# PCMH Transformation Update
Cohort 1

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## Family Medicine Residency of Idaho
Emerald/Meridian/Raymond

- PCMH Transformation Projects:
  - Risk Stratification
  - Transitions of Care
  - Screen & Intervene Program
- Successes:
  - CHW Partnership

## Glenns Ferry Health Center, Inc.
Glenns Ferry/Desert Sage

- PCMH Transformation Projects:
  - NCQA Re-certification
  - Referral Tracking
  - Care Management/Coordination
- Successes:
  - Re-focus of PCMH efforts
  - PCMH orientation for all providers/staff

## Primary Health Medical Group
Overland/Pediatrics/West Boise

- PCMH Transformation Projects:
  - Adolescent Depression Screening
  - Care Management/Coordination
  - Health Literacy
- Successes:
  - Open communication
  - Provider interaction
  - Focus on innovation

## Sonshine Family Health Clinic

- PCMH Transformation Projects:
  - Maximizing new EHR capability
  - NCQA Pre-validation process
  - Behavioral Health Integration
- Successes:
  - Implementation of new EHR
  - PCMH policy and procedure development
    - Referral tracking/patient access/staff roles

## Saint Alphonsus Medical Group
Eagle/McMillan/Overland

- PCMH Transformation Projects:
  - Behavioral Health Integration
  - Clinical Quality Measures
  - Care Coordination
  - Care Team Development
  - Improving Access/Patient Experience
- Successes:
  - Improved quality measures
  - Care team development
  - Standardizing PCMH throughout SHIP clinics

## St. Luke's Health System
SLIM Cloverdale/McCall

- PCMH Transformation Projects:
  - Team Huddles
  - Referral Tracking/Closing the Loop
  - PCMH policy/procedure documentation
  - Staff/resource allocation
- Successes:
  - Centralization of referrals
  - Implementation of CHW Role
  - Partnership with PHD QI staff
  - Staff buy-in and improved communication

## Terry Reilly Health Services
Boise

- PCMH Transformation Projects:
  - Advanced Access
  - Empanelment
  - Culture Change/Customer Service Program
  - Risk Stratification
  - Registries
- Successes:
  - Joint Commission certification
  - PCMH training for all staff
  - Hybrid of Advanced Access

## QI Change Facilitation
Projects

- Culture Change Roll-Out
- AIM Statements/PDSA Cycles
- LEAN Mapping
- New EHR Implementation
- Empanelment
- Open Access
- Health Literacy
- NCQA Recognition
- Patient/Provider Engagement
- SDOH Rx/Community Resource Linking

## Barriers/Challenges of Transformation

- Coordination/Communication
- Consistent Messaging
- Autonomy vs. Standardization
- Time Constraints/Resource Allocation
- Staff Turnover/Repurposing Roles
- Implementation of new EHR

# #1 PCMH Transformation Need

## Next Steps

- Staffing
- Care Coordination
- Risk Stratification Tools
- Care Management Registries
- Behavioral Health Integration
- Patient & Family Advisory Council
- NCQA Recognition/Re-certification

# Community Resource Rx

## Ada County

### Food

**Idaho Foodbank**
208-336-9643
idahofoodbank.org

**Boise Salvation Army**
Food Pantry
208-433-4423

**St. Vincent de Paul**
Food Pantry
208-333-1460

### Utilities

**El-Ada Community Action Partnership**
208-322-1242
www.eladacap.org

**Catholic Charities of Idaho**
208-345-6031
ccidaho.org

**Project Share**
Energy Bill Assistance
208-433-4424

### Housing

**Ada County Indigent Services**
208-287-7960
adacounty.id.gov

**Boise City/Ada County Housing Authority**
208-345-4907
www.bcacha.org

**Jesse Tree of Idaho**
208-383-9486
jessetreeidaho.org

### Transportation

**Valley Regional Transit**
208-846-8547
valleyregionaltransit.org

**Valley Ride - GoRide Mobility Program**
208-345-7433
valleyride.org

**Idaho NEMT (Medicaid)**
1-877-503-1261
Idahotransport.com

### Safety

**Community Partnerships of Idaho**
208-376-4999
www.cp-of-idaho.com

**Safe Place Ministries**
208-323-2169
safeplaceministries.com

**Women's and Children's Alliance**
208-343-3688
www.wcaboise.org

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# State of Idaho, Department of Medicaid

Region 4 - Boise

Report created: 8/30/2016

## Notes & Criteria

Reports are based off of claims paid by Idaho Medicaid

Claims for Dates of Service: 5/8/2015 to 5/8/2016

Participants must have been enrolled with their clinic as of the last day of the reporting period shown above and have been enrolled with the clinic for at least 6 months of the year reporting period.

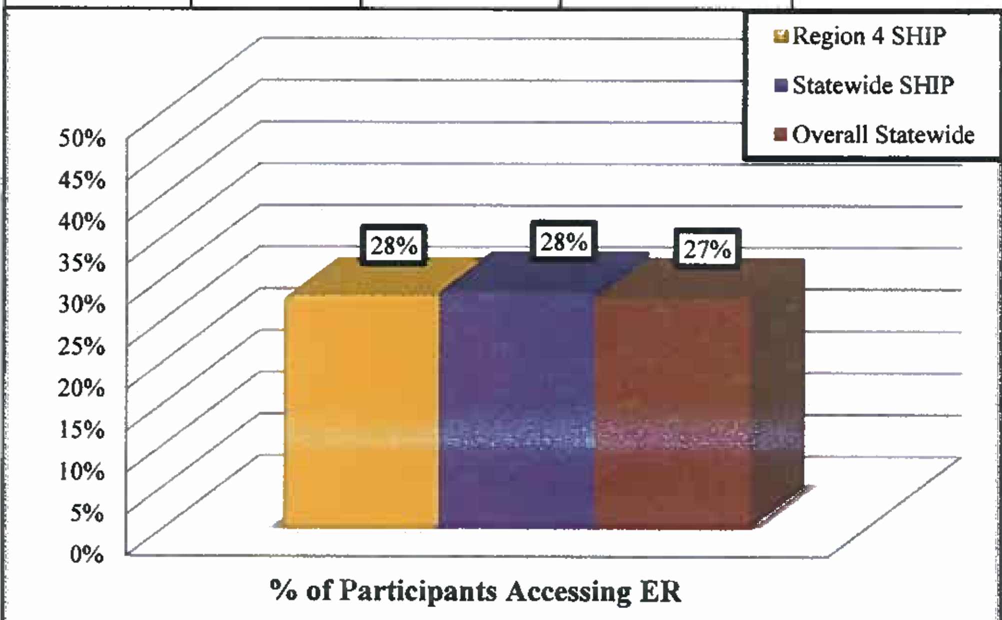
Patient Engagement is defined as an Evaluation & Management or Wellness Office Visit at a Healthy Connections Service Location within the same organizational NPI.

Wellness Visits are **not** limited to visits occuring within the organizational NPI.

Data will not reflect paid claims for members with other primary insurance.

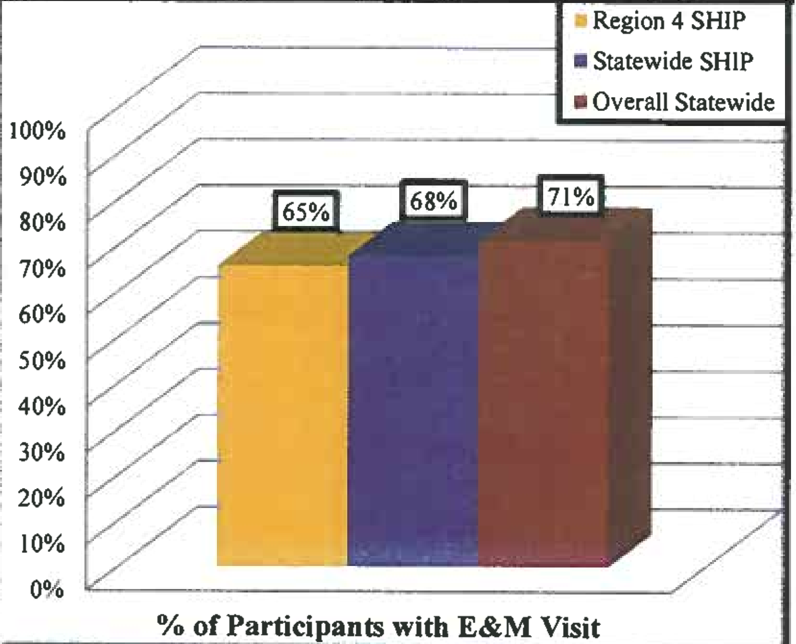
## 1. SHIP Clinics Healthy Connections E.R. Utilization

| Group | Total Population | Participants Accessing ER | % of Participants Accessing ER | Total ER Visits |
|---|---|---|---|---|
| Region 4 SHIP | 16,325 | 4,492 | 28% | 9,235 |
| Statewide SHIP | 55,282 | 15,517 | 28% | 31,120 |
| Overall Statewide | 224,358 | 61,337 | 27% | 120,977 |



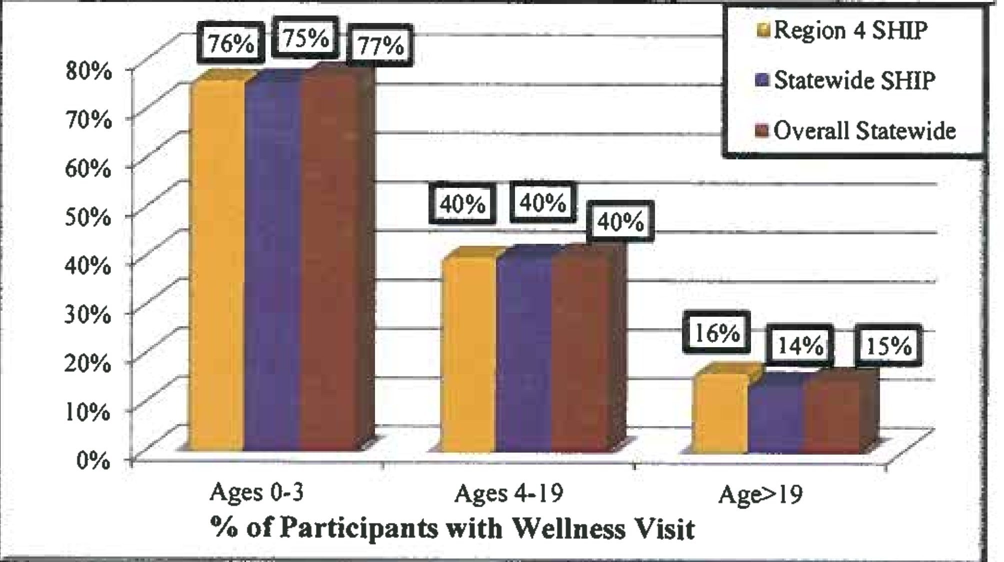
## 2. SHIP Clinics Healthy Connections Engagement

| Group | Total Population | Participants with E&M Visit | % of Participants with E&M Visit |
|---|---|---|---|
| Region 4 SHIP | 16,325 | 10,671 | 65% |
| Statewide SHIP | 55,282 | 37,380 | 68% |
| Overall Statewide | 224,358 | 158,934 | 71% |




## 3. SHIP Clinics Healthy Connections Wellness Services

| Group | Ages 0-3 | | Ages 4-19 | | Ages >19 | |
|---|---|---|---|---|---|---|
| | Total Population | % of Participants with Wellness Visit | Total Population | % of Participants with Wellness Visit | Total Population | % of Participants with Wellness Visit |
| Region 4 SHIP | 2,118 | 76% | 9,776 | 40% | 4,431 | 16% |
| Statewide SHIP | 8,083 | 75% | 35,087 | 40% | 12,112 | 14% |
| Overall Statewide | 36,809 | 77% | 141,462 | 40% | 46,087 | 15% |



# Collaborative Care Compact

## Transition of Care

### *Mutual Agreement*

- Maintain accurate and up-to-date clinical record.
- Agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD]
- Ensure safe and timely transfer of care of a prepared patient

### *Expectations*

| Primary Care | Specialty Care |
|---|---|
| ☐ PCP maintains complete and up-to-date clinical record including demographics.<br>☐ Transfers information as outlined in Patient Transition Record.<br>☐ Orders appropriate studies that would facilitate the specialty visit.<br>☐ Informs patient of need, purpose (specific question), expectations and goals of the specialty visit<br>☐ Provides patient with specialist contact information and expected timeframe for appointment. | ☐ Determines and/or confirms insurance eligibility<br>☐ Identifies a single referral contact person to communicate with the PCMH<br>☐ When PCP is uncertain of appropriate laboratory or imaging diagnostics, assist PCP prior to the appointment regarding appropriate pre-referral workup |

## Access

### *Mutual Agreement*

- Be readily available for urgent help to both the physician and patient via phone or e-mail.
- Provide visit availability according to patient needs.
- Be prepared to respond to urgencies.
- Offer reasonably convenient office facilities and hours of operation.
- Provide alternate back-up when unavailable for urgent matters

### *Expectations*

| Primary Care | Specialty Care |
|---|---|
| ☐ Determines reasonable time frame for specialist appointment<br>☐ Communicate with patients who "no-show" to specialists.<br>☐ Determines reasonable time frame for specialist appointment.<br>☐ Provide a secure email option for communication with patient and specialist.. | ☐ Notifies PCP of first visit 'no-shows' or other actions that place patient in jeopardy.<br>☐ Provides visit availability according to patient needs.<br>☐ Be available to the patient for questions to discuss the consultation.<br>☐ Schedule patient's first appointment with requested physician.<br>☐ Be available to PCP for pre-consultation exchange by phone and/or secure email.<br>☐ When available and clinical practical, provide a secure email option for communication with established patients and provider.<br>☐ Provides PCP with list of practice physicians who agree to compact principles. |

## Collaborative Care Management

| Mutual Agreement |
|---|
| • Define responsibilities between PCP, specialist and patient.<br>• Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up).<br>• Maintain competency and skills within scope of work and standard of care.<br>• Give and accept respectful feedback when expectations, guidelines or standard of care are not met<br>• Agree on type of specialty care that best fits the patient's needs |

| Expectations | |
|---|---|
| Primary Care | Specialty Care |
| ☐ Follows the principles of the Patient Centered Medical Home<br>☐ Manages the medical problem to the extent of the PCP's scope of practice, abilities and skills<br>☐ Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence based guidelines.<br>☐ Reviews and acts on care plan developed by specialist. ♦ Resumes care of patient when patient returns from specialist care. ♦ Explains and clarifies results of consultation, as needed, with the patient. Makes agreement with patient on long-term treatment plan and follow-up. | ☐ Reviews information sent by PCP<br>☐ Addresses referring provider and patient concerns.<br>☐ Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization.<br>☐ Confers with PCP before refers to secondary/tertiary specialists for problems within the PCP scope of care and uses a preferred list to refer when problems are outside PCP scope of care. Obtains proper prior authorization when needed.<br>☐ Sends timely reports to PCP to include a care plan, follow-up and results of diagnostic studies or therapeutic interventions.<br>☐ Notifies the PCP office or designated personnel of major interventions, emergency care or hospitalizations.<br>☐ Prescribes pharmaceutical therapy in line with insurance formulary with preference to generics when available and if appropriate to patient needs.<br>☐ Provides useful and necessary education/ guidelines/protocols to PCP, as needed |

## Patient Communication

| Mutual Agreement |
|---|
| • Engage and utilize a secure electronic communications platform<br>• Prepare the patient for transition of care.<br>• Consider patient/family choices in care management, diagnostic testing and treatment plan.<br>• Provide to and obtain informed consent from patient according to community standards. Explores patient issues on quality of life in regards to their specific medical condition and shares this information with the care team |

| Expectations | |
|---|---|
| Primary Care | Specialty Care |
| ☐ Explains specialist results and treatment plan to patient, as necessary.<br>☐ Engages patient in MH concept and identifies whom the patient wishes to be included in their care team. | ☐ Informs patient of diagnosis, prognosis and follow-up recommendations.<br>☐ Provides educational material and resources to patient.<br>☐ Recommends appropriate follow-up with PCP.<br>☐ Will be accountable to address patient phone calls/concerns regarding their |

*Adopted from the Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation.*