FINAL REPORT

Patient-Centered Medical Home Pilot

(LB 396 – 2009)

Provided to the

Governor of the State of Nebraska and the

Health and Human Services Committee of the Legislature

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NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

PATIENT-CENTERED MEDICAL HOME PILOT

FINAL REPORT – Executive Summary

INTRODUCTION

In 2009, the Nebraska Legislature, through enabling legislation *(Attachment A)*, initiated the Nebraska Medical Home Pilot Program Act to be designed and implemented by the Division of Medicaid and Long-Term Care (DHHS). The two-year pilot began in February, 2011, with two rural practices and 7000 Medicaid patients. The focus for the pilot was to transform the two practices into recognized patient-centered medical homes (PCMH) in order to improve health care access and health outcomes for patients and contain costs of the medical assistance program. The pilot concluded February, 2013.

FINDINGS

The findings for this pilot culminated through the collection of data and information from Medicaid claims, clinical data, patient satisfaction surveys, provider and employee satisfaction surveys, and the general experience of the practice management teams. The pilot operated under multiple assumptions and constraints, including the factor that it takes one to two years to set up a PCMH properly with any measurable return on investment taking additional years. In spite of this, the early return on findings for this two-year pilot included some noteworthy results:

- significant decrease in the rate of overall Emergency Room (ER) visits per 1,000
- no significant difference in revisits to the ER for the same complaint
- a slight increase in hospital readmissions, yet noticeable reduction in proportion of all admissions that were caused by ambulatory care sensitive conditions tracked in this pilot
- small decrease in costs for high-tech radiology
- significant decrease in the rate of prescriptions written and spending per 1,000
- total expenditures per client per month reflected a slight decrease
- patient indicators suggested an increase in satisfaction with the services provided
- provider and employee satisfaction fluctuated over the course of the pilot and did not reflect overall significant improvement by the end
- distinct improvement in patient health outcome

The practices successfully transformed into recognized PCMHs through meeting prescribed standards that moved them from doctor-centered to patient-centered services. The most significant finding was the improvement of health for the population through targeted care coordination. This component of the model increased patient education and patient engagement in taking responsibility for management of chronic health conditions. Additionally, through the utilization

of care coordinators, there was individualized attention given to overutilization of the ER, follow-up on referrals to specialists, medication management, and whole person health care.

RECOMMENDATIONS

DHHS determined that the Patient-Centered Medical Home model has merit. This pilot demonstrated improved patient satisfaction, marked efficiencies with the modification of office practices, improvements in patient health through care coordination and patient education, and indicators showing potential for containment of costs.

Based on this experience, DHHS recommends the follow:

- Payment Reform. Consideration should be given to linking payment rates to the quality of care and realigning provider incentives away from promoting utilization and toward efficiency and improved health outcomes.

- Continue PCMH. The PCMH model should be continued in the provision of services through the Medicaid Managed Care Program statewide due to the large number of Medicaid clients and longevity of the program. In 2012, DHHS required the Managed Care contractors statewide to develop and maintain a certain minimum of PCMH practices, following the model of this pilot.

Quality is often defined as providing the right care in the right way at the right time. But a patient-centered vision would define quality as providing the care the patient wants in the way the patient wants at the time the patient wants it…Increasingly, patients want direct access to information and the ability to be active partners in their care. That will require listening to patients much more and reorienting primary care practice to provide care that works for patients." – Commonwealth Fund

TABLE OF CONTENTS

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

PATIENT-CENTERED MEDICAL HOME PILOT

FINAL REPORT

INTRODUCTION

The term "medical home" originated in pediatrics. In 1967, the American Academy of Pediatrics (AAP) introduced the medical home concept and later published a statement defining the medical home as "accessible, continuous, comprehensive, family-centered, coordinated, and compassionate care…delivered or directed by well-trained physicians who are able to manage or facilitate all aspects of …care."

Today, investments are being made by physician practices nationwide, the Centers for Medicare and Medicaid Services, and managed health care plans, to test the model of patient-centered medical home in order to improve health care and save money. Since 2006, almost half of the states have implemented some form of medical home for the Medicaid population according to the National Academy for State Health Policy.

In 2009, the Nebraska Legislature, through enabling legislation *(Attachment A)*, initiated the Nebraska Medical Home Pilot Program Act calling for a medical home pilot that emphasizes care coordination to be designed and implemented by the Division of Medicaid and Long-Term Care of emphasizing care coordination. The two-year pilot began in February, 2011, with two rural practices and 7000 Medicaid patients. The focus for the pilot was to transform the two practices into recognized patient-centered medical homes in order to improve health care access and health outcomes for patients and contain costs of the medical assistance program. The pilot concluded February, 2013.

Acronyms/Terminology in this Report

Council: Medical Home Advisory Council appointed by the Governor

DHHS: Nebraska Department of Health and Human Services

Mean: An average; a numerical value that represents the central value of a set of numbers.

NCQA: National Committee for Quality Assurance; a national medical home credentialing Organization

PCMH: Patient-Centered Medical Home

PMPM: Per Member Per Month; applicable to payments to pilot practices and Medicaid costs per client

Statistically Significant: Based on a specific statistics test, there is 95% certainty that the shift from baseline was due to a change in the behavior of the population, and not just a random variation at the time of measurement.

BACKGROUND

This section chronicles the design elements and resulting development of the Nebraska Medicaid Patient-Centered Medical Home Pilot.

Advisory Council. In the fall of 2009, the Governor appointed the Medical Home Pilot Advisory Council as outlined in the legislation. The Council voting members included six licensed practitioners in an active practice in these categories: two primary care, two pediatrics, two internal medicine and one representative from a licensed hospital in Nebraska. A member of the Health and Human Services Committee of the Legislature served as an ex officio, nonvoting member. *(Attachment B)*

The Council met monthly for two years to make recommendations to the Department for the design and operation of the pilot. In the final years of the pilot, the Council met quarterly to monitor the progress of the pilot.

Resource Teams. DHHS began initial planning in the fall of 2009 through the development of seven internal teams of staff devoted to planning for: Client Engagement, Communication/ Marketing, Evaluation, Information Systems Support, Medical Home Standards, Payment Strategies, and Provider Engagement/Technical Assistance. Through extensive research of medical home literature and models, the teams developed draft proposals. These teams formed the groundwork of ideas that were brought to the Council for review and eventually materialized into final plans by DHHS.

Definition of Patient-Centered Medical Home for the Pilot. The Council recommended, and DHHS approved, a pilot-specific definition for patient-centered medical home as a health care delivery model in which a patient establishes an ongoing relationship with a physician in a physician-directed team. This team provides comprehensive, accessible, and continuous evidence-based primary and preventive care and coordinates the patient's health care needs across the health care system in order to improve quality, safety, access, and health outcomes in a cost effective manner.

Development of Medical Home Standards. A goal of the pilot program was to transform primary practices into fully recognized and operating medical homes that met the criteria of a patient-centered medical home. DHHS reviewed standards utilized in other states along with the national credentialing organization, NCQA, standards. The final standards for Nebraska's pilot were a hybrid of several models.

The standards were developed around these core competencies:

- Facilitate ongoing patient relationship with physician in a physician-directed team;
- Coordinate continuous patient-centered care across the health care system;
- Provide for patient accessibility to the services of the medical home;
- Commitment to efficiency of care by reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of health care services; and
- Engage in a quality improvement process with a focus on patient experience, patient health, and cost-effectiveness of services.

The standards were comprised of two Tiers: Tier 1, Required Minimum Standards and Tier 2, Optional Advanced Medical Home Standards. *(Attachment C)* The pilot practices were required to complete Tier 1 and the PMPM (per-member-per-month) payment methodology was linked to this Tier. If a practice successfully met the Tier 2 standards, it was eligible for an additional incentive payment.

Development of Payment Methodology. The payment to the practices was attached to the achievement of the standards. *(Attachment D)* A PMPM was established for patient care coordination and administration expenses. Initially the pilot practices received $2 PMPM and once they achieved the Tier 1 minimum standards, the PMPM was increased to $4. One practice met the minimum standards six months after the start of the pilot and the other practice at nine months. A practice meeting the optional Tier 2 standards received a 5% enhanced fee-for-service payment on office visits. One practice achieved Tier 2 six months prior to the end of the pilot.

Attribution Process. The participation in this pilot by the Medicaid clients was voluntary and invisible. Since a client did not have to formally select a practice, Medicaid patients were attributed to each practice for payment based on this process: the initial attribution to each practice was a look-back over the most recent 12 months of Medicaid claims for all of the patients seen by each of the practices. Subsequent attribution was made on a monthly basis with a continual 12-month look-back, but adding the new month and dropping the oldest month.

Development of Pilot Outcomes. DHHS conducted an extensive review of the literature and other PCMH models around the nation to determine the desired outcomes and measures for the pilot. The pilot focus was to transform a practice into a PCMH to increase the availability of primary health care services to clients and contain costs. With this in mind, five outcomes emerged followed by the development of a set of measurements. *(Attachment E)* The measures guided the data collected through the Medicaid Management Information System (Claims) and through patient and provider surveys.

OUTCOMES:
- Improve health care access
- Improve health outcomes
- Contain costs
- Patient satisfaction
- Provider satisfaction

National Technical Assistance. In 2009, the National Academy for State Health Policy (NASHP) awarded Nebraska and seven other states one year of technical assistance (TA) to help with the design and implementation of the medical home model. This included 3 days of training with other states and national experts, three days of on-site TA assistance from national experts, and ongoing TA from staff at NASHP and webinars. This proved invaluable for DHHS and all design elements were based on input from national expertise.

Additional technical assistance came from TransforMED, a national leader in PCMH transformation. Key leadership met with DHHS staff and the Council during the design phase of the pilot and then throughout the pilot.

CMS Authority. The Centers for Medicare and Medicaid (CMS) granted authority for the PCMH program through approval of a Medicaid State Plan amendment and an amendment of the 1915(b) waiver.

Selection of Pilot Practices. In September, 2010, DHHS began the selection process for the pilot practices in rural Nebraska by sending an invitation via a Request for Information (RFI). The notice went to practices that were General Practice, Family Practice, Internal Medicine and/or Pediatrics in Scottsbluff, Sidney, Ogallala, North Platte, McCook, Lexington, Kearney, Holdrege, Hastings, Grand Island, Columbus and Norfolk. These communities were selected because they were not in a Medicaid Managed Care county and had practices with a sufficient number of Medicaid patients for an evaluation of the pilot.

To be considered for participation, the applicant practice had to be enrolled as a Medicaid provider; commit to two years; agree to engage in practice transformation planning and implementation with practice coaches to meet the DHHS medical home standards; participate in learning sessions; utilize a patient registry; have broadband access; facilitate a patient advisory committee; submit claims within 60 days of service; and be willing to work with DHHS in evaluation of the pilot.

Of the applicants, Kearney Clinic in Kearney *(11 Family Practice; 8 Pediatricians; 1 Nurse Practitioner)* and Plum Creek Medical Group in Lexington *(7 Family Practice; 1 Physician's Assistant, 1 Nurse Practitioner)* were chosen to participate in the pilot.

Supports Provided. One key factor kept emerging in the other PCMH models researched and that was the need to provide sufficient support to transforming practices. DHHS provided the following:

Care Coordinator Staffing

For two years, DHHS funded one full-time Care Coordinator, hired by and embedded in each practice. The requirement for this position was a Bachelor's in Nursing degree or Associates degree in Nursing and 3-5 years of experience or Nursing Diploma and 3-5 years of experience.

> "Physicians identify the non-compliant, disease-specific patients for me to follow-up with…they tell me that this greatly improves their efficiency throughout the day and frees up the nurses and physicians to spend more time with other patients." - Care Coordinator

Technical Assistance

DHHS arranged for TransforMED, a subsidiary of the National Academy of Family Physicians and a national technical assistance contractor, to provide two years of on-site and distance technical assistance to both practices. In the first few weeks, they conducted on-site visits and conference calls to introduce the model, discuss roles and responsibilities and observe processes/workflows. From that, they developed a baseline assessment of the practices for future tracking of data on progress. Regular weekly conference calls, two additional site visits, and ongoing virtual training and consultation occurred during the pilot. In addition, the practices had full access to Delta Exchange, an extensive web-based resource center provided by TransforMED. A full report of their work and results can be found in *Attachment F.*

To begin the pilot, TransforMED facilitated a one-day Orientation/Kickoff for the practices in February 2011 in Lincoln. Participants included members of the practice teams, DHHS staff,

Medical Home Advisory Council, and TransforMED staff. The orientation opened with remarks from Vivianne Chaumont, Medicaid Director, and the agenda included featured speakers that were renowned experts in the field of patient-centered medical home. TransforMED provided an overview of the pilot and the support and technical assistance that would be provided. (*Attachment G)*

During the second, year, TransforMED arranged for the two Care Coordinators to complete the Johns Hopkins Online Guided Care course. Additionally, they facilitated a seminar on Care Management and Coordination for the staff at both practices. *(Attachment G)*

Access to Medicaid Data

DHHS provided the following Medicaid claims data to each practice on their attributed Medicaid clients, providing aggregate numbers for all on a quarterly basis and by client on a monthly basis for all except the last two

- Re-visits to Emergency Room within 72 Hours of Discharge from ED
- Visits to the Emergency Room within 72 Hours of Discharge from the Hospital
- Visits to the Emergency Room
- Admissions to Hospital Inpatient for Ambulatory Care Sensitive Conditions
- Readmissions to Inpatient Hospital Within 30 Days of Discharge
- Visits to Specialty Care Providers
- Office Visits to Same Provider Type, but not to Pilot Provider
- Office Visits to Practice
- Expenditures: Emergency Room; High-tech Radiology Utilization; and Total Medicaid Expenditures

Patient Registry System

Since a requirement to participate in the pilot was a patient registry system, DHHS provided the opportunity for funding for a patient registry system if a practice did not have one.

PILOT EVALUATION - FINDINGS

At the start of the pilot, DHHS was aware that there was limited national data examining the principles of the PCMH model. This factor provided both a challenge and an opportunity to create an evaluation process.

"Not everything that counts can be measured and not everything that can be measured, counts."
- Albert Einstein

Although, DHHS also recognized that outcome data was limited in the models, one theme emerged: the unnecessary utilization of the Emergency Room and minimizing preventable readmissions to a hospital offered key opportunities to begin to improve quality and reduce costs so the focus began there for data elements. This was a significant influence on determining what data to capture and the development of the pilot outcomes and measures *(Appendix E)*.

It was also apparent that other states were using multiple methodologies for evaluation. Taking resources into consideration, DHHS chose to use Medicaid claims data, patient satisfaction surveys, practice employees and physician satisfaction surveys, clinical measures as available, and metrics on transformation process collected by TransforMED.

With the premise that this was an evaluation of the PCMH model and not scientific research, DHHS, in consultation with nationally recognized authorities on PCMH, determined a suitable size sample based on a minimum for the pilot as a whole with a confidence interval of 3-4% and confidence level of 95%.

The evaluation process operated under these assumptions and constraints:

- National data and experience indicates that it takes one to two years to set up a PCMH properly with the return on investment taking longer than that.
- A time lag exists between the delivery of care and the availability of Medicaid claims data pertaining to that care.
- A large number of people with disabilities and chronic conditions in the Medicaid population may affect the readmission data.
- No specific measurements of the pilot outcomes were identified for pre-and post-comparison, as the intent is to capture the pilot experience in transforming practices to the PCMH model.
- Due to a lack of equivalent data in other states, we would not be able to make any comparisons to other models.
- With the mobility of the population, a control group could not be established.
- The completion of patient and provider surveys was voluntary.

FINDINGS – Medicaid Claims Data

All conclusions in the analysis of Medicaid claims data were based on the total measurements from the two pilot practices, and the total change from the 2010 reported baseline group, which was based on estimated numbers. The numbers in the baseline group were comprised of Medicaid

recipients whose primary care providers were at the two pilot practices during the 12-month period prior to the implementation of the pilot.

The pilot population experienced a reduction in size with the implementation of statewide Medicaid Managed Care July 1, 2012. While the initial intent was to "protect" the Medicaid population involved with the pilot practices, a coding circumstance negated that intent and Medicaid clients who, for various reasons, were dropped from the Medicaid rolls, were placed in the Medicaid Managed Care program upon reinstatement instead of the pilot. From the implementation of statewide Managed Care to the end of the pilot, the pilot population decreased 22%. For this reason, **all data comparisons reflected were made using standardization methodologies (primarily percentages and per 1,000 population) to increase the validity of conclusions.** A complete analysis and tables of data can be found in *Attachment H.*

Emergency Room (ER) Utilization. The PCMH model, through care coordination and patient education, can reduce emergency room utilization resulting in reduced costs as well as improved health care. Frequent visits and particularly those that are non-emergency are extremely costly and often can be provided by the less expensive setting of a PCMH. The focus of this data was to observe the anticipated change in patient's behavior regarding emergency room utilization through the utilization of Care Coordinators with these results:

- Statistically significant decrease in the rate of overall ER visits per 1,000 clients.
- Borderline significant increase in the percentage of ER visits that were considered non-emergency.
- While the total number of visits to the ER decreased, the expenditures did not decline as steeply; this would suggest that the mean cost per visit must have increased.

Revisits to Emergency Room (ER). An operational PCMH, through close monitoring of a patient's health by the patient's team and a Care Coordinator, theoretically could impact the occurrence of a re-visit to the ER within 72 hours of visit to an ER or discharge from a hospital for the same complaint. This data measured that concept with the following results:

- Revisits from ER to ER or from hospital to ER within 72 hours of discharge for the same complaint, did not have sufficient differences in the data to draw conclusions.

Readmissions to Hospital. Likewise, through close monitoring of a patient while hospitalized and then following discharge, the PCMH could be an intervention for the prevention of readmissions to a hospital within 30 days of discharge for the same complaint. The pilot data resulted in this finding:

- Though not statistically significant, the percent of hospital discharges that resulted in a readmission to a hospital within 30 days increased.

Hospital Admissions for Ambulatory Care Sensitive Conditions. For this pilot, four Ambulatory Care Sensitive Conditions were selected for evaluation: chronic obstructive

pulmonary disorder, congestive heart failure, diabetes, and pediatric asthma. These were chosen based on a literature search of the top conditions causing hospitalizations. The data results:

- Each ambulatory care sensitive condition in itself did not have a sufficient sample size to draw individual conclusions; however overall there was a small, statistically significant, but unsubstantial decrease in the proportion of all admissions that were caused by one of these conditions.

High-tech Radiology Expenditures. Included in a PCMH model is the aspect of minimizing unnecessary costs for tests using expensive technology. For the pilot, we chose to observe the utilization of high-tech radiology. The data for this measurement indicated:

- There was a decrease between the quarterly averages spent on high-tech radiology; however, this shift was not statistically significant.

Prescription Expenditures. One of the projected measurements of savings was an increase in the utilization of generics. The data for all prescriptions indicated:

- No statistically significant difference in the mean percentage of prescriptions that were written for generics.
- Rate of prescriptions written per 1,000 clients significantly decreased; however the rate of prescriptions for generic drugs written per 1,000 clients significantly decreased by a greater amount.
- Statistically significant decrease in the mean number of prescriptions paid for each client per quarter.
- Significant decrease in spending for prescriptions per 1,000.

Visits to Specialty Care Providers. The purpose for this data was to track the utilization of specialty care providers. The success of a PCMH, in part, depends on a collaboration between the PCP and specialists for the care of the patient. The specialist may be imbedded in the practice or the care of the patient could be provided by the PCP in consultation with a specialist. Data findings included:

- Significant decrease in the percentage of total visits to specialists.
- Significant decrease in the rate of visits to a specialist per 1,000 clients.
- Borderline significant increase in the mean per-visit Medicaid expenditure for visits to specialists, increasing from $76.64 to $101.67.
- Increase in rate of spending on specialist visits per 1,000 clients, but not statistically significant.

While considering an increase in expenditure on specialists a successful aspect of the pilot may seem counterintuitive to cost containment, the increased expenditure per visit coupled with the decrease in the percentage of visits that were made to specialists could suggest that the referrals were due to more complex problems more appropriate for specialist care.

Office Visits to Same Provider Type, but Not to Pilot Provider. One key to a successful PCMH is the relationship built between the PCMH and the patient. This data looked at the frequency of

clients visiting the same type of provider as the pilot PCMH, but not a pilot PCMH. It should be noted that a variable impacting this data included the move of two APRN's from one pilot PCMH into another clinic in town with a number of clients moving with them. The data reflected:

- Statistically significant increase in visits per quarter per 1,000 clients
- Statistically significant increase in Medicaid expenditures per 1,000 clients

Office Visits to Pilot Providers. As noted before, a tenet of the PCMH model is a relationship between the PCMH and the patient. Regular office visits is one aspect of that, not only to develop a relationship, but also an opportunity to monitor the patient's health. The purpose of this data was to observe the frequency of visits resulting in this pilot:

- Statistically significant decrease in the average number of office visits made each quarter per client.

Total Expenditures Per Member Per Month. This data captured the total Medicaid expenditures per client per month during the pilot period with this result:

- The mean per member per month cost for all Medicaid services reflected a decrease, but it was not statistically significant.

FINDINGS – Clinical Data

Patient engagement and education is critical to changing behaviors and realizing improved health outcomes. The practices demonstrated the inclusion of both throughout the pilot. Even with this, based on our experience and as demonstrated throughout other national models, two years is considered less than ideal to realize significant results for improved health outcome. In most PCMH models, improvements in health care data are normally not seen until the PCMH has been operational for three years or more. In spite of this, the clinical data in the pilot showed encouraging progress.

> "What I find most interesting is that the patients have a new respect for healthcare, just because someone else has taken an interest in their health."
> - Care Coordinator

While the pilot practices were not required to provide reports on clinical data related to health outcomes, both were expected to maintain patient registries and one had been utilizing electronic health records for several years prior to the pilot. In addition, both practices were chosen by Blue Cross Blue Shield of Nebraska to participate in their pay-for-performance pilot to measure certain health outcomes. The following shows some of the improvements in patient health:

Kearney Clinic

At the start of the pilot, Kearney Clinic was not utilizing electronic health records. However during the pilot, the clinic implemented a Patient Registry to collect data. For this reason, they did not have baseline information. Therefore, the following represents clinical data from first year to the second year:

- Increased average daily visits by 6% by converting to a standardized schedule with slots for same day appointments
- Breast cancer screenings up 2%
- Tobacco use screenings up 19%
- Tracking BMI (body mass index) up 42%
- A1c (blood sugar) under control up 41%
- LDL (bad cholesterol) control up 40%
- Blood pressure control up 64%

Additionally, by the Care Coordinator tracking hospital admissions and ER visits to provide follow-up, ER visits were extensively reduced.

Plum Creek Medical Group

Plum Creek had been utilizing Electronic Health Records for several years prior to the pilot. The following represents clinical outcome from baseline to data as of August 2013:

- Breast cancer screenings up 54.30%
- Tobacco use screenings up 92.3%
- Pneumococcal Vaccine up 71.9%
- Tracking BMI up 90.6%
- A1c (blood sugar) under control up 65.6%
- LDL (bad cholesterol) control up 42.7%
- Blood pressure control up 69.4%
- Patients 65 and older screened for fall risk up 33%

FINDINGS – Patient Experience (PEAT)

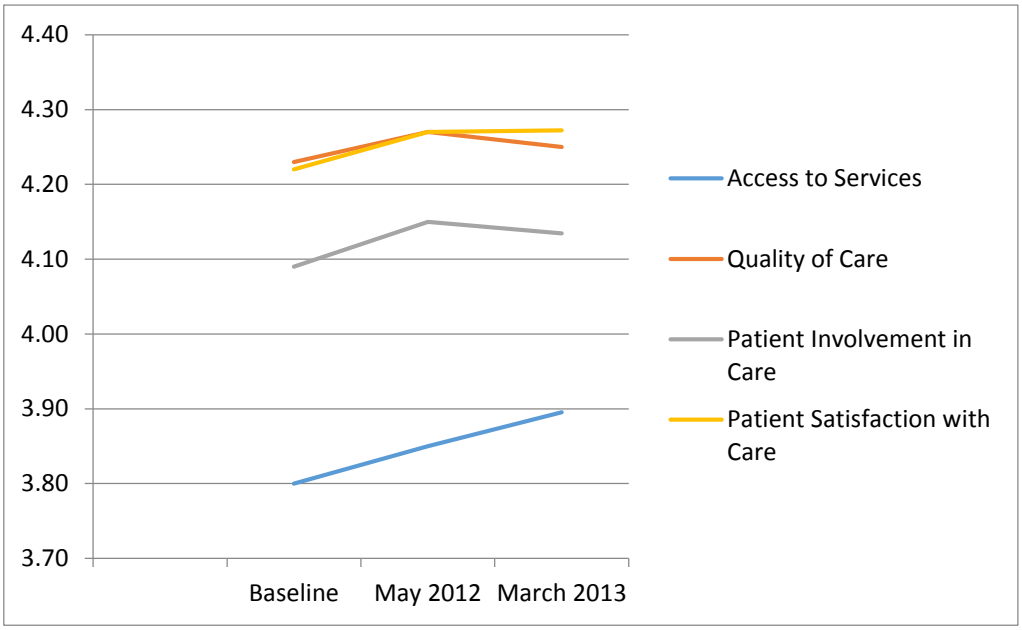
TransforMED administered a survey *(PEAT – Patient Experience Assessment Tool)* to all patients, willing to participate, at the practices at the beginning of the pilot, after the first year, and at the end of the pilot. Participation by the patient was voluntary and anonymous, with an identifier code to indicate those with Medicaid, in order to collect results for our population. Over 1500 surveys were collected from the practice population each time. The 23-question survey covered the patient's experience and overall satisfaction related to elements such access to care and information, ability to provide self-care management, and physician and staff communication.
TransforMED's general analysis of the results for all patients was that the practices overall averages for each measure were just slightly lower than the comparison group of other practices undergoing PCMH transformation. See Appendix K of the TransforMED Final Report *(Attachment F)*

The full analysis for the Medicaid-only survey responses can be found in *Attachment I.* The following summarizes the results for the Medicaid population alone:

The questions were divided to represent four dimensions of care. On a Likert Scale, with 5 being a response of Strongly Agree, this was the final result for each of these dimensions by practice:

	Practice A Baseline	Practice A End	*Practice A Difference*	Practice B Baseline	Practice B End	*Practice B Difference*
Access to Services	**3.82**	**3.92**	**+ *.10***	**3.77**	**3.83**	**+ *.06***
Quality of Care	**4.26**	**4.29**	**+ *.03***	**4.15**	**4.14**	**- *.01***
Patient Involvement in Care	**4.11**	**4.19**	**+ *.08***	**4.04**	**4.00**	**- *.04***
Patient Satisfaction with Care	**4.26**	**4.30**	**+ *.04***	**4.11**	**4.19**	**+ *.08***

The following figure represents the change in these dimensions during the two years:



- The survey showed statistically significant changes in numerous indicators, and most of these measures **suggest an increase in satisfaction with the services provided by both PCMH's.**
- One specific measure related to self-care, "I made a list of my concerns before my visit with the care team" significantly increased the first year, but significantly decreased the second year which suggests that patient involvement may have temporarily increased, but was lacking in the second year.
- The data from the survey showed that there was no significant change in the two dimensions of Patient Involvement in Care and the Quality of Care provided.

FINDINGS – Practice Provider and Employee Experience

TransforMED conducted satisfaction surveys with the providers and staff of the two practices, at the beginning of the pilot, after one year, and at the end of the pilot. Participation was anonymous and voluntary with the highest participation at the beginning of the pilot, a drop for the second assessment, and an increase for the final assessment. The full results with graphs can be found in Appendix I of the TransforMED Final Report in *Attachment F*.

Employee Survey Results. Staff at the two practices generally believed they work with a supportive team and had the tools and resources needed to perform their job. However, a few striking observations:

- There was a decrease in employees who agree that their ideas and suggestions about PCMH were being considered from baseline to Year 1. An increase occurred by the end of the pilot. However, less indicated "strongly agree."
- Across all assessment periods, the majority of employees agree that they had opportunities to grow in their job. However, there was a small increase in employees who "strongly agree" from baseline to Year 1 but then dropped even lower at the end of the pilot. In comparison to data collected in other TransforMED projects for this measure, generally this dimension increases steadily as a practice is transforming.

Provider Survey Results. Providers at the practices were generally satisfied with the amount of time they spend with patients and believe they have the tools and resources needed to perform their job. The greatest concern in the results was a lack of "Strongly Agree" with the following:

- For "I look forward to coming to work each day", there was a steady rise over the three assessment periods in "agree" and a steady decrease in "strongly agree". While not especially alarming, based on TransforMED's experience, there should be a steady increase over time.
- For the response to "I am able to practice medicine as I envisioned when I finished my training," when the pilot began, the majority of providers agreed, but there was a striking decrease by the end of the first year, followed by an increase at the end of the pilot. However, the final increase did not bring the results back to the pre-pilot level.

TransforMED occasionally sees staff and provider satisfaction decrease toward the middle of a project, as they are undergoing substantial changes. These scores tend to improve as the practice becomes more efficient and comfortable with the new processes. The pilot scores were slightly lower at this point than typical, **which indicates that the practices were still in the transitory stage at the end of the pilot.**

FINDINGS – Medical Home Administration Experience

TransforMED Assessment. During the course of the pilot, TransforMED collected measurements on the transformation to a PCMH related to the management and improvement of financial practices, clinical performance and office flow or efficiency. These are the observations:

> "Change is a process. Constant communication is a necessity to succeed in the transformation to a PCMH." - Pilot Practice

- Financial. Management of practice finances is the foundation to everything in the PCMH. Due to confidentiality, no specific results can be articulated. Both practices have been monitoring their data well since the beginning of the pilot.

- Clinical Quality & Performance Measures. Evidence-based clinical practice is the focus of this measurement. The comprehensive average of each clinical measurement increased substantially by the end of the pilot. Both practices pulled baseline data and set improvement goals to continue monitoring. The practices were able to enhance communication to patients so the patients understood the importance of their involvement in their health. In addition, the practices developed basic reminder systems to help lessen missed appointments.

  Both practices lacked processes for follow-up on test results and/or referrals to specialists. Each practice corrected this aspect to make improvements for pro-active outreach as needed to a provider and/or the patient to assure completion of necessary follow-up.

  Initially, the notification process when patients were either admitted to the hospital or visited the ER was less than reliable for one practice to allow sufficient follow-up with the patient. The other practice, as staff of the hospital, had access to all records. By the end of the pilot, both practices were able to gain needed information to follow-up with patients after discharge. Both practices provided ongoing education about the availability to be seen at the office rather than using the ER at the hospital and there was proactive outreach to all patients that had unjustified usage of the ER.

  Both practices understand the concept of population management for improved health outcome and now have the tools to accomplish this.

- Office Efficiency & Work Flow.
  Both practices have good access to care for their patients including extended hours and 24 hours, 7 days/week coverage by their providers. Both developed new brochures and marketing initiatives to inform patients of services and the new approach to PCMH care.
  Same day appointments were available and one practice considered implementing "Quick Sick Visits" during the lunch hour to provide access to patients for specific acute conditions.

An important distinction is that one practice used paper charts and implemented a patient registry system during the pilot while the other had been using electronic medical records for several years. While technology enhanced implementation of practice redesign and workflow efficiencies at different levels for the two practices, both were able to attain the same level of accomplishment even though the process of paper charts was definitely more challenging.

Creating a care team required redistribution of roles and responsibilities which included reassignment of duties historically performed by providers. Job descriptions were revised and some physicians were more willing to train and delegate than others, so care teams progressed at different rates.

Enhanced communication to and among physicians and staff was continuously addressed. Brief morning huddles allowed the practices to convene appropriate team members to plan for changes in the workflow and manage crises before they emerged.

Pre-visit planning including the determination of services due and testing ordered to be completed prior to the visit so the results could be discussed at that time, rather than needing to schedule another visit.

The complete report of findings can be found in Appendix J of the TransforMED Final Report in *Attachment F*.

Care Coordination. Each practice utilized a nurse Care Coordinator in their pilot work. Activities included pre-visit planning with the nursing staff; tracking and follow-up on ER visits and hospital admissions; participating in the leadership team planning; patient education; follow-up with chronically ill patients; setting up appointments and contacting no-shows; working with the patient advisory group; and referring patients to community resources such as transportation, medication assistance programs, emergency food, etc.

> "I have the Care Coordinator's direct contact information and I really appreciate being able to get hold of someone at the moment I call. This has helped me stay out of the ER."
>
> - Practice Patient

Initially, in both practices, the role of the Care Coordinator was difficult to integrate into the practice workflow. In time, the Care Coordinator role was recognized as a valued asset not only internally, but externally as well. In one practice, the hospital invited the Care Coordinator to join the hospital in their regular meetings on readmissions to look at reducing the rate as a collaborative effort.

This scenario is an example of results: A patient was diagnosed with Type II Diabetes through an ER visit and came to the practice for a follow-up appointment. The patient had developed a diabetic wound and required wound care at the hospital. Because the patient's job did not provide insurance, he was unable to afford his diabetic medication along with wound care and physician appointments. The Care Coordinator was able to get him enrolled in a medication assistance program for a minimal price. The Diabetes is now under control, which aided in the healing of his wound and therefore eliminating the cost of his wound care appointments and reoccurring issues.

FINDINGS – Cost

As reflected in the "Findings – Medicaid Claims" section of this report, the mean per member per month cost for all Medicaid services reflected a decrease, but it was not statistically significant. This trend in reduction of costs, nevertheless, is encouraging given the national perspective, noted earlier, that the return on investment (ROI) for a PMCH takes longer than two years.

The cost to DHHS for administrative expenses specific to the ongoing operations of the two PCMH practices was $192,000 for Care Coordinator staff and $546,000 to the practices for the monthly payment incentives for a total of $738,000.

An accurate return on investment is not feasible given the limited time period of this pilot to produce results. As supported in the literature, DHHS recognizes that an adequate picture of ROI would come, at the earliest, after 3-4 years of a practice operating fully as a PCMH and is therefore not able to determine a realistic calculation nor any adequate assumptions on cost savings. However, with the efficiencies that emerged from the transformation of the practices that subsequently resulted in increased patient health outcomes, DHHS does consider the expenses for support to the practices for this transition to be a good investment.

OVERALL FINDING

While there is evidence of progress in that patient satisfaction improved, adjustments in office procedures created efficiencies, practices were beginning to see improved patient health, some costs were contained, and care coordination was making a difference, it is not possible to make a definitive statement about any particular outcome of the pilot.

DHHS determined that the PCMH model has merit, but the length of the pilot was too short to produce enough significant results to draw any conclusions of cost effectiveness of the model or sizable improvements. Nevertheless, this is a step in the right direction to continue efforts to improve health outcomes and to contain costs of health care.

SUCCESSES AND LESSONS LEARNED

"At the end of our two years of participation, we are proud of the accomplishments and improved coordination of care." – Pilot Practice

The two practices provided mixed responses when asked, "Would you do this again?" One said that absolutely they would, but the other indicated that, because of the reluctance of some of the physicians in the practice, they probably wouldn't. The following captures the essence of the final reports from the practices and the observations of DHHS. The final report from each practice can be found in *Appendix J.*

Successes

- Standardization of care protocols, nursing policies, and workflows
- Better patient care management
- Initiation of pre-visit planning to enable efficiency and patient care during the visit
- Improved oversight and care management for patients with chronic conditions
- Attention to medication reconciliation at each visit
- Engagement of patients in their care
- Documenting the same thing, same way, same place, every time
- All staff working at the top of their license or ability
- Relationship built with the local hospital who hired a care coordinator to work with the practice in identifying high risk patients
- Patient care coordination that includes linking with the health care community as a whole and local community services
- Disease registries developed and monitored
- Development of After Visit Summary to provide to patients when leaving appointment
- Expansion of clinic hours to increase accessibility to health care

Lessons Learned

- More time in the beginning should be spent on change management when beginning to transform a practice. Both the transformation consultant and the practices felt that was sacrificed in order to work on and meet Tier 1 standards in the first 6 months as requested.
- Physician engagement of all members of the practice is critical to a valued transformation into a PCMH. In both practices, there were physicians who did not understand the model. Some felt apathy and some expressed resistance. This created a hardship for the rest of the team in working to change internal processes in workflow and patient management.
- Transformation is a developmental process over a period of time and not neatly completed in 24 months.

"There was a range of emotions to the changes. By working together as a team and with persistence the resistance lessened and they began to see the benefit of changing how we care for patients."
– Pilot Practice

- In order for the physicians and ancillary professionals to spend the necessary time with a patient, there needs to be processes in place to allow staff to complete tasks before and during the visit to free up physician time spent on paperwork or other tasks staff are capable of doing.
- Training must be very easy to access to insure physician and staff engagement.
- Implementing an electronic health records system while transforming a practice into a PCMH compounds an already stressful environment of change.

RECOMMENDATIONS

Through the experience of conducting this pilot, DHHS concludes this report with these recommendations.

- Payment Reform. Consideration should be given to linking payment rates to the quality of care and realigning provider incentives away from promoting utilization and toward efficiency and improved health outcomes.

- Continue PCMH. The PCMH model should be continued in the provision of services through the Medicaid Managed Care Program statewide due to the large number of Medicaid clients and longevity of the program. In 2012, DHHS required the Managed Care contractors statewide to develop and maintain a certain minimum of PCMH practices, following the model of this pilot.

Administrative Recommendations from the Pilot Practices:

- Best to focus on three main disease processes to monitor progress.
- The team should choose some easy wins, so to experience success and not feel like a failure when something doesn't work.
- Practices need to know the Electronic Health Record system well, i.e., how, where, and what to document to capture data for reports.
- The Lead Physician must be involved and committed to the process as he/she is vital to promoting the concept to peers and staff.
- Education of both staff and providers necessary for understanding of the concept and the goals of the PCMH.
- Review of staffing the practice is critical as may need to re-allocate staff resources and in some cases hire temporary staff.

ACKNOWLEDGEMENTS

DHHS would like to acknowledge the Medical Home Advisory Council for sharing their valuable time, expertise, and enthusiasm to design the pilot and support it to closure; the staff and physician teams at Plum Creek Medical Group, with Dr. Joe Miller as lead, and Kearney Clinic, with Dr. Ken Shaffer as lead, for their dedication in transforming to PCMH practices; TransforMED for providing expert technical assistance and support to DHHS and the pilot practices; to the National Academy for State Health Policy, in particular, Neva Kaye, Mary Takach, and Jason Buxbaum, for the invaluable year-long access to national resources and expertise during the development of this pilot as well as continual support throughout.

MEDICAL HOME PILOT PROGRAM ACT (LB 396)
Nebraska Revised Statutes

68-957. Medical Home Pilot Program Act; act, how cited; purpose; termination.

Sections 68-957 to 68-961 shall be known and may be cited as the Medical Home Pilot Program Act. The Medical Home Pilot Program Act terminates on June 30, 2014. The purposes of the act are to improve health care access and health outcomes for patients and to contain costs of the medical assistance program.

68-958. Medical Home Pilot Program Act; terms, defined.

For purposes of the Medical Home Pilot Program Act:

(1) Division means the Division of Medicaid and Long-Term Care of the Department of Health and Human Services;

(2) Medical home means a provider of primary health care services to patients that meets the requirements for participation in the medical home pilot program established under section 68-960;

(3) Patient means a recipient of medical assistance under the Medical Assistance Act; and

(4) Primary care physician means a physician licensed under the Uniform Credentialing Act and practicing in the area of general medicine, family medicine, pediatrics, or internal medicine.

68-959. Medical home pilot program; designation; division; duties; evaluation; report.

(1) No later than January 1, 2012, the division shall design and implement a medical home pilot program, in consultation with the Medical Home Advisory Council, in one or more geographic regions of the state to provide access to medical homes for patients. The division shall apply for any available federal or other funds for the program. The division shall establish necessary and appropriate reimbursement policies and incentives under such program to accomplish the purposes of the Medical Home Pilot Program Act. The reimbursement policies:

(a) Shall require the provision of a medical home for clients;

(b) Shall be designed to increase the availability of primary health care services to clients;

(c) May provide an increased reimbursement rate to providers who provide primary health care services to clients outside of regular business hours or on weekends; and

(d) May provide a post evaluation incentive payment.

(2) No later than June 1, 2014, the division shall evaluate the medical home pilot program and report the results of such evaluation to the Governor and the Health and Human Services Committee of the Legislature. The report submitted to the committee shall be submitted electronically. Such report shall include an evaluation of health outcomes and cost savings achieved, recommendations for improvement, recommendations regarding continuation and expansion of the program, and such other information as deemed necessary by the division or requested by the committee.

68-960. Medical home; duties.

A medical home shall:

(1) Provide comprehensive, coordinated health care for patients and consistent, ongoing contact with patients throughout their interactions with the health care system, including, but not limited to, electronic contacts and ongoing care coordination and health maintenance tracking for patients;

(2) Provide primary health care services for patients and appropriate referral to other health care professionals or behavioral health professionals as needed;

(3) Focus on the ongoing prevention of illness and disease;

(4) Encourage active participation by a patient and the patient's family, guardian, or authorized representative, when appropriate, in health care decisionmaking and care plan development;

(5) Encourage the appropriate use of specialty care services and emergency room services by patients; and

(6) Provide other necessary and appropriate health care services and supports to accomplish the purposes of the Medical Home Pilot Program Act.

68-961. Medical Home Advisory Council; created; members; chairperson; expenses; removal; duties.

(1) The Medical Home Advisory Council is created. The council shall consist of seven voting members appointed by the Governor as follows:

(a) Two licensed primary care physicians actively practicing in the area of general and family medicine;

(b) Two licensed primary care physicians actively practicing in the area of pediatrics;

(c) Two licensed primary care physicians actively practicing in the area of internal medicine; and

(d) One representative from a licensed hospital in Nebraska.

(2) The chairperson of the Health and Human Services Committee of the Legislature or another member of the committee designated by the chairperson shall serve as an ex officio, nonvoting member of the council.

(3) The council shall annually select one of its appointed members to serve as chairperson of the council for a one-year term. Appointed members of the council shall be reimbursed for their actual and necessary expenses as provided in sections 81-1174 to 81-1177. The division shall provide administrative support to the council.

(4) The Governor may remove appointed members of the council for good cause upon written notice and an opportunity to be heard. Any appointed member of the council who ceases to meet the requirements for appointment to the council shall cease to be a member of the council. A vacancy on the council shall be filled in the same manner as provided for the original appointment.

(5) The Governor shall make initial appointments to the council no later than October 1, 2009. The council shall conduct its initial organizational meeting no later than October 31, 2009.

(6) The council shall (a) guide and assist the division in the design and implementation of the medical home pilot program and (b) promote the use of best practices to ensure access to medical homes for patients and accomplish the purposes of the Medical Home Pilot Program Act.

Attachment B

Medical Home Advisory Council

Terms – September 25, 2009 – June 30, 2014

PHYSICIANS:

General and Family Medicine
Dr. Robert Wergin, Milford

Dr. Thomas Werner, Grand Island (CHAIR)

Pediatric
Dr. Jane Carnazzo, Omaha

Dr. Nancy Knowles, Omaha

Internal Medicine
Dr. Donald Darst, Omaha

Dr. Lissa Woodruff, Kearney

HOSPITAL REPRESENTATIVE:
Dr. Martin Hickey, Alegent, Omaha (2009 – 2010)

Ken Klaasmeyer, Nebraska Methodist Hospital, Omaha (2011 – 2012)

(Ex Officio) HEALTH AND HUMAN SERVICES COMMITTEE REPRESENTATIVE:

Senator Mike Gloor, Grand Island

Nebraska Medicaid Patient-Centered Medical Home Pilot Standards

A goal of the Nebraska Medicaid Patient-Centered Medical Home Pilot is to develop fully recognized and operating medical homes that meet the criteria of a patient-centered medical home. To achieve this, the pilot Medical Home will receive technical assistance to help transform the practice into a recognized medical home including guidance on meeting the Tier 1 required minimum standards outlined below. The Medical Home will receive a PMPM for care coordination and administration costs as a participant of the pilot. In exchange, the Medical Home will agree to meet the Tier 1 minimum standards within six months.

Once the minimum standards have been met, the Medical Home will have the option to receive an enhanced FFS on selected Evaluation and Management codes by meeting Tier 2 standards.

Tier 1 – Required Minimum Standards

In order to be recognized as a Medical Home, these minimum standards must be met in six months.

Core Competency 1: Facilitate an ongoing patient relationship with physician in a physician-directed team.

1.1	Utilize a written plan for patient communication including accommodation for patients who have a hearing or visual impairment or for patients whose second language is English (ESL).
1.2	Utilize written materials for patients to explain the features and essential information related to the Medical Home and published in primary language(s) of the community.
1.3	Utilize patient-centered care planning (including patient's goals, values and priorities) to engage patients in their care. The Medical Home plan may include a written "After Visit Summary" outlining future care plan that is given to a patient at every visit.
1.4	Utilize reminder/notification system for health care services such as, appointments, preventive care, and preparation information for upcoming visits; follow up with patients regarding periodic tests or screening; and when planned appointments have been missed.
1.5	Provide patient education and self-management tools and support to patients, families, and caregivers.
1.6	Utilize a Medical Home team that provides team based care composed of, but not limited to, the primary care physician(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.
1.7	Create and use a written action plan for the implementation of the Medical Home including a description of work flow for team members.

Core Competency 2: Coordinate continuous patient-centered care across the health care system.

2.1	Utilize written protocol with hospital(s) outlining referral and follow-up care coordination, and admission and discharge notifications.
2.2	Provide care coordination and supports family participation in care including providing connections to community resources.
2.3	Utilize a system to maintain and review a list of patient's medications.
2.4	Track diagnostic tests and provide written and verbal follow-up on results with the patient plus follows up after referrals, specialist care and other consultations.
2.5	Utilize a patient registry.
2.6	Define and identify high-risk patients in the Medical Home who will benefit from care planning and provides a care plan to these individuals
2.7	Provide and coordinate Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services.
2.8	Provide transitional care plan for patients transferring to another physician or medical home.
2.9	Organize clinical data in a paper or electronic format for each individual patient.
2.10	Utilize a system to organize and track and improve the care of high risk and special needs patients.

Core Competency 3: Provide for patient accessibility to the services of the Medical Home.

3.1	Provide on-call access for patients to the Medical Home team 24 hours/day, 7 days/week
3.2	Offer appointments outside traditional business hours of Monday – Friday, 9 a.m. to 5 p.m.
3.3	Utilize a system to respond promptly to prescription refill requests and other patient inquiries.
3.4	Provide day-of-call appointments.
3.5	Utilize written Medical Home standards for patient access.

Core Competency 4: Commitment to efficiency of care by reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of health care services.

4.1	Establish at least two out of three of these specific waste reduction initiatives: generic medication utilization, reducing avoidable ER visits or reducing hospital readmissions.
4.2	Implement an intervention to reduce unnecessary care or preventable utilization that increases cost without improving health.

Core Competency 5: Engage in a quality improvement process with a focus on patient experience, patient health, and cost-effectiveness of services.

5.1	Establish a quality improvement team that, at a minimum, includes one or more medical staff who deliver services within the medical home; one or more care coordinators, and if a clinic, one or more representatives from administration/management, with input for the team from a patient advisory group.
5.2	Develop a formal plan to measure effectiveness of care management.
5.3	Develop an operational quality improvement plan for the Medical Home with at least one focus area.
5.4	Utilize a patient survey on their experience of care and sets a schedule for utilization. (May be developed or provided through technical assistance.)
5.5	Identify one or more patient health outcomes to improve through a clinical quality improvement program using evidence-based guidelines.

Tier 2 – Advanced Medical Home Standards (OPTIONAL)

In order to be recognized as an advanced Medical Home, upon successful completion of the Tier 1 minimum standards, the Medical Home Has the option to meet Tier 2 Advanced Medical Home Standards.

6.1	Offer patient education and self-management tools and support to patients, families and caregivers through the Medical Home and/or coordination of community resources.
6.2	Utilize a system to monitor drug usage, drug interaction and effectiveness of a patient's medications.
6.3	Offer end-of-life planning or counseling to patients who may benefit from these services.
6.4	Develop enhanced care plans that are coordinated with school, nursing home, home care, chronic care and/or end of life plans for identified high risk patients.
6.5	Work towards the use of or currently use electronic medical records.
6.6	Demonstrate an increase in patient compliance with preventative care, ex. immunizations, cancer screenings, diabetes checks, heart disease screenings.
6.7	Implement all three of these specific waste reduction initiatives: generic medication utilization, reducing avoidable ER visits and reducing hospital readmissions.
6.8	Monitor the effectiveness of the intervention/project selected in Tier 1 Minimum Standard 4.2.

Nebraska Medicaid
Patient-Centered Medical Home Pilot
Payment Methodology

Reimbursement:

Fee-for-Service (FFS):
The Medical Home Pilot practices will be reimbursed for all allowable Medicaid services.

To receive the incentive payments below, the Medical Home Pilot practice will sign an agreement to work with the practice transformation contractor to meet Tier 1 minimum standards within 6 months. Tier 2 advanced standards will be optional for the practice.

Per Member Per Month (PMPM):
For patient care coordination and administration expenses, the Medical Home Pilot practices will initially receive a $2 PMPM. This payment will begin once the agreement is signed and the practice must achieve Tier 1 minimum standards within six months. If the Tier 1 standards are not met within six months, the PMPM will be suspended until the Tier 1 standards have been met. Once the Tier 1 standards are met, the payment will be increased to a $4 PMPM.

Enhanced FFS:
Upon successful completion of Tier 1 minimum standards, the Medical Home Pilot practices have the option of continuing to transform the practice to meet Tier 2 advanced standards. Once the Tier 2 standards are met, the practice will receive an additional 5% enhanced FFS on selected Evaluation and Management and Preventive procedures.

Additional Practice Support:

The medical home practices in the pilot will also receive the following support:

- Two years of practice transformation technical assistance
- Two years one full-time Care Coordinator staff
- Training sessions with an honorarium and travel reimbursement for attendees
- Patient registry

Exclusions to the Payment Methodology Design:

- Risk Adjustment: For this pilot, payments will not be adjusted for risk.
- Savings Sharing: For this pilot, initially there will be no savings over cost neutral sharing but this will be reviewed after one year of operation.
- P4P: For this pilot, there will be no pay-for-performance.

Nebraska Department of Health & Human Services
Outcomes and Measures for
Evaluating the Medical Home Pilot

Outcome: Improve Health Care Access

Proposed Measures:

a. Routine source of health care
b. Able to schedule appointment on day wanted
c. Patient perception of access to care

Outcome: Improve Health Outcomes for Patients

Proposed Measures:

a. Days of work or school lost due to patient's health condition
b. Self-reported health status
c. Readmission to a hospital within 30 days for the same complaint
d. Readmission to an emergency room within 72 hours for the same complaint

Outcome: Contain Costs in the Medical Assistance (Medicaid) Program

Proposed Measures:

a. Number of emergency room visits
b. Expenditures for emergency room care vs. Non-emergent care in the ER
c. Number of inpatient hospital admissions for ambulatory care-sensitive conditions (ACSC)-COPD, CHF, Diabetes Mellitus, Pediatric Asthma
d. Expenditures for inpatient hospital care for ACSCs- COPD, CHF, Diabetes Mellitus, Pediatric Asthma
e. Number of specialty care visits
f. Expenditures for specialty care
g. Expenditures for high-tech radiology use
h. Total expenditures per member per month
i. Expenditures for prescribed drugs
j. Percent of prescriptions for generic drugs

Patient Satisfaction

Proposed Measures:

a. Patient/parent satisfaction
b. Patient/parent perception of quality/coordination of care

Provider Satisfaction

Proposed Measures:

a. Provider satisfaction

TransforMED℠
TRANSFORMING MEDICAL PRACTICES

Patient Centered Medical Home Project
Final Report

State of Nebraska/Medicaid

March 2013

Table of Contents

Planning Phase

On September 22, 2010, a formal contract was entered into between the State of Nebraska, Department of Health and Human Services, Division of Medicaid and Long-Term Care (hereinafter referred to as the "Department") and TransforMED.

In the planning phase, the Department requested assistance in selecting practices that would be appropriate participants for the Patient Centered Medical Home (hereinafter referred to as PCMH) project. This process was initiated by Colleen Stack, primary TransforMED Practice Enhancement Facilitator (assigned to the project). Colleen began with an introductory call to each of the practices to discuss the selection process and ascertain their interest in remaining as an applicant. All elected to remain as applicants.

A customized survey was created and disseminated to all interested applicants in order to assess their culture, current change management environment, leadership style, knowledge of and interest in PCMH, current technology, challenges they would anticipate with the transformation process, and why they felt their practice would be a good candidate for the project (Appendix A— PCMH Questionnaire).

TransforMED's analysis recommended to the Department by ranking each of the seven practices that could be eligible for consideration. The Department ultimately decided to select the following two practices.

Based on the results, practice recommendations were submitted and the Department selected two practices (Appendix B – Recommendations on Nebraska Medicaid PCMH Finalists):

- Kearney Clinic in Kearney, Nebraska
- Plum Creek Clinic in Lexington, Nebraska

Assessment Phase

The Kick-Off event, originally scheduled for January 11, 2011, was postponed due to inclement weather. In an effort to avoid any delays in the assessment process, TransforMED hosted a live webinar on January 18, 2011, to explain the "assessment phase," provide an overview of the objectives of the PCMH project, and discuss the timeline for the entire project (Appendix C - Project Timeline). The "online assessment phase" began with deployment of surveys on January 20, 2011. The purpose was to provide an:

a. Assessment of current practice procedures related to the timely delivery of care
b. Assessment of practice protocols that are in place that impact workflows
c. Assessment of the use of evidence-based guidelines in the delivery of care
d. Assessment of the operations and processes
e. Assessment of patient flow and access
f. Assessment of team-based care and communication channels used both internally and externally.
g. Assessment of how care coordination is handled internally as well as with external entities
h. Evaluation of the Care Management process to the extent that the practice utilizes tools to manage the care of its patient population, particularly people with chronic disease.

TransforMED customized a Staff and Provider Satisfaction Survey based on the Department's needs. A separate survey was deployed to each member of the practices to gauge their culture and assess the readiness to embrace change in five key areas, including - change management, communication, leadership, teamwork and work satisfaction.

The online assessment phase was open for one month, closing in mid-February. The other key component of the "assessment phase" was the "on-site assessment "conducted by Megan Rackish and Colleen Stack on February 8, 2011, at Kearney Clinic and February 9, 2011, at Plum Creek. The compilation of the entire assessment process data was presented to each practice, and the Department, in the form of a Practice Assessment Report specific to each practice (Appendix D - Kearney Clinic & Plum Creek Patient Centered Medical Home Practice Assessments & Progress Reports).

The TransforMED standard Patient Satisfaction Survey was customized to meet specific requirements of the Department and the first round collection began. The practices chose to collect them manually and, as a result, this process took several months to capture the necessary number of Medicaid patients. All surveys from each practice were sent to TransforMED, manually entered by staff, and compiled into a single report.

The Kick-Off event was rescheduled for February 22, 2011, and took place in Lincoln, Nebraska. Participants included employees from the Department, each of the pilot practices and TransforMED. Keynote speakers, Dr. Don Klittguard and Dr. Len Fromer (Appendix E – Kick-Off Agenda) were engaged by TransforMED to provide their experiences and expertise in PCMH.

Transformation Phase

The Department developed Nebraska Patient-Centered Medical Home Pilot Tier I Standards which were to be accomplished by July 31, 2011. The transformation phase began by focusing on the implementation of the standards in conjunction with the TransforMED Gap Analysis and Progress Report. There is substantial correlation between the Practice Transformation Plan (PTP) and the Nebraska PCMH Standards so we prioritized accomplishing the Tier I Standards within the first six (6) months, as required by the project.

In consideration of an impacted timeline, less time was allocated to the foundational concept of development and improvement of teamwork, leadership, and communication at the onset of the project; however, the leadership teams at both sites were established quickly and remained actively engaged throughout the project. Plum Creek included Dr. Miller, Rusty Sutton (CEO), Carol Meyer (office manager) and Marion (nurse manager) and later included Crystal Dowling when she was hired as Care Manager. Kearney Clinic relied on a very large leadership team, representation from each department - totaling approximately 15 employees – all of whom did an excellent job of educating their respective departments about PCMH initiatives and progress. This primary team was responsible for forming sub teams as specific project needs arose. For example, when Kearney was working on Care Coordination, and specifically on communication and notifications from the hospital, they engaged Dr. Clint Black as he served on a hospital committee that was working to develop in-patient notification to physician offices. Despite the inability to allocate more time to Teamwork, Leadership, and Communication (TLC), the characteristics of a learning organization were effectively developed.

One important distinction to keep in mind is that Kearney Clinic was using paper charts and Plum Creek had been using Allscripts electronic medical record for several years. There are many examples of how technology enhanced implementation of practice redesign and workflow efficiencies; however, both practices essentially were able to attain the same level of accomplishment even though the manual process of paper charts was definitely more challenging.

CORE COMPETENCY 1: Facilitate an ongoing relationship with physician in a physician-directed team.

As work began on the Required Minimum Standards (Appendix F - Tier 1 - Required Minimum Standards) *Core Competency 1* required creation of team-based care and empanelment, developing relationships between patients and their care team, as well as documenting the roles of the care team. There was a need for technical assistance in many aspects of this competency. In terms of empanelment, Kearney had never assigned a Primary Care Provider to each patient which is fundamental to continuity of care and population management. We used the Institute for Healthcare Improvement (IHI) four-cut method to create protocol for assigning each patient to their Primary Care Provider. Patient engagement had not been a major focus of either group. We improved the educational resources provided to patients and their caregivers by utilizing the medical library resources and websites from specialty organizations, etc. The practices also created new brochures to educate their patients about the differences of being cared for in a medical home, the roles and responsibilities of the patient and their care team, and access to care and information through a portal and websites - with specific attention to accommodations of literacy, language and possible impairments.

Patients began receiving an “After-Visit Summary” of their visit, based on CMS Meaningful Use criteria:

Recommendations for their Clinical Summary Included providing the patient with relevant and actionable information and instructions containing the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms. This was particularly challenging and expensive for Kearney Clinic because of the paper charts and having to create and order carbon tear-off forms to satisfy the requirement. There were unwritten policies but many protocols in place regarding accommodations for patients with impairments and language barriers. To formalize the process, we created Policy and Procedure manuals which were periodically revised and updated.

Creating a "care team" is always a challenge because it requires redistribution of roles and responsibilities of the care team and, most importantly, reassignment of duties which have historically been performed by providers. Mapping out workflows by using Lean Principals helped to identify gaps and duplication of routinely-performed tasks. We performed process assessment in an effort to find opportunities for appropriate delegation to team members in order to improve efficiency and assure that all staff are working to the top of their ability and licensure. Job descriptions were revised to reflect the additional responsibilities of each of the team member and included in the Policy and Procedure manual. Evaluation of workflows is an evolving process and will continue to develop and mature within the respective learning organizations. Some physicians were more willing to train and delegate than others, so care teams progressed at different rates. We worked to standardize the rooming process, message-taking, the triage process, medication reconciliation and the refill process by providing tools, templates and algorithms that could be customized to their specific clinical needs and workflows. Continuous review of workflows and holding team members accountable for their specific tasks was a recommended necessity for *sustainability of Team Based Care*.

The need for enhanced communication was continuously addressed. We discussed the need for communication on two separate levels; first, we communicated to the office staff to explain "why" processes were changing and to help each team member understand their importance and role in the enhanced primary care model. Recommendations included posting the PCMH model and creating a "PCMH Bulletin Board" in a common area for all to remain informed. Posting agendas and minutes of leadership meetings and Action Items provides an inclusive atmosphere and helps to engage staff in the transformation activities to enhanced primary care. We worked to improve daily communication among the care teams through "huddles". Video replication of other clinic huddles and sample "Huddle agendas" were provided to assist in developing t meaningful meetings/huddles.

The second level of enhanced communication was educating the patients so that they understood the importance of their involvement in their health and to engage them as a member of the team. Basic reminder systems were in place for contacting a patient when they missed an appointment but we worked to implement a more proactive approach and developed scripts for staff to ask the patient why they were unable to keep their appointment. Attempts were made to determine the barrier to patient compliance and to provide appropriate accommodations for their unique needs. Clinical staff also

utilized this as an opportunity to explain to the patient the challenges caused to patient workflows and provider schedules when an appointment was missed. . All staff were reminded and encouraged to participate in patient education So that staff members understood their role in impacting patient behavior.
In our experience, the inclusion of all staff in the transformation journey is imperative to ensuring the sustainability of the enhanced primary care model. Each person in the practice is important to the team and has a specific role and responsibility to improve the patient's experience.

CORE COMPETENCY 2: Coordinate continuous patient-centered care across the healthcare system.

The nascent stage of pre-visit planning began at Plum Creek with a project of review patient records for overdue immunizations. This new workflow of record review in advance bourgeoned into review for preventative services; mammograms and colonoscopies as well as flu shots and pneumococcal vaccinations in advance of the visit. Marion, Supervisor of Nursing at Kearney Clinic, worked with several physician-nurse teams to begin their pre-visit process, assigned the responsibility for monitoring and documenting to the nursing staff so eventually the preventative services would be performed in advance of the visit, allowing the physician to discuss the with the patient at the time of the visit. Both practices worked toward having laboratory tests drawn in advance. This efficiency reduced the volume of phone calls to patients to report lab results and also provided a more comprehensive visit with the provider. For all testing that could not be performed in advance, we implemented workflows to ensure all patients were contacted with test results, both normal and abnormal. Marion, Supervisor of Nursing at Plum Creek took advantage of the TransforMED Delta Exchange network to query how others had implemented pre-visit planning.

Each office identified three important conditions to their practice and the physicians reached consensus on adoption of Evidence-Based Guidelines for each chronic condition. Evidence-based care was embedded into the workflow; various team members were assigned responsibility to determine any services that were due. For example, when patients with diabetes were on the schedule but prior to their appointment, their chart was reviewed to assure they had had a current HgA1C, retinal exam within the past year, as well as the preventive services such as colonoscopy, mammogram per guidelines. Any testing was ordered to be completed prior to the visit. Each diabetic patient was to have a foot exam included in their visit as well as discuss the results of the recent testing. Allscripts had health maintenance functionality to alert for the required services. This health maintenance screen was to be reviewed several days in advance for the patients with chronic disease and approximately two weeks in advance for the high acuity patients.

The same pre-visit review of patient charts was implemented at Kearney Clinic. They began reviewing charts of patients scheduled for physicals to determine overdue services with the goal of scheduling testing prior to the annual physical examination so as to have the results available to review with the patient at the time of the visit. This was later integrated into routine follow-up appointments and managed at the time the patient called to make an appointment. Kearney Clinic enhanced their reporting to the State Immunization Registry in conjunction with the pre-visit review of immunizations. An added benefit of updating this registry was that childhood immunizations records were available to the parents reducing the time spent by clinical staff providing the child's immunization records.

A much more challenging process to implement was to "track testing to completion." There was due diligence in both practices to provide the test results to the patient in a very timely fashion. However, there was no process in place to neither monitor for testing that had not occurred nor a workflow to reach out to patients regarding the same. In an effort to satisfy this standard, Kearney Clinic created notebooks at each provider work station with three (3) different worksheets. One worksheet logged services ordered by the provider, another documented referrals to specialists and the third worksheet was created to track for high-risk patient follow-ups. Protocols were created for monitoring to completion and contacting patients who had not complied with recommended testing. Implementation of this new process was manual and very time consuming for the clinical staff at Kearney Clinic. I continually reassured them that the workflow would become much more automated and much less time consuming with their impending registry technology.

Plum Creek was utilizing the Allscripts orders module and test results were attached to the patient record and reported to patient upon completion. However, there was no process to monitor for testing that had not been completed and this was a rather complicated task with Allscripts technology however, it did reveal voluminous uncompleted services as well as provide the opportunity to improve upon the utilization of their electronic ordering/tracking system. They implemented a workflow to review for non-completion of tests and the appropriate follow-up. The appropriate follow-up typically identifies which facilities and/or specialists are not providing test results or consult notes. When it was determined that a specialist or facility was not providing timely documentation of the consult or test results, the Specialist Agreement Letter was offered as a solution to define expectations. If it was determined that the results were not available because the patient had not followed provider recommendations for studies or consults, proactive outreach to those patients became routine, further developing the relationship of the patient/care team and engaging the patient in their care. Patient engagement is vital to the sustainability of the PCMH and we have identified multiple opportunities throughout the project to improve patient engagement.

The notification process when patients were either admitted to the hospital or visited the Emergency Department was less than reliable at the Kearney Clinic. Having provided examples of hospital agreements defining notification, appropriate record sets for transfer and coordination of transitions of care, Dr. Jones worked with hospitals on this project , to include Children's in Omaha to improve communication, medication reconciliation across all settings and care coordination. A letter was drafted on behalf of Kearney physicians to GHS and other facilities explaining the PCMH project and requesting the facilities automate the notification process for admission and discharge of their patients. They also requested that the facilities would report back to Kearney Clinic when patients did not show up for the testing that had been ordered at their facilities. Plum Creek physicians staff their local hospital therefore they had complete access to the records when their patients were admitted, discharged or seen in the Emergency Department. They did reach out to other facilities to improve communication and define transfer of care roles and responsibilities.

Both practices maintain a very comprehensive list of community services available to patient's in their localities. Further communication was recommended to develop more collaborative relationships as well as define the appropriate patient record sets for transitions of care from each setting. There have been ongoing meetings with Home Health agencies, Hospice, Skilled Nursing Facilities, and Discharge Planners to name a few. There is now inclusion of family and caregivers for additional success in transitions of care. The documentation of recommendations to community resources is now

documented in the patient medical record. Continued communication with Key Stakeholders in the Community will provide sustainability of coordination of care throughout the community.

CORE COMPETENCY 3: Provide for patient accessibility to services.

Kearney Clinic and Plum Creek have good access to care for their patients. Kearney has Saturday hours until noon and an Urgent Care Clinic at their facility which offers evening hours until 8pm and Sunday from 1-4pm. Both practices have 24 hours per day, 7 days per week coverage by their providers. Each practice updated their brochures and website to inform patients of the access to care and information and focused on the new approach to care as they became PCMHs. Kearney advertised many times in their local newspaper to inform patients of services available at the clinic, specific conditions for which it was appropriate to utilize the emergency room, and which conditions should be handled by their office (Appendix G –Kearney Clinic Brochures).

Work to standardize the type and length of appointments was successful and both offices had same-day appointment availability. We ran reports comparing availability at the beginning and end of the day to adjust for demand of same-day appointments. Both practices will most likely continue to double book some appointments as they allow patients to walk in if they need to be seen. We also tracked continuity of care by determining what percent of the time a patient saw their assigned PCP and care team. Kearney had traditionally been closed during the lunch hour but increased access by opening availability for patients during that time. Plum Creek considered implementing "Quick Sick Visits" during the lunch hour to provide access to patients during their lunch hour for specific acute conditions, such as upper respiratory symptoms.

Both practices provided their patients with ongoing education about the availability to be seen at the office rather than using the emergency department at the hospital. There was proactive outreach to all patients that had unjustified usage of the emergency department. Patient reminder calls were instituted 2-3 days in advance and pre-visit planning calls were made to specific patient populations in an effort to minimize "no- show patients." Patients were contacted when they missed an appointment to ascertain any barriers they had encountered to keeping their appointment as well as educate them about their responsibility for involvement in their care and problems created when they did not come for their appointment. No-show policies were documented and shared with appropriate patients. Policies were written to document access to care/information to include timely response to patient phone calls, reporting of test results, refill requests. Implicit in providing enhanced primary care in a PCMH is the ability for the patient to see their care team when they have a need. Providing access to care is an element of sustainability that allows reduction of hospitalizations, readmissions and emergency room services.

CORE COMPETENCY 4: Commitment to efficiency of care by reducing unnecessary healthcare spending, reducing waste and improving cost-effective use of healthcare services.

At the onset of the project, there was a high utilization of ER visits and unnecessary hospital readmissions. Interventions to reduce cost were gradually implemented throughout the project beginning with the education of patients that they are considered members of the healthcare team, should be engaged in their care and that they have access to their health care team who should always be the first point of contact for any of their health concerns. Risk stratification of patients allows for appropriate levels of awareness and attention to higher-acuity patients. By identifying three most

prevalent conditions at their practices, patients with a specific chronic disease were provided evidence-based care with proactive outreach when services were overdue. Population Health Management was put into place by monitoring specific subsets of patients for chronic and preventative services. This intervention began with running reports by physician and specific diagnosis, further drilling down to specific information and developing a workflow by category. Care Managers proactively reached out to patients who were in the emergency room to evaluate the need for office follow-up within 48 hours. All unjustified emergency room visits were also discussed with the patient. Unfortunately, there is a conflicting system requirement that perpetuates overutilization of the emergency room which PCMH physician leaders have discussed with the State. It is more difficult to reduce ER utilization with the policy in place as many Medicaid patients realize one visit to the Emergency Department will satisfy their expenditure requirement for the month.

Care Managers or nurses were also in contact with patients upon hospital discharge to schedule follow-up office visits based on the patient acuity, diagnosis and high-risk drug classifications. It will be important to maintain proactive outreach to patients as their care transfers back to home to assure proper care is provided. It is also important to have protocol in place as patient care transitions across all settings. Improving the quality of care while reducing costs of ER and readmissions is not sustainable without continuous efforts of communication across all care settings.

Generic drugs are first choice by protocol for cost control of medications. In an effort to further control costs to the system and abuse, Kearney Clinic also created an" Agreement" which patients who are prescribed controlled substances are required to sign. Treatment protocol was also reviewed. A conservative approach to imaging, intervention and treatment is routine standard of care by most physicians. Despite this current approach, we had multiple discussions to reinforce the importance of reviewing for duplication of services as well the utilization of imaging and specialty consultations.

CORE COMPETENCY 5: Engage in quality improvement process with focus on patient experience, patient health and cost-effectiveness of services.

Quality improvement in the PCMH is an ongoing process. Both practices have instituted routine monitoring of preventative services, evidence-based care for chronic diseases, standardizing processes such as patient rooming process, refill process, tracking orders to completion. . Care teams discuss clinical pathways as means of educating the patient. There are protocols for transitions of care across all settings and care plans are being created and mutually agreed upon by patient and provider.

Creating a culture of continuous improvement can aid in the decision making process to measure the effectiveness of practice process. Metrics should be collected on a routine basis to ensure quality improvement in clinical outcomes, workflow processes and the effect this has on the overall improvement of the quality of care and reduction of costs in the PCMH.

The ongoing process of notification and review of patient activity in the hospital setting will be an indicator of quality improvement in the care provided at the primary care clinic settings. Proactive outreach to patients who have utilized hospital and emergency department services should enhance patient education as well as review of Ambulatory Sensitive Admissions. Proactive review of preventive and chronic care will provide patient access to the necessary services in the outpatient setting, resulting in better care and reduced expenses.

Demonstrating patient centeredness begins with engaging patients to provide feedback on their experience. In an effort to measure and monitor this, there have been multiple patient satisfaction surveys deployed throughout the project. In addition, each practice has formed an Advisory Committee which meets to discuss their recommendations for improved patient experience. Quality improvement also resonates in the area of compliance as chart completion and comprehensive documentation in the medical record.

Registry

The State so graciously and intuitively provided the practices with registry for improved population management. Plum Creek had MD Data Corp in place but worked throughout the project to improve the functionality and better manage their patient population. Kearney Clinic was scheduled to implement MD Data Corp; however, within weeks of implementation, MD Data Corp cancelled the agreement as they "were no longer working with practices of that size."

TransforMED assisted in the search for alternative registries, working with the NEB HIE, and scheduling demonstrations of McKesson, Phytel and Wellcentive products. The best solution for Kearney was Wellcentive; however, the implementation was very difficult. Integration of data was rather unsuccessful and the entire process took much longer than expected with much less data transferred into the registry than expected. Much patient information had to be manually entered. Dr. Haskett created a form capturing demographic information to be filled out by the patient and vitals to be filled out by the nurse when she was rooming the patient. Mammograms were not recorded as the CPT code was not recognized, ICD-9 information was not able to upload, and patient account numbers were an impossible task to correct. In spite of all of the complications, Kearney Clinic has worked through the challenges. I am sure they will become extremely proficient in managing their populations through the registry.

Utilization of registry technology is accomplished best with well- planned implementation. Using discrete, standardized fields allows for robust reporting of data. All clinical staff must be responsible for documentation of required data by protocol in each patient chart. The importance of holding each team member accountable for documenting specific data in specific fields has been emphasized with accountability being monitored by routine reporting on the data. Workflows have been established assigning roles for specific data entry. Routine reporting on provider panels are encouraged to manage the provider patient population. We worked on specific reports that should be provided to individual physicians, such as: All of Dr. Miller's patients that have diabetes, hypertension and CAD who have current labs, further drilling into the lab values to determine those in acceptable ranges and all preventive services are current. Further to identify those out of range, those that are overdue for labs, overdue for preventive services, etc. and a workflow for each group. Eventually, the diabetic population will be current for services, routine maintenance will be provided in a standardized manner and high acuity patients will be identified by a process of risk stratification.

Population management is an integral part of enhanced primary care and will be the foundation to accomplish the triple aim of improved health, increased quality and reduced expenses. The two pilot practices have the advantage of understanding this concept and having been provided the tools to accomplish population health management.

Care Manager

The other terrific enhancement provided by the State to each practice was an embedded Care Manager. As an introduction to their role, TransforMED provided a grant which paid for both Crystal and Serena to take the Johns Hopkins online Guided Care course. This provided basic overview as well as detailed instructions as how Care Management should be integrated into the primary care setting.

Initially and in both settings, the role of Care Manager was difficult to integrate into the practice workflow. Our experiences have revealed that this role is easily siloed or simply treated as another nurse. We advise a concerted effort to identify the role of the Care Manager in the practice prior to the implementation. Physicians need to reach consensus as to how they can best utilize this additional team member.

During the July site visit, I worked with each Leadership Team to solidify the role for their practice. I provided many tools and templates and examples of job descriptions for their discussions. It was determined that there should be a continued focus on the ER patients, in-patient discharges but that each physician should identify no more than 10 patients that they categorized as high acuity and request Care Manager intervention when appropriate. My fear was that this would be an extremely high number of patients however, the integration of services between Care Manager and the primary care team will allow for a manageable census of patients.

We have worked to develop collaborative relationships between Serena and Crystal; they have great rapport and share successes and challenges with one another and have utilized Delta Exchange to learn of other experiences in the Care Manager arena. They both provide such enhancement of care to the patients, families and caregivers at their clinics and their compassion and support is a wonderful addition to the clinical teams.

The highlight of collaboration among the practices with focus on the Care Manager as an integral team member in their primary care practice was in September when TransforMED provided a full-day Care Manager Training (Appendix H – CM Agenda). Both practices were in attendance. Dr. Shaffer, Peggy and Serena attended from Kearney Clinic. Dr. Miller allowed nine of his nurses to attend along with their supervisor, Josette and Crystal their Care Manager. I was accompanied by Diane Cardwell, NP our Director of Innovation Services and Kristi Boling-DeMetz, RN, BSN, MBA, Manager of the Center of Excellence for Care Management and Patient Engagement. They had heard about the wonderful work going on in Nebraska and were extremely willing to provide additional support to the project. It was very rewarding to observe the teamwork, collaboration and progress during the day. It was a very interactive setting, didactic with many break-outs to work on activities around Care Management and Care Coordination. The seminar was extremely well rated by attendees and definitely emphasized the increased value of Care Management and Coordination in the PCMH. The conference was a wonderful way to end such an important project.

Practice Metrics & Survey Information

Employee and Provider Satisfaction Surveys (Appendix I)

During the assessment phase of the project, we conducted satisfaction surveys among providers and employees. The surveys provided a baseline assessment of satisfaction levels at the start of the project. Over the course of the engagement, we measured satisfaction levels at the end of Year 1 and the end of Year 2—for a total of three assessment periods. For both satisfaction surveys (employee and provider), we had the highest participation at baseline, a drop in participation for the second assessment and an increase for the final assessment. What follows is a summary of the findings and comparative results from these surveys.

Employee Survey Results

Employees at the two practices generally believe they work with a supportive team and have the tools and resources needed to perform their job. However, of particular concern are the following dimensions:

• **I am paid fairly for the work that I do.** There is a striking increase in employees who agree that they are paid fairly from January 2011 to January 2012 but then it drops back down in January 2013. It is suggested that the timing of this data is reviewed and discussed, in order to determine if something notable happened to explain these changes. In regards to the *strongly* agree response option, there is a small jump from January 2011 to January 2012 in employees who *strongly* agree that they are paid fairly for the work they do and it remains consistent through January 2013. However, regardless of the slight increase at year 1, a relatively small number of employees responded with *strongly agree* to this dimension.

• **My ideas and suggestions are being considered, as part of the practice's transition to being a patient-centered medical home.** There is a striking decrease in employees who agree that their ideas and suggestions about PCMH are being considered from January 2011 to January 2012 but then a prominent increase occurs by January 2013. In regards to the *strongly* agree option, there is a striking increase in employees who strongly agree that their ideas and suggestions about PCMH are being considered from January 2011 to January 2012 but then it drops back down even lower in January 2013. More insight and suggestions regarding this dimension are included below.

• **I have opportunities to grow in my job.** Across all assessment periods, the majority of employees agree that they have opportunities to grow in their job. However, there's a small increase in employees who *strongly agree* that they have opportunities to grow in their job from January 2011 to January 2012 but then it drops back down by January 2013. These results should be carefully evaluated to determine root causes, as we generally see this dimension increase steadily as a practice is transforming into a patient-centered model. Typically, if a practice begins to implement new workflows and processes in their practice, including giving employees more substantial responsibilities that are more closely related to the direct care of the patient, these numbers will increase. This requires ensuring that all employees are given responsibilities that allow them to work to the top of his/her licensure and ability, which often necessitates a change of mindset for practices.

In order for a practice to successfully transform into a Patient-Centered Medical Home, it is absolutely necessary that the foundation of teamwork, leadership, and communication be established and

continuously improved upon. Although it can seem a basic concept to many practices, we have found it to be an essential component to the success of becoming a fully-functioning practice. One particular low-scoring area from the Nebraska PCMH Employee Satisfaction Surveys is ensuring that each staff member's ideas and suggestions are being considered as part of the practice's transition to becoming a patient-centered medical home. This is one area that the practices can somewhat easily improve upon, by ensuring that they are meeting weekly or monthly to discuss the Patient Centered Medical Home, and how they are going to implement changes in their practice. It will be important that all employees are involved in this process and allowed to give input, as the changes will likely affect everyone in the practice. During any all-staff meetings, or separate workgroup meetings, it will be important to ensure everyone is involved by allocating each person to a specific role or task, while also allowing input and feedback on the process, as they progress. This has been coached upon throughout the project, and the practices should continue to work on this area moving forward. This is an opportunity for what we describe as a "quick win".

Another aspect from the employee surveys that should continue to be improved upon is ensuring that the staff members have opportunities to grow in their jobs. As mentioned above, there are many ways that this can be accomplished, including ensuring that all staff and providers are working to the highest of their license and/or ability. Practices can begin by working through a "roles and responsibilities task list" (this can be found on Delta Exchange), in which the practices determine who is currently completing tasks at this time, how they are being completed, whether that is the most appropriate person and/or workflow to complete that specific task, and what would be the most efficient way to accomplish those tasks in the future. This can also be accomplished through a "Plan Do Study Act" (PDSA), in which the practice's review a task or workflow, attempt to accomplish that task or workflow in a more efficient manner, go back and determine if it was successful and/or if any changes need to be made, and then move forward with the new process.

Provider Survey Results

During the first assessment period, the majority of respondents were physicians, during the second period all respondents were physicians and during the final assessment period it returned to the majority being physicians. Providers at these practices are generally satisfied with the amount of time they spend with patients, and believe they have the tools and resources needed to perform their job. When reviewing the two practice's results in comparison to each other, it appears that Practice B's results are overall slightly more positive that Practice A. Specifically, the "I look forward to coming into work each day" and "I am paid fairly for the work I do" dimensions. This will of course be something that each practice will need to evaluate separately, and determine causes for any fluctuations in these results over time, as well as improvements that can be made, including implementing some of the changes suggested below.

Of concern for both practices is a lack of strong agreement with the following:

• **I look forward to coming to work each day.** There was a steady rise over the three assessment periods in *agree* responses but a steady decrease in *strongly agree* responses during this timeframe. Although this data isn't especially alarming, the obvious goal is that this dimension steadily increases over time. It will be important that the practice take this information and determine possible causes for this, and how it can be improved upon.

• **I am able to practice medicine as I envisioned when I finished my training.** In January 2011 the majority of providers agreed that they were able to practice medicine as they envisioned, but there was a striking decrease by January 2012, followed by an increase in January 2013. The final increase still did not bring the results back to the positive level they were at initially.

We have found that there are several ways that PCMH processes can help to improve provider's work satisfaction, including the same aspects mentioned above regarding ensuring that they are consistently working to the top of their licensure each day in the practice. Because PCMH concepts are centered on the patient, part of that includes the need for providers to spend the necessary time with patients, doing those things that they were trained to do. In order for this to happen, the practices will need to ensure that they have the processes in place to allow staff to complete tasks before and during the visit, that will allow the provider to spend his/her time with the patient in the most beneficial way. This will help free up provider time that was previously spent on paperwork or other tasks that staff are capable of completing. If the practices truly make these substantial changes in the way that they are functioning, they will likely see both staff and provider satisfaction levels increase.

Although we occasionally see staff and provider satisfaction scores decrease towards the middle of a project, as practices are implementing various concepts into their practice and undergoing substantial changes, often times these scores tend to improve as practices become more efficient and comfortable with the new processes. The Nebraska PCMH satisfaction scores are slightly lower at this point than is typical, which indicates the practices are most likely still in that transitory stage, and will need to ensure that they remain focused on their sustainability and growth moving forward. However, the substantially lower percentage of survey participants for the second round of surveys should also be noted, as it could account for a portion of the trend in the data. In order for practice satisfaction to improve overall, PCMH must be fully integrated into the practice, with all staff members consistently involved in the process.

Practice Metrics (Appendix J)

Measurement is fundamental for the management and improvement of many aspects of the typical medical office practice. In order to have a professional approach to the management of office finances, clinical quality and office efficiency, the practice must gather, analyze and act on data. Useful data can be organized into three main categories: financial; clinical performance; and office flow or efficiency. At TransforMED, we believe that the use of data is critical to a practice's future success and therefore should not be considered an optional activity. We have carefully selected a few measures from each of the three categories that offer a snapshot of how well a practice is running and we recommend that systems be established to collect and interpret these metrics on a regular basis and for the long term. Ideally, measurement should be set up to be part of the natural workflow and not a separate activity.

Practice Finances

Management of practice finances is actually the foundation to everything else we are trying to accomplish in the patient centered medical home. Without good financial management a practice will have difficulty fulfilling its primary mission of caring for the patients it serves. Every practice or business unit within a larger practice should have a budget, depicting revenue and expenses which is reviewed monthly. A budget is primarily a forecasting tool that helps practices know if the assumptions they make about income and expenses are on track or need adjustments. When individual line items in the budget are significantly higher or lower than expected, practices should seek to understand why that has happened and take appropriate actions to correct the situation or the assumptions. The alternative is

waiting until the end of the year and finding out they have a big problem when it may be too late to do something about it. They should also be monitoring cash flow and accounts receivable statements on a monthly basis. We suggest that practices use the Medical Group Management Association (MGMA) or other nationally recognized systems of accounting definitions and chart of accounts.

Advanced practices may monitor their financial numbers on a weekly basis and often use rolling 12 month budget presentations to make it easier to understand seasonal variations in income or expenses. If a practice or business unit is part of a larger organization that "does the accounting for them," they should still have direct access to these critical financial metrics on a regular basis because most of the determinants of both revenue and expense are very local. If practices are going to manage their **business**, they must know their numbers. Although we have not included any specific financial data in this report due to confidentiality, the practices have been coached on the importance of this metrics category and have been monitoring this data since the beginning of the project.

Clinical Quality & Performance Measures

In the past, we have assumed that if clinicians were well trained and educated about evidenced-based clinical practice guidelines then the quality of care for every individual within the practice should be fine. The rising demand for objective measures of both cost and quality has clearly made this assumption obsolete. Most clinical practice guidelines for the common chronic illnesses have now been distilled down to a few clinical performance measures for each. Keep in mind that the most important reason to use clinical metrics in the practice is to drive systematic quality improvement which results in better performance. For example, many clinicians are surprised to find that less than half of the patients in the practice with a diagnosis of hypertension have their blood pressure under control. Changes in office procedure such as using a registry or training the care team in patient self-management support techniques has been shown to remarkably improve the percentage of patients whose blood pressure is under control.

The TransforMED team recommends that each practice choose two or three chronic illnesses that are common in the population they serve (e.g. diabetes, asthma, hypertension, coronary artery disease, ADHD or COPD). Optimal care for chronic illness requires the use of a registry to proactively manage all the patients in the practice with that condition.

Some clinical or screening measures are better managed with data from outside of the practice. Keeping track of the percentage of women between 50 and 69 years of age who have had a mammogram within the last two years is actually best monitored by using claims data. This is related to the multiplicity of ways women might come to have this test done. The practice can, however institute practice processes that will optimize that percentage; for example, an automatic query for all women in

the age group about when the last mammography was done, coupled with a standing order to schedule the test. Of course the practice can include data about mammography in their registry or EMR and then use those tools to estimate their rate.

It is very difficult to assess the quality of care that the practice provides to each individual patient. Their assessment is an anecdote or like a clinical study with an "N" of one. The best way to know the quality of care they provide is to average the clinical outcomes of care over a larger number of patients with a similar problem, for instance 200 patients with diabetes. Only then can they know if their "system of care" is effective. At the practice level, this is also what we mean by population management. If they are going to manage their **clinical quality**, they must know their numbers.

As you can see from the comparative data included in the metrics comparison report, the comprehensive average of each clinical measure listed has increased substantially since the beginning of the project. One measure in specific that continuously improved throughout the course of the project is documentation of the percentage of patients age 13 or older who were asked a question on tobacco use during the previous 2 years. As evident from the comparative report, the practices made a deliberate effort to actively acquire and track this information, which has resulted in increased quality of care for a percentage of their patient population.

Based on this data, it appears that both practices have begun improving the management of their patient population by pulling baseline data on various clinical measures, setting improvement goals by updating and streamlining their processes and procedures, and then going back to continuously measure and track their effectiveness. These are trends that we typically see as a practice implements a more patient-centered approach in their practice. Clinical quality measures can be improved with a teamwork methodology, which includes providers and staff working together to ensure they are taking a more proactive approach to patient care. The increasing quality metrics in each practice is verification that the practices have started doing this, which is a large success of the project. However, as mentioned several times to the practices, this and other PCMH items will need to be continuously sustained and improved upon moving forward. This will include ensuring that they have the most efficient workflows in place to accomplish their quality goals, to make certain these do not become temporary endeavors.

******One important aspect to note regarding the Nebraska Medicaid practice's metrics data is the fact that each practice did not submit conclusive metrics information each time TransforMED requested. Although they might have submitted their spreadsheets during each requested assessment period (Baseline, Year 1, and Year 2), there were many measures that Practice A was unable to provide during those reporting periods. For this reason, it is strongly suggested that this data be reviewed via the individual practice comparison reports, which show the practice's individual data, with a comparison of each quarter. These individualized reports show which exact measures the practices were able to report on during each period, which also gives a better indication of the realistic trends in the data. The first and sometimes biggest step for practices to improve their quality measures is to determine how they will obtain this data, and then integrate a workflow to continuously track this data. During the beginning of a PCMH project, the practices must determine how, when, and what data to pull and track. This likely explains the lack of metrics information we received from the practice's at the beginning of the project.

In addition, by reviewing the reports separately, it's evident that although both practices have improved most all of their measures since the beginning of the project, they are also really focusing their efforts

on different clinical measures. For example, Practice A has drastically improved their BMI, HBa1C control, LDL control, and BP control; while Practice B has drastically improved their breast cancer screening and tobacco use documentation.

Office Efficiency & Work Flow

Quality improvement is really just about using measurement to monitor how things are working and to be able to tell if changes the practice has made actually result in an improvement in how they work. Measures used for evaluating work flow and efficiency may not need to be rigorously evidence-based or risk adjusted and they may only be required for a relatively short period of time to test if a change is an improvement.

Satisfaction surveys provide a nice example of using periodic measurement for improvement. Many patient centered medical home projects and payment models require patient satisfaction monitoring activities. In order to keep the work of satisfaction surveys manageable, the TransforMED team recommends that practices establish a sampling routine. For example, they might distribute patient satisfaction surveys to every patient who comes through the office during one or two weeks and commit to doing this once per quarter. They might gain valuable insights from surveying physicians and staff on a similar schedule. The Nebraska PCMH practices have conducted these surveys using the TransforMED Patient Experience Assessment Tool (PEAT), which we will discuss in more detail later in this report. Another measure known as “cycle time” is useful to measure on a periodic basis because it turns out to be a proxy for overall office efficiency. The cycle time is simply the average length of time from when a patient comes in the front door until they exit that door. Once again, measuring cycle time for one week quarterly may be all that is needed.

Implementing a new process within the office may require measurement during the start-up phase. Open access scheduling has been shown to improve patient satisfaction, reduce “no show” rates and minimize the work required to manage a large inventory of scheduled appointments. During the conversion to open access, the practices may want to measure and monitor the percentage of appointments that are open at the start of each day of the week. Other measures such as the “third next available appointment” have also been useful for this work. Once the new system is in place, periodic measurement would be wise to be sure they maintain the level of access required for their patient population.

PEAT Year 2 Analysis

The practices were asked to administer the Patient Experience Assessment Tool in their practice(s) three separate times throughout the project. During each period, the practices collected the PEAT over an approximately three month time frame. The PEAT was collected via the paper method, and we received a great response rate from both practices. During the first round of the PEAT, we received 2552 total surveys, the second round 2226 surveys, and the third round 1766 surveys. The percentage of Medicaid surveys increased during the first round from 41%, to 51% in the second round, and 41% in the third round. The data reported back looks at all patients in practice.

The data trends for each practice are fairly consistent with what we see especially when looking at the shift in each practice's data per survey item from baseline, to Year 1, to Year 2. However, the practices overall averages for each measure are just slightly lower than the comparison group of other practices undergoing PCMH transformation.

- Practice A data has gone down for 4 of 20 items since the previous round at Year 1, and has gone up 6 of 20 items. The other items remained constant. Practice B has had a decrease for 7 of 20 items, and an increase of 7 of 20 items. The others remained constant. – Although there is a decrease in some data points, this is not cause for concern because decreased amount is not of statistical significance/very minimal decrease (.01 - .02).
- Decrease in data over first year of project is typical as a result of patient education in the type of care that should be receiving in the practice – education and awareness of patient centered care and approach in practice. However, by the end of Year 2, we typically see this data slightly increase as the practices progress further along in the process and begin addressing the low-scoring areas on their previous survey results.

- Recommendations for the practices:
    - Review with the team.
    - Consider where data has decreased BUT more importantly data points below the 80% threshold/"best practice" line. For both practices, those survey items that were below the 80%/4 threshold are still around this area and should remain areas of focus and discussion when reviewing data.
    - Best practice: review data with practice as a whole and then Physician/provider team to assess data to see who is receiving above 80% and initiate discussion around what he/she might be doing differently.
- In terms of the 6 PCMH dimensions
    - Similar trend with very slight increase in data on the PCMH dimensions. All data has minimally increased or remained the same.
    - Overall, nothing substantially alarming about the data – most surprising is that there was such a minimal change in a two year period. Practice should continue to work on patient engagement in their care, self management, activating the patient as a member of the team.

The goal for practices moving forward should be to see a positive increase in data as patient engagement in their care should continue again.

The most important thing for practices to do with the data is sit down as a practice team and look at their overall data in comparison to individual provider data and learn from those “best practices” where providers have the higher data points.

Outcomes

Unfortunately, but not at all unusual, the hospitals were not able to provide data regarding the utilization of the emergency room services, or hospital admission or readmission rates. Therefore the reduction in costs for these services was not readily available. Both practices have attempted and continue to work with the hospital administrations to have access to this data.

Also unfortunate, was the inability to retrieve data from any of the commercial carriers which also precluded the practices to prove the reduction in hospital services or overall Total Cost of Care (TCOC).

The State provided reports on their Medicaid patients created from claims data which reflected a very impressive TCOC or Total Expenditures PMPM reduction of 33.6% when comparing the only two complete quarters of data, first quarter of 2010 to the first quarter of 2012. A decision on which data provides your baseline is important to identify going forward.

Ongoing review of data will be important to analyze TCOC on an ongoing basis. Recommendations for continued efforts with hospital administrations were discussed, knowing the increased importance of monitoring the readmission rates from a hospital administrative perspective should enhance the ability to retrieve that data at the practice level.

Hopefully the reports from the State will be available by the contract end date and will provide positive outcomes in the area they have monitored.

Plan for Sustainability

The key areas for ensuring sustainability of the enhanced primary care model are:

- Empaneled patients have access to their care team when necessary
- Patient engagement in their own healthcare, education of their responsibility as a team member
- Ongoing communication and relationships with key stakeholders in the community to provide coordination of care for the patient across all care settings
- 24 hour a day, 7 day a week access to the patient record
- Risk stratification of patient population
- Integrated population management of patients for improved quality of care

During the final site visit in July, I provided both practices with Dashboards delineating metrics that they should integrate into their monthly, quarterly and annual reporting. There are measures around Team Based Care, Access, Care Management, Care Coordination, Quality and Safety, and Practice Management that will create a monitoring mechanism for sustainability. (Appendix L - Dashboards).

If Kearney Clinic and Plum Creek continue the integration of the processes with the care team and create protocol for monitoring the metrics from reports suggested on the dashboards around each area, the continued improvement of care to patients, increased quality of care and reduction of cost of care will be eminent. The learning organizations that both Kearney Clinic and Plum Creek have matured into, understand the importance of Measurement… Improvement… Measurement.

I want to once again thank the State of Nebraska Division of Health and Human Services for the opportunity to work together toward the common goal of improving healthcare throughout the State of Nebraska. These practices are certainly privileged to have had the additional resources you so strategically provided to them. It was very apparent that the Nebraska Council was extremely educated and knowledgeable about Patient Centered Medical Home transformation. The results have been tremendous and for me this has been an exemplary project with which to be associated.

Thank you all from the entire TransforMED team that has been working in the background of this project.

Sincerely,

Colleen Stack

Nebraska Medicaid PCMH Questionnaire

Congratulations on being a finalist in the Nebraska Medicaid Patient Centered Medical Home (PCMH) Pilot program. In order to make a final selection, we need more information to supplement the application your practice has already made for the project. A summary of this information will be shared with Nebraska Medicaid Program for final selection. Individual responses will be kept confidential.

When filling out this application, practices should use the following guide:
• Please answer all questions
• This application may take up to a half hour to complete.

Please complete each question that follows - and thanks in advance for your time and attention.

*** 1. Practice Name**

2. Rank the following factors according to the difficulty you would encounter if you were to make changes related to becoming a Medical Home.

	1 = Least Difficult	2	3	4	5	6	7 = Most Difficult
Time	◯	◯	◯	◯	◯	◯	◯
Funding	◯	◯	◯	◯	◯	◯	◯
Information Technology Systems	◯	◯	◯	◯	◯	◯	◯
Organizational Systems	◯	◯	◯	◯	◯	◯	◯
Staff	◯	◯	◯	◯	◯	◯	◯
Resources	◯	◯	◯	◯	◯	◯	◯
Space Limitations	◯	◯	◯	◯	◯	◯	◯
Schedule	◯	◯	◯	◯	◯	◯	◯

Other (please specify)

3. If you have a registry system, what reports do you review from this system (check all that apply).

- ☐ We Do Not Have a Registry
- ☐ Chronic Disease Outcomes (HbA1C, blood pressure, etc.)
- ☐ Preventive Medicine Outcomes (Mammograms, Colon Cancer Screening, etc.)
- ☐ Point of Care Reminders
- ☐ Other (please specify)

Nebraska Medicaid PCMH Questionnaire

4. Who in your practice has been involved in making the decision to apply, and how was it decided to apply?

5. What percentage of the practice's physicians favor participation in the PCMH Pilot?

6. What do you anticipate will be the most difficult challenge your practice will have in implementing the Patient Centered Medical Home model?

7. Why do you think your practice will be successful in becoming a PCMH?

8. What benefit do you hope to gain by participating in the PCMH pilot?

9. Describe a recent change effort in your practice. What worked and what did not?

10. What is the status of each of the following PCMH elements in your practice.

	Not Started	Discussions, but No Action	Implementation Started	Implementation Complete	Do Not Know
Access to Care	◯	◯	◯	◯	◯
Access to Information	◯	◯	◯	◯	◯
Practice-Based Services	◯	◯	◯	◯	◯
Care Management	◯	◯	◯	◯	◯
Care Coordination	◯	◯	◯	◯	◯
Practice-Based Care Team	◯	◯	◯	◯	◯
Practice Management	◯	◯	◯	◯	◯
Health Information Technology	◯	◯	◯	◯	◯
Quality & Safety	◯	◯	◯	◯	◯
Patient Centeredness	◯	◯	◯	◯	◯

Nebraska Medicaid PCMH Questionnaire

11. Rank the following elements of the medical home according to the challenges you would encounter if you were to implement and/or improve them in your practice.

	1 = Least Difficult	2	3	4	5	6	7 = Most Difficult	Do Not Know
Access to Care	◯	◯	◯	◯	◯	◯	◯	◯
Access to Information	◯	◯	◯	◯	◯	◯	◯	◯
Practice-Based Services	◯	◯	◯	◯	◯	◯	◯	◯
Care Management	◯	◯	◯	◯	◯	◯	◯	◯
Care Coordination	◯	◯	◯	◯	◯	◯	◯	◯
Practice-Based Care Team	◯	◯	◯	◯	◯	◯	◯	◯
Practice Management	◯	◯	◯	◯	◯	◯	◯	◯
Health Information Technology	◯	◯	◯	◯	◯	◯	◯	◯
Quality & Safety	◯	◯	◯	◯	◯	◯	◯	◯
Patient Centeredness	◯	◯	◯	◯	◯	◯	◯	◯

Other (please specify)

12. When change is implemented in your practice, is it evaluated, and corrections made accordingly (on an ongoing basis)? Please describe.

13. Are major practice changes maintained once they are successfully implemented? Please explain.

14. Practice members understand how their roles support the mission of the practice, and providing care to patients.

◯ Yes

◯ No

Comments:

15. Who is a on your leadership team?

16. Describe the leadership style that is demonstrated in your practice.

17. Which of the following communication methods are used in your practice (check all that apply):

- [ ] Suggestion Box
- [ ] Internal Email
- [ ] Staff Meetings
- [ ] Department Meetings
- [ ] Newsletter
- [ ] Other (please specify)

Recommendations on Nebraska Medicaid PCMH finalists

Selection of the appropriate practices is the first step for ensuring a successful pilot project. We at TransforMED appreciate the opportunity to make recommendations on the finalists that were chosen by the State of Nebraska.

In the process of making our recommendation, many factors were considered and the following analysis of the five practices was performed. In addition to the initial application, a second survey was given to each practice by TransforMED that further explored the practice's teamwork, leadership, communication and change management abilities. From each individual practice analysis, we determined the strengths of that particular practice that could drive a successful change process as well as the opportunities that might present challenges and more positive outcomes during the transformation. Opportunities can often be a significant driver for change and result in a tremendous success for the practice and the pilot. From the strengths and opportunities, an overall impression of the practice was formed. This, in addition to the size and location of the practice, helped determine our ranking and recommendations.

The timeframe for completion of the Tier 1 minimum standards for the medical home pilot, it becomes imperative that teamwork, leadership and communication are intact and capable of transformation.

Analysis of each practice

Community Action Partnership of Western Nebraska Health Center

Providers - 1 Family Practice, 4 PA, 3 residents

Location – Gering, Nebraska (West central)

Strengths:

- The decision to apply to the pilot involved members of administrative and physician staff with approval by the CAPWN board and involved numerous discussions. The decision making process is inclusive of various members of the team.
- No opposition among physicians of the PCMH concept and subsequent discussion followed of what may need to change. The current leadership team is diversified.

- Being an FQHC, the practice has been implementing parts of PCMH with clinical outcome analysis, access, and care coordination.
- Previous change efforts have included planning, implementation and evaluation of results.
- Practice's analysis of the most difficult PCMH modules to implement – care management and HIT.

Opportunities:

- Stated challenges were overall practice understanding of the concept as a worthwhile change and having time to plan for changes.
- The timing is consistent with the implementation of a new practice management and EMR.
- Funding is the number one difficulty identified.

Impression:

Based on the information that was provided, this practice would have some key elements of teamwork, leadership and communication already in place with a philosophical understanding of what PCMH will provide for their practice. They have undergone change successfully and all physicians are engaged in the process. The size is small with the opportunity to work and engage residents.

Grand Island Clinic

Providers - 5 Pediatric, 5 Family Practice, 1 Internal Medicine

Location – Grand Island (Southeast)

Strengths:

- The practice has a combination of pediatric, internal medicine and family practice physicians
- Large sole provider of Medicaid pediatrics population in community.
- Stated culturally diverse community.

Opportunities:

- Although this practice appears to have a strong physician champion who led the discussion and vote regarding applying for this pilot, most physicians are not in favor of participation.
- Time, funding and staffing were the difficulties identified.
- Developing a written care plan was a challenge identified by the practice.
- Identified benefit of the PCMH pilot was preparation for meaningful use.
- This practice feels it is providing most of the services currently and just needs formal written policies.
- Last change initiative was the EMR. It was stated that the change was difficult for physicians but staff adapted well.

- The practice feels they have completed work on access, care coordination and HIT. They feel the most difficult will be team based care and care management.
- Leadership team is defined by the physician owners.

Impression:

There seems to be many opportunities with this practice and the true meaning of PCMH and this pilot seems to be lost. The answers contradict the report that the practice has completed work in the PCMH modules as stated. Teamwork, leadership and communication would be a starting point for this practice and may take a significant amount of time at the front end of the project. The challenge of taking on a practice with these many identified challenges is physician engagement and the ability to effect change quick enough for the identified timeline. The payoff would be tremendous if the practice makes the transformation.

Kearney Clinic P.C.

Providers - 11 Family Practice, 8 Pediatric, 1 NP

Location – Kearney (Southeast)

Strengths:

- Decision making is by the physicians as a group with 90% favoring participation.
- Largest clinic and sole provider of pediatric services in Kearney.
- Several key PCMH components have been implemented:
    - Access includes Saturday and Sunday hours along with an Urgent Care
    - Clinical outcomes are monitored with a registry tool
    - Mental health is offered onsite.
- Past changes have been evaluated and input has been sought by direct users before processes are fine-tuned.
- Leadership team is diverse and inclusive of all departments.
- Stated understanding of the overall philosophy of PCMH.

Opportunities:

- Stated challenges are patient education and compliance.
- Practice states they have fully implemented access and practice based team care. However, they state that practice based team care will be the biggest challenge of this project.
- Past recent minor change in the practice was overwhelming but now staff can see the benefit.
- Time and staffing were the difficulties identified.

Impression:

This practice appears to have a good leadership, teamwork and communication philosophy and makes decisions well. They seem realistic in their assessment of their needs and what they want from the pilot program. They have begun work on PCMH in some areas. They have physician engagement and a good decision making process. Recent changes have not gone as well as expected and this will be a great opportunity to improve the change process.

Plum Creek Medical Group P.C.

Providers - 7 family practice

Location – Lexington (South central)

Strengths:

- EMR is in place with registry functions.
- This practice is part of the Blue Cross Medical Home for Diabetes program, currently working with BC on other programs involving health care outcomes.
- Stated understanding of PMCH components and philosophy.
- Decision to participate made inclusively by management and providers. 100% of providers favor participation.
- Recent successful changes have included Involving employees, planning and communication throughout the change.
- Leadership team is a diverse team covering all disciplines.

Opportunities:

- Started implementation of access, care management, patient centeredness. They feel that access and care coordination are the most difficult.
- Change is directed from the top and the ways to implement are developed by the employees.
- Stated challenges are time and knowing what to do.
- Time, schedule and staff were difficulties identified.

Impression:

This practice has been successful by using leadership, teamwork, and communication. Change is directed from the top and this could be an opportunity to improve their change management skills. They understand the PCMH process and have been participating in clinical outcome analysis and several other PCMH modules. It appears they are looking for direction on putting it all together.

Regional West Physicians Clinic - possibly in conjunction with CAPWN

Providers - 13 Family Practice, 7 Internal Medicine, 3 Pediatric, 4 PAs, 3 NPs

Location – Scottsbluff (West central)

3 possible individual sites among the 30 providers

1) 7 IM, 9 FP, 4 midlevel in Scottsbluff
2) 4 peds in Scottsbluff
3) 4 FP in Gering

Strengths:

- The decision to participate was made by the physicians with no opposition and made in conjunction with CAPWM.
- Practice has been working on becoming a PCMH prior to working on this project.
- Stated understanding of the PCMH philosophy.
- Recent change to an Independent Delivery System involved a 3 year development plan and was very successful by involving and engaging physicians in governance and operations including evaluation of efforts.
- Leadership team includes physicians, clinic and hospital administration. Leadership style is open and collaborative.

Opportunities:

- Minimal action on access and patient centeredness. Some initial action on care management, care coordination, and team based care.
- Stated most difficult in moving forward would be hardwiring the behavioral changes.
- Challenges are access to information, practice based team care and HIT.
- Information technology and funding were difficulties identified in moving forward with the pilot.

Impression:

This practice is 3 sites instead of one. Teamwork, leadership and communication are strong and they have successfully weathered a significant change. They seem to understand the challenges and philosophy of PCMH and have physician engagement.

Overall recommendation

After completing the analysis, we are recommending the following ranking of the practices to be considered for the PCMH pilot:

1. Plum Creek Medical Group
2. Kearney Clinic
3. 4. 5. Regional West – three sites
6. CAPWM

7. Grand Island Clinic

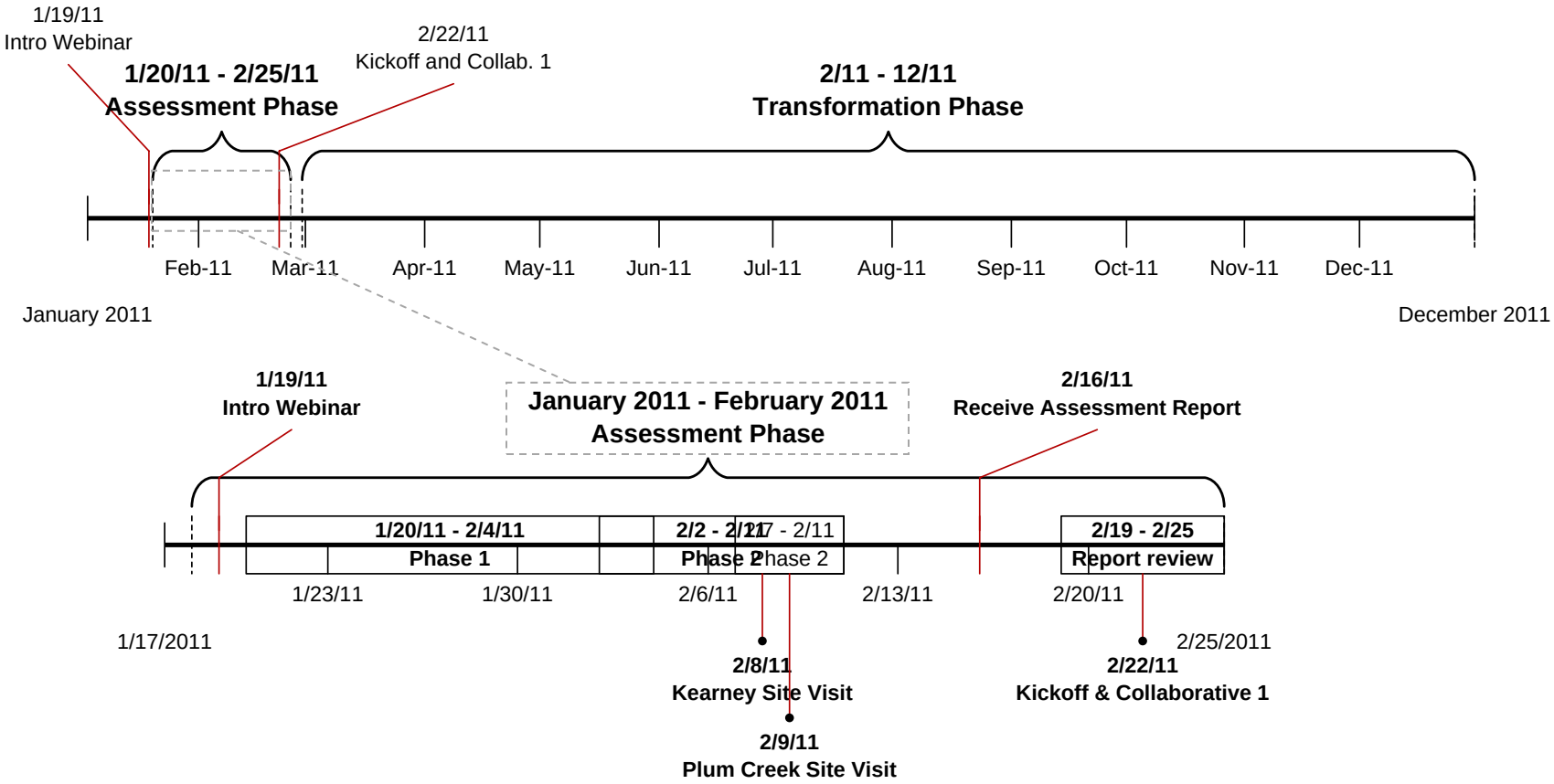
Physician breakdown

	Total physicians / midlevel providers / residents	FP	IM	Peds	Midlevel providers	Residents
Top 2						
Plum Creek	7	7				
Kearney	19 + 1	11		8	1	
Total phys	**26**	**18**		**8**	**1**	
Top 3,4,5						
Regional 1	16 + 1	9	7		4	
Regional 2	4			4		
Regional 3	4	4				
Total phys	24 + 26 = **50**	**31**	**7**	**12**	**8**	
Top 6						
CAPWM	1 + 4 + 3	1			4	3
Total phys	50 + 1 = **51**	**32**	**7**	**12**	**12**	**3**

Respectfully submitted,

Sheila Richmeier, MS, RN, FACMPE, Director of Practice Transformation

Colleen Stack, Practice Enhancement Facilitator


1/19/11
Intro Webinar
2/22/11
Kickoff and Collab. 1
1/20/11 - 2/25/11
Assessment Phase
2/11 - 12/11
Transformation Phase
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
January 2011
December 2011
1/19/11
Intro Webinar
January 2011 - February 2011
Assessment Phase
2/16/11
Receive Assessment Report
1/20/11 - 2/4/11
Phase 1
2/19 - 2/25
Report review
1/23/11
1/30/11
2/6/11
2/13/11
2/20/11
1/17/2011
2/25/2011
2/8/11
Kearney Site Visit
2/22/11
Kickoff & Collaborative 1
2/9/11
Plum Creek Site Visit

TransforMED℠
TRANSFORMING MEDICAL PRACTICES

Patient Centered Medical Home Practice Assessment Practice A

Report prepared: February 2011

TransforMED℠
TRANSFORMING MEDICAL PRACTICES

Table of Contents

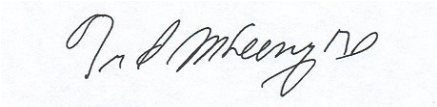
Dear Leadership Team,

On behalf of the entire patient-centered medical home (PCMH) team, we would like to congratulate you and the members of your practice as you formalize your efforts to transform your practice. The journey you are undertaking will be both challenging and rewarding.

The enclosed report establishes baseline information from which you can begin to plan future strategies for your practice's transformation to a PCMH. Highlighted in the report are the current strengths of your practice as well as those areas where opportunity exists to enhance services and practice processes. We are prepared to assist you and your practice every step of the way.

Our mission is the transformation of healthcare delivery to achieve optimal patient care, professional satisfaction, and success of primary care practices. We look forward to working with you.

Sincerely,



Terry L. McGeeney, MD, MBA, FAAFP
President and CEO
TransforMED

Executive Summary

Dear Practice Leadership Team:

On behalf of our PCMH team, we want to thank you for the opportunity to work with your practice team and to provide this report for Practice A. TransforMED has been contracted to provide the following:

- Full facilitation for transformation to a Medical Home
  - Base-line assessment
    - Access to care and information
    - Care management
    - Care Coordination (Continuity of care services)
    - Practice based care team
    - Quality and safety
    - Practice management and financial review
    - Change readiness checklist
  - Collaboration with the practice to develop a process to implement elements of the Medical Home
  - Patient engagement assessment twice over a one year time frame
  - Monitoring of real time progress, setting goals, and offering solutions geared toward improving the value of the practice
  - Learning Collaboratives
- Collaborating with the State of Nebraska to ensure practices meet State designated Patient Centered Medical Home (PCMH) Standards within the first six months of the project

This assessment report will provide important information about where the practice stands in relation to the patient centered model of care.

Assessment Process

The assessment process involves several types of data collection. These include self-reporting, surveying, interviews with key staff and providers, and onsite observations. TransforMED began work with Practice A in January 2011.

Report Organization

The following report is organized around the Patient Centered Care Model. We note some key strengths and opportunities for Practice A. A quick overview of the Strengths we noted in our working with the practice highlight Patient Centered Care, Practice –Based Care Team and Practice-Based Services. These will provide an excellent basis for transformation. The Opportunities for Growth are areas that will clearly define and expand the practice capabilities in moving forward.

Strengths at Practice A

Patient centered care begins with a culture that values the primary care provider (PCP)-patient relationship. The presence of this relationship at Practice A provides a strong foundation to further develop the patient centered care model. Active engagement of the patient as a member of the team through effective communication and a consistent message by all team members will be important.

Practice based services are extensive at Practice A, and the patients are well informed about the availability and accessibility of care provided. They are educated to utilize Practice A, as well as Practice A Urgent Care, therefore overutilization of the Emergency Room is well controlled.

All parties at the clinic displayed a strong sense of kindness and attentiveness toward patients and with each other. We found the Practice Manager to be organized, to be an effective communicator, and to possess the necessary skills to lead the Practice through this process; we found the Physician leader engaged in the PCMH discussions and committed/enthusiastic about beginning the process. Unfortunately we were not able to interact with most physicians and we hope to have them participate in the future activities and learning collaboratives. It is important for all members to be engaged in the process of change and especially critical for the physician leaders to maintain a positive outlook with regard to the project.

Opportunities at Practice A

Team based care using all members to the top of their ability is best accomplished with defined processes and written protocols/guidelines that staff members can use to provide appropriate care in a timely manner. Moving to a culture of team based care involves strong leadership that guides the process of creating consistency across the practice. This consistency in frequently performed processes is important for efficient use of team members that complements the unique PCP-patient-team relationship. Practice A physicians vary in their use of nursing staff, which creates problems for cross training and impedes the ability to perform at the top of one's licensure. Standardization of the processes such as medication reconciliation would create time efficiencies and prescribing accuracies at Practice A.

Effective care coordination is closely tied to efficient healthcare. Efficient communication with consulting physicians and facilities used by patients of the practice can result in a decrease in duplication of care and unnecessary usage. This can be accomplished by identifying frequently used consulting physicians, hospitals and community resources. Effective relationships for all can be facilitated with discussions, negotiations and written agreements that define roles, methods of communication and follow-up that ensures all who provide care have accurate information at the time of the patient interaction.

Care management requires comprehensive, consistent access to each patient's complete medical record. Standardization of required documentation through formatting processes

ensures necessary information is reported on every patient, every time. Completion of required documentation ensures the health record contains all current information. Systems must be put in place to ensure all available medical records are included in the chart. Paper charts and the use of outguides complicate collation but policies must address the necessity of all-inclusive medical records.

Care management and care coordination processes are closely affiliated with improved quality and efficiency. Use of evidence based care measures by all team members at the point of care is a key efficiency in reaching and sustaining quality care.
Financial implications and return on investment (ROI) must be considered with all activities during the PCMH transformation process. Financial sustainability through primary care reimbursement that is based on quality and efficiency and less on volume will be important to the future of the role of primary care in the healthcare system. Use of practice based quality reports and data should be an integral part of driving a reimbursement system that supports a patient centered model of care.

Preparing for Change

From the experience of TransforMED facilitators there are several elements that should be discussed in implementation of the recommendations put forth in this report. These elements include three keys for success to prepare the practice to manage forthcoming changes. In our experience, leadership, teamwork and communication provide the foundation for successful change initiatives. Without these elements in place, the practice will have difficulty managing project implementation success, team dynamics, and conflict.

Effective, sustainable change must be managed and takes time! Practice members will experience many successes and challenges along the way. Caution should be exercised by the practice leaders and the team neither to become too discouraged with challenges and setbacks nor to become too confident with early successes. As the changes are implemented there will be ups and downs along the way. Developing resilience and commitment to the long range goals will sustain practice members through the process. In addition, what they will learn from their experiences will allow them to provide guidance and information to patients (who will also be impacted by the changes).

Thank you for the opportunity to partner with you in this effort.

Colleen Stack
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913-906-6321

Megan Rackish
Project Manager
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913-906-6349

Patient Centered Care Assessment

The following segment of the report provides a summary of Strengths and Opportunities for your practice. These are organized around the nine components of the TransforMED Patient-Centered Model: Patient Centeredness, Access to Care and Information, Practice-Based Services, Care Management, Care Coordination, Practice-Based Care Team, Quality & Safety, Health Information Technology, and Practice Management.

Patient Centered Care

A continuous patient-care team relationship is foundational to effective whole person care. Mutual trust and respect serve as catalysts to shared decision-making and motivate the patient to consistently seek front line care from the medical home. The Patient Centered Care module addresses:

- Mindful clinician-patient communication
- Patient engagement
- Delivery of care sensitive to diverse populations
- Processes that identify barriers to a patient's ability to successfully pursue a course of treatment
- Patient rights and responsibilities
- A continuous relationship between the patient and the care team

Strengths

- Practice A sees a large volume of patients of Hispanic origin and other ethnicities. Whereas this could be a complication as some practices, Practice A has implemented translators in key areas. In addition, there is an effective process in place for interpreters to be available "on call" via the handheld phone system.
- During patient paths, it was evident that Physicians and team members at the practice have good rapport with the patients. The majority of nurses and doctors were able to interact easily with the patients not only discussing medical matters, but all personal information.
- Wait time for patients seems to be minimal. The process of getting patients back to the lab and over to the waiting room is expeditious. The only exception is patients in some cases may wait in the exam room while their lab results are being processed.
- Practice A provides materials to the patient including a patient packet, information for new/expecting Moms and families, etc. This information includes the Mission and Vision of the clinic.

Opportunities

- The practice does not identify and track a Primary Care Provider for all patients in the practice, but patients see their preferred Provider 51-75% of the time.
- At this point in time, there have not been any meetings with the Physician and Clinical team regarding how to involve patients more directly in their care. This specifically refers to involvement in joint decision making and motivation to be involved in care.
- Practice A is not providing written care plans to patients following their visit. The practice might consider a method to provide back information discussed in the appointment as this will help to engage and involve patients more in their care.

- Approximately 280 – 600 patients cycle through Practice A on a daily basis and Physicians see anywhere from 20-60 patients per day. Although this promotes open access for all, there is a potential concern around spending quality time with each patient and actually operating like a primary care practice versus solely an urgent care clinic. It was observed that some physicians spend time with patients and have an established relationship, but in some cases it seemed moving the patients through the practice took priority over establishing and building the patient relationship.

Access to Care & Information

Access to care and accurate, up-to-date health care information are critical to the patient's sense of having partnered with a provider. Readily available appointments, test results, and information prepare the patient to proactively pursue and maintain good health. This Patient Centered Medical Home (PCMH) module encompasses:

- Ensuring timely delivery of care
- Access to information
- Alternatives to conventional office visits
- Same day access
- Policies and processes related to the availability of appointments and information

Strengths

- Access to Care is optimal at Practice A as the clinic is open 7 days a week with extended hours all weekdays from 6:00 – 8:00. In addition, the practice opened the Urgent Care portion of the practice approximately 10 years ago which gives patients access to the practice on Saturday and Sunday for a portion of the day.
- It is estimated that approximately 50% of the patient visits are those that walk-into the clinic without a scheduled appointment. Practice A does not ever turn patients away from the clinic who have walked in for an appointment. .
- The Urgent Care side of the practice is open to patients on weekends with Physicians rotating through on call at the clinic.
- A follow up procedure is in place for no-show patients and this process is tracked.
- Since the urgent care has been implemented and the practice sees high volumes of walk-ins, patients know to come to the practice over the ER. It has been stated that this has reduced patient hospitalizations and ER visits.

Opportunities

- With regard to scheduling patients, there is not a standard appointment type or length across the board for all providers. Appointment types and lengths vary drastically by provider. The scheduling process seems fairly complex and the clinic should consider simplifying, standardizing and coming to consensus among providers in order to improve the scheduling process.
- As the practice takes many walk-ins, some complications arise with duplicate tickets being created.
- Certain Physicians at the practice are not accepting new patients.
- Panel size is unknown for all providers. There's an estimate as to how many patients are seen by each provider, but this includes duplicate appointments. It is critical to know what providers are over-paneled as well as those who can take on new patients.
- The practice has some written procedures in place around access. For example, in the scheduling software, each Provider has specific rules recorded around scheduling.

Although, these are written, it would be a good idea to revisit these procedures and come up with a standardized set of access procedures for all Providers.
- Practice A does not have designated open appointment slots for same day patients or walk-ins. Although most provider schedules have available slots and walk-ins are always seen, it would be helpful to consider holding a certain percentage of slots open on all provider schedules.
- The practice does double book and when double booking, the front office team has to check with the clinical team or Physician about 25% as to whether they can schedule a certain appointment or double book. This creates inefficiency, with needing to call back and ask instead of having a standardized scheduling process.

Practice Services

An important component of the medical home is the availability—on site or through targeted referrals—of a comprehensive ranges of diagnostic, therapeutic, and support services. By administering point of care services effectively the practice offers quality patient care while responsibly managing its finances. The following categories of services are addressed in this module:

- Acute care
- Chronic care
- Wellness promotion
- Procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Strengths

- Practice A's lab is estimated to be larger than area hospital labs, offering a full range of services to patients while in the clinic.
- Lab results are provided back to patients at the time of visit. At time of arrival for the visit, the patient checks in with the front desk and is then directed back to the lab if needed. Patients are seen quickly and labs are conducted. Results are then provided by the doctor during the appointment. This provides a great opportunity for patients to discuss both positive and negative results with their doctor at the time of visit. In addition, this enhances efficiency at the practice because phone calls to the patient after the visit are not needed.
- Lab results can be picked up easily once available as they print directly to the designated "pod" in the practice. This is an efficiency that was implemented by the IT Team.
- The clinic offers an array of procedures including minor dermatological procedures, laceration repair, fracture management, colopscopy, vasectomy, joint injections, punch biopsy, IUDs, trigger point injections, casting, circumcision, and breast biopsy.
- All Providers at Practice A are able to perform EKGs, pulmonary function/spirometry, lab and x-ray.
- Other services available onsite include behavioral health, an onsite pharmacy, counseling, diabetic education, wound care, a Pediatric heart clinic 4 times a year, and Pediatric Genetic clinic 4 times per year. The team thinks of Practice A as a "one stop shop" for all patient care needs.

Opportunities

- Patients remain in the lobby until all labs are completed which may require somewhat longer wait time for patients, but would allow the provider to have complete information for the visit and any necessary medication adjustments prior to the patient's departure.

Care Management

Systematically reviewing and planning on behalf of patient populations generates outcomes that cannot be accomplished solely through an episodic approach. Ideally, care management should occur within the context of an ongoing relationship between patient and provider and should involve multiple members of the practice-based care team. In the Care Management module the following capabilities are addressed:

- The ability of the practice to promote wellness and disease prevention in a targeted fashion
- The proactive management of chronic diseases and patient populations using evidence-based outcomes
- Consistent practice-wide coordination of care
- Patient engagement and education

Strengths

- Practice A has hired and will begin implementing the role of a Care Manager in the practice.
- The clinic is using evidence based guidelines for Preventive care, chronic care, and various designated associations such as American Cancer Society, American Heart Association, etc.
- Written protocols are in place for screening, prevention and chronic disease. These protocols can be used by RN/LPN, MA, and clinical administrative staff.

Opportunities

- Currently Practice A is not able to report on clinical outcomes. In addition, reports on certain clinical measures cannot be run in the practice.
- There is not s system or flag in place that prompts the provider at the time of service to provide evidence based care.
- Develop the role of care manager and role of the practice in care management

Care Coordination

Care Coordination speaks to the extension of the patient care team beyond the walls of the practice. Deliberately crafted relationships with a network of health and wellness professionals help ensure that the practice remains well informed when a portion of the patient's care is provided elsewhere. The Care Coordination module encompasses:

- Coordination of care with other providers
- Integration of services
- Collaborative relationships with hospitals, behavioral health, maternity, specialists, community-based services, etc.
- Timely exchange of information
- Plans for after-hours coverage
- Tracking of lab and imaging tests

Strengths

- Practice A utilizes community based services for their patients such as public health clinics, education resources, support groups**,** behavioral health, and state immunization records.

- The clinic is able to access hospital records in particular patient care reports. Also, through Sentinel, the practice has Medication Access for patients and is able to view UNK Student Health.
- In addition to rotating in the practice's urgent care clinic, the Providers actively participate in providing hospital services.
- Although the practice does not always receive information for specialists in a timely manner, and in some cases has difficulty providing information to referring practices, there is a process in place to communicate with specialists via letters for lab information, phone calls, the dictated records, x-rays taken in the clinic, etc.

Opportunities

- In some cases, the hospital or specialists request information that is needed quickly from the practice, but the Physician may not have yet signed off on the dictation. The result is inefficiencies in getting the necessary information over to other groups because the medical records team then needs to go sift through charts to get the information.
- The practice gets much information from the hospital, but they do not currently get information on Emergency Room visits.
- It is difficult for the medical records team to understand certain information when there is a vague reference to something that is a hard copy in the chart, for example "see form in chart". About 10-20% of the time, the team will have to go pull the chart in order to determine what was being referenced. The Clinical team and Physicians could consider implementing a process to ensure they are referencing the correct/complete form name that is recognizable and searchable to all parties. This may be improved as a template is implemented into the Word Client process.
- At this time the clinic does not use a designated set of specialists.
- There is not a mechanism in place to track patients sent to the ER or referred to specialists.

Practice Based Care Team

Efficient team work serves as the foundation for the medical home by freeing collective energies to be focused on the patient and his/her well-being. An effective team is characterized by the following elements:

- Leadership monitors the pulse of staff as an indicator of whether they (leadership) are effectively modeling the desired practice culture.
- Team members feel comfortable discussing differences in a constructive manner when conflict arises.
- Providers and staff are empowered to function to the fullest extent of their training and ability.
- The patient receives care from a variety of practice members.
- Communication within the team is positive, timely and effective.
- Standardization and cross-training of staff facilitate the group's flexibility in adapting to the unexpected.

Strengths

- Throughout the practice, team members are cross trained on roles within their area. For example, the front desk check-in team can rotate through to the various areas in the front office area. The lab team members are all able to fill in for any position as they rotate regularly to keep up to speed with the various roles and responsibilities.

- Due to the established team concept at the practice and the working relationship between providers and clinical team, the nurses are able to order certain testing for the patient prior to the patient being seen by the physician.
- An effective process is in place around triaging patient calls into the practice. There is a designated nurse on each team that answers calls and responds to patient's requests or asks the appropriate doctor when possible. Phone triage is divided up throughout the clinic so all calls are handled in a timely manner.
- A Nurse Practitioner is used effectively in the practice. The NP has her own panel of patients and the PA is assigned to surgery.

Opportunities

- The clinic is not providing appointment reminder phone calls or emails to patients to remind them of their upcoming visit.
- Some activities are in place around pre-visit planning such as Chart review, ordering labs, reviewing pre-visit history, and entering of Pediatric immunizations, but this is not necessarily standard across the practice.
- The medication list is reviewed and updated by the nurse at the time of the visit and in some cases is then also reviewed by the doctor with the patient. Duplication of effort is time wasted.
- To have an effective team, we promote using all team members to the highest level of their licensure. All nurses, despite title and role, perform similar tasks such as taking vitals. Practice A might consider how to effectively use the team so MAs are doing what they're able to do, RNs and LPNs are also working up to their level of ability, and Providers are functioning at the top of their ability.

Quality & Safety

In order to provide safe, high quality care for the individual patient, a global systems approach must be in place behind the scenes. Therefore, the Quality and Safety module addresses:

- The use of evidence-based clinical guidelines in the delivery of care
- Medication management
- Patient satisfaction feedback
- Evidence-based outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Strengths

- Immunizations are available in the practice and can be administered to children or adults depending on Family Practice or Pediatrics patients.
- The practice keeps a log on refrigeration control.
- Physicians try to use generics as much as possible. One Physician reviewed the cost of medications with the patient before selecting the pharmacy to fill the medication and the specific drug.
- Medications are rotated and checked for outdates.
- Patient satisfaction surveys are conducted on an ongoing basis. These surveys are accessible in the practice and through the website. Results are then shared with the physicians or departments involved in the survey.
- Practice A participates in quality reporting for insurance companies.

- Policies and procedures are in place for OSHA, HIPAA, and the compliance plan.
- Competency assessments are performed for CLIA waived labs.

Opportunities

- Narcotics are kept in the office and the clinic does have a sample closet.
- The practice cycles drug reps through on a regular basis. In some cases these reps may host a lunch or breakfast for the physicians or even provide an afternoon snack. In addition, the representatives have rooms available in the practice to detail physicians.

Health Information Technology

The availability and effective use of basic and advanced technology can facilitate the practice in providing exceptional patient care. The Information Systems module addresses:

- Electronic Health Records
- e-Prescribing
- Lab interfaces
- Disease registries
- Evidence-based decision support and point-of-care reminders
- Population-based management software
- e-Visits
- Web-based information sharing with patients
- HIPAA compliance and practice security

Strengths

- The Information Technology team has worked together with the Physician team to consistently enhance efficiency and make improvements related to all technology needs in the practice. The IT team is empowered to observe and recommend changes needed and then they are implemented.
- Although the clinic does not have an EMR at this time there is an electronic dictation system, Word Client, in place so information that would typically be found in an EMR is still available to the patient team.
- Word Client has increased efficiencies and flow throughout the practice even with the continued use of paper charts.
- The team is using e-prescribing effectively for the most part. Some physicians even take a PDA into the exam room and e-prescribe through AllScripts instantaneously.
- Technology is widely accepted and robustly used in the practice, especially considering there is not yet an electronic medical record. Advancements and improvements are being made on an ongoing basis.
- Staff is trained on updates to the Word Client system before implementation and there's a level of proficiency expected.
- The practice has a comprehensive website that offers ample information about the practice (www.Practice Aclinic.com).

Opportunities

- While the practice continues to look for an EMR that is the right fit for the Physician team, the Word Client dictation system works well, but certain bottlenecks arise. The practice is considering implementing a template for what must be entered in the dictation each time. With this template, issues would be eliminated related to certain providers or nurses not

entering all pertinent information. In addition, if certain fields are not completed, the system will not allow you to move forward, which would improve the current process.

Practice Management and Financial Review

Practice management plays a key role in transformation to a patient centered medical home. If this component is not addressed it could have a marked effect on a practice's ability to sustain itself in the marketplace. The Practice Management module focuses on:

- Disciplined financial management
- Optimized billing and coding
- Proactive change management
- Optimized office design/redesign
- Cost/benefit decision making
- Revenue enhancement
- Human resources administration

Strengths

- Insurance eligibility verification works well at Practice A through the use of the Navicare system. At the time of the appointment, if the patient does not have their insurance card, the front office is able to check quickly whether the patient still has the same insurer and information is up to date.
- The practice divided billing and payment duties across the team, and the process seems to work effectively. Spot checks are done within the Word Client system to ensure there are not coding errors.
- In addition to the spot checks, before a lab can be done, the physician has to code. This is an additional methodology in place to double check and account for errors.
- Within the past year, an outside auditor has performed a professional coding audit.
- The front office team does an excellent job of asking all patients, every time, to get an update on their demographic information. Patients need to say their information back to the front desk versus the front office saying the information to the patient to agree on.
- Meetings are held regularly in the practice including an all Physician meeting, Physician Executive Team meetings, Supervisor meetings, Department meetings, Safety Committee meeting, and IT Committee meeting. Minutes are taken and action items are identified in these meetings.
- Co-pays are collected at check in and past due balances are collected at both check-in and out.
- Competency checks are done for nursing procedures and injections.

Opportunities

- All staff meetings are held yearly, regular staff meetings will improve communication and engagement in change.
- There is no Performance Management System in place at this time.

Appendix A: Physician and Staff Satisfaction Results

Provider Satisfaction Results

Please indicate your role with the practice.		
Answer Options	**Response Percent**	**Response Count**
Physician	90.0%	9
Resident (Physician)	0.0%	0
Nurse Practitioner or Physician's Assistant	10.0%	1
	answered question	10
	skipped question	0

I have the tools and resources needed to perform my job.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	0.0%	0
Agree	50.0%	5
Strongly Agree	50.0%	5
	answered question	10
	skipped question	0

I look forward to coming to work each day.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	10.0%	1
Agree	40.0%	4
Strongly Agree	50.0%	5
	answered question	10
	skipped question	0

I am able to practice medicine as I envisioned when I finished my training.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	10.0%	1
Disagree	10.0%	1
Neutral	0.0%	0
Agree	50.0%	5
Strongly Agree	30.0%	3
	answered question	10
	skipped question	0

I am paid fairly for the work that I do.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	10.0%	1
Neutral	20.0%	2
Agree	20.0%	2
Strongly Agree	50.0%	5
	answered question	10
	skipped question	0

My current work-life balance is what I had envisioned.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	0.0%	0
Agree	70.0%	7
Strongly Agree	30.0%	3
	answered question	10
	skipped question	0

I have adequate clinical and clerical support while performing my job functions and taking care of patients.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	20.0%	2
Agree	40.0%	4
Strongly Agree	40.0%	4
	answered question	10
	skipped question	0

Staff Satisfaction Results

I have the tools and resources needed to perform my job.

Answer Options	Response Percent	Response Count
Strongly Disagree	2.0%	2
Disagree	7.0%	7
Neutral	20.0%	20
Agree	52.0%	52
Strongly Agree	19.0%	19
	answered question	100
	skipped question	2

I have opportunities to grow in my job.

Answer Options	Response Percent	Response Count
Strongly Disagree	8.8%	9
Disagree	21.6%	22
Neutral	35.3%	36
Agree	30.4%	31
Strongly Agree	3.9%	4
	answered question	102
	skipped question	0

I look forward to coming to work each day.

Answer Options	Response Percent	Response Count
Strongly Disagree	6.0%	6
Disagree	9.0%	9
Neutral	30.0%	30
Agree	52.0%	52
Strongly Agree	3.0%	3
	answered question	100
	skipped question	2

I am paid fairly for the work that I do.

Answer Options	Response Percent	Response Count
Strongly Disagree	17.6%	18
Disagree	32.4%	33
Neutral	31.4%	32
Agree	17.6%	18
Strongly Agree	1.0%	1
	answered question	102
	skipped question	0

I work with a supportive team.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	4.9%	5
Disagree	10.8%	11
Neutral	24.5%	25
Agree	45.1%	46
Strongly Agree	14.7%	15
	answered question	102
	skipped question	0

I can tell my boss what I think.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	11.9%	12
Disagree	14.9%	15
Neutral	21.8%	22
Agree	35.6%	36
Strongly Agree	15.8%	16
	answered question	101
	skipped question	1

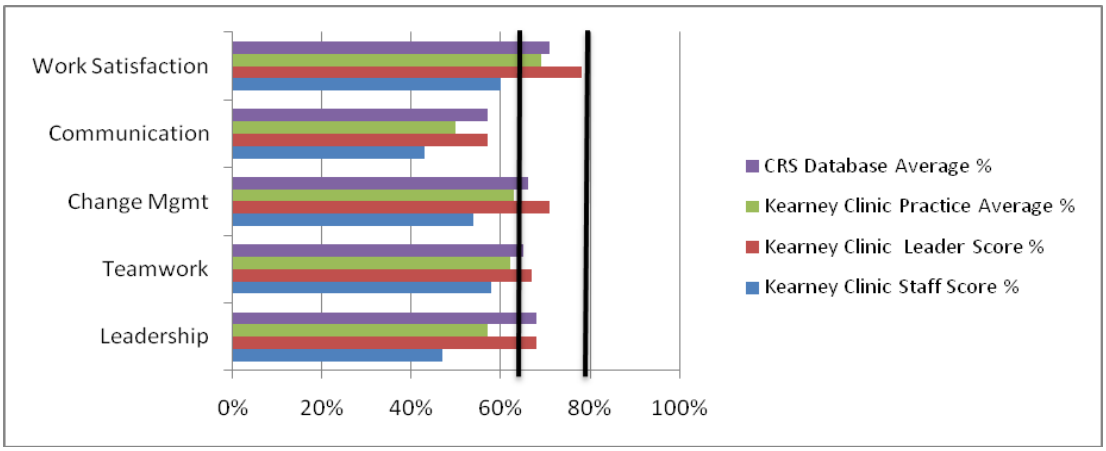
My ideas and suggestions are being considered, as part of the practice's transition to being a patient-centered medical home.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	8.9%	9
Disagree	18.8%	19
Neutral	45.5%	46
Agree	24.8%	25
Strongly Agree	2.0%	2
	answered question	101
	skipped question	1

Appendix B: Change Readiness Assessment Results

Practice A's Change Readiness Survey (CRS) results are shown by staff, and aggregate practice results in comparison to the TransforMED Database group data. Practice A's Leadership results are somewhat similar to the overall TransforMED Database, but Staff results as a whole are significantly lower. A line is present at 80% which represents a realistic target for practices. In addition, a line is present at 65% and areas below this line represent areas for improvement. The practice should select one or two areas to focus on such as Communication (57%) and Leadership (68%). Note the discrepancies between the Staff scores and the Leadership Scores for the practice specifically note that none of the Staff scores reach the 65% threshold. All dimensions of the CRA contribute to the development of the practice climate/culture. By focusing on how to improve one area such as communication, the practice can affect the perception of leadership. A few possible questions to ask to get started are below. Consider how leaders and staff respond differently.

1. How is information communicated at the practice?
2. Who communicates information and are there opportunities for feedback and dialogue?
3. Who is responsible for ensuring information is communicated to all areas of the practice?
4. What does the practice communicate with regard to change?
5. When is information that impacts the practice communicated?

	Leadership	Teamwork	Change Mgmt	Communication	Work Satisfaction	Total
Practice A Staff Score %	47%	58%	54%	43%	60%	54%
Practice A Leader Score %	68%	67%	71%	57%	78%	69%
Practice A Practice Average %	57%	62%	63%	50%	69%	61%
CRS Database Average %	68%	65%	66%	57%	71%	66%



Practice A Baseline Progress Report - February 2011

1= no action has been taken	1
2 = some action has been taken, or working on it	2
3 = action has been addressed and is now currently working	3

Practice A		Year One			Year Two			
	Base line	2Q	3Q	4Q	IQ	2Q	3Q	4Q
Model Components and Factors								
Patient Centered Care								
Practice policies communicated to patient	2							
Patient rights and responsibilities communicated to patient	1							
Patient experience survey by practice (PEAT)	2							
Patient - PCP relationship promoted	2							
Continuous patient-provider relationship metrics available	1							
Visit and health information shared with patient	2							
Patient education on PCMH	1							
Patient advisory group	1							
Patient engagement in care promoted by staff and providers	2							
Average Patient Centered Care	1.56							
Access to Care and Information								
Access to care and information policy in place	2							
Scheduling guidelines simplified and consistent across practice	1							
Access metrics dashboard reviewed (care and information)	1							
Establish same day access goals	1							
After hours coverage communicated and coordinated	3							
Extended office hours provided	3							
Patient portal available	1							
E mail communication and/or e-visits provided	1							
Nurse and/or group visits provided	1							
Practice open to all patients	2							
Test results provided to patient -- normal and abnormal	2							
Average Access to Care and Information	1.64							
Practice Based Services								
Comprehensive care for acute & chronic conditions	3							
Multiple procedures done in the practice	3							
Lab draw station and CLIA waived lab capabilities	3							
Appropriate testing offered on site	3							
Prevention - screening services on site	2							
Average Practice Based Services	2.80							

Participating Practice Site	Kearney Clinic				Kearney Clinic			
	Base	2Q	3Q	4Q	Base	2Q	3Q	4Q
Care Management								
Population management process in place	1							
Decision support - point of care reminders for EBC	1							
Provides and documents patient self management information	1							
Pre-visit planning for routine care	1							
Patient reminders - outreach for EBC	2							
Average Care Management	1.20							
Care Coordination								
Effective relationships/ communication with providers - settings	2							
Hospital/ER follow-up is defined	1							
Agreements with hospital/ER providers	1							
Agreements with consulting/referral physicians	1							
Community based services utilized	2							
Consult /referral process defined and tracked	1							
Medication reconciliation across all providers/settings	2							
Average Care Coordination	1.43							
Practice-Based Team Care								
Provider leadership of clinical team defined	2							
NP-PA role defined	2							
Clinical teams identified	1							
Effective team communication in place	1							
Team member tasks and responsibilities defined	1							
Guidelines or protocols for frequent tasks developed & used	2							
Utilization of medication refill protocols & standing orders	2							
Team efficiency metrics reviewed	1							
Average Practice Based Team Care	1.5							
Quality and Safety								
Quality improvement activities	1							
Clinical measures -outcome report review for QI	2							
Reporting mechanism for patient safety issues	1							
Regulatory compliance	2							
Average Quality and Safety	1.50							

Participating Practice Site	Kearney Clinic				Kearney Clinic			
	Baseline 1Q	2Q	3Q	4Q	Baseline 1Q	2Q	3Q	4Q
Health Information Technology								
Efficient use of EMR and skill sharing process in place	1							
Electronic prescribing used across practice	2							
Demographic-clinical information in searchable fields	2							
Lab and x=ray interface	3							
Electronic informaion sharing with outside providers/settings	2							
Registry -reporting capability in practice	1							
Customized interactive practice web site	2							
Regional exchange participation/utilization	1							
Maximize electronic billing - claim submission - payer validation	2							
Average Health Information Technology	1.78							
Practice Management								
Leadership team and change process in place	1							
Effective communication to staff -and providers	1							
Vision statement consistent with PCMH	2							
Regular meeting schedule / effective meeting structure	2							
Providers - staff engaged in PCMH	1							
Financial dashboard/reporting to providers & manager	2							
Financial management processes in place	2							
Coding audit process in place	2							
Operating policy and procedures in place	1							
Job descriptions in place for all staff members	1							
Performance management process in place	1							
Employee handbook with policies and procedures	2							
Average Practice Management	1.5							

Quarterly Average **1.63**

TransforMED℠
TRANSFORMING MEDICAL PRACTICES

Patient Centered Medical Home Practice Assessment Practice B

Report prepared: February 2011

TransforMED℠
TRANSFORMING MEDICAL PRACTICES

Table of Contents

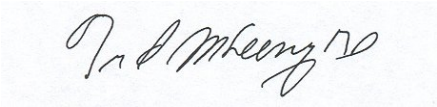
Dear Leadership Team,

On behalf of the entire patient-centered medical home (PCMH) team, we would like to congratulate you and the members of your practice as you formalize your efforts to transform your practice. The journey you are undertaking will be both challenging and rewarding.

The enclosed report establishes baseline information from which you can begin to plan future strategies for your practice's transformation to a PCMH. Highlighted in the report are the current strengths of your practice as well as those areas where opportunity exists to enhance services and practice processes. We are prepared to assist you and your practice every step of the way.

Our mission is the transformation of healthcare delivery to achieve optimal patient care, professional satisfaction, and success of primary care practices. We look forward to working with you.

Sincerely,



Terry L. McGeeney, MD, MBA, FAAFP
President and CEO
TransforMED

Executive Summary

Dear Practice Leadership Team:

On behalf of our PCMH team, we want to thank you for the opportunity to work with your practice team and to provide this report for Practice B. TransforMED has been contracted to provide the following:

- Full facilitation for transformation to a Medical Home
  - Base-line assessment
    - Access to care and information
    - Care management
    - Care Coordination (Continuity of care services)
    - Practice based care team
    - Quality and safety
    - Practice management and financial review
    - Change readiness checklist
  - Collaboration with the practice to develop a process to implement elements of the Medical Home
  - Patient engagement assessment twice over a one year time frame
  - Monitoring of real time progress, setting goals, and offering solutions geared toward improving the value of the practice
  - Learning Collaboratives
- Collaborating with the State of Nebraska to ensure practices meet State designated Patient Centered Medical Home (PCMH) Standards within the first six months of the project

This assessment report will provide important information about where the practice stands in relation to the patient centered model of care.

Assessment Process

The assessment process involves several types of data collection. These include self-reporting, surveying, interviews with key staff and providers, and onsite observations. TransforMED began work with Practice B in January 2011.

Report Organization

The following report is organized around the Patient Centered Care Model. We note some key strengths and opportunities for Practice B. A quick overview of the Strengths we noted in our work with the practice highlight Patient Centered Care, Practice –Based Care Team and Practice-Based Services. These will provide an excellent basis for transformation. The Opportunities for Growth are areas that will clearly define and expand the practice capabilities in moving forward.

Strengths at Practice B

The practice demonstrates a very strong desire to put the patient in the center of the practice. The providers and staff represent a strong commitment toward a continuous relationship with their patients by accommodating cultural diversity and providing interpretation services, and witnessed by effective connection between the physicians and their patients. It was also evident that the staff (clerical, nursing, and administrative), and providers are focused on being responsive to patient needs, dedicated to making the patients feel welcome, and are dedicated to improving the health of the communities it services.

The use of technology will be important to maximizing efficiencies. The process of implementing an EMR is just an initial step in the ongoing discovery of tools. Efficient use of the EMR as a tool in primary care is another step, and there must be an ongoing process to ensure consistent use by all team members. Technology use must also include quality reporting for each provider and practice. The reporting process is an integral part of developing an ongoing quality improvement process that has value to the practices and their patients. The ability to monitor and report quality measures and outcomes will drive and support behaviors that result in improved patient care. In addition, efficient point of care reminders that are patient specific based on data entered and diagnosis codes used is an important efficiency for primary care.

Practice B physicians exclusively staff the Lexington hospital allowing for very efficient Care Coordination for hospitalization and emergency room visits. The same level of communication should be provided to and from specialists to ensure comprehensive care coordination.

We found the physician leader engaged in the PCMH discussions, committed, and enthusiastic about beginning the transformation process.

Opportunities at Practice B

Continuous efforts need to be applied to simplifying and standardizing scheduling protocols and access for patients to their primary provider. There are often access policies in place, whether written or not, that support the physician and providers in the practice. As part of the Patient Centered Medical Home transformation the practice needs to consider expanding its effort to provide timely information, such as care plans, and updated medication lists. The practice could also consider the adoption of various advanced access strategies such as increased same day access availability, eliminating double-booking.

The ultimate objective of Team Based Team Care is to free physicians from tasks that could be done by someone else. Practice based care teams are an opportunity to gain some much needed relief from the overwhelming amount of time physicians spend doing clerical and administrative work and to simultaneously develop the staff for greater satisfaction and fulfillment. Attention should be given to roles and responsibilities of each member of the

team so that better utilization of the care team can be established to assure that all members are working at the top of their licensure and supporting each other to reach their full functionality.

Care management processes should support the culture of proactive vs. reactive care. This can be accomplished with pre-visit planning that facilitates completion of evidence based care (EBC) measures prior to the visit and allows review of this information at the time of the visit. Effective care management is reflected in quality measures. Having the ability to report on quality measures and outcomes in the practice is important to engaging the team in quality improvement initiatives.

Effective, transparent reporting processes should be established so that all review individual provider's reports and the practice report. Care management is accomplished with effective point of care reminders that are auto-populated based on individual patient information and nationally recognized EBC guidelines.

Preparing for Change

From the experience of TransforMED facilitators there are several elements that should be discussed in implementation of the recommendations put forth in this report. These elements include three keys for success to prepare the practice to manage forthcoming changes. In our experience, leadership, teamwork and communication provide the foundation for successful change initiatives. Without these elements in place, the practice will have difficulty managing project implementation success, team dynamics, and conflict.

Effective, sustainable change must be managed and takes time! Practice members will experience many successes and challenges along the way. Caution should be exercised by the practice leaders and the team neither to become too discouraged with challenges and setbacks nor to become too confident with early successes. As the changes are implemented there will be ups and downs along the way. Developing resilience and commitment to the long range goals will sustain practice members through the process. In addition, what they will learn from their experiences will allow them to provide guidance and information to patients (who will also be impacted by the changes).

Thank you for the opportunity to partner with you in this effort.

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Patient Centered Care Assessment

The following segment of the report provides a summary of Strengths and Opportunities for your practice. These are organized around the nine components of the TransforMED Patient-Centered Model: Patient Centeredness, Access to Care and Information, Practice-Based Services, Care Management, Care Coordination, Practice-Based Care Team, Quality & Safety, Health Information Technology, and Practice Management.

Patient Centered Care

A continuous patient-care team relationship is foundational to effective whole person care. Mutual trust and respect serve as catalysts to shared decision-making and motivate the patient to consistently seek front line care from the medical home. The Patient Centered Care module addresses:

- Mindful clinician-patient communication
- Patient engagement
- Delivery of care sensitive to diverse populations
- Processes that identify barriers to a patient's ability to successfully pursue a course of treatment
- Patient rights and responsibilities
- A continuous relationship between the patient and the care team

Strengths

- Practice B sees a large volume of patients of Hispanic origin and other ethnicities. Whereas this could be a complication as some practices, Practice B has implemented interpreters in key areas. In addition, there are interpreters "on call" that are brought to the front to go with patients through their visit. This establishes a sense of continuity for the patient as the same person is with the patient through the whole visit.
- During patient paths, it was evident that Physicians and clinical team members at the practice have good rapport with the patients. The majority of nurses and doctors were able to interact easily with the patients not only discussing medical matters, but personal information as well.
- Wait time for patients seems to be minimal. The process of getting patients back for labs if needed or into the exam room seems fairly expeditious.

Opportunities

- Practice B does not identify a Primary Care Physician for each patient in all cases. There is no certainty around how often patients are able to see their provider of choice.
- At this point in time, there have not been any meetings with the Physician and Clinical team regarding how to involve patients more directly in their care. This specifically refers to involvement in joint decision making and motivation to be involved in care.
- Although Practice B has not been providing written care plans to patients following their visit, there have been discussions around implementing something like this. The practice might consider a method to provide back information discussed in the appointment as this will help to engage and involve patients more in their care.

Access to Care & Information

Access to care and accurate, up-to-date health care information are critical to the patient's sense of having partnered with a provider. Readily available appointments, test results, and information prepare the patient to proactively pursue and maintain good health. This Patient Centered Medical Home (PCMH) module encompasses:

- Ensuring timely delivery of care
- Access to information
- Alternatives to conventional office visits
- Same day access
- Policies and processes related to the availability of appointments and information

Strengths

- Patients have good access to care at Practice B with the practice providing office hours Monday through Friday from 7:45 – 5:30 and also weekend hours on Saturday.
- Physicians rotate through the clinic on Saturdays and patients can schedule an appointment or walk in to be seen.
- All Physicians are accepting new patients.
- Late afternoon acute care is usually handled in the practice. As a last resort patients may be sent to the Emergency Room, but in most cases they can be worked into the schedule.
- All walk-ins are seen. These patients are either double-booked, get the next available slot, or directed to an on call doctor.
- Practice B has procedures in place for no-show patients and these patients are tracked.

Opportunities

- Appointment slots are not consistently open at the beginning of each day for all providers.
- The practice double books appointment slots throughout the day.
- Practice B has many appointment types and lengths that differ for each provider. This makes scheduling very difficult for the front office. In addition, it seems that there are a lot of blocks in place related to scheduling permissions.
- Each Providers panel size is not known at this time. This information can be pulled from the EMR. The practice should consider reviewing provider panel size to ensure providers are not over or under paneled. This data will also help the practice review access supply and demand.

Practice Services

An important component of the medical home is the availability—on site or through targeted referrals—of a comprehensive ranges of diagnostic, therapeutic, and support services. By administering point of care services effectively the practice offers quality patient care while responsibly managing its finances. The following categories of services are addressed in this module:

- Acute care
- Chronic care
- Wellness promotion
- Procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Strengths

- The practice provides a variety of services onsite in the practice. All providers are able to perform minor dermatological procedures, laceration repair, fracture management, punch biopsy, and trigger point injections. Some providers are able to do vasectomy, joint injections, and IUDs.
- Preventive services provided in the practice are EKG, Pulmonary function/spirometry, labs, and x-ray.
- LabCorp handles all lab related work for the practice.

Opportunities

- Some lab results are available at the time of the visit for the Physician to review with the patient. Others that may not be available require further follow up with the patient following the appointment. Although this leads to a wonderful relationship between doctor and patient, the practice should consider reviewing the efficiency of this practice. Consider whether the doctor needs to be calling back patients who have normal results, and who might be more appropriate to do this on the patient care team.

Care Management

Systematically reviewing and planning on behalf of patient populations generates outcomes that cannot be accomplished solely through an episodic approach. Ideally, care management should occur within the context of an ongoing relationship between patient and provider and should involve multiple members of the practice-based care team. In the Care Management module the following capabilities are addressed:

- The ability of the practice to promote wellness and disease prevention in a targeted fashion
- The proactive management of chronic diseases and patient populations using evidence-based outcomes
- Consistent practice-wide coordination of care
- Patient engagement and education

Strengths

- The practice is in the process of hiring Care Managers. The Care Managers will most likely be hired from within the practice which we have seen to work well in the past as this person is already familiar with the practice, operations within the practice, and needs.
- Evidence based guidelines are in place for Preventive and Chronic care.
- Reports can be run by age, gender, chronic disease, diagnosis code, and high acuity patients.

Opportunities

- At this time, there is not a formal process in place for reporting on clinical outcomes.
- The practice should consider implementing written protocols for managing outcomes. If these are put in place, various areas in the practice will be able to use these protocols.

Care Coordination

Care Coordination speaks to the extension of the patient care team beyond the walls of the practice. Deliberately crafted relationships with a network of health and wellness professionals help ensure that the practice remains well informed when a portion of the patient's care is provided elsewhere. The Care Coordination module encompasses:

- Coordination of care with other providers
- Integration of services
- Collaborative relationships with hospitals, behavioral health, maternity, specialists, community-based services, etc.
- Timely exchange of information
- Plans for after-hours coverage
- Tracking of lab and imaging tests

Strengths

- Practice B understands the need for referral tracking. This is important to this practice in particular as the majority of referrals have to be sent out of town. Although there is not a process in place at this time, there is an initiative to put this in place in March.
- When referring, it seems to work well for the practice to do the referral right there at the time of the patient visit while filling in the chart. Practice B has built in all fax numbers of specialists which creates efficiency around the referring process.
- Care Coordination with the hospital is excellent as the Practice B providers are the only group that covers the ER so they are aware of their patients in the hospital.
- Within the community, education resources and support groups are available for Practice B patients. State immunization records can be utilized by the practice as well.

Opportunities

- Practice B does not use a designated set of specialists, but they have established a process of "firing" specialists if they are not communicating well with the practice.

Practice Based Care Team

Efficient team work serves as the foundation for the medical home by freeing collective energies to be focused on the patient and his/her well-being. An effective team is characterized by the following elements:

- Leadership monitors the pulse of staff as an indicator of whether they (leadership) are effectively modeling the desired practice culture.
- Team members feel comfortable discussing differences in a constructive manner when conflict arises.
- Providers and staff are empowered to function to the fullest extent of their training and ability.
- The patient receives care from a variety of practice members.
- Communication within the team is positive, timely and effective.
- Standardization and cross-training of staff facilitate the group's flexibility in adapting to the unexpected.

Strengths

- Practice B calls patients to remind them of upcoming appointments.

- Written protocols are in place for standard workflows such as rooming patients, procedures and checking patients in.
- Nursing staff are able to order testing prior to the physician visit depending upon the patient's symptoms.
- Chart review and medication refills are the pre-visit planning initiatives in place currently.
- The NP's have their own panel and are used like other providers in the practice. In addition, the practice is considering hiring a PA to support with specified doctor's panels.

Opportunities

- Certain doctors seem to have difficulty allowing their clinical team to do certain tasks. By standardizing processes and roles, the nurses will be able to function at their highest level and relieve physicians of certain tasks that they do not necessarily need an MD degree to do.
- Nurses seem to worry about their role when working with different providers. Currently when nurses rotate, inefficiencies result because they are unsure of their responsibilities under different doctors. The practice needs to determine certain standards that are expected on each physician/nurse team and not deviate from those. There can be some nuances, but there should be a set list that's agreed upon in order for the teams to operate more smoothly.
- Phone triage works fairly well with the exception of the process related to calling back to the clinical team to receive permission to book certain appointments.

Quality & Safety

In order to provide safe, high quality care for the individual patient, a global systems approach must be in place behind the scenes. Therefore, the Quality and Safety module addresses:

- The use of evidence-based clinical guidelines in the delivery of care
- Medication management
- Patient satisfaction feedback
- Evidence-based outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Strengths

- Practice B administers immunizations to adults and children.
- A log is kept on refrigeration control. Medications are rotated and checked for outdates.
- There are policies and procedures in place for OSHA and HIPAA, and a Compliance Plan.

Opportunities

- Narcotics are kept in the practice.
- The practice does have a sample closet.
- Pharmaceutical representatives are able to schedule a luncheon or breakfast and/or request space to detail physicians one on one.
- There is not a patient satisfaction survey in place at this time.
- Practice B does not have a formal quality improvement program.

Health Information Technology

The availability and effective use of basic and advanced technology can facilitate the practice in providing exceptional patient care. The Information Systems module addresses:

- Electronic Health Records
- e-Prescribing
- Lab interfaces
- Disease registries
- Evidence-based decision support and point-of-care reminders
- Population-based management software
- e-Visits
- Web-based information sharing with patients
- HIPAA compliance and practice security

Strengths

- The practice has an EMR in place, AllScripts 9.2 which is the most current version available. Staff and Providers seem to be using this technology robustly and disconnects between the practice management system and EMR are continuously being addressed. Practice B is met with limited resistance from team members when upgrades and new technology implementations take place. When changes to technology arise, staff and team members are trained prior to implementation.
- Certain processes within the EMR seem to work very well. For example, when a mammogram is complete, this is scanned into the system and put in the same place in all patient charts where applicable. It is then stamped for review and the Physician will begin getting used to looking in the "Patient Manager" portion of the software as the goal is that this is the one stop for any refills, patient needs, things to sign off on, etc.
- E-prescribing works pretty effectively at the practice. The practice estimates that 90% of prescriptions occur through e-prescribing. On some occasions, prescriptions are still hand-written.
- There are 3 pharmacies in town and they all are fairly consistent with sending e-refills into the practice to sign off on or fax back to the practice for Med Records to scan into the patient's chart. This has cut down on phone calls back and forth between the practice and pharmacies.

Opportunities

- During patient appointments, the nurse reviews Medications with the patient. In some cases it did not seem that this process allowed for a comprehensive, thorough review of all medications. It seemed that certain medications such as vitamins had defaulted to another area of the EMR and were not visible to the nurse and doctor.

Practice Management and Financial Review

Practice management plays a key role in transformation to a patient centered medical home. If this component is not addressed it could have a marked effect on a practice's ability to sustain itself in the marketplace. The Practice Management module focuses on:

- Disciplined financial management
- Optimized billing and coding
- Proactive change management
- Optimized office design/redesign

- Cost/benefit decision making
- Revenue enhancement
- Human resources administration

Strengths

- Roles and responsibilities around the front and back office have been separated very well. For example, Carolyn is responsible for front office staff and Med Records, Carolyn and Rusty are working together on a new Compliance plan, Marian is responsible for OSHA, and LabCorp handles anything CLIA related.
- Provider and the Physician Executive Team have regular meetings with the Practice Management team at Practice B.
- All staff meetings are held monthly.
- There is a performance management system in place to assess administrative staff and a separate system to assess clinical staff.
- Staff evaluations are done yearly.
- A missing ticket report is worked regularly.
- Provider coding is double checked, but no outside coding audit has been done in the last year.
- Financial statements are run by the Practice Manager and provided back to the Physician team.

Opportunities

- The goals and targets of the practice are constantly changing. This makes it difficult to focus on projects as new initiatives are constantly introduced.
- At this time there is not an insurance verification system or eligibility report in place.
- There is not a written mission or vision statement in place.
- Co-pays and past due balances are collected at both check-in and check-out but does not appear to be strictly enforced.

Appendix A: Provider and Staff Satisfaction Results

Provider Satisfaction Results

Please indicate your role with the practice.		
Answer Options	**Response Percent**	**Response Count**
Physician	87.5%	7
Resident (Physician)	0.0%	0
Nurse Practitioner or Physician's Assistant	12.5%	1
	answered question	8
	skipped question	0

I have the tools and resources needed to perform my job.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	0.0%	0
Agree	50.0%	4
Strongly Agree	50.0%	4
	answered question	8
	skipped question	0

I look forward to coming to work each day.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	12.5%	1
Agree	25.0%	2
Strongly Agree	62.5%	5
	answered question	8
	skipped question	0

I am able to practice medicine as I envisioned when I finished my training.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	0.0%	0
Agree	75.0%	6
Strongly Agree	25.0%	2
	answered question	8

I am paid fairly for the work that I do.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	12.5%	1
Agree	37.5%	3
Strongly Agree	50.0%	4
	answered question	8
	skipped question	0

My current work-life balance is what I had envisioned.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	37.5%	3
Agree	37.5%	3
Strongly Agree	25.0%	2
	answered question	8
	skipped question	0

I have adequate clinical and clerical support while performing my job functions and taking care of patients.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Neutral	0.0%	0
Agree	62.5%	5
Strongly Agree	37.5%	3
	answered question	8
	skipped question	0

Staff Satisfaction Results

I have the tools and resources needed to perform my job.

Answer Options	Response Percent	Response Count
Strongly Disagree	5.1%	2
Disagree	0.0%	0
Neutral	0.0%	0
Agree	41.0%	16
Strongly Agree	53.8%	21
	answered question	39
	skipped question	1

I have opportunities to grow in my job.

Answer Options	Response Percent	Response Count
Strongly Disagree	5.1%	2
Disagree	7.7%	3
Neutral	23.1%	9
Agree	56.4%	22
Strongly Agree	7.7%	3
	answered question	39
	skipped question	1

I look forward to coming to work each day.

Answer Options	Response Percent	Response Count
Strongly Disagree	5.1%	2
Disagree	0.0%	0
Neutral	10.3%	4
Agree	48.7%	19
Strongly Agree	35.9%	14
	answered question	39
	skipped question	1

I am paid fairly for the work that I do.

Answer Options	Response Percent	Response Count
Strongly Disagree	2.6%	1
Disagree	2.6%	1
Neutral	35.9%	14
Agree	51.3%	20
Strongly Agree	7.7%	3
	answered question	39
	skipped question	1

I work with a supportive team.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	5.1%	2
Disagree	0.0%	0
Neutral	2.6%	1
Agree	51.3%	20
Strongly Agree	41.0%	16
	answered question	39
	skipped question	1

I can tell my boss what I think.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	5.1%	2
Disagree	2.6%	1
Neutral	12.8%	5
Agree	56.4%	22
Strongly Agree	23.1%	9
	answered question	39
	skipped question	1

My ideas and suggestions are being considered, as part of the practice's transition to being a patient-centered medical home.		
Answer Options	**Response Percent**	**Response Count**
Strongly Disagree	5.3%	2
Disagree	5.3%	2
Neutral	21.1%	8
Agree	44.7%	17
Strongly Agree	23.7%	9
	answered question	38
	skipped question	2

Practice B Baseline Progress Report - February 2011

1= no action has been taken	1
2 = some action has been taken, or working on it	2
3 = action has been addressed and is now currently working	3

Practice B		Year One			Year Two			
	Base line	2Q	3Q	4Q	IQ	2Q	3Q	4Q
Model Components and Factors								
Patient Centered Care								
Practice policies communicated to patient	1							
Patient rights and responsibilities communicated to patient	1							
Patient experience survey by practice (PEAT)	1							
Patient - PCP relationship promoted	1							
Continuous patient-provider relationship metrics available	2							
Visit and health information shared with patient	1							
Patient education on PCMH	1							
Patient advisory group	1							
Patient engagement in care promoted by staff and providers	2							
Average Patient Centered Care	1.22							
Access to Care and Information								
Access to care and information policy in place	1							
Scheduling guidelines simplified and consistent across practice	1							
Access metrics dashboard reviewed (care and information)	1							
Establish same day access goals	1							
After hours coverage communicated and coordinated	3							
Extended office hours provided	2							
Patient portal available	1							
E mail communication and/or e-visits provided	1							
Nurse and/or group visits provided	1							
Practice open to all patients	3							
Test results provided to patient -- normal and abnormal	2							
Average Access to Care and Information	1.55							
Practice Based Services								
Comprehensive care for acute & chronic conditions	2							
Multiple procedures done in the practice	3							
Lab draw station and CLIA waived lab capabilities	3							
Appropriate testing offered on site	3							
Prevention - screening services on site	3							
Average Practice Based Services	2.80							

Participating Practice Site	Plum Creek				Plum Creek			
	Base	2Q	3Q	4Q	Base	2Q	3Q	4Q
Care Management								
Population management process in place	2							
Decision support - point of care reminders for EBC	3							
Provides and documents patient self management information	1							
Pre-visit planning for routine care	1							
Patient reminders - outreach for EBC	2							
Average Care Management	1.80							
Care Coordination								
Effective relationships/ communication with providers - settings	2							
Hospital/ER follow-up is defined	3							
Agreements with hospital/ER providers	2							
Agreements with consulting/referral physicians	1							
Community based services utilized	1							
Consult /referral process defined and tracked	1							
Medication reconciliation across all providers/settings	1							
Average Care Coordination	1.57							
Practice-Based Team Care								
Provider leadership of clinical team defined	2							
NP-PA role defined	2							
Clinical teams identified	2							
Effective team communication in place	2							
Team member tasks and responsibilities defined	2							
Guidelines or protocols for frequent tasks developed & used	1							
Utilization of medication refill protocols & standing orders	2							
Team efficiency metrics reviewed	1							
Average Practice Based Team Care	1.8							
Quality and Safety								
Quality improvement activities	1							
Clinical measures -outcome report review for QI	2							
Reporting mechanism for patient safety issues	1							
Regulatory compliance	3							
Average Quality and Safety	1.75							

Participating Practice Site	Plum Creek				Plum Creek			
	Baseline 1Q	2Q	3Q	4Q	Baseline 1Q	2Q	3Q	4Q
Health Information Technology								
Efficient use of EMR and skill sharing process in place	2							
Electronic prescribing used across practice	3							
Demographic-clinical information in searchable fields	2							
Lab and x=ray interface	2							
Electronic informaion sharing with outside providers/settings	3							
Registry -reporting capability in practice	3							
Customized interactive practice web site	1							
Regional exchange participation/utilization	2							
Maximize electronic billing - claim submission - payer validation	3							
Average Health Information Technology	2.33							
Practice Management								
Leadership team and change process in place	1							
Effective communication to staff -and providers	2							
Vision statement consistent with PCMH	1							
Regular meeting schedule / effective meeting structure	2							
Providers - staff engaged in PCMH	1							
Financial dashboard/reporting to providers & manager	2							
Financial management processes in place	2							
Coding audit process in place	2							
Operating policy and procedures in place	2							
Job descriptions in place for all staff members	2							
Performance management process in place	2							
Employee handbook with policies and procedures	2							
Average Practice Management	1.8							

Quarterly Average **1.79**

TransforMED℠
TRANSFORMING MEDICAL PRACTICES

TransforMED – Nebraska Medicaid Kickoff Meeting

Date
January 11, 2011
Time
9:30 a.m. – 2:00 p.m.

Location - **Lincoln Nebraska Palace**

9:30 – 9:45 a.m.	**Welcoming Remarks, Introduction of Council** *Vivian Director of Medicaid Services*
9:45 – 10:30 p.m.	**TransforMED: Who We Are** **Nebraska Medicaid/TransforMED Partnership** **Patient-Centered Medical Home – National Level View** *Terry McGeeney, M.D., M.B.A., TransforMED President & Chief Executive Officer*
10:30 – 10:45 a.m.	**Break**
10:45 – 11:30 a.m.	**Overview of expectations** *Pat Taft, Program Specialist, Nebraska Dept of Health & Human Services* *Margaret Brockman, RN, MSN, Program Specialist, Physician Services, Division of Medicaid and Long Term Care, Nebraska Dept of Health & Human Services*
11:30 – 12:00 p.m.	**Lunch**
12:00 – 1:15 p.m.	**A Patient-Centered Medical Home Perspective Using Facilitation** *Unknown Physician Champion*
1:15 - 1:35 p.m.	**Blue Cross Blue Shield – Focus on PCMH** *Dr. Filipi, Medical Director BCBS Nebraska*
1:35 – 1:45 p.m.	**Nebraska Patient-Centered Medical Home-Support & Next Steps** *Colleen Stack, TransforMED Facilitator*
1:45 – 2:00 p.m.	**Senator's Closing Remarks**

Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care
Medical Home Standards
Verification and Validation: Tier 1

Tier 1 - Required Minimum Standards

Name of Practice

Key: 1 = Meets standard minimally 2 = Meets standard 3 = Exceeds standard

Core Competency 1: Facilitate an ongoing patient relationship with physician in a physician-directed team.

Standard	
1.1 Utilize a written plan for patient communication including accommodation for patients who have a hearing or visual impairment or for patients whose second language is English (ESL). *Documentation: Copy of the practice's written plan for patient communication.*	Score: ○ 1 ○ 2 ○ 3
1.2 Utilize written materials for patients to explain the features and essential information related to the Medical Home and published in primary language(s) of the community. *Documentation*: Sample of the practice's written materials for patients (ex. brochure, patient handbook, letter of explanation, etc.)	Score: ○ 1 ○ 2 ○ 3
1.3 Utilize patient-centered care planning (including patient's goals, values and priorities) to engage patients in their care. The Medical Home plan may include a written "After Visit Summary" outlining future care plan that is given to a patient at every visit. *Documentation: Sample of the practice's patient-centered treatment plan including information like patient's goals, diagnosis, current medications, patient's symptoms requiring follow-up home instructions for patient, referrals, etc.*	Score: ○ 1 ○ 2 ○ 3
1.4 Utilize reminder/notification system for health care services such as, appointments, preventive care, and preparation information for upcoming visits; follow up with patients regarding periodic tests or screening; and when planned appointments have been missed. *Documentation:* *1. Copy of the policy for reminder/notification system including follow-up for missed appointments; and* *2. Copy of a patient's record noting reminder/notification and/or* *3. Copy of electronic report of notices sent.*	Score: ○ 1 ○ 2 ○ 3
1.5 Provide patient education and self-management tools and support to patients, families, and caregivers. *Documentation: Sample of the practice's patient-centered written materials for patients, families, and caregivers (ex. patient booklet, brochure, screen shot of practice web site, etc.)*	Score: ○ 1 ○ 2 ○ 3
1.6 Utilize a Medical Home team* that provides team based care composed of, but not limited to, the primary care physician(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician. *Definition of Medical Home team: All staff that have contact with the patient. *Documentation:* *1. Organization chart of Medical Home team* *2. Job descriptions for each team member*	Score: ○ 1 ○ 2 ○ 3
1.7 Create and use a written action plan for the implementation of the Medical Home including a description of work flow for team members. *Documentation: Copy of the written plan for implementation of the medical home concept including a description of work flow.*	Score: ○ 1 ○ 2 ○ 3

COMMENTS:

Core Competency 2: Coordinate continuous patient-centered care across the health care system.

Standard	
2.1 Utilize written protocol with hospital(s) outlining referral and follow-up care coordination, and admission and discharge notifications. *Documentation: Copy of the written protocol with hospital(s).*	Score: ○ 1 ○ 2 ○ 3
2.2 Provide care coordination and supports family participation in care including providing connections to community resources. *Documentation*: Copy of a patient's record showing *documentation* of the family participation, if applicable, and connections to community resources.	Score: ○ 1 ○ 2 ○ 3
2.3 Utilize a system to maintain and review a list of patient's medications. *Documentation:* *1. Written explanation of the system used to maintain and review patient's medications; and* *2. Copy of a patient's record showing list of medications*	Score: ○ 1 ○ 2 ○ 3
2.4 Track diagnostic tests and provide written and verbal follow-up on results with the patient plus follows up after referrals, specialist care and other consultations. *Documentation:* *1. If in writing, copy of a written follow-up sent to a patient; and/or* *2. If verbal, copy of a patient's record documenting verbal follow-up.*	Score: ○ 1 ○ 2 ○ 3
2.5 Utilize a patient registry. *Documentation: Screen shot of patient registry showing patient information.*	Score: ○ 1 ○ 2 ○ 3
2.6 Define and identify high-risk patients in the Medical Home who will benefit from care planning and provide a care plan to these individuals. *Documentation:* *1. Written definition of high-risk patients; and* *2. Written explanation of how high-risk patients are identified; and* *3. Copy of a care plan provided to a patient.*	Score: ○ 1 ○ 2 ○ 3
2.7 Provide and coordinate Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services. *Documentation:* *1. Written explanation of how eligible children are identified and the notification process; and* *2. Copy of a patient's record showing EPSDT services provided or a checklist for a patient showing EPSDT components provided.*	Score: ○ 1 ○ 2 ○ 3
2.8 Provide transitional care plan for patients transferring to another physician or medical home. *Documentation: Written explanation of the practice's transitional care plan with examples of any materials used such as a checklist, letter, documentation of phone calls, etc.*	Score: ○ 1 ○ 2 ○ 3

2.9 Organize clinical data in a paper or electronic format for each individual patient. *Documentation: Copy of blank patient's record showing how an individual's clinical data is organized in a patient specific charting system.*	Score: ○ 1 ○ 2 ○ 3
2.10 Utilize a system to organize and track and improve the care of high risk and special needs patients. *Documentation:* *1. Written explanation of the system used to organize and track the care; or* *2. Copy of patient's record showing documentation of tracking.*	Score: ○ 1 ○ 2 ○ 3

COMMENTS:

Core Competency 3: Provide for patient accessibility to the services of the Medical Home.

Standard	
3.1 Provide on-call access* for patients to the Medical Home team 24 hours/day, 7 days/week. *Definition of On-call Access: At a minimum, clinical advice is available by telephone directly with a licensed heath care professional representing the Medical Home team. *Documentation: Copy of written protocol for on-call access.*	Score: ○ 1 ○ 2 ○ 3
3.2 Offer appointments outside traditional business hours of Monday – Friday 9 a.m. to 5 p.m. *Documentation*: Written explanation of appointment hours outside of 9 a.m. to 5 p.m.	Score: ○ 1 ○ 2 ○ 3
3.3 Utilize a system to respond promptly to prescription refill requests and other patient inquiries. *Documentation:* *1. Written explanation of the system for prescription refills and other patient inquiries including staff responsibilities; and* *2. Copy of a patient's record documenting patient inquiry and response; and* *3. Copy of a patient's record documenting prescription refill or electronic report if using e-prescribing*	Score: ○ 1 ○ 2 ○ 3
3.4 Provide day-of-call appointments. *Documentation: Ten documented patient situations where patient was provided day-of-call appointment.*	Score: ○ 1 ○ 2 ○ 3
3.5 Utilize written Medical Home standards for patient access. *Documentation: Copy of the standards set by the Medical Home practice for patient access (ex. use of phone calls, e-mails, staff on-call, visits to nursing home patients, etc.)*	Score: ○ 1 ○ 2 ○ 3

COMMENTS:

Core Competency 4: Commitment to efficiency of care by reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of health care services.

Standard	
4.1 Establish at least two out of three of these specific waste reduction initiatives: generic medication utilization, reducing avoidable ER visits or reducing hospital readmissions. *Documentation*: Written explanation of two initiatives chosen and how they will be implemented including patient engagement, staff responsibilities, and plan for monitoring.	Score: ○ 1 ○ 2 ○ 3
4.2 Implement an intervention* to reduce unnecessary care or preventable utilization that increases cost without improving health. *Example of intervention: reduction of unnecessary imaging studies, excessive office visits, utilizing nutrition counseling vs. drug treatment, etc. *Documentation: Written explanation of the intervention selected and how it will be implemented.*	Score: ○ 1 ○ 2 ○ 3

COMMENTS:

Core Competency 5: Engage in a quality improvement process with a focus on patient experience, patient health, and cost-effectiveness of services.

Standard	
5.1 Establish a quality improvement team that, at a minimum, includes one or more medical staff who deliver services within the medical home; one or more care coordinators, and if a clinic, one or more representatives from administration/ management, with input for the team from a patient advisory group. *Documentation:* *1. Written description of the Quality Improvement team including who is on the team, goals of the team, and planned frequency of meetings; and* *2. Copy (ies) of meeting notes.*	Score: ○ 1 ○ 2 ○ 3
5.2 Develop a formal plan to measure effectiveness of care management. *Documentation: Copy of the plan to measure effectiveness of care management including planned data sources.*	Score: ○ 1 ○ 2 ○ 3

5.3 Develop an operational quality improvement plan for the Medical Home with at least one focus area. *Documentation: Copy of the plan to improve the quality of the operations of the practice. (Example of focus areas: work flow, fiscal efficiencies, internal communication process, etc)*	Score: ○ 1 ○ 2 ○ 3
5.4 Utilize a patient survey on their experience of care and sets a schedule for utilization. (May be developed or provided through technical assistance.) *Documentation:* *1. Written explanation of how patient survey will be conducted including planned schedule and how information will be compiled; and* *2. Copy of patient survey tool.*	Score: ○ 1 ○ 2 ○ 3
5.5 Identify one or more patient health outcomes to improve through a clinical quality improvement program using evidence-based guidelines. *Documentation: Written explanation of outcomes chosen and what evidence-based guidelines will be used. (Outcome examples: diabetes, asthma, CHF, COPD, etc.)*	Score: ○ 1 ○ 2 ○ 3

COMMENTS:

I certify that all of the Tier 1 Minimum Standards have been met to our satisfaction.

TransforMED Representative Signature	Title	Date

I have reviewed the *documentation* provided and validate that all Minimum Standards have been met to be recognized as a Patient-Centered Medical Home for the Medicaid Medical Home Pilot.

DHHS Representative Signature	Title	Date

The Patient-Centered Medical Home

The **Kearney Clinic, P.C.** is taking a new approach to patient care. We are transforming our offices to patient-centered medical homes to serve as your consistent, reliable source for preventive care, as well as for treatment of illness and chronic medical conditions. The focus of a medical home is you and your relationship with your doctor. We want to be the first place you think of for health care.

Make Each Doctor's Visit Work For You

Before your visit:

- Write down your questions and worries. If it is a long list, ask for a longer visit.
- If you see a specialist ask them to send their report to your primary doctor.
- On the day of your visit, put all your medicine in a bag and bring it with you to your doctor visit.
- Bring your Medicare, Medicaid or other insurance card.
- Bring your list of questions.
- If you need help, ask a friend or family member to join you.

At your doctor's office:

- Relax! Ask questions! Take notes. Tell your doctor when you don't understand. Remember your doctor wants the very best for you.
- Ask your doctor to tell you the values of your blood pressure, weight and lab tests. Keep a record of these values.
- Ask your doctor when you should schedule your next visit.

Partners in Care

Your medical home is a place you feel comfortable and confident-both in the relationship with your doctor and the quality of care you receive. You and your doctor together will focus on your specific health care needs and ongoing wellness.

Our Commitment

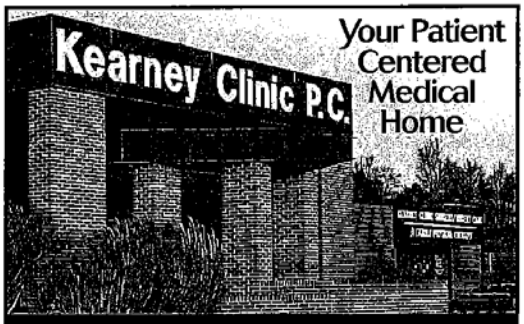
We promise to deliver personalized care and:

- Provide the best treatment and advice based on current medical evidence
- Manage acute illness and chronic disease to help you stay healthy
- Provide timely access to care
- Offer a medical decision maker through our office 24 hours a day
- Use computers and other technology to improve your care
- Support you in your health care goals and desires
- Arrange your health care with other qualified specialists as needed
- Explain diseases, treatments, medications and results in a way that is easy to understand
- Respect your privacy by keeping medical information and records private in compliance with state and federal law
- Make you feel comfortable and welcome

Your Role

As an active partner in your care, we ask you to:

- Provide all information about your health, medications and illnesses.
- Tell us about services you receive elsewhere, such as flu vaccines and treatments by other providers.
- Follow your treatment plan; if you are unable to, let us know so we can suggest other options.
- Work with us to make decisions and manage your health.
- Describe your needs and concerns.
- Learn about wellness and preventing disease.
- Make healthy decisions about your daily habits and lifestyles.
- Call us first with all medical problems, unless it is an emergency.
- Keep your scheduled appointments or call in advance if you need to reschedule.
- Give us feedback so we can improve our service.



We want to help YOU take good care of YOU!

Kearney Clinic is moving from a "sick" care model to a "preventative" care model.

YOU can help improve your health by taking an active role in your healthcare...

- Lead a Healthy Lifestyle
- Regular Health Exams
- Regular Exercise
- Healthy Eating

Help your doctor manage your care...

- Bring a complete medication list to your doctor visit (include over the counter products)
- If you see another doctor (including eye doctors) have them forward reports to our clinic
- Bring a list of symptoms and concerns to your visit
- Follow your doctor's advice and take prescribed medications as instructed
- Call your pharmacy FIRST for medication refills

Kearney Clinic, P.C.

A TRADITION OF EXCELLENCE IN HEALTH CARE

211 West 33rd Street • Kearney, NE 68845
308-865-2141 • Appointment Line: 308-698-1576
www.kearneyclinic.com
Monday - Friday 8:30 a.m.-5 p.m. • Saturday 8:30 a.m. - 12 p.m.

TransforMED℠
TRANSFORMING MEDICAL PRACTICES

Nebraska Care Manager Training
Thursday, September 6, 2012
9:30am – 5:00pm

Holiday Inn
Kearney, Nebraska

LEARNING OBJECTIVES:

- Understand the role of the Care Manager/Coordinator in the PCMH
- Learn how to effectively manage individual patients and patient populations
- Explore tools for the Care Manager
- Realize the cost benefit of the Care Manager
- Utilization of Health Information Technology (HIT) in Care Management
- Understand strategies for patient and family support
- Develop Motivational Interviewing Skills

Roles and Responsibilities of the Care Manager	Diane Cardwell, TransforMED
Care Management: Patients and Populations	Kristi Bohling-DaMetz, TransforMED
BREAK	
Care Coordination	Colleen Stack, TransforMED
LUNCH	
Cost Benefit of the Care Manager	Colleen Stack, TransforMED
Patient & Family Assessment & Support	Diane Cardwell, TransforMED
Patient Engagement, Activation, and Education	Kristi Bohling-DaMetz, TransforMED
BREAK	
Care Planning, Care Summary	Kristi Bohling-DaMetz, TransforMED
Community Health Workers (supporting implementing plans and progressing toward goals – Peers model)	
Motivational Interviewing	
Questions and Closing Announcements	TransforMED & participants
Adjourn	

TransforMED℠
TRANSFORMING MEDICAL PRACTICES

Nebraska Medicaid PCMH: Aggregate Employee Satisfaction Data Comparison

February 6, 2013

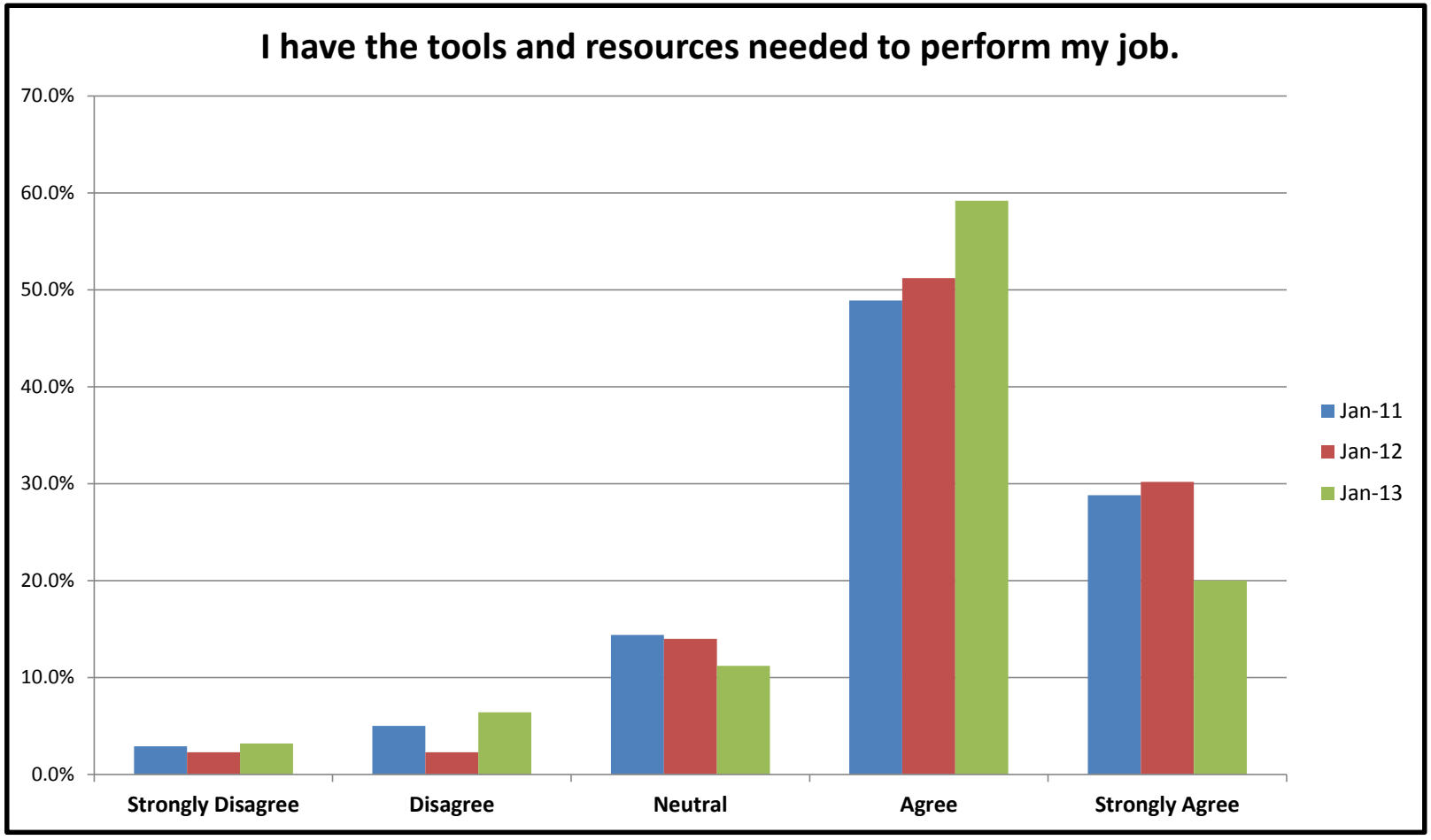
January 2011 Survey Count = 142

January 2012 Survey Count = 87

January 2013 Survey Count = 125

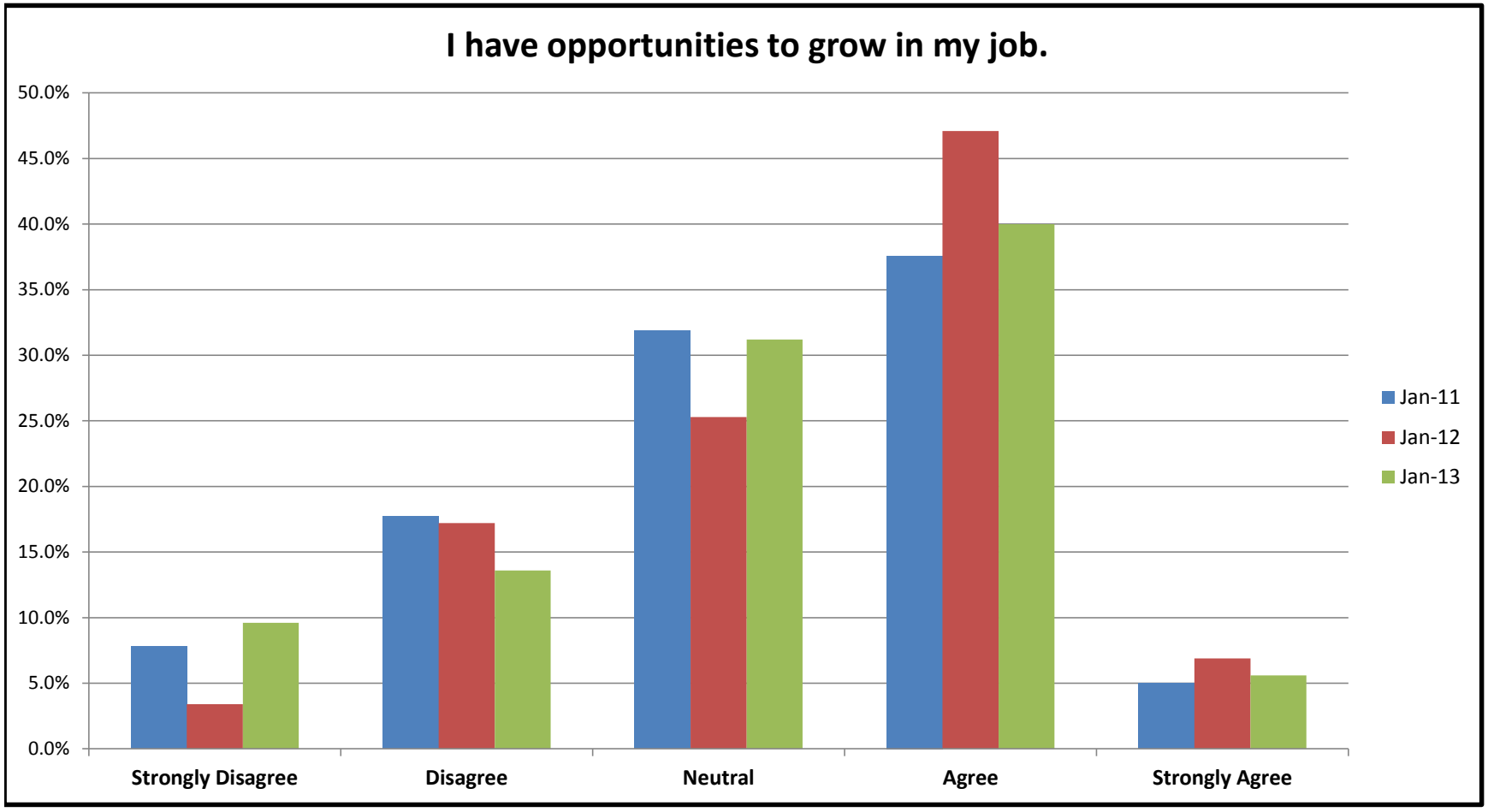
Tools and Resources

	Jan-11	Jan-12	Jan-13
Strongly Disagree	2.9%	2.3%	3.2%
Disagree	5.0%	2.3%	6.4%
Neutral	14.4%	14.0%	11.2%
Agree	48.9%	51.2%	59.2%
Strongly Agree	28.8%	30.2%	20.0%



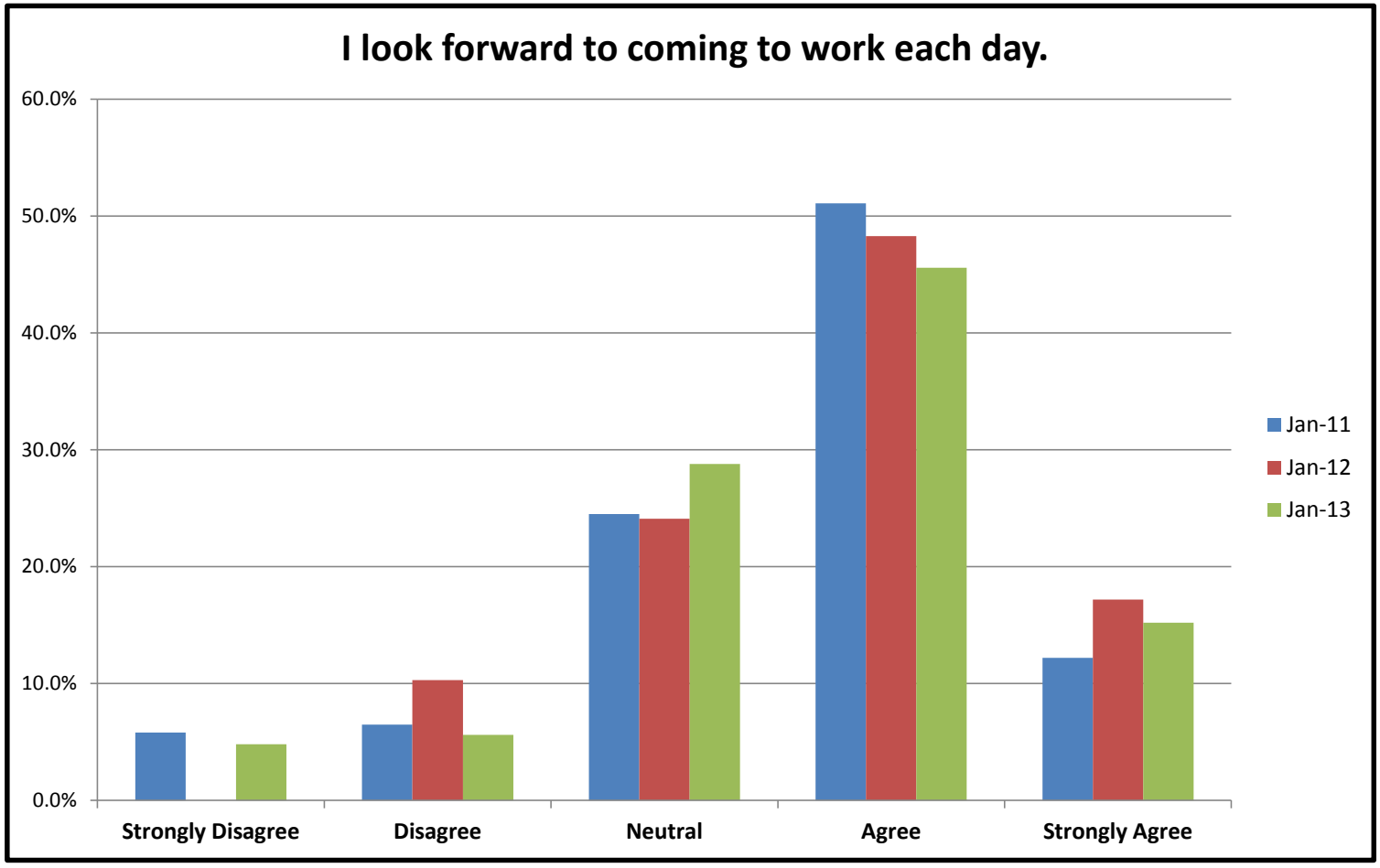
Opps to Grow

	Jan-11	Jan-12	Jan-13
Strongly Disagree	7.8%	3.4%	9.6%
Disagree	17.7%	17.2%	13.6%
Neutral	31.9%	25.3%	31.2%
Agree	37.6%	47.1%	40.0%
Strongly Agree	5.0%	6.9%	5.6%



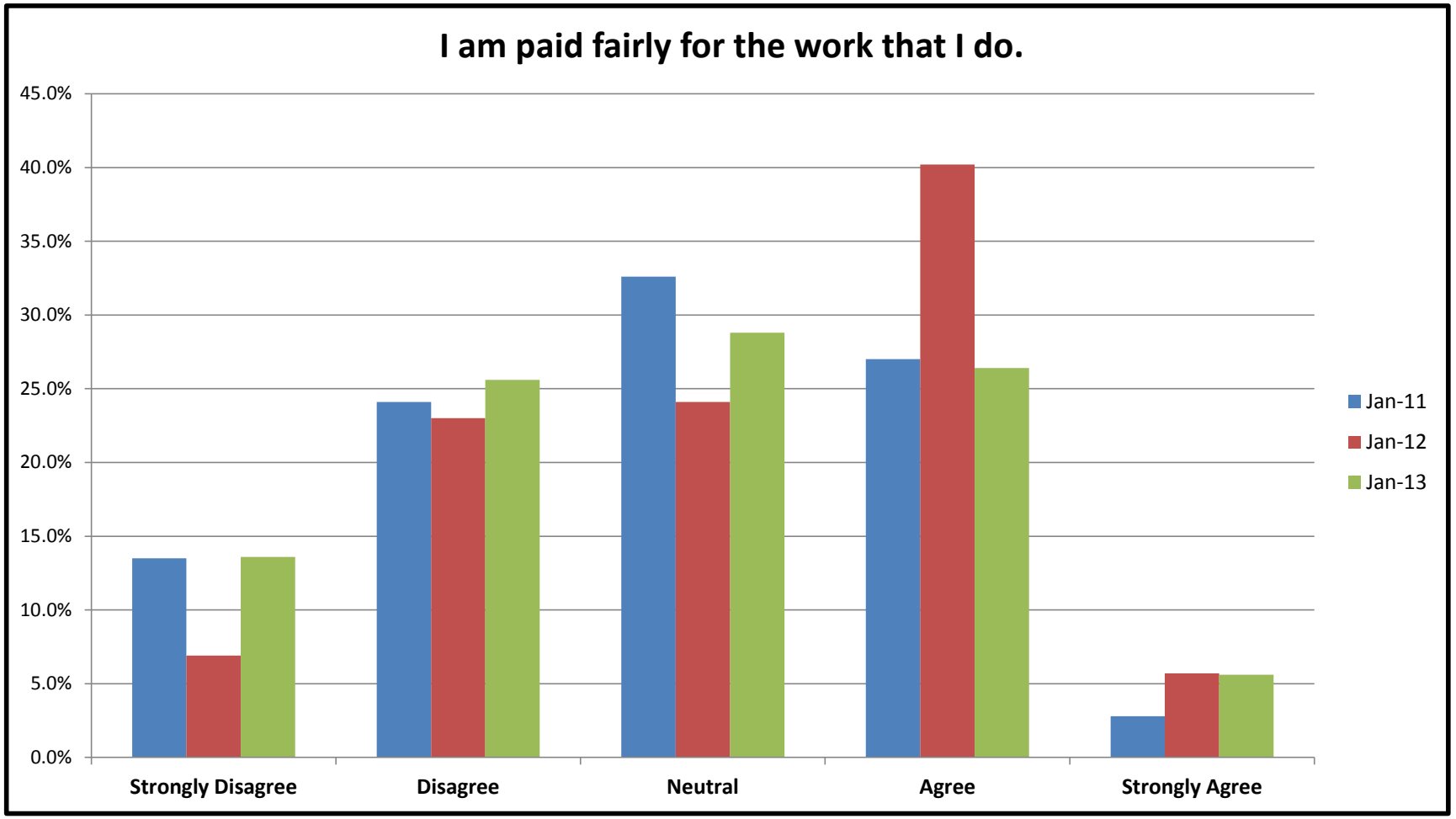
Look Forward

	Jan-11	Jan-12	Jan-13
Strongly Disagree	5.8%	0.0%	4.8%
Disagree	6.5%	10.3%	5.6%
Neutral	24.5%	24.1%	28.8%
Agree	51.1%	48.3%	45.6%
Strongly Agree	12.2%	17.2%	15.2%



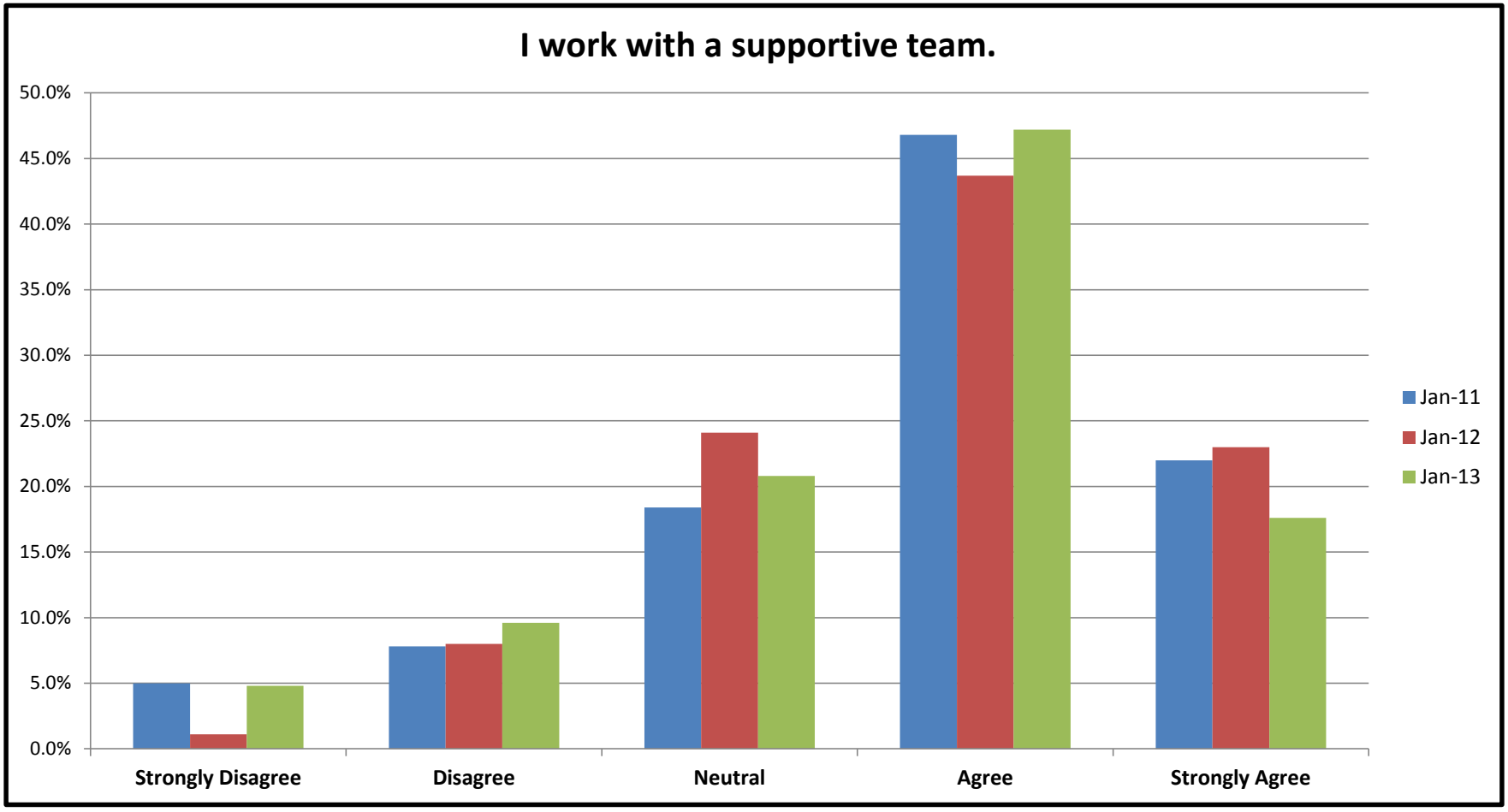
Paid Fairly

	Jan-11	Jan-12	Jan-13
Strongly Disagree	13.5%	6.9%	13.6%
Disagree	24.1%	23.0%	25.6%
Neutral	32.6%	24.1%	28.8%
Agree	27.0%	40.2%	26.4%
Strongly Agree	2.8%	5.7%	5.6%



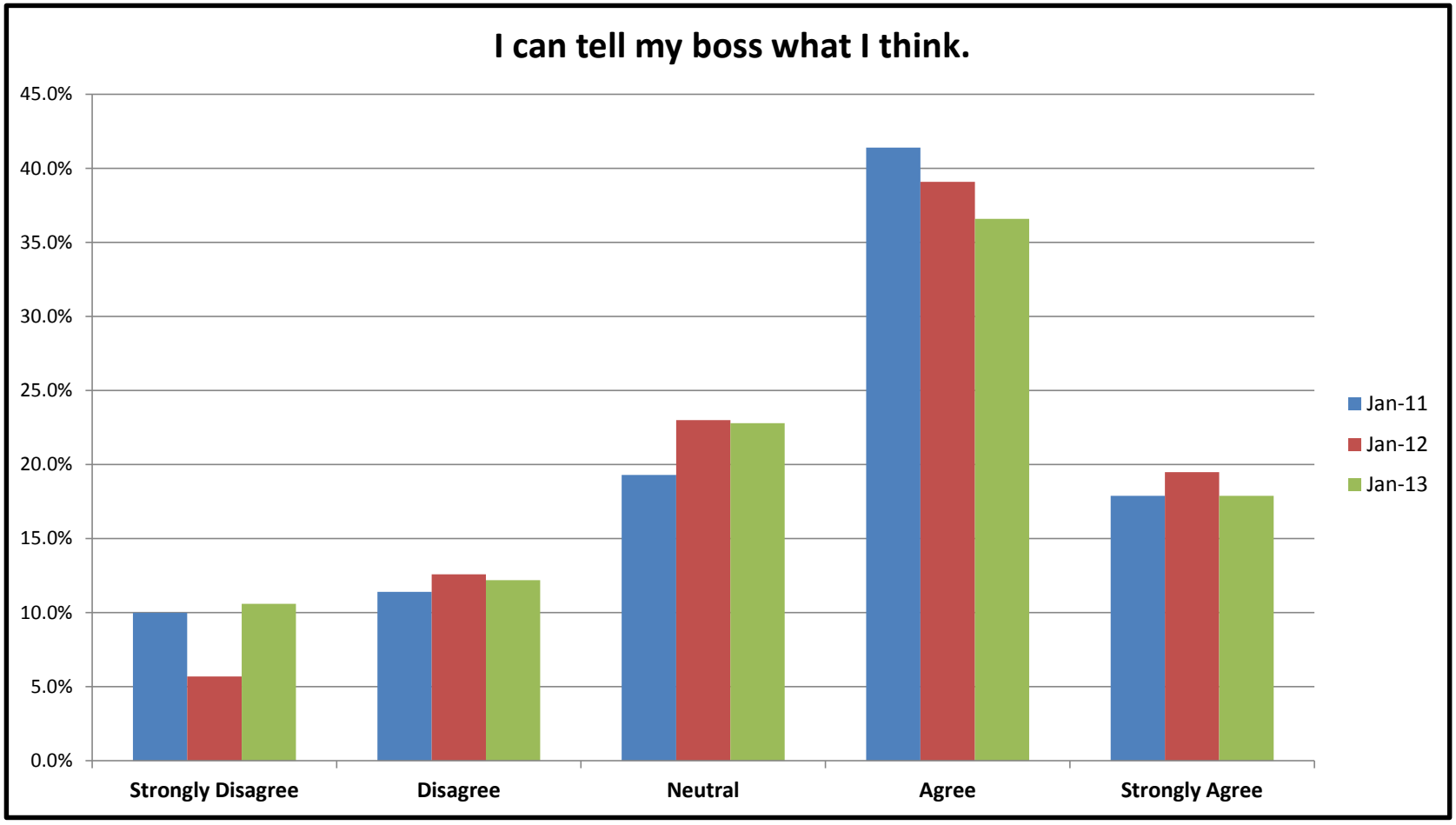
Supportive Team

	Jan-11	Jan-12	Jan-13
Strongly Disagree	5.0%	1.1%	4.8%
Disagree	7.8%	8.0%	9.6%
Neutral	18.4%	24.1%	20.8%
Agree	46.8%	43.7%	47.2%
Strongly Agree	22.0%	23.0%	17.6%



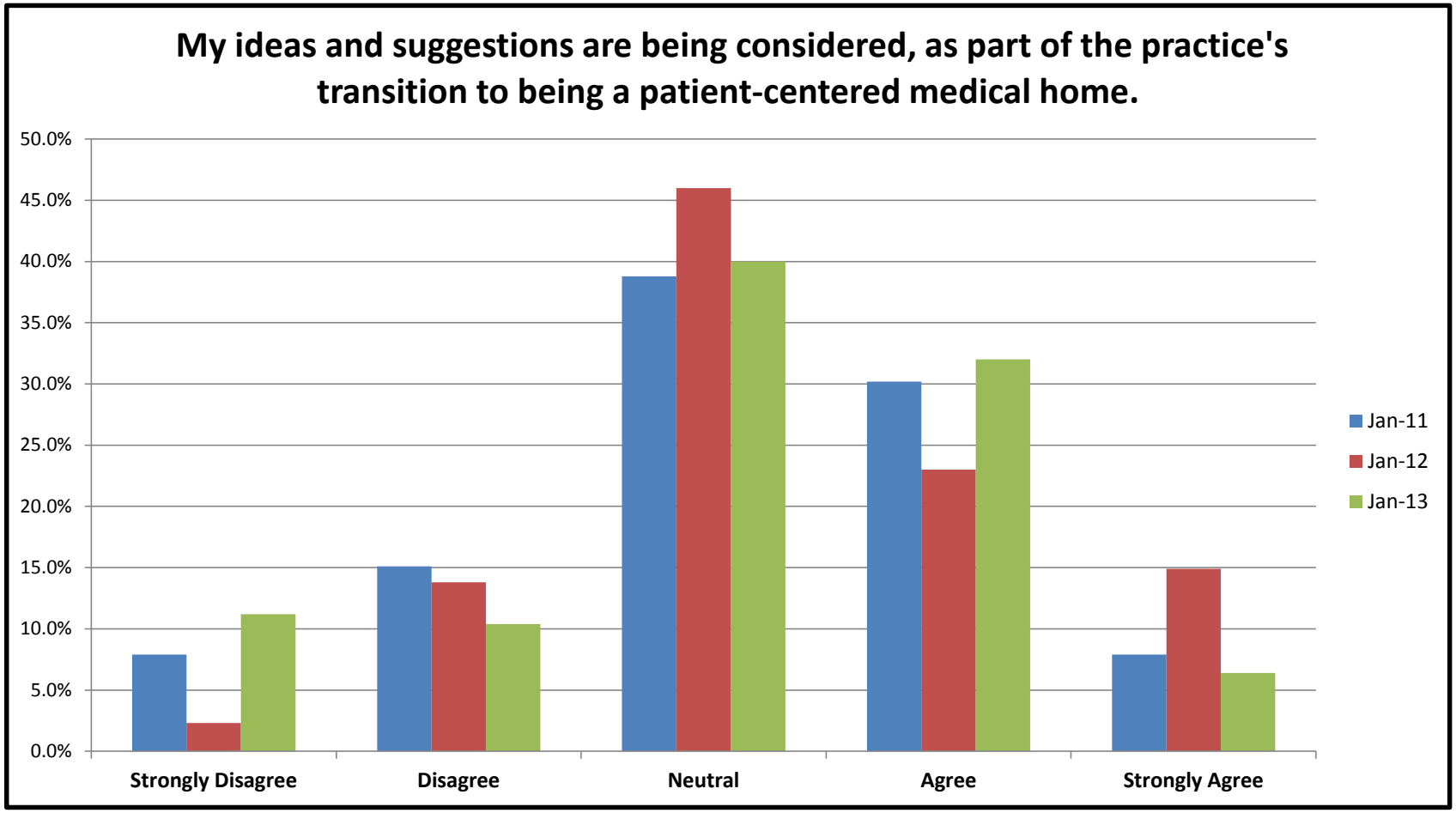
Tell Boss

	Jan-11	Jan-12	Jan-13
Strongly Disagree	10.0%	5.7%	10.6%
Disagree	11.4%	12.6%	12.2%
Neutral	19.3%	23.0%	22.8%
Agree	41.4%	39.1%	36.6%
Strongly Agree	17.9%	19.5%	17.9%



Ideas Considered

	Jan-11	Jan-12	Jan-13
Strongly Disagree	7.9%	2.3%	11.2%
Disagree	15.1%	13.8%	10.4%
Neutral	38.8%	46.0%	40.0%
Agree	30.2%	23.0%	32.0%
Strongly Agree	7.9%	14.9%	6.4%



TransforMED℠
TRANSFORMING MEDICAL PRACTICES

Practice A

Nebraska Medicaid PCMH: Employee Satisfaction Data Comparison

February 6, 2013

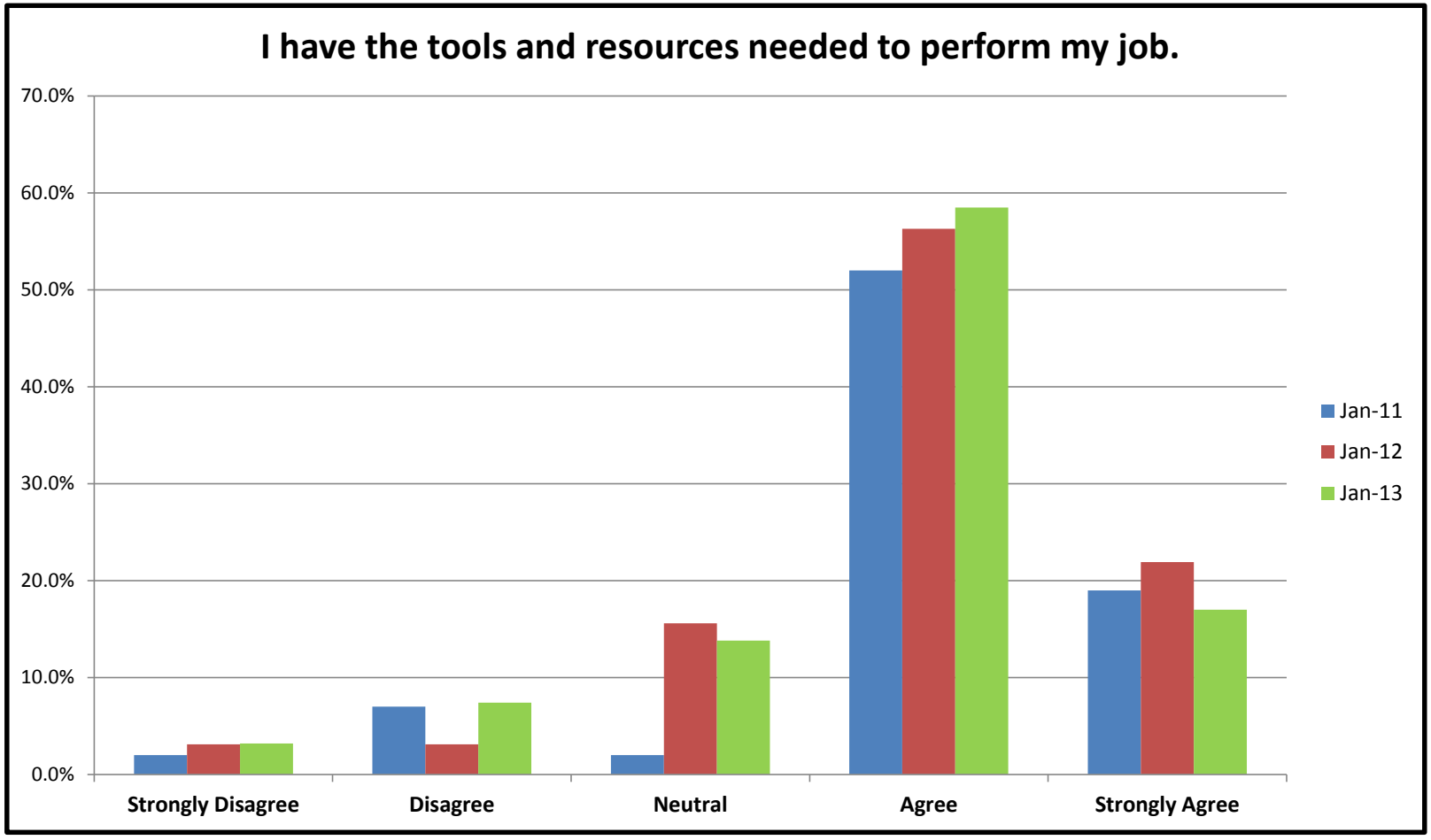
January 2011 Survey Count = 107

January 2012 Survey Count = 64

January 2013 Survey Count = 94

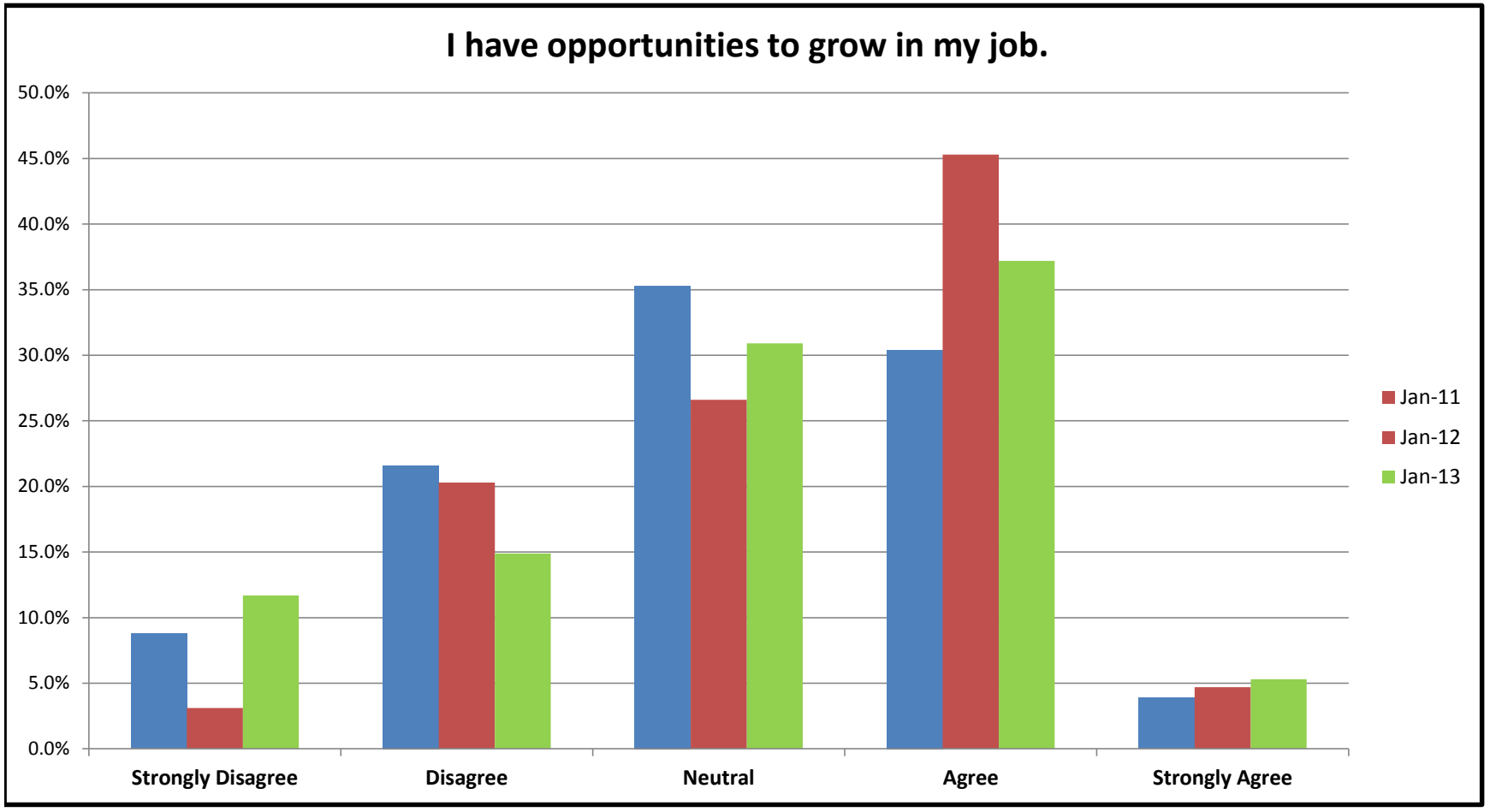
Tools and Resources

	Jan-11	Jan-12	Jan-13
Strongly Disagree	2.0%	3.1%	3.2%
Disagree	7.0%	3.1%	7.4%
Neutral	2.0%	15.6%	13.8%
Agree	52.0%	56.3%	58.5%
Strongly Agree	19.0%	21.9%	17.0%



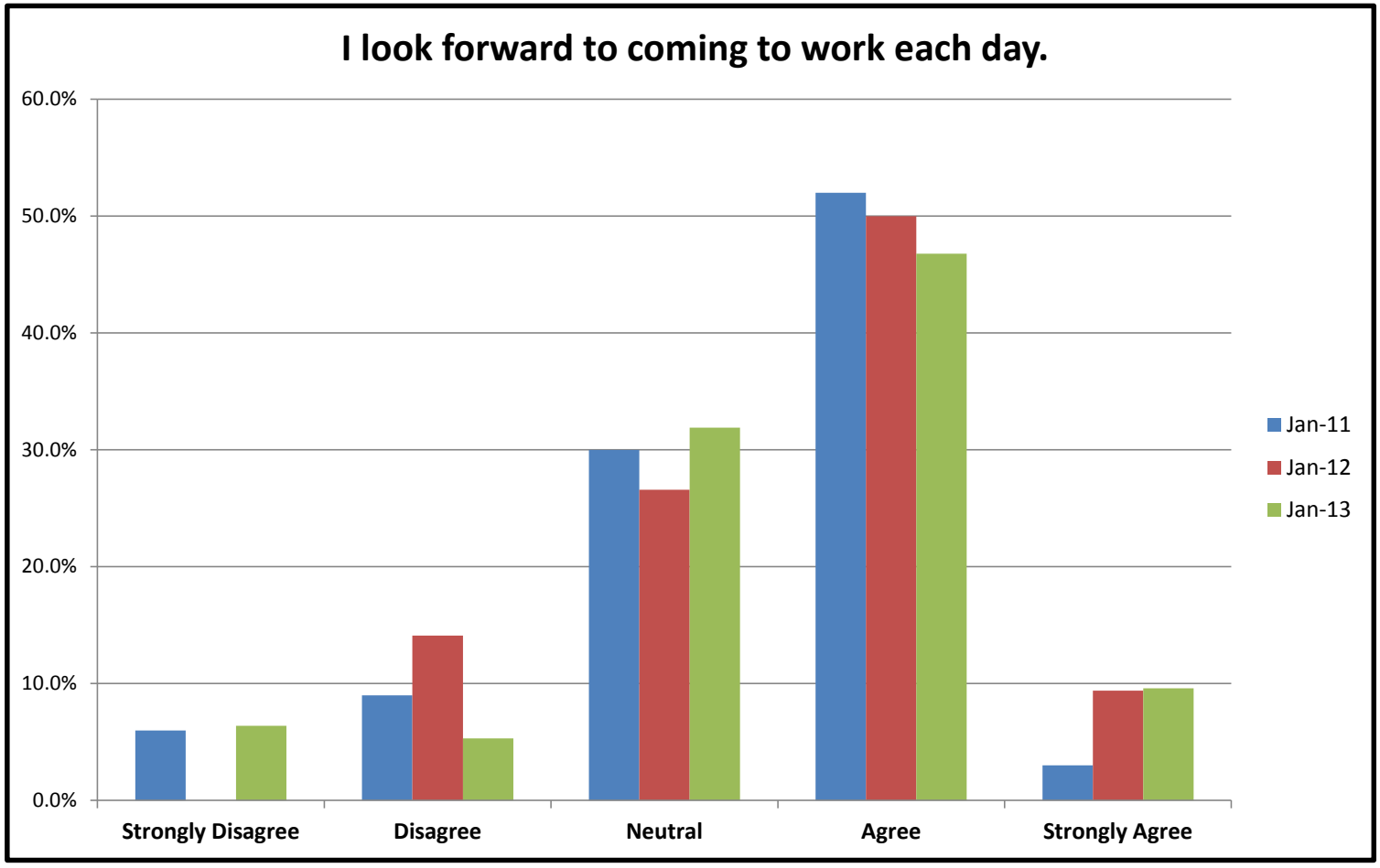
Opps to Grow

	Jan-11	Jan-12	Jan-13
Strongly Disagree	8.8%	3.1%	11.7%
Disagree	21.6%	20.3%	14.9%
Neutral	35.3%	26.6%	30.9%
Agree	30.4%	45.3%	37.2%
Strongly Agree	3.9%	4.7%	5.3%



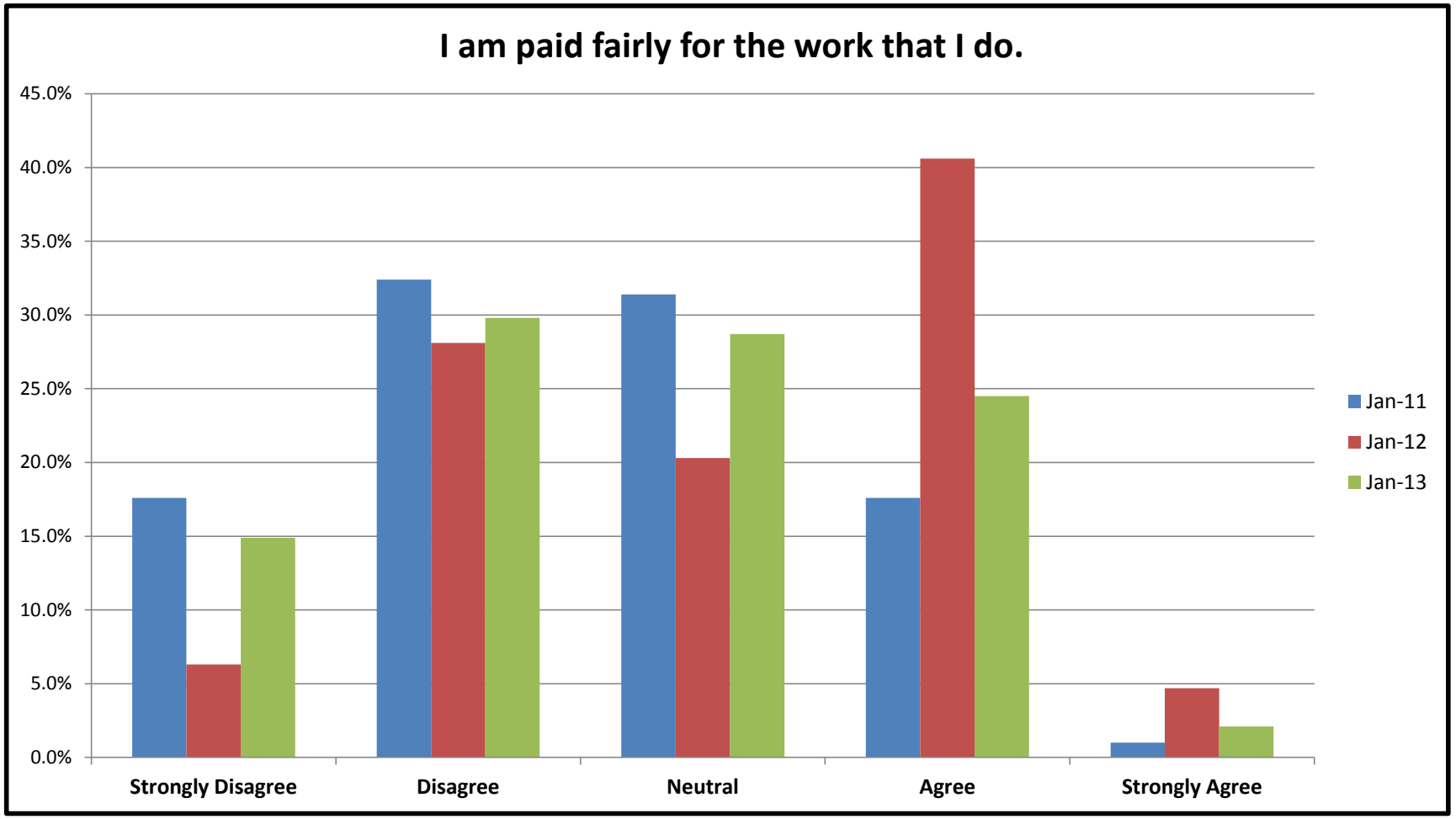
Look Forward

	Jan-11	Jan-12	Jan-13
Strongly Disagree	6.0%	0.0%	6.4%
Disagree	9.0%	14.1%	5.3%
Neutral	30.0%	26.6%	31.9%
Agree	52.0%	50.0%	46.8%
Strongly Agree	3.0%	9.4%	9.6%



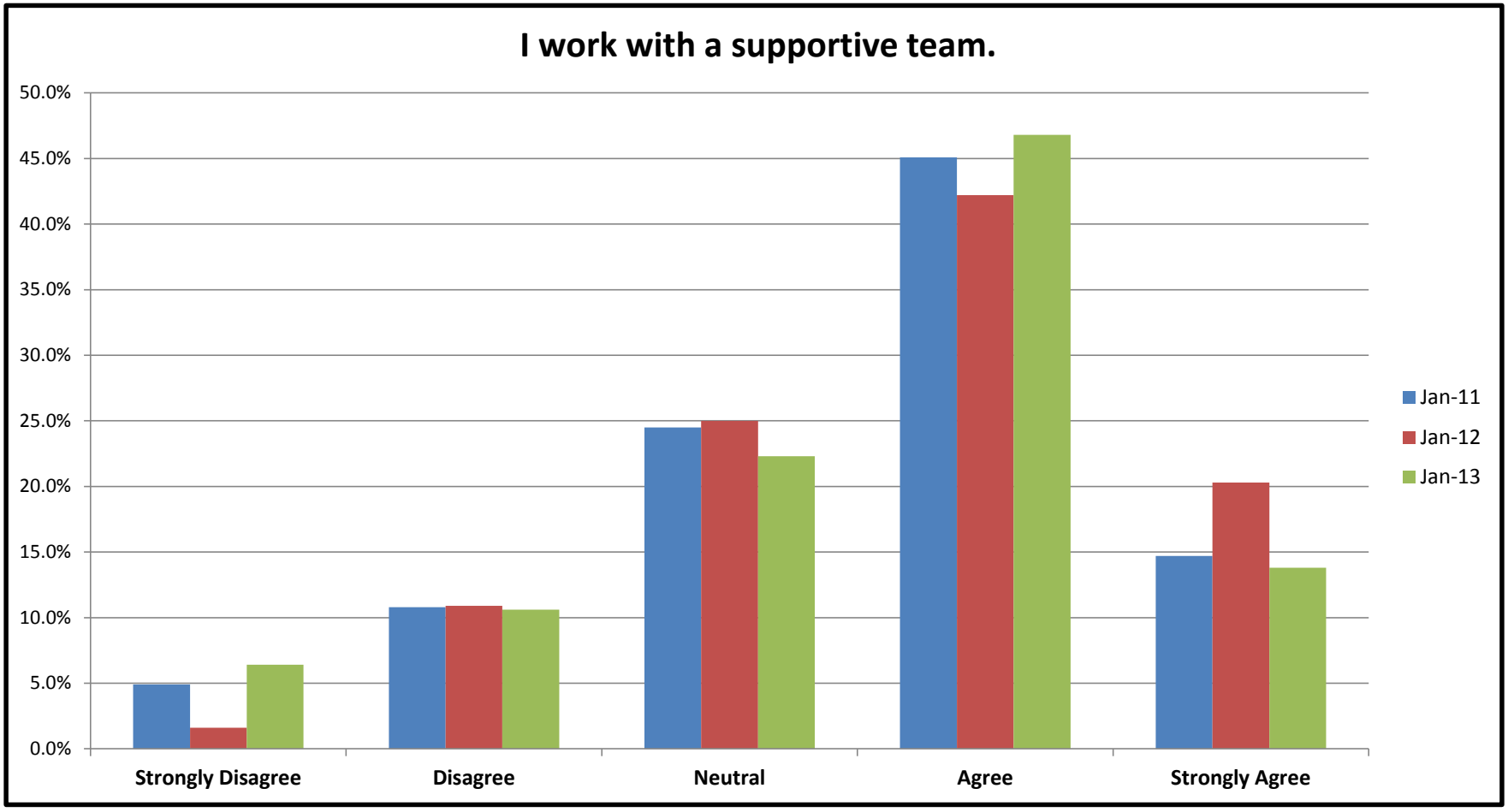
Paid Fairly

	Jan-11	Jan-12	Jan-13
Strongly Disagree	17.6%	6.3%	14.9%
Disagree	32.4%	28.1%	29.8%
Neutral	31.4%	20.3%	28.7%
Agree	17.6%	40.6%	24.5%
Strongly Agree	1.0%	4.7%	2.1%



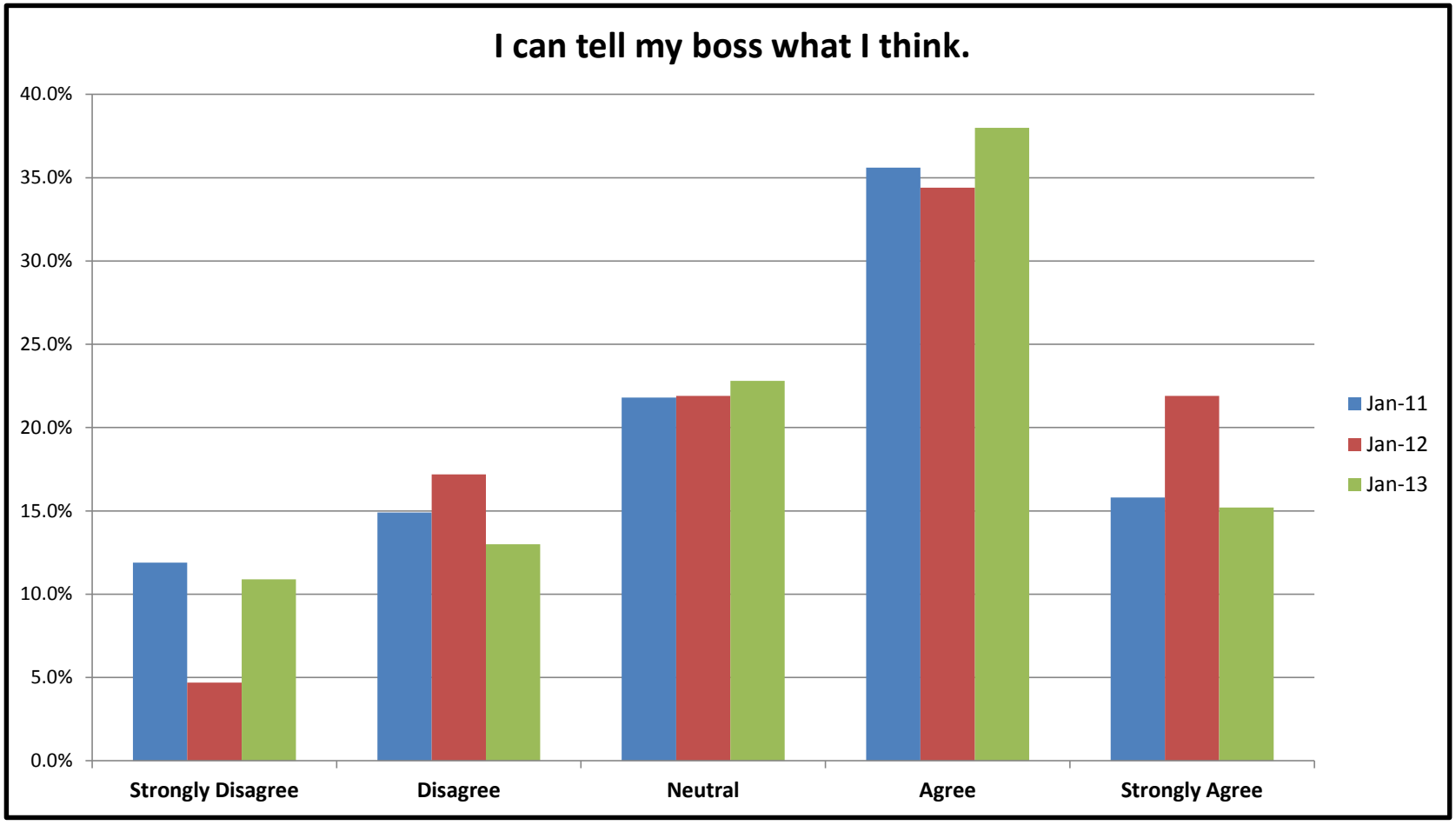
Supportive Team

	Jan-11	Jan-12	Jan-13
Strongly Disagree	4.9%	1.6%	6.4%
Disagree	10.8%	10.9%	10.6%
Neutral	24.5%	25.0%	22.3%
Agree	45.1%	42.2%	46.8%
Strongly Agree	14.7%	20.3%	13.8%



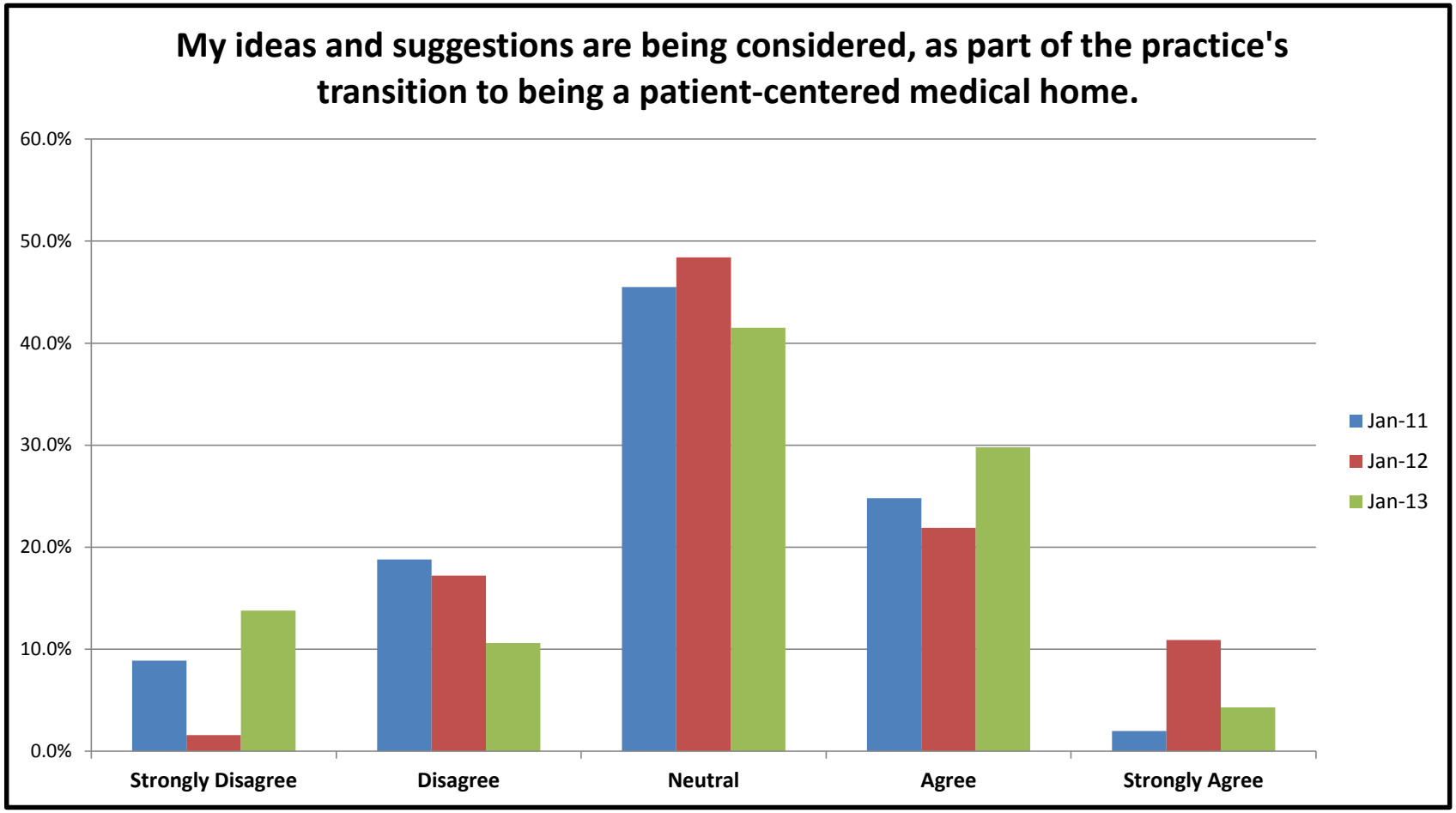
Tell Boss

	Jan-11	Jan-12	Jan-13
Strongly Disagree	11.9%	4.7%	10.9%
Disagree	14.9%	17.2%	13.0%
Neutral	21.8%	21.9%	22.8%
Agree	35.6%	34.4%	38.0%
Strongly Agree	15.8%	21.9%	15.2%



Ideas Considered

	Jan-11	Jan-12	Jan-13
Strongly Disagree	8.9%	1.6%	13.8%
Disagree	18.8%	17.2%	10.6%
Neutral	45.5%	48.4%	41.5%
Agree	24.8%	21.9%	29.8%
Strongly Agree	2.0%	10.9%	4.3%



TransforMED℠
TRANSFORMING MEDICAL PRACTICES

Practice B

Nebraska Medicaid PCMH: Employee Satisfaction Data Comparison

February 6, 2013

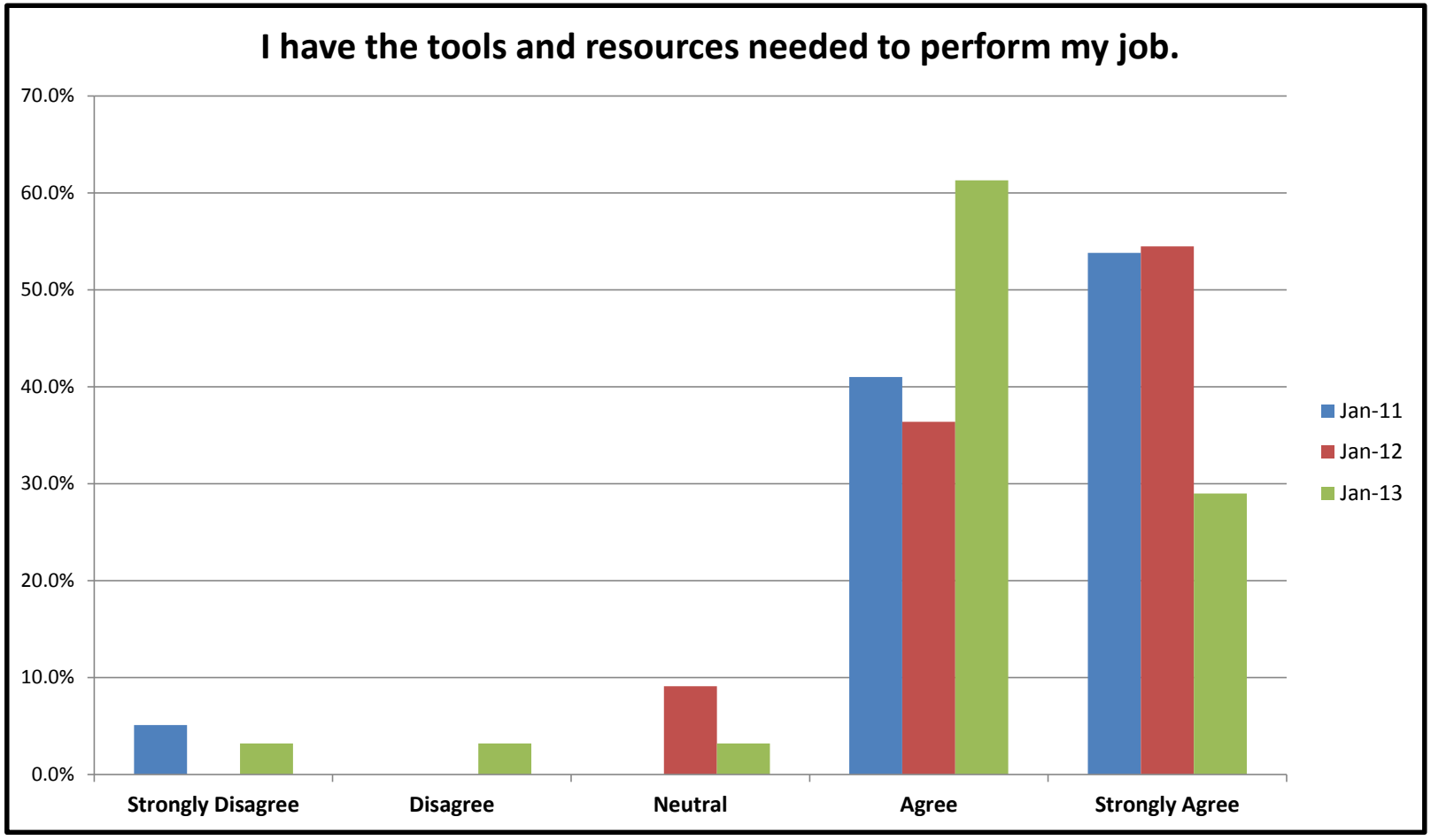
January 2011 Survey Count = 40

January 2012 Survey Count = 23

January 2013 Survey Count = 31

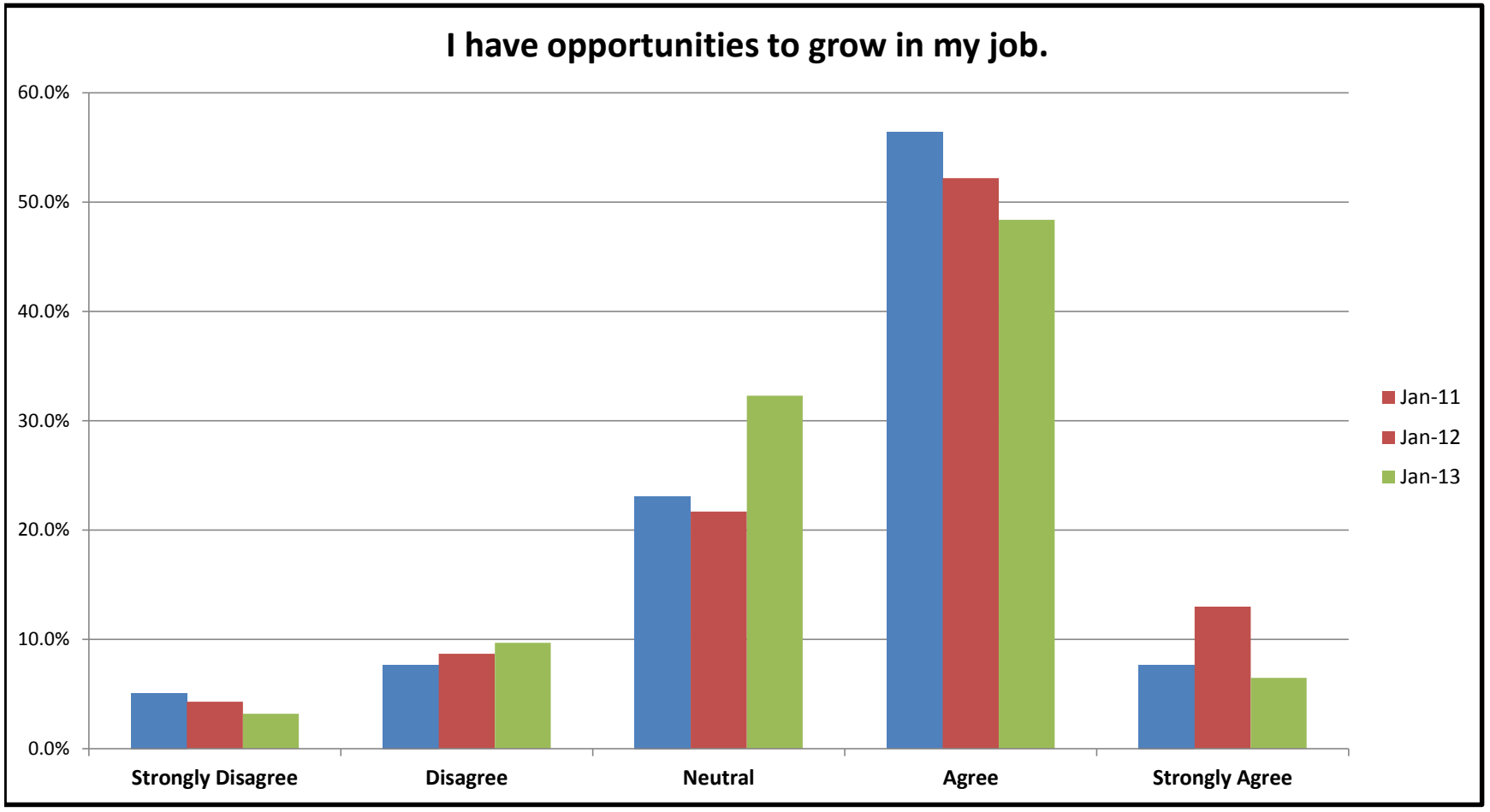
Tools and Resources

	Jan-11	Jan-12	Jan-13
Strongly Disagree	5.1%	0.0%	3.2%
Disagree	0.0%	0.0%	3.2%
Neutral	0.0%	9.1%	3.2%
Agree	41.0%	36.4%	61.3%
Strongly Agree	53.8%	54.5%	29.0%



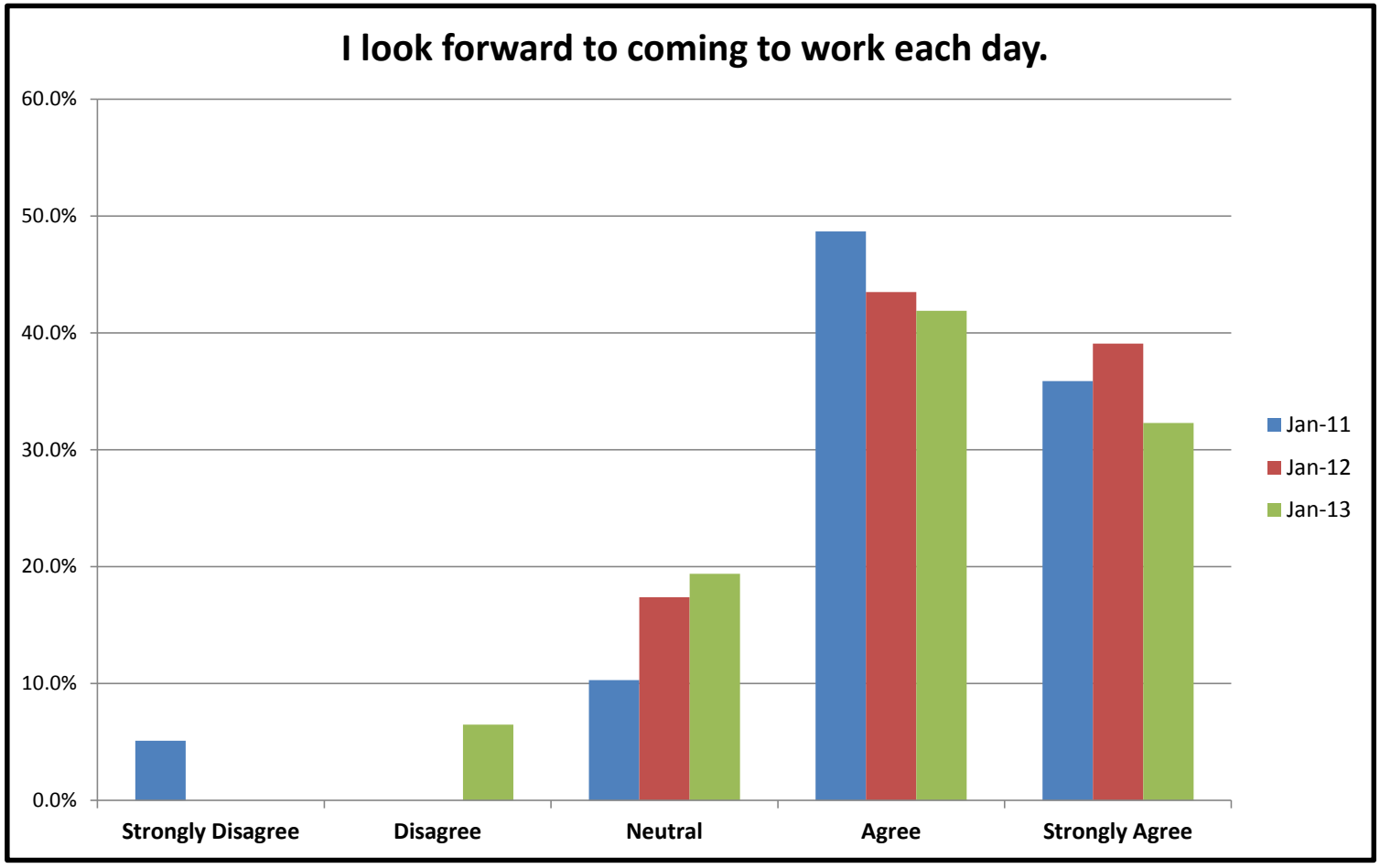
Opps to Grow

	Jan-11	Jan-12	Jan-13
Strongly Disagree	5.1%	4.3%	3.2%
Disagree	7.7%	8.7%	9.7%
Neutral	23.1%	21.7%	32.3%
Agree	56.4%	52.2%	48.4%
Strongly Agree	7.7%	13.0%	6.5%



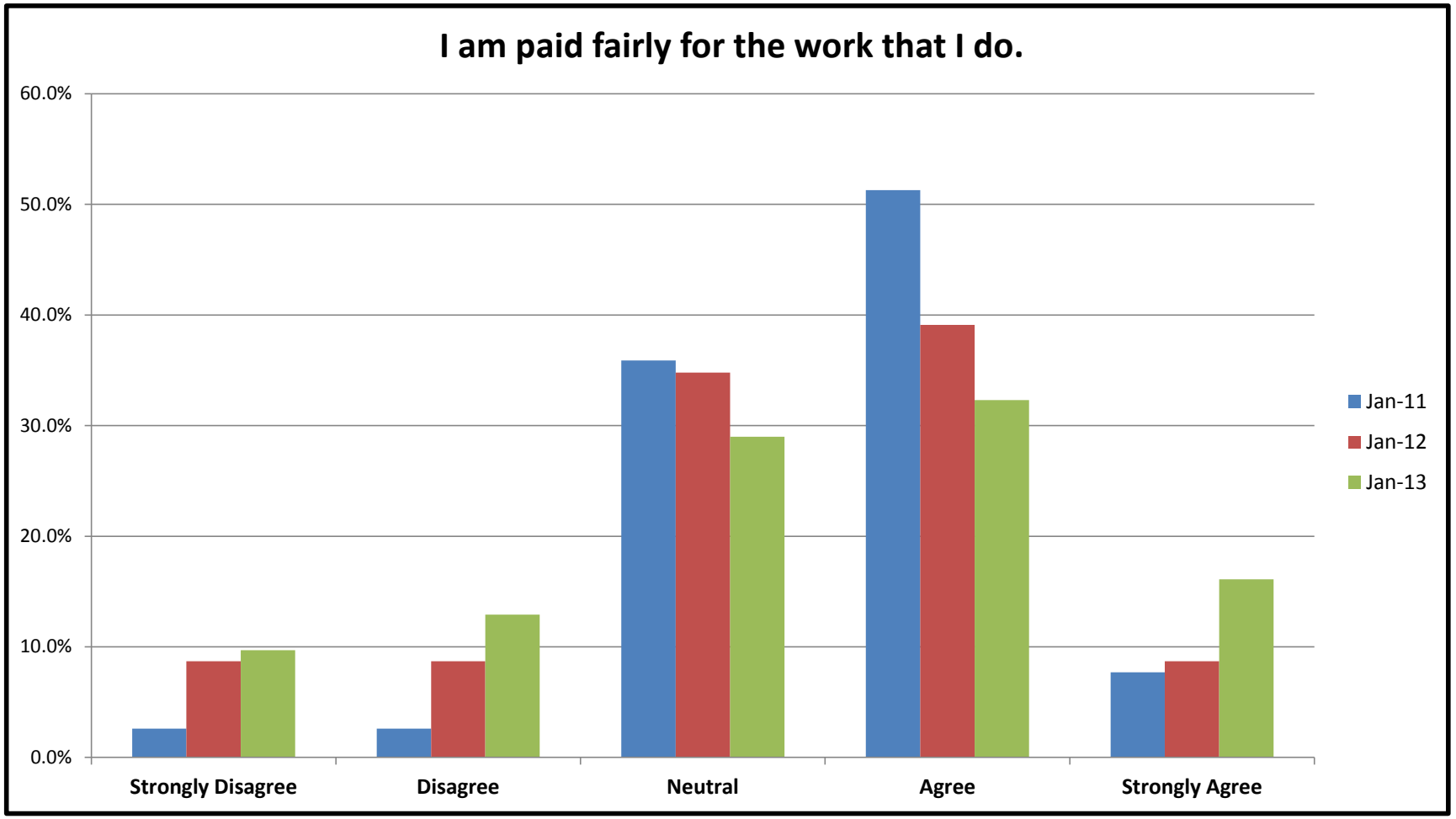
Look Forward

	Jan-11	Jan-12	Jan-13
Strongly Disagree	5.1%	0.0%	0.0%
Disagree	0.0%	0.0%	6.5%
Neutral	10.3%	17.4%	19.4%
Agree	48.7%	43.5%	41.9%
Strongly Agree	35.9%	39.1%	32.3%



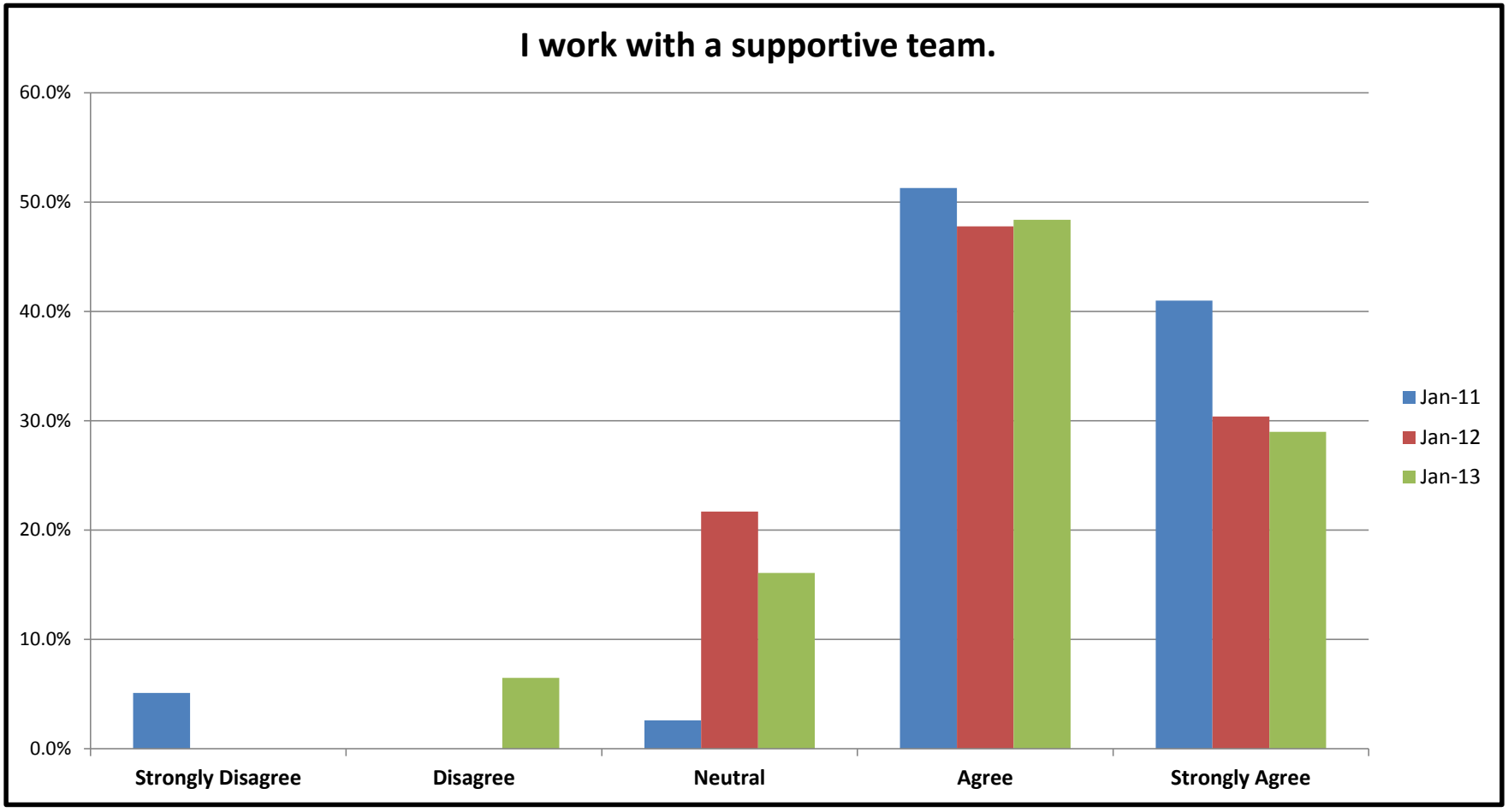
Paid Fairly

	Jan-11	Jan-12	Jan-13
Strongly Disagree	2.6%	8.7%	9.7%
Disagree	2.6%	8.7%	12.9%
Neutral	35.9%	34.8%	29.0%
Agree	51.3%	39.1%	32.3%
Strongly Agree	7.7%	8.7%	16.1%



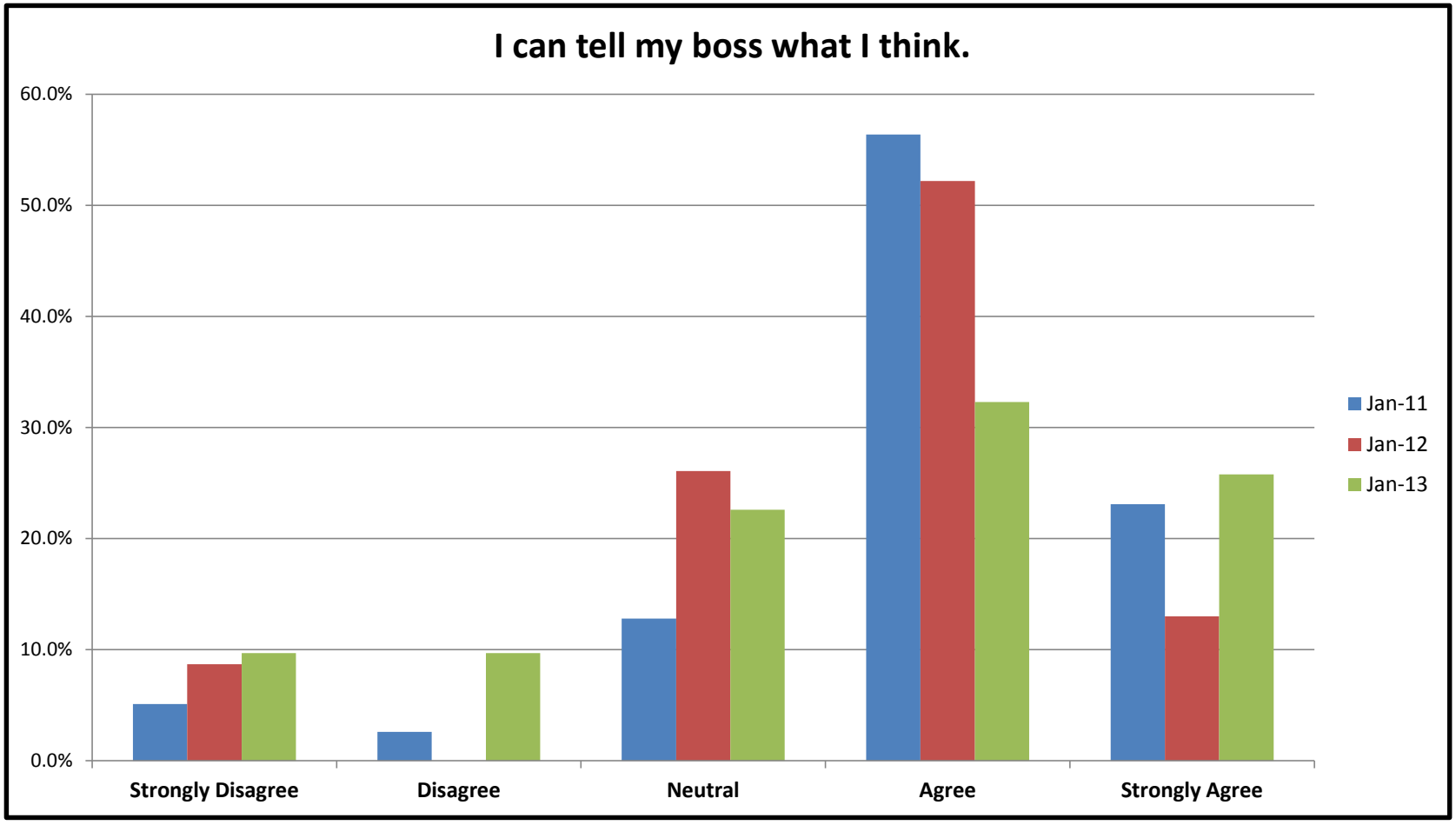
Supportive Team

	Jan-11	Jan-12	Jan-13
Strongly Disagree	5.1%	0.0%	0.0%
Disagree	0.0%	0.0%	6.5%
Neutral	2.6%	21.7%	16.1%
Agree	51.3%	47.8%	48.4%
Strongly Agree	41.0%	30.4%	29.0%



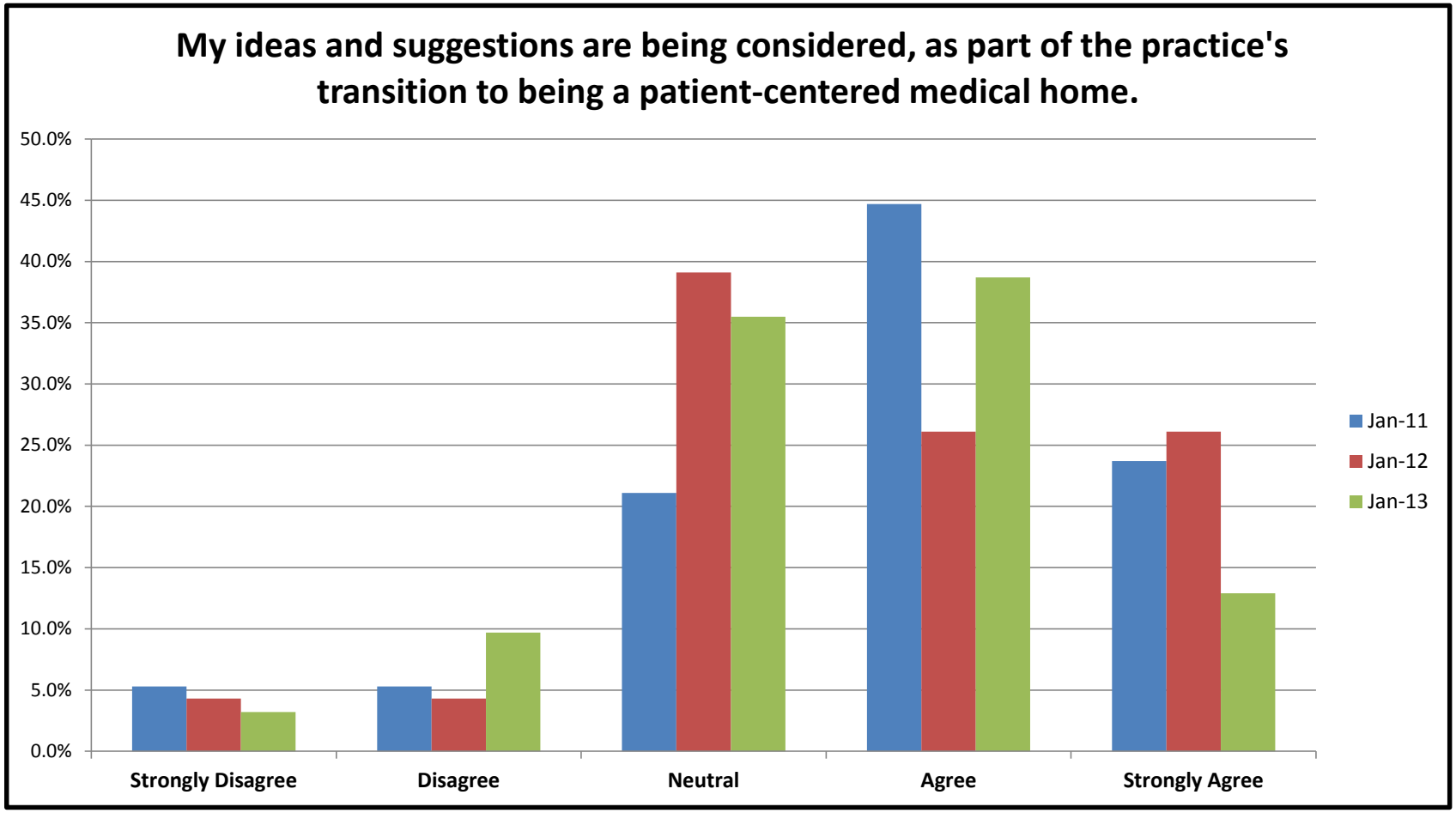
Tell Boss

	Jan-11	Jan-12	Jan-13
Strongly Disagree	5.1%	8.7%	9.7%
Disagree	2.6%	0.0%	9.7%
Neutral	12.8%	26.1%	22.6%
Agree	56.4%	52.2%	32.3%
Strongly Agree	23.1%	13.0%	25.8%



Ideas Considered

	Jan-11	Jan-12	Jan-13
Strongly Disagree	5.3%	4.3%	3.2%
Disagree	5.3%	4.3%	9.7%
Neutral	21.1%	39.1%	35.5%
Agree	44.7%	26.1%	38.7%
Strongly Agree	23.7%	26.1%	12.9%



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TRANSFORMING MEDICAL PRACTICES

Nebraska Medicaid PCMH: Aggregate Provider Satisfaction Data Comparison

February 6, 2013

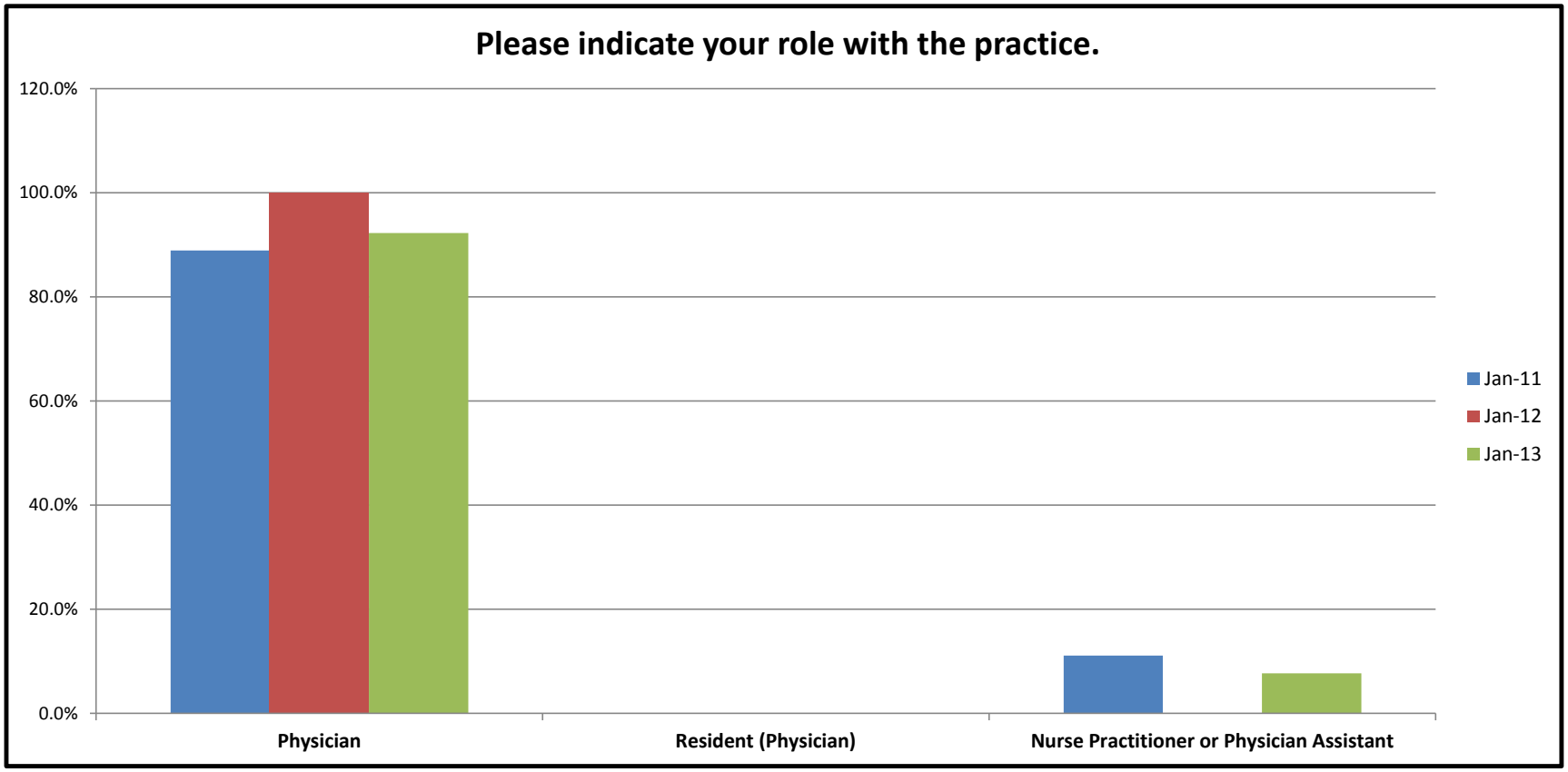
January 2011 Survey Count = 18

January 2012 Survey Count = 8

January 2013 Survey Count = 13

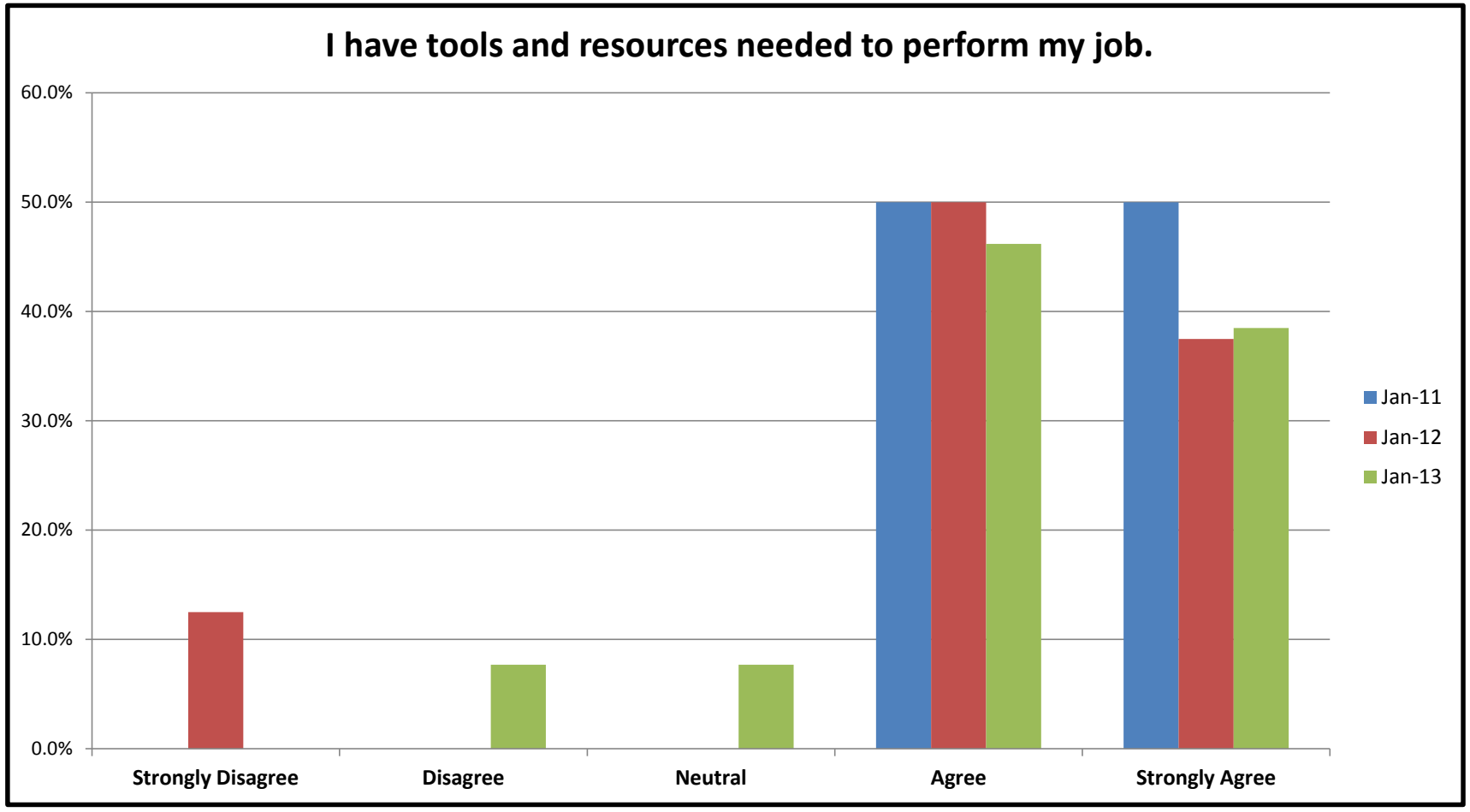
Role

	Jan-11	Jan-12	Jan-13
Physician	88.9%	100.0%	92.3%
Resident (Physician)	0.0%	0.0%	0.0%
Nurse Practitioner or Physician Assistant	11.1%	0.0%	7.7%



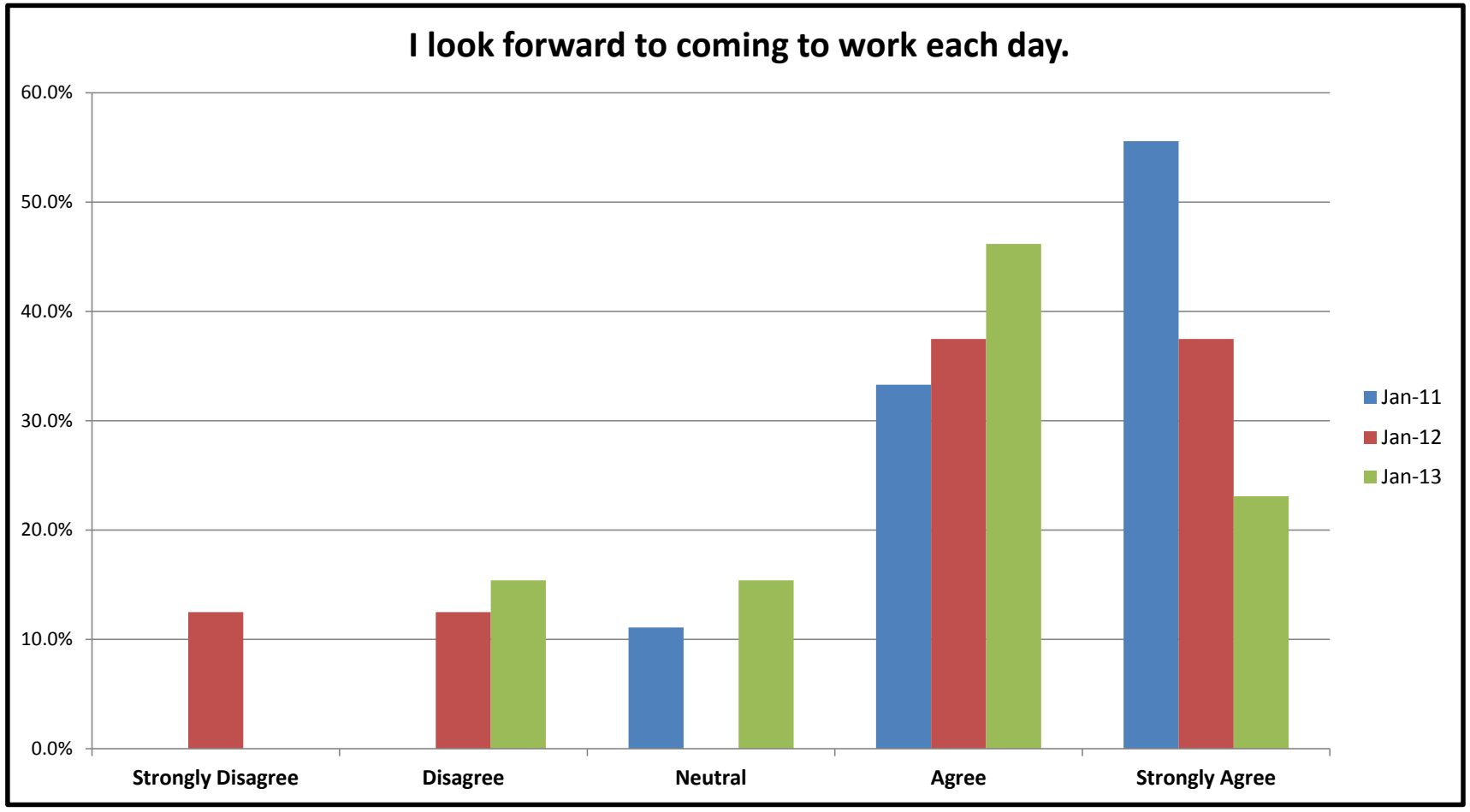
Tools and Resources

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	12.5%	0.0%
Disagree	0.0%	0.0%	7.7%
Neutral	0.0%	0.0%	7.7%
Agree	50.0%	50.0%	46.2%
Strongly Agree	50.0%	37.5%	38.5%



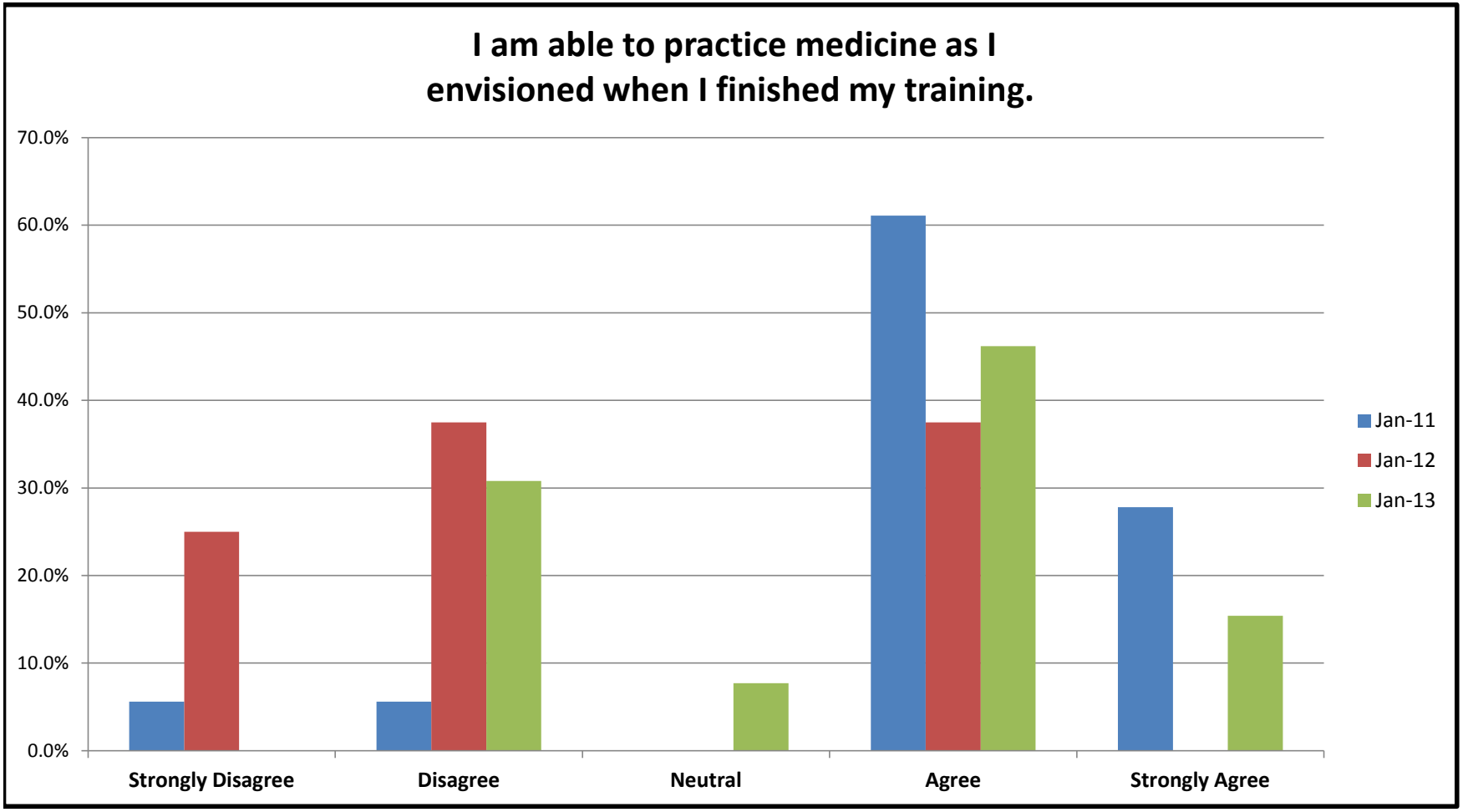
Look Forward

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	12.5%	0.0%
Disagree	0.0%	12.5%	15.4%
Neutral	11.1%	0.0%	15.4%
Agree	33.3%	37.5%	46.2%
Strongly Agree	55.6%	37.5%	23.1%



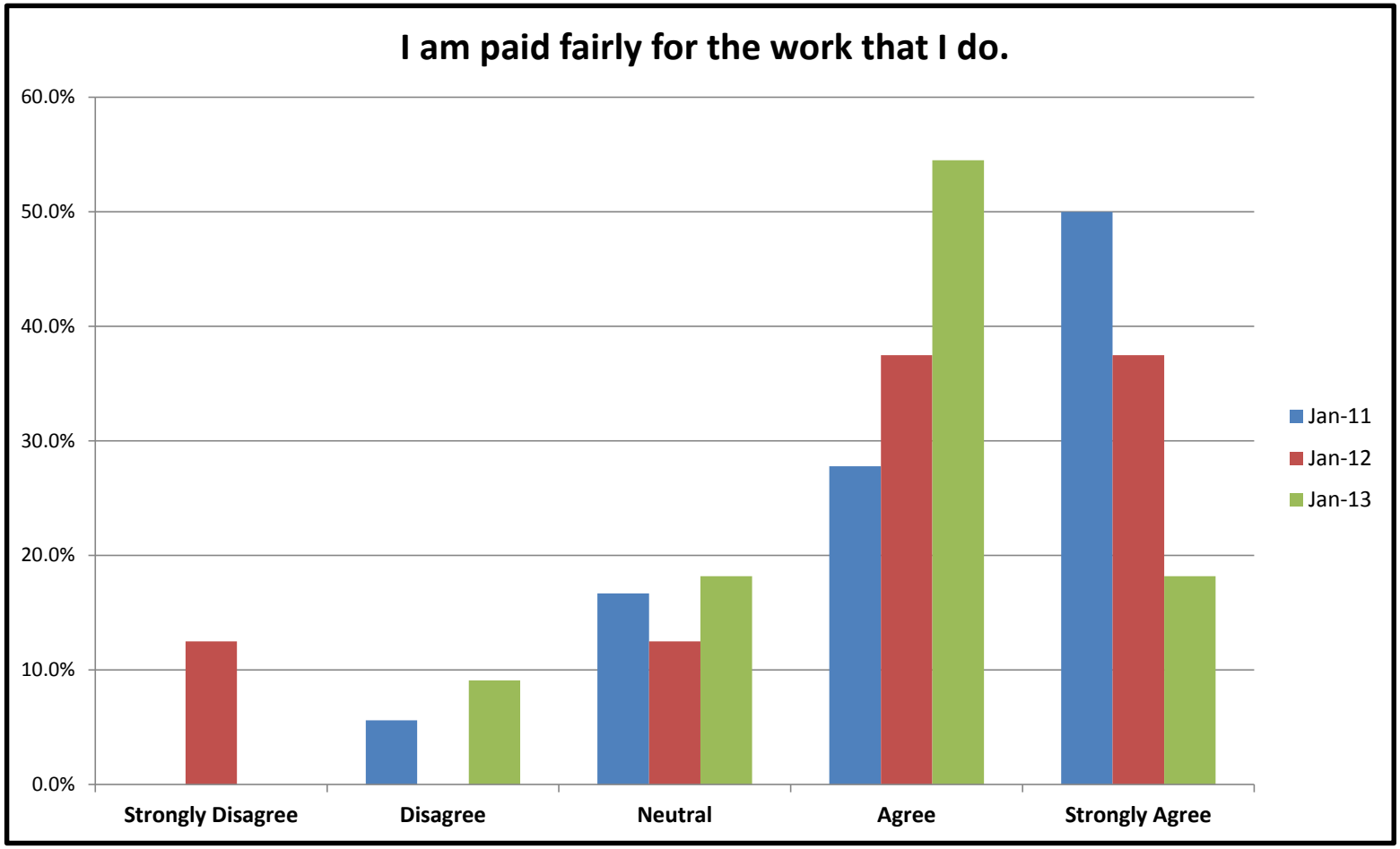
Able to Practice

	Jan-11	Jan-12	Jan-13
Strongly Disagree	5.6%	25.0%	0.0%
Disagree	5.6%	37.5%	30.8%
Neutral	0.0%	0.0%	7.7%
Agree	61.1%	37.5%	46.2%
Strongly Agree	27.8%	0.0%	15.4%



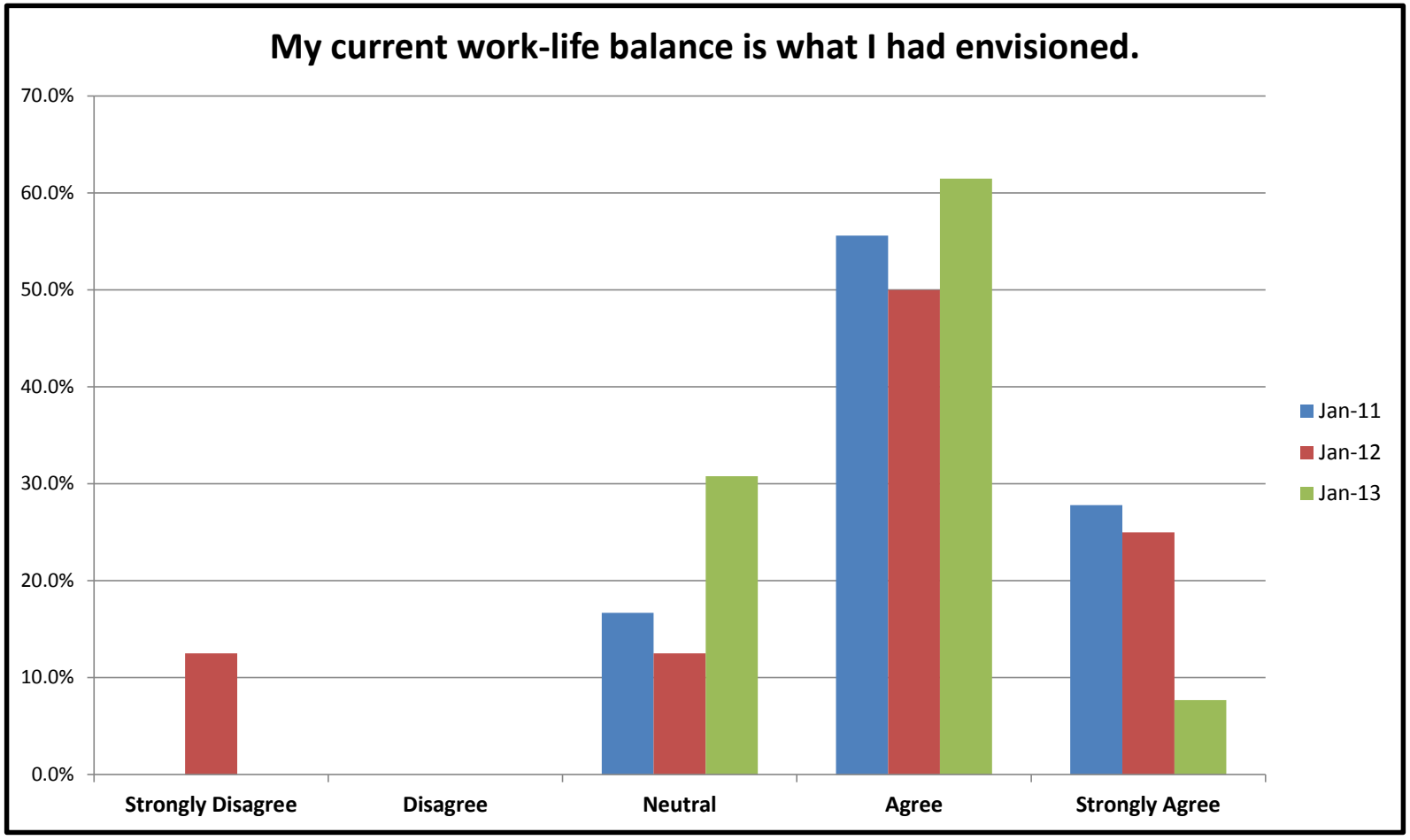
Paid Fairly

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	12.5%	0.0%
Disagree	5.6%	0.0%	9.1%
Neutral	16.7%	12.5%	18.2%
Agree	27.8%	37.5%	54.5%
Strongly Agree	50.0%	37.5%	18.2%



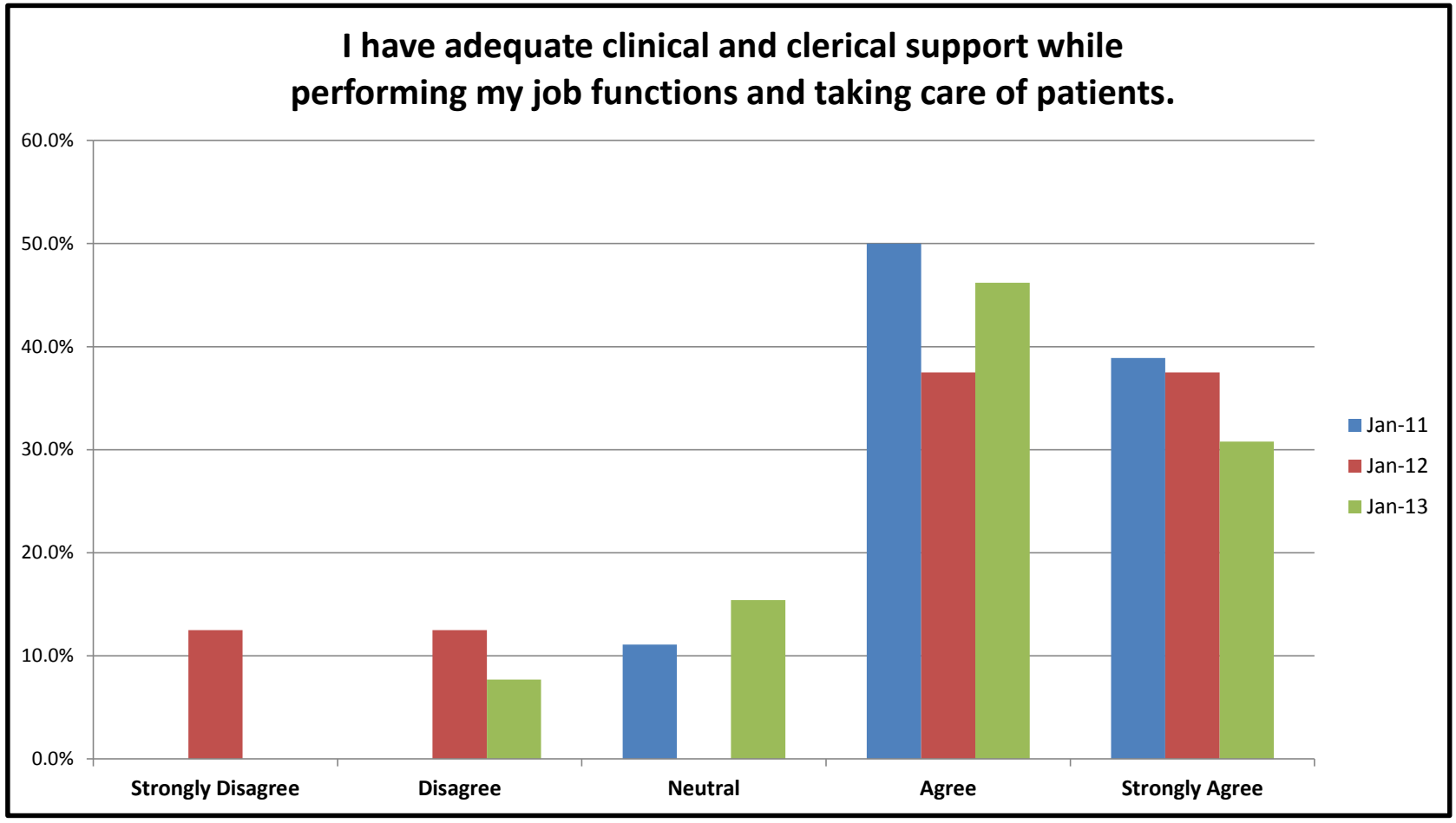
Work-Life Balance

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	12.5%	0.0%
Disagree	0.0%	0.0%	0.0%
Neutral	16.7%	12.5%	30.8%
Agree	55.6%	50.0%	61.5%
Strongly Agree	27.8%	25.0%	7.7%



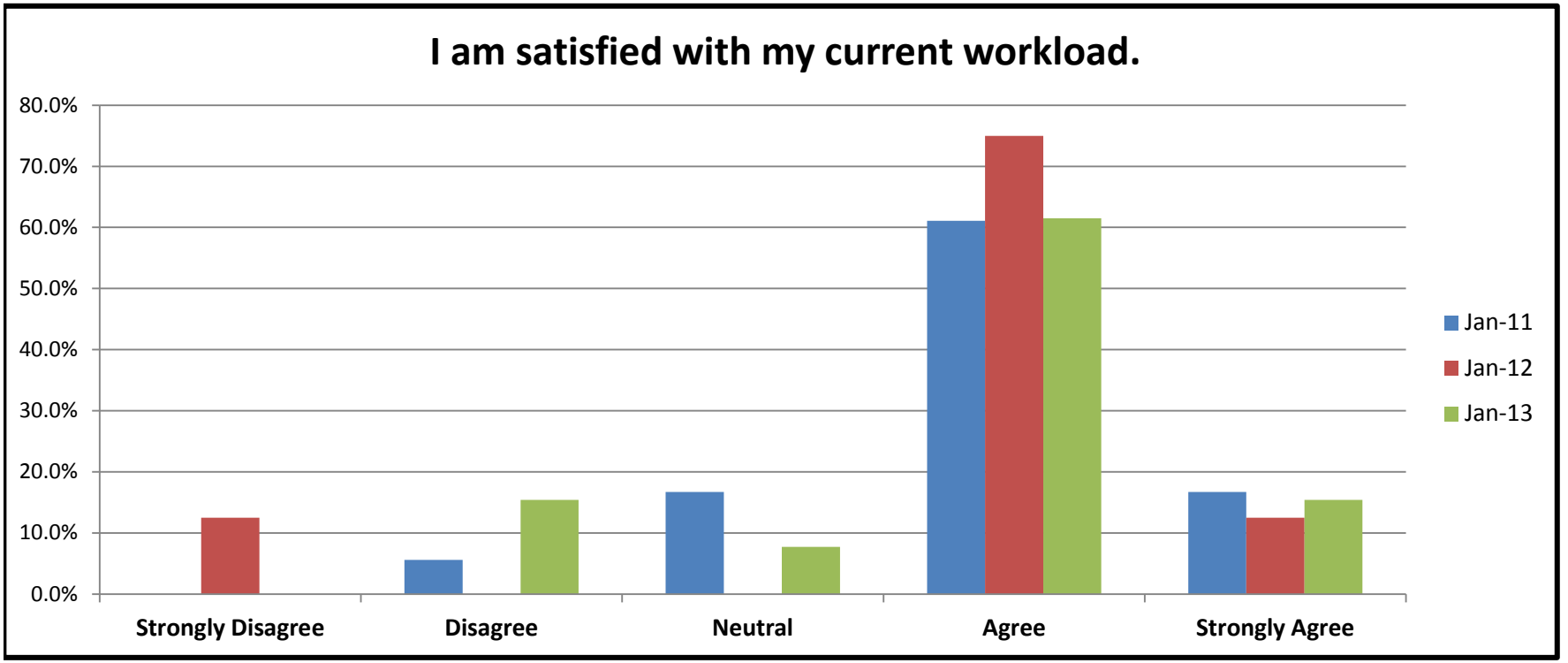
Adequate Support

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	12.5%	0.0%
Disagree	0.0%	12.5%	7.7%
Neutral	11.1%	0.0%	15.4%
Agree	50.0%	37.5%	46.2%
Strongly Agree	38.9%	37.5%	30.8%



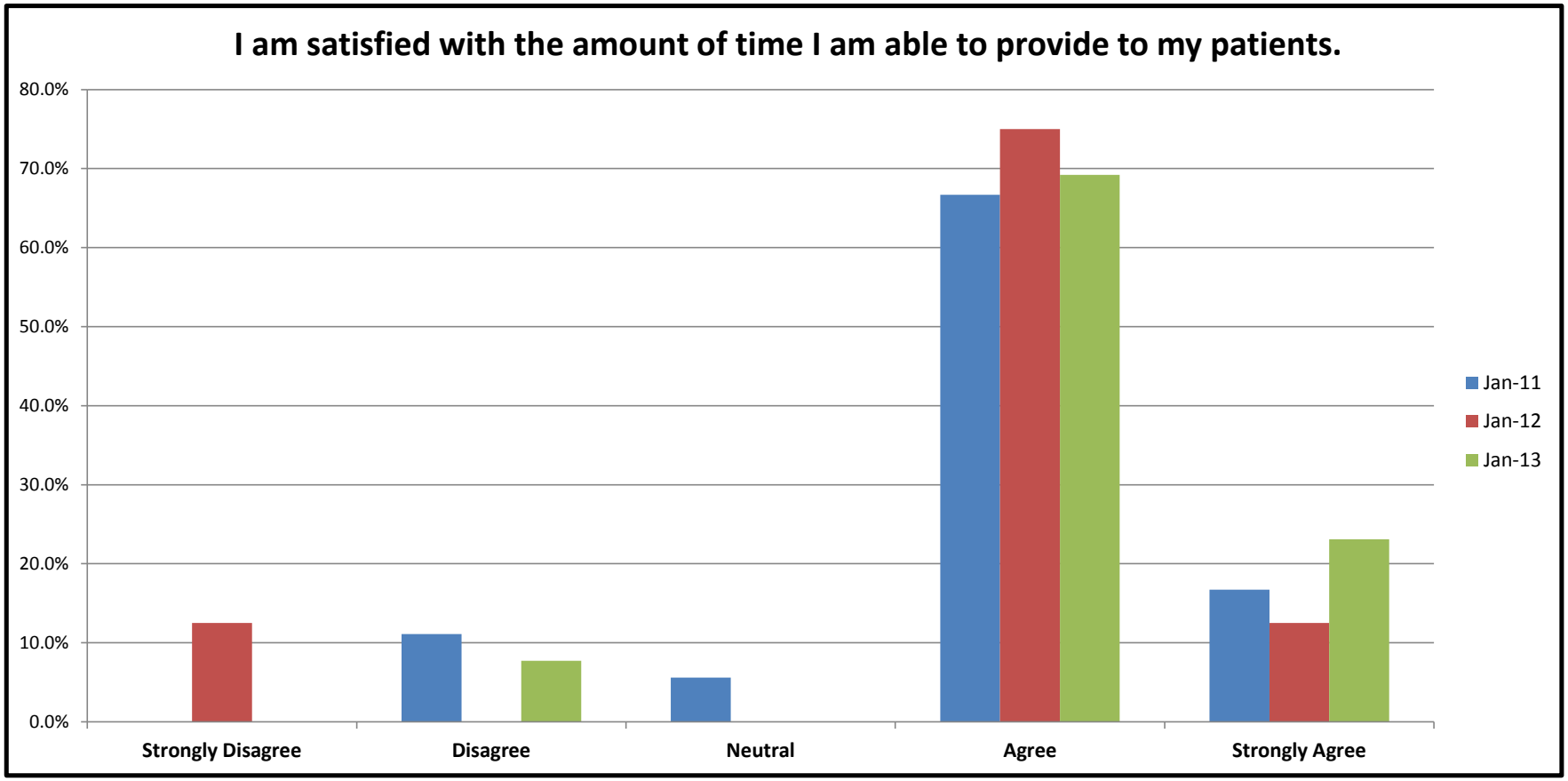
Current Workload

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	12.5%	0.0%
Disagree	5.6%	0.0%	15.4%
Neutral	16.7%	0.0%	7.7%
Agree	61.1%	75.0%	61.5%
Strongly Agree	16.7%	12.5%	15.4%



Time with Patients

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	12.5%	0.0%
Disagree	11.1%	0.0%	7.7%
Neutral	5.6%	0.0%	0.0%
Agree	66.7%	75.0%	69.2%
Strongly Agree	16.7%	12.5%	23.1%



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TRANSFORMING MEDICAL PRACTICES

Practice A

Nebraska Medicaid PCMH: Provider Satisfaction Data Comparison

February 6, 2013

January 2011 Survey Count = 10

January 2012 Survey Count = 4

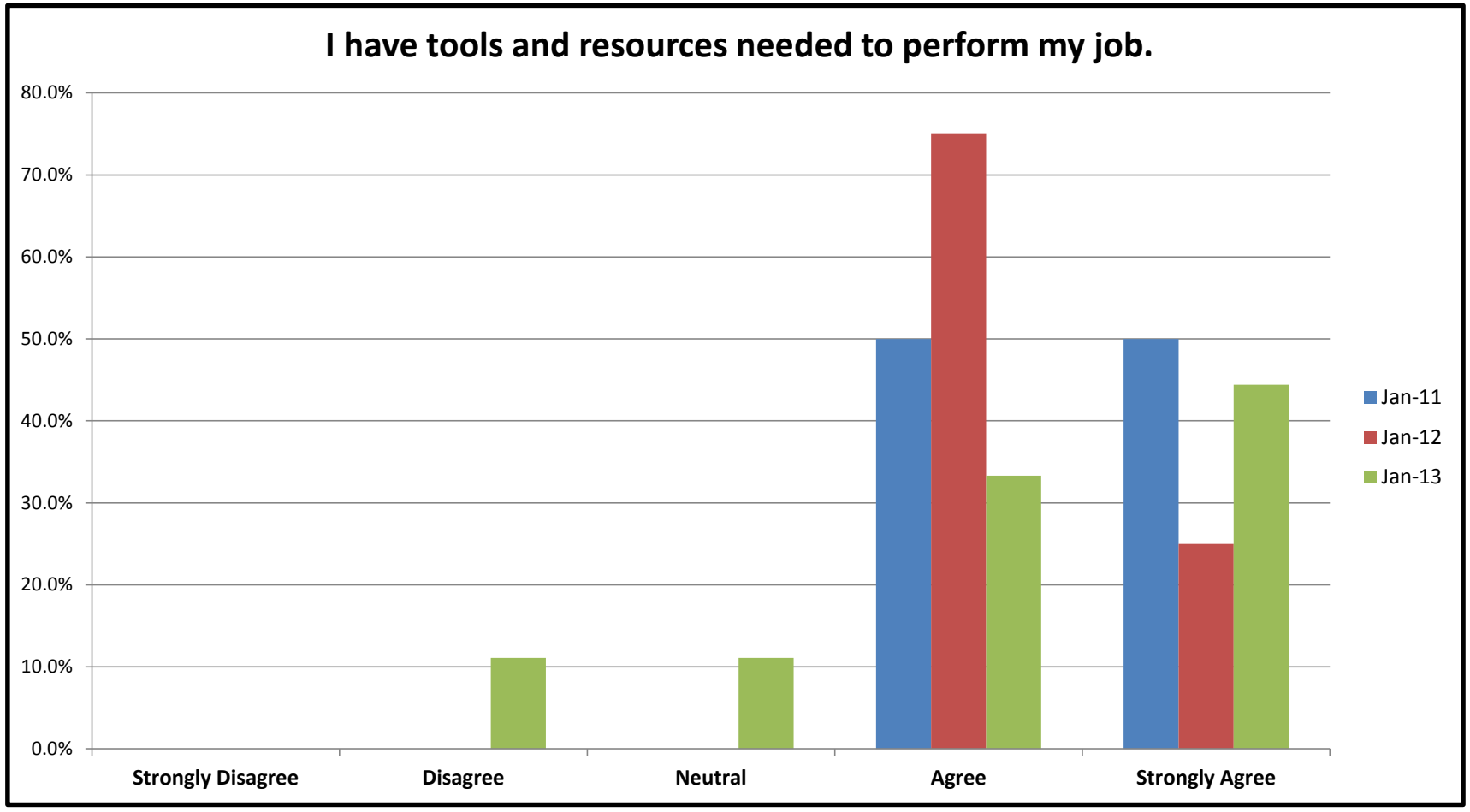
January 2013 Survey Count = 9

Role

	Jan-11	Jan-12	Jan-13
Physician	90.0%	100.0%	88.9%
Resident (Physician)	0.0%	0.0%	0.0%
Nurse Practitioner or Physician Assistant	10.0%	0.0%	11.1%

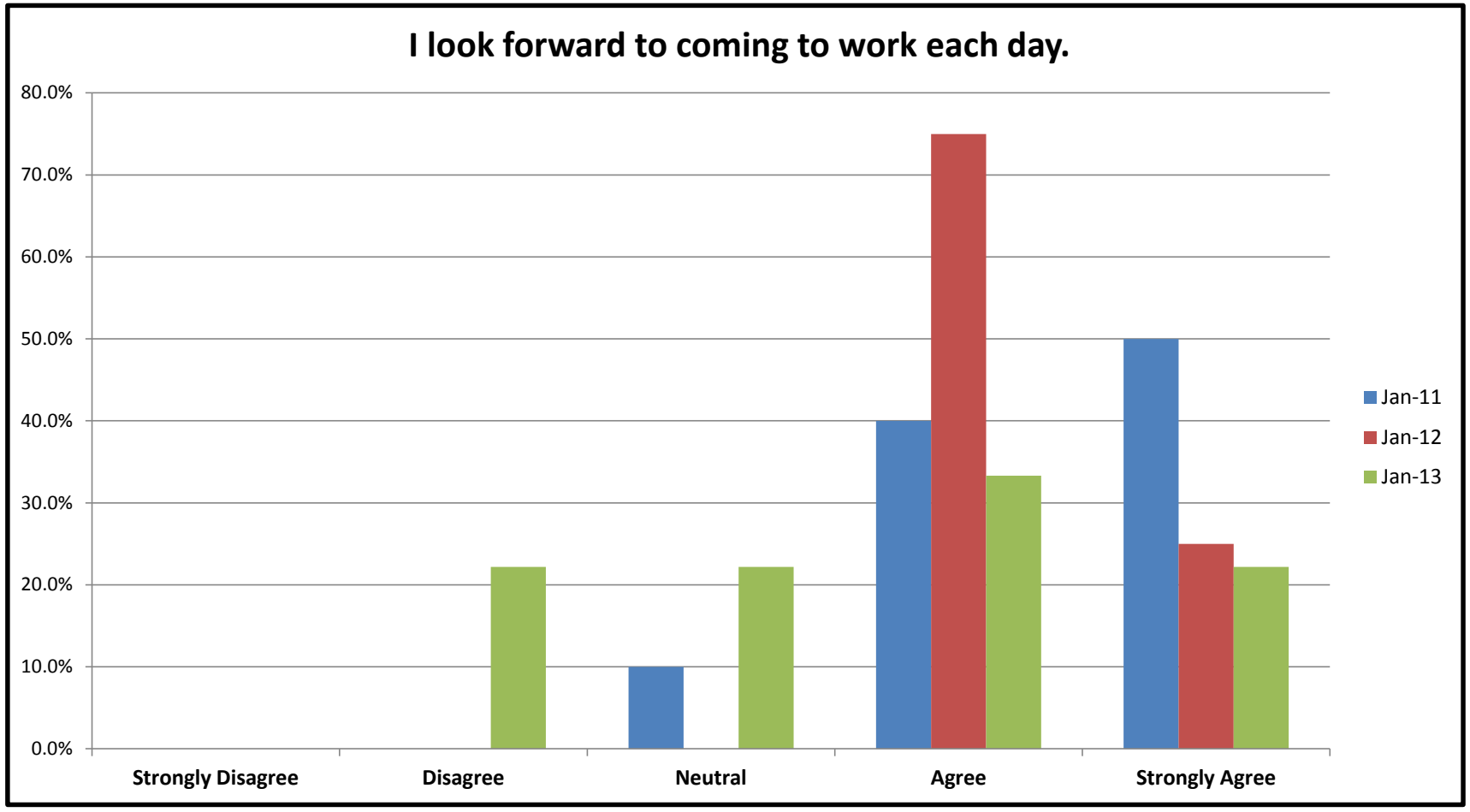
Tools and Resources

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	0.0%	0.0%
Disagree	0.0%	0.0%	11.1%
Neutral	0.0%	0.0%	11.1%
Agree	50.0%	75.0%	33.3%
Strongly Agree	50.0%	25.0%	44.4%



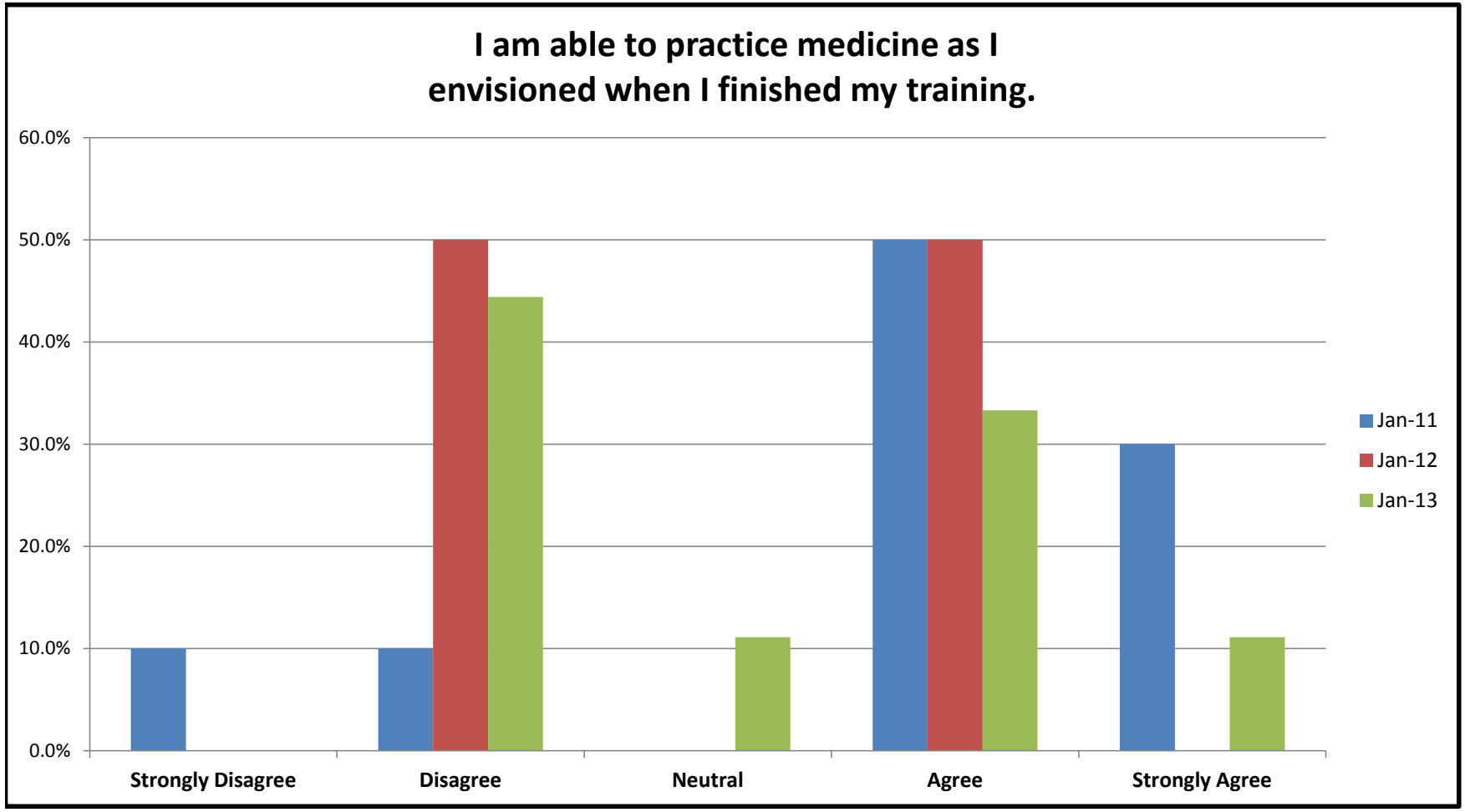
Look Forward

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	0.0%	0.0%
Disagree	0.0%	0.0%	22.2%
Neutral	10.0%	0.0%	22.2%
Agree	40.0%	75.0%	33.3%
Strongly Agree	50.0%	25.0%	22.2%



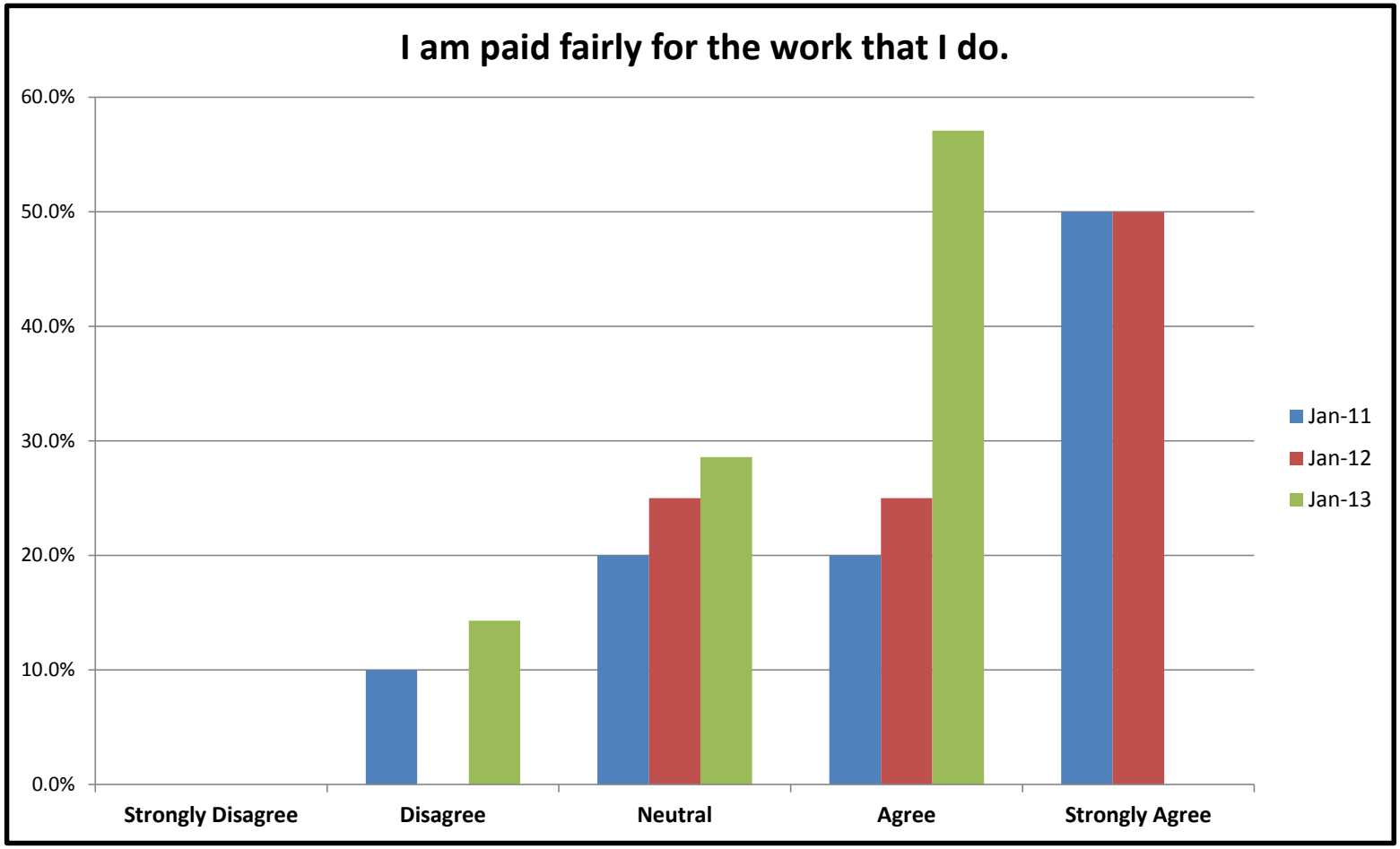
Able to Practice

	Jan-11	Jan-12	Jan-13
Strongly Disagree	10.0%	0.0%	0.0%
Disagree	10.0%	50.0%	44.4%
Neutral	0.0%	0.0%	11.1%
Agree	50.0%	50.0%	33.3%
Strongly Agree	30.0%	0.0%	11.1%



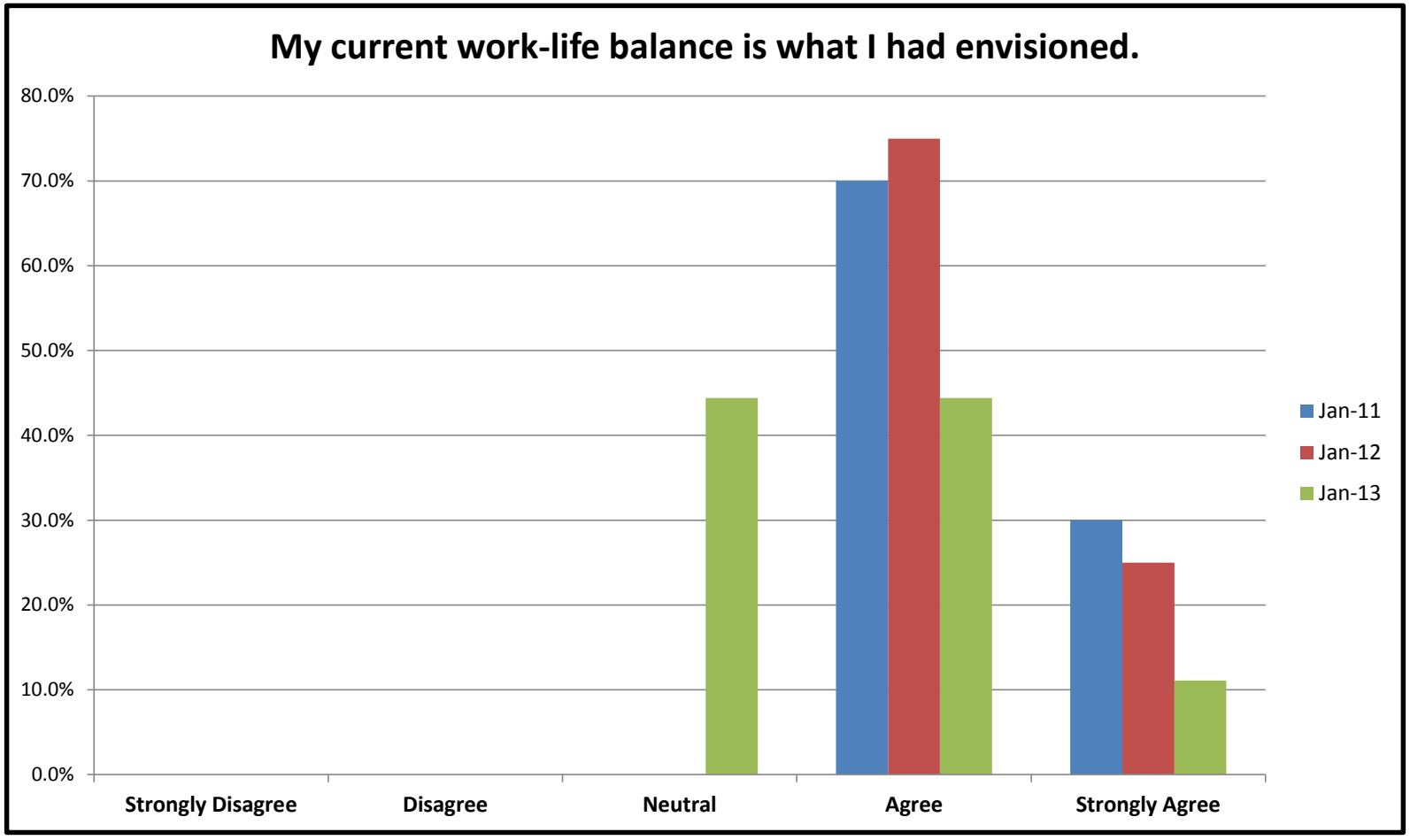
Paid Fairly

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	0.0%	0.0%
Disagree	10.0%	0.0%	14.3%
Neutral	20.0%	25.0%	28.6%
Agree	20.0%	25.0%	57.1%
Strongly Agree	50.0%	50.0%	0.0%



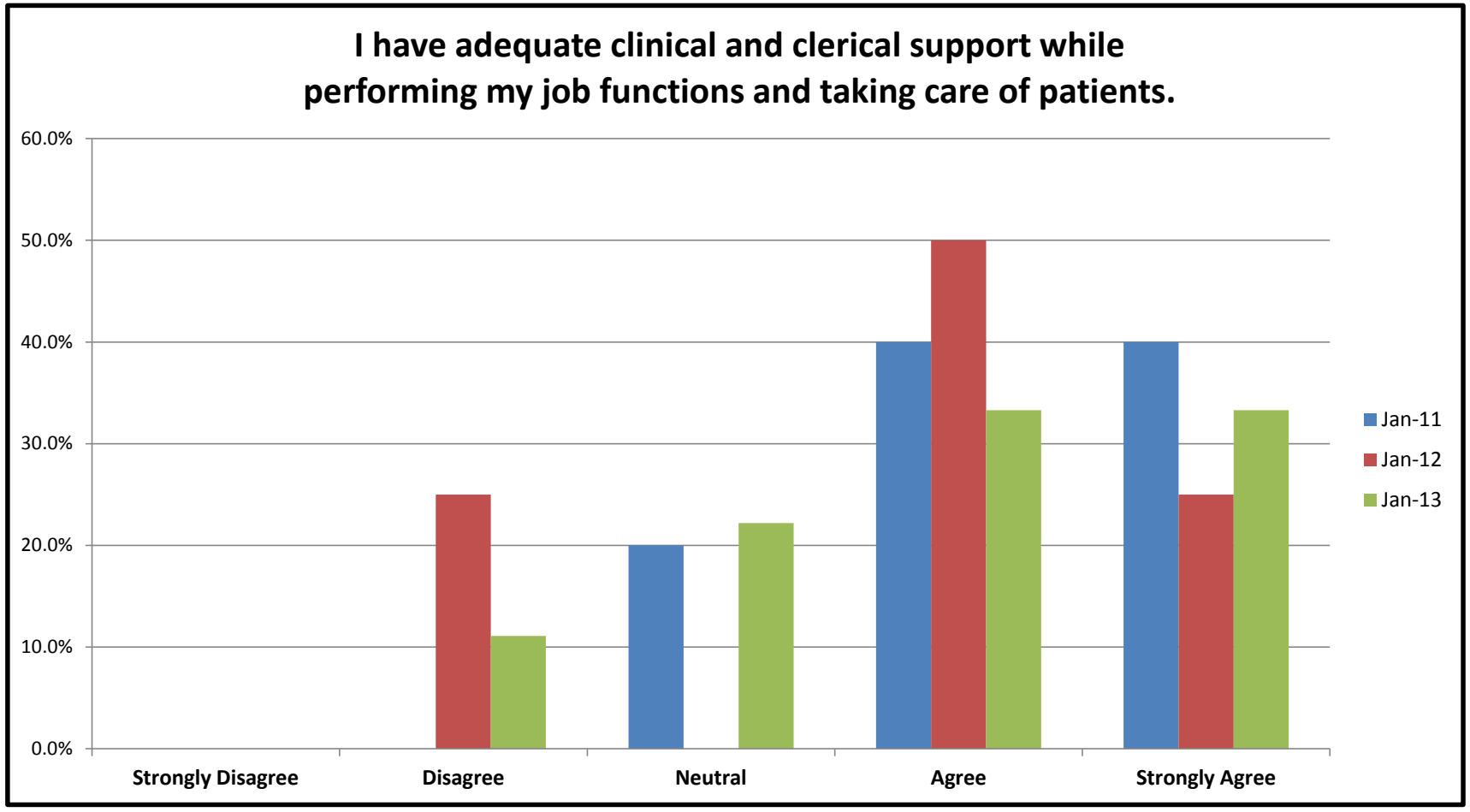
Work-Life Balance

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	0.0%	0.0%
Disagree	0.0%	0.0%	0.0%
Neutral	0.0%	0.0%	44.4%
Agree	70.0%	75.0%	44.4%
Strongly Agree	30.0%	25.0%	11.1%



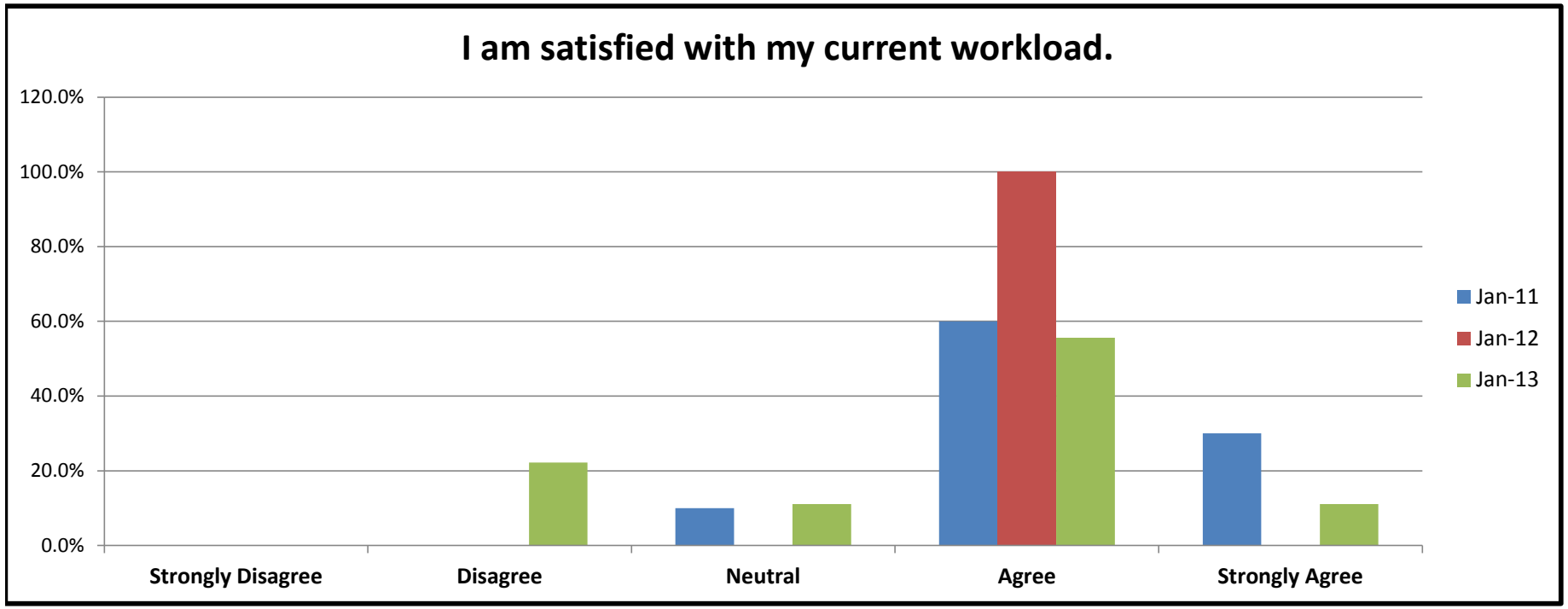
Adequate Support

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	0.0%	0.0%
Disagree	0.0%	25.0%	11.1%
Neutral	20.0%	0.0%	22.2%
Agree	40.0%	50.0%	33.3%
Strongly Agree	40.0%	25.0%	33.3%



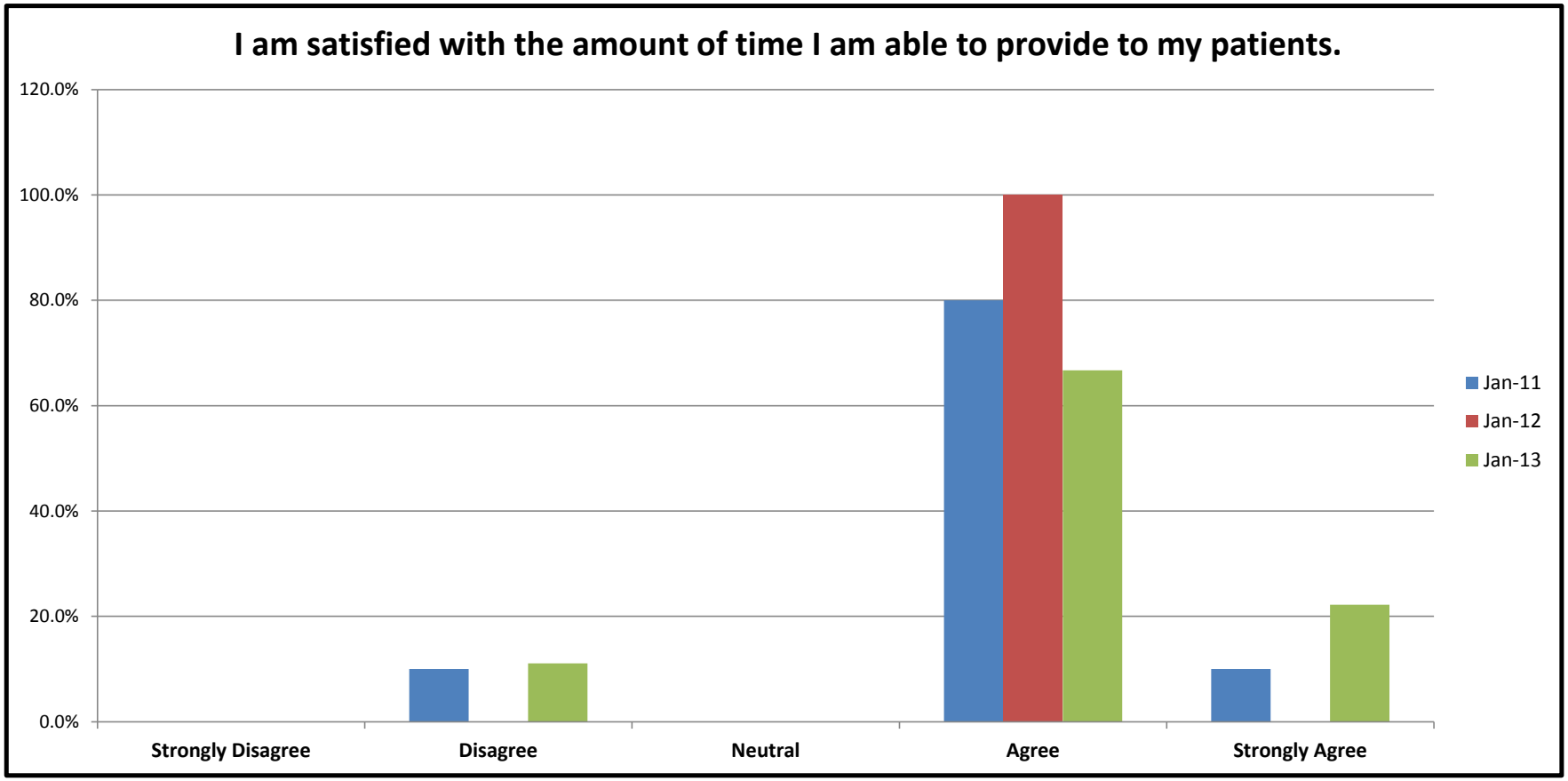
Current Workload

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	0.0%	0.0%
Disagree	0.0%	0.0%	22.2%
Neutral	10.0%	0.0%	11.1%
Agree	60.0%	100.0%	55.6%
Strongly Agree	30.0%	0.0%	11.1%



Time with Patients

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	0.0%	0.0%
Disagree	10.0%	0.0%	11.1%
Neutral	0.0%	0.0%	0.0%
Agree	80.0%	100.0%	66.7%
Strongly Agree	10.0%	0.0%	22.2%



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TRANSFORMING MEDICAL PRACTICES

Practice B

Nebraska Medicaid PCMH: Provider Satisfaction Data Comparison

February 6, 2013

January 2011 Survey Count = 8

January 2012 Survey Count = 4

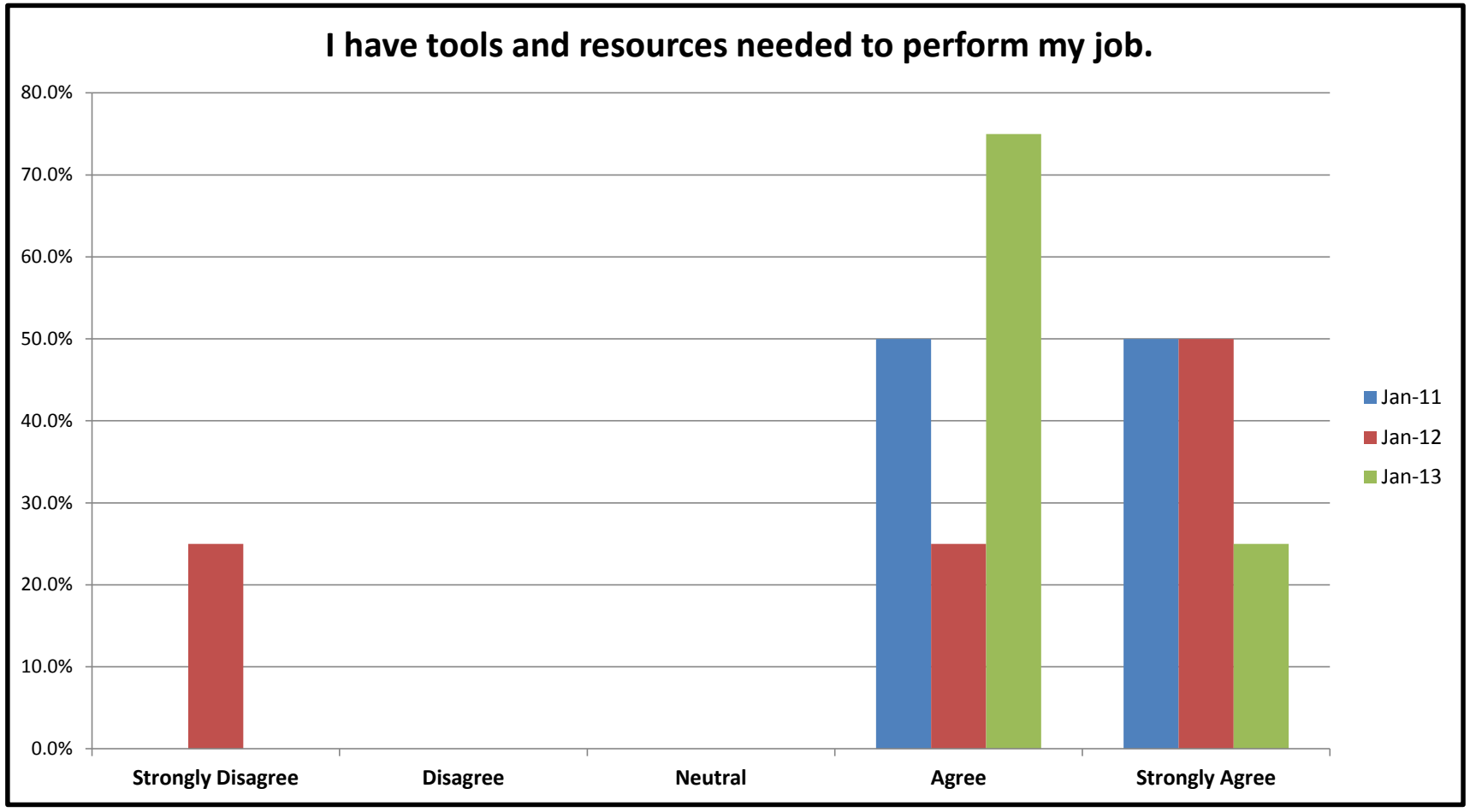
January 2013 Survey Count = 4

Role

	Jan-11	Jan-12	Jan-13
Physician	87.5%	100.0%	100.0%
Resident (Physician)	0.0%	0.0%	0.0%
Nurse Practitioner or Physician Assistant	12.5%	0.0%	0.0%

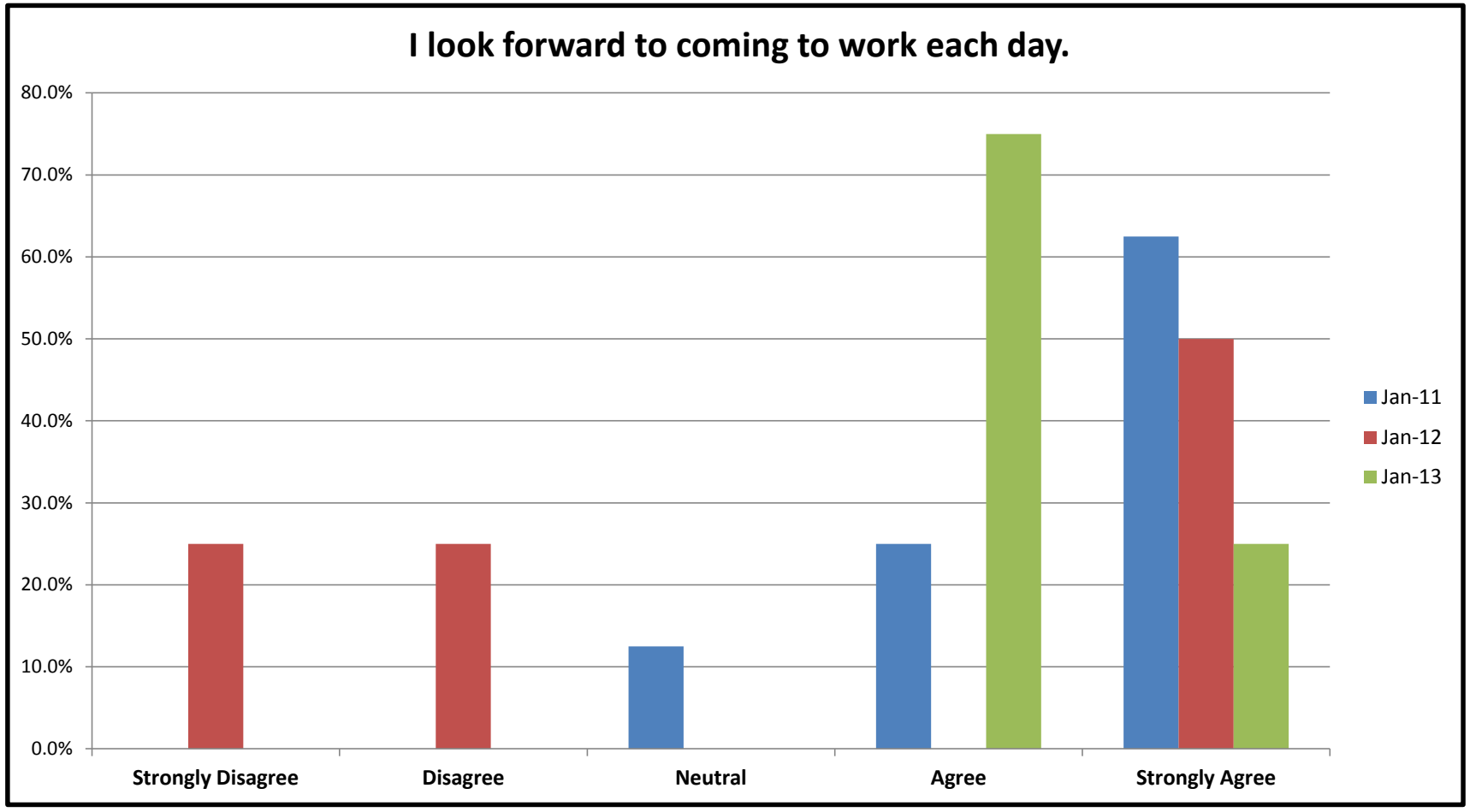
Tools and Resources

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	25.0%	0.0%
Disagree	0.0%	0.0%	0.0%
Neutral	0.0%	0.0%	0.0%
Agree	50.0%	25.0%	75.0%
Strongly Agree	50.0%	50.0%	25.0%



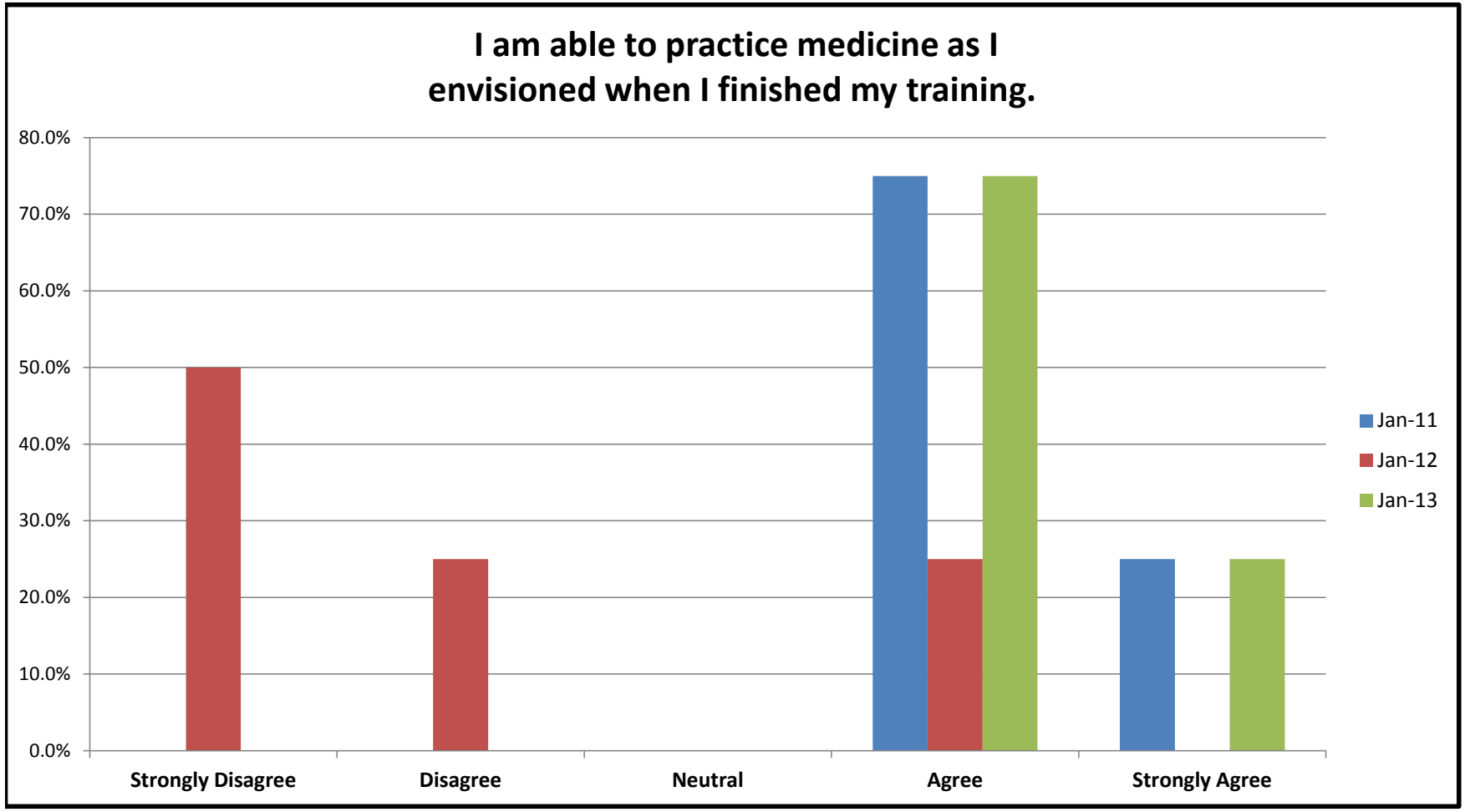
Look Forward

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	25.0%	0.0%
Disagree	0.0%	25.0%	0.0%
Neutral	12.5%	0.0%	0.0%
Agree	25.0%	0.0%	75.0%
Strongly Agree	62.5%	50.0%	25.0%



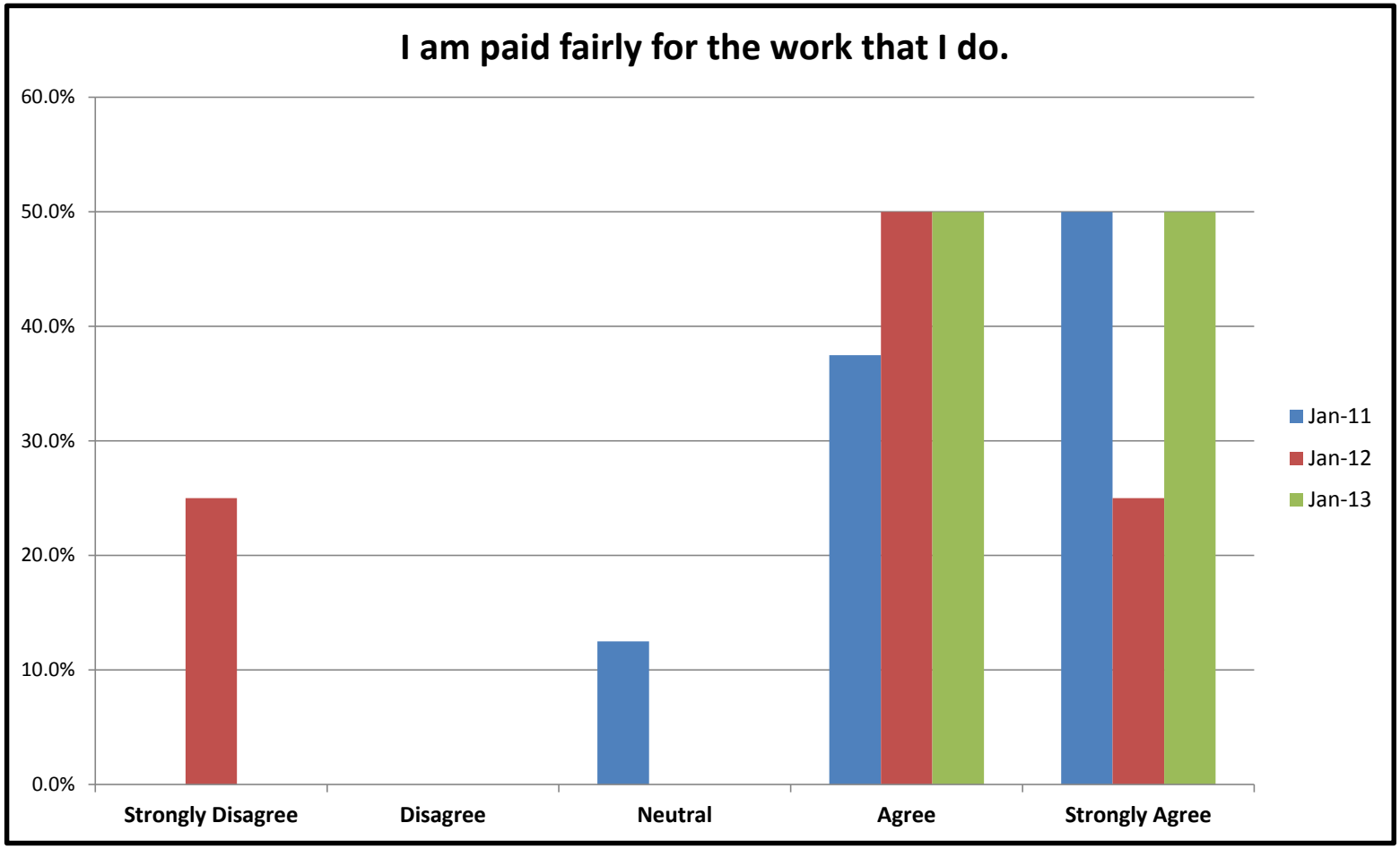
Able to Practice

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	50.0%	0.0%
Disagree	0.0%	25.0%	0.0%
Neutral	0.0%	0.0%	0.0%
Agree	75.0%	25.0%	75.0%
Strongly Agree	25.0%	0.0%	25.0%



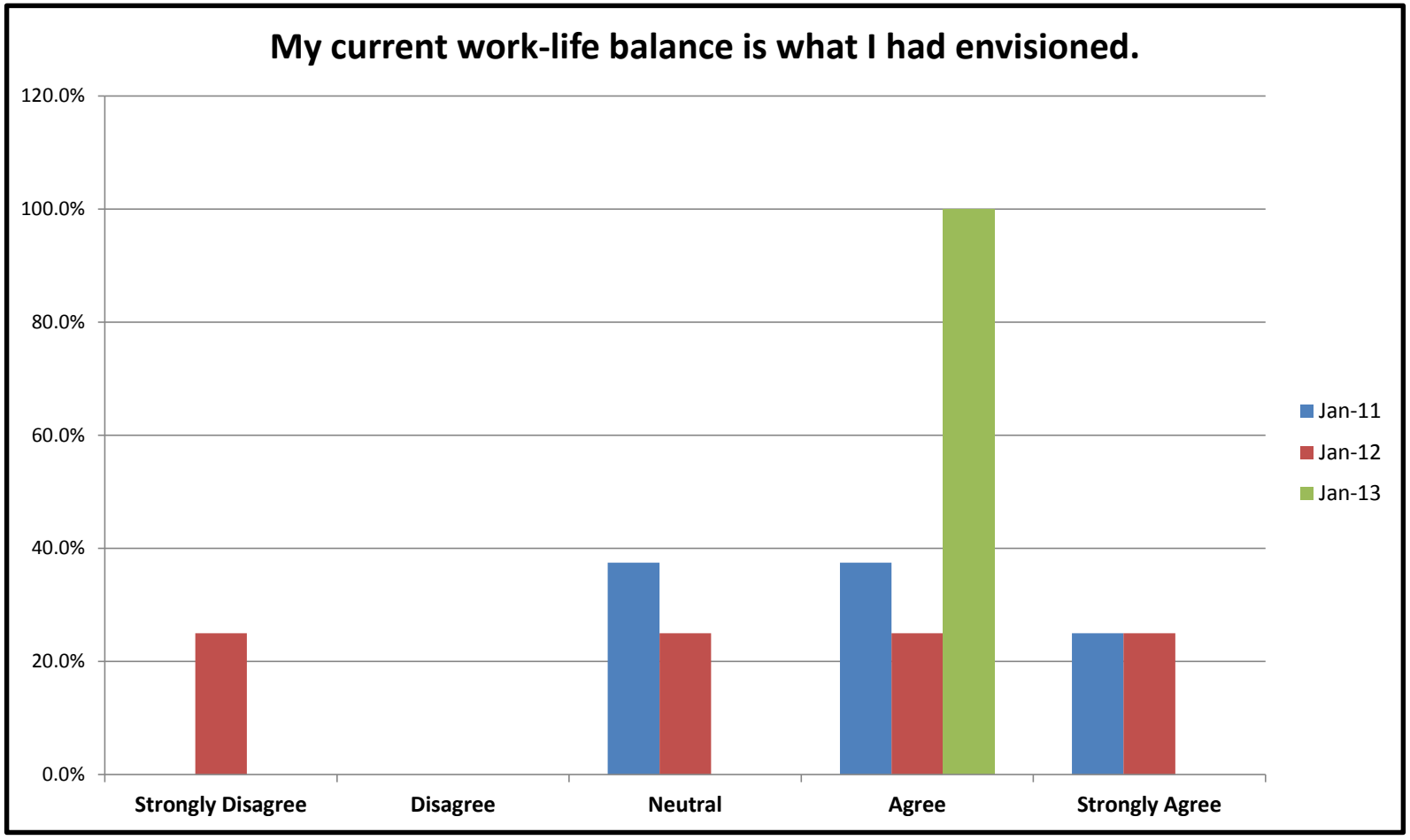
Paid Fairly

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	25.0%	0.0%
Disagree	0.0%	0.0%	0.0%
Neutral	12.5%	0.0%	0.0%
Agree	37.5%	50.0%	50.0%
Strongly Agree	50.0%	25.0%	50.0%



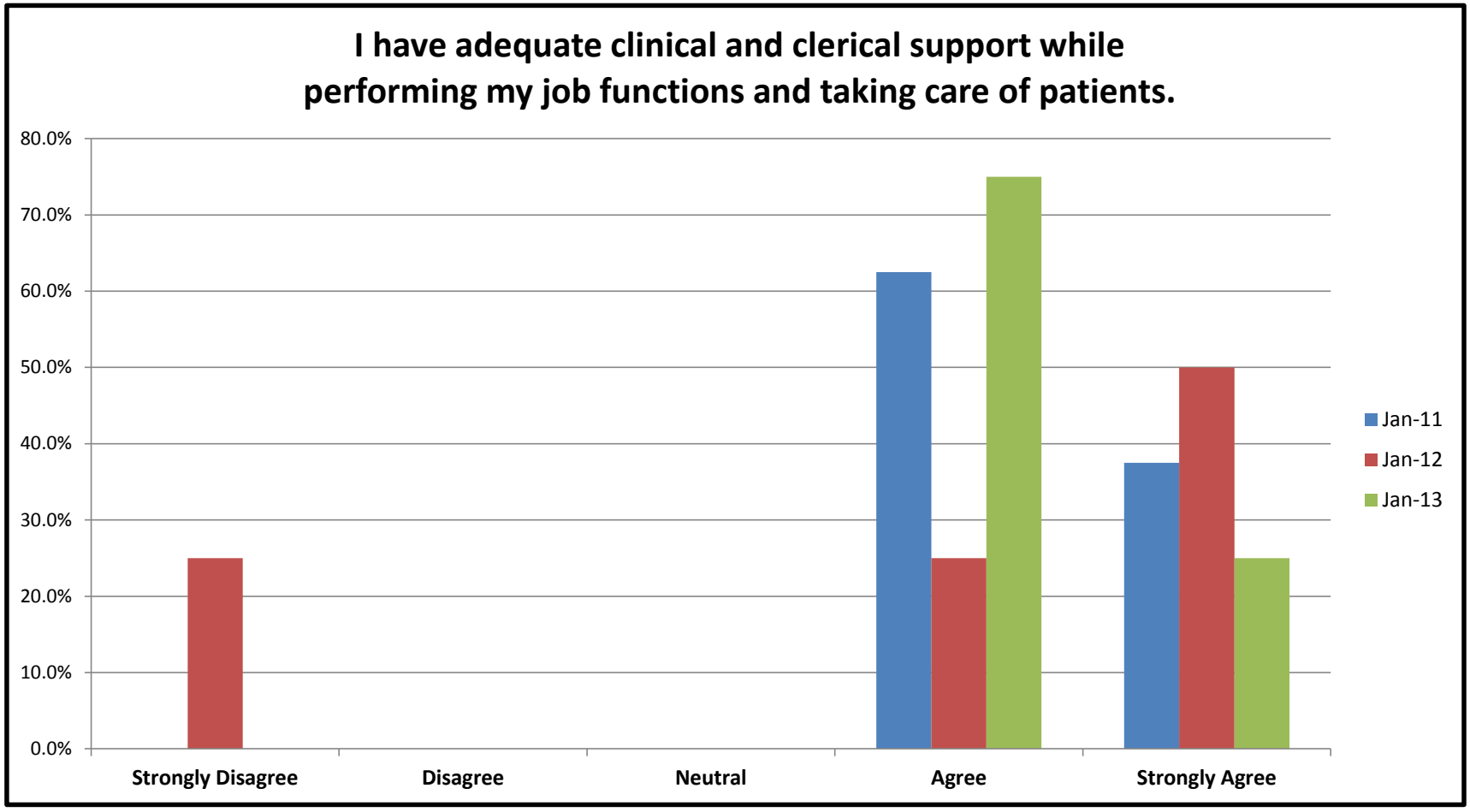
Work-Life Balance

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	25.0%	0.0%
Disagree	0.0%	0.0%	0.0%
Neutral	37.5%	25.0%	0.0%
Agree	37.5%	25.0%	100.0%
Strongly Agree	25.0%	25.0%	0.0%



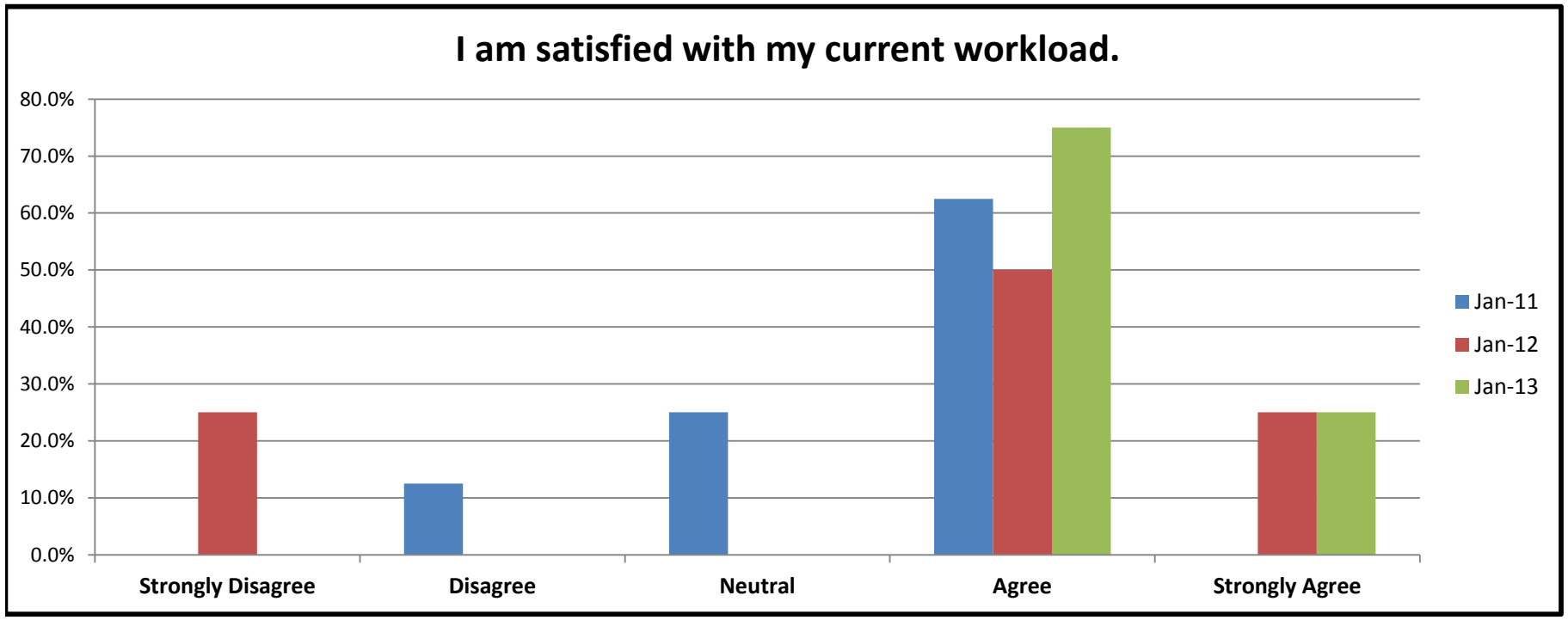
Adequate Support

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	25.0%	0.0%
Disagree	0.0%	0.0%	0.0%
Neutral	0.0%	0.0%	0.0%
Agree	62.5%	25.0%	75.0%
Strongly Agree	37.5%	50.0%	25.0%



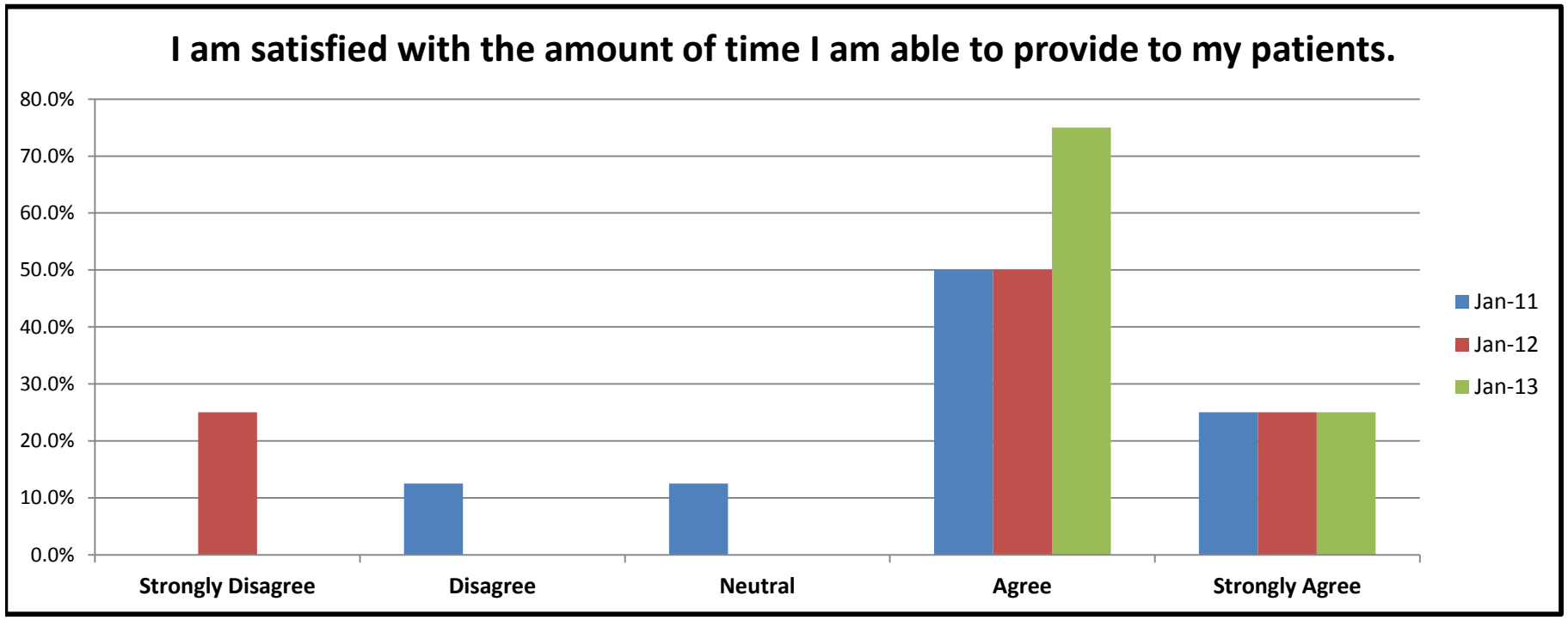
Current Workload

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	25.0%	0.0%
Disagree	12.5%	0.0%	0.0%
Neutral	25.0%	0.0%	0.0%
Agree	62.5%	50.0%	75.0%
Strongly Agree	0.0%	25.0%	25.0%



Time with Patients

	Jan-11	Jan-12	Jan-13
Strongly Disagree	0.0%	25.0%	0.0%
Disagree	12.5%	0.0%	0.0%
Neutral	12.5%	0.0%	0.0%
Agree	50.0%	50.0%	75.0%
Strongly Agree	25.0%	25.0%	25.0%



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Practice A

Metrics Spreadsheet	Averages across Providers/Practice	Averages across Providers/Practice	Change	Averages across Providers/Practice	Averages across Providers/Practice	Change
	Jan-11	Jan-12		Jan-12	Jan-13	
Description						
Same day availability	N/A	30.00%	N/A	30.00%	20.00%	-10%
Avg visits per day per	29.32	23.32	-6	23.32	28.85	6
Panel Size	N/A	1398.45	N/A	1398.45	2329.60	931
EMR	No	No	No	No	No	No
E-prescribing used	Yes	Yes	Yes	Yes	Yes	Yes
Breast cancer screening	N/A	2.00%	N/A	2.00%	4.33%	2%
Tobacco use	N/A	15.52%	N/A	15.52%	34.14%	19%
Pneumococcal vaccine	N/A	0.50%	N/A	0.50%	N/A	N/A
BMI	N/A	9.66%	N/A	9.66%	51.53%	42%
HbA1c control	N/A	2.35%	N/A	2.35%	43.72%	41%
LDL control	N/A	0.55%	N/A	0.55%	40.21%	40%
BP control	N/A	2.58%	N/A	2.58%	66.86%	64%
Note: n/a entered where two data points were not available to provide a comparison						

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Practice B

Metrics Spreadsheet	Averages across Providers/Practice	Averages across Providers/Practice	Change
	Jan-11	Jan-13	
Description			
Same day availability	N/A	N/A	N/A
Avg visits per day per provider	N/A	116	N/A
Panel Size	N/A	N/A	N/A
EMR	Yes	Yes	Yes
E-prescribing used	Yes	Yes	Yes
Breast cancer screening	23.04%	43.53%	↑ 20%
Tobacco use	1.87%	79.66%	↑ 78%
Pneumococcal vaccine	52.53%	68.75%	↑ 16%
BMI	73.64%	88.18%	↑ 15%
HbA1c control	52.85%	38.16%	↓ -15%
LDL control	N/A	31.16%	N/A
BP control	54.72%	67.05%	↑ 12%
Note: n/a entered where two data points were not available to provide a comparison			

Patient Experience Assessment
State of Nebraska
Final Data

Report Prepared March 14, 2013

State of Nebraska PEAT Survey Data, March 2013
Total Surveys Completed = 1766
Total Medicaid Surveys = 1111
% Medicaid Surveys = 63%

State of Nebraska PEAT Survey Data, March 2012
Total Surveys Completed = 2226
Total Medicaid Surveys = 1135
% Medicaid Surveys = 51%

State of Nebraska Baseline PEAT Survey Data, July 2011
Total Surveys Completed = 2552
Total Medicaid Surveys = 1,058
% Medicaid Surveys = 41%

Patient Experience Assessment

Introduction

The Patient Experience Assessment Tool (PEAT) was developed to provide information on the patient's experience and overall satisfaction related to various elements of the patient centered model of care. In particular, questions were asked to address key elements of the Patient Centered Medical Home (PCMH) such as the patient's perception of their ability to provide self-care management, physician and staff communication abilities, and satisfaction regarding access to care and information.

Results are provided on your practice overall and by provider. Share the results of the assessment with all the members of your practice so that everyone might develop a better understanding of how your patients experience your practice overall.

Narrative Comments

On the pages that follow, the data and feedback relates to how the patients in your practice responded in relation to the Comparison Group. The Comparison Group is representative of practices involved in transformation. We have provided the average score for your practice in relation to the Comparison Group by survey item in both a numerical and graphic format. The answer options were as follows:

Strongly Disagree = 1
Disagree = 2
Neither Agree nor Disagree = 3
Agree = 4
Strongly Agree = 5

Please refer to this key as you review your reports. The higher the score, the better it reflects on your practice.

Evaluating the Data

Review and discuss the questions below as they relate to your data.

- How does your practice rate versus the Comparison Group?
- Which questions identify strengths in your practice (i.e. questions >4.0)? Consider how these strengths relate to the TransforMED Model of Care.
- Where are the opportunities for improvement in the practice (i.e. questions <4.0)? Consider how these opportunities for improvement relate to the TransforMED Model of Care. For example, if survey item 1 is <4.0, this item relates to Access to Care. Discuss with your practice team questions such as what % of your day is open to same day appointments, how many patients have to be referred to urgent care due to lack of provider availability to provide care, etc.?
- Identify the people in your practice who need to be involved to address these areas for improvement. What providers might have best practices on certain survey items?
- Develop your PEAT Plan to help prioritize next steps related to your areas for improvement.

Table 1: Survey item Averages

Practice A Averages vs. Practice B Averages vs. Comparison Group Survey item Averages

Report date: March 14, 2013

	PEAT Survey Item	Practice A Round 3, March 2013	Practice A Round 2, March 2012	Practice A Baseline	Practice B Round 3, March 2013	Practice B Round 2, March 2012	Practice B Baseline	Comparison Group
1	I was able to schedule an appt. on the day I wanted.	4.17	4.18	4.14	4.25	4.24	4.24	4.45
2	I made a list of my concerns before the visit with my care team.	3.62	3.63	3.60	3.72	3.74	3.68	3.61
3	My clinician asked my thoughts on the treatment goals to which we agreed.	4.05	4.05	4.03	3.99	4.00	3.98	3.8
4	My questions were answered in a way that I could understand	4.38	4.39	4.38	4.25	4.24	4.23	4.34
5	I was satisfied with the amount of time I spent with my clinician	4.28	4.27	4.27	4.18	4.18	4.17	4.65
6	I was able to see the clinician I requested.	4.29	4.29	4.27	4.22	4.20	4.15	4.54
7	My clinician is concerned about me as a person, not just my illness.	4.32	4.32	4.31	4.21	4.21	4.19	4.68
8	My care team contacts me to remind me I need to come in for my checkup	3.63	3.56	3.43	3.82	3.81	3.76	3.89
9	I know my rights and responsibilities as a patient of this practice.	4.27	4.27	4.24	4.20	4.21	4.2	4.68
10	I am at ease asking questions about my healthcare concerns.	4.41	4.42	4.40	4.29	4.28	4.26	4.8
11	My clinician is a good listener.	4.44	4.44	4.43	4.30	4.31	4.32	4.86
12	I can manage my health better because of what I learn from my clinician and the care team.	4.26	4.26	4.24	4.14	4.15	4.16	4.71
13	My clinician tells me the common side effects for each of my treatment choices.	4.11	4.11	4.09	4.06	4.08	4.08	4.69
14	I have a say in decisions about my care.	4.28	4.28	4.26	4.14	4.16	4.16	4.73
15	I am notified in a timely manner of test results after I have had lab work or x-rays.	4.13	4.14	4.14	4.09	4.09	4.07	4.45
16	I am asked about my satisfaction with my healthcare.	3.89	3.87	3.83	3.94	3.94	3.97	3.64
17	When I have questions about my bill, my questions are answered politely.	3.91	3.90	3.91	4.01	4.00	3.99	4.18
18	The practice makes information available to me through their website.	3.61	3.57	3.52	3.38	3.37	3.37	3.77
19	I can easily get in touch with the practice after regular hours and on weekends.	3.71	3.69	3.68	3.65	3.63	3.64	3.62
20	I would refer my family and friends to this practice.	4.33	4.33	4.31	4.15	4.15	4.15	4.71

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PCMH Dimensions and Corresponding Survey Items Key

Comments: Each survey item corresponds to a PCMH Dimension. As you review your data, consider possible next steps and action items with relation to both the PCMH Dimension and corresponding survey items.

Corresponding PCMH Dimension	Survey Item Number	Survey Item
Access to Care	**1**	I was able to schedule an appointment on the day I wanted.
	3	My clinician asked my thoughts on the treatment goals to which we agreed.
	18	The practice makes information available to me through their website.
Access to information	**12**	I can manage my health better because of what I learn from my clinician and the care team.
	14	I have a say in decisions about my care.
	15	I am notified in a timely manner of test results after I have had lab work or x-rays.
	16	I am asked about my satisfaction with my healthcare.
	19	I can easily get in touch with the practice after regular hours and on weekends.
Communication	**6**	I was able to see the clinician I requested.
	7	My clinician is concerned about me as a person, not just my illness.
	8	My care team contacts me to remind me I need to come in for my checkup
	9	I know my rights and responsibilities as a patient of this practice.
	10	I am at ease asking questions about my healthcare concerns.
Overall patient satisfaction with care	**17**	When I have questions about my bill, my questions are answered politely.
	20	I would refer my family and friends to this practice.
Patient Centered Whole Person Care	**2**	I made a list of my concerns before the visit with my care team.
	4	My questions were answered in a way that I could understand.
Patient Self Management	**5**	I was satisfied with the amount of time I spent with my clinician.
	11	My clinician is a good listener.
	13	My clinician tells me the common side effects for each of my treatment choices.

Table 3: PCMH Dimensions Practice
Practice A vs. Practice B vs. Comparison Group

Report date: March 14, 2013

PCMH Dimension	Practice A March 2013	Practice A March 2012	Practice A Baseline	Practice B March 2013	Practice B March 2012	Practice B Baseline	Comparison Group
Communication	4.19	4.17	4.13	4.15	4.14	4.11	4.77
Patient Self-Management	4.28	4.27	4.26	4.18	4.19	4.19	3.62
Access to Care	3.95	3.94	3.91	3.90	3.90	3.89	4.33
Access to Information	4.06	4.05	4.04	4.00	4.00	4.00	4.38
Patient Centered Whole Person Care	4.00	4.01	3.99	3.99	3.99	3.96	4.71
Overall patient satisfaction with care	4.12	4.11	4.11	4.08	4.07	4.07	4.71

Table 4: Insurance Breakdown

Report date: March 14, 2013

Practice A

March 2012

Counts Analysis % Respondents	
Total	**1580** **100%**
Respondent gender	
Commerical Insurance	647 41%
Medicare	150 9%
Medicaid	812 51%
Self-pay	77 5%
Other	- -

July 2011

Counts Analysis % Respondents	
Total	**1711** **100%**
Respondent gender	
Commerical Insurance	656 38%
Medicare	146 9%
Medicaid	751 44%
Self-pay	64 4%
Other	180 11%

March 2013

Counts Analysis % Respondents	
Total	**1204** **100%**
Respondent gender	
Commerical Insurance	364 30%
Medicare	86 7%
Medicaid	797 66%
Self-pay	31 3%
Other	1 0%

Practice B

March 2012

Counts Analysis % Respondents	
Total	**646** **100%**
Respondent gender	
Commerical Insurance	178 28%
Medicare	161 25%
Medicaid	323 50%
Self-pay	44 7%
Other	4 1%

July 2011

Counts Analysis % Respondents	
Total	**683** **100%**
Respondent gender	
Commerical Insurance	251 37%
Medicare	151 22%
Medicaid	307 45%
Self-pay	35 5%
Other	1 0%

March 2013

Counts Analysis % Respondents	
Total	**562** **100%**
Respondent gender	
Commerical Insurance	175 31%
Medicare	113 20%
Medicaid	314 56%
Self-pay	25 4%
Other	- -

Table 5: Patients with Routine Healthcare Source

Report date: March 14, 2013

21. Do you have a routine source of healthcare?

Practice A

March 2012

Counts Analysis % Respondents	
Total	**1435** **100%**
Do you have a routine source of healthcare?	
Yes	1182 82%
No	253 18%

July 2011

Counts Analysis % Respondents	
Total	**1613** **100%**
Do you have a routine source of healthcare?	
Yes	1287 80%
No	326 20%

March 2013

Counts Analysis % Respondents	
Total	**1134** **100%**
Do you have a routine source of healthcare?	
Yes	961 85%
No	173 15%

Practice B

March 2012

Counts Analysis % Respondents	
Total	**545 100%**
Do you have a routine source of healthcare?	
Yes	365 67%
No	180 33%

July 2011

Counts Analysis % Respondents	
Total	**693 100%**
Do you have a routine source of healthcare?	
Yes	456 66%
No	237 34%

March 2013

Counts Analysis % Respondents	
Total	**525 100%**
Do you have a routine source of healthcare?	
Yes	386 74%
No	139 26%

Table 6: Rating of Overall Health

Report date: March 14, 2013

22. How would you rate your overall health?

Practice A

March 2012

Counts Analysis % Respondents	
Total	**1528** **100%**
How would you rate your overall health?	
Excellent	255 17%
Very good	505 33%
Good	597 39%
Fair	153 10%
Poor	18 1%

July 2011

Counts Analysis % Respondents	
Total	**1667** **100%**
How would you rate your overall health?	
Excellent	271 16%
Very good	571 34%
Good	640 38%
Fair	164 10%
Poor	21 1%

March 2013

Counts Analysis % Respondents	
Total	**1179** **100%**
How would you rate your overall health?	
Excellent	182 15%
Very good	390 33%
Good	489 41%
Fair	104 9%
Poor	14 1%

Practice B

March 2012

Counts Analysis % Respondents	
Total	**598** **100%**
How would you rate your overall health?	
Excellent	59 10%
Very good	130 22%
Good	295 49%
Fair	99 17%
Poor	15 3%

July 2011

Counts Analysis % Respondents	
Total	**737** **100%**
How would you rate your overall health?	
Excellent	82 11%
Very good	168 23%
Good	368 50%
Fair	110 15%
Poor	9 1%

March 2013

Counts Analysis % Respondents	
Total	**548** **100%**
How would you rate your overall health?	
Excellent	60 11%
Very good	144 26%
Good	266 49%
Fair	62 11%
Poor	16 3%

Table 7: Frequency of Missing School or Work

Report date: March 14, 2013

23. During the past 90 days, how many days of school or work did you miss due to illness?

Practice A

March 2012

Counts Analysis % Respondents	
Total	**1503** **100%**
During the past 90 days, how many days of school or work ...	
0	588 39%
1-5	539 36%
6-9	44 3%
10-15	23 2%
16 or more	14 1%
I do not work or go to shcool	295 20%

July 2011

Counts Analysis % Respondents	
Total	**1646** **100%**
During the past 90 days, how many days of school or work ...	
0-9	1246 76%
10-19	42 3%
20-29	12 1%
30-39	8 0%
40 or more	10 1%
I do not work or go to shcool	328 20%

March 2013

Counts Analysis % Respondents	
Total	1156 100%
During the past 90 days, how many days of school or work ...	
0	396 34%
1-5	424 37%
6-9	52 4%
10-15	31 3%
16 or more	16 1%
I do not work or go to shcool	237 21%

Practice B

March 2012

Counts Analysis % Respondents	
Total	572 100%
During the past 90 days, how many days of school or work ...	
0	205 36%
1-5	135 24%
6-9	19 3%
10-15	6 1%
16 or more	16 3%
I do not work or go to shcool	191 33%

July 2011

Counts Analysis % Respondents	
Total	700 100%
During the past 90 days, how many days of school or work ...	
0-9	458 65%
10-19	29 4%
20-29	10 1%
30-39	5 1%
40 or more	4 1%
I do not work or go to shcool	194 28%

March 2013

Counts Analysis % Respondents	
Total	**539** **100%**
During the past 90 days, how many days of school or work ...	
0	200 37%
1-5	163 30%
6-9	21 4%
10-15	11 2%
16 or more	6 1%
I do not work or go to shcool	138 26%

FACE TO FACE ACCESS DASHBOARD

	Provider 1	Provider 2	Provider 3	Provider 4	Provider 5	Provider 6
Patient Panel (identified PCP)						
Number of Appointment Types						
Average Appointment length						
Appointment length (10, 15, 20 , 30, 45)						
Any blocks present						
Written guidelines for appointments						
Who has authority over appointments						
When can appointments be scheduled same day						
Double/triple-booking present						
Capacity (Supply)						
Demand						
Unmet Demand						
Lead time – 3rd next available						
Acute						
Non-acute						
Urgent care utilization						

Definitions

- **Number of appointment types** - different types of appointments on schedule – office visit; physical; extended office visit; quick visit, etc.
- **Average appointment length**: average of all differing appointment lengths in a day
- **Appointment length** – 10 min, 15 min, 20 min, 30 min, 45 min, 60 min how many of each if blocked?
- **Any blocks present** – limits on number of types of appointments or length of appointments - For example, no more than 3 Px per day; no back to back 45 minute appointments, etc.
- **Capacity- Supply**: Average number of appointments per day (take 2 – 4 week schedule and average per day)
- **Demand:** Number of requests for an appointment (take 2 weeks of request data and average per day)
  This should include appointments scheduled when day starts
- **Unmet Demand:** Capacity minus Demand

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Care Coordination Dashboard

Metric	Description	Provider 1	Provider 2	Provider 3
Specialty Referrals				
% of consults scheduled within practice guidelines: (emergent, urgent, routine)				
% of written specialists agreements in place (specify)				
% of consult/referrals tracked to completion				
% of consultant reports received by PCP in timely manner (define)	Consider this by each specialty			
% of patients sent for consult/referral with medication reconciliation in a timely manner (define)				
% outside services reported by patient, e.g. flu shot				
Routine tracking of referral to specialists-specialty utilization data				
Hospital / ER				
% of ER/Hospital admissions w access to PCP PHI				
% of ER / Hospital admission notification to PCP within 24 hours				
% of ER/Hospital discharge patients receiving follow-up care by protocol	Should include f/u phone call and med recon as well as visit when applicable			
% of ER/Hospital discharge medication reconciliation				
ER visits / 1000 (consider for Ambulatory Sensitive Conditions ASC)				

Hospital admissions/ 1000 (consider for ASC)				
Hospital readmission / 1000				
Community Referrrals				
% of eligible patients referred to community resources	Pharmacy, mental health, substance abuse, diabetic educator, nutritionist, behavioralist, etc.			
% of eligible patients referred who complete visit to community resources				
% of community service referrals appropriately documented in patient EMR				

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Care Management Dashboard

Metric	Description	Provider 1	Provider 2	Provider 3
Patient panel for each provider	# of patients who consider each provider their PCP -- may use 4 point system			
Demographic information on patient panel	Age, gender, chronic disease distribution of patient panel			
Acuity or stratification of patient population	% of patients who are at high risk based on specific criteria			
% of visits with updated medication list				
% of pre-visit planning: –a) routine physicals b) chronic disease c) new patient physical	Number of routine (complete physical and chronic disease rechecks) that are planned with EBG care completed at time of visit (numerator) as compared to total number of routine visits (denominator)			
% of patients with specific EBG metrics completed a) Preventative b) Chronic	Quality metrics			
% of orders tracked to completion— a) lab b) imaging c) referral to specialist				
% utilization of generic meds				
# of chronic diseases for which population management is in place				

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Patient Engagement Dashboard

Metric	Description	Time Span (when applicable)	Provider 1	Provider 2	Provider 3
% of patients who receive after visit summary	EHR	Varies – 3 months			
% of patients with current care plan	EHR or Manual	Varies – 3 months			
% of patients with identified patient goals	EHR or Manual	Varies – 3 months			
% of patients with electronic access to PHI	EHR	Varies			
% of patients requesting refills between appointments					
% of patients who achieve patient identified goals		Varies – 6 months			
% of patients who provide information of outside services					
Patient Experience data	Select specific questions -- regarding information/resources for self-management				
% of No Shows					

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Quality & Safety Dashboard

Metric	Description	Time Span (when applicable)	Provider 1	Provider 2	Provider 3
# of patient safety errors		Annual			
# of safety errors involving physicians and/or staff					
Review of sample expiration dates					
Immunizations refrigerated and monitored for expiration dates					
Quality reporting to state or federal					
Utilization of Generics					
Utilization of Radiology					
Total cost of care					

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Practice-Based Team Dashboard

Metric	Description	Time Span (when applicable)	Provider 1	Provider 2	Provider 3
Touch time / Cycle time data		2-4 weeks			
Front Desk					
% of co-pay collection at time of visit		1 month			
% of payer eligibility prior to visit		1 month			
% of contact information update at any interaction		1 month			
% of demographic field completion		3 months			
Clinical					
% of specific workflows completed as defined	Rooming process, medication reconciliation,	1 week			
% of eligible refills not completed per protocol	# of refills that are sent to physician or provider that could have been completed per protocol (numerator)/ total # of refills (denominator)	1 week			
% of message requests completed per guidelines	# of message request sent to physician or provider that could have been completed per guidelines (numerator) / total # of information requests	1 week			
% of clinical documentation completed		1-3 months			
% of pharmacy verified for this interaction		1 week			
% of progress notes accurately reflecting care provided and potential next steps		1 week			

PCMH Progress Report

0 =	0
1= no action has been taken	1
2 = some action has been taken, or working on it	2
3 = action has been addressed and is now currently working	3

Practice A	Year One				Year Two			
	Baseline	2Q	3Q	4Q	IQ	2Q	3Q	4Q
Model Components and Factors								
Patient Centered Care								
Practice policies communicated to patient	2	2	3	3	3	3	3	
Patient rights and responsibilities communicated to patient	1	2	2	3	3	3	3	
Patient experience survey by practice (PEAT)	2	2	2	2	3	3	3	
Patient - PCP relationship promoted	2	2	2	3	3	3	3	
Continuous patient-provider relationship metrics available	1	1	1	2	2	2	2	
Visit and health information shared with patient	2	2	2	2	3	3	3	
Patient education on PCMH	1	2	2	2	2	2	3	
Patient advisory group	1	1	2	2	2	3	3	
Patient engagement in care promoted by staff and providers	2	2	2	2	2	2	3	
Average Patient Centered Care	1.56	1.78	2.00	2.33	2.56	2.67	2.89	
Access to Care and Information								
Access to care and information policy in place	2	2	2	2	2	2	3	
Scheduling guidelines simplified and consistent across practice	1	1	1	2	2	3	3	
Access metrics dashboard reviewed (care and information)	1	1	1	1	1	2	3	
Establish same day access goals	1	1	2	2	2	3	3	
After hours coverage communicated and coordinated	3	3	3	3	3	3	3	
Extended office hours provided	3	3	3	3	3	3	3	
Patient portal available	1	1	1	1	2	2	2	
E mail communication and/or e-visits provided	1	1	1	1	2	3	3	
Nurse and/or group visits provided	1	1	1	2	2	2	3	
Practice open to all patients	2	2	2	3	3	3	3	
Test results provided to patient -- normal and abnormal	2	2	2	2	2	3	3	
Average Access to Care and Information	1.64	1.64	1.73	2.00	2.18	2.64	2.91	
Comprehensive care for acute & chronic conditions	3	3	3	3	3	3	3	
Multiple procedures done in the practice	3	3	3	3	3	3	3	
Lab draw station and CLIA waived lab capabilities	3	3	3	3	3	3	3	
Appropriate testing offered on site	3	3	3	3	3	3	3	
Prevention - screening services on site	2	2	2	2	2	3	3	
Average Practice Based Services	2.80	2.80	2.80	2.80	2.80	3.00	3.00	

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	Year One				Year Two			
	Baseline	2Q	3Q	4Q	IQ	2Q	3Q	4Q
Care Management								
Population management process in place	1	2	2	2	2	3	3	
Decision support - point of care reminders for EBC	1	1	1	2	2	3	3	
Provides and documents patient self management information	1	1	2	2	2	3	3	
Pre-visit planning for routine care	1	1	2	2	2	3	3	
Patient reminders - outreach for EBC	2	2	2	2	2	3	3	
Average Care Management	1.20	1.40	1.80	2.00	2.00	3.00	3.00	
Care Coordination								
Effective relationships/ communication with providers - settings	2	2	2	2	2	2	3	
Hospital/ER follow-up is defined	1	2	2	2	2	3	3	
Agreements with hospital/ER providers	1	1	2	2	2	2	3	
Agreements with consulting/referral physicians	1	1	2	2	2	2	3	
Community based services utilized	2	2	2	2	3	3	3	
Consult /referral process defined and tracked	1	1	2	2	2	3	3	
Medication reconciliation across all providers/settings	2	2	2	2	2	2	3	
Average Care Coordination	1.43	1.57	2.00	2.00	2.14	2.43	3.00	
Practice-Based Team Care								
Provider leadership of clinical team defined	2	2	2	2	2	3	3	
NP-PA role defined	2	2	2	2	2	3	3	
Clinical teams identified	1	1	1	2	2	3	3	
Effective team communication in place	1	1	1	2	2	3	3	
Team member tasks and responsibilities defined	1	1	1	2	2	3	3	
Guidelines or protocols for frequent tasks developed & used	2	2	2	2	2	3	3	
Utilization of medication refill protocols & standing orders	2	2	2	2	2	3	3	
Team efficiency metrics reviewed	1	1	1	1	2	2	3	
Average Practice Based Team Care	1.5	1.5	1.5	1.88	2	2.9	3	
Quality and Safety								
Quality improvement activities	1	1	2	2	2	2	2	
Clinical measures -outcome report review for QI	2	2	2	2	2	3	3	
Reporting mechanism for patient safety issues	1	1	1	1	2	3	3	
Regulatory compliance	2	2	2	2	2	3	3	
Average Quality and Safety	1.50	1.50	1.75	1.75	2.00	2.75	2.75	

	Year One				Year Two			
	Baseline	2Q	3Q	4Q	IQ	2Q	3Q	4Q
Health Information Technology								
Efficient use of EMR and skill sharing process in place	1	1	1	1	1	2	2	
Electronic prescribing used across practice	2	2	2	2	2	2	3	
Demographic-clinical information in searchable fields	2	2	2	2	2	3	3	
Lab and x=ray interface	3	3	3	3	3	3	3	
Electronic informaion sharing with outside providers/settings	2	2	2	2	2	3	3	
Registry -reporting capability in practice	1	1	1	1	2	3	3	
Customized interactive practice web site	2	2	2	2	2	3	3	
Regional exchange participation/utilization	1	1	1	2	2	2	2	
Maximize electronic billing - claim submission - payer validation	2	2	2	2	2	3	3	
Average Health Information Technology	1.78	1.78	1.78	1.89	2.00	2.67	2.78	
Practice Management								
Leadership team and change process in place	1	1	1	2	2	3	3	
Effective communication to staff -and providers	1	1	2	2	2	3	3	
Vision statement consistent with PCMH	2	2	2	3	3	3	3	
Regular meeting schedule / effective meeting structure	2	2	2	2	2	3	3	
Providers - staff engaged in PCMH	1	1	1	2	2	2	3	
Financial dashboard/reporting to providers & manager	2	2	2	2	2	3	3	
Financial management processes in place	2	2	2	2	2	3	3	
Coding audit process in place	2	2	2	3	3	3	3	
Operating policy and procedures in place	1	1	1	2	2	2	3	
Job descriptions in place for all staff members	1	1	2	2	3	3	3	
Performance management process in place	1	1	1	2	3	3	3	
Employee handbook with policies and procedures	2	2	2	2	2	3	3	
Average Practice Management	1.5	1.5	1.67	2.17	2.33	2.8	3	
Quarterly Average	1.63	1.69	1.84	2.09	2.23	2.74	2.93	

PCMH Progress Report

0 =	0
1= no action has been taken	1
2 = some action has been taken, or working on it	2
3 = action has been addressed and is now currently working	3

Practice B	Year One				Year Two			
	Base line	2Q	3Q	4Q	IQ	2Q	3Q	4Q
Model Components and Factors								
Patient Centered Care								
Practice policies communicated to patient	1	1	2	2	3	3	3	
Patient rights and responsibilities communicated to patient	1	1	1	2	2	3	3	
Patient experience survey by practice (PEAT)	1	1	2	2	3	3	3	
Patient - PCP relationship promoted	1	1	2	2	2	2	3	
Continuous patient-provider relationship metrics available	2	1	1	2	2	3	3	
Visit and health information shared with patient	1	1	2	2	3	3	3	
Patient education on PCMH	1	1	2	2	2	3	3	
Patient advisory group	1	1	1	2	3	3	3	
Patient engagement in care promoted by staff and providers	2	2	2	2	2	2	2	
Average Patient Centered Care	1.22	1.11	1.67	2.00	2.44	2.78	2.89	
Access to Care and Information								
Access to care and information policy in place	1	1	2	2	2	3	3	
Scheduling guidelines simplified and consistent across practice	1	1	1	1	2	3	3	
Access metrics dashboard reviewed (care and information)	1	1	1	2	2	2	3	
Establish same day access goals	1	1	2	2	2	2	3	
After hours coverage communicated and coordinated	3	3	3	3	3	3	3	
Extended office hours provided	2	2	2	2	3	3	3	
Patient portal available	1	1	1	1	2	2	2	
E mail communication and/or e-visits provided	1	1	1	1	2	2	2	
Nurse and/or group visits provided	1	1	1	1	2	3	3	
Practice open to all patients	3	3	3	3	3	3	3	
Test results provided to patient -- normal and abnormal	2	2	2	2	2	3	3	
Average Access to Care and Information	1.55	1.55	1.73	1.82	2.27	2.64	2.82	
Practice Based Services								
Comprehensive care for acute & chronic conditions	2	2	2	2	2	3	3	
Multiple procedures done in the practice	3	3	3	3	3	3	3	
Lab draw station and CLIA waived lab capabilities	3	3	3	3	3	3	3	
Appropriate testing offered on site	3	3	3	3	3	3	3	
Prevention - screening services on site	3	3	3	3	3	3	3	
Average Practice Based Services	2.80	2.80	2.80	2.80	2.80	3.00	3.00	

TransforMED℠ TRANSFORMING MEDICAL PRACTICES

	Year One				Year Two			
	Base line	2Q	3Q	4Q	IQ	2Q	3Q	4Q
Care Management								
Population management process in place	2	2	2	2	2	3	3	
Decision support - point of care reminders for EBC	3	2	2	2	2	3	3	
Provides and documents patient self management information	1	1	1	2	2	2	3	
Pre-visit planning for routine care	1	1	1	2	2	3	3	
Patient reminders - outreach for EBC	2	2	2	2	2	3	3	
Average Care Management	1.80	1.60	1.60	2.00	2.00	2.80	3.00	
Care Coordination								
Effective relationships/ communication with providers - settings	2	2	2	2	2	2	2	
Hospital/ER follow-up is defined	3	2	2	2	2	2	3	
Agreements with hospital/ER providers	3	3	3	2	2	2	2	
Agreements with consulting/referral physicians	1	2	2	2	2	2	3	
Community based services utilized	1	1	1	2	2	3	3	
Consult /referral process defined and tracked	1	1	1	2	2	2	3	
Medication reconciliation across all providers/settings	1	2	2	2	2	2	3	
Average Care Coordination	1.71	1.86	1.86	2.00	2.00	2.14	2.71	
Practice-Based Team Care								
Provider leadership of clinical team defined	2	2	2	2	2	3	3	
NP-PA role defined	2	2	N/A	N/A	1	3	3	
Clinical teams identified	2	2	2	2	2	3	3	
Effective team communication in place	2	2	2	2	2	3	3	
Team member tasks and responsibilities defined	2	2	2	2	2	3	3	
Guidelines or protocols for frequent tasks developed & used	1	1	1	2	2	3	3	
Utilization of medication refill protocols & standing orders	2	2	2	2	2	3	3	
Team efficiency metrics reviewed	1	1	1	1	1	2	3	
Average Practice Based Team Care	1.8	1.8	1.7	1.9	1.8	2.9	3	
Quality and Safety								
Quality improvement activities	1	1	1	2	2	3	3	
Clinical measures -outcome report review for QI	2	2	2	2	2	3	3	
Reporting mechanism for patient safety issues	1	1	1	2	2	3	3	
Regulatory compliance	3	3	3	3	3	3	3	
Average Quality and Safety	1.75	1.75	1.75	2.25	2.25	3.00	3.00	

	Year One				Year Two			
	Base line	2Q	3Q	4Q	IQ	2Q	3Q	4Q
Health Information Technology								
Efficient use of EMR and skill sharing process in place	2	2	2	2	3	3	3	
Electronic prescribing used across practice	3	3	3	3	3	3	3	
Demographic-clinical information in searchable fields	2	2	2	2	3	3	3	
Lab and x=ray interface	2	2	2	2	2	3	3	
Electronic informaion sharing with outside providers/settings	3	2	2	2	2	3	3	
Registry -reporting capability in practice	3	3	2	2	2	3	3	
Customized interactive practice web site	1	1	1	1	1	1	2	
Regional exchange participation/utilization	2	2	2	2	2	2	3	
Maximize electronic billing - claim submission - payer validation	3	2	2	2	3	3	3	
Average Health Information Technology	2.33	2.11	2.00	2.00	2.33	2.67	2.89	
Practice Management								
Leadership team and change process in place	1	1	2	2	2	3	3	
Effective communication to staff -and providers	2	2	2	2	2	3	3	
Vision statement consistent with PCMH	1	1	1	1	2	2	3	
Regular meeting schedule / effective meeting structure	2	2	2	2	2	3	3	
Providers - staff engaged in PCMH	1	1	1	1	2	2	2	
Financial dashboard/reporting to providers & manager	2	2	2	2	2	3	3	
Financial management processes in place	2	2	2	2	2	3	3	
Coding audit process in place	2	2	2	2	2	3	3	
Operating policy and procedures in place	2	1	2	2	2	3	3	
Job descriptions in place for all staff members	2	1	2	2	3	3	3	
Performance management process in place	2	2	2	2	3	3	3	
Employee handbook with policies and procedures	2	2	2	2	2	3	3	
Average Practice Management	1.8	1.6	1.8	1.8	2.2	2.8	2.9	
Quarterly Average	1.80	1.73	1.86	2.00	2.21	2.73	2.90	

Nebraska Patient-Centered Medical Home Pilot Kickoff

February 22, 2011
Wilderness Ridge *(Bitterroot Room)*
1800 Wilderness Woods Place, Lincoln, Nebraska

9:30 – 9:45 a.m.	**Welcoming Remarks, Introductions** *Vivianne Chaumont, Director, Division of Medicaid & Long-Term Care* *Nebraska Department of Health and Human Services*
9:45 – 10:30 p.m.	**TransforMED: Who We Are** **Nebraska Medicaid/TransforMED Partnership** **Patient-Centered Medical Home – National Level View** *Len Fromer, MD, FAAFP, Executive Medical Director* *Group Practice Forum, LA and Assistant Clinical Professor, Department of Family Medicine, University of California – Los Angeles*
10:30 – 10:45 a.m.	**Break**
10:45 – 11:15 a.m.	**Pilot Happenings and Q&A** *Pat Taft, Program Specialist, Pilot Co-Coordinator* *Margaret Brockman, RN, MSN, Program Specialist, Pilot Co-Coordinator* *Division of Medicaid & Long Term Care* *Nebraska Department of Health and Human Services*
11:15 – 11:30 a.m.	**Blue Cross Blue Shield – Quality and Outcomes Pilot** *David Filipi, M.D., Blue Cross Blue Shield of Nebraska*
11:30 – 12:30 p.m.	**Lunch provided**
12:30 – 1:45 p.m.	**A Patient-Centered Medical Home Perspective Using Facilitation** *Don Klitgaard, M.D., FAAF, Medical Director* *Myrtue Medical Center Clinics, Harlan, Iowa*
1:45 – 2:00 p.m.	**Break**
2:00 – 2:45 p.m.	**TransforMED Technical Assistance** *Colleen Stack, TransforMED Facilitator*
2:45 – 3:00 p.m.	**Closing Remarks** *Senator Mike Gloor* *Nebraska Legislature*

Nebraska Care Manager Training
Thursday, September 6, 2012
9:30am – 5:00pm
Holiday Inn
Kearney, Nebraska

LEARNING OBJECTIVES:

- Understand the role of the Care Manager/Coordinator in the PCMH
- Learn how to effectively manage individual patients and patient populations
- Explore tools for the Care Manager
- Realize the cost benefit of the Care Manager
- Utilization of Health Information Technology (HIT) in Care Management
- Understand strategies for patient and family support
- Develop Motivational Interviewing Skills

Roles and Responsibilities of the Care Manager	Diane Cardwell, TransforMED
Care Management: Patients and Populations	Kristi Bohling-DaMetz, TransforMED
BREAK	
Care Coordination	Colleen Stack, TransforMED
LUNCH	
Cost Benefit of the Care Manager	Colleen Stack, TransforMED
Patient & Family Assessment & Support	Diane Cardwell, TransforMED
Patient Engagement, Activation, and Education	Kristi Bohling-DaMetz, TransforMED
BREAK	
Care Planning, Care Summary	Kristi Bohling-DaMetz, TransforMED
Community Health Workers (supporting implementing plans and progressing toward goals – Peers model)	
Motivational Interviewing	
Questions and Closing Announcements	TransforMED & participants
Adjourn	

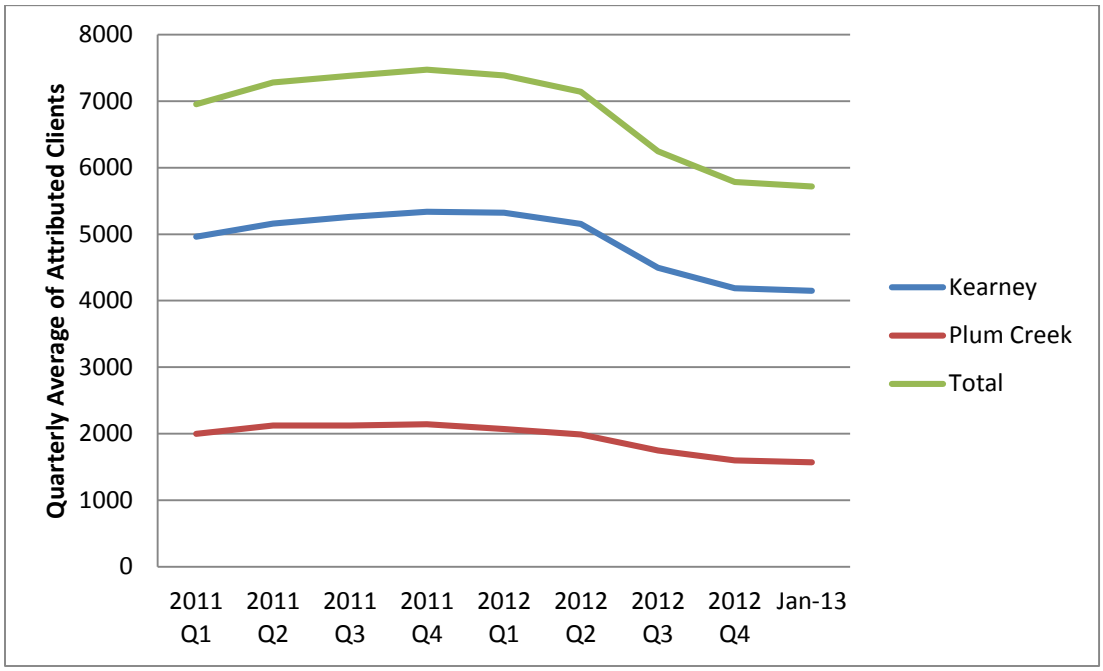
DATA DRAWN FROM MEDICAID CLAIMS

Nebraska Medicaid Patient-Centered Medical Home Pilot

ANALYSIS

All conclusions in the analysis of Medicaid claims data were based on the total measurements from the two clinics, and the total change from the 2010 reported baseline group, which was based on estimated figures. The baseline group was comprised of Medicaid recipients whose primary care providers were at the two pilot practice clinics during the 12-month period prior to the implementation of the pilot. The pilot population experienced a reduction in size with the implementation of Medicaid Managed Care July 1, 2012. While the initial intent was to "protect" the Medicaid population involved with the pilot practices, a coding circumstance negated that intent and Medicaid clients who, for various reasons, were dropped from the Medicaid rolls, were placed in the Medicaid Managed Care program upon reinstatement instead of the pilot. The percent decrease in population over time is illustrated in Figure 1. From the implementation of Managed Care to the end of the pilot, the pilot population decreased 22%. All comparisons made between the baseline group and the final population were made using standardization methodologies to increase the validity of conclusions.

Figure 1: Change in Population since 2011 1ST Calendar Quarter by Quarterly Population Average



Emergency Room Utilization (Table1). This table shows Emergency Room (ER) utilization in terms of emergency and non-emergency visits. There was a borderline significant increase in the percentage of ER visits that were considered non-emergency i.e. inappropriate use of the ER, with16.1% of all visits in the 2010 baseline increasing to 20.7% in 2012. A comparison of means test showed that this increase was a statistically significant one. There was a 28.8% increase in the proportion of visits that were non-emergency visits. In terms of the rate of overall ER visits per 1,000 clients in the population, there was a statistically significant decrease in the rate of total ER visits and of emergency ER visits from the 2010 baseline group to the 2012 data.

Emergency Room Utilization (Table 2). Table 2 explores ER utilization further by examining expenditures. We compared the reduction in total visits and the reduction in total costs. While the total number of trips taken by participants to the ER declined 18.5%, whether due to the decline in population, external factors, or the medical home's true effect, the expenditures did not decline as steeply, reducing only by 6.8%. This suggests that the mean cost per ER visit must have increased from 2010 to 2012. The mean cost of a non-emergency visit increased from $48.21 in 2010 to $49.42 in 2012. This difference of 2.5% is greater than the cumulative Medicaid reimbursement rate increase of 1.54% from 2010 to 2012. *(Medicaid reduced reimbursement rates for services incurred in 2011, and increased reimbursement rates for 2012. This resulted in 2012 reimbursement rates that were 1.54% greater than reimbursement rates in 2010.)* Although this rate increase would account for some of the increase in per-ER visit expenditure, there is still a 1% increase left unaccounted for. The difference between these mean costs was not statistically significant, suggesting that the unexplained difference was due to random variation, and not due to a real increase in per-visit cost.

ER and Hospital Revisits (Tables 3 and 4). Care Coordination in the medical home model is key to the success in reductions in visits, admissions, re-visits or re-admissions, whether to the ER or hospital. Re-visits to the ER within 72 hours of discharge from the ER for the same complaint and visits to the ER within 72 hours of discharge from the hospital for the same complaint did not have sufficient differences between the 2010 baseline and 2012 data to draw conclusions. There were very slight increases in the proportion of all re-visits to the ER, but in both cases the difference was less than a percentage point.

Readmissions to the Hospital (Table 5). The number of readmissions to the hospital, found that the percent of discharges that resulted in a readmission within 30 days increased from 13.9% in the 2010 group to 16.7% in the 2012 group; however, this difference was not statistically significant.

Hospital Admissions for Ambulatory Care Sensitive Conditions (Table 6). Although each ambulatory care sensitive condition did not have a sufficient sample size to draw individual conclusions, the combination of all of these conditions did show a small, statistically significant but unsubstantial decrease, in the proportion of total admissions with one of these conditions as

the primary diagnosis listed as the cause for admission. This rate reduced from 4.4% of admissions to 3.8% of admissions.

High-tech Radiology Expenditures (Table 7). There was a decrease between the quarterly averages spent on high-tech radiology for the 2012 group compared to the quarterly average spent on high-tech radiology in the baseline group; however, this shift was not statistically significant. Additionally, no significance was found in the decrease in the rate of high tech radiology expenditure per 1,000 clients.

Prescription Expenditures (Table 8). Prescription spending was examined in two ways: percentage of prescriptions that were for generic pharmaceuticals and prescription expenditure in dollars. There was no statistically significant difference in the mean percentage of prescriptions written for generics between the baseline and the 2012 groups.

There was a significant decrease in spending for prescriptions. There was a statistically significant decrease in the mean prescription cost, from $59.39 for prescriptions filled for the baseline group to $55.00 in the 2012 group. The rate of prescriptions written per 1,000 clients significantly decreased 12.6%; however, the rate of prescriptions for generic drugs written per 1,000 clients significantly decreased by a greater amount: 14.2%. Although there was a larger decrease in generic prescriptions than prescriptions overall, there was a significant decrease of 19.0% in prescription expenditure per 1,000 clients.

There was a statistically significant decrease in the mean number of prescriptions paid for each client seen per quarter, decreasing from 3.23 prescriptions per client seen per quarter in the 2010 baseline to 2.88 prescriptions written per client seen per quarter in the 2012 group.

(Note: The number of individual clients seen is calculated each quarter. While two visits from the same client in one quarter would not create duplication in the denominator, one visit each from the same client in multiple quarters would lead to their inclusion in each of those quarters' denominators.)

Visits to Specialty Care Providers (Table 9). The purpose of this data was to track the utilization of specialty care providers. A difference of means test was used to determine whether there was a difference in the mean percentage of total visits that clients had with specialists in the 2010 baseline and the 2012 data. This test was also used to determine whether there was a difference in the mean cost of a visit to the specialist. There was a significant decrease in the percentage of total visits that were made to specialists, reducing from 6.1% s to 5.4% of all office visits. There was a significant decrease in the rate of visits to a specialist per 1,000 clients from a mean of 237.5 specialist visits per 1,000 clients each quarter to 204.1.

There was a borderline significant increase ($p=0.05$) in the mean per-visit Medicaid expenditure for visits to the specialist in the 2012 group compared to the 2010 group, increasing from $76.64

to $101.67. The increase in rate of spending on specialist visits per 1,000 clients was not statistically significant.

Office Visits to Same Provider Type, but Not to Pilot Provider (Table 10). This table explores the frequency and expenditure of visits to providers outside of the PCMH. There was a statistically significant increase in the number of visits to outside providers per 1,000 members between the 2010 baseline and the 2012 population, increasing from 239.3 visits per quarter per 1,000 members in the baseline to 269.4 visits per quarter per 1,000 members. There was no significant difference between the average Medicaid expenditures per visit to outside providers in the 2010 baseline and the 2012 data. There was also a statistically significant increase in Medicaid expenditures on visits to outside providers per quarter, per 1,000 members, increasing from $12,718.80 to $14,196.89.

Office Visits to Pilot Providers (Table 11). Table 11 compares the total number of office visits and the number of individual clients from each group seen each quarter to calculate the average number of office visits per quarter, per client in each group. A comparison of means test found that there was a statistically significant decrease in the average number of office visits made each quarter per client seen, from 0.99 in the 2010 group to 0.86 in the 2012 group;

Total Expenditures – Per Member Per Month (PMPM) (Table 12). This data captures the total Medicaid expenditures per client per month during the pilot period. The mean per member per month cost for all Medicaid services reflected a decrease, but it was not statistically significant.

Analysis prepared by:
Rachel Cooper
Research Analyst
Division of Medicaid and Long-Term Care
NE Department of Health and Human Services

PEAT (Patient Experience Assessment Tool) Survey
Results for Medicaid Clients Only

The PEAT survey was a 23-question survey (attached) distributed to clients in the pilot yearly to determine client perception of their medical care. Three of these questions asked clients to self-report several health-status questions. Clients answered 20 questions based on a 5 point Likert scale, with 5 being a response of Strongly Agree, regarding their opinions about the practice they attended. The survey showed statistically significant changes in 7 of these indicators. Most of these measures suggest an increase in satisfaction with the services provided by the Medical Homes. Measures 8, 17 and 18 also suggest that the services provided actually improved. One measures, #2 "I made a list of my concerns before my visit with the care team" significantly increased from a means score of 3.63 at baseline to 3.71 in 2012. However, it significantly decreased to 3.60 in 2013. This measure change suggests that patient involvement may have temporarily increased, but follow through was not long term. Figure 1 presents the trajectory of these significant results.

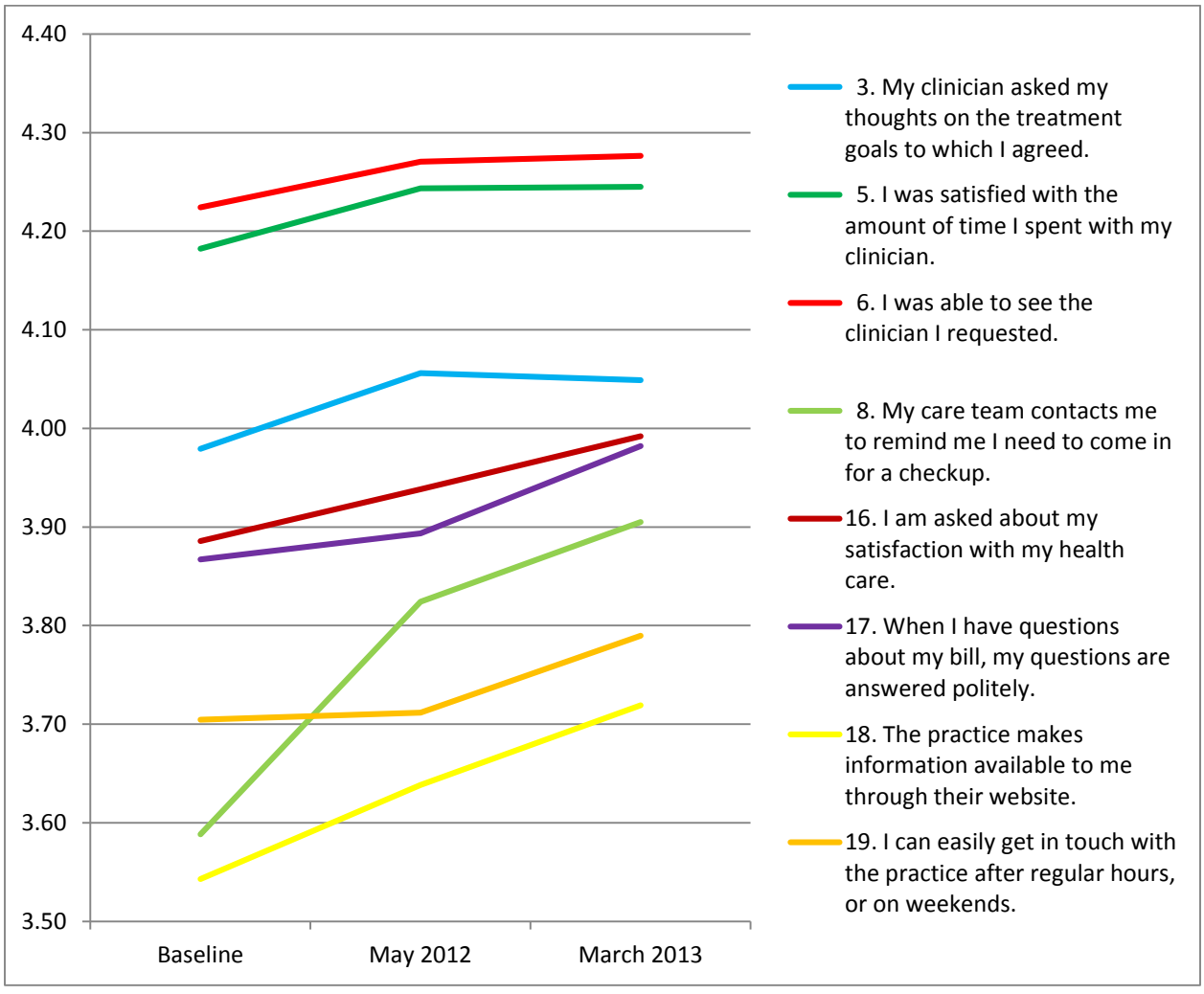


Figure 1: Significant Increases in Client Survey Results

The questions were divided to represent four dimensions of care: Access to Services, Quality of Care, Patient Involvement in Care and Patient Satisfaction with Care. Access to Services and Patient Satisfaction with Care both significantly increased in the span of the study. This supports the conclusion that patient satisfaction increased as well as the amount of services provided. There was no significant change in Patient Involvement in Care or the Quality of Care provided.

After dividing the survey results by practice, one practice had significantly higher mean scores than the other on measures 3, 4, 7, 9, 10, 11, 12, 13, 14, 18, and 20. Almost half of these measures are included in the Quality of Care dimension. However, there was still no significant difference in the Quality of Care mean scores from baseline to 2013 for either location. Practice A mean scores for each dimension were higher than the mean scores for Practice B. See Figure 2.

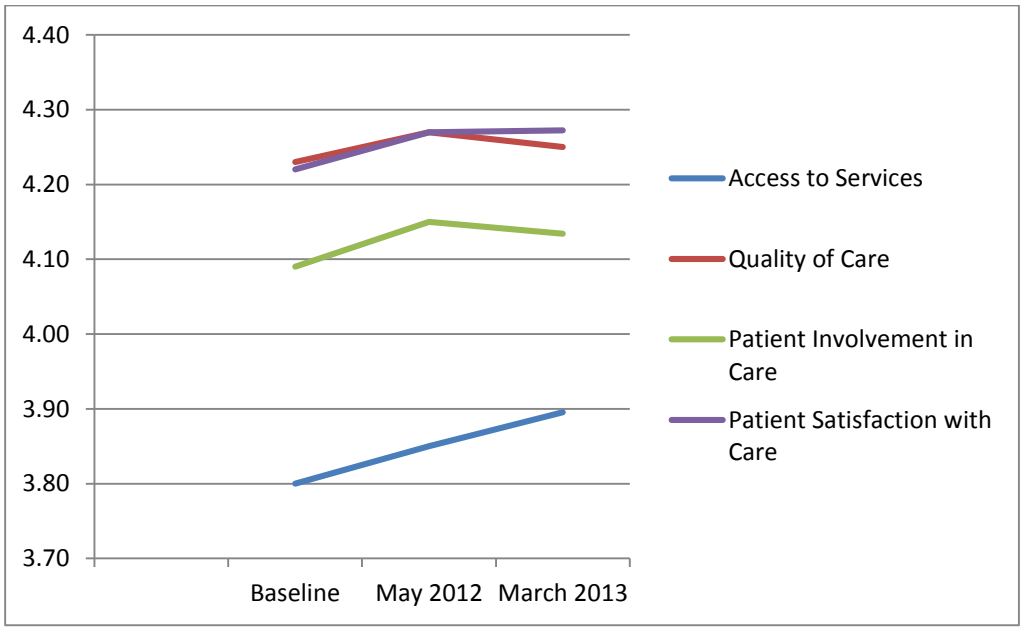


Figure 2: Dimensions of Care Mean Scores

Analysis provided by:

Stacey Dangler
Research Analyst
Division of Medicaid and Long-Term Care
NE Department of Health and Human Services

Patient Experience Assessment

We want you to tell us about your experience with our services. The questions we are about to ask relate to your recent visit and your overall relationship with the practice. Your feedback will help us make our services better. Your name will remain confidential; only the combined results of the surveys gathered at your practice will be shared. On this survey, **Clinician** means your physician (M.D. or D.O), nurse practitioner (NP), or physician's assistant (PA). **Care Team** means everyone else in the practice (led by the physician) that assists with your visit, including nurses, medical assistants, schedulers, and billing office staff. Indicate the best answer for each question by filling in the "bubble" next to your answer.

My clinician (doctor, nurse practitioner, physician assistant) for my most recent visit was: _____

What year were you born: _____

I am currently covered by the following insurance (circle all that apply): Commercial Insurance Medicare Medicaid Self-pay

Please select your gender (please circle): Male Female

1 I was able to schedule an appointment on the day I wanted it.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

2 I made a list of my concerns before my visit with the care team.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

3 My clinician asked my thoughts on the treatment goals to which we agreed.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

4 My questions were answered in a way that I could understand.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

5 I was satisfied with the amount of time I spent with my clinician.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

6 I was able to see the clinician I requested.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

7 My clinician is concerned about me as a person, not just my illness.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

8 My care team contacts me to remind me I need to come in for a checkup.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

9 I know my rights and responsibilities as a patient of this practice.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

10 I am at ease asking questions about my healthcare concerns.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

11 My clinician is a good listener.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

12 I can manage my health better because of what I learn from my clinician and the care team.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

13 My clinician tells me the common side-effects for each of my treatment choices.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

14 I have a say in decisions about my care.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

15 I am notified in a timely manner of test results after I have had lab work or x-rays.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

16 I am asked about my satisfaction with my health care.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

17 When I have questions about my bill, my questions are answered politely.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

18 The practice makes information available to me through their website.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

O	O	O	O	O

19 I can easily get in touch with the practice after regular hours, and on weekends.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

20 I would refer my family and friends to this practice.

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
O	O	O	O	O

21 Do you have a routine source of healthcare?

Yes	No
O	O

If yes, can you name your family doctor or health care provider? _____

22 How would you rate your overall health?

Excellent	Very good	Good	Fair	Poor
O	O	O	O	O

23 During the past 90 days, how many days of school or work did you miss due to illness?

0	1-5	6 - 9	10 - 15	16 or more	I do not work or go to school
O	O	O	O	O	O

FINAL REPORTS
Kearney Clinic and Plum Creek Medical Group
February, 2013

Kearney Clinic: Kearney

Kenton L. Shaffer, M.D.
Lead Physician for the PCMH Team

The Patient-Centered Medical Home transition was both challenging and rewarding.

Challenges:
The first challenge was employee/provider buy-in into the project. Education of both staff and Providers was necessary for understanding of the concept and the goals of the project – to move from the "sick care" model to the "preventative care model."

The next challenge was workflow changes to improve efficiency and communication. At times it was overwhelming in a 28-provider practice. We had basically 6 months to meet the Standards set by HHS. A team of representatives from each department was formed and met weekly to improve communication and discuss/decide needed work flow changes. Physicians were invited to participate. Several physicians led development of core competencies (i.e. standardization of prescription refills, medication reconciliation, care plans engaging patients in their care, transitional care plans, protocol for test tracking and follow-up). The team concept helped everyone understand the interconnectivity of all departments and how decisions affect other departments. It was necessary to re-allocate staff resources and in some cases hire temporary staff.

Challenge #3 – change management and resistance to change. There was a range of emotions to the changes. By working together as a team and with persistence the resistance lessened and they began to see the benefit of changing how we care for patients.

Kearney Clinic (with the assistance of HHS) hired an RN Nurse Care Coordinator as well as installed a registry data management system to manage individual patients as well as patient populations. At the time of the project we did not have an Electronic Medical Record. We actually go live April 1, 2013. Even though the project was for Medicaid patients, Kearney Clinic applied the concept to ALL patients.

Rewards:

Standardization of care protocols and workflows - below is a list of 26 workflow processes that were changed.

Better patient care management – the registry has allowed us to identify patients with particular diseases to better manage their care.

Pre-visit planning – review patient needs prior to the visit and prepare orders for Lab or radiology, as well as recommend vaccinations or diagnostic testing (i.e. mammo, colonoscopy)

Chronic care management – review of ER and hospital discharge reports with follow-up by RN Care Coordinator to identify chronic patients and care needed by use of the registry.

Medication reconciliation – efforts are being made to engage the patient in their care.

Patient engagement – efforts are being made to engage the patient in their care.

At the end of our two years of participation, we are proud of the accomplishments and improved coordination of care.

WORKFLOW CHANGES

- Brochures, ads, posters introducing the PCMH to patients – Spanish and English
- Formed a PCMH team to represent all areas of the clinic – weekly meetings
- Formed teams of providers to work on particular projects – medication reconciliation, after-visit summary, etc.
- Redirected appointment calls to an appointment scheduler placed away from the Front Desk
- Standardized provider patient schedules by specialty
- Standardized protocols for phone nurses
- Standardized care protocols between providers
- Pre-visit planning – review chart for testing due; educational materials for child preventative visits are printed ahead and attached to the patient chart
- Rooming patients – made a standard sheet to collect vital signs and demographics
- Medication reconciliation at each visit
- After visit summary for patient to take with them
- Patient logs for outside testing to track orders, results and patient notification
- Track "no shows" and attempt to reschedule their appointment
- Implemented the Wellcentive Registry system
- Standardized educational materials and placed them in the Wellcentive Registry for easy access and tracking for Meaningful Use
- Entered the past 2-10 years of Mammography, colonoscopies, paps, and Dexascans into the Registry
- Added printers throughout the clinic

- Developed Transfer of Care letters with Children's Hospital and Good Samaritan Hospital
- Standards agreement for "drug seekers"
- Better control of patient access-refill protocols, locked doors to care area, drug seekers
- Improved patient chronic care management by RN Care Coordinator – ER and discharges patient follow-up
- Standardized stamp on reports to indicate provider has reviewed
- Lab orders – made appointments priority over walk-in patients; providers review next day patients and get orders to lab; shut lab walk-in patients off at 3:30 so results can be processed by end of the day
- Improved communication
- Teamwork throughout the clinic
- Made a patient portal available to employees with intention to roll out to patients

Kearney Clinic went through a total transformation with our processes and care protocols while participating in the pilot. The standardization among the providers has greatly improved our ability to provide consistent care across the clinic.

We plan to continue the Patient-Centered Medical Home concept. We have agreements in place with the two Managed Medicaid plans – Arbor Health and Coventry Care, as well as BCBS of Nebraska, for participation in their PCMH projects. We are participating in the UNMC/Walgreen/BCBS Pharmacy pilot to improve communication and health outcomes of hypertensive and diabetic patients and the Million Hearts initiative sponsored by CIMRO of Nebraska and Wide River Tech. Our clinic is also exploring a Clinically Integrated Network (CIN) in coordination with Sentinel HC (PHO) and Good Samaritan Hospital as well as evolving future care and payment models.

Our new focus on preventative care and encouraging patient participation in their healthcare management in addition to patient data will help Kearney Clinic transition into the new evolving models of care and payment systems.

Thank you for the opportunity to participate in this pilot.

Plum Creek Medical Group: Lexington

Joseph Miller, M.D.
Lead Physician for PCMH Team

Successes:

- Patient Advisory Group
- ER Utilization, Admissions and Re-admissions, Referral Tracking and Follow Up Care
    - Developed protocols and processes to better coordinate patient care to help reduce ER utilizations and hospitalizations.
    - Local hospital hired a care coordinator who works closely with our care coordinator to identify high risk patients.
    - Patient care coordination with community services.
        - Case Study: A 51 year old male patient who was diagnosed with Type II Diabetes, Uncontrolled, Hypertension, Gout, Renal Failure, and Depression. The patient utilized our local ER has his primary source of healthcare. In a short span of a few months he had accumulated six ER visits and seven hospitalizations. He was identified as a high risk patient by the admitting physician and scheduled to see the clinic care coordinator. With the assistance of social services and the care coordinator, disability for the patient was obtained. He established a primary caregiver with our practice and began the process of regular follow up visits for his disease processes, scheduled preventative screenings for wellness, and as needed referrals to specialists to help him gain back control of his health. His healthcare team of physicians, nurses, care coordinator, schedulers, billing, and community resources were able to help this gentleman regain control of his life through communication and coordination of his healthcare needs.

- Easy Wins: Rooming of Patients, Standardization of Nursing Policies (i.e. lab orders, medication refills, and immunizations), and Medication Reconciliation.
- Documenting the Same Thing—Same Way—Same Place—Every Time
- All Staff working at the top of their license or ability.

Accomplishments in First Year:

- Leadership team formed with weekly meetings
- Employee/Management procedure improvement committee formed with regular meetings
- Patient Advisory Council formed – meet quarterly
- Standardized front desk check in and check out
- Standardized rooming of patients
- Established refill protocols using nurses as prescribing agents
- Established medication reconciliation policy
- Standardized lab protocols for disease processes based on evidence based guidelines
- Standardized and established care protocols for Diabetes Mellitus patients based on evidence based guidelines
- Standardized and established care protocols for asthma patients based on evidence based guidelines
- Established protocols for patient reminders and notification system
- Established protocols for coordination of services and follow-up care
- Patient education organized and printed and handed out to patient prior to physician visit
- Developed disease registry for Diabetes patients and in process for COPD and CHF patients

Lessons Learned:

- Change is a process. Constant communication is a necessity to succeed in the transformation to a Patient Centered Medical Home.
- Share results with the entire staff to create a competitive environment. Physicians and nurses are a competitive group and they do not like to see their area at the bottom of the chart.
- Failures are going to happen. Workflows are going to become bottlenecks and changes will not work. You just try again.

Recommendations:

- Focus on three main disease processes to monitor progress.
- Choose some easy wins, so you don't feel like a failure all the time.
- Electronic Health Record: Know your system (how, where, and what to document to capture data for reports)

- Lead Physician must be involved and committed to the process. They are vital to promoting the concept to their peers and staff.

Future Plans:

- Continue to develop referral coordination with other facilities (i.e. contracts with specialists, imaging facilities regarding what we expect from them as a referral facility, etc.)
- Continue the process of focusing on preventative healthcare and not sick care as our standard practices.
- NCQA Level III Certification