Implementing Successful Patient Centered Medical Homes through Transforming and Optimizing Team Members’ Roles

University of Michigan & UNITE Health Center
Session Learning Objectives

- Understand staffing models and roles for team members in the Patient Centered Medical Home.
- Enhance the skills & broaden the scope of team members’ through curriculum development, collaborative practice agreements training, protocols, templates, & competencies.
- Describe how team members partner with providers to improve clinical management, provide self management support, goal setting and transition care.
- Identify barriers to expanding roles for medical assistants and other team members.
- Assess the effects of redesign through quality and satisfaction measures.
University of Michigan

• Background/Staffing Models and Team Roles
  Connie J. Standiford, MD
  Clinical Associate Professor of Internal Medicine
  Associate Medical Director, Ambulatory Care Services

• Expanding Team Member Roles
  Hae Mi Choe, PharmD, CDE
  Clinical Associate Professor of Pharmacy
  Director, Ambulatory Care Pharmacy Services

• Using Information Technology to Improve Care
  Steven J. Bernstein, MD, MPH
  Professor of Internal Medicine
  Director, Quality Management Program
University of Michigan Health Center
University of Michigan - health clinic
Michigan Medical Home

- Includes primary care physicians from:
  - Family Medicine
  - General Medicine
    - 9 General Internal Medicine Practices
    - 40 Clinical FTE Faculty (59 total faculty)
    - 120 Internal Medicine Residents
  - Medicine-Pediatrics
  - General Pediatrics

- 20 UMHS Primary Care clinics received Patient Center Medical Home (PCMH) designation from Blue Cross Blue Shield of Michigan in July 2009
General Medicine Productivity

![Bar chart showing General Medicine Productivity with years FY06, FY07, FY08, and FY09. The chart compares RVU/FTE, Visits/FTE, MGMA RVU/FTE Benchmark (75th percentile), and Clinical FTEs.]

RVU = relative value unit        FTE = Full time equivalent        MGMA = Medical Group Management Association
Benchmarks

Staffing:

- Total support staff / MD FTE = 3.45
- Clerical staff / FTE = 1.85
- MA / LPN / FTE = 1.2
- RN / FTE = 0.36 (+ 0.4 for coverage)

Expense: (avg. salary without benefits)

- Medical Assistant $25,000
- Office Assistant $28,000
- Dietician $52,000
- Social Worker (BS) $41,000
- Social Worker (MSW) $54,000
- LPN $40,000
- RN $70,000
- PA / NP $93,000
- PharmD $104,000
## Paying for Additional Team Members

- **Pay for Participation:** BCBSM payment for PCMH implementation and other initiatives
- **E&M Uplift:** BCBSM PCMH designated sites received an additional 10% E&M payment for BCBS patients
- **T-Code Billing:** BCBSM and Blue Care Network payment for “face-to-face” and phone encounters by licensed staff

<table>
<thead>
<tr>
<th></th>
<th>Period</th>
<th>Funds to Clinics</th>
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</thead>
<tbody>
<tr>
<td>Pay for participation</td>
<td>FY 2009</td>
<td>$610,000*</td>
</tr>
<tr>
<td>E&amp;M Uplift</td>
<td>7/09 – 12/09</td>
<td>$407,000</td>
</tr>
<tr>
<td>T-Code Billing</td>
<td>7/09 – 12/09</td>
<td>$130,000</td>
</tr>
</tbody>
</table>

* An additional $610,000 of these funds were allocated to the Quality Management Program
Chronic Care Model (CCM)

Health System
- Health Care Organization
  - Clinical Information Systems
  - Decision Support
  - Delivery System Design
  - Self-Management Support

Informed, Activated Patient
- Improved Outcomes
- Productive Interactions
- Prepared, Proactive Practice Team

E. Wagner, MD Group Health Cooperative Supported by the RWJF
Clinical Information Systems

What to focus on?

- Registries
  - Asthma (14,500 patients)
  - Diabetes (9,500 patients)
  - Coronary Artery Disease (6,000 patients)
  - Congestive Heart Failure (4,400 patients)
  - Chronic Controlled Substances (2,200)
  - Chronic Obstructive Pulmonary Disease
  - Chronic Kidney Disease
  - Multiple Chronic Diseases/Meds/High Utilization

- Preventive Care

- Transition Care
  - Hospital Discharges
Delivery System Redesign

• Define and expand roles
  - Medical Assistants
  - Outpatient Office Assistants
  - Panel Manager
  - Social Worker
  - Nurses
  - Dietician
  - Pharmacists
  - NP / PA

• Redesign the work appropriate to level of training/professionalism of the team member
Registered Nurses (RN)
- Take “live” symptomatic calls and provide triage/advice
- Follow up on complicated test results
- Call patients 1-2 days after discharge (Transition Care)
- Provide patient education and counseling

Licensed Practical Nurses (LPN)
- Renew prescriptions based on delegation protocol
- Follow up on abnormal, but non-complicated test results
- Provide nurse follow up visits (e.g., BP follow up)
Transition Care Pilot

• Implement nurse telephone outreach to reconnect patients to their medical home after hospital discharge

• Assess Patient/Caregiver Understanding/Needs
  - Current medications
  - Home care services
  - Follow up appointments are scheduled
Transition Care Process (1)

- **Date of Hospital Discharge:**
  - PCP:

- **Discharge Diagnosis:**
  - Treatment Plan/Goals: See Discharge Summary ("Improving medication, follow up care and visit adherence")
  - Assess patient status
  - Assess caregiver status (Social Support)

- **Medications:**
  - Per Discharge Note:
    - New medications prescribed at hospital discharge
    - Medications changed or discontinued at hospital discharge
    - Medication(s) reviewed with patient or caregiver and PSL updated to reflect current medications
  - Patient / caregiver able to identify all medications: name, dose, frequency what time to take and the reason for taking
  - Barriers related to medications: financial, complexity, etc
    - If yes, describe:______________________________
    - Yes ☐ No ☐
    - Yes ☐ No ☐
    - Yes ☐ No ☐
**Transition Care Process (2)**

- **Medications (continued)**
  - Yes  No
  - Patient is experiencing side effects from medications
  - If yes, describe: __________________________

- **Home Care Service:**
  - Needed equipment in home is present
  - If yes, patient has following equipment in home (specify):____
  - If no, patient needs:
    - Walker
    - Bedside Commode
    - Other
    - Wheelchair
    - Oxygen
  - Visiting Nurse/PT/OT/SW/RT ordered at hospital discharge
  - If yes, did home care services contact the patient?

- **Follow-up**
  - Post-discharge labs and/or tests completed
  - Follow-up appointment scheduled with PCP within 5 - 7 days following discharge or sooner per discharge instructions

- **Other Barriers / Concerns**
  - If yes, describe:_________________________
Add New Team Members: Social Worker

- Provide counseling and psychosocial spiritual assessment of adjustment issues, support systems, coping and needs

- Facilitate appropriate patient referrals for:
  - chronic substance use
  - chronic mental health services
  - UMHS complex care management
  - other appropriate community resources
Debbie,

As I have said many times before, the inclusion of an experienced clinical social worker into the fabric of the Briarwood Clinic is an outstanding model and it should be used everywhere. It is hard to imagine what my life might have been like without your crystal clear insights these past 2 years.

Thanks again, and -- again -- Happy Social Worker Month.

Jim
Redesign Team Members’ Roles

• Outpatient Office Assistant or Medical Assistant: “Panel Manager/Chronic Care Coordinator”
  - Call patients who need follow up appointments/testing
  - Order lab testing prior to planned visits per protocols
  - Act on prompts on point of care reminders
  - Update medical record with pertinent information obtained from patient e.g., date of last eye exam, immunizations
Combined Actionable Report: a point-of-care reminder

<table>
<thead>
<tr>
<th>Date</th>
<th>A1c</th>
<th>Chol</th>
<th>Trig</th>
<th>HDL</th>
<th>LDL-C</th>
<th>UMA</th>
<th>Drug Test</th>
<th>EGF</th>
<th>B-E-GFR</th>
<th>Ha</th>
<th>K</th>
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<tbody>
<tr>
<td>03/01/10</td>
<td>5.7</td>
<td>128</td>
<td>59</td>
<td>54</td>
<td>3</td>
<td>85</td>
<td>103</td>
<td>143</td>
<td>3.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/01/09</td>
<td>5.9</td>
<td>152</td>
<td>50</td>
<td>69</td>
<td>5</td>
<td>57</td>
<td>117</td>
<td>142</td>
<td>4.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/27/09</td>
<td>5.6</td>
<td>130</td>
<td>48</td>
<td>52</td>
<td></td>
<td>66</td>
<td>104</td>
<td>141</td>
<td>3.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/16/09</td>
<td>5.9</td>
<td>130</td>
<td></td>
<td></td>
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<td>66</td>
<td>104</td>
<td>141</td>
<td>3.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/26/09</td>
<td>5.1</td>
<td>167</td>
<td>45</td>
<td>120</td>
<td>7</td>
<td>97</td>
<td>118</td>
<td>143</td>
<td>4.4</td>
<td></td>
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<tr>
<td>11/03/09</td>
<td>6.0</td>
<td>131</td>
<td>45</td>
<td>70</td>
<td>69</td>
<td>97</td>
<td>118</td>
<td>141</td>
<td>4.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09/26/09</td>
<td>6.3</td>
<td>275</td>
<td>51</td>
<td>158</td>
<td>97</td>
<td>97</td>
<td>118</td>
<td>141</td>
<td>4.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Labs: □ A1c □ LDL-C □ Urine Microalbumin □ Urine Drug Screen (comprehensive)

Exams/Tests: □ Diabetic foot exam □ Diabetic eye exam □ Assess ejection fraction □ Pulmonary Function Test/Spirometry

Medications: □ Anti-platelet □ ACEI/ARB □ Beta-blocker □ Short-acting beta-agonist □ Statin

Education: □ Asthma action plan □ Asthma education □ DM pre-conception education □ Self-management goal □ Controlled substance agreement □ MAPS assessment

Recommended Action Items: □ Preventive Health □ Mammography □ Colon cancer screening □ Thin Prep pap □ DEXA scan □ AAA screen

Immunizations: □ Influenza vaccine □ H1N1 influenza vaccine □ Pneumovax □ Zostavax

Discuss/Referral: □ Smoking cessation □ Discussion or referral AICD □ MI Visiting Nurse (asthma) □ Dietician / Nutrition Counseling

*This report is not intended to replace the medical record. The patient's PCP is assigned based on an algorithm and so may be different from the one listed in the medical records. Items that are gray are on-hold at the present time.
# Preventive Services

<table>
<thead>
<tr>
<th></th>
<th>Briarwood</th>
<th>Brighton</th>
<th>Canton GM</th>
<th>Chelsea</th>
<th>EAA GM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammograms, elig.</td>
<td>2,495</td>
<td>2,096</td>
<td>1,739</td>
<td>775</td>
<td>1,492</td>
</tr>
<tr>
<td>Mammograms, received</td>
<td>2,012</td>
<td>1,477</td>
<td>1,379</td>
<td>590</td>
<td>1,134</td>
</tr>
<tr>
<td><strong>Mammography Rate</strong></td>
<td><strong>80.64%</strong></td>
<td><strong>70.47%</strong></td>
<td><strong>79.30%</strong></td>
<td><strong>76.13%</strong></td>
<td><strong>76.01%</strong></td>
</tr>
<tr>
<td>PAP Smears, eligible</td>
<td>5,134</td>
<td>4,131</td>
<td>3,082</td>
<td>824</td>
<td>3,133</td>
</tr>
<tr>
<td>PAP Smears, received</td>
<td>3,994</td>
<td>2,875</td>
<td>2,191</td>
<td>568</td>
<td>2,279</td>
</tr>
<tr>
<td><strong>Pap Rate</strong></td>
<td><strong>77.80%</strong></td>
<td><strong>69.60%</strong></td>
<td><strong>71.09%</strong></td>
<td><strong>68.93%</strong></td>
<td><strong>72.74%</strong></td>
</tr>
<tr>
<td>Colon Cancer Screening, elig.</td>
<td>4,997</td>
<td>4,455</td>
<td>3,939</td>
<td>1,491</td>
<td>3,082</td>
</tr>
<tr>
<td>Colon Cancer Screening, rec'd</td>
<td>3,234</td>
<td>2,543</td>
<td>2,878</td>
<td>1,070</td>
<td>1,764</td>
</tr>
<tr>
<td><strong>Colon Cancer Screen Rate</strong></td>
<td><strong>64.72%</strong></td>
<td><strong>57.08%</strong></td>
<td><strong>73.06%</strong></td>
<td><strong>71.76%</strong></td>
<td><strong>57.24%</strong></td>
</tr>
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</table>
Add New Team Members: 

Clinical Pharmacist

- Evaluate and optimize therapeutic regimen
- Provide medication management to achieve treatment goals
- Assess and address barriers to medication adherence due to cost, complexity of regimen, or side effects
- Self management goal setting and motivational interviewing
# Clinical Doctors of Pharmacy

<table>
<thead>
<tr>
<th>Leslie Shimp, Pharm.D.</th>
<th>Trisha Wells, Pharm.D.</th>
</tr>
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<tbody>
<tr>
<td><strong>Faculty Appointment:</strong></td>
<td>Professor&lt;br&gt;College of Pharmacy</td>
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<tr>
<td><strong>Additional Title:</strong></td>
<td>Clinical Pharmacist, Briarwood Medical Group</td>
</tr>
<tr>
<td><strong>Education and Credentialing:</strong></td>
<td>PharmD, 1976</td>
</tr>
<tr>
<td><strong>Clinical Interests:</strong></td>
<td>drug therapy assessment, motivational interviewing, medication cost savings, herbs and dietary supplements</td>
</tr>
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</table>
Provide education and self-management support

Patient ABC sheet

### Diabetes care: The ABCs to better health

<table>
<thead>
<tr>
<th>Test</th>
<th>How often</th>
<th>Ideal level</th>
<th>Your result</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1c measures blood sugar control</td>
<td>Every 3-6 months</td>
<td>less than 7%</td>
<td>8</td>
</tr>
<tr>
<td>Blood pressure control</td>
<td>Every visit</td>
<td>less than 135/60</td>
<td></td>
</tr>
<tr>
<td>Cholesterol (LDL) level</td>
<td>Every year</td>
<td>less than 100 mg/dL</td>
<td></td>
</tr>
<tr>
<td>Diabetes kidney microalbumin test</td>
<td>Every year</td>
<td>less than 30 mg/dL</td>
<td></td>
</tr>
</tbody>
</table>

#### Eye exam

- If your last eye exam was abnormal: Every year
- If your last eye exam was normal: Every 2 years
- Detecting early eye damage may prevent blindness

### Goals for self-management

- **My goal:**
  - Helps you better control your diabetes

### Home glucose testing

- Ask your doctor if this is right for you

### Immunizations and Heart Medications

- **Influenza (Flu vaccine):** Every year
- **Pneumonia (Pneumovax):** At least once
- **Statins and Aspirin - reduce heart attacks:** Daily if needed

### Just ask for a referral to

- **Diabetes Education Classes**
- **Nutrition Counseling**
- **Weight Management Programs**
- **Smoking Cessation Programs**

Prepared by the University of Michigan Diabetes Quality Improvement Committee. © The Regents of the University of Michigan – March 2007
## Diabetes Registry Feedback

**Physician report by patient**

### High Priority Patients (five or more opportunities exist or A1C >= 9%, LDLC >= 130 mg/dL or blood pressure >= 150/90)

<table>
<thead>
<tr>
<th>CPI</th>
<th>Name</th>
<th>Age</th>
<th>Prior 12-18 Mos</th>
<th>Prior 6-12 Mos</th>
<th>Prior 6 Mos</th>
<th>On Insulin</th>
<th>LDLC Date/Result</th>
<th>Statin</th>
<th>BP</th>
<th>Proteinuria Date/Result</th>
<th>ACE or ARB</th>
<th>Foot Exam</th>
<th>Eye Exam</th>
<th>Self Mgt Goal</th>
<th>Next Visit</th>
<th>Care Providers</th>
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</thead>
<tbody>
<tr>
<td>45</td>
<td></td>
<td>63</td>
<td>8.5</td>
<td>6.3</td>
<td>6.3</td>
<td>07/06</td>
<td>137</td>
<td>Y</td>
<td>145/85</td>
<td>01/05</td>
<td>Y</td>
<td>02/06</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td></td>
<td></td>
<td>14.0</td>
<td>14.0</td>
<td>14.0</td>
<td></td>
<td></td>
<td>Y</td>
<td>130/90</td>
<td>03/05</td>
<td>Y</td>
<td>07/05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td></td>
<td></td>
<td>8.6</td>
<td>9.7</td>
<td>9.4</td>
<td>09/05</td>
<td>135</td>
<td>A</td>
<td>140/80</td>
<td>11/05</td>
<td>Y</td>
<td>03/06</td>
<td></td>
<td></td>
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</table>

### Moderate Priority Patients (two to four opportunities)

<table>
<thead>
<tr>
<th>CPI</th>
<th>Name</th>
<th>Age</th>
<th>Prior 12-18 Mos</th>
<th>Prior 6-12 Mos</th>
<th>Prior 6 Mos</th>
<th>On Insulin</th>
<th>LDLC Date/Result</th>
<th>Statin</th>
<th>BP</th>
<th>Proteinuria Date/Result</th>
<th>ACE or ARB</th>
<th>Foot Exam</th>
<th>Eye Exam</th>
<th>Self Mgt Goal</th>
<th>Next Visit</th>
<th>Care Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td></td>
<td>45</td>
<td>7.1</td>
<td>7.6</td>
<td>6.4</td>
<td>02/06</td>
<td>114</td>
<td>Y</td>
<td>124/84</td>
<td>02/06</td>
<td>neg</td>
<td>02/06</td>
<td>03/06</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>37</td>
<td></td>
<td></td>
<td>9.8</td>
<td>7.7</td>
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<td>05/06</td>
<td>122</td>
<td>Y</td>
<td>122/74</td>
<td>05/06</td>
<td>neg</td>
<td>04/06</td>
<td>04/05</td>
<td></td>
<td>09/19/06</td>
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</tr>
<tr>
<td>26</td>
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</table>
### Exception Reporting

<table>
<thead>
<tr>
<th>Health Center Clinic</th>
<th>No ASA, Statin or LDL test</th>
<th>LDL &gt;100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briarwood Gen Med</td>
<td>109</td>
<td>187</td>
</tr>
<tr>
<td>Brighton Gen Med</td>
<td>124</td>
<td>227</td>
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<tr>
<td>Canton Gen Med</td>
<td>122</td>
<td>227</td>
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<tr>
<td>Chelsea Gen Med</td>
<td>58</td>
<td>92</td>
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<tr>
<td>E. Ann Arbor Gen Med</td>
<td>90</td>
<td>145</td>
</tr>
<tr>
<td>Livonia Gen Med</td>
<td>34</td>
<td>55</td>
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<tr>
<td>Saline Gen Med</td>
<td>34</td>
<td>50</td>
</tr>
<tr>
<td>Taubman GMF</td>
<td>89</td>
<td>127</td>
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<tr>
<td>W. Ann Arbor Gen Med</td>
<td>37</td>
<td>61</td>
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## Diabetes Registry Feedback

### Health system report by clinic

<table>
<thead>
<tr>
<th>N</th>
<th>A1c Test</th>
<th>A1c &lt;= 9%</th>
<th>A1c &lt;= 8%</th>
<th>A1c &lt;= 7% Limited</th>
<th>LDLC Test</th>
<th>LDLC &lt; 100 mg/dL</th>
<th>On Statin</th>
<th>Monitor for Nephropathy</th>
<th>Urine Protein on ACE or ARB</th>
<th>Foot Exam</th>
<th>Eye Exam</th>
<th>BP &lt; 135/80</th>
<th>Self Mgt Goal</th>
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<tbody>
<tr>
<td><strong>Family Medicine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Briarwood</td>
<td>672</td>
<td>95</td>
<td>80</td>
<td>71</td>
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<td>86</td>
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<td>90</td>
<td>94</td>
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<td>83</td>
<td>55</td>
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<tr>
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<td>88</td>
<td>91</td>
<td>80</td>
<td>77</td>
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<td>Domino's Farms</td>
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<td>83</td>
<td>72</td>
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<td>86</td>
<td>54</td>
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<td>88</td>
<td>78</td>
<td>83</td>
<td>57</td>
</tr>
<tr>
<td>Ypsilanti</td>
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## Executive Summary: UMHS All Payor Diabetes Performance Measures; By Resident Clinic at Taubman GMO

Data Current through 7/1/2009

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<th>A1c ≤ 8%</th>
<th>A1c ≤ 7% Limited</th>
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<th>On Statin</th>
<th>Monitor for Nephropathy</th>
<th>Urine Protein &amp; on an ACE/ARB</th>
<th>Foot Exam</th>
<th>Eye Exam</th>
<th>B.P. &lt; 135/80</th>
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| FGP           | 9,959 | 95 | 82 | 69 | 40 | 82 | 55 | 92 | 90 | 89 | 74 | 74 | 60 | 33 |
UMHS Diabetes Performance

- A1C Test
- A1C ≤ 9%
- A1C ≤ 8%
- LDL-C Test
- LDLC < 100mg/dL
- On Statin
- Foot Exam
- Eye Exam
- BP < 135/80
- Self Mgmt. Goal

Comparison:
- June 2004
- June 2009
Rating of UMHS Ambulatory Care Service

Mean Score Index (range 0 – 100)

Target 90
UNITE Health Center

• UHC History
  Jonathan Arend, MD
  Clinical Assistant Professor, New York Medical College
  Primary Care Provider

• Transforming MA Roles
  Maria Pitaro, MD
  Associate Medical Director

• Obstacles and Lessons Learned
  Audrey Lum, RN, MPA
  Chief of Clinical Services
Freestanding Article 28 D&T Center

Est. 1914 by the ILGWU; now serves members of the UNITE HERE union, their families, and retirees

12 primary care providers, 40 specialists, > 50 support staff

Multilingual/cultural staff

54 exam rooms, physical therapy, radiology, pharmacy, lab services

EMR
UNITE Health Center

- 10,000 active patients
- 1,100 DM
- 85% < 200% FPL
- 60% Spanish-speaking, 66% women
- Union members insured through Health and Welfare Fund; capitation for majority of union members
Early Improvements

• Redesign, Advanced Access

• NYC DOHMH Diabetes and Depression Collaborative and Spread Initiative

• Special Care Center (SCC)
  - SCC Team
    - 3 provider/MA teamlets
    - Clinical Coordinator
    - 2 health coaches (MA’s)
    - Referral coordinator
    - Nutritionist, SW, IT
Medical Home

• Spread of SCC best practices center-wide
  ➢ Primary Care Teams – PCP/MA pairs, health coaches, floor coordinators, referral coordinators, pharmacist, social worker, greeters
  ➢ Specialty Care

• NCQA – Level 3 PCMH
Outcomes: 2009

Exhibit 1: ABCs for Panel of Diabetics 2005-09*

*Difference between 2009 - 2005 for all 4 outcomes significant at p<.05 based on exact McNemar test of homogeneity (Source: UNITE Health Center Diabetic Registry).

Panel: N=510
Outcomes: 2009

A1c>9.0 All DM Patients vs Panel of DM Patients

All DM pts: N=1100; Panel: N=510
Transforming MA Roles

Maria Pitaro, MD
Associate Medical Director
UNITE Health Center
Transforming MA Roles

- Gradual process of change over several years
- For 12 PCPs we have 1 RN, 1 Clinical Coordinator
- Recruitment – all start as MA’s with MA school certificate
- All MA’s get the same training
- Multiple roles based on competency – work with PCP, health coach, floor coordinator
First Steps – DM Collaborative

• Basic curriculum for DM Education
• PCAs trained using patient education handouts, focusing on ABCs
• Results of most recent testing reviewed with patients while waiting for PCP
• Monofilament foot exams yearly
• Pneumovax and annual ophthalmology exams
Next Steps: SCC & Health Coaches

• Define gaps in current MA curriculum
• Determine which communication and clinical skills are needed
• Develop written curriculum and evaluation tools
• Train and evaluate the staff
Communication Skills

- Basic interviewing skills
- Principles and techniques of self management support including goal setting and assessment of readiness to change
- Motivational interviewing
Training in Communication Skills

- NYC DOHMH for self management support
- Outside consultants for basic interviewing and motivational interviewing
- Interactive sessions with follow-up based on patient cases
- Training was tailored to the skill level of medical assistants
Training in Communication Skills

- Nursing and nutritionist attended the trainings
- Nursing staff supervise the MA’s and the trainings
- Written curriculum that is used by our own staff for ongoing training
- Active involvement by clinical coordinator and NP in ongoing training and supervision
- Evaluation by observation
Self Management Support Training

- Eight 2 hour sessions
- Didactic portion, video clips, role playing
- Relationship building – reflective listening, empathy, non-verbal communication
- Stages of change
- Techniques of motivational interviewing
- Confidence scale
- Collaborative Goal Setting
Self Management Support Training

• Follow-up after each session to practice with a patient

• Report brought to next class
  ➢ Techniques tried from last week’s session
  ➢ Example of what went well
  ➢ Example of a challenging patient
  ➢ Questions for clarification

• Additional follow-up sessions in 2-3 months
MY SELF-MANAGEMENT GOAL

One way I want to improve my health is:

What I will do:

When I will start and when I will do it:

How often I will do it:

What might get in the way of my plan:

How I can overcome this barrier:

How confident I am that I can reach this goal (0-10):
Goal Follow-up:

Past Goal Follow-up:

FOLLOW UP BY:  
- Office Visit
- Phone

Total SM time spent with patient:  

ORDER

Completed By:
Self Management Evaluation

- Written Quiz after completing the sessions
- Health Coach competency evaluation
- Self management evaluation is included in the evaluation for each clinical topic
Clinical Skills for Chronic Disease Management

- Diabetes
- Hypertension
- Cholesterol
- Asthma
- Smoking Cessation
- Cancer Screening and Adult Immunizations
- Healthy Eating/Obesity/Weight Management
Curriculum and Templates

- For each topic, templates developed for EMR by PCP staff
- Templates refer to handouts that are given to patients
- PCAs are trained using the templates and the handouts
- Self management is included in each template
- Supervision by nursing and NP during the training period
Staff Evaluation

- Written test based on templates and curriculum
- Observation for effectiveness of communication skills, use of motivational interviewing skills and self management goal-setting techniques
- Skills assessment – monofilament testing
Health Coaches

• MA’s who demonstrate competency in all areas are promoted to health coaches

• Two health coaches on each Primary Care team

• See scheduled patients for visits and phone follow-up: BP checks, goal setting, chronic disease management, smoking cessation, blood sugar checks, follow up phone calls

• Some progress to floor coordinator
Health Coaches

• Integral team members
• Follow individual patients
• Close communication with PCPs and rest of team
• Review their scheduled patients with PCPs each day at huddle to update plan
• Lead patient support groups
• Floor Coordinator manages flow in the clinic
Obstacles and Lessons Learned

Audrey Lum, RN, MPA
Chief of Clinical Services
UNITE Health Center
PCP Buy-In

- PCPs must be willing to give up tasks and trust MA’s abilities
- Involve PCPs in template development and training sessions
- PCP observation of competency for monofilament exam
- Ongoing team interaction
MA Engagement

- Increased patient contact and clinical responsibility
- Outside consultants
- Nursing support
- Health coach meetings
Staff Recruitment

- MA training programs
- Internships
- Solid clinical skills
- Shared cultural and linguistic background
- “Emotional Intelligence”
Staff Retention

- Career ladder
- Ongoing training and evaluation
- Team support
QUESTIONS?