A Louisiana PCMH Success Story

June 2019

Kate Hill, RN
The Compliance Team
Trish Irwin, RN, BSN
Clinic Director
Goals

• Understand the value of PCMH to your clinic
• Learn how to begin the process towards a PCMH
• Get the real scoop on the PCMH process
Elements of the PCMH Model

Comprehensive Care
Patient Centered
  Coordinated Care
  Accessible Services
  Quality and Safety
What is a Patient Centered Medical Home?

Clearly it’s a journey, not a destination!
Why Become a Patient Centered Medical Home

• Puts patients first
• Make primary care more accessible
• Improves staff satisfaction
• Improves patient satisfaction
• Improves patient outcomes
• Mitigates health disparities
• Increase revenue
• Become the provider of choice in your community
• Consistent reductions of high cost care
Why Become a Patient Centered Medical Home

- It is different than a traditional PCP, being more patient and provider-friendly
- Increased access to care responds to the real-life needs of patients in the community.
- Patients are empowered and utilize fewer staff resources when they use customized self-management plans to achieve goals or manage their diseases.
- High-risk patients benefit, as pro-active coordination and follow-up communication by the Care Team saves them (and their caregivers) both time and money.
- Staff members report greater happiness when focusing on “what matters most” to the patient.
- Care Coordinators feel pride in collaborating with healthcare providers and community resources.
- Providers report satisfaction by keeping their most vulnerable patients out of the hospital.
- Care Team members function at their highest level, “to the top of their license or certificate”.
- PCMH Accreditation results in higher reimbursement from some payers.
Why Become a Patient Centered Medical Home

- The PCMH model ties in with the “Quadruple Aim”
  - Enhancing patient experience
  - Improving population health
  - Reducing overall healthcare costs
  - Improving the work life of health care providers
Why Become a Patient Centered Medical Home

- PCMH as a Value-Based Strategy
- Medicare has moved to change how it structures payment from a quantity to a quality approach. It will provide incentives for better processes and outcomes.
- Medicaid programs have made enhanced payments to providers who achieved certain distinctions or process measures.
• Every $1.00 increase in Primary care spending equals $13.00 in savings.
• This study provides another piece of evidence supporting the hypothesis that PCMH can lead to lower cost of care.
• Nevertheless, this study shows a consistent pattern, suggesting a robust cost saving across all the cost categories. Study shows the PCMH impact on each of the three main components of the total cost: acute inpatient, outpatient, and professional costs.

(Geisinger Study)
Barriers to Becoming a Patient Centered Medical Home

- Resistance to change
- Inadequate financial resources
- Low workforce
- Low adaptive reserve
- Your EHR
- Staff buy in
- Motivation
Most PCMH Programs can be...

- Rigid
- Burdensome
- Labor Intensive
- Expensive
- Overwhelming

Robs time devoted to patient care.
Rethinking PCMH

• Anything taking you away from patient care is heading in the wrong direction!

• Our Team’s PCMH Accreditation Program focuses on getting back to patient care and looks at day to day operations.

• Its a Winning Approach for both Clinics and Patients.
Good news

- Most practices are already doing much of this informally but not getting credit for it.

- Becoming a PCMH formalizes the process and identifies performance gaps.
OUR JOURNEY THROUGH PCMH

“Time for Lesson 1 in our new language.”

Bunkie General Hospital
BUNKIE GENERAL RURAL HEALTH CLINIC

PROVIDERS
Mary Hood, NP, Dr. Mohit Srivastava, M.D., & Olivia Vasquez, NP

VOLUME
MONTHLY ADMISSION LIST
MAY 2019

<table>
<thead>
<tr>
<th>Physician</th>
<th>Medicare Patients</th>
<th>Medicaid Patients</th>
<th>Blue Cross Patients</th>
<th>Commercial Patients</th>
<th>Private Patients</th>
<th>Total Patients</th>
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<td>Mary, NP</td>
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<td><strong>167</strong></td>
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<td><strong>88</strong></td>
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## PROVIDERS

**Dr. Roger Blanchard M.D.**
& **Janelle Juneau, NP**

## VOLUME

**MONTHLY ADMISSION LIST**
**MAY 2019**

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<td><strong>604</strong></td>
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BUNKIE GENERAL RURAL HEALTH CLINIC
EXTENDED HOURS

BEFORE

MONDAY 8:00 AM – 5:00 PM
TUESDAY 8:00 AM – 5:00 PM
WEDNESDAY 8:00 AM – 5:00 PM
THURSDAY 8:00 AM – 5:00 PM
FRIDAY 8:00 AM – 5:00 PM

NOW

MONDAY 8:00 AM – 5:00 PM
TUESDAY 8:00 AM – 5:00 PM
WEDNESDAY 8:00 AM – 5:00 PM
THURSDAY 8:00 AM – 7:00 PM
FRIDAY 8:00 AM – 5:00 PM
BUNKIE GENERAL FAMILY CARE CLINIC
EXTENDED HOURS

BEFORE

MONDAY 8:30 AM – 5:00 PM
TUESDAY 8:30 AM – 5:00 PM
WEDNESDAY 8:30 AM – 5:00 PM
THURSDAY 8:30 AM – 5:00 PM
FRIDAY 8:30 AM – 5:00 PM

NOW

MONDAY 8:00 AM – 5:00 PM
TUESDAY 8:00 AM – 7:00 PM
WEDNESDAY 8:00 AM – 7:00 PM
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TheComplianceTeam
Exemplary Provider Accreditation
**Things We Do Daily to Prepare for Our Patients**

### CHART-SCRUBBING

- **Forecast Immunizations at every visit.**

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>INTERVAL</th>
<th>NEXT DUE</th>
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<tr>
<td>Health History</td>
<td>Meds Match Hx</td>
<td>Now- if not done</td>
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<tr>
<td>PHQ2 Screening</td>
<td>Yearly</td>
<td>Next due:</td>
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<tr>
<td>PHQ9</td>
<td>Every visit if dx of depression on problem list</td>
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<tr>
<td>Chlamydia/Gonorrhea Screening</td>
<td>African-American, sexually active, under 30: Yearly</td>
<td></td>
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<tr>
<td></td>
<td>All other sexually active women under 25: Yearly</td>
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<tr>
<td></td>
<td>If pregnant and under 30, screen at first prenatal visit</td>
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<tr>
<td>Pap Screening</td>
<td>Every 2 years for age 21 - 29</td>
<td>Next due: Age 21</td>
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<tr>
<td></td>
<td>Every 3 years for age 30 - 65</td>
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<tr>
<td>Mammogram</td>
<td>Age 40 - 49: Discuss with provider</td>
<td>Next Due: Age 40 discuss</td>
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<tr>
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<td>Age 50 - 74: Yearly</td>
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<tr>
<td></td>
<td>Age &gt; 75 Stop</td>
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<td>Lipid Screening</td>
<td>Age 45 and up, every 5 years</td>
<td>Next due: Age 45</td>
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<tr>
<td>Colorectal Screening</td>
<td>Age 50 and up, yearly FOBT or colonoscopy every 10 years</td>
<td>Next due: Age 50</td>
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<tr>
<td>Bone Density Screening</td>
<td>Age 65 and Up, one time</td>
<td>Next Due: Age 65</td>
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<td>UDS - Controlled substance Agreement - 3 months</td>
<td>Preventative</td>
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<td>Flu Vaccine</td>
<td>Yearly</td>
<td>Preventative</td>
</tr>
<tr>
<td>Pneumovax</td>
<td>One time after age 18, booster dose at age 65</td>
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<tr>
<td>Communication</td>
<td>Each Visit</td>
<td>Internal Process</td>
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<td>Order Chronology</td>
<td>Each Visit</td>
<td>Internal Process</td>
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<td>A1c</td>
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<td>Health Hx</td>
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<td>Dental Exam</td>
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<td>Monofilament Foot Exam</td>
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WHAT'S GOING ON HERE?

THE MORNING HUDDLE

GEAUX TEAM!

Who Are Our Patients?  
What Are Their Needs?  
How Many Lab Draws 
Do We Anticipate?  
Who Has Been To The ER?  
Any TCM’s? Any CCM’s?  
How Many Wellness 
Preventatives?  
Anyone Leaving Early?  
Any Procedures Today?  
Identified Wellness 
Or CCM Needs?  
Any Comments Or 
Compliments?
RHC PATIENT- CARE TEAMS

Dr. Mohit Provider

Jennifer Receptionist

Trikelsa Floor Nurse

Kim Desk Nurse

Samantha – Wellness Coordinator
Marsha – Chronic Care Coordinator

Mary Provider

Michelle Desk Nurse

Tina Receptionist

Michelle Desk Nurse

Kayla Floor Nurse

Haley Floor Nurse

Olivia Provider

Tina Receptionist
FCC PATIENT- CARE TEAMS

Dr. Blanchard
Provider

Connie
Desk Nurse

LORI
MARSHA

Candace
Receptionist

Meagan
Floor Nurse

Sherri
Desk Nurse

LORI
MARSHA

Coshayla
Floor Nurse

Janelle
Provider

Naomi
Receptionist

Laurie – Wellness Coordinator
Marsha- Chronic Care Coordinator
TEAMWORK
coming together is a beginning
keeping together is progress
working together is success

- Henry Ford
Studies show that PCMH:

- Make primary care more accessible, comprehensive and coordinated.
- Provides better support and communication
- Creates stronger relationships with your providers
- Improves patient outcomes
- Lowers overall healthcare costs
Positive outcomes within months!

Stronger team!

• This is due to daily huddles. During our huddles we share daily work and short term goals. Our huddles help everyone to know the goals and work toward them.

• Chart scrubbing has improved the nurse/tech to provider communication as well as to the patient. We scrub charts for short and long term goals.

• Our team is a part of our culture of change. We share knowledge daily listen to concerns and work together through the challenges.
Positive outcomes within 4 months!

• And the best one:

  “Great medicine is being done outside the patient visit. mostly in follow up activities”
Questions? Call us.

Kate Hill, RN
215-654-9110

khill@thecomplianceteam.org

Trish Irwin