Patient Centered Medical Home at Atrius Health

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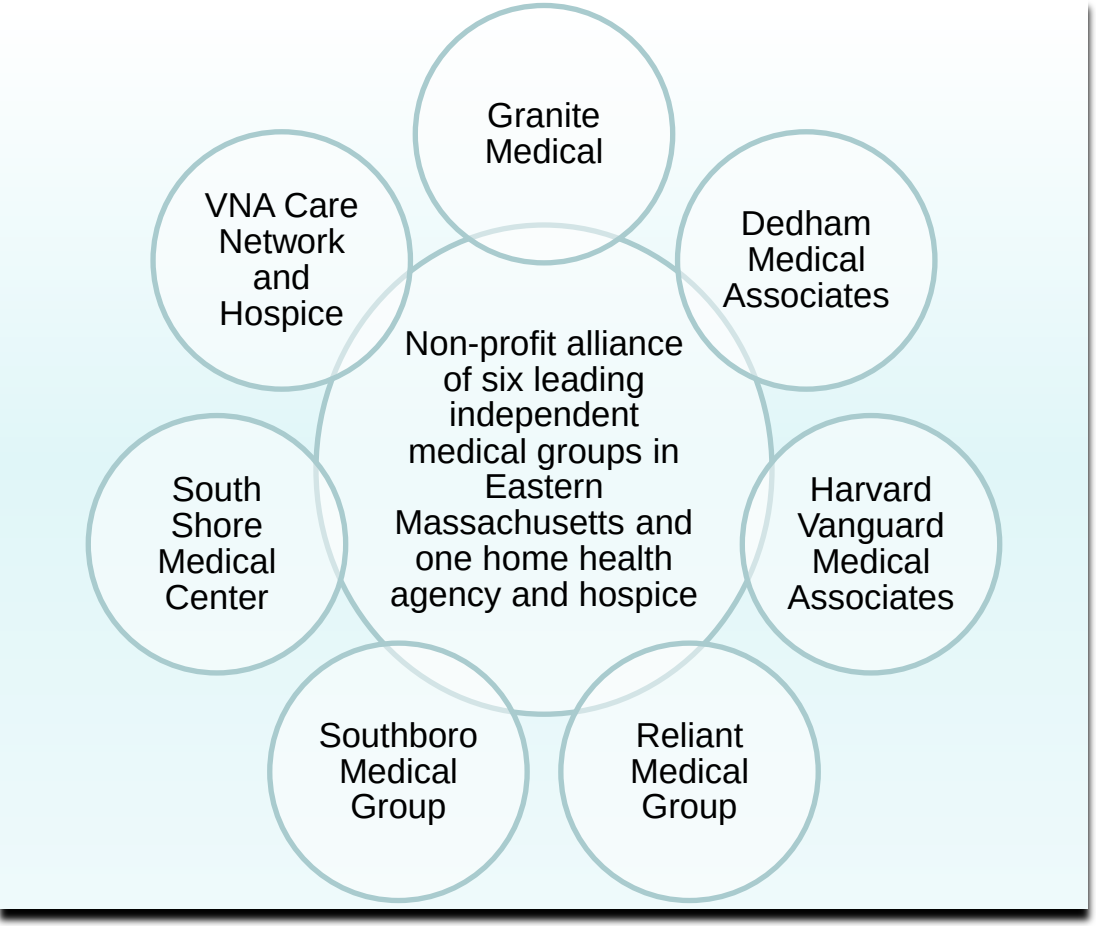

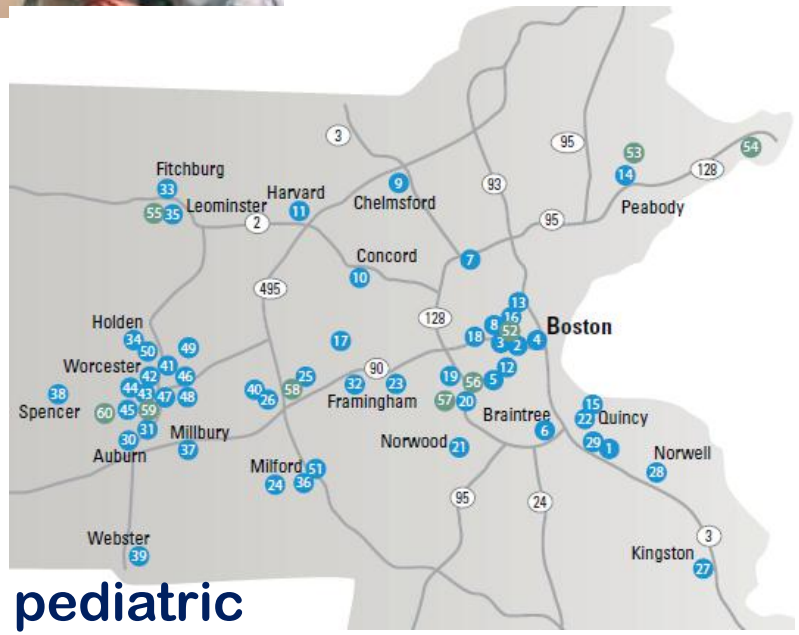

Providing care for ~ 1,000,000 adult and pediatric patients with 1000 physicians, 2100 other healthcare professionals across 35 specialties

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PCMH: Concepts

Principles of PCMH

- Patient-centric/personal PCP
- PCP-directed medical team
- Whole person orientation
- Care is coordinated and integrated
- Emphasis on quality and safety
- Enhanced access
- Appropriate reimbursement.

Source: American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient-centered medical home. February 2007.

PCMH: Concepts

TODAY'S MEDICAL PRACTICE	TOMORROW'S MEDICAL HOME
My patients are those who make appointments to see me	Our patients are those who are registered in our medical home
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet health needs, with or without visits
Care varies by scheduled time and memory or skill of the doctor	Care is standardized according to evidence-based guidelines
I know I deliver high quality care because I'm well trained	We measure our quality and make rapid changes to improve it
Patients are responsible for coordinating their own care	A prepared team of professionals coordinates all patients' care
It's up to the patient to tell us what happened to them	We track tests and consultations, and follow-up after ED and hospital
Clinic operations center on meeting the doctor's needs	An interdisciplinary team works at the top of our licenses to serve patients

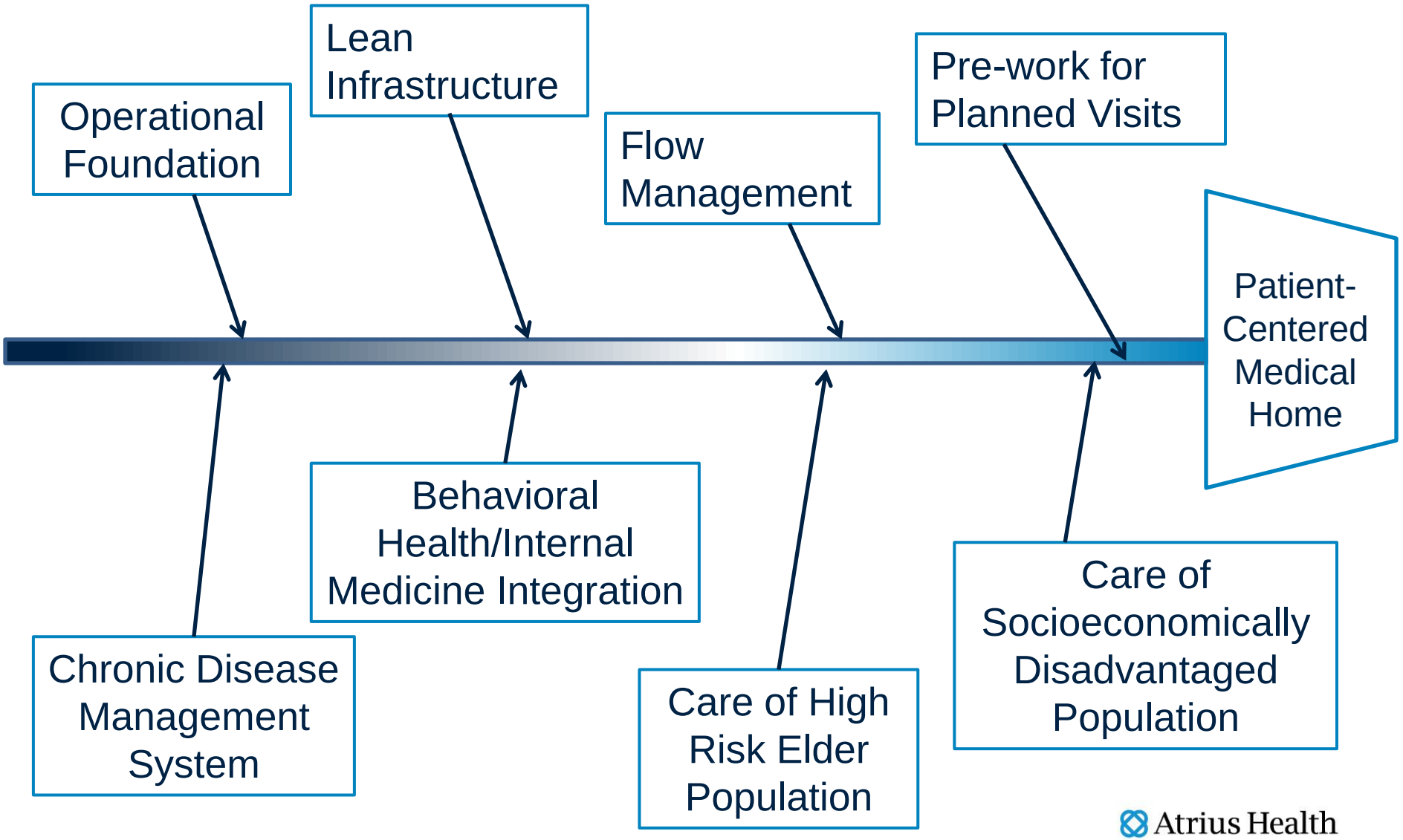
Atrius Health Competencies Support PCMH

- Long history with and majority of revenue under **Global Payment** across commercial and public payers
- **Patient-Centered Medical Home** foundation, including use of NPs/PA's, nutrition, behavioral health, geriatricians, and strong connection to in-house specialists
- **Enhanced Access**: **alternatives to the emergency room**: same-day care during the week, weekend and holiday urgent care, 24/7 medical telephone advice from advanced care practitioners who see EMR, patient portal
- **Population Managers** in each practice support physicians with pro-active outreach to patients in need of screening or treatment
- **Nurses** assigned to high risk patients and to call patients post hospital-discharge
- New connections with local ASAPs to provide support in community
- Newest Addition to Atrius Health: Home health care, private duty nursing and hospice care through VNA Care Network and Hospice

Atrius Health HIT Competencies Support PCMH

- Long-time use of single **EPIC Electronic Medical Record** across all groups
- Decision support tools built into EMR help at point of care
- **Corporate Data Warehouse** integrates single platform electronic health record data with multi-payer claims data to manage quality and cost
- Web portals connect preferred hospital partners electronic medical record with Atrius Health
- Identify patients at highest risk of hospitalization; all practices engaged in interdisciplinary high risk roster review
- Sophisticated development and reporting of **Quality Measurement** and performance, including detailed scorecards

Improving the Patient-Centered Medical Home



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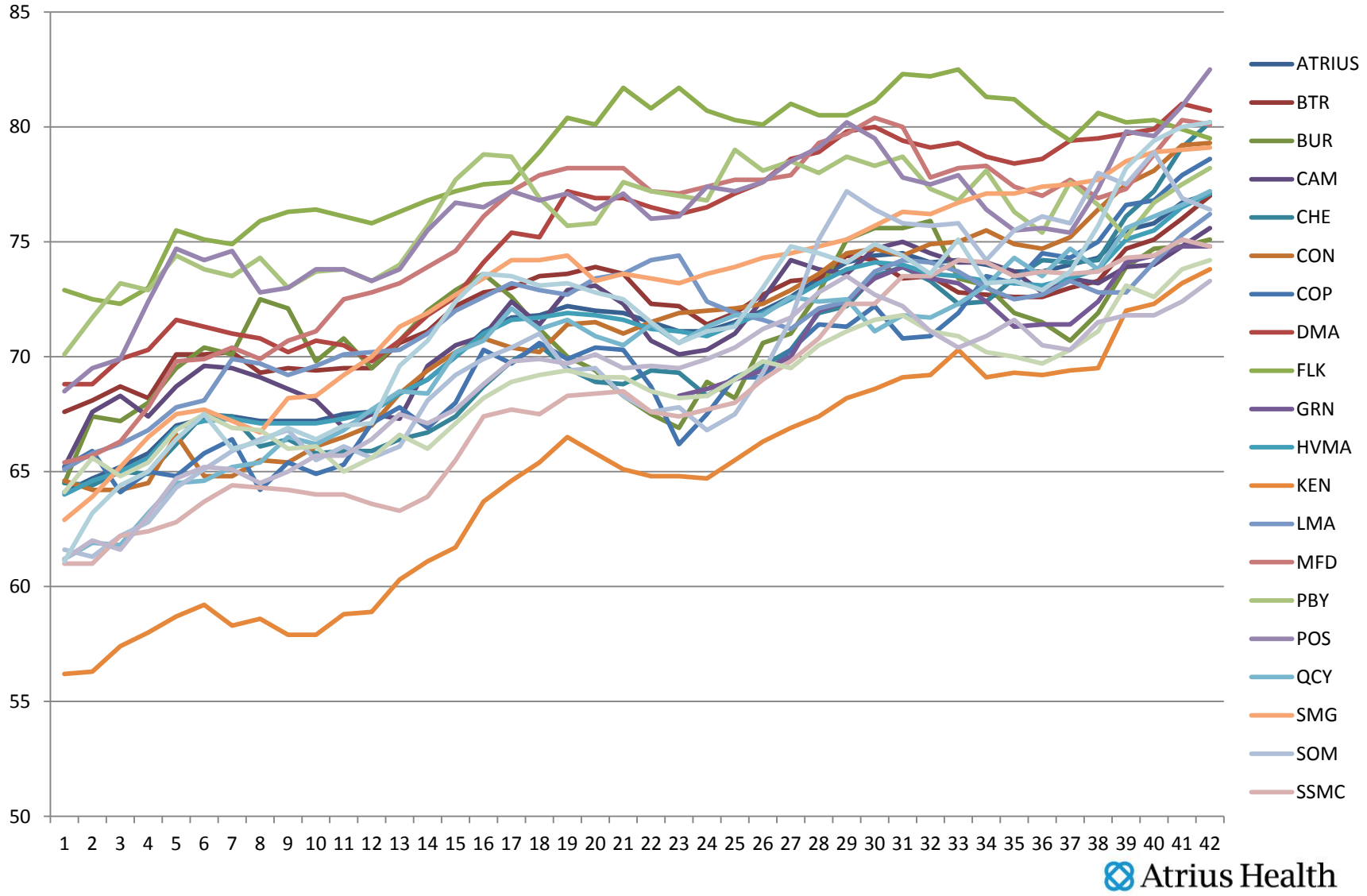
Improvement activities have to occur at every level of the practice (a few examples)

- **RN role**
  - Standard work and monitoring system for RNs including balancing chronic illness outreach work with acute triage, post ER and hospital follow-up calls
- **Behavioral Health integration in primary care**
  - Co-development and implementation of the Care Assessment Team for same day behavioral health evaluation and management within the IM department.
- **In-basket Management**
  - Standard work for clinical team and support staff in routing and triaging test results to reduce clinician work load that is not top of license
  - Standard work for clinical team in “closing the loop” on orders that have not been completed (overdue results folder)
  - Standard work to flow the in-basket (telephone calls, prescription requests and MyHealth messages) to reduce clinician tendency to “batch and queue”
- **Pre-visit process**
  - Standard work for ordering and tracking pre-visit labs for chronic illness and periodic health reviews
- **Paperwork management**
  - Standard work for support staff to sort and present paperwork to clinician in timely and organized fashion to achieve better turn around time of orders, forms and clinical correspondence

Improving each quality measure also takes detailed work, e.g. Hypertension Tactics Menu

- **Engage Patient**
  - No copay BP check
  - Measured by MA with whom patient has a relationship
- **Measurement logistics**
  - Annual checking of MA competency at BP check; watch NEJM video at a staff mtg
  - Check MA stethoscopes – are they effective?
  - Consider purchasing at least 1 auto BP cuff – leave patient alone to check BP
- **Internal Communications/Triggers—closing the loop**
  - Effective communication of high BP by MA to clinician so that clinician rechecks BP
  - Communication of high BP to check-out person and BP check routinely booked within 4 weeks (MA, RN – depending on dept protocol); no copay BP checks
  - Outreach to pts who do not f/u with BP check in 4 weeks (use of pt reminder system in Epic)
  - Review of patient rosters (PCP & MA) to identify next steps in care
- **Doctor Patient Piece**
  - Make sure all BPs are documented in Vital Signs (not just progress note)
  - Inquire about medication adherence, and try to address them. If not resolved, book patient with APC for long visit to address medication barriers
  - Review of BP meds at visit – consider changing medications instead of ↑ the dosage
  - Document plan in patient's AVS for patient to refer to
  - Provide patient with educational materials on HTN

Practices work together to improve quality
e.g. HTN control <139/89: Mar 2009 – Aug 2012



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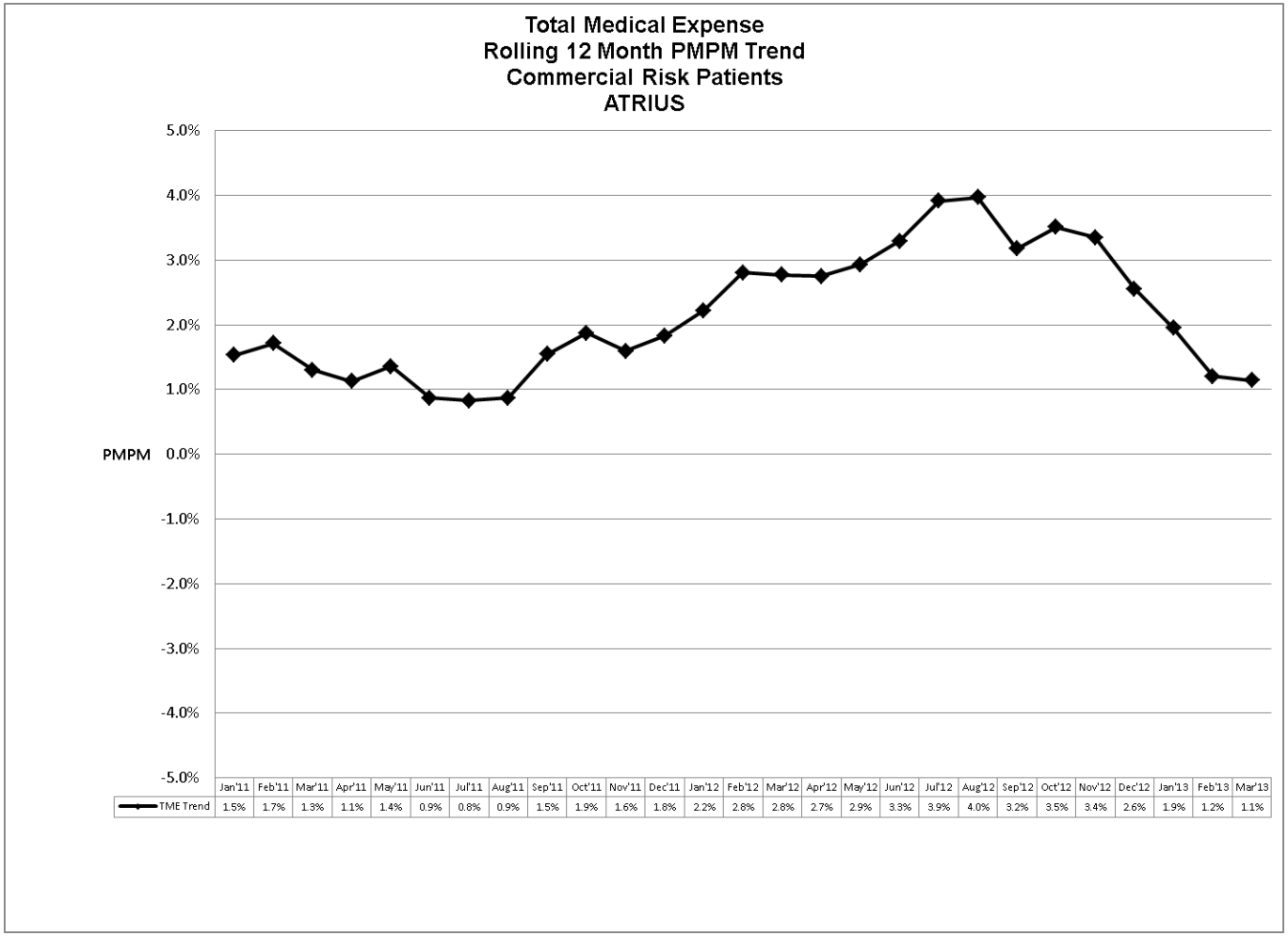
Focus on Total Medical Expenses is critical



	Jan'11	Feb'11	Mar'11	Apr'11	May'11	Jun'11	Jul'11	Aug'11	Sep'11	Oct'11	Nov'11	Dec'11	Jan'12	Feb'12	Mar'12	Apr'12	May'12	Jun'12	Jul'12	Aug'12	Sep'12	Oct'12	Nov'12	Dec'12	Jan'13	Feb'13	Mar'13
TME Trend	1.5%	1.7%	1.3%	1.1%	1.4%	0.9%	0.8%	0.9%	1.5%	1.9%	1.6%	1.8%	2.2%	2.8%	2.8%	2.7%	2.9%	3.3%	3.9%	4.0%	3.2%	3.5%	3.4%	2.6%	1.9%	1.2%	1.1%

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NCQA Accreditation for PCMH

- The PCMH 2011 program's six standards align with the core components of primary care.

  PCMH 1: Enhance Access and Continuity
  PCMH 2: Identify and Manage Patient Populations
  PCMH 3: Plan and Manage Care
  PCMH 4: Provide Self-Care Support & Community Resources
  PCMH 5: Track and Coordinate Care
  PCMH 6: Measure and Improve Performance

- **Collectively, a total of 100 points can be awarded to an applicant from these 6 domains.** In addition, there are 6 must-pass elements. The point allocation for the three levels is :

  Level 1: 35–59 points and all 6 must-pass elements
  Level 2: 60–84 points and all 6 must-pass elements
  Level 3: 85–100 points and all 6 must-pass elements

NCQA Accreditation for PCMH at Atrius Health

- **Atrius Health's six medical groups:**
  - **37 internal medicine practices NCQA certified at Level 3**
- **3-year certification, completed separately by each medical group and augmented with data at site level**
- **1776 charts reviewed manually in detail across Atrius Health (48 per site)**
- **Harvard Vanguard's application included 150 supporting documents (e.g. policies, standard work, screen shots from EMR)**