

# 2010 Military Health System Conference

## Patient-Centered Medical Home

Baseline View Across the Services and HA/TMA

Sharing Knowledge: Achieving Breakthrough Performance

Dr. Kugler, CAPT Padden, CDR Miller, LtCol Kosmatka, Lt Col Motsinger, LTC Caffrey, Dr. Howes

25 January 2010



The Military Health System

# Session Overview



- PCMH within the Context of the MHS (Dr. Kugler)
- Navy (CAPT Padden, CDR Miller)
- Air Force (LtCol Kosmatka, LtCol Motsinger)
- Army (LTC Caffrey)
- Purchased Care Sector (Dr. Howes, Dr. Kugler)

# 2010 Military Health System Conference

## PCMH in the Context of the MHS

- Background, principles, and initial progress

Sharing Knowledge: Achieving Breakthrough Performance

Dr. John P. Kugler

25 January 2010



The Military Health System

# Civilian Background



- Term was introduced by the AAP in 1967.
- Adopted by Family Medicine in 2002.
- Concept fully endorsed by the AAP, AAFP, ACP, and AOA. Additionally endorsed by several large third party payors, employers, and health plans.
- PCMH becomes prominent feature of most Health Care Reform initiatives in 2008-2009.

# Background Within the MHS

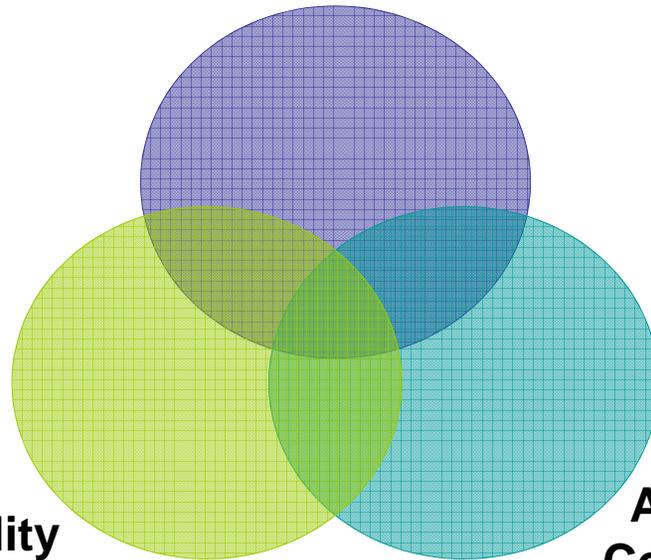


- Prior to TRICARE in 1998, patient enrollment panels generally exist only in select clinics.
- PCMBN became “policy” of the MHS with onset of TRICARE in 1999.
- In Summer 2008, a “crisis in patient perception” stemming from continued access concerns and persistent patient satisfaction gap between direct and purchase care sectors is highlighted by MHS Senior Leadership. Action plans requested.

# Key Elements of Patient Satisfaction in Primary Care



**Effective Communication in  
a respectful environment**



**Continuity and quality**

**Appropriate Access,  
Convenience & Choice**

# Seven Core Principles



- Personal Primary Care Provider (PCMBN).
- Primary Care Provider Directed Medical Practice
- Whole Person Orientation (respectful, patient centered not disease or provider centered).
- Care is Coordinated and/or Integrated (across all levels of care).
- Quality and Safety (evidenced-based & safe care)
- Enhanced Access (from the patient perspective).
- Payment Reform (incentivize the development and maintenance of the medical home).

# The BOTTOM LINE from the Evidence



**“Care delivered by primary care providers in a Patient-Centered Medical Home is consistently associated with better outcomes, reduced mortality, fewer preventable hospital admissions for patients with chronic diseases, lower utilization improved patient compliance with recommended care, and lower Medical Spending.”**

*Source: <http://www.pcpcc.net/content/evidence-quality>*

# Military Unique Issues in Adapting the 7 Core Principles



- **Personal Physician:** PCM based and involves non-physician providers along with primary care physician providers in PCM roles.
- **Physician Directed Medical Practice:** The concept of a team of professionals, under the leadership of a team leader, is highly valued as a key component of the MHS culture.
- **Whole Person Orientation:** Active and retired Service members expect that all aspects of care be comprehensively addressed for themselves and their family members.

# Military Unique Issues in Adapting the 7 Core Principles (continued)



- **Care is coordinated/integrated:** All military beneficiaries are entitled to comprehensive, coordinated and accessible primary care and the processes are in place to deliver that care. The challenge is in the execution.
- **Quality and Safety:** MHS has fully embraced the evidenced-based model of care, including an evidenced-driven medical benefit, an extensive DoD/VA Clinical Practice Guidelines Program and a sophisticated and evolving Patient Safety Program.
- **Enhanced Access:** The MHS recognizes this basic Principle through formal policy. Access standards for primary care are clearly stated and defined for acute, routine, and wellness visits.
- **Payment:** From the MHS payment perspective the financial model remains rigid and constrained by external budgetary realities. Significant effort will be required to align Medical Home performance with financial incentives.

# Redesigning Healthcare Delivery



	Current Practice	Medical Home
<b>Access</b>	<ul style="list-style-type: none"> <li>- Episodic / Random</li> <li>- Patient-initiated</li> <li>- Suboptimal chronic care access</li> </ul>	<ul style="list-style-type: none"> <li>- Open access for acute care</li> <li>- Proactive appointing for chronic and preventive care</li> </ul>
<b>Quality</b>	<ul style="list-style-type: none"> <li>- Based on Individual Patient</li> <li>- Provider-Centered</li> </ul>	<ul style="list-style-type: none"> <li>- Based on Patient populations</li> <li>- Team-Centered</li> </ul>
<b>Patient-Centered Care</b>	<ul style="list-style-type: none"> <li>- Staff-Driven Process Improvement</li> <li>- Provider-Centered</li> </ul>	<ul style="list-style-type: none"> <li>- Patient-Driven Process Improvement</li> <li>- Promote patient and family participation</li> </ul>
<b>Communicate</b>	<ul style="list-style-type: none"> <li>- Telephone Communication</li> <li>- Delayed, inaccurate communication</li> </ul>	<ul style="list-style-type: none"> <li>- Electronic Communication</li> <li>- Efficient, timely, and direct patient communication</li> </ul>
<b>Coordination</b>	<ul style="list-style-type: none"> <li>- Provider-Dependent</li> <li>- No formal tracking mechanism</li> </ul>	<ul style="list-style-type: none"> <li>- Team-Dependent</li> <li>- Managed tracking system</li> </ul>
2010 MHS Conference		

CONTINUOUS RELATIONSHIP

### Team-Based Healthcare Delivery

- Creation of Clinical Micropractices
- Appropriate utilization of medical personnel
- Improve communication among team members

### Population Health

- Emphasis on preventive care
- Form basis of productivity measures
- Evidence-based medicine at the point of care

### Access to Care

- Improve phone and electronic appt scheduling
- Open access for acute care
- Emphasis on coordination of care
- Proactive appointing for chronic and preventive care

### Advanced IT Systems

- Secure mode of e-communication
- Creation of education portal
- Reminders for preventive care
- Easy, efficient tracking of population data

### Patient-Centered Care

- Empower active patient participation
- Seamless communication
- Encourage patient participation in process improvement

## THE PATIENT-CENTERED MILITARY MEDICAL HOME

### Decision Support Tools

- Evidence-Based Training
- Integrated Clinical Guidelines
- Decision Support Tools at the point of care

### Refocused Medical Training

- Emphasize health team leadership
- Incorporate patient-centered care
- Focus on quality indicators
- Evidence-based practice

### Patient & Physician Feedback

- Real-time data
- Performance reporting
- Patient feedback
- Partnership between patients and care teams to improve care delivery

PATIENT-CENTERED CARE

WHOLE PERSON ORIENTATION

PERSONAL PHYSICIANS

Model adapted from the NNMC Medical Home

# Progress to Date within the MHS



- Nov 2008- White Paper titled “Transforming Military Primary Care Operations: Recommendations for the Patient Centered Medical Home”, completed and delivered to the SMMAC resulting in mission to make recommendations of PCMH Guidelines/Standards and additional outcome measures
- May 2009- SMMAC R&A
  - Services present PCMH best practices and Leadership requests a common set of PCMH measures
- August 2009- SMMAC R&A
  - Services present early results of PCMH performance and Leadership endorses development of common PCMH standards
- September 2009- MHS Medical Home Summit
  - HA/TMA, Services, and others (e.g. NCQA) convene for Inaugural Tri-Service Medical Home Summit and participants develop recommendations for PCMH standards and measures
- September 2009- PCMH Policy
  - ASD(HA) releases “Policy Memorandum Implementation of the PCMH Model of Primary Care in MTFs”
  - Policy references attributes/criteria (i.e. standards) and measures of effectiveness (measures) for the PCMH.
- December 2009-Standards and Measures endorsed by leadership.

# HA Policy Memo: “Team Enhanced Primary Care Managers by Name (PCMBN) and the Patient-Centered Medical Home



(PCMH)” (signed 18 September 2009)

- Incorporates the principles of the patient-centered medical home model as the foundation for refocusing the primary health care delivery model within the MHS.
- Restates MHS primary care access standards, the definition of a PCM, the requirement for an individual PCMBN in the context of the PCM team, and defines the maximum size of the PCM provider team.
- Emphasizes the need for a communication plan for beneficiaries and other key stakeholders about the PCMH.
- Ties compliance with the policy performance to specific and currently collected metrics on satisfaction, access, continuity, communication and healthcare quality.
- Requires these metrics and the efforts to improve performance to be monitored regularly at multiple levels within the MHS, including the MHS Clinical Quality Forum, **the Clinical Proponency Steering Committee**, and the Senior Military Medical Advisory Committee.

# PCMH Summit and Tiger Team Recommendations



- Create mechanism to recognize Medical Homes (NCQA standards with additional standards for military unique aspects)
- Adopt a standard set of PCMH Performance Measures for MHS
- Expand current PCMH efforts
- Support unbiased assessment of Medical Homes



## PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts	Standard 5: Electronic Prescribing	Pts
A. Has written standards for patient access and patient communication**	4	A. Uses electronic system to write prescriptions	3
B. Uses data to show it meets its standards for patient access and communication**	5	B. Has electronic prescription writer with safety checks	3
	9	C. Has electronic prescription writer with cost checks	2
Standard 2: Patient Tracking and Registry Functions	Pts		8
A. Uses data system for basic patient information (mostly non-clinical data)	2	Standard 6: Test Tracking	Pts
B. Has clinical data system with clinical data in searchable data fields	3	A. Tracks tests and identifies abnormal results systematically**	7
C. Uses the clinical data system	3	B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
D. Uses paper or electronic-based charting tools to organize clinical information**	6		13
E. Uses data to identify important diagnoses and conditions in practice**	4	Standard 7: Referral Tracking	PT
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3	A. Tracks referrals using paper-based or electronic system**	4
	21		4
Standard 3: Care Management	Pts	Standard 8: Performance Reporting and Improvement	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	3	A. Measures clinical and/or service performance by physician or across the practice**	3
B. Generates reminders about preventive services for clinicians	4	B. Survey of patients' care experience	3
C. Uses non-physician staff to manage patient care	3	C. Reports performance across the practice or by physician **	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5	D. Sets goals and takes action to improve performance	3
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5	E. Produces reports using standardized measures	2
	20	F. Transmits reports with standardized measures electronically to external entities	1
Standard 4: Patient Self-Management Support	Pts		15
A. Assesses language preference and other communication barriers	2	Standard 9: Advanced Electronic Communications	Pts
B. Actively supports patient self-management**	4	A. Availability of Interactive Website	1
	6	B. Electronic Patient Identification	2
		C. Electronic Care Management Support	1
			4

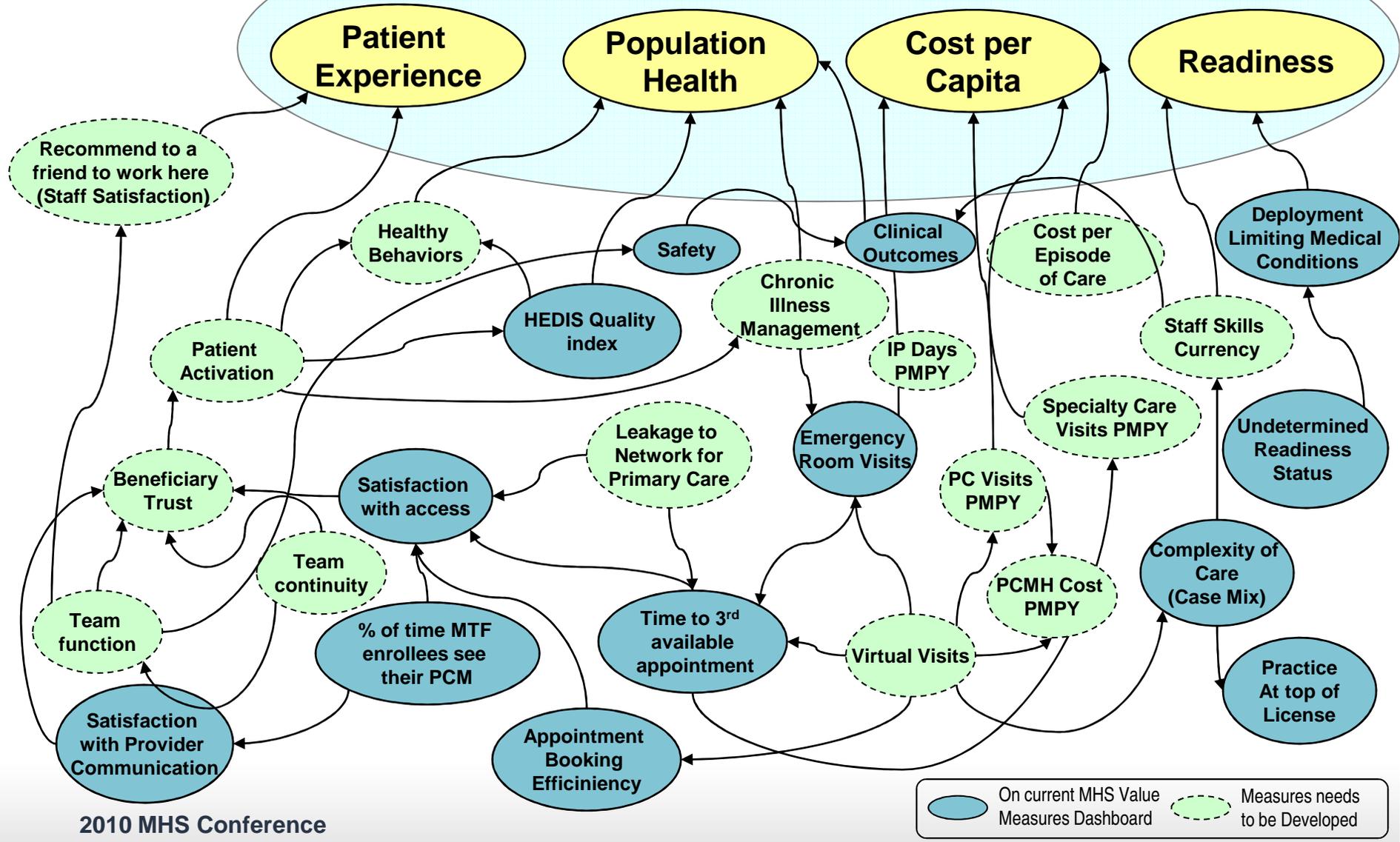
\*\*Must Pass Elements



# Proposed PCMH Measures for the MHS (From Summit)



## Quadruple Aim



# Focused “Quadruple Aim” Measures



- EXPERIENCE OF CARE
  - Satisfaction with Provider Communication
  - Satisfaction with Access
    - % of Visits where MTF enrollees see their PCM
    - Booking Efficiency and Time to 3<sup>rd</sup> Available Appointment
    - Leakage to Network
- POPULATION HEALTH
  - HEDIS Quality Index and Healthy Behaviors
- Readiness
  - Deployment limiting conditions
  - Complexity of care (Case Mix)
- Per Capita Cost
  - PMPM Expense (ER Visits/PC Visits PMPY/Specialty Care Visits PMPY)

# Current Service-Specific Initiatives (Evolving “best practices”)



- Navy
  - NMC San Diego
  - NH Pensacola
  - NNMC Medical Home Pilot Project
- Air Force
  - Family Health Initiative Project
  - COMPASS Initiative
- Army
  - Ft. Meade MEDDAC (Health Care System Strategic Planning)
  - PHR efforts at Madigan and Washington State PCMH Collaborative
  - Team Courage pilot at Ft. Bragg
  - Facility remodeling at Ft. Benning
  - WTU efforts Army-wide
  - PCMH Community-based Primary Care Clinics
- Network/TAO/TRO/DP's
  - Convenience Clinics initiatives (TRO North and TRO South)
  - Subcontractor Survey/primary care optimization consultation program (TRO West)
  - Nurse Advice Line (TAO Europe)
  - DP's: PacMed, Johns Hopkins, Martin's Point

# 2010 Military Health System Conference PCMH Within the MHS

- Current Navy Initiatives

Sharing Knowledge: Achieving Breakthrough Performance

CAPT Maureen Padden, CDR. Patricia Miller

25 January 2010



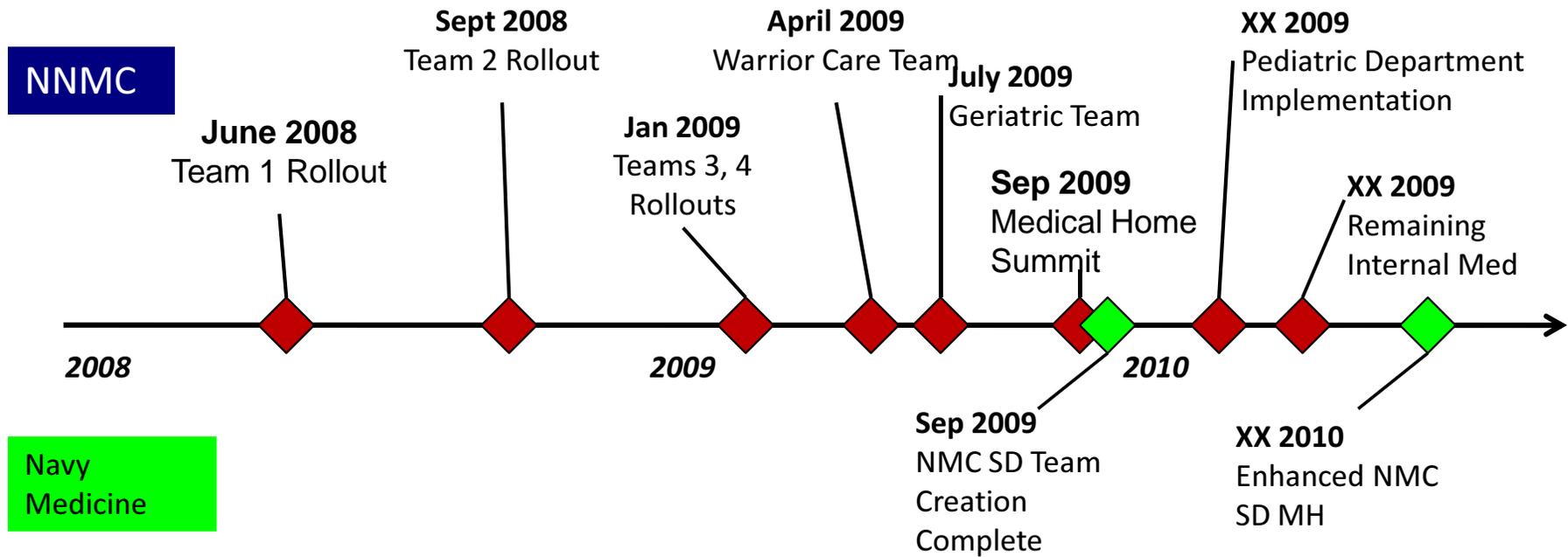
US Navy Medical Department

# US Navy PCMH Roll Out



- First efforts at NNMC Bethesda
- Pilot began June 2008
- Already shown improvements in:
  - PCM continuity
  - Access to care
  - Evidence-based healthcare metrics
  - Pt satisfaction
- Decreasing ER and specialty visits

# Timeline



**Today there are ~12,000 NNM patients (representing ~60% of all Internal Medicine patients) receiving care by 6 Medical Home Teams**

# Results



Measure	Before	After	% Δ
Enrollee Preventive Health Quality Index (HEDIS)	0 of 7 measures at 75 <sup>th</sup> percentile	7 of 7 measures At 90 <sup>th</sup> percentile (>20 Index Score)	
PCM Continuity of Care (% of time Enrollees See PCM when PCM is in Clinic)	56.6%	75.3% (79.3% - team)	+33%
Patient Satisfaction (Monitor Survey - NNMC IM Clinic)* The provider listened. The provider explained. Overall satisfaction	95% 93% 93%	** 96% 95% 92%	
Access (3 <sup>rd</sup> Next Available Appointment)	N/A	1-3 days	
Network ER Visits per 100 enrollees	7.7	6.1	-20.8%
Total Annual ER Visits per 100 enrollees	70.1	42.4	-39.5%
Purchased Specialty Care visits per 100 enrollees	11.5	5.0	-56.5%
Total Specialty Care visits per 100 enrollees	663.0	395.0	-40.4%
Virtual Visits (patient/staff/provider initiated secure messages)	0	444	
Patient Activation & Behavioral Health Measures		TBD	
PCMH Cost Per Enrollee		TBD	

\* The percentage of "4" and "5" responses using a 5-point scale for each question

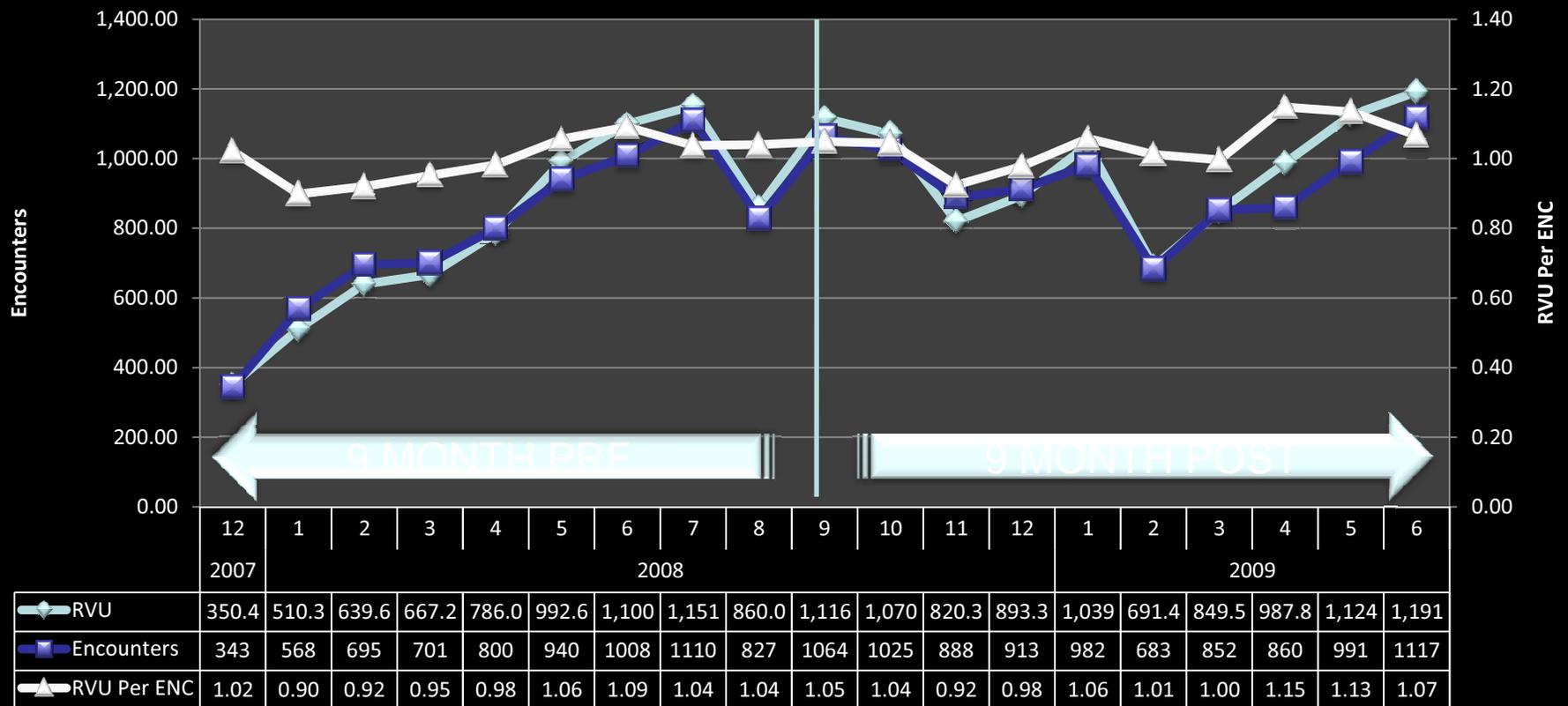
\*\*Only 7% Response Rate. CNA study goal is to better capture satisfaction of Medical Home patients.

# Medical Home NNMC



## Medical Home Aggregate Productivity

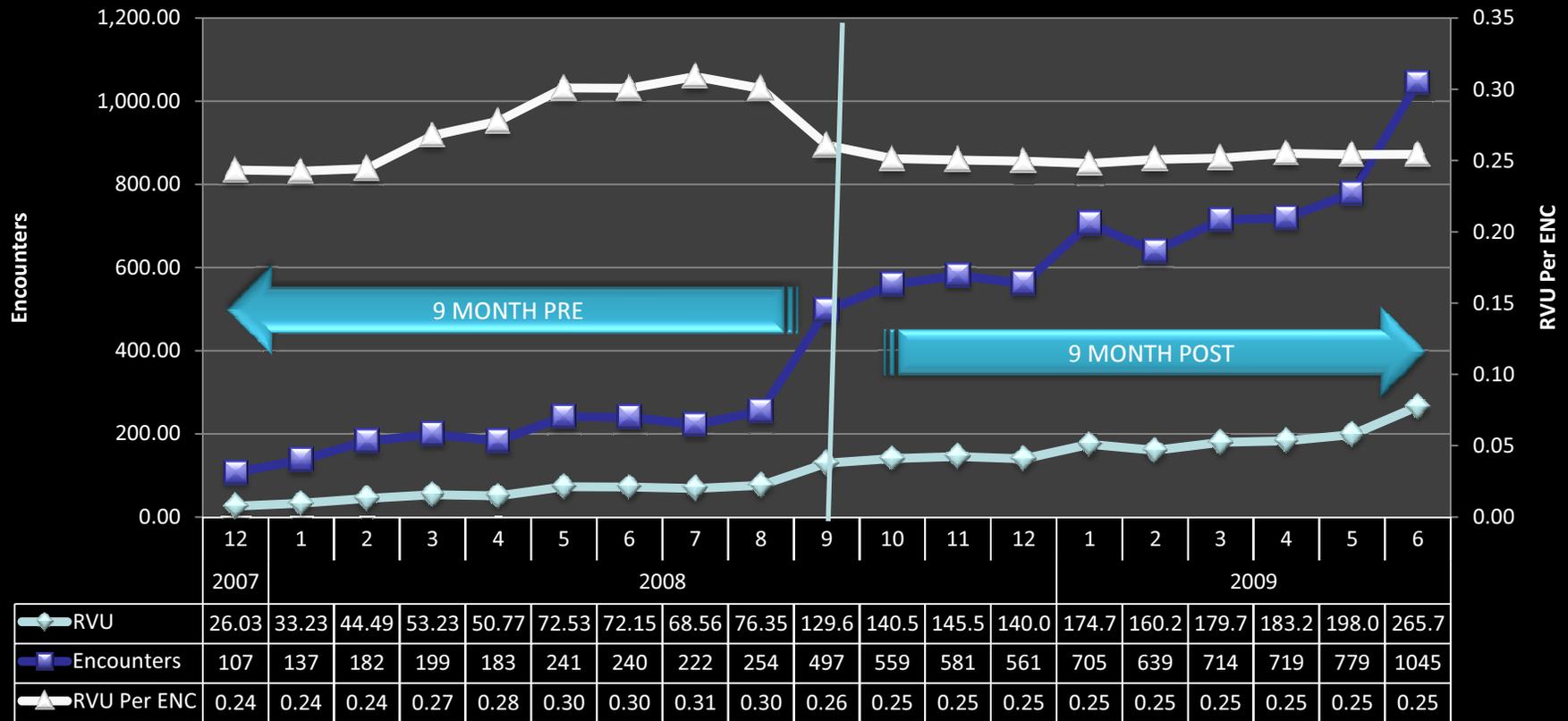
Completed SADRS, Excludes T-Cons



# Medical Home Aggregate (T Cons)



## Medical Home Aggregate Productivity Completed SADR ( T-Cons only)



# PCMH at NH Pensacola



- Building PCMH concept throughout PC
  - Family Medicine (3 total); 1<sup>st</sup> opened Nov 09
  - Pediatrics opens Feb/Mar 2010 (1)
  - Internal Medicine Feb/Mar 2010 (2)
  - No new money
    - Strategic reinvestment of current resources
    - Facility modifications
    - Decentralization of appointing back to PCMH
    - IT challenges
  - PCMH with GME embedded

# Family Medicine PCMH



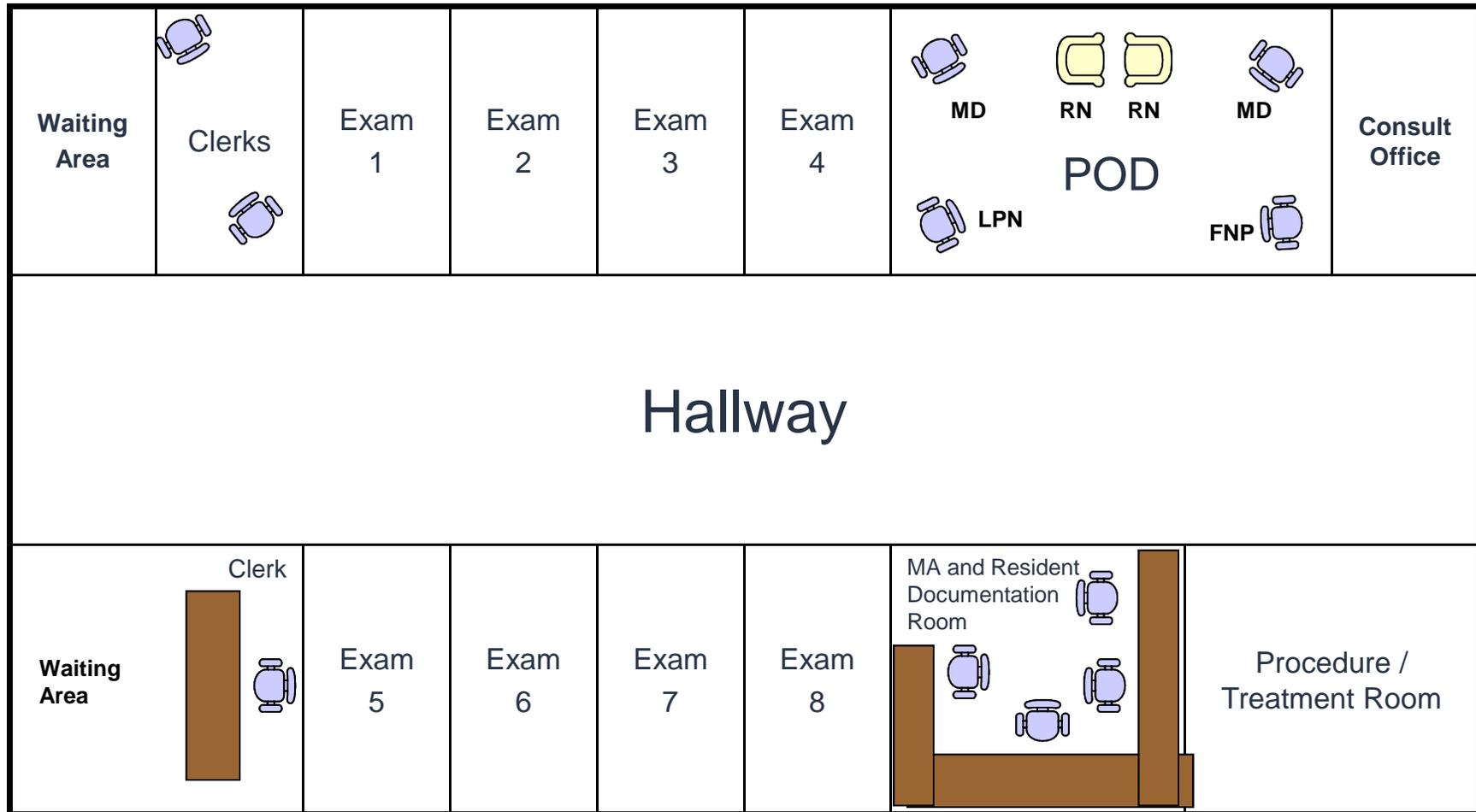
- Typical Team (Aggregate of 4 to 5 c-FTE):
  - 4-5 Family Physician Faculty (0.3 – 0.6 C-FTE)
  - 1 FNP/PA (0.9 c-FTE)
  - 6-7 Family Medicine residents (~1.0 c-FTE)
  - 2 RN's
  - 1 LPN
  - 9 HN / MA
  - 3 clerks
- Embed Mental Health, Readiness, Case Mgmt

# Access



- Open access appointing
- Two appointment types used in templates:
  - ACUT: 24 hrs (same day access) any reason
  - EST: Tomorrow and beyond access
- All 20 minute slots; 16-18 templated
- Explicit business rules
- Secure e-communication / wireless pending
- Demand management

# Green Team Medical Home Demo



# Things to Consider



- Culture Change: Don't underestimate
  - Training and team building
  - Staff work at top of license
  - Ownership of population
  - Work flow modification necessary
- Change emphasis from productivity to health
- Wellness: Not separate from Primary Care
- Staffing Model: What is optimal? Strategic reinvestment of current resources takes work
- Transformation: Where to start?
- Significant business planning necessary

# 2010 Military Health System Conference PCMH Within the MHS

- Current USAF Initiatives

Sharing Knowledge: Achieving Breakthrough Performance

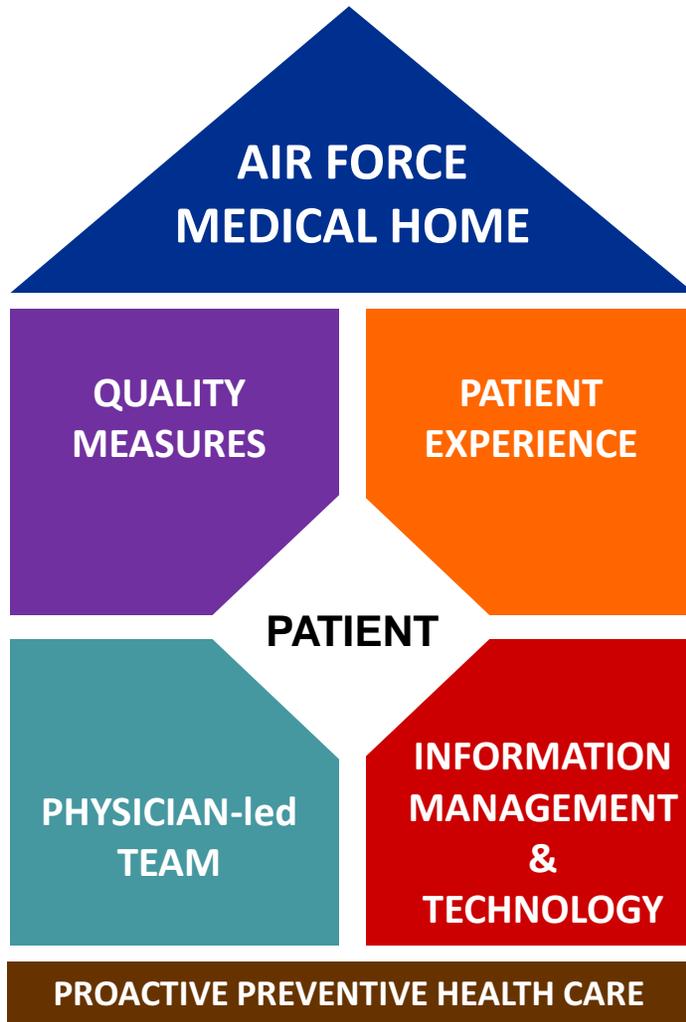
LtCol Timothy Kosmatka, LtCol Charles Motsinger

25 January 2010



USAF Medical Department

# Air Force Family Health Initiative



Family Health Initiative (FHI) is the Air Force PCMH

# AF SG Key Tenets of PCMH

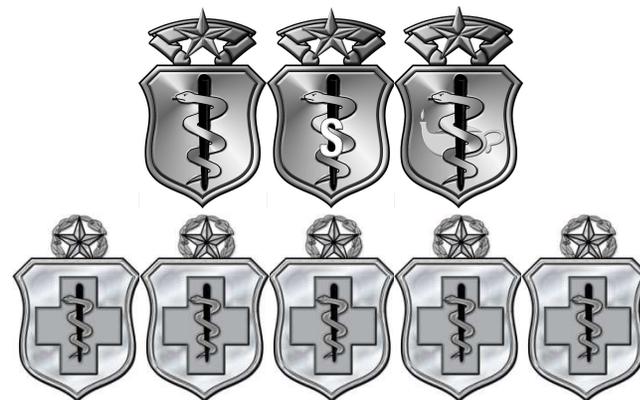


- **P** Physician-Led Team
- **A** Availability of 90 appointments/week
- **C** Cross-booking -- NONE
- **T** Time managed by provider/team



## *Family Health Team*

- Family Practice Physician
- Mid-level provider or GMO
- Nurse
- 5 Medical Technicians



### ■ Additional Key Components

- Disease Mgt Nurse
- Case Mgt Nurse
- Health Care Integrator
- Group Practice Manager

# Implementation Process



- Site Selection
  - Based off proximity of assigned manning to authorizations
- FHI Workshop
  - Standardized initial instruction; established pre-work for facilities
- 2 Visits from FHI Implementation Team
  - Initial approximately 6-8 weeks out, second at “turn-on”
- Continued engagement with facilities after implementation
  - Medical Home Cell at AFMOA developed to support sustainment
  - Ongoing teleconference/VTC with facilities
  - Monthly push reports to facilities to track key measures
  - Pre/post staff satisfaction surveys
  - Follow-up SME visits as requested by facilities
- Air Force Instruction (AFI) to accompany in coordination

# Air Force Medical Homes



## 13 Sites completed by end of 2009

Edwards & Ellsworth (2008)

Scott

Misawa

Patrick

FE Warren

Andrews

Bolling

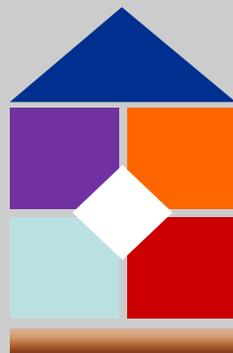
Hill

Sheppard

Laughlin

Elmendorf

Lakenheath



## 20 "Homes" to be "built" in 2010

Barksdale

McGuire

Charleston

Offutt

Columbus

Ramstein

Davis-Monthan

Randolph

Goodfellow

Shaw

Hickam

Spangdahlem

Hurlburt

Travis

Keesler

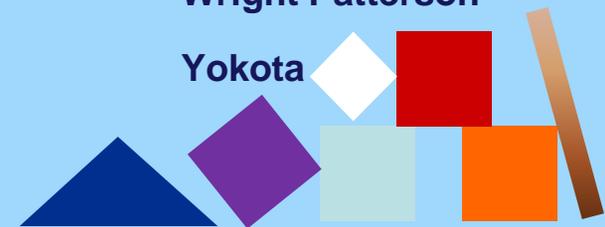
Vance

Langley

Wright Patterson

Luke

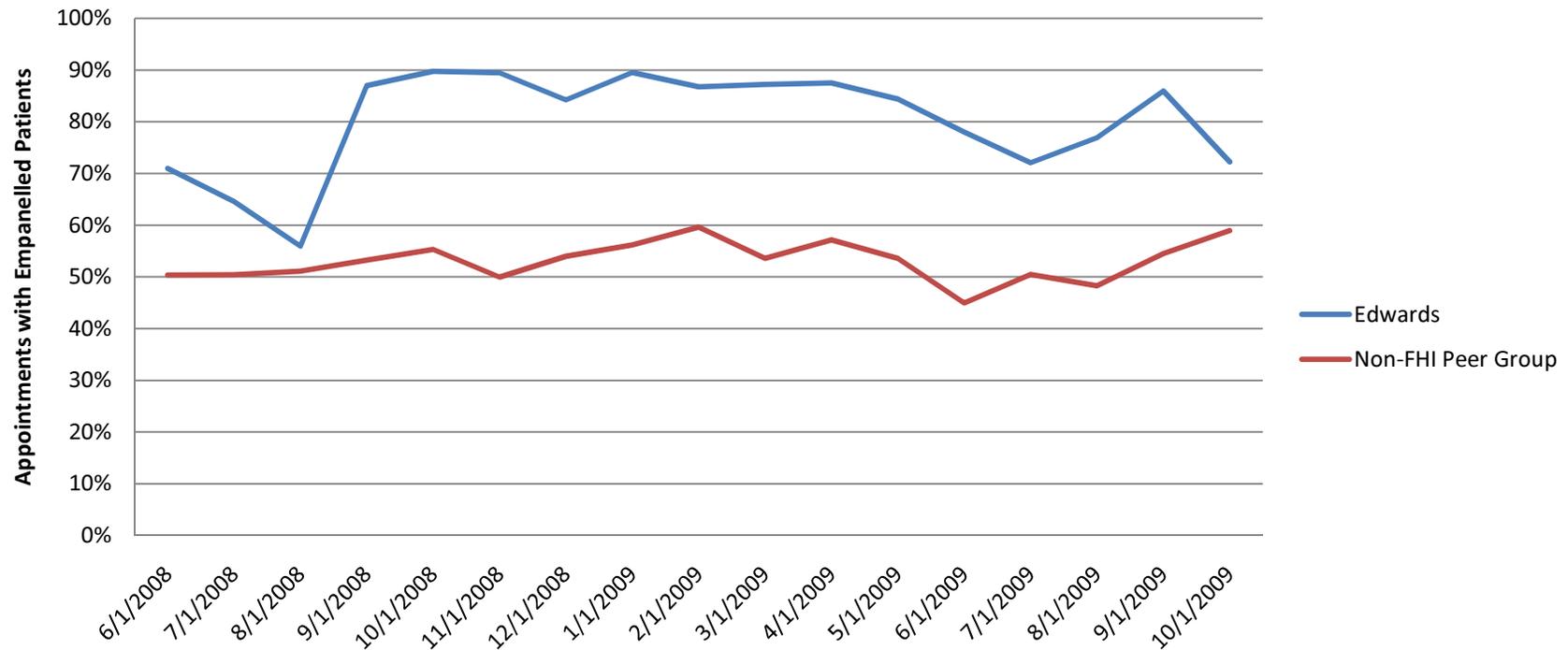
Yokota



# Key Measure - Continuity



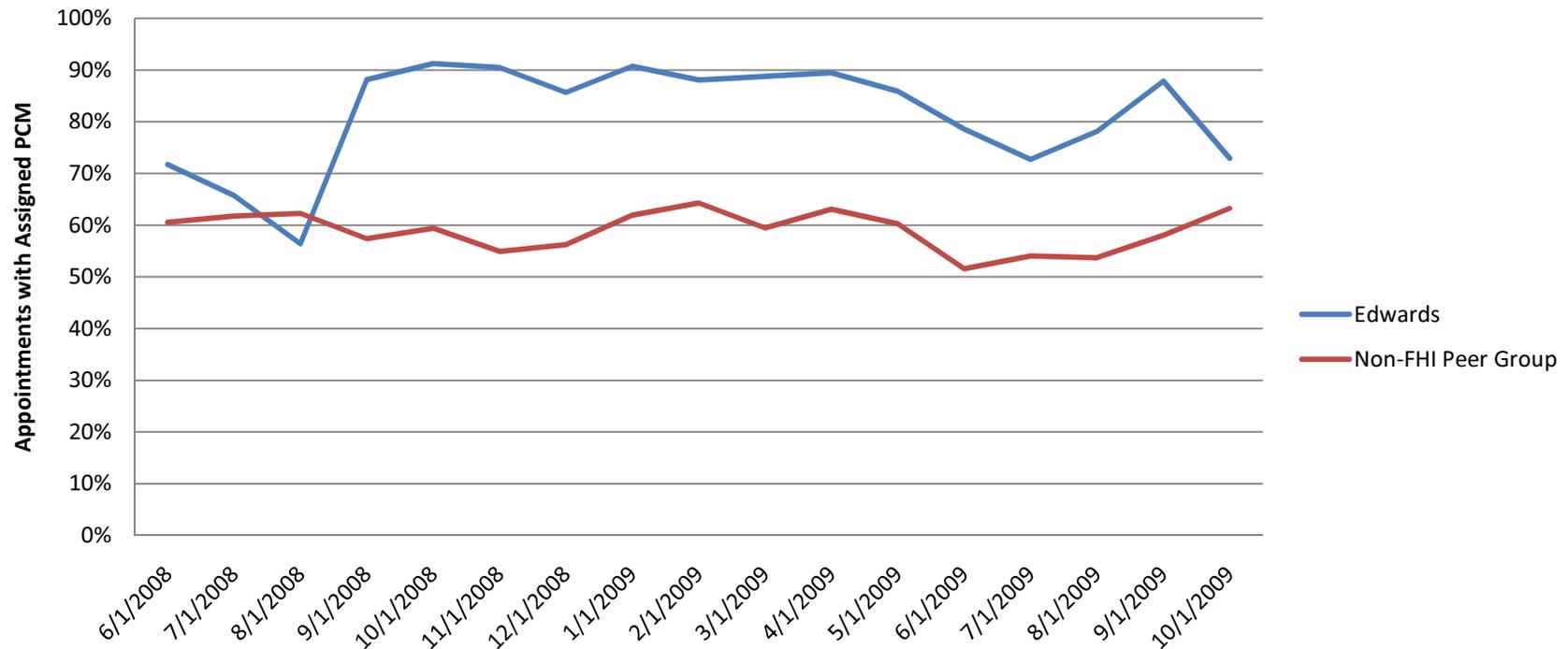
**Percentage of Provider Appointments  
with Empanelled Patients  
(Family Health Providers)**



# Key Measure - Continuity



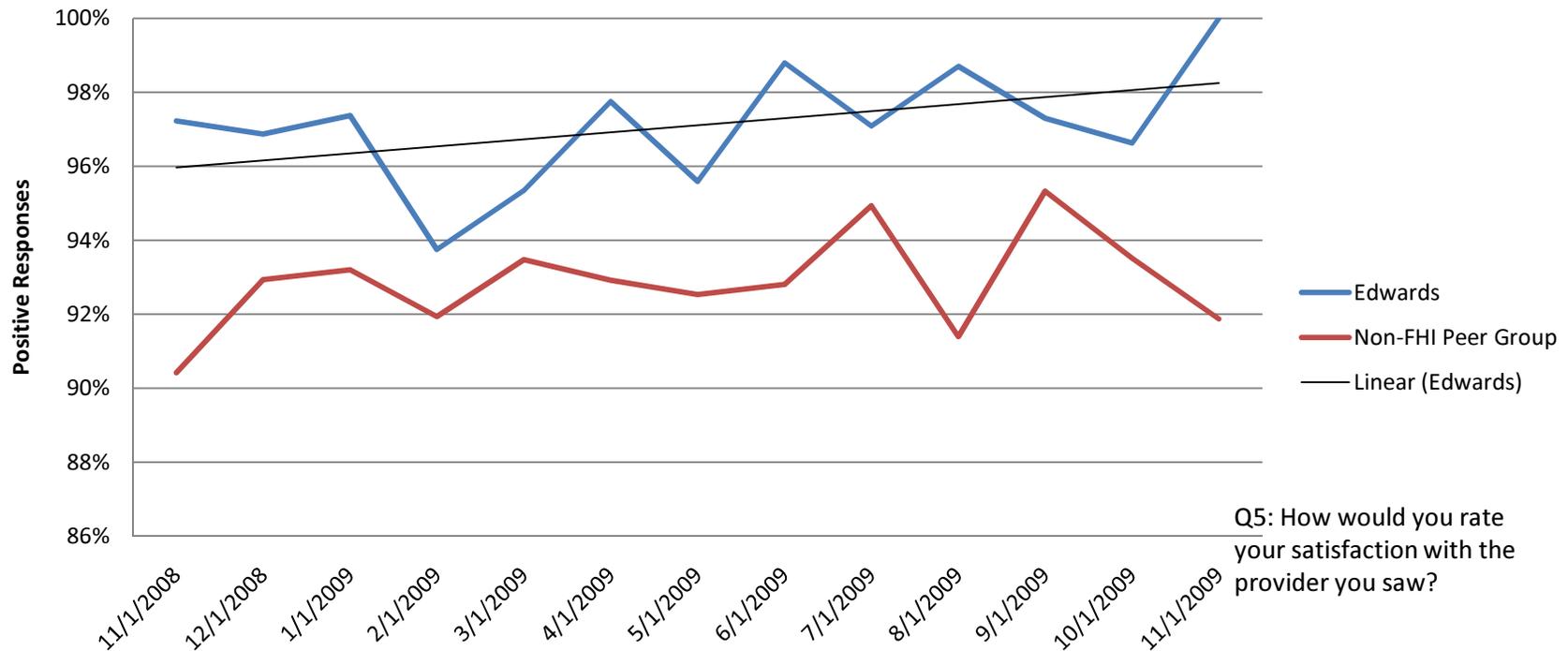
**Percentage of Patient Appointments with Assigned Primary Care Provider (Family Health Providers)**



# Key Measure - Satisfaction



### Patient Satisfaction with Provider Seen (Family Practice Providers)



# Key Measure – Improved Patient Outcome



Pre DM



Post DM



	July 07	Dec 08	Jan 09 (internal metrics)
Annual A1C	88.6%	93.8%	<b>96.9%</b>
A1C Control ( $\leq 9$ )	49.6%	81.3%	<b>93.9%</b>
Annual LDL	84.0%	89.8%	<b>95.5%</b>
LDL Control	48.7%	52.8%	<b>65.6%</b>
A1C Control ( $\leq 7$ )		62.3%	<b>77.0%</b>

Hill Air Force Base

# Key Measure – Improved Patient Outcome



<b>HEDIS METRIC</b>	<i>Pre – FHI &amp; DM</i>	<i>Post - FHI &amp; DM</i>
	<b>JUNE 08</b>	<b>JUNE 09</b>
<b>A1C Control &lt;9</b>	<b>71.0%</b>	<b>78.0%</b>
<b>A1C Control &lt;7</b>	<b>42.9%</b>	<b>59.6%</b>
<b>Annual A1C</b>	<b>92.2%</b>	<b>92.2%</b>
<b>LDL Control</b>	<b>50.2%</b>	<b>62.0%</b>
<b>Annual LDL</b>	<b>88.3%</b>	<b>91.8%</b>

Edwards Air Force Base

# Medical Home Recognition



- Mock survey performed by MHS Office of Strategic Management at Edwards AFB Dec 09
  - Used published NCQA PPC-PCMH standards
- Score: 81.5/100
- 10/10 “Must-Pass” Elements Met
- Level 3 Recognition (Highest)

# *What is COMPASS??*



- **It's a Team Workflow for AHLTA**
- **It works NOW**
- **It's Simple**
- **It brings clinical decision support to the point of care for preventive health services (PHQ-9, AUDIT)**
- **It allows patient centered EMB guideline incorporation into documentation at time of encounter.**



AIM - COMPASS CORE

AutoNeg

Undo

Details

Browse

Shift Browse

Note View

HPI

Military-PHA

RDS

PE

Vision Assessment & Audiometry

Prevention & Counseling

Coding

AFMS Draft COMPASS Core 20091222 HELP Page

Outline View

**NOTE: DO NOT ERASE information in free text boxes. If you see words or phrases, type after it. If you see squiggly line(s) type before it.**

**Chief Complaint / History of Present Illness**

The Chief Complaint is:

History of Present Illness (2000 Character Limit) -- Type <CTRL>+<ENTER> for new line --

Additional Hx Pain Severity / 10

NOT Deployment-Related  RDS

Deployment-Related If YES, enter Deployment Location / Date ----->  RDS

**If the Patient is taking an Antidepressant, Go to the Social History Section, Click on the (>>) Button Next to Depression and Complete the Suicidal Question**

**Past Medical / Surgical History and Medications**

Medical History

Surgical History

Family History

Include Dosage, Route and Frequency

Current Medications

: ( ) No Medications  
( ) Current Medications Reviewed and Reconciled

Current Allergies Reviewed

List Allergies in the box to the right and if a new allergy is identified, please add it to the Allergies in Screening.



AIM - COMPASS CORE    AutoNeg    Undo    Details    Browse    Shift Browse    Note View

HPI | Military-PHA | RDS | PE | Vision Assessment & Audiometry | **Prevention & Counseling** | Coding | AFMS Draft COMPASS Core 20091222 HELP Page | Outline View

**Preventive Medicine for AFMS COMPASS AIM Form**  
Info gathered from U.S. Preventive Services Task Force (USPSTF) and Centers for Disease Control and Prevention (CDC) (Last Update Nov 09)

**For Preventive Medicine Services and Disease Specific Monitoring Below, please enter the status (i.e. ordered, pending, etc.) or result and the date ordered or resulted.**

**To Access the latest Immunization and Screening Recommendations from the CDC and USPSTF - click the ? to the right**

Screening Exams - Current USPSTF Recommendations -----> [?] ?

Current Immunization Schedule All Ages - CDC Recommendations -----> [?] ?

**Preventive Medicine Services**

**Disease-Specific Monitoring**

DIABETES:



ePSS HOME

About ePSS

About USPSTF

Grade Definitions

Instructions for Use

Tools

Search for Recommendations

Browse by Topic

[Search for Recommendations >>](#)

## Search for Recommendations

Enter the following information to retrieve recommendations from the USPSTF Preventive Services Database.  
All fields are optional.

Age:  Years

Sex:  Female  Male  
Pregnant:

Tobacco User:  Yes  No

Sexually Active:  Yes  No

Reset

Show Recommendations





\* Indicates a new grade definition

View All **A** **B** **C** **D** **I**

**17 - Recommended (A, B)**

Grade	Title	Risk Info.	Details
<b>A</b>	Cervical Cancer: Screening – Women who are sexually active		
<b>A</b>	Chlamydia: Screening – Women Ages 24 and Younger OR Women Ages 25 and Older at Increased Risk		
<b>A*</b>	Folic Acid: Supplementation – All Women Planning or Capable of Pregnancy		
<b>A</b>	HIV: Screening – Adults and Adolescents at Increased Risk		
<b>A*</b>	High Blood Pressure: Screening – Adults 18 and Older		
<b>A</b>	Lipid Disorders in Adults: Screening – Women 18 and Older at Increased Risk for CHD		
<b>A</b>	Syphilis: Screening – Men and Women at Increased Risk		
<b>B</b>	Alcohol Misuse: Screening and Behavioral Counseling – Pregnant Women and Pregnant Women		
<b>B</b>	BRCA Mutation Testing for Breast and Ovarian Cancer – Women at Increased Risk		
<b>B</b>	Breast Cancer: Preventive Medication Discussion – Women, Increased Risk		
<b>B*</b>	Breastfeeding: Primary Care Interventions to Promote – All Pregnant Women and New Mothers		
<b>B*</b>	Depression: Screening – Adults age 18 and over – When staff-assisted depression care supports are in place		
<b>B</b>	Gonorrhea: Screening – Pregnant Women and Women at Increased Risk		
<b>B</b>	Healthy Diet: Counseling – Adults with Hyperlipidemia and Other Risk Factors for CVD		
<b>B</b>	Obesity: Screening and Intensive Counseling – Obese Men and Women		
<b>B*</b>	Sexually Transmitted Infections: Behavioral Counseling – Sexually Active Adolescents and Adults at Increased Risk		
<b>B*</b>	Type 2 Diabetes Mellitus: Screening Men and Women – Sustained BP 135/80+		

- Cut
- Copy**
- Paste
- Select All
- Print...
- Print Preview...
- Search with Google
- All Accelerators



**Preventive Medicine for AFMS COMPASS AIM Form**  
Info gathered from U.S. Preventive Services Task Force (USPSTF) and Centers for Disease Control and Prevention (CDC) (Last Update Nov 09)

For Preventive Medicine Services and Disease Specific Monitoring Below, please enter the status (i.e. ordered, pending, etc.) or result and the date ordered or resulted.

To Access the latest Immunization and Screening Recommendations from the CDC and USPSTF - click the ? to the right

Screening Exams - Current USPSTF Recommendations -----> ?

Current Immunization Schedule All Ages - CDC Recommendations -----> ?

**Preventive Medicine Services**

- A Cervical Cancer: Screening -- Women who are sexually active
- A Chlamydia: Screening -- Women Ages 24 and Younger OR Women Ages 25 and Older at Increased Risk
- A\* Folic Acid: Supplementation -- All Women Planning or Capable of Pregnancy
- A HIV: Screening -- Adults and Adolescents at Increased Risk
- A\* High Blood Pressure: Screening -- Adults 18 and Over
- A Lipid Disorders in Adults: Screening -- Women 45 and Older, Increased risk for CHD
- A Syphilis: Screening -- Men and Women at Increased Risk
- B Alcohol Misuse: Screening and Behavioral Counseling -- Men, Women, and Pregnant Women
- B BRCA Mutation Testing for Breast and Ovarian Cancer: Women, Increased Risk
- B Breast Cancer: Preventive Medication Discussion -- Women, Increased Risk
- B\* Breastfeeding: Primary Care Interventions to Promote -- All Pregnant Women and New Mothers
- B\* Depression: Screening -- Adults age 18 and over -- When staff-assisted depression care supports are in place
- B Gonorrhea: Screening -- Pregnant Women and Women at Increased Risk
- B Healthy Diet: Counseling -- Adults with Hyperlipidemia and Other Risk Factors for CVD
- B Obesity: Screening and Intensive Counseling -- Obese Men and Women
- B\* Sexually Transmitted Infections: Behavioral Counseling -- Sexually Active Adolescents and Adults at Increased Risk
- B\* Type 2 Diabetes Mellitus: Screening Men and Women -- Sustained BP 135/80+

**Disease-Specific Monitoring**

DIABETES:

# 2010 Military Health System Conference PCMH Within the MHS

- Current Army Initiatives

Sharing Knowledge: Achieving Breakthrough Performance  
LTC Timothy Caffrey  
25 January 2010



US Army MEDCOM

# Army Initiatives



- Ft. Meade MEDDAC (Health Care System Strategic Planning)
- Madigan and Washington State PCMH Collaborative
- Team Courage pilot at Ft. Bragg
- Family Medical Home at Ft. Benning
- WTU efforts Army-wide
- **PCMH Community-based Primary Care Clinics**

# Community-based Primary Care Clinics Initiative



- Army run, off-post, leased space primary care clinics.
- 21 clinics in 13 markets.
- Enroll active duty family members.
- Turn-key franchise operation based on PCMH model.

# Business Logic



Directive: Improve Access



Make vs. Buy



Cost competitive?



Quality advantage?

# Proposed Staffing Model



PRACTICE – LEVEL  
ADMINISTRATIVE AND CLINICAL SERVICES

GROUP PRACTICE MANAGER  
ADMIN ASST, COURIER  
NURSE CASE MANAGER  
BEHAVIORAL HEALTH  
PHARMACIST AND PHARMACY  
LAB TECH (2)  
LOCUM CLINICIAN

1 TRIAGE/PHONE NURSE  
1.5 CARE COORDINATOR

1 PCM  
2 MAs

1 PCM  
2 MAs

1 PCM  
2 MAs

# Outcomes



- Access
  - Same day appointment availability
  - Patient satisfaction with access
  - PCM Continuity
  - Defer to network rate
  - Urgent care and ED utilization rate
  - Referral/consult rate

# 8 Point Implementation Strategy



- Site selection, design, outfitting
  - Function follows form
  - Team rooms, exam room ratio
- Marketing
  - Value alignment (help patients see value in what PCMH delivers, e.g. PCMBN, team, continuity, virtual appointments, etc.)
  - Build “brand identity” to decrease transaction costs
  - Improve operational communications

# 8 Point Implementation Strategy



- HR
  - Write position descriptions that incorporate principles of team and matrix responsibilities
  - Develop effective incentive plans/performance objectives
  - Use PCMH to enhance recruitment
- Training
  - Change the culture
  - Teach the business model

# 8 Point Implementation Strategy



- Operations Manual
  - Franchise model
  - NCQA Recognition-ready
  - Define standards that:
    - Lower operating costs
    - Ensure a common user interface
    - Support valid performance comparisons

# 8 Point Implementation Strategy



- IM/IT
  - Identify and deploy the basic tool-kit:
    - Enhanced AHLTA functionality
    - Patient registers
    - Team communication
    - Patient dashboard
    - Population health
- Performance measures
  - Build on PBAM success

# 8 Point Implementation Strategy



- Getting Paid
  - Virtual interactions
  - Team care
  - Coordination of care

# 2010 Military Health System Conference PCMH Within the MHS

- Purchased Care initiatives

Sharing Knowledge: Achieving Breakthrough Performance

Dr. David Howes, Dr. John P. Kugler

25 January 2010



TRICARE Management Activity (TMA)

# Purchased Care Sector Initiatives



- TRO-West: TriWest conducting survey of subcontractors and providing primary care optimization consultations advocating PCMH principles.
- TRO-South and TRO-North: HMS and HNFS coordinating Convenience Care Clinics/focus on access optimization/assessing impact.
- DPs: PCMH pilot activities at PacMed, Johns Hopkins, **Martin's Point**

# Who is Martin's Point Health Care



- **Martin's Point is a not-for-profit provider of direct care and health plan services in ME, NH, VT and NY.**
- **Our Health Plans – 54,000 members**
  - Uniform Services Family Health Plan (USFHP)
  - Medicare Advantage
  - Population Health Services for Maine employers
- **Our Health Centers – 65,000 patients**
  - 8 locations in Maine, 1 in NH
  - Accept all health coverage types

# Why the Patient Centered Medical Home



## Medical Home is one of the more promising solutions for:

- Rising health care costs;
- Inconsistent care quality and outcomes;
- Increased dissatisfaction among patients and providers.



# Our PCMH “Primary Care Model” Vision



- The Martin’s Point primary care model depends on practices in **community-based** locations bringing joy to the experience of care.
- Our **team-based** primary care driven model will offer care that is patient-centered, coordinated and integrated.
- It will demonstrate **measurable** and superior **patient outcomes** and **experiences** as well as proper **stewardship of resources**.

# Building the Care Team in a PCMH

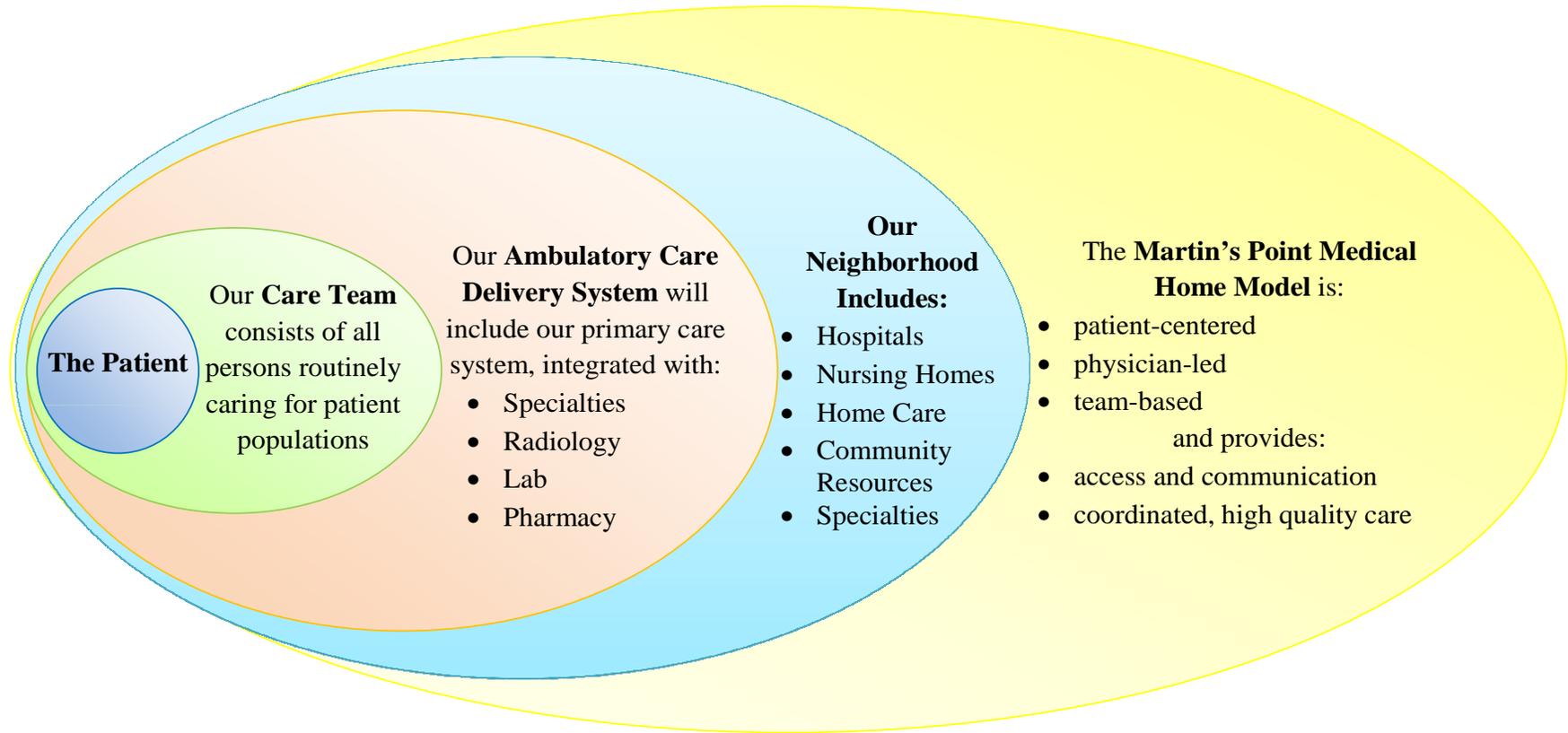


## Care teams might include:

- Physicians/ PA's/ NP's
- Nurses/ MA's
- Patient Service Reps
- Case managers
- Home Health
- Patient educators/coaches
- Mental health professionals



# The Martin's Point Medical Home



Our overarching strategy is to achieve the **Triple Aim** goals of:

- Improving the experience of care
- Improving the health of populations
- Reducing per capita cost of health care

# What Does it Mean for Patients



**“It is my medical home base.”**

- I can get help and/or be seen when needed.
- My doctor and care team know me, and I know them.
- My care team coordinates all of my care.
- I feel comfortable - I trust them, and I’m confident I’m getting the best care.
- My Care Team gives me good information and helps me do what I need to do to stay as healthy as I can.

# Work Done to Date at Martin's Point



## Phase I:

- Electronic Health Records
- Disease Registries
- Microsystems Development
- Open Access
- Patient input for medical home development

## Phase II:

- Define the Care Model Vision
- Define performance metrics (Triple Aim)
- Define teams and team member responsibility

## Phase III:

- Integrate care model with plan and practice
- Build, grow, & expand all team and sites
- Engage physicians in next steps

# Next steps at Martin's Point



- Establish Guiding Principles, developed by MD's
- Engagement across the organization
- Take the message to the stakeholders
- Leadership development and formation of physician leadership council
- Gap analysis and road map
- Build on developing care teams and add team members (eg: care manager); get new ideas out there, try them etc
- EHR/interconnectivity with plan, pharmacy, add specialty care

# Key Points to Remember



## **Our health care system is in crisis**

- Health system must be reoriented around primary care.
- The PCMH is a promising model for improving health, reducing costs and increasing satisfaction.
- A successful health care system must:
  - Provide clinically effective care
  - Be satisfying for patients and families
  - Offer cost effective care

# Panel Questions and Wrapup



- PCMH within the Context of the MHS (Dr. Kugler)
- Navy (CAPT Padden, CDR Miller)
- Air Force (LtCol Kosmatka, LtCol Motsinger)
- Army (LTC Caffrey)
- Purchased Care Sector (Dr. Howes, Dr. Kugler)