

## **Connecticut State Medical Society – IPA, Inc.**

# **Patient-Centered Practice Model Participating Physician Manual**

### **Mission Statement:**

*To promote high-quality, cost-effective medical care  
that is physician driven, financially sustainable  
and valued by health care stakeholders*

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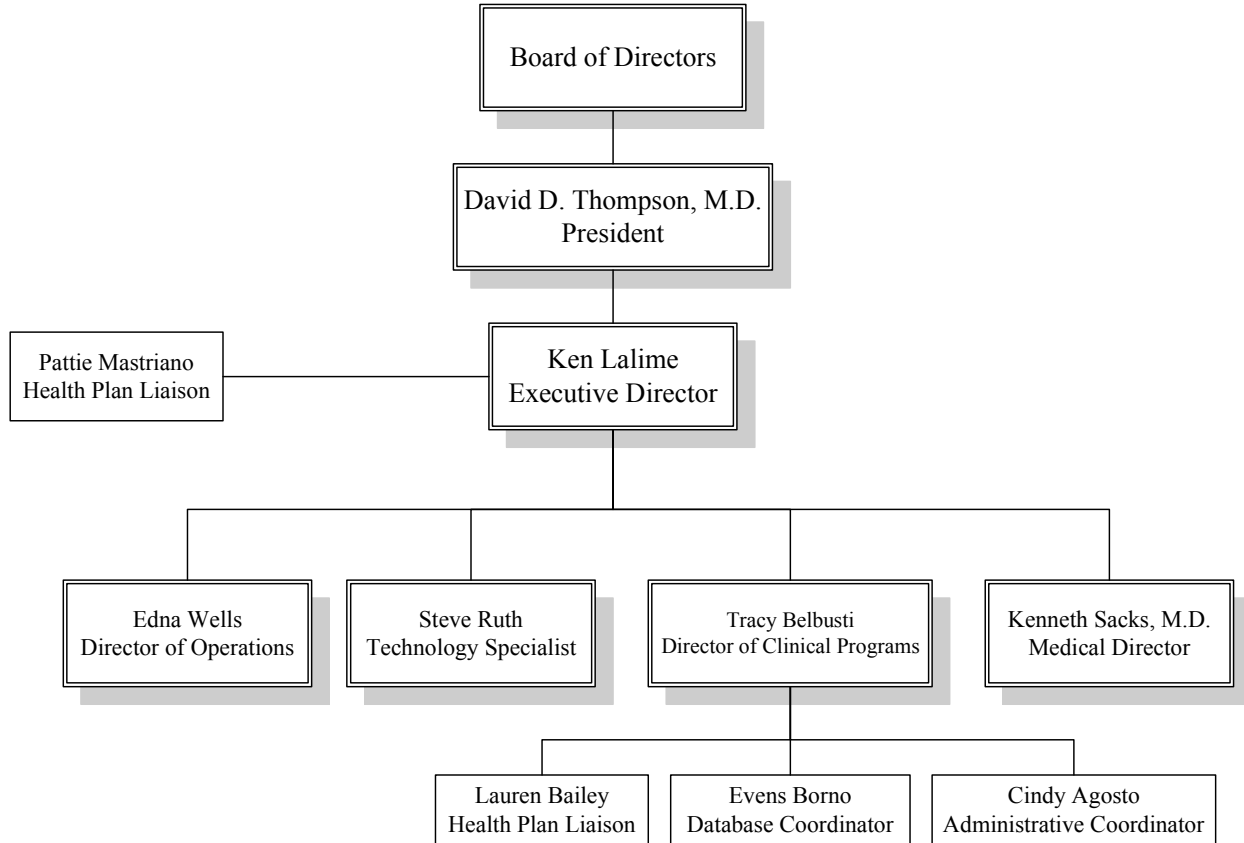
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## Introduction

Widely hailed as the panacea for what ails the United States health care system, the implementation of a Patient Centered Medical Home (PCMH) addresses many of the issues at the forefront of the medical-political debate. Improved quality and efficient delivery of health care, necessary to stabilize cost seem to be possible when this model is in place. Also, by rewarding the Primary Care Providers (PCP) differently, which this model embraces, it is hoped that more medical school students will opt to enter primary care rather than selecting the currently higher earning specialties. This will be necessary if we are to provide access to the soon expanding numbers of “baby boomers” reaching ages that historically have required an increase in medical care services. Unless there are fundamental changes in how physicians are compensated and how health care is delivered, the issues of quality and efficiency will continue to vex health care planners and all health care stakeholders.

A functioning PCMH, as defined by the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP) and the American Osteopathic Association (AOA), has the ability to impact the needed shifts in the health care paradigm required to address what many are calling a health care crisis. For this manual and the programs directed by the CSMS-IPA, the PCMH will be renamed the Patient Centered Practice Model (PCPM). This places the emphasis on the relationship between the Patient and the Practice and an associated linkage with a Primary Care Physician, customarily referred to as a PCP. The Primary Care Physician will also function within the Practice as the Physician Leader (PL), a designation which fits the PCPM concept. All available literature addressing the PCPM concept refers to seven principles which define the PCPM.

Historically, the concept of a PCMH was first formulated in 1967 by the AAP. It has since been adopted and adapted by AAFP, ACP and the AOA. The PCPM is an approach to providing comprehensive primary care in a setting that facilitates partnerships between patients, all their doctors and other providers and, when appropriate, the patient’s family. Although there is a formal recognition program through the National Committee on Quality Assurance (NCQA), it may not be necessary to gain such recognition in order to function in a PCPM mode which can

result in improved quality of care, decreased cost and greater patient satisfaction. The NCQA recognition program may be a desired component of some current and evolving pilot programs and will be addressed by the PCPM development process. There are data suggesting that practices which embrace the concept of a PCPM deliver higher quality and less costly care than those who do not. This is achieved through wellness programs, coordinated disease management, improved access to care and judicious use of Health Information Technology (HIT) instruments. As a result of these programs, hospitalizations and emergency room (ER) visits are decreased and coordination of care is increased. The discussion of the PCPM implementation will be built off the seven principles contained in all descriptions of a PCPM.

### **The Seven Principles of the Patient Centered Practice Model:**

#### **1. Personal Physician:**

- The PCPM Physician Leader (PL) is charged with providing “continuous” and “comprehensive” care.
- The PCPM PL will render care, coordinate team-care activities, and approve testing and procedures as part of the relationship with their patients. The tools to perform these functions flow from remaining Principles.

2. **Physician Directed Medical Practice:** The PCPM PL leads a team of individuals who collectively take responsibility for comprehensive patient care. This Principle assumes that a solitary physician can not meet the responsibilities of a PCPM without other professionals’ assistance. The team includes specialist consultants, nursing, dietary, case management, pharmacists, physical therapy, etc. Some team members may be part of the PCPM practice, others not. The operative word for the PL is “lead”. Leading is the PL role.

3. **Whole Person Orientation:** This is self explanatory. The PCPM PL is to deliver all levels of care, acute, chronic and end of life, with the assistance of the team as indicated in Principle #2.

4. **Care is to be coordinated and/or integrated across all elements of the complex health care spectrum:** This is accomplished with team support and connectivity. Here is the first opportunity for HIT to play a role in the PCPM. This can take the form of clinical disease registries, health information exchange, eRx and an integrated EHR. These HIT elements, used appropriately, facilitate adherence to this Principle.
5. **Quality and Safety:** These are the hallmarks of a PCPM. Quality and safety are accomplished by adhering to evidence based medicine and making use of clinical decision support tools. Such tools can be imbedded in an EHR/eRx or made available via on line portals. Either way, the use of HIT becomes paramount. The PCPM PL must be accountable and participate in quality measurements and quality improvement programs. Patient education is part of this Principle and is supported again by HIT instruments. The inclusion of case management is certainly part of achieving quality and safety. Case management can take various forms. The most common is a nurse or health care tech communicating, optimally, in person, with chronic disease patients to insure that the care plan is implemented. Drug compliance is a major component. Use of home monitoring devices (BP/Glucose/weight) which connect to the care manager and ultimately to the PL will add another level to this process. Having achieved in this Principle, PCPs may wish to proceed ultimately to gain NCQA recognition
6. **Enhanced Access:** Without improved access to the PCPM, the mission of providing continuous and comprehensive care can not be maximized. This includes open scheduling to accommodate urgent visits, expanded hours, electronic capabilities for communication with the PCPM team (secure portal) and possibly electronic consultation. Again the expanding role for HIT and connectivity is seen.
7. **Payment:** The added value of PCP must be recognized and fairly compensated. To do so involves compensation for activities which fall outside the face-to-face interactions and may involve a per member per month (PMPM) payment for “care coordination” activities. This includes elements of care coordination and case management. Financial support for HIT adoption and enhanced physician/patient communication should be

offered. Other components that can be considered as part of the overall change in compensation include Pay for Performance programs and access to contracting models that include “gain sharing” or “surplus sharing” opportunities.

To summarize, creation of a functioning PCPM needs to include:

- Physician education as to the responsibilities of a PL in a PCPM.
- Team building both within and outside the PCPM.
- Adoption of HIT to support the needs of a PCPM.
- Create or enhance connectivity between other providers, hospitals and patients.
- Improve patient access.
- Place a functioning payment method behind it all.

This manual follows the American College of Physicians “Medical Home Builder®” program (software application) with emphasis on the role which the IPA can play in assisting a practice in the transformation toward a PCPM. Great detail is provided in the Medical Home Builder® program and physicians are encouraged to refer to it. Each section of the application contains a “practice biopsy” which allows self assessment and concrete examples of processes which practices have utilized to transform.

**Access to this ground breaking software is provided at no expense to practices that agree to participate in the PCPM programs through the CSMS-IPA. Call the CSMS-IPA to schedule a web based demonstration or to obtain the software to get started on better understanding your practices opportunities.**

## **Patient Centered Care and Communication**

High-performing practices provide patient-centered care. The Institute of Medicine defined patient-centered care as "Healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants,

needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care".

Care delivered with this orientation can improve clinical outcomes and patient satisfaction with health care. The key attributes that define this approach include

- a) Education and shared knowledge
- b) Involvement of family and friends to support patients
- c) Collaboration and team management of care
- d) Sensitivity to nonmedical and spiritual dimensions of care
- e) Respect for patient needs and preferences
- f) Good communication techniques
- g) Free flow and accessibility of information.

One of the best way to begin to address this component of the PCPM is to access the patient's perception of a practice. This can be accomplished with a patient satisfaction survey. If your practice has not initiated a survey program, you may want to consider one. The CSMS-IPA will be looking to incorporate patient information modules through the CSMS-IPA website for those practices that do not access this type of information through their EMR/EHR. These programs promote wellness and self care. Much of this can be provided by members of the health care "team" and training in sensitivity and communication is key. Actions which can be taken are:

- Patient Satisfaction Survey
- Meeting with team before patient arrives for visit
- Create goals and objectives along with the patient and family
- Promote education focused on self care and wellness

### **Access and Scheduling**

A practice that is easily accessed, by both patients and other clinicians, is perceived to provide better quality care. This perception can play a significant role in health care. Patients who can access their personal clinician when they need to and who engage with their physician

in understanding their conditions and treatment options are more likely to think highly of the practice. Furthermore, data suggest that patients who have a good relationship with their physicians are more likely to follow their care plan, for example, by adhering to medication schedules and directions. Also, improved access and communication can reduce unnecessary and inappropriate ER visits, resulting in fewer hospital admissions.

The CSMS-IPA encourages practices to offer flexible hours, after-hours accessibility, weekend hours and teamwork to respond to patient problems in an efficient manner as practical solutions to access and scheduling issues. Actions which can be taken are:

- Welcome letter to patients discussing the opportunities for better communication
- Initiate telephone hours
- Early morning “walk-in” hours
- Consider electronic consultations
- Create a block of time for “urgent” same day visits
- Expand hours to include evenings and weekends
- Educate patients to call before accessing an emergency department (ED)
- Follow up when patients do visit the ED

The CSMS-IPA will work with each PCPM practice to develop a “Welcome letter” that introduces the practices patients (initially those involved with applicable contracts) to the basic communication concepts outlined in this manual. The letter is intended to enhance the communications between the patient and the care team.

### **Organization of the Practice**

How well your practice is organized may significantly determine how well it delivers care. Whether the chart you use is paper or electronic, your documentation needs to be entered and maintained in a way that facilitates communication not only between clinician and patient but between clinician and staff and external resources and agencies. Similarly, how well your

practice organizes and manages laboratory tests and imaging procedures directly affects how effectively you can provide care. As important, how well organized your staff is makes the difference between an office that functions efficiently and one that does not.

The adoption of HIT instruments can play a valuable role in practice organization. Electronic Medical Records (EMR) or registries, problem lists and medication lists permit ready access to information which promotes quality improvement. The CSMS-IPA can help in the adoption process by various programs to defer the cost of HIT implementation. A team approach to patient problems and care is encouraged. The team, with the PCPM PL as its leader, will provide coordinated, evidenced based care which includes age appropriate preventive services, chronic disease management and episodic management. Actions which can be taken are:

- Problem list and medication list for every patient
- HIT adoption in the form of registries, EMR and electronic prescribing
- Creation of a team responsible for patient needs

### **Care Coordination and Transitions in Care**

Care transitions are an important source of medical errors and overuse of medical resources. They also lead to significant patient and clinician dissatisfaction. The American College of Physicians (ACP), Society of Hospital Medicine (SHM), Society for General Internal Medicine (SGIM), Centers for Medicare & Medicaid Services (CMS), and National Quality Forum recently made transitions of care a priority for policy and measure development. A policy paper endorsed by the ACP, SHM, SGIM, American Geriatric Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine was published, and performance measures have been based on this paper.

Coordination and transition of care can be seen as issues in multiple settings. Patients seeking specialist services without knowledge of the PL and without specialist communication can result in fragmented and redundant care. Patients being discharged from the hospital without

an accurate and timely discharge summary, especially with the advent of hospitalists, and lack of information from an ER visit can all lead to medical errors and duplication of unnecessary services. Transitions of care problems affect patient safety and the quality of care they receive. The CSMS-IPA PCPM paradigm will include the use of a simplified, online specialist notification process to help track and coordinate care with the specialist. Regarding hospital and ED visits, the CSMS-IPA will assist in creating partnerships with hospitals to insure that information is available in a timely fashion. The CSMS-IPA may also be able to provide access to a “care coordinator” to help ensure communications and follow up care activities. Please contact the CSMS-IPA to see if this service is available in your area. A listing of specialists agreeing to communicate and coordinate care will be provided to the PL. Actions which may be taken are:

- Demand timely and complete discharge summaries from hospital and ED
- Create a process to follow up on pending results
- Insist on timely communication and coordination from specialists
- Promote patient/family education and self care

### **Use of Technology**

The use of electronic technology can help make the daily operations of your practice more efficient, increase your compliance with regulatory agencies, and decrease your medical liability. Electronic health/medical records, e-prescribing, secure email communication, web visits, and personal digital assistants (PDAs) are some of the electronic tools that can enhance your practice.

Implementing technology is expensive, particularly for a small practice, and should not be undertaken without careful planning. Deciding what type of tool, which vendor, and when and how to implement the tool can seem monumentally overwhelming. You may wish to begin with electronic prescribing and a disease registry. Full functionality can be accomplished with a

Certification Commission for Health Information Technology (CCHIT) certified EMR. This can be housed within your practice or web based (ASP). Actions for consideration are:

- Adopt a fully functional CCHIT certified EMR. All of these will have registry and electronic prescribing and other components such as clinical decision support.
- Adoption of a stand alone electronic prescribing product
- Adoption of a clinical disease registry program

## **Population Management**

Practices that have a care management program built on their three most *important* or *frequent* clinical conditions and use nationally recognized, age-appropriate prevention measures and exploit data reports can improve chronic disease care for a large segment of their population. This approach may also increase practice revenue through Pay for Performance (P4P) Programs and Physician Quality Reporting Initiative (PQRI) reporting.

Key to this identification is the accurate coding (ICD-9) of patients conditions. Included in the PCPM development cycle is an educational program called Hierarchical Condition Category (HCC) coding. This program will help practices appropriate code patients conditions and is useful in identifying patients that have higher medical needs and will most likely be candidates for disease management programs (payer or practice) as well as inclusion on practice disease registries for appropriate care coordination. Please refer to the separate documents provided by the CSMS-IPA on this program.

The goal here is the adherence to the most up to date clinical guidelines available. Many EMR products and several electronic prescribing products have built in clinical support tools. There are on line support programs such as “Up to Date” which provide a plethora of guidelines that are easily accessible and practical solutions for the busy practitioner. Once again, the CSMS-IPA can help with the adoption of these HIT tools. Focus on wellness/preventive care and major chronic disease conditions. Actions for consideration are:

- Use clinical support tools
- Focus on chronic disease states and include patient information to promote wellness and self care
- Consider case management to promote wellness and compliance
- Practice preventive measures for every patient every visit

## **Quality Improvement and Performance Improvement**

Clinicians often want to improve their practice but just don't know how to get started or how to keep the momentum going when they hit barriers.

The first step is to measure performance. Once again, here is where the adoption of HIT can facilitate such measurement. Given the data, a plan can be formulated to address quality improvement. Periodic review and reporting satisfy this requirement. The value of an EMR or registry in this process can not be over emphasized. Actions which may be considered include:

- Use of registries for selected disease states
- Regular periodic measurements and reporting
- Patient self care promotion

*The Connecticut State Medical Society IPA (CSMS-IPA) is pleased that you have elected to participate in the Patient Centered Practice Model (PCPM) and welcomes your feedback on the tools and communications provided as part of the program. Please visit the IPA's website for regular updates.*