Our Patient-Centered Medical Home – a Process, not a Click

Richard Johnston, M.D.
President,
Medical Clinic of North Texas, P.A.
Medical Clinic of North Texas, P.A.
MCNT

- Physician Owned Primary Care Medical Group Practice since 1995
- Electronic health records (NextGen) since 2000
- Strong Group Culture
- 140 providers taking active part in various decision making committees formed around 5 Pillars: Quality, Growth, People, Service & Financial Strength
- Multiple Specialties:
  - Internal Medicine/Pediatrics
  - Pediatrics
  - Podiatry
  - OB/Gyn
  - Neurology
  - Rheumatology
  - Endocrinology
  - Family Practice
  - Family Practice/Sports Medicine
  - Infectious Disease
  - Internal Medicine
  - Internal/Geriatric Medicine
MCNT (continued)

44 Clinics in 5 counties in the Dallas-Fort Worth Metroplex
First Medical Home Pilot in Texas

- First to approach us with a Medical Home initiative was CIGNA (Contract for an Enhanced Coordination Pilot effective September 1st, 2009).
- Next was BCBC of Texas. The contract with them created a Multipayer Medical Home Pilot.
- Along with managing the contracts we began application for Patient-Centered Medical Home recognition with the National Committee for Quality Assurance NCQA. This recognition enables us to demonstrate how Patient-Centered Medical Home standards are being met in each clinic.
Steps in Building the Medical Home

- Extensive education on the aspects of the Medical Home & NCQA Standards
- Formation of physician Medical Home Subcommittee
- Best Practices in Adult Medicine, OBGYN, PEDS. Each one of the committees reviews the Medical Home data quarterly.
- Medical Home Preparedness Assessments
- Negotiations with different payors
- Active participation in various Medical Home initiatives and forums like PCPCC and TMHI (Texas Medical Home Initiative)
- Implementation of Cost and Evidence Based Standards & Measuring all Providers on multiple levels
Steps in Building the Medical Home, cont.

• Complete transparency of provider performance data disclosure
• Participation in BCBS’ Performance Based Rewards System
• NCQA Diabetes Physician Recognition
• Project management
• IT research and development
• Making the Medical Home a crucial part of the Group’s long term strategy
  – For a second year in a row the topic of Medical Home will be a part of the Annual Physicians Retreat. This time it will be the center of discussion along with ACOs.
MCNT’s Current Use of HIT:
- Next Gen EHR/EPM
- Data Analysis
- Chronic Disease Protocol Engines
- Integrated Lab Information System
- Automated Clinical Recalls
- E-mail Portal – NextMD
- Community Health Solutions – CHS:

MCNT is partnering with HCA & Specialist Groups to create and implement a Health Portal with patient information accessible to the physicians directly from their EHR without the need to logon to a third external database.
Clinical Decision Support at the Point of Care

Patient Specific

Automated

Produced for every patient, at every visit, regardless of the reason for visit

Utilized by ALL providers NP, PA, MA, CDE, etc

<table>
<thead>
<tr>
<th>Active Diagnoses</th>
<th>Risk Factors</th>
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</thead>
<tbody>
<tr>
<td>CHD 10Yr Risk &gt; 20%</td>
<td>Pneumonia (Age &gt; 64 OR Risk Dx)</td>
</tr>
<tr>
<td>Goal not met: A1c &gt; 7.0%</td>
<td>Goal not met: LDL &gt;70</td>
</tr>
<tr>
<td>Goal met: BMI &lt;= 30</td>
<td>Goal Met: MicroAlbunin/Creat Ratio &lt;= 30</td>
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<tr>
<td>Goal met: BP &lt;130/80</td>
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<table>
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<tr>
<th>Active Meds</th>
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<tbody>
<tr>
<td>HUMALOG</td>
<td>100 U/ML</td>
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<tr>
<td>HUMALOG MIX 75-25</td>
<td>75-25 U/ML</td>
</tr>
<tr>
<td>LISINOPRIL</td>
<td>5 MG</td>
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<tr>
<td>SIMVASTATIN</td>
<td>80 MG</td>
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<tr>
<td>ASPRIN</td>
<td>81MG * 1T PO QD</td>
</tr>
<tr>
<td>ACCU-CHEK AVIVA</td>
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<tr>
<td>ASCENSION CONTOUR</td>
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<tr>
<td>CHLORAL</td>
<td>20 MG UAD</td>
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<tr>
<td>INSULIN PEN NEEDLE</td>
<td>25GX1/2</td>
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<tr>
<td>VITAMIN D</td>
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<td>Trig</td>
<td>125</td>
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<tr>
<td>Chol</td>
<td>153</td>
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<tr>
<td>LDL</td>
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<tr>
<td>HDL</td>
<td>36</td>
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<tr>
<td>Gluc, Fasting</td>
<td>213</td>
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<tr>
<td>Gluc, Random</td>
<td>213</td>
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<tr>
<td>HbA1c</td>
<td>11.2</td>
</tr>
<tr>
<td>MicroAlb/Cr</td>
<td>14.6 mg/g creat</td>
</tr>
<tr>
<td>PSA</td>
<td>1.06/10</td>
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<table>
<thead>
<tr>
<th>Measures / Calculations</th>
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<tbody>
<tr>
<td>BP</td>
<td>100/60</td>
</tr>
<tr>
<td>CHD Risk</td>
<td>&gt;20%</td>
</tr>
<tr>
<td>BMI(Wt)</td>
<td>25 (204lb)</td>
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<tr>
<td>Ideal Wt</td>
<td>152-199</td>
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<tr>
<td>Est. CrCl</td>
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<table>
<thead>
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<th>Diagnostic Testing</th>
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<tbody>
<tr>
<td>Colonoscopy</td>
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<table>
<thead>
<tr>
<th>Routine Visits: Next Visit:</th>
<th>Comp. Exam Visits: Next Visit:</th>
<th>Insurance:</th>
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<tbody>
<tr>
<td>Next Visit: Last Visit:</td>
<td>Next Visit: Last Visit:</td>
<td>Cigna Open Access Plus</td>
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<tr>
<td>--------------------------</td>
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<tr>
<td>02/15/2010</td>
<td>01/05/2010</td>
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<tr>
<th>Vaccine</th>
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<tr>
<td>Tetanus</td>
<td>6/01/06</td>
</tr>
<tr>
<td>Tdap</td>
<td>10/31/06</td>
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<tr>
<td>Pneumococal</td>
<td>10/18/07</td>
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*Unless contraindicated
Medical Home Building Blocks

- Access to seeing a PCP promptly to prevent admissions
- Daily lists, from the health plans, of patients currently in the hospital
- Care Coordinators working with the hospital case managers to insure safe discharge & follow up
- Additional self-management education and support for the chronically ill
- Patients seen by their PCP within 48 hours of discharge
- Medication reconciliation after discharge
- Proactive follow up and intervention by Care Coordinator to prevent ER visits, hospital readmissions and complications
- Support from the Payors
- Modification of the Physician Compensation Model
What are MCNT’s Physicians being asked to do in the Pilot?

- Use registries to proactively manage patients with chronic diseases
- Improve appointment access to reduce ER Visits
- Collaborate with the health plans and get access to their resources (such as condition and lifestyle management programs) and data to close some of the gaps in patient care
- Outreach to our communities and help our patients reconnect with them and use their resources
- Reduce re-admissions through timely discharge follow-ups
- Utilize the plans’ formularies as much as possible
- Attain NCQA recognition as a Patient-Centered Medical Home
The Patients in MCNT’s Medical Home

**Focus on High Risk Patients:**
- Uncontrolled Diabetics
- Patients with Asthma, CHF, CAD
- Hypertensive patients
- Patients who are in the hospital
- ER ‘Frequent Flyers’

**Benefits:**
- Get more holistic & coordinated (less fragmented) care
- Have easier access to care
- Able to build a relationship with their personal physician
- Enhanced communication including telephone calls and e-mails
- Have a care coordinator who will:
  - follow up with them
  - work closely with them and their families to educate them on prevention and management of their conditions.
- Receive the right care at the right time from the right provider
The Health Plans’ Contribution

Full-Time RN Care Coordinators
- Paid for upfront
- Supported by the Health Plans’ case managers, pharmacists, mental health and social workers

Data:
- ER Reports
- Daily Hospital Census
- Pharmacy Formulary
- Preventive and condition specific screening reports

Financial Incentives:
- Fee for service payment base
- Bonus for achieving quality performance metrics
- Transitioning payment system to include pay for value on the overall success of the program
Additional Medical Home Needs

- Additional Diabetes Education
- Pharmacy Medication Reconciliation
- Home Monitoring
- Coverage for Gaps in Care
- Psychosocial Health
- Fitness Coaching
- Alternative Medicine (acupuncture, chiropractics, massage)
- EHR - Connectivity to hospitals, specialists and support services