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SETMA's Provider Training for October, 2013

As SETMA continues to examine the structure and the dynamic of Patient-Centered Medical Home our monthly provider training is more and more focused on true transformation of our practice into a medical home. We started this pilgrimage on February 17, 2009. We achieved PC-MH recognition as a Tier Three PC-MH by NCQA in June, 2010 and re-recognition August 2013. We achieved AAAHC accreditation for Ambulatory Practice and medical home in 2010 and re-accreditation for three years in June, 2011. We are currently apply for URAC and will apply for Joint Commission medical home accreditation over the next three months. However it has only been the past six months were we have experienced what we believe to be true patient-centeredness in the hospital, in the clinic and in our relationships with our patients. .

The following is the contents of our provider training for this month.

1. We reviewed the invitation by the American Board of Family Practice to participate in a research project for the improvement of healthcare quality through information technology. And, We then removed the October 14, 2013 correspondence with the Vice President for Research and Planning of the ABFM who opined, "I have every confidence that when this is up and running, you (SETMA Family Physicians) will be the benchmark for high quality when other physicians compare their outcomes." (ABFM Research Project and Vice President's reponse used October 15, 2013 training session)

2. We reviewed the Your Life Your Health column for October 17, 2013 which is entitled "The Conversation Project". This a summary of the Institute for Healthcare Improvement's application of IHI President and CEO's life experience with in of life issues. This also includes Maureen Bisognano's response to the above referenced article. (Maureen Bisognanoâ€™s response to The Conversation Project)

3. We reviewed *Your Conversation Started Kit* (http://theconversationproject.org/wp-content/uploads/2013/01/TCP-StarterKit.pdf) which is "dedicated to helping people talk about their wishes for end-of-life care.

4. We reviewed IHI's document entitled *How To Talk To Your Doctor* (or any member of your healthcare team) (http://theconversationproject.org/wp-content/uploads/2013/01/TCP-TalkToYourDoctor.pdf) which is "can be usedâ€¦as a workbook to make notes of what to tell the health care team â€" whether you're getting ready to discuss your own wishes, or you're helping someone else get ready to discuss theirs."

5. Each provider received an information booklet about our Consumer Assessment of Healthcare Provider and Systems (CAHPS) vendor's service (http://www.themyersgroup.net/?s=Healthcare+solutions). SETMA's deployment of the ambulatory CAHPS program began October, 2013. Coupled with our HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) internal audit (http://www.jameslhollymd.com/epm-tools/SETMAs-Internal-HCAHPS-Survey-Tutorial), we believe these are effective measures of SETMA's patient-centeredness. In our September, 2013 provider meeting (http://www.jameslhollymd.com/Presentations/SETMAs- Provider-Training-for-September-2013) we laid the ground work for this discussion.

6. We reviewed our internal audit of SETMA's HCAHPS. This is only the second month we have been doing this audit. We are learning and becoming more patient-centered in our hospital care.

7. As we begin to look at CMS' 2015 deployment of the Complex Chronic Care Coordination (CCCC) codes, SETMA has begun to design the automation of as much of this process as possible. The selection of patients eligible for this care and payment and many of the elements of plan of care can be automated. Recently, SETMA rewrote the tutorial for our Patient-Centered Medical Home Coordination Review Tutorial (http://www.jameslhollymd.com/epm-tools/Tutorial-Medical-Home-Coordination-Review). In our training this morning, we determined that many of the features which we design three years ago can be automated. We realized that this tool can be used as foundation for the CCCC function and that with modifications and additions, it could be an effective way of fulfilling this very important new step in patient care.

8. As we improve our "plans of care" and "treatment plans" in our medical home, we have adapted a tool we built ten years ago. That is the Medical Home Transtheoretical Model Assessment of Stages of Change (http://www.jameslhollymd.com/epm-tools/medical-home- transtheoretical-model-assessment-stages-of-change-tutorial). Combined with the

Framingham Risk Scores and the "What if Scenario" (http://www.jameslhollymd.com/epm- tools/framingham-tutorial), the "stages of change" allows us to assess a patient's readiness for change and to develop motivational language which can advance the patient's activation, re-activation, engagement and re-engagement.

9. After auditing provider performance on the Transitions of Care Management codes performance and Initial Preventive Physical Examination (IPPE) and Annual Wellness Examination, we found the following: 3078 annual wellness examines were eligible to be done and only 385 were done for FFS Medicare; 3375 Medicare Advantage annual wellness exams were eligible to be done and only 1m,352 were done. An intense discussion was held about how inappropriate this level of performance was. The audit included percentages of compliance by individual provider. We then review the tools which SETMA had built to make fulfilling these billing opportunities (http://www.jameslhollymd.com/epm-tools/transition-of-care-management-code-tutorial). After length discussion, all agreed we could do better, that the patients would benefit and that the practice would benefit. We all agreed that if were to continue to provide the level of uncompensated and un-reimbursed services to our patients, we would have to capture the revenue which our work warranted.

10. During the Provider Meeting, October 15, 2013, the following issues were addressed. Questions were asked and answers need to be looked up and changes to the EMR were recommended. Additional training for staff and providers were agreed upon. The following is the link to this information: Provider Meeting Follow Up: October 15, 2013

Next month, we will spend our time on the Medical Home Tools which we have built and continue to exam patient-centeredness in our approach to patient care and conversations.