
PCMH/HH Monthly Webinar
Wed, February 24, 2016
7:30 – 8:15am

Audio available: 1-866-740-1260, Access Code 2520060
Today’s Facilitators

Rhonda Selvin, APRN, CNP

Rhonda is the Medical Director, Adult Programs at Maine Quality Counts, providing leadership and support for quality improvement efforts across the state. Rhonda has practiced in Maine as a primary care provider for more than 18 years specializing in family practice, most recently at Augusta Family Medicine.

Kim A. Gardner, LPN, BS, CPC

Kim recently joined Quality Counts this past August as Director of Quality Improvement. She comes to QC with over 30 years' experience in clinical practice, operations management, business management, and health care delivery.
Disclosure Statement

Presenters/Facilitators do not have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.
Webinar Notes

• To minimize background noise, all lines have been muted
  – To **UNMUTE** line and talk, press *7
  – To **MUTE** line, press *6

• To ask questions or share comments:
  – Via Chat: Type your question or comment into the “Chat” box on the lower left-hand side of the screen
  – To speak via Webinar: Use “Raise your Hand” function, we’ll call on you to speak

• **Please state your name when speaking**

• Webinar is being recorded; materials to be posted to website
Webinar Objectives

• Describe and define empanelment and tools to implement it
• Understand effect of empanelment on demand, supply, and capacity
• Explore benefits of empanelment to patients and families, providers and teams
Transforming Patient Centered Care

Culture change
• Improving the quality and the nature of the relationship with our patients

Operational change
• Technical change that improves operational functions

Maine Quality Counts
The Change Concepts for Practice Transformation

Transforming Care through PCMH/HH and BHH Core Expectations

1. Demonstrated leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Enhanced access to care
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community
9. Commitment to waste reduction
10. Patient-centered HIT
Care Transitions Roadmap for Change
Definition of Empanelment

- A *deliberate set of actions* to identify the group of patients for whom a primary care clinician and care team are responsible.
- An operational change that moves a practice toward Patient Centered Care and Access.
- Ensures every patient has PCP, but more than a payer identifying a PCP.
Empanelment

- Assigns individual active patients to an individual primary care provider (MD, NP, PA, DO) and care team
- Patients are able to reliably visit their same provider and care team every visit
- Focuses on a population of patients to ensure every patient receives optimal care whether seen or not
- Accepts responsibility for a finite number of patients allows provider and care team to focus more directly on the needs of each patient
- A way to manage supply and demand and balance
What is an Active Patient

• Determine which patients to empanel vs temporary or supplemental services
• Patients move, transfer care, panel does not necessarily need to match enrollment or new patient definition
• Practices use different definitions, helps to look at your utilization patterns.
• Use same definition across panel size, clinical measures, continuity
Affects Demand, Supply, Capacity

Steps:

1. Determine Supply and Demand for patient panel
2. Assign patients to Primary Care Provider (PCP)
3. Risk adjust
3. Review as an on-going process
Capacity

• Helps to make productivity goals
• Moves from individual to a defined population yet improves the care of the individual too
• Move from reactive to proactive care
• Understand panels will look very different post FFS, with email, phone, out of office care, telehealth
Why Empanel? It Benefits the Patient

- Enhances patient centeredness
- Better care for patients that come in or not
- Builds relationship with the PCP, long term
- Improves continuity of care
- Improves understanding of PATIENT needs
- Fosters communication, respect and patient autonomy
- Empowers patient/family and facilitates shared decision making
Teams are forged by the work they do together to achieve their common purpose

- Team small group of people; complementary skills; committed to a common purpose, performance goals and approach for which they are mutually accountable
- Team challenges are complex enough to require the skills, experience, training of more than one person to be successfully completed

It Benefits the Team

• Relationship between PCP, care team and patient is at the heart of Patient Center Medical Home

• Empanelment supports continuity of care and access

• one PCP as source of first contact and coordinator of referrals

• These relationships build trust, consistency in treatment plan, reduces need for provider intensive chart reviews of unknown patients, controls cost by mitigating duplicate tests and medications

• Population care for chronic illness and prevention
Benefits to the System

• Caring for our patients well: facilitates caring for ourselves and our staff
• Healthier work environment
• Less Burnout
• Less staff turnover
• Sorts patients, including those that don’t come in, into populations improving care and data reporting
Key Changes

• Assign patients to a provider panel and confirm assignments with PCP and patient/family
• Assess practice supply and demand and balance patient load accordingly
• Use panel data and registries to proactively to contact, educate and track patients by disease status, risk status, self-management, community and family need
Engage Providers and Teams in the Process

- Medical leadership is essential in this process
- Use a process designed to engage providers and care teams so panels are accepted, embraced, owned by provider and patient
- Allow all providers to review their panel for correctness; encourage discussion, questions
  - Source AmitShah, MD, Multnomah County, OR
Start Where You Are

- Self assessment
- Use Resource guides
- Expect to invest in all staff training, the more you invest the more you’ll gain
- Empower proactive team care
- Consider care plans
- Part time providers/ panel share?
Resources for Implementation


Tools to Implement: Team Support

- Huddles
- Prepared visit (from front desk through MA, nurse, care coordinators, behavior health and health educator/coach)
- Barrier free schedule access
- Phone care
- Call management/portal
- Proactive tracking & management of registries
Assess: Supply and Demand

Formula for determining the number of patients a provider can take care of:

\[(\text{provider visits/day})(\text{days in clinic/year}) = (\# \text{ patients})(\text{patients visits/year})\]

SUPPLY

DEMAND

Average visits per Patient per Year by Specialty

- Internal Medicine 4.5
- Family Practice 3.5
- Pediatric 2.8

The 4-Cut Method for Panel Assignment

<table>
<thead>
<tr>
<th>CUT</th>
<th>PATIENT DESCRIPTION</th>
<th>ASSIGNMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patients who have seen only one provider</td>
<td>To that sole provider</td>
</tr>
<tr>
<td>2</td>
<td>Patients who have seen multiple providers, but one provider the majority of the time</td>
<td>To the majority provider</td>
</tr>
<tr>
<td>3</td>
<td>Patients who have seen two or more providers equally (no majority can be determined)</td>
<td>To the provider who performed the last physical</td>
</tr>
<tr>
<td>4</td>
<td>Patients without a physical or health check who have seen multiple providers</td>
<td>To provider seen most recently</td>
</tr>
</tbody>
</table>

Keep in Mind

• The more we move into Patient Centered Care the more important training becomes
• After Panels are created they must be managed
• Change must be operationalized from leadership across the system
• Fluid process, re-evaluated often
• Providers and patients set visit agenda each time
Stories from the Field
Questions
Year Ahead - Save the Dates!

• Learning Sessions
  – Friday, June 3, 2016 – Coming to Your Region!
    • Locations TBD
  – Thursday, September 29, 2016
    • Augusta Civic Center

• Regional Forums – Thurs, March 10, 2016
  – Presque Isle, Machias, Orono, Lewiston, Augusta, Portland
News, Updates, and Info

Webinar Reminder

• Webinar recordings available online or via podcast within 48 hours following live webinar

• New to podcasting? Learn how to access our podcasts via our website (http://www.mainequalitycounts.org/articles/57-1185/pcmh-hh-webinars-available-as-podcasts/3)
Next PCMH/HH Webinar

Next PCMH and HH Webinar:
• Wednesday, March 23, 2016
• 7:30 – 8:15 a.m.
Purpose of the Primary Care Report

• The goal of the Primary Care Practice Report is to demonstrate practice pattern variation in cost and quality compared to state benchmarks. How does the cost and quality of all healthcare services received by my practice’s patients compare to the cost and quality of all healthcare service received by other primary care practices’ patients?

• A wide variety of measures are included to give each practice a detailed understanding of how the care their patients receive differs from the average. This enables practices to create action plans targeted at improving specific aspects of their patients’ care.

• Training  Please feel free to email our data team (data@mehmc.org) to discuss any questions you may have concerning your report. We are available to schedule trainings with you to review your reports in more detail; please let us know how we can help you.
Contact Info/Questions for PCMH/Health Home Practices

• PCMH/HH Quality Improvement (QI) Specialist
• Maine Quality Counts website
  – [www.mainequalitycounts.org](http://www.mainequalitycounts.org)
• Maine PCMH/HH webpage
  (See “Programs” → Maine PCMH/HH → Learning Collaborative)
  (can also go to “What We Do” → “Helping Practices Improve Quality” → Maine PCMH/HH)
Thank You for spending your time with us!

• Contact information:
  • For Rhonda rselvin@mainequalitycounts.org
  • For Kim kgardner@mainequalitycounts.org
  • For QIS abanister@mainequalitycounts.org, peaton@mainequalitycounts.org, cedwards@mainequalitycounts.org
Register Today! Early Bird Rates Expire February 29
mainequalitycounts.org/qc2016

Wednesday, April 6th