cholesterol levels, or patients who frequently no-show or ignore ordered services (Domain 4).

Write Down any questions or thoughts you have for your PCMH contact for Domain 6

Patient Centered Medical Home (PCMH) Primer: Domain 8: Electronic Prescribing and Management of Controlled Substance Prescriptions

Goal:

All providers use electronic prescribing and actively manage controlled substance prescriptions

Getting Primed for Domain 8:

Exercise 1:

1. **Locate the practice capability sheet**
2. **Locate the Interpretive Guidelines Pg. 69-70**
3. Read the selected pages of the interpretive guidelines alongside the capability sheet focusing on the Capabilities the practice has fully in place

Exercise ~~3~~ 2: Find the practice's-controlled substance agreement. Is it current?

Exercise 4 3: **Refer to pages 70-72:** and go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it Up with The Why

Electronic prescribing and managing controlled substances provides benefits to the patient and provider, especially, if the patient has access to a web-portal, which will also be discussed in Domain 12. Through a portal, the patient can request a medication refill which is sent through the patient's EMR to the provider from office staff when the patient calls, or directly from the patient and their portal. Increased access and ease-of-care is

accomplished. If the patient is taking a controlled substance, a contract is held with the PCP who educates and monitors for overuse disorders and ensures the patient is following the contract, which aids in preventive services (Domain 9).

Patient Centered Medical Home (PCMH) Primer: Domain 9: Preventive Services

Goal:

Actively screen, educate, and counsel patients on preventative care and health behaviors

Getting Primed for Domain 9:

Exercise 1:

1. **Locate the practice capability sheet**
2. **Locate the Interpretive Guidelines Pg. 70-79**
3. Read the selected pages of the interpretive guidelines alongside the capability sheet focusing on the capabilities the practice has fully in place

Exercise 2:

1. **Locate the practice capability sheet:** if the practice has 9.6, 9.8 and or 9.9 marked fully in place, these capabilities require written materials or new and current staff training.
2. Complete the following for each fully in place capability:
    a. 9.8- What is the practice's process for educating new and current staff yearly regarding current health promotion and disease prevention and incorporated preventive-focused practices into ongoing administrative operations?
        i. Where and how is the training documented?
        ii. Have you been trained on these concepts?
        iii. What materials are used and where are they?
        iv. Who completes the training?
            1. **Agenda_Check**
    b. 9.6 and 9.9- Find the practice's written process for planned visits. 9.9 process may be its own document or combined with 4.8 and 4.14
        i. When was the process last updated?
        iii. Could this written process be used as a training tool for new staff?
            1. **Suggested:** It is good to review processes at least 1x a year. Refer to: Suggested reasoning.
            2. **Agenda_Check**

Exercise 4: **Refer to pages: 72-81:** Go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it Up with The Why

Preventive Services are as they sound, a way to prevent disease and keep the population healthy as possible through screening, education and modification of health behaviors. The efforts from Domain 9 require outreach (Domain 1), help close gaps in care (Domain 2), improve performance reports (Domain 3), and planned visits help ensure preventive service gaps in care are conversed and needed education/educational materials are provided (Domain 4). Through each touch with the patient regarding preventive services, the patient should be reminded of Extended Access (Domain 5) which helps build the patient-provider relationship (Domain 1) and directly decreases inappropriate ED visits and health care spending. Test result tracking and follow-up helps ensure preventive services are completed and helps determine high-risk for certain co-morbidities so that more preventive steps can be taken including education (Domain 6). The patient benefits from E-prescribing for

medication refills that prevent their current diagnosis from worsening. If the patient takes a controlled substance, an agreement exists between them and the provider to assist in preventing any overuse disorders (Domain 8). All these efforts combined should deliver high-quality care provided by the practice, resulting in optimal incentive performance across multiple payers.

Write Down any questions or thoughts you have for your PCMH contact for Domain 9

Patient Centered Medical Home (PCMH) Primer: Domain 10: Linkage to Community Services

Goal:

Expand the PCMH-Neighborhood to include community resources. Incorporate use of community resources into patients' care plans and assist patients in accessing community services.

Getting Primed for Domain 10:

Exercise 1:

1. **Locate the practice capability sheet**
2. **Locate the Interpretive Guidelines Pg. 79-85**
3. Read the selected pages of the interpretive guidelines alongside the capability sheet focusing on the capabilities the practice has fully in place

Exercise 2:

1. **Locate the practice capability sheet:** if the practice has 10.4 marked fully in place, this capability requires new and current staff training.
2. Complete the following for each fully in place capability:
    a. 10.4- What is the practice's process for educating new and current staff yearly on community resources and on how to identify and refer patients appropriately?
        i. Where and how is the training documented?
        ii. Have you been trained on these concepts?
        iii. What materials are used and where are they?
        iv. Who completes the training?
            1. **Agenda_Check**

Exercise 3: Check out some community resources supplied on the NPO website and accessed via: https://www.npoinc.org/in-the-news/resources/. There are more resources behind the member login. If you do not have a member login, please contact your PCMH contact.

Exercise 4: **Refer to pages: 81-85** Go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it Up with The Why

Linkage to Community Resources is a very important piece of the PCMH model. The term non-compliant is slightly outdated; today, the approach is to identify and understand barriers patients may have to receiving care. If basic needs are not being met, this can hamper access to care and can also contribute to anxiety and depression (both screened during Preventive Services (Domain 9)). By helping patients get to the resources they need, the patient-provider relationship benefits (Domain 1). Also, when the patient has the resources they need, inappropriate ED visits may decrease; the patients can be educated on extended access at each community resource touchpoint (Domain 5). The screening can be tied in with planned visits (Domain 4). Referrals to

community resources are tracked and follow-up is completed for high-risk patients (Domain 6). Once the patient's basic needs are met, the patient may be better positioned and ready to focus on preventive health concepts, and the practice can close more gaps in care and directly influence registry reports (Domain 2), performance reports (Domain 3), and incentive performance across multiple payers Optimal connected care equals optimal results!

Patient Centered Medical Home (PCMH) Primer: Domain 11: Self-Management Support

Goal:

Systematic approach to empowering patients to understand their central role in effectively managing their illness, making informed decisions about care, and engaging in healthy behaviors

Getting Primed for Domain 11:

Exercise 1:

1. **Locate the practice capability sheet**
2. **Locate the Interpretive Guidelines Pg. 85-88**
3. Read the selected pages of the interpretive guidelines alongside the capability sheet focusing on the capabilities the practice has fully in place

Exercise 2:

1. **Locate the practice capability sheet:** if the practice has 11.1 and or 11.8 marked fully in place, these capabilities require new and current staff training.
2. Complete the following for each fully in place capability:
    a. 11.1 What is the practice's process for educating new and current staff yearly regarding self-management support concepts and techniques?
        i. Where and how is the training documented?
        ii. Have you been trained on these concepts?
        iii. What materials are used and where are they?
        iv. Who completes the training?
            1. **Agenda_Check**
    b. 11.8 At least one member of PO or Practice is formally trained through completion of a nationally or internationally-accredited program in self-management support concepts and techniques, and regularly works with appropriate staff members within the practice to educate them so they can actively use self-management support concepts and techniques.
        i. The formally trained members are almost always the Care Managers
        i. Who in the office has this training?
        ii. NPO offers Care Management Courses training as need exists
        iii. Does your practice have Medical Assistants who have taken these classes? MAs can bill for certain care management codes.

Exercise 5: **Refer to pages: 85-90** Go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it Up with the Why

Care Managers who are taught self-management skills can teach patients and other staff members. Appropriate staff members are taught self-management skills so that they can better assist patients with these skills as well creating a better experience for the patient. Care Managers and appropriate staff who have been taught self-

management skills can assist the patients to better self-manage their chronic illnesses or other health struggles. Through assessment, it may be found a patient has needs such as transportation that will help them better self-manage their care and conditions. (Domain 10). Self-management can prevent worsening of conditions or developing new conditions (Domain 9). Self-management or Care Management patients are tracked and followed by their care managers to assess progression of the health care plan (Domain 6). Patients with poorly managed chronic illnesses are prone to ED visits; helping them self-manage their conditions and educating on ease-of-access can decrease the amount of ED visits (Domain 6). Planned visits are a great way screen for patients who may benefit from Self-Management/Care Management (Domain 4). All these aspects combined aid in a stronger patient-provider relationship (Domain 1), producing more manageable registry lists (Domain 2) and increased performance, (Domain 3) which results in higher quality care and incentive performance across multiple payers. The pieces of PCMH/Domains work well together!

Write Down any questions or thoughts you have for your PCMH contact for Domain 11

Patient Centered Medical Home (PCMH) Primer: Domain 12: Patient Web Portal

Goal:

Patients have access to a web-based platform enabling patients to access medical information and to have electronic communication with providers

Getting Primed for Domain 12:

Exercise 1:

1. **Locate the practice capability sheet**
2. **Locate the Interpretive Guidelines Pg. 88-92**
3. Read the selected pages of the interpretive guidelines alongside the capability sheet focusing on the capabilities the practice has fully in place

Exercise 2: Locate the practice capability sheet and assess the patient portal the practice uses. For each capability the practice has in place: Do you know how the portal works? Consider from a patient perspective: can you explain the portal benefit and functions of the portal to the patient?

Exercise 3: Refer to pages: 90-95: Go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it Up with The Why

The Patient Web Portal expands access and ease-of-care to the patient, increasing quality of care and the patient experience. Depending on the functions of the portal, the patient can: request or schedule their own appointments, actively log self-administered tests, participate in telehealth, review test results (Domain 6), request prescription refills (Domain 8), view visit summaries, communicate with their provider (Domain 1) , communicate with their Care Manager (Domain 11) and that communication may be about a needed resource (Domain 10) or education about Ease of Access (Domain 5), the office staff can also provide outreach and reminders through the portal (Domain 1,2,4,9). The portal can have many benefits to increasing quality or care, performance (Domain 3) and again incentive performance across multiple payers. Remember the fun facts in Domain 4? They apply for Domain 11 as well; refer to Blue Cross Blue Shields of Michigan Care Management Fun Facts: **BCBSM_Fun_Facts**. The big picture is forming!

Write Down any questions or thoughts you have for your PCMH contact for Domain 12

Patient Centered Medical Home (PCMH) Primer: Domain 13: Coordination of Care

Goal:

Patient transitions are well-managed and patient care is coordinated across health care settings through a process of active communication and collaboration among providers, patients and their caregivers

Getting Primed for Domain 13:

Exercise 1:

1. **Locate the practice capability sheet**
2. **Locate the Interpretive Guidelines Pg. 92-97**
3. Read the selected pages of the interpretive guidelines alongside the capability sheet focusing on the capabilities the practice has fully in place

Exercise 2:

1. **Locate the practice capability sheet:** if the practice 13.7 marked fully in place, this capability requires new and current staff training and a written process
2. Complete the following for each fully in place capability:
    a. 13.7 What is the practice's process for educating new and current staff on the care coordination process
        i. Where and how is the training documented?
        ii. Have you been trained on these concepts?
        iii. What materials are used and where are they?
        iv. Who completes the training?
            1. **Agenda_Check**
    b. 13.7 Find the practice's written process for the care coordination process
        i. When was the policy last updated?
            1. Could this written process be used as a training tool for new staff?
            2. **Suggested:** It is good to review processes at least 1x a year. Refer to Suggested for reasoning.
            3. **Agenda_Check**

Exercise 5: Refer to pages: 95-10094 Go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it up

There is huge benefit related to Coordination of Care; it starts to bring the PCMH-N to life by ensuring there is connection and communication between the PCP and the patient's outside encounters related but not limited to: specialist, ED, and rehab. When this connection and communication occurs, the patient's experiences are improved and higher quality of care is delivered. Through Care Coordination, gaps in care can be closed, (Domain 2 and 9) increasing performance (Domain 3). For instance, a patient may have received needed lab work from an outside encounter that helps the PCP meet a quality incentive measure. If that information is communicated, it can be updated in the patient chart, the provider is aware and can act as needed, and there is decreased risk for a repeated lab service which helps lower health care cost and don't forget incentive performance across multiple payers. The patient and provider relationship grows stronger when the patient feels their PCP is aware of their outside health encounters (Domain 1). Some of this care coordination is tracked; for instance, a colonoscopy is scheduled and followed until the results are generated (Domain 6). The practice also receives Admission, Discharge and Transfer reports on patients who were in the ED or skilled nursing facility, providing a great opportunity for a team member— possibly Care Manager— to provide outreach education on access of care

(Domain 5), assessing need for community resources, condition education, and/or scheduling appointments may be appropriate (Domain 10, 11). The neighborhood is part of the team and has meaningful influence!

Write Down any questions or thoughts you have for your PCMH contact for Domain 13

Patient Centered Medical Home (PCMH) Primer: Domain 14: Specialist Pre-Consultation and Referral Process

Goal:

Process of referring patients from PCPs to specialists, and from specialists to sub-specialists, is well coordinated and patient-centered, and all providers have timely access to information needed to provide optimal care.

Getting Primed for Domain 14:

Exercise 1:

1. **Locate the practice capability sheet**
2. **Locate the Interpretive Guidelines Pg. 97-100**
3. Read the selected pages of the interpretive guidelines alongside the capability sheet, focusing on the capabilities the practice

Exercise 2:

1. **Locate the practice capability sheet:** if the practice has 14.1 and 14.8 marked fully in place, these capabilities require written materials or new and current staff training.
2. Complete the following for each fully in place capability:
    a. 14.8- What is the practice's process for educating new and current staff yearly regarding all aspects of the specialist referral process?
        ii. Where and how is the training documented?
        iii. Have you been trained on these concepts?
        iv. What materials are used and where are they?
        v. Who completes the training?
            2. **Agenda_Check**
    b. 14.8- Find the practice's written process for each phase of the specialist referral process including desired timeframes for appointment and information exchange for all providers
        vi. When was the process last updated?
            4. Could this written process can be used as a training tool for new staff? **Suggested:** It is good to review policy at least 1x a year. Refer to: Suggested for reasoning.
            5. **Agenda_Check**

Exercise 5: **Refer to pages: 100-105** Go through each of the PCMH Validation Notes for Site Visit for each capability your practice has in place. Can the practice effectively demonstrate each of the validation notes?

Wrapping it up

The Specialist Pre-Consultation and referral process strengthens the PCMH-N even further by directly creating relationships with the practice unit (PCMH) and specialty unit (PCMH-N). The practice should have developed materials and processes in place for different specialties they refer and processes to track specialty visits (Domain 6). When done properly, the communication can decrease duplication of services, decreasing unnecessary health care costs. For instance, if a patient sees an endocrinologist, they may receive most of their diabetic care through the specialist and not require as much from their PCP, but the PCP should receive notice of all care the patient receives from the endocrinologist and follow-up with the patient about endocrinologist appointments; this

coordinated care helps build the provider-patient relationship (Domain 1). If a patient self-refers themselves to a specialist, the specialist should find out who the patient's PCP is so that information can be exchanged; in case this does not occur, the patient should always be asked about outside health care encounters at each visit. If the specialist office is part of the PCMH-N, they should collaborate with the PCP regarding the patient's care which could help close gaps in care (Domain 2, 4, 9) depending on the specialty type. For example, if the patient sees an endocrinologist some of their diabetic gaps in care may be taken care of with the endocrinologist. Closing gaps in care can positively affect practice performance (Domain 3). The PCMH and PCMH-N together increase quality of care, increase patient experience, and secure optimal incentive performance across multiple payers. The PCP and Neighborhood are in this together! It takes a team!

Patient Centered Medical Home (PCMH) Primer: In conclusion

Goal:

In completion of this Primer, the most important aspect is the learner understanding WHY PCMH and realizing how it can positively drive the practice. Independently, and with help of the PCMH Contact, the learner should gain knowledge and be able to explain and demonstrate what the PCMH/PCMH-N model is and how it functions within the practice for the utmost quality of care. PCMH is the foundation that can help the practice to perform their best on all incentives, helping the practice gain the revenue to which they are entitled. Through completion of the primer, hopefully processes have been confirmed to be functioning as they should or areas for improvement were found; maybe some improvements were accomplished or set in motion! If this goal was met, the practice should be well prepared for a site visit if chosen.

Site-Visits: From the Interpretive Guidelines: **Locate the Interpretive Guidelines and read Pg. 6, 12.** Site visits occur annually and are selected at random by BCBSM. If the practice is chosen, you will be notified by NPO with some advance notice to "spruce up" as needed. The PCMH contact will help you prepare and help you verify everything as it should be. Site visits are casual and are a conversation between you, the BCBSM representative, and PCMH contact from NPO.

In Closing, Words from NPO Doctors

The Patient Centered Medical Home: Meeting the Patient's Needs. **NPO physician designated since 2013**

After over 15 years of practice, I had the opportunity 3 years ago with 3 other physicians to open a new pediatric practice. Our goal was to provide state of the art pediatric care and foster a practice environment of compassion and availability to our patients and their families.

We began the application process for designation as a patient centered medical home shortly after opening our new office. We found that the PCMH structure helped us to organize our office and formalize our policies and procedures to meet our goal of quality care and availability to our patients and their families.

The PCMH structure promotes close monitoring of all patient medical care, whether that care is provided in our office, in the emergency room, in urgent care clinics or in the offices of subspecialists. As part of the PCMH capabilities, we review each incident of care for a given patient that has been performed outside of our office. After working with this system, I am certain that the PCMH structure applied to our office procedures helps me to have a much more thorough knowledge of the issues and needs of individual patients.

We contact families by phone after each emergency room visit, each urgent care visit, and each hospitalization. The follow up of visits to emergency rooms and walk in clinics by phone, sends the message to patients that we are aware of their medical problems, concerned about their progress and are available for their ongoing medical needs.

We have learned how helpful the PCMH structure is in caring for our medically complex patients. We track this care in our Chronic Care Registry. We have assigned nurse managers to work with complex patients and their families. Identifying a primary care provider and a "go to" nurse for our chronically ill complex patients has improved the quality and efficiency of care we give to these patients. Our nurse managers get to know the

patients and their families, and nurses and ancillary care providers who care for these patients at other institutions as well. This helps us to meet the patients' needs in all areas of their ongoing care.
The PCMH model also employs patient registries for population management. We identify, through quarterly review of the performance reports taken from information in these registries, areas where improvement in our care is needed to meet quality standards.
The PCMH model has given us the structural foundation to deliver care based upon quality measures. This model also helps us to be available to provide comprehensive care to our individual patients. As medicine moves from recognition of quantity of care to recognition of quality of care, I believe that our adaptation of this model will help us to move forward and meet the challenges of medicine in the future. I would strongly encourage any practices to consider the value of the PCMH system in enhancing the delivery of comprehensive, quality care to their patients

Team approach leads to high-quality care: **NPO Physician practice designated for 10+ years**

The practice firmly believes that a team approach is the best way to achieve high-quality care.

"We have a high-functioning team that operates much like a family," he said. "As a result, we experienced very little turnover during the pandemic, which is a testament to our shared commitment to providing the best possible care to patients."

The practice's team-based approach is rooted in the Patient-Centered Medical Home model of care. The practice has been part of Blue Cross Blue Shield of Michigan's Patient-Centered Medical Home designation program for more than 10 years.

"The PCMH Interpretive Guidelines provide a great outline for delivering high-quality care and holding the practice accountable to ensure they have a standardized and documented process to catch any patients who might otherwise fall through the cracks," he said.

To further help patients, the practice has added care management to the array of services they provide, which has been helpful in engaging patients who need additional support and closing gaps in care. "The use of care management, registries and other PCMH tools has helped us to not only manage individual patients, but better manage the entire patient population," he said.

Advice for other practices

The first step in implementing PCMH capabilities, the physician said, is to assess which capabilities are most relevant to the practice, with an end goal of improving patient outcomes, enhancing the patient experience, and reducing costs. "It's crucial to create processes and procedures with this framework in mind," he said.

He added that building a strong team of committed staff members who work well together is crucial for success. And he recommends that practices engage with their physician organization early on to learn from others who have gone through the same journey.