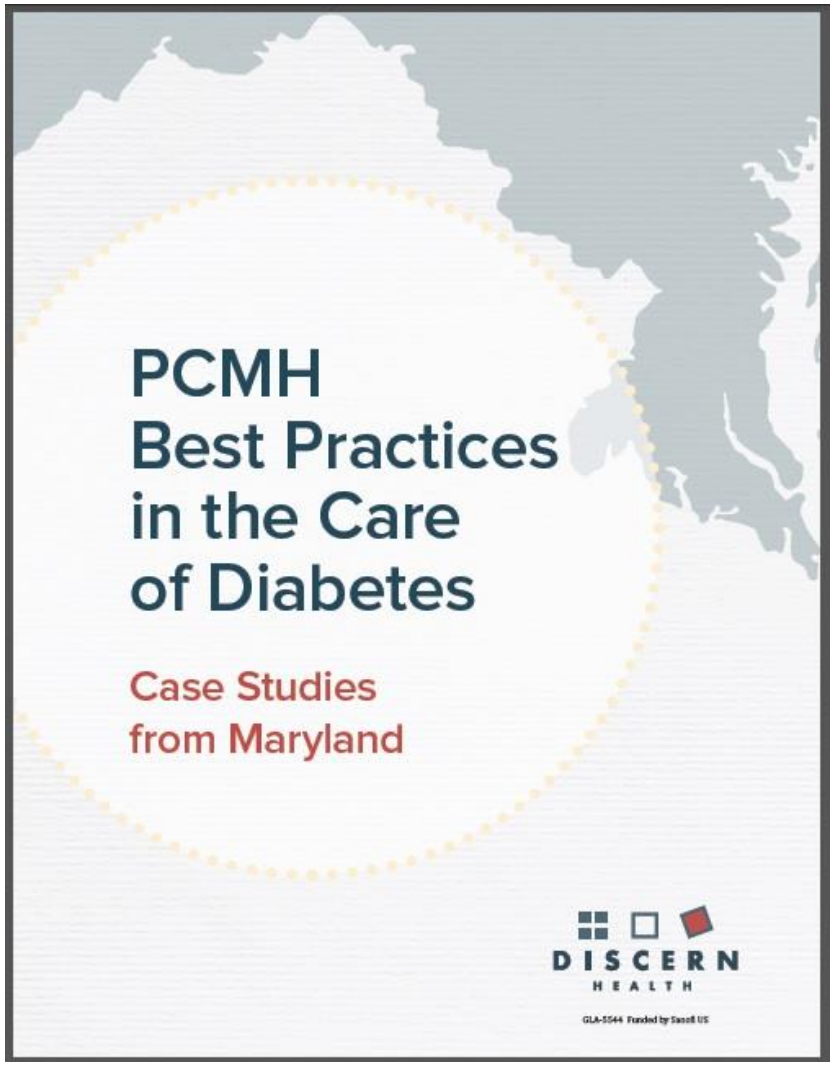
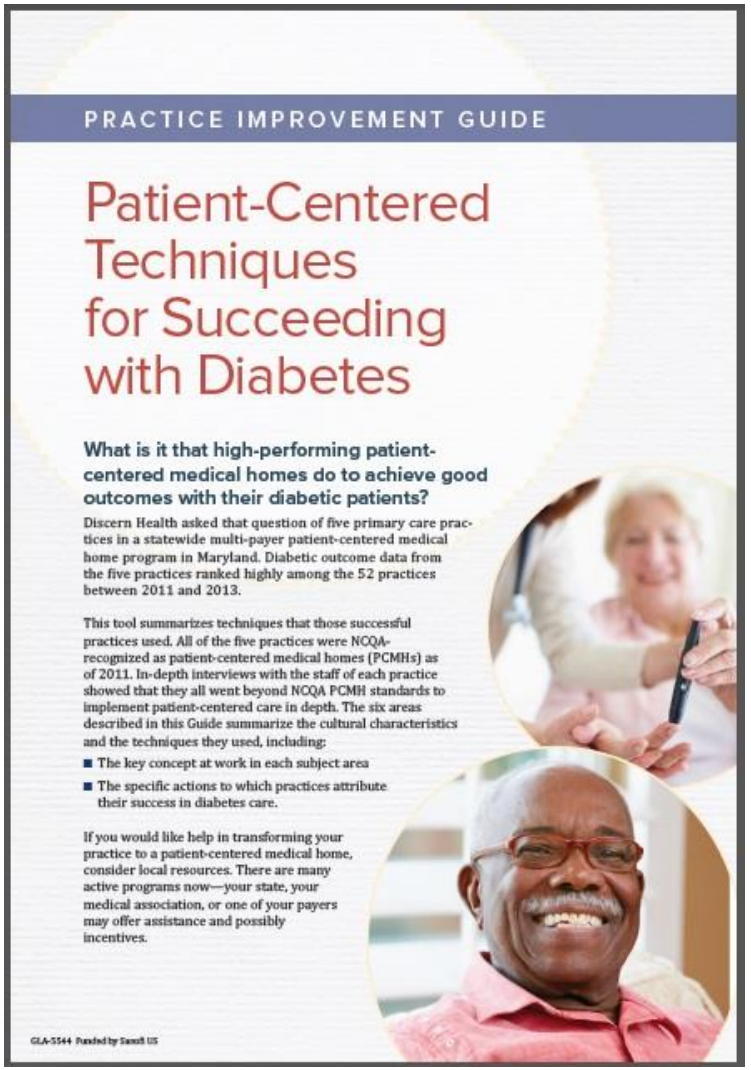
Patient-Centered Best Practices

October 23, 2014

Diabetes Best Practices Report and Guide





Discern Health PCMH Best Practices Case Studies in Diabetes

1. Chose practices based on **outcomes:**
   - Diabetes measures
   - Related measures
2. **Diversified** for 5 practices
3. Interviewed teams in depth: **How** do you get good outcomes?
4. Found each practice had a unique **culture**
5. Found all 5 cited 6 similar **methods**

Criteria for selecting practices to interview

Primary selection criteria:

1) High performance in diabetes quality measures
2) High performance in diabetes-related quality measures

Secondary selection criteria:

1) NCQA Ranking (Special notice taken of Level III practices)
2) Shared savings performance
3) Size
4) Independent or large group practice
5) Geography
6) Urban/rural

Preferred: wide representation among top performers.

Measures To Identify Best Performing Practices

1) Core Diabetes Measures in 2011 and 2012
   a) HbA1c Control
   b) HbA1c Poor Control
   c) Diabetes BP control

2) Related Measures 2012
   Measures that strongly correlated to good performance in Core Measures:
   a) IVD LDL<100
   b) Tobacco intervention
   c) Weight screening and follow-up ages 18-64

Practices ranked for each measure and averaged to obtain a comprehensive rank.

Best PCMH Practices Findings

1. Follow-up

Continually mine data or follow up with future appointments

- NCQA only requires once-a-year population management

2. Customized Plans

Tailor goals to each patient's lifestyle and interests

- NCQA requires this for identified Care Management patients

3. Care Management

Identify, organize, and assign this function

- NCQA requires care planning, self-management support, overcoming barriers, reconciling meds

Discern Best PCMH Practices Findings

4. Great Use of IT

Use your EHR to its maximum capability

- NCQA requires some Meaningful-Use-like reports
- NCQA requires assessment of record completeness

5. Comprehensiveness

Work with the whole person; consider sub-specialists carefully

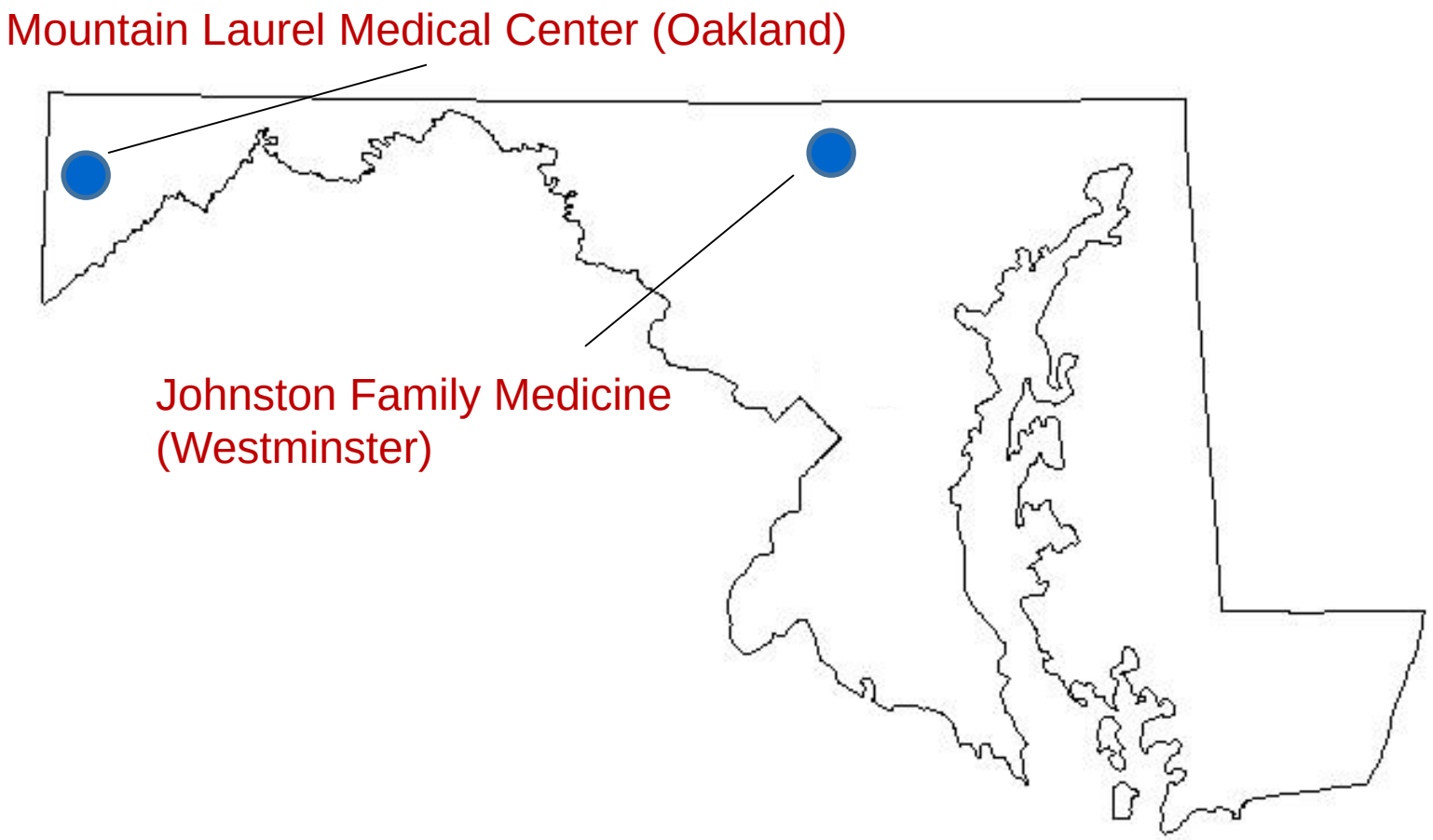
- NCQA requires actively incorporating behavioral health and actively managing referrals

6. TLC

Constantly attend to Teamwork, Leadership, Communication

- NCQA requires team roles, team communication about patients, including the patient on the team

Two Top Practices



MOUNTAIN LAUREL Medical Center

……Compassionate care in your community

- Open to everyone in the community regardless of a person's ability to pay, socioeconomic or insurance status
- Offers a sliding fee discount to people who qualify based on income.

MOUNTAIN LAUREL Medical Center

- **Located in Garrett County** the westernmost county of the state of Maryland bordering West Virginia and Pennsylvania.

- **A private non-profit health care organization** that meets certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receive funds under the Health Center Program (Section 330 of the Public Health Service Act).

- **Funded and operational in 2006** as a new health center to provide comprehensive primary health care services as well as supportive services (education, translation and transportation, etc.) that promote access to health care.

- **Governed by a community board** composed of a majority (51% or more) of health center patients who represent the population served.

MOUNTAIN LAUREL Medical Center

- **Support and management** are provided by a competent staff of 38 including (3) family physicians, (2) nurse practitioners and (3) P.A.'s
- **A *culture* built on** patient centeredness and quality driven care
- **Early adopter of Patient Centered Medical Home** model of care, NCQA Level III recognized
- **Expansion including a satellite office** in the Grantsville, MD area in 2014

Johnston Family Medicine

Our Speakers

- Beth Little Terry
  - CEO, Mountain Laurel Medical Center, since 2007
  - Formerly COO of an Alaska Community Health Center, and Director of a Florida Medicaid Program
- Kimberly Johnston, MD
  - Physician and Owner, Johnston Family Medicine, since 2000
  - University of Maryland Medical School, Internship, and Residency

Questions for Beth Little Terry and Kim Johnston MD

1. What is your practice's "brand," a short statement about your culture.
2. How do you do the basic blocking and tackling, i.e., making sure diabetics come in every 3 – 6 months? (This is often called population management.)
3. What's your position on getting lab work done ahead of the visit, and how do you handle that?
4. How does your practice carry out care management? How do you define the function, and who does it?
5. Give us an example of engaging a patient with diabetes. The patient delivers most of her own health care—how do you customize goals with the patient?

6. Both your practices offer direct counseling and help with lifestyle change. Can you describe what you do, and how it interacts with chronic care management for patients?
7. Now I want to ask about your practice's development as a PCMH. What was the key to making the transformation?
8. What was most difficult about becoming a PCMH? How did you interact with the Maryland Multi-Payer PCMH Pilot, and what support did you get to help in the transformation?
9. Your two practices are similar in having NPs and Pas carry their own panel of patients with chronic illness. Can you tell me how that works?

10. Your two practices both have excellent clinical outcomes, yet are different in your levels of NCQA Recognition. Can you tell us your rationale for seeking a Level 3, or staying at a Level 2?

Thank you!

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