

Patient-Centered Medical Home: Time to Start Building a Medical Home Base

A Learning Experience



Patient-Centered Medical Home

Symposium and Workshop

September 10, 2008

7:30am – 4:00pm

Oakland University
Rochester, Michigan

Patient-Centered Medical Home

Paul Grundy, MD, MPH, FACOEM, FACPM; IBM's Director of Healthcare, Technology and Strategic Initiatives for IBM Global Wellbeing Services; Chairman of the PCPCC

Mike Hindmarsh, Principal of Hindsight Healthcare Strategies; Associate Director of Clinical Improvement at the MacColl Institute for Healthcare Innovation; Kellogg Fellow in Residence

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Tsveti Markova, MD, FAAFP, Associate Professor in the WSU Department of Family Medicine and Public Health Sciences serving as the Residency Program Director, Director of Clinical Operations at University Family Physicians-Detroit and Vice Chair for Clinical Affairs; Outstanding Teacher of the Year

- Herbert Smitherman, MD, MPH, FACP, Assistant Dean of Community and Urban Health, and Assistant Professor of Internal Medicine and Karmanos Cancer Institute, Wayne State University School of Medicine; President and CEO of Health Centers Detroit Medical Group, a Federally Qualified Health Center Look Alike in the city of Detroit; Salzburg Healthcare Fellow; author ***Taking Care of the***

Slide 4

Uninsured: A Path to Reform

Patient-Centered Medical Home

Invited

Moira Stewart, MD

University of Western Ontario

Co-author ***Patient Centered Medicine***

Elizabeth Olmstead-Teisberg, PhD, M. Engineering

Co-author ***Redefining Healthcare : Creating Value Based Competition on Results*** (Michael Porter, PhD)

Deadline for response: August 11, 2008

Mailing of postcards/fliers: August 13, 2008

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- Wayne State University Physician Group, WSU Department of Family Medicine, WSU Department of Internal Medicine and WSU Department of Pediatrics; Oakland University, Department of Allied Health and Health Sciences; NOMC Family Practice Residency Program; IHP; MNO; Merck; and Relay Health.
- PGIP members are invited to collaborate in this learning event. No funds required to support Symposium/Workshop

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- Registration online at REGONLINE link located on Practice Transformation Institute's website
- Cost \$50 per person to cover meals, facility, videotaping; and all handouts
- In process of securing CME (MD and DO) and CEU

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Keystone presentations in the am

Paul Grundy, MD
Mike Hindmarsh
Tsveti Markova, MD
Herbert Smitherman, MD

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Four interactive sessions in the pm

Preparation, recommendation and implementation

Panel discussion

Question and Answer Session

Wrap-up

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Keystone Topics

- Levers of Change for Patient-Centered Care
- Strategies for Advancing the Practice of Patient-Centered Care
- Processes for Sharing Information and Best Practices
- Actions to Mobilize the Public and Healthcare Community
- Vision for Patient-Centered Care
- Vision of Providers' Commitment to their Patients
- Vision for Leaders in Patient-Centered Care
- Vision for medical education
- Personal experience

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- Leadership, planning and education
- Patient-centered: What does it mean?
- Internal and external communication plan for PCMH
- Effective Patienthood Begins With Good Communication
- How the principles of patient centered care can be taught during specific patient encounters
- Team building process for primary care practice
- Improve office efficiency to make the most out of a patient visit
- Characteristics of Advanced or Open Access Scheduling and how it differs from other scheduling systems
- Benefits and drawbacks of Advanced or Open Access Scheduling
- EBM at the Point of Care and primary care case management

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- Culture Transmission and Change
- Practice re-design and transformation
- Innovation Team
- Improvement Team
- Physical Redesign
- Maintain momentum
- PDSA and Quality Improvement Training
- Introduction to LEAN
- What is not LEAN ready?

Patient-Centered Medical Home Implementation

Implementation

- Implement in PHO and PO
- **Recruit variety of practice shapes and sizes**
 - Large multi-specialty groups
 - Smaller group practices
 - Solo and Duo Practice groups
- **BCBSM Practice Designation**
- **NCQA Practice Designation - PPC**
- **Timing: Q1/Q2 2008**

Coordination

- **Coordinate with other payers, especially CMS**
 - Critical mass of patients necessary for PCMH success
- **Coordinate with other programs**
 - Pay for Performance
 - Disease Management
 - Transparency Programs
 - Decision-support

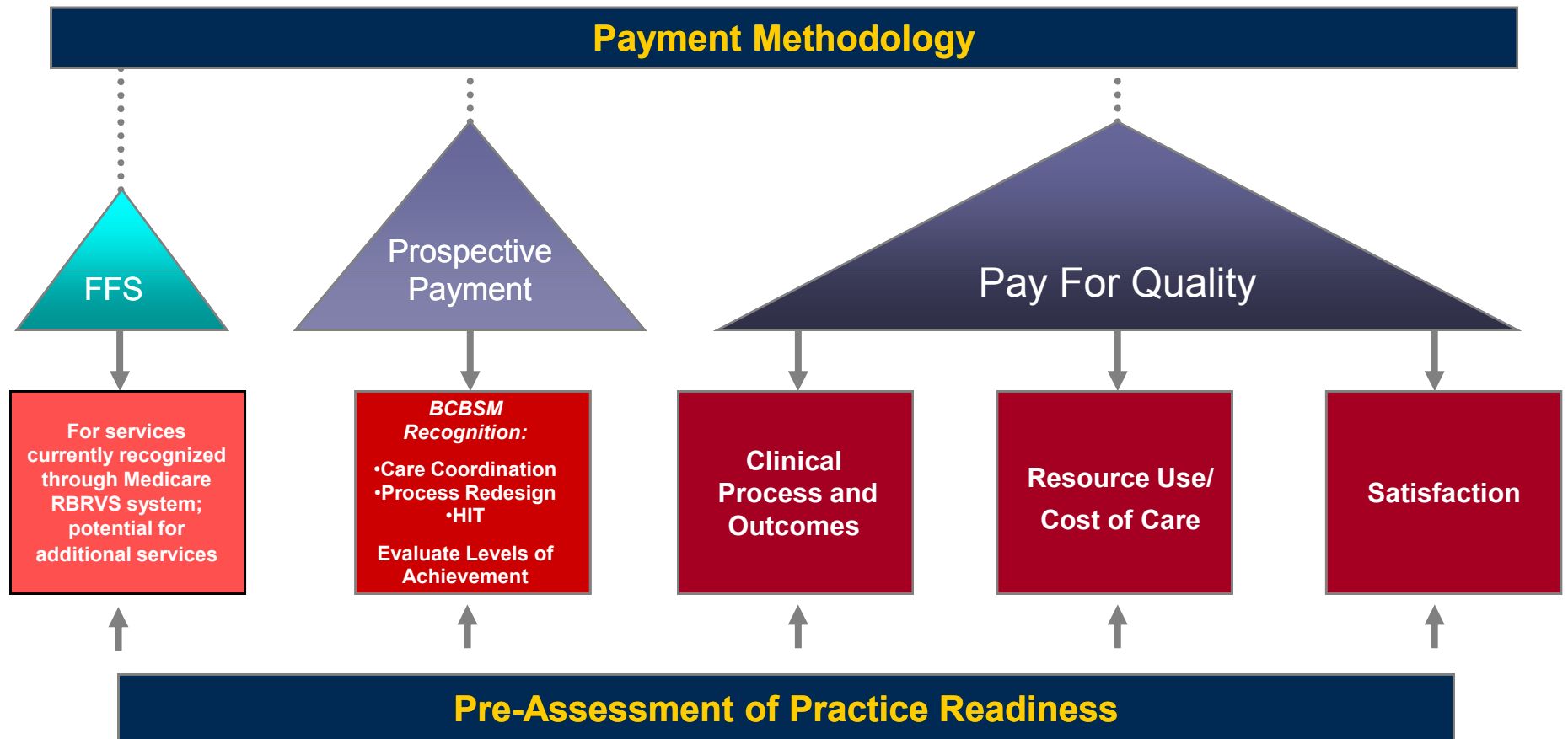
Evaluation



- **Comprehensive evaluation**
- **Discussions with State of Michigan and other health plans**

Patient-Centered Medical Home

Reimbursement and incentive structure aligned to support practice transformation, clinical process/outcomes, cost of care and satisfaction



PCMH Project Questions

- **Practice Recruitment**
 - Up to PO or PHO to nominate
 - Coordinate with primary care practices
 - Urban/suburban/rural
 - Large/medium/small/single
 - What is critical payer mass for practice
- **PCMH Designation**
 - BCBSM Program – time to get practices designated
 - What about NCQA?
 - Who pays?
 - Differences by level of designation attained
 - Technical Support?
 - “Reward” for increasing levels
- **Purchaser participation**
 - Employee incentives to use Medical Home practices?
 - PCPCC
- **Care Coordination Future Payment**
 - All patients (HEDIS) or just chronic disease? Which disease(s)?
 - How much? How often?
 - Opt in or opt out model for patients
- **Timing of Program: Start, interim evaluation, final evaluation**
 - At least 18 month for adequate trial of effects
 - What to do in the interim
- **Evaluation**
 - Where, What, Who and How
 - Self-reporting?
 - Definition of Success?
 - Key components of success vs. elements that provide no incremental value
- **Transparency**
- **What if.....**

Patient-Centered Medical Home Tools

