PCMH
Success Plan

May 15, 2015
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Joann Emge, Co-Chair
Ken Reid, Co-Chair

Quick Review

Why Are We Here?

What Have We Done?

Where Are We Going?
The Shaky Bridge

**The Bridge**

- **Learn Best Practices**
- **Build Common Infrastructure**
- **Enhance Value Performance**

**ICAHN**

**At a Glance**

- **A2619: Illinois Rural Community Care Organization LLC**
  - Board Managers (9 Managers, selected by Participating (member) Hospitals, affirmed by ICAHN Board)
  - 75 percent of the governing body must be comprised of MSSP ACO Participants
  - One Manager must be an independent Medicare beneficiary

**Administrative Team**

- Executive Director: Pat Schou
- Chief Medical Officer: Gregg Davis
- Corporate Compliance Officer: Angela Charlet

**Network Compacts/Task Forces**

- **Population Health Management Strategies**
  - A. Practice Transformation
  - B. Data Analytics for risk stratification

- **QI / QA**
  - A. Clinical guideline development
  - B. Clinical guideline implementation

- **Payer/Employer Engagement**
  - **Not Yet Active**
    - A. Marketing
    - B. Contract Negotiations
    - C. Contract Monitoring

- **Data Analytics and Information Technology**
  - Ellen Maxwell & Pat Schou
  - Identify and implement supportive technologies

**Participating Providers**

- Hospital Participation Agreements
- Physician Participation Agreements
- Clinic Participation Agreements

**Audit/Finance Committee**

- Chair: Pat Schou

**Executive Committee**

- Chair: Steve Penhouse

**Governance Committee**

- (Corporate Compliance)
  - Chair: Angela Charlet

**Conflict Resolution Process**

**ICAHN**

**501(c)(3) Not for Profit**

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IRCCO GOAL

Comprised of rural medical providers, hospitals and their associated support organizations, established for:

_The purpose of developing local systems of care to better coordinate care and services for residents of their communities._
What Do We Know?

PCMH + Care Coordination = Medical Neighborhood

Standardizing Practice and Efficiencies = Improved Quality

Improved Quality = Increased Patient Satisfaction

Market Share and Local Care Staying in Rural

Encompassing All Aspects = Decreased Healthcare Cost

How Do We Get There?

Improve the patient/care giver experience

Risk Stratification on Diagnosis and Readmissions

Preventative Health Measures

Standardize Care of At-Risk Population
A Year in the Life of a Patient

Healthcare wrapped around the patient
Care Navigator ensures team-based and use of EBP

Result: Triple Aim
Higher Quality
Higher Service
Lower Costs
Patient-Centered Medical Home: Foundation

• Enhanced Primary Care Delivery Model
  • Better Access
  • Coordination of Care
  • Prevention
  • Quality
  • Safety

• Creates strong partnership between the patient and primary care provider

• Referenced many times in the Affordable Care Act as best practice to improve health outcomes through care coordination

Benefits of the Medical Home
Infrastructure: Building the Walls

Internal Resources
Three Domains to Cover
  Operational
  Management
  Quality
Today: Operational Resources
  Create the baseline data to develop individualized workplans

Expectations/Resources Thus Far

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<th>PCMH Kick-Off</th>
<th>Follow-Up</th>
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<td>Overview</td>
<td>CFO Engagement</td>
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<tr>
<td>Staff Roles</td>
<td>Create Org Chart</td>
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<td>Lunch n Learn to educate staff</td>
<td>Structure Communication</td>
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<td>Meeting Agenda</td>
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<td>Daily Huddle</td>
<td>Start the PCMH Binder</td>
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<tr>
<td>Reach Out to One Patient</td>
<td>Review of Quality Measures</td>
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Today: Operations Assessment

Questionnaire: 30 Questions

Provides quick glance of where each practice is within the development process

Identifies the ‘PCMH Team’

Due to ICAHN: May 28th

BizMed Solutions

www.bizmedsolutions.com

Tasks
Enroll either as single provider or corporate (>3 practices)

Download the BizMed Getting Started Guide

Toolbox: 2014 PCMH Tools

Page 1:
  Care Team Member Responsibilities
  Huddle Form
  Patient Community Resource List

Tasks cont.
Page 2:
  PCMH Orientation Checklist

Page 4:
  Short Training Videos Form
  All recommended

Expectations: All completed by June 15th

We will be providing a quick checklist of ‘Must Have’s’ for everyone with this recording.
Timeline: Quick Look

May 28th
- Completed the operations assessment and returned

June 15th
- Signed on to BizMed
- Downloaded Guidebook
- Trained Staff
- Began Huddles
- Started Community Resource list
- Look at Quality Metrics: Can you collect these measures?

Workplans

Focus on Must-Have Elements of PCMH Model of Care
Look at four types of activities:
- Things you MUST do
- Things you already do
- Things you want to do
- Things you can do

Establishes framework within the context of IRCCO
What Comes Next?

May 30th: Care Coordination Team Meeting
- Stratifies all assessments and groups by implementation process
- Schedule 1:1 meetings with each practice to build workplans
  (may be as regional meeting and/or at practice site)

June 30th – July 15th: Complete Workplans

August:
- Initial Quality Metrics data abstraction: identify gaps in process
- Regional Meetings for training and assistance

September:
- Section 1 (Operations of Workplan)
- Section 2a (Medical Neighborhood): Collaborative Session begin

October:
- Section 2b (Care Management): Collaborative sessions

*Remember: We have two different consultants that are here to help should you request any assistance: BizMed: Margalit and Mike; Elizabeth Burrows*

Oct – Nov – Dec

Patient Surveys will be released by ACO CAHPS selected vendor

December: Quality Metrics to begin abstraction

2016

Jan-Feb: Quality Metrics Submitted through GPRO Portal
- Satisfaction Surveys Completed
Care Coordination

Move focus from individual instances of care (tasks) within care settings
Change to delivering continuous care between settings
Think in terms of the care goals for the patient rather than the processes
Move to a team-based care rather than traditional physician-patient relations where physician in charge and patient is passive partner

“handoff” traditional implies a relief of responsibility versus “transition” as ongoing patient engagement in their care and all relevant communication including patient goals and comprehension to learn

Care Coordination

Parallel to PCMH Implementation

June

- Stratify our Quality Data for cohort by disease/condition
- Begin identification of Standards of Care Resources/Inventory (Medical Director and team)
- Create schedule of cohort meetings (ongoing through August)
- Identify Care Navigators by either regional location or per hospital/practice

July

- Completed training staff on PCMH Model of Care
- Identified beneficiaries and care navigator resources
- Cohort collaborative training/meeting sessions (to extend through remainder of year)

Expectation: By 1Q2016 Community Councils established
Standards of Care Implemented
Policy & Procedures Established
June 2016

- Care Coordination Implemented
- PCMH Rolled Out and Efficiencies established
- Standards of Care Operationalized
- Medical Neighborhood Established
- Patient Engagement Realized
- Action Plans for Enhanced Quality Improvement

Reminder

- Introductory Training Webinar to Quality Data
- Pat’s Email Announcement
- Individual discussion to follow after this webinar
Questions