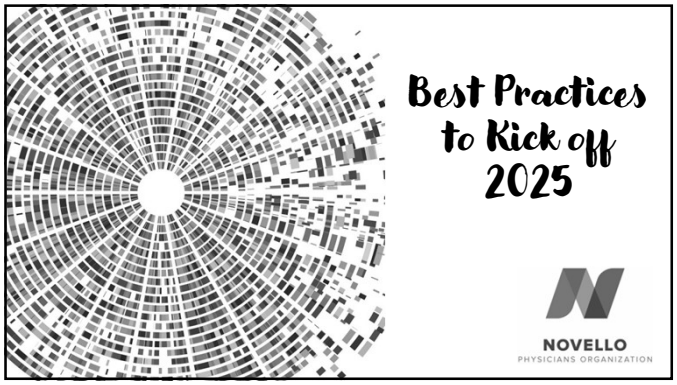

1

PCMH Annual Education

Description	Initiative	Last Date
PCMH		
Patient-Centered Medical Home Model	1.1	
Chronic Care Model	4.1	
Practice Transformation Concepts	4.1	
Unconscious Bias Clinical Staff (Every 2 Years)	5.13	
Unconscious Bias Non-Clinical Staff (Every 2 Years)	5.14	
Inclusive/Affirming Care for LGBTQ+ patients (Every 2 Years)	5.16	
Test Tracking Policy and Procedures	6.8	
Health Promotion and Disease Prevention (regular training through the year)	9.8	
Community Resources	10.4	
Self-Management Support Concepts	11.1/ 11.8	
Care Coordination Processes	13.7	
Specialist Pre-Consultation and Referral Process	14.8	

For Capability 5.17 is highly recommended that the practice reviews policies and procedures for LGBTQ+ patients and staff and updates/trains staff on any changes

★ *5.17 use to be part of 5.16*

Collaborative Care Model (CoCM) * Only NPO PCMH practices participating in CoCM Practice has an established suicide protocol.	2.4	

NOVELLO
PHYSICIANS ORGANIZATION

2

PCMH Annual Education & Materials

- **Multiple touch points on staff education is highly encouraged**
- **WHY:**
- Good for less staff
- Good for staff turnover
- Helps with staff moral
- Helps find process breakdown sooner than later
- **Practice Concern:** Documenting this training
- Stick to documenting one training for the required and or the practice annual training of call required capabilities
  - Add to your process, training also occurs throughout the year during huddles and or practice management walking around and having short conversations with appropriate staff. These are not documented due to administrative burden *(Practice could choose to simply write date and topic on Calander or not. IE Week of Jan 22nd, 2025- PCMH Conversation reminder during huddle)*

- **Materials/ NPO Help**
- PCMH Primer
- Pair with Monthly Staff education
  - End of PCMH Request- helpful?
  - Any other ways NPO can assist?

NOVELLO
PHYSICIANS ORGANIZATION

3

Keeping an Annual Agenda

- **One practice reports**: I keep a calendar to make sure reports are run throughout the year. I think the reports are a good indication of services and preventative care and help with the overall efforts to provide comprehensive care to our patient population while also taking into account the individual and specific needs and circumstance of each patient.

- Reports are one PCMH task to be completed each year
  - N/D report for PCMH conversation
  - Health Focus PCMH Reports to assist with Registry Reports
- Pat Sat Survey or Care Manager Survey
- PCMH Education
- Add other practice annual tasks

4

Annual Agenda Example

January	February	March	April	May	June
1. Run Numerator/ Denominator report of active patient population (18 months) 1.3-1.8 2. Run patients not seen in last 12 months and start outreach process 1.2 3. Educate staff over 1.1	1. Educate Staff over 4.1 and review Planned Visit/ Chart prep process 4.6 making sure up to date/ noting any changes	1. 2.1 Complete/ Work Diabetic Registry (PCMH Diabetes Report in Health Focus) and Educate staff on importance of diabetes care 9.8 to assist them in outreach	1. 5.13 clinical staff Unconscious Bias training (every two years Due 2023, Next 2025) 2. Complete/ Work Colonoscopy Registry list and Educate staff on importance of receiving colonoscopies 9.8 to assist them in outreach	1. 6.1 and 6.6. Train staff over test tracking process. Update written process with any changes. 2. Complete/Work Mammogram Registry List and Educate staff on importance of receiving colonoscopies 9.8 to assist them in outreach 3.) Complete/Work HTN Registry List	1. Updated STO process (as long as provider agree and no changes, Sign and date) 2. Complete/ Work Cervical CA Registry List and Educate staff on importance of receiving colonoscopies 9.8 to assist them in outreach 3. Run list of patients due for Medicare AWV and PE schedule for remainder of year if not already scheduled
July	**August**	**September**	**October**	**November**	**December**
	1. 10.4. Staff Community Resource Education 2. 2.1 Repeat Diabetic Registry work 3. Repeat Colonoscopy Registry List	1. Educate staff on specialist referral process 14.8 and make any appropriate changes to specialist referral written process 14.1 2. Repeat Mammogram registry list 3. Repeat Cervical CA Registry List	1. Educated staff on Care Coordination process and make any appropriate changes to the written document 13.7 (Not yet completed will work on in 2024) 2. Repeat HTN/ Registry list	Review Health Focus and practice can also ask NPO of areas of opportunity to focus on for end of year	Review Health Focus and practice can also ask NPO of areas of opportunity to focus on for end of year

Updated January 2024 Page 1 of 1

5

Health Focus Registry Reports

PCMH Capability	Health Focus Report Name
2.1 Diabetes Registry	PCMH Diabetes
2.10 Asthma Registry *New 2.30 COPD	PCMH Asthma and COPD
2.11 Coronary Artery Disease	PCMH Coronary Artery Disease
2.12 Congestive Heart Failure	PCMH Congestive Heart Failure
2.13 Registries Containing 2 other Conditions	PCMH Hypertension PCMH Hyperlipidemia PCMH Depression
2.14 Preventative Services Registry	PCMH Adult Preventative PCMH Well Child Care
2.16 Chronic Kidney Disease	PCMH Chronic Kidney Disease
2.17 Pediatric Obesity Registry	PCMH Pediatric Obesity
2.18 Pediatric ADD/ADHD	PCMH ADD and ADHD
2.19 * If Care Managers are assigned to patients in Health Focus the practice can choose to have them in the reports listed above	

Health Focus: Please contact NPO if you do not know how to use Health Focus for PCMH Registry Reports

6

Chlamydia Screening

- Many NPO practices struggle with this measure.
- One NPO practice and provider who does well with these screening's reports:
  - *The PCP Provider tells the patients and their parents that urine screening for chlamydia is required starting at age 16, regardless of sexual activity, and we collect the urine sample at their well child visit.*

NOVELLO
PHYSICIANS ORGANIZATION

7

Performance Reporting

NOVELLO
PHYSICIANS ORGANIZATION

- Who views this information and what is the process?
- Can the process be improved upon?
- Performance reporting can be added to the Annual Agenda
- **Most importantly! What happens with this information and how is it used?**
- Integrate into huddles
- Integrate into staff or team meetings
- Make specific goals
- Share with providers; especially provider specific reports

Health Focus: Please contact NPO if you do not know how to use Health Focus for Performance Reports

8

Post Discharge follow-up Calls

NOVELLO
PHYSICIANS ORGANIZATION

- **Why are these calls important?**
  - Helps lower non-emergent ED visits
  - Provide opportunity to educate on when to go to the ER vs Urgent Care
  - Provide opportunity to educate on after hours. Call us first!
  - Provide opportunity to increase Care Management case load and billing opportunities
  - Provide opportunity to educate patients in general and help them receive needed care
  - Set-up follow-up visit
  - Determine SDOH needs. Perhaps a need isn't being met that is causing frequents ED visits.

Health Focus: Please contact NPO if you do not know how to use Health Focus for ADT. Many practices are preferring Health Focus ADT.

9

Post Discharge follow-up Calls

- **Utilize NPO's Adult and Pediatric Phone Scripts**
  - PDCM and 1111F Billing Opportunities
  - Prompts for Timely Follow-up (ACO Reach Practices)
- **Introduction to Team Based Care for Medial Assistance or other unlicensed team members completing these phone calls (BCBSM PDCM)**
- Team Based Care Training Required
  - 1111F
  - 98966-98968 Phone Codes *(Would not bill if a TOC visit will be scheduled to completed the TOC process. However, these codes will close the Timely Follow-up measure.)*
  - 99487-99489 Care Coordination Codes
- **Can also be utilized for Medicare and CCM Billing**
- Any staff time contributes to the CCM Billing
- Great for Medicare Patient's who are difficult to get in the office
- Utilize 99490 to close out timely follow-up measure
- Encourage follow-up once a week for 4 weeks to meet time requirements (See Slide 12)

10

Post Discharge follow-up Calls

- **Other Materials**
- Adult and Pediatric Medication Charts
- Tips for Medication Reconciliation and TCM
  - Do no wait until all components of TCM are completed before submitting 1111F
  - *Highly recommended* MICMTS: Optimizing Medication Reconciliation: Role of the Care Team Member: https://micmt-cares.org/events?type%5B7571%5D=7571
- Tips Timely Follow-up ACO Reach Measure *NPO has room for improvement*

11

Post Discharge follow-up Calls

- **Follow-up with patients for 4 weeks** Especially those patients who may not come in to see the DR. (Knee, shoulder, hip, hand surgery etc.)
  - **Benefit to Patient:**
    - Depression after surgery is a risk with these types of surgeries
    - Helps improve patient outcomes and lower rates or readmissions
  - **Great for increasing PDCM billing encounters by the MA or RN/ Social Worker Care Manager**
  - Great for meeting CCM (20 min in month) and or PCM (30 min in month) Time requirements for billing 99490, utilizing any clinical staff deemed appropria**te**
    - **99490 will close the timely Follow-up measure**

12

Care Management: 4-week follow-up Continued.

- **What other area's can 4 week-follow- up be good for**
  - MAs can complete follow-up for 4 weeks by using phone codes for PDCM and any clinical staff deemed approraptie can complete follow-up calls for CCM time accumulation
    - **New Diagnosis (Diabetes, HTN, Depression, Anxiety, ADD/ADHD, CKD or other chronic disease)**
    - New Medication started (Diabetes Medication, Depression or Anxiety medication, ADHD medication etc.)
    - **NPO Care Management Templates**
      - Scripting for these calls

13

Care Management: Provider Engagement

- **Share Success stories**
- How often do you communicate with your Care Managers?
- **Ask for a success story each month**
- Send it out to the office and providers or share in staff huddle or staff meeting making sure its somewhere the providers can hear!
- **Can this work for other areas you want to increase provider engagement?**
- High performing practices have high provider engagement!
- ****Scheduled G9007 Case Reviews****

14

Care Management: Motivational Interviewing

- **Motivation Interviewing can greatly impact the success of Care Management**
- Many Care Managers report forgetting to utilize MI these reasons can be:
  - **Being busy**
  - Frustration with the Care Manager Relationship
  - **Focusing on the provider goal**
  - Getting comfortable in a Care Management patient relationship
- **Is there way the office can help them remember or encourage the use!?**
- Hang a flyer in the workstation, reminders in huddles or staff meetings

15

Advanced Care Planning

NOVELLO
PHYSICIANS ORGANIZATION

- **How is this occurring/ What is the process?**
- Focus on the Conversation rather than the paperwork
- **What is the Target Population: Start with one and move on to another**
- Goal: Make these conversations the norm! Consider with younger patients
- **Resources**
  - Care Manager Templates for working with Patients and Post Discharge Phone scripts contain S0257 prompts and prompts for younger patients.
  - Serious Illness Training ***Highly recommended*** :https://micmt-cares.org/training/pdcm/palliative-care

16

Patients Want Convenience

- Telehealth
- **Able to call during lunch**
- Expanded Hours
- **Portal Capability for refills, scheduling,**
- On-call provider availability
- **Low wait times or communication about wait times**
- Collaboration of Care
- **Good communication from their Providers and Health care staff**
- Any Other Ideas? What do you like as a patient?
- **CoCM**

NOVELLO
PHYSICIANS ORGANIZATION

17

Health Focus–Is the practice Utilizing

NOVELLO
PHYSICIANS ORGANIZATION

- **Can Help with but not limited to:**
  - Registry Reports
  - **Performance Reporting**
  - ADT
  - **Care Management**
  - Planned Visit/ Point of Care Form
  - **Assessing Risk**
  - Persistency

Please contact NPO if your practice needs a review of any of these Health Focus abilities.

18

All processes/ practices discussed in this PowerPoint can help reduce cost of care which benefits community, patients, and physicians in risk contracts such as ACO Reach and BCBSM Blueprint

NOVELLO
PHYSICIANS ORGANIZATION

19

If the practice has any questions or needs assistance about implementing any of the best practices discussed in this PowerPoint please reach out to Rachael Smart rsmart@npoinc.org, Kris Elliott kelliott@npoinc.org, or Kelsey Baker smusser@npoinc.org

NOVELLO
PHYSICIANS ORGANIZATION

20