### Assumptions

**Private Practice**
- Less practice variation
- Better appointment access
- More continuity
- More patient focus
- Stable staff, low turnover
- More patients per session
- More opportunities for clinical income
- Easier to navigate as a patient

**Academic Practice**
- More diverse population
- Higher medical complexity
- Part-time providers
- Split focus
  - Clinical
  - Research
  - Education
- Resident training requirements
- Complex management structure
- Large staff and numerous providers
How do these assumptions affect our approach to PCMH and a PCMH application?
The PCMH Model

- PCMH is a model of care that seeks to:
  - Strengthen the physician-patient relationship
  - Replace episodic, complaint-driven care with coordinated/planned care
  - Promote a long-term, continuous healing relationship
  - Involve the patient in their own care

- In this model, the physician-driven team is responsible for the patient
- This model requires a systematic approach to population and disease management

A Medical Home...is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”

American Academy of Pediatrics
What does PCMH mean to you?

• ‘Patients identify who their doctor is and use their doctor as the center of their healthcare. [Their] doctors manage their care ……more proactively rather than reactively.’

The future???

• PCMH is ‘a way of structuring and compensating providers for some of the work necessary for high quality care that is not directly compensated under previous payment models. This work includes care coordination, preventive care, and coordinated, team-based care for chronic conditions.’
NCQA Specifics
NCQA 3-Tiered Recognition

Level 1
‘Basic’
25 points
5 must pass
60% recognized

Level 2
‘Intermediate’
50 points
10 must pass
5% recognized
60% recognized

Level 3
‘Advanced’
75 points
10 must pass
35% recognized

9 Standards,
30 Elements,
180 Factors
Nationally, NCQA PCMH applications are on the rise

- **June 2009**
  - 30 applications per month
  - 150 Practices with recognition

- **January 2010**
  - 100 applications per month
  - 383 practices with recognition
NC Practices & PCMH Recognition

Accessed NCQA.ORG  Physician Directory 2.8.2010

• UNC, Department of Family Medicine
• Novant Medical Group, Maplewood Family Practice
• Duke Family Medicine
• Robert M Horton Family Practice
NC Practices & PCMH Recognition

Accessed NCQA.ORG  Physician Directory 3.23.2010

• Triangle Pediatric Center
• Wake Internal Medicine Consultants
• Raleigh Family Practice
• Cary Healthcare Associates
• Chapel Hill Pediatrics and Adolescents
• Downtown Health Plaza Adult Medicine Clinic
• Raleigh Children and Adolescents Medicine
PCMH Application Examples from UNC HCS
Key UNC Health Care Considerations

- Three practices targeted initially
  - Family Medicine (Campus- Aycock)
    - Began process 2008
    - Application 2009
  - General Medicine (Campus- ACC)
    - Began process 2008
    - Application 2009
  - University Pediatrics at Highgate (CBP-Durham)
    - Began process 2008
    - Application 2009
- Level 3 recognition was the goal
  - Interested in the ‘transformative’ potential
UNCHCS Example: Family Medicine (FM)

- PPC 1B: Patient communication & correspondence (*Must Pass*)
  - The practice shows that it meets standards documented in 1A
- FM is testing a system that parallels WebCIS (EHR) phone messages and tracks response times to requests

**Response times for Phone & Email Requests**

![Bar chart showing response times for different durations]

- 72 hrs
- 60 hrs
- 48 hrs
- 36 hrs
- 24 hrs

Goal should be determined in P&P. Demonstrate adherence to P&P.
PPC 2E: Identifying important conditions (Must Pass)

The practice uses a system to identify diagnoses and conditions.
- **PPC 5A: Electronic prescription writing** *(NOT a must pass)*
  - The practice uses an electronic prescription writer
  - With or without built in decision support
**UNCHCS Example: Family Medicine (FM)**

- **PPC 7: Practices to track patient referrals (Must Pass)**
  - Tracking system for ‘critical’ referrals
  - Origination and status are key

![FMC Referral Rate Graph](image)

**FMC Referrals - Time To Appointment by Clinic/Service and Within/Outside of UNC HCS**

<table>
<thead>
<tr>
<th>Clinic/Service</th>
<th>Avg Days from Referral to Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
<td></td>
</tr>
<tr>
<td>Pediatric Surgery</td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology (Liver)</td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
</tr>
<tr>
<td>OB/Gyn</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology (Eye Clinic)</td>
<td></td>
</tr>
<tr>
<td>Orthopedics</td>
<td></td>
</tr>
</tbody>
</table>

**Volume - Top 5 Referral Sites**

<table>
<thead>
<tr>
<th>Site</th>
<th>Referral Volume %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology/Mammogram</td>
<td>19.4%</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>19.3%</td>
</tr>
<tr>
<td>GI Procedures</td>
<td>19.8%</td>
</tr>
<tr>
<td>Radiology/Ultrasound</td>
<td>19.3%</td>
</tr>
<tr>
<td>Ophthalmology (Eye Clinic)</td>
<td>19.8%</td>
</tr>
</tbody>
</table>
How has the PCMH application process changed our practices?

• Revision of policy and procedure to include goals and focus on the patient/patient experience

• Highlighted the need for centralized reporting and IT support
  » Additional reporting requirements, i.e. self-efficacy, language, continuity, etc.
  » Increased utilization of point of care decision making through use of disease registry forms
  » Developed tracking systems for referrals and patient communications

• Improved outreach to high risk patients

• Patient-centered care is a regular topic at the HCS level
The UNC HCS Strategic Plan
A system approach to PCMH at UNC HCS

2009
FM phase 1
FM phase 2
GIM
HGP

Now

PCMH application

Summer 2010
Internal collaborative
Template for change

2012
PCMH goals attained

Reporting
CDW
WebCIS
P&P
Clinic teams
QI expertise
PCMH is integral to key initiatives & incentives

**Medical Home Objective:** Create true care coordination, with proactive patient tracking and population/disease management to improve clinical outcomes

**Patient-Centered Medical Home Elements**
- Access and Communication
- Patient Tracking and Registry Functions
- Case Management
- Patient Self-Management Support
- Test and Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communications

**Key Initiatives and Incentives**
- Medicare 646 Waiver
- Physician Quality Reporting Initiative
- Negotiation Tool for other Payers
- Medicare E-Prescribing Incentive
- HITECH Incentives and Meaningful Use
- Becoming the leading academic medical center in the nation
- Market differentiation
PCMH:
‘Intent vs. ‘Application’
A New Clinical Intervention: Patient Centered, Planned Care
Medicare Demonstration Program for Dually Eligible Recipients (aka, 646)

- Dually eligible patients ‘touched’ by UNC HCS primary care providers are eligible
- Expansion of Carolina Access model
- Interventions include case management for:
  - Transitions
  - Long-term care
  - Community dwelling mentally ill
- Goals
  - Improved quality of clinical care
  - Decreased cost of care
  - Improved provider and staff satisfaction
An Example of Work to Come:
HITECH/meaningful use
HIT Incentives and Meaningful Use

- Incentive payments, require:
  - Certified EMR
  - “Meaningful Use”
- Two distinct incentive models
  - Hospital incentives
  - Physician incentives:
    - Based on Medicare and Medicaid charges
    - Exclude “hospital-based physicians who substantially furnish their services in a hospital setting” …”such as a pathologist, anesthesiologist or emergency physician”
Results: Few Providers E-Prescribe On A Regular Basis

“How often do you e-prescribe?” (n=220)

- Always (76-100% of the time) - 46%
- Frequently (51-75% of the time) - 23%
- Sometimes (26-50% of the time) - 16%
- Rarely (0-25% of the time) - 15%

Over 75% eRx is the goal
<table>
<thead>
<tr>
<th>PCMH Standards</th>
<th>HIT/MU</th>
<th>646</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Access and Communication</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>2) Patient Tracking and Registry Functions</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>3) Care Management</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>4) Patient Self-Management Support</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>5) Electronic Prescribing</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>6) Test Tracking</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>7) Referral Tracking</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>8) Performance Reporting and Improvement</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>9) Advanced Electronic Communications</td>
<td>■</td>
<td>?</td>
<td>■</td>
</tr>
</tbody>
</table>
UNC HCS, PCMH, and the next 5 years

• PCMH Level 3 should be the standard
• All primary care community-based practices achieve PCMH recognition
• All campus-based primary care clinics achieve PCMH recognition
  » UNC Gen Pediatrics is next
• All interested, applicable specialty practices achieve recognition (*This may be somewhat controversial*)
  » Expressed interest
    • Infectious Disease
  » May be of interest to me
    • GI
    • Solid organ Transplant
    • Multidisciplinary Oncology
Lessons learned from UNC

- Our campus (academic) practices are different from our private (community) practices
  - Only crossover was the EHR
- A patient centered approach can minimize differences
- Appropriate organization of the process was key
  - Well defined Aims
  - Divide the workload
  - Each setting a leader and a processor
- Keep a tracking tool and document as you go
- The application process can be prolonged if complex clinic structures exist and/or sophisticated population management methods are used
- Focus on the ‘intent’ and the potential for transformation
Important Tools

- A previous investment in quality or performance improvement is invaluable but not required
  - Started with disease focused recognitions
- Reporting should include:
  - Quality
  - Access
  - Efficiency
- Quality examples:
  [http://www.med.unc.edu/imb/staff/QI/reports/](http://www.med.unc.edu/imb/staff/QI/reports/)
### Important Tools

**Manage your projects, maintain time lines, and report**

<table>
<thead>
<tr>
<th>Project / Lead(s)</th>
<th>Main Outcome (goal)</th>
<th>Last measure/date</th>
<th>Most recent measure/date</th>
<th>Next Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone/Fax Messaging Protocol</td>
<td>Avg hrs to Call finalization (Goal 80% of call returned within 24 hours)</td>
<td>Jan 77.59</td>
<td>Feb 57.63</td>
<td>Contact ISD for report refinements and additional data. Need to review provider and staff listing, some appear to not be ours, others missing.</td>
</tr>
<tr>
<td>Malinda Williams, Penny Chunley</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Robb Malone - ISD report), Steve</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desper</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Message volume finalized/not</td>
<td></td>
<td>Jan 422/6</td>
<td>Feb 387/20</td>
<td></td>
</tr>
<tr>
<td>finalized/ not finalized</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avg hrs to first response</td>
<td></td>
<td>Jan 74.88/37</td>
<td>Feb 58.81/69.56</td>
<td></td>
</tr>
<tr>
<td>finalized/not finalized</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual provider/staff response time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adherence to standard messaging format</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax response times</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax refill returned to pt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>within 48 hrs (Goal 80%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax DME, pre-auth, etc returned to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vendor 72 within hrs (Goal 80%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised 4/6/2010
### Important Tools

<table>
<thead>
<tr>
<th>PPC1</th>
<th>Access and Communication</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>Access and Communication Processes</td>
<td>1A</td>
<td></td>
</tr>
<tr>
<td>A1</td>
<td>Scheduling each patient with a personal clinician for continuity of care</td>
<td>Pending</td>
<td>Wait until 1B is complete</td>
</tr>
<tr>
<td>A2</td>
<td>Coordinating visits with multiple clinicians and/or diagnostic tests during one trip</td>
<td>Pending</td>
<td>Request submitted</td>
</tr>
<tr>
<td>A3</td>
<td>Determining through triage how soon a patient needs to be seen</td>
<td>Pending</td>
<td>Request submitted</td>
</tr>
<tr>
<td>A4</td>
<td>Maintaining the capacity to schedule patients the same day they call</td>
<td>Pending</td>
<td>Sampling now</td>
</tr>
<tr>
<td>A5</td>
<td>Scheduling same day appointments based on practice's triage of patients' conditions</td>
<td>Pending</td>
<td>Request submitted</td>
</tr>
<tr>
<td>A6</td>
<td>Scheduling same day appointments based on patient/s family's requests</td>
<td>Pending</td>
<td>Request submitted</td>
</tr>
<tr>
<td>A7</td>
<td>Providing telephone advice on clinical issues during office hours by physician, nurse, or other clinician within a specified time</td>
<td>Pending</td>
<td>Sampling methods developed</td>
</tr>
<tr>
<td>A8</td>
<td>Providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week</td>
<td>Pending</td>
<td>Sampling methods developed</td>
</tr>
<tr>
<td>A9</td>
<td>Providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specific time</td>
<td>Not Eligible</td>
<td>Developed process, testing</td>
</tr>
<tr>
<td>A10</td>
<td>Providing an interactive practice Web site</td>
<td>Not Eligible</td>
<td>Revising policy</td>
</tr>
<tr>
<td>A11</td>
<td>Making language services available for patients with limited English proficiency</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>A12</td>
<td>Identifying health insurance resources for patients/families without insurance</td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>1B</td>
<td>Access and Communication Results</td>
<td>1B</td>
<td></td>
</tr>
<tr>
<td>B1</td>
<td>Visits with assigned personal clinician for each patient</td>
<td>Submitted</td>
<td>Uploaded to web</td>
</tr>
<tr>
<td>B2</td>
<td>Appointments scheduled to meet the standards in items 1-6 in 1A:</td>
<td>Ready</td>
<td>Reviewed, filed in ‘ready’ folder</td>
</tr>
<tr>
<td>B3</td>
<td>Response times to meet standards for timely response to telephone requests</td>
<td>Ready</td>
<td>Reviewed, filed in ‘ready’ folder</td>
</tr>
<tr>
<td>B4</td>
<td>Response times to meet standards for timely response to e-mail and interactive Web requests</td>
<td>Ready</td>
<td>Reviewed, filed in ‘ready’ folder</td>
</tr>
<tr>
<td>B5</td>
<td>Language services for patients with limited English proficiency</td>
<td>Not Eligible</td>
<td>Add invoices</td>
</tr>
</tbody>
</table>

- Critically appraise your practice
- What is your goal?
- Start with ‘must pass’
- Do not overstate or over estimate your capabilities
- Perfection may not be required
- Keep your tracking tool up to date
Significant workflow/personnel changes

• Health Care System Level
  » Centralization of staff to facilitate HCS applications and coordinate improvement efforts
    • 1 Director
    • 2 Change managers/analysts
  » Investment of IT resources to develop tracking and reporting systems

• Practice Level
  » Reorganization to invest in QI infrastructure (staff) to lead improvement efforts
    • QI Coordinator (General Medicine)
    • QI Coordinator (Community-Based Practices)
  » Reorganization of current staff to process visit documentation
  » Reorganization of current staff to provide more support to patient communication processes
  » New clinical resources to meet requirements of ‘three important conditions’ (Family Medicine)
 UNC HCS: Immediate Considerations

- Link PCMH and ‘Meaningful Use’ and other initiatives
- QI methodology & change management
  » Develop expertise, monitoring, reporting
  » Create educational/career tracks (incorporate in PREP)
- Referral system for requests, tracking, and reporting
  » Standardize process throughout UNC for all internal referrals
  » Facilitate access for outside referring providers
- Interactive Web-based patient portal
  » Enable patients to make appointment requests, obtain personal health record, access patient-education and tools
  » Facilitate provider-patient email correspondence: establish billing process and standards for response time
- Disease management registries
• **E-prescribing utilization**
  » Promote electronic prescribing whenever possible as the standard
  » Improve function in WebCIS to facilitate efficiency and ease of use
  » Create standing orders and authorize eligible staff (within scope of practice) to refill applicable prescriptions electronically

• **EMR utilization**
  » Require all providers to use WebCIS (at least key portions)
  » Develop protocols/training to standardize utilization and reduce variation

• **Clinic visit summaries**
  » Concise clinical summary for providers
  » Visit planner for care team and patients
  » Patient visit summary and goals

• **Care coordination**
  » Implement strategies for in- to out-patient transition care/follow up
  » Create care teams to work together at the top of their licenses
Questions?

Key UNC HCS contacts for PCMH:
Robb Malone (robb_malone@unchealthcare.org)
Jennifer Lord
David Anderson
Mimi Benjamin
Sam Weir
Kevin Tate
Mike Steiner