Report to the Legislature on the Washington Patient-Centered Medical Home Collaborative

January 2011

Washington State Department of Health

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DOH 345-281
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Contents

Executive Summary

This is the annual progress report on the Patient-Centered Medical Home Collaborative, as required in Second Substitute House Bill 2549 in 2008. In 2010, 32 primary care practices completed the first half of a two-year training program to adopt patient-centered medical home principles. This training method, the Washington State Collaborative, includes:

- Face-to-face exchanges of best practices.
- Monthly webinars.
- Practice coaching via site visits.
- Phone consultation.
- Monthly newsletters.
- Monthly reports from enrolled practices.

Training focuses on the eight essential elements of a medical home. Face-to-face training emphasized the themes of office teamwork, patient-centered care, and care coordination.

The evaluation process focused on four areas: provider and staff satisfaction, patient experience, the degree of implementation of a medical home, and clinical changes in patient care. After only one year, practices demonstrated significant clinical improvement in blood sugar, blood pressure, and cholesterol of diabetes patients. There was also marked improvement in the monitoring of kidney function.

2010 Progress Report

The Institute for Healthcare Improvement originated the collaborative method under the direction of Dr. Don Berwick. Dr. Berwick has a reputation for health system change using quality improvement techniques. He currently administers the Center for Medicare and Medicaid Services. Department of Health staff trained at the institute to bring these methods for changing systems of care into Washington's primary care offices.

Since 1999, more than 200 primary care practices across the state have enrolled in collaboratives sponsored by the department. The Washington State Collaborative, now in a seventh edition, teaches practices how to become a patient-centered medical home using continuous quality improvement. The previous six collaboratives focused on improving care for patients with specific chronic diseases like diabetes, asthma, or heart disease.

The intentional shift to train primary care providers to be a patient-centered medical home was directed by the legislature (Engrossed Second Substitute House Bill 2549 in 2008). With the loss of legislative funding, we looked for partners to carry out the intent of this legislation. The Washington Academy of Family Practice now provides funds and staff for the practice coaching element of the Washington Patient-Centered Medical Home Collaborative, and assists with the learning sessions.

Enrolled Teams
Thirty-three primary care practices began the Collaborative in September 2009. (See appendix A). One practice dropped out when the owner closed the practice. Another team, on observer status, may return when they're able to participate on a regular basis. Thirty-one practices actively participate.

Training Methods
Learning sessions, the primary method of teaching practices the principles of a medical home, brings practices together to share successful improvements. In 2010 two learning sessions, held March 29-30 and September 27-28, each hosted more than 250 participants. Practices receive $1,600 per learning session. Each team consists of at least three people. The stipend compensates in part for the lost revenue of the provider missing two days of work. (See Appendix B for the agenda of each learning session.)

Webinars
Each month practices participate in a webinar to supplement their learning. Agency staff members select the topic and enlist faculty presenters. An average of 20 practices participate in the hour-long sessions. (See Appendix C for the list of webinar topics.)

Coaching
Four coaches support the practices. The Washington Academy of Family Physicians and the department each coach half the practices. Practice coaches visit each site at least once between learning sessions. In addition, regular phone calls and e-mail develop strong working relationships.

Newsletter
A monthly newsletter informs practice teams about collaborative events, report or registration deadlines, and resources. Highlights from team reports make it easy to support new ideas participants may want to try. (See Appendix D for a sample newsletter.)

Website
We maintain a website for practices to register for and post presentations from learning sessions. The website includes a public site describing the collaborative and a site just for participants to support team learning. See www.doh.wa.gov/cfh/MH-Coll.

Evaluation Data

The comprehensive evaluation design for the collaborative includes four areas: Medical Home Index, provider and staff satisfaction, patient experience, and clinical outcomes. We collect data on a regular schedule and share this with the practices to assist with their progress. The evaluation data also drives quality improvement activities within the practices.

Medical Home Index
Each September, the practices assess their progress on implementing the concepts of a medical home. The Medical Home Index, designed by Children's Hospital at Dartmouth-Hitchcock Medical Center, asks the practice to determine the progress made in eight areas. As practices learn more about being medical homes, they understand with increasing depth the changes needed to be a medical home. The

Medical Home Index captures this progress. It also assists the team to identify areas needing improvement and define improvement objectives.

Provider and Staff Satisfaction
Each September, the providers and office staff take a satisfaction survey. Physicians are choosing to leave primary care because of job dissatisfaction for a number of reasons. Becoming a medical home can increase provider and staff satisfaction.[1] These surveys capture changes in provider and staff attitudes that increase job satisfaction.

Patient Experience
As a patient identifies one provider as their medical home, they often see improved care coordination through the larger medical system.[2] This reduces duplication of services. It also builds a trusting relationship that makes compliance with treatment more likely. It creates the security that the primary care provider knows the patient and their medical issues. The department attempts to capture patient satisfaction through two surveys. We conducted one in March 2010, and will conduct the other in July 2011. The March 2010 survey demonstrated strong ratings of providers by the patients. However, office efficiencies and coordination with specialists received lower scores. Patients also want providers to verify that patients understand provider instructions for self-care. (See Appendix E for patient experience survey results.)

Clinical Outcomes
Practices submit a narrative report each month that captures progress on practice improvements. Monthly reports on clinical outcomes for their patients with diabetes show changes in blood sugar, blood pressure, cholesterol, eye exams, foot exams, and kidney evaluation. After only one year, practices demonstrated significant clinical improvement in blood sugar, blood pressure, and cholesterol of diabetes patients. There was also marked improvement in the monitoring of kidney function. (See Appendix E.)

After 10 years of offering collaborative training to primary care, never have the outcomes improved this dramatically in such a short time. We see these results across the country when practices implement the concepts of a medical home.[3]

Practices report quarterly on a set of prevention measures for children, adults, and seniors. These measures are more difficult to report because electronic medical records do not routinely capture all of the data. If the practice lacks an electronic system to capture this data, the practice faces reporting challenges. The limited data reported here represents baseline data. (See Appendix E.)

Community Advisory Committee

Since 2006, a committee of organizations with a vested interest in strengthening primary care and improving the health care system has advised the department on the development and implementation of the Washington State Collaborative. This public-private partnership leverages funding, faculty

[1] Grumbach, Kevin, Bodeheimer, Thomas, Grundy, Paul The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies, August, 2009, Patient-Centered Primary Care Collaborative.
[2] Center for Studying Health System Change Policy Perspective: Insights into Health Policy Issues, No 1, December 2008 Making Medical Homes Work: Moving from Concept to Practice.
[3] 2010 Medical Home Performance Benchmarks. Healthcare Intelligence Network.

support, and connection to other medical home efforts in Washington and the nation. This advisory committee provides a direct link to provider practices for focus group testing and enrollment to spread practice changes into primary care. (See Appendix F.)

The advisory committee helps locate primary care practices ready to learn how to improve healthcare quality. The committee advised us to add coaching and outreach to smaller or rural practices. In early 2011 the committee will design the structure for the next collaborative to begin after September 2011. At this writing, we plan to bring learning sessions to rural areas of Washington. The goal is to reach smaller practices faster to spread the lessons learned from the Patient-Centered Medical Home Collaborative.

Moving From Pilot to Statewide Implementation

Adopting the principles of a medical home by providers depends on training, resources, and the practice's desire to make substantial workflow changes. This work challenges even well-functioning offices. The collaborative offers the training and provides modest resources to support the practice in this transition. The practice must bring the desire and apply what is learned to transform into a medical home. All sustainable change is hard work, especially when the current payment system for medical care lacks compensation for being a medical home.

We carefully screened collaborative practices for their readiness to participate in this two-year process to improve quality. All demonstrated experience with electronic medical records or a patient registry operating in the practice. This is not typical of the average primary care practice.

To implement statewide:

- The collaborative must attract more small rural practices.
- The collaborative must expand capacity to enroll more practices.
- The third-party payment system must compensate practices for essential functions of a medical home that are not currently billable. The most notable function, care coordination, is the key ingredient to prevent avoidable emergency room visits and hospitalization.

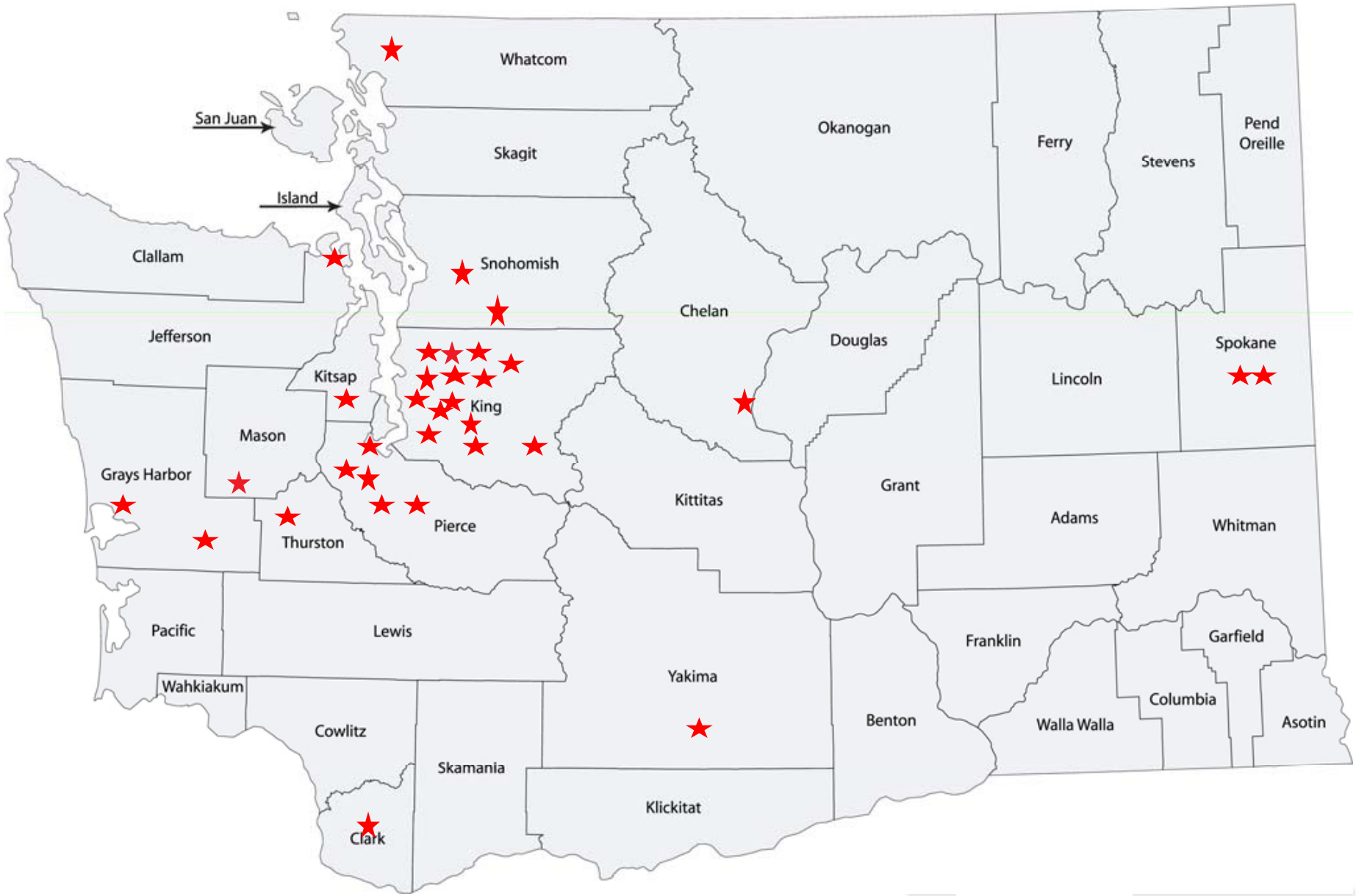
Washington multi-payer reimbursement pilot
The Health Care Authority and the Puget Sound Health Alliance co-sponsor the Multi-Payer Reimbursement Pilot, mandated by the legislature. This pilot trials two compensation plans for practices implementing a medical home. The department helped create the application criteria and process for this pilot. Designed to begin in the second quarter of 2011, 12 of 14 applicants for the pilot are collaborative practices. Third-party payers share the savings from reduced emergency room visits and reduced hospitalizations with participating practices. This three-year pilot paves the way for reimbursement reform that could be available to all primary care practices in Washington.

Next Steps
The department will support current practice teams to complete this two-year collaborative. A planning process to attract more small rural practices, and train more practices within a collaborative cycle, begins in December 2010. We continue to work closely with Health Care Authority and the

Puget Sound Health Alliance to implement the multi-payer reimbursement pilot. The collaborative supports the mission of the department to improve the health of all people living in Washington.

APPENDIX A

Washington Patient-Centered Medical Home Collaborative Teams



Washington
Patient-Centered Medical Home Collaborative

A joint project of the Washington State Department of Health and the Washington Academy of Family Physicians

EASTERN WASHINGTON

Chelan County
Columbia Valley Community Health Center, Wenatchee

Spokane County
Rockwood Cheney Clinic, Cheney
Rockwood Medical Lake Clinic, Medical Lake

Yakima County
Central Washington Community Health, Yakima

WESTERN WASHINGTON

Clark County
Family Medicine of Southwest Washington, Vancouver

Grays Harbor County
SeaMar Community Health Center, Aberdeen
Mark Reed Health Care Clinic, McCleary

Jefferson County
Olympic Primary Care, Port Townsend

King County
Covington Primary Care Valley Medical Center, Covington
Evergreen Clinic-Canyon Park, Bothell
Evergreen Clinic-Family Medicine of Redmond, Redmond
Harborview Adult Medicine, Seattle
Harborview Family Medicine, Seattle
HealthPoint, Auburn
International Community Health Services, Seattle
Lakeside Family Physicians, Issaquah
Overlake Medical Clinics: The Bellevue Clinic, Bellevue
Pacific Medical Center, Seattle
Swedish Community Health-Medical Home, Ballard
The Polyclinic, Seattle
U of W Physicians Network, Kent/DeMoines

Kitsap County
Port Orchard Medical Clinic, Port Orchard

Mason County
Olympic Physicians, PLLC, Shelton

Pierce County
Cornerstone Family Physicians, Lakewood
Gig Harbor Medical Clinic, Gig Harbor
Madigan Family Medicine Clinic, Lakewood
Mathew White, MD, Lakewood
Tacoma Family Medicine – MultiCare, Tacoma

Snohomish County
Providence Physician Group, Monroe
Edmonds Family Medicine-Puget Sound Family Physicians, Edmonds

Thurston County
Providence St. Peter Family Medicine, Olympia

Whatcom County
Lynden Family Medicine - Family Care Network, Lynden,

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AGENDA

Learning Session 2
Day One
Monday, March 29, 2010

TIME / ROOM	TOPIC / DESCRIPTION	PRESENTER
7:30-8:00 Blue	**Sign-in and Continental Breakfast**	
8:00 – 8:15 Blue	**Welcome to Learning Session 2**	Jan Norman, RD, CDE
8:15-9:00 Blue	**The Patient-Centered Medical Home** In this panel discussion, patients respond to questions about medical home and offer teams a patient's view of primary care. • Summarize patients' viewpoints of an ideal medical home. • Recognize patients' perceptions of barriers to accessing primary care services. • Describe attributes of a primary care office visit that patients identify as most consistent with excellent care. • Appreciate the patients' perspectives on how best to help them become active managers of their own health. • Describe the attributes of understandable, patient-centered health information.	Moderator: Berdi Safford, MD
9:00-9:45 Blue	**What's the big deal about teamwork? (We're already a great team.)** • Describe the new model for primary care teamwork. • Describe the characteristics of a high functioning team.	Berdi Safford, MD

TIME/ROOM	TOPIC/DESCRIPTION	PRESENTER
	• Discuss what physicians and other team members can learn to do differently. • Describe the challenges and benefits inherent to the high functioning team in a primary care office.	
9:45-10:00	**Break & Transition to Team Activity**	
10:00 – 11:30	**Team Activity** See ***Team Assignments*** for rooms	
11:30-12:15 Blue	**Lunch**	
12:15-1:15 Blue	**Health Literacy: Essential Element in the Patient Centered Medical Home** • Describe the scope of the health literacy problem. • Summarize the consequences in terms of patient outcomes and health care costs. • Describe strategies to accommodate low health literacy. • Demonstrate patient health literacy assessment skills using *The Newest Vital Sign.* • Discuss "Universal Precautions" as an alternative to assessment.	Darren Dewalt, MD, MPH .
1:15-1:30	**Transition time to Workshops**	
	Workshop A: Skills and Concepts	
1:30-2:30 Red	**A-1** *Repeats as D-1 on Tuesday afternoon* **Hardwiring Health Literacy: What your clinic can do to improve *and* earn the stipend** • Learn what it takes to "hardwire" health literacy practices into your clinic. • Describe the work required to earn a health literacy stipend for your clinic from the Aetna Foundation grant as part of your Collaborative work. • Describe specific ways to test and implement health literacy "universal precautions."	Pat Justis, MA *Suggest a minimum of one team member per clinic if the team wishes to be eligible for the health literacy stipend.*

TIME/ROOM	TOPIC/DESCRIPTION	PRESENTER
	A-2	
Blue	**Diabetes Self-Management that Works** • Describe the key elements of self-management support. • Integrate patient education and self-management support. • Draft a plan for how this will work in your practice. • Practice goal-setting.	Darren DeWalt, MD, MPH
	A-3	
Teal	**Managing Change: Survey Results and Techniques for Measuring Your Progress** • Introduce concepts and strategies for change management through self assessment. • Review the results of the Medical Home Index assessment tool and introduce the short version for use in practice. • Review the results of the provider and staff satisfaction surveys. • Review the method for the patient experience survey.	Mark Stephens, Consultant Staci Lewis, MPH, CHES
	A-4 (*Repeats as D-3 on Tuesday afternoon)*	
White	**The Expanded Roles for RNs, LPNs and MAs in Team-Directed Care** • Discuss the roles for nursing and medical assistants and clinicians in team-based care. • Discuss scope of practice. • Describe what it means to work to the "top of licensure." • Describe communication skills/tools needed between team members for effective team-based care.	Colette Rush,BSN, RN

TIME/ROOM	TOPIC/DESCRIPTION	PRESENTER
Orange	**A-5** (*Repeats as D-4 on Tuesday afternoon)* **Elderly With Complex Needs: Organized Approaches to Care.** • List attributes of care important to frail older adults. • Describe systems of care involving advanced directives, medications, access, and dementia.	Marty Levine, MD
Purple	**A-6** **Addressing Language Barriers** • Describe how to identify the communication needs and preferences of patients. • Discuss how to aid communication throughout all steps in the care process. • Develop effective systems for patient communication in the outpatient setting. • Describe best practices and examine case examples that illustrate how to address language barriers.	Martine Pierre-Louis, MPH Bria Chakosky-Lewy, RN
Green	**A-7** (*Repeats as D-6 on Tuesday afternoon)* **How to Make Your Electronic Medical Record (EMR) a Partner for Planned Care** • Describe how to get the right information to the right people at the right time. • Describe the role of the EMR in a planned care workflow, and how the patient flow and information flow connect and interact. • Discuss the important things to do in the set up of information flow so that things do not fall through the cracks. • Discuss useful strategies and how to respond to challenges in using the EMR effectively.	Jeff Hummel, MD, MPH
2:30-2:45	**Break-Snack & Transition to Workshops**	

APPENDIX B

TIME/ROOM	TOPIC/DESCRIPTION	PRESENTER
2:45-4:00	**Workshop B:**	
	Themed Discussions The leader of these sessions will facilitate a structured discussion on a theme or topic. Participants will have the opportunity to voice ideas, ask questions and describe their own experiences. Participants will join the instructor to impart knowledge and skills. Together we can wrestle with challenges and tough questions as we create a true learning community. These sessions will offer some answers, and they will also pose come challenging questions.	
	B-1	
Blue	**Same day appointments: the joys, the challenges, the dirty little secrets** A discussion on the basic principles, benefits and challenges of open or advanced access.	L. Gordon Moore, MD
	B-2	
Green	**Health Information Technology roundtable discussions** Discuss the challenges and solutions related to your electronic medical record and registry.	Jeff Hummel, MD, MPH
	B-3	
Orange	**Standardizing Your Approach to Primary Care Workload: An Essential Step To Create A Medical Home** A conversation about the importance of standardizing the clinical visit, from preparation to closing your notes and clearing your inbox. Discuss key principles in workload management.	Marty Levine, MD

TIME/ROOM	TOPIC/DESCRIPTION	PRESENTER
Purple	**B-4** **If it's Wednesday you must be my doctor: Continuity of relationship in residency clinics and community health centers** A discussion on how residency clinics and community health centers can create continuity of relationship and manage empanelment amidst the unique challenges of a teaching clinic or health center. Discuss how to communicate the importance of relationship to the entire clinic. Explore how to wrestle with who gets what days off and why there has to be limits on physician and team member schedule preferences.	Jim Davis, MD, MS *Residency clinics and Community health centers will find this session geared to their concerns. Others are welcome to attend if they have concerns about consistency of relationship and issues related to empanelment*.
Red	**B-5** **What's the big deal about teamwork? (We're already a great team.)** An interactive workshop transfers ideas from the plenary on teamwork into practice. You will discuss how the new model for primary care teamwork has impacted your own team. Characteristics of a high functioning team and your team's strengths and opportunities to improve will be explored. Learn from the experience of other teams as you identify common challenges and how to do things differently.	Berdi Safford, MD *Please note: your entire team needs to attend this session together. A minimum of three teams must attend to hold this session.*
Teal	**B-6** **Tools to engage and communicate medical home to patients** Learn about Port Orchard and Gig Harbor Medical Clinic's experience with medical home letters to their patient panel and the Polyclinic's Open House to educate patients about medical home. Participants will have the opportunity to ask questions of the presenters regarding the fears or myths that patients or families might have about medical home. See a variety of tools used to communicate the medical home concept to patients.	Linda Barnhart, MSN, RN Barbara Wall, JD with presentations from the PolyClinic , Gig Harbor Medical Clinic and Port Orchard Medical Clinic.

TIME/ROOM	TOPIC/DESCRIPTION	PRESENTER
	B-7	
White	**Does "non-compliance" have any place in patient-centered care?** Explore the patient's perspective of treatment compliance, and how the needs of the provider or team can influence their perception of patient behavior. Examine the definition of paternalism and examine how patient-centered care moves away from traditional paradigms of treatment relationships. Build empathy for choices that weigh quality of life versus quality of treatment, exploring how truly informed consent can work to build rapport and improve outcomes.	Pat Justis, MA
4:00	**Evaluation and Adjourn**	

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AGENDA

Learning Session 2
Day Two
Tuesday, March 30, 2010

TIME/ROOM	TOPIC	PRESENTER
7:30 – 8:00 Blue	**Sign-in and Continental Breakfast**	
8:00 – 8:30 Blue	**Welcome and Questions and Answers with Faculty and Staff**	Moderator Karla Graue Pratt
8:30-9:00 Blue	**A Discussion of the Primary Care Multi-Payer Reimbursement Model Pilot** Listen to Jan Norman's "live" interview with Richard Onizuka, a co-director of the State of Washington's Primary Care Multi-Payer Reimbursement Models Pilot. Take the opportunity to ask questions at the end of the interview. • Describe the multi-payer demonstration project. • Discuss the importance of changes to utilization and how those changes can align with patient-centered values. • Identify the timeline for the pilot.	Jan Norman, RD, CDE Richard Onizuka, PhD
9:00-9:45 Blue	**The Best of What is Known** • Describe the changes in practice that have led to desirable outcomes in patient-centered medical home and other closely aligned primary care transformations • Discuss the political and social context for change and how that may impact process improvement.	L. Gordon Moore, MD

TIME/ROOM	TOPIC	PRESENTER
	• Provide a synthesis of what is currently known about the impact of a patient-centered medical home. • Identify the "open questions" we are still exploring.	
9:45-10:00	**Break & Transition to Workshops**	
10:00-11:00	**Workshop C:** **Exemplary Practices** Interact with your colleagues as they share practical guidance associated with measurable improvement in their practices.	
	C1	
Green	**New Job Roles: Health Coaches, Population Management Assistants and More** Learn about several new job roles and how they respond to needs. Madigan's Population Assistant job role, Gig Harbor's Patient Navigator, Fall City's integration of behavioral health roles.	Madigan Family Medicine Clinic- Holly Kimball, RN Fall City Medical Clinic- Ken Wiscomb, PA-c , Dawn Finney, MSW and Andrew Heinz, MSW Gig Harbor Medical Clinic- Dr. Harrison
	C2	
Red	**Pre-Visit Work Flow and Tools** Rockwood Clinics will discuss pre-visit patient information card and pre-visit chart reviews. International Community Health Services will present a Huddle work flow sheet.	Rockwood Clinics- Sharon Gilmore, Health Coach International Community Health Services- Lisa Hansen
	C3	
Purple	**Advanced Access and Related Work Flows** Family Medicine of Southwest Washington will describe their advanced access scheduling system. University of Washington Physician's Network Kent-DeMoines clinic will discuss their scheduling strategies and work to improve continuity of care. HealthPoint will describe how they work with panel size limits for new patients and assure the needs of existing patients are met.	Family Medicine of Southwest Washington- Marilyn Darr, MD University of Washington Physician's Network Kent-DeMoines clinic Doreen Kiss, MD HealthPoint-Lillian Wu, MD

TIME/ROOM	TOPIC	PRESENTER
	C4	
Blue	**Patient Portals** Learn what successful patient web portals offer and the work it takes to create a portal. Swedish Community Health Medical Home and Mathew White, MD will talk about their experiences planning and implementing a patient web portal.	Swedish Community Health Medical Home- Carol Cordy, MD Mathew White, MD
White	**C5**	
	Group Visits Family Medicine of SW WA and Providence St. Peter Family Medicine will describe the group visits they each provide for patients with diabetes.	Family Medicine of South West Washington-Amber Whited, MD Providence St. Peter Family Medicine-Devin Sawyer, MD
	C6	
Yellow	**Lean Principles Showcase** Evergreen Clinic – Redmond will describe how the standardization of workspaces and exam rooms has reduced waste. Central Washington Community Health will discuss how lean principles were used for a clinic redesign.	Evergreen Clinic – Redmond- Robert Bayles, MD Central Washington Community Health- Leslie Myrick
	C7	
Teal	**Self-Management** Evergreen Clinic – Canyon Park and Fall City Medical Clinic will describe how they approach patient self-management.	Evergreen Clinic – Canyon Park- Amy Hoing, MD Fall City Medical Clinic- Patricia Yetneberk, DNP
11:00-11:15	**Transition to Plenary Session**	
11:15-12:00 Blue	**The Beauty of Failure** Listen to our faculty confess to their own “beautiful failures.” Discuss the role of failure in the learning process, describe how false pride interferes with the willingness to fail and describe the value of transparent failure for the team.	Moderated by: L. Gordon Moore, MD and Jim Davis, MD, MS Ed Wagner, MD, MPH Berdi Safford, MD Jeff Hummel, MD, MPH Marty Levine, MD

APPENDIX B

TIME/ROOM	TOPIC	PRESENTER
12:00-12:45	**Lunch**	
12:45-1:45	**Workshop D:** **Assorted Topics**	
	D-1 *Repeat of A-1 from Monday*	
Red	**Hardwiring** **Health Literacy: What your Clinic Can Do to Improve *and* Earn the Stipend**	Pat Justis, M.A.
	D-2	
Purple	**Weaving Prevention Seamlessly into Your Work Flow** • Discuss how complex it can be to orchestrate prevention in a busy clinical practice. • Describe how to make preventive care an integral part of the clinic work flow. • Discuss what it means to practice optimal population management. • Discuss the most important things to measure to avoid bogging down in endless data.	Jim Davis, MD,MS
	D-3 *Repeat of A-4 from Monday*	
White	**The Expanded Roles for RNs, LPNs and MAs in Team-Directed Care**	Colette Rush, BSN, RN
	D-4 *Repeat of A-5 from Monday*	
Orange	**Elderly With Complex Needs: Organized Approaches to Care.**	Marty Levine, MD

TIME/ROOM	TOPIC	PRESENTER
	D-5 *Repeat of B-5 from Monday*	
Teal	**What's the Big Deal About Teamwork? (We're already a great team.)** An Interactive Workshop	Berdi Safford, MD *Please note: your entire team needs to attend this session together. A minimum of three teams must attend to hold this session.*
	D6 *Repeat of A-7 from Monday*	
Green	**How to Make Your Electronic Health Record a Partner for Planned Care**	Jeff Hummel, MD, MPH
	D-7	
Blue	**Consulting with faculty** Join faculty members to discuss your team's progress toward a patient-centered medical home. Both have experience and knowledge related to national health care quality and can offer an in-depth perspective on your situation. Pose a specific question and or describe a specific challenge.	L. Gordon Moore, MD Ed Wagner, MD, MPH
1:45-2:00	**Break-Snack &Transition to Workshops**	
2:00-4:00	**Team Meetings: Planning for Action Period 2 Evaluations** Meet with your coach in assigned rooms. ***Please complete action plan and turn in to your coach to earn full attendance credit and stipend.***	
4:00	**Adjourn**	

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AGENDA

Learning Session 3

Monday, September 27, 2010

Overlake Christian Church 9900 Willow Rd NE Redmond WA 98052

TIME/ROOM	TOPICS	PRESENTERS
7:30 - 8:00 Blue	**Sign-in and Continental Breakfast**	
8:00 - 8:15 Blue	Welcome to Learning Session 3	Jan Norman, RD, CDE
8:15 - 8:45 Blue	Voice of the Patient DVD Opening remarks	Berdi Safford, MD
8:45 - 9:30 Blue	***Opening Plenary*** Care Coordination	Ed Wagner, MD, MPH, FACP
9:30 - 10:00 Blue	Care Coordination in Action: Three examples	Moderated by Ed Wagner, MD, MPH, FACP Participants Patrick Ogilvie, MD Mark Reed Health Care Marc Cordova, MD The Polyclinic Roger Maldonado, RN Harborview Medical Center Adult Medicine
10:00 - 10:15	**Break & Transition to Team Activity**	
10:15 - 11:00	**Team Activity 1** Care Coordination See ***Team Assignments*** for rooms	Quality Improvement Coaches

TIME/ROOM	TOPICS	PRESENTERS
	Senior Leaders to attend team meetings	
11:00 - 11:30	**Team Activity 2** Survey completion	
11:30 - 12:15 Blue	**Lunch**	
12:15 - 1:00 Blue	***Data Presentation:*** Patient experience and clinical outcomes	Francisco Arias-Reyes Angela Kemple, MPH
1:00 - 1:30 Blue	***Mini-Plenary*:** Access	L. Gordon Moore, MD
1:00 - 3:00 Green	***Senior leader track*** Primary care in partnership with hospitals	***Panel moderator*** Jan Norman, RD, CDE **Washington State Hospital Association** Bonnie Burlingham Dekker Dirkson **Olympic Primary Care** Joe Mattern, MD **Jefferson Healthcare** Paula Dowdle, COO **Swedish Community Health Medical Home** Jay Fathi, MD **Swedish Health Services** Jeff Veilleux, CFO **Edmonds Family Medicine** Marcy Shimoda **Stevens Hospital** Nancy Wood, RN
1:30 - 1:45	**Transition Time to Workshops**	
1:45 - 2:45	**Workshop A: Care Coordination & Key Change Concepts**	
Red	**A-1 (Repeats as C6)** Shared decision-making with patients about referrals **Objectives** • Describe the elements of shared decision-	L. Gordon Moore, MD

TIME/ROOM	TOPICS	PRESENTERS
	making • Explore how patient values can impact on referral decisions • Discuss the skills providers need to engage in shared decision making	
Teal	**A-2 (Repeats as C7)** Crafting service agreements for seamless care with our consultant specialists **Objectives:** • Discuss the importance of creating "seamless handoffs" between primary care and consultants • Describe new models for interfacing our care with consultant specialists • Discuss how to negotiate service agreements with other physician groups • List some typical elements to include in a service agreement	Berdi Safford, MD
Blue	**A-3** Coordination between primary care and hospitals: A panel of examples **Objectives** • Explore the challenges and solutions in the process of learning how primary care can work more closely with emergency departments and inpatient hospitals • Discuss practical examples of increased coordination • Describe lessons learned from the teams who have been "pioneers" along the path	***Panel moderator*** Larry Mauksch, MEd *PANEL* **Rockwood Clinic-Cheney and Medical Lake** Sharon Gilmore Michelle Lowe **Harborview Adult Medicine** Kathy Mertens, RN **Harborview Family Medicine** Kate Friedenbach, RN **Family Medicine of SW WA** Diana Ferguson, LPN Amber Whited, MD **Columbia Valley Community Health** Sarah Duffey, RN
Purple	**A-4** The Colorado mini-pilots: Four primary care clinics and four hospitals build bridges **Objectives:** • Describe the framework of the overall	Marje Harbrecht, MD Health TeamWorks (Formerly Colorado Clinical Guidelines Collaborative)

TIME/ROOM	TOPICS	PRESENTERS
	Colorado Multi-Payer, Multi-State Patient Centered Medical Home Pilot • Discuss the mini-pilot project and describe the objectives, participants, improvements tested, high level timeline and outcomes • Summarize the key challenges and lessons learned from the mini-pilot • Discuss the initial steps a primary care team might take to initiate improvement work in collaboration with a hospital	
Brown	**A-5 (Repeats as C-4)** Care coordination of older adults with poly-pharmacy: The integration of pharmacists into medical home using lean problem solving **Objectives:** • Describe the evidence that led the Collaborative to choose the measure of older adults with 15 medicines or more Practice using a lean problem solving skill set applied to the challenge of care coordination related to older adults with poly-pharmacy • Discuss how patient-centered medical homes and pharmacy can integrate to create optimal care coordination for fragile patients with complex needs	Martin Levine, MD Steven Erickson, PharmD. Providence Everett Medical Center, Monroe Clinic
White	**A-6** The patient's experience of coordinated care **Objectives:** • Describe Project Red and the role of "Louise" • Discuss what Louise does that human providers can learn from, and the implications for improving the patient experience • Discuss the patient's view of the provider team, patient teaching and the need for coordination	James Davis, MD, MS
Orange/Yellow	**A-7** The medical neighborhood in rural settings: Special challenges in care coordination **Objectives:** • Review the statewide rural health plan, explaining why medical homes are a key	Andrew Craigie, CEO Garfield Public Hospital Bonnie Burlingham, MPH Washington State Hospital Association

TIME/ROOM	TOPICS	PRESENTERS
	component • Describe the Health Home Strategic Plan as an example of how one rural community envisions working with the medical neighborhood • Discuss how to design care coordination and how to create linkages with community resources and remote specialty care from the rural setting	
2:45 - 3:00	**Break-Snack & Transition to Team Meetings**	
3:00 - 4:00	**Team Activity 3** Setting team targets using the Medical Home Index See *Team Assignments* for rooms	Quality Improvement Coaches
4:00	**Evaluation and Adjourn**	

Washington
Patient-Centered Medical Home Collaborative

A joint project of the Washington State Department of Health and the Washington Academy of Family Physicians

AGENDA

Learning Session 3
Tuesday, September 28, 2010

Overlake Christian Church 9900 Willow Rd NE Redmond WA 98052

TIME/ROOM	TOPICS	PRESENTER
7:30 - 8:00 Blue	**Sign-in and Continental Breakfast**	
8:00 - 8:15 Blue	Welcome Questions and answers with faculty and staff	Moderator: Jan Norman, RD, CDE
8:15 - 8:30 Blue	*Opening remarks* The importance of medical home in health reform	Maxine Hayes, MD, MPH State Health Officer
8:30 - 9:15 Blue	***Plenary:*** What—You want *US* to change too? Spreading improvements to your colleagues	Berdi Safford, MD
9:15 - 9:30	**Transition to Team Activity**	
9:30 - 10:15	**Team activity #4** Action plans and acceptance of improvements See ***Team Assignments*** for rooms	Quality Improvement Coaches
10:15 - 10:30	**Break & Transition to Workshop**	

TIME/ROOM	TOPICS	PRESENTER
10:30 - 11:30	**Workshop B: The theme of care coordination viewed through the needs of a particular patient population**	
Teal	**B1** Care coordination: Focus on asthma **Objectives:** • Describe how to incorporate current asthma guidelines into care coordination activities • Discuss the role of health information technology in care coordination for asthma patients • Describe patient support examples for coordinated asthma care • Outline strategies to improve the coordination of care for patients living with asthma	Sara Barker, MPH
Brown	**B2** Care coordination: Focus on behavioral health **Objectives:** • Explore how every member of the team can play a role with behavioral health integration in primary care • Describe the continuum of coordination needs patients in a practice may have and how to respond to different levels of need • Discuss how function exists separately	Larry Mauksch, MEd
Red	**B3** Care coordination: Focus on pre-diabetes **Objectives:** • Describe the role each clinic staff has in identifying patients with pre-diabetes and referral to community resources • Name 2 key messages to provide to patient with pre-diabetes diagnosis • List 3 risk factors for pre-diabetes (and or 1 diagnosis criteria for pre-diabetes) • List 1 example PDSA a clinic could institute to improve pre-diabetes screening and referral to community resource	Marcelle Thurston, MS, RD, CDE Jeanne Harmon, RD, CDE, MBA

TIME/ROOM	TOPICS	PRESENTER
White	**B4** Care coordination: Focus on hypertension **Objectives:** • Describe the technique in taking accurate blood pressure readings and how these protocols can be integrated at the participant's clinic • List three current evidence based care strategies for addressing pre-hypertension and for reaching or making improvements towards reaching blood pressure goals • Discuss the key care coordination strategies that can positively impact the care patients with hypertension receive	Colette Rush, RN
Green	**B5** Care coordination: Focus on cancer survivorship *Quality Care for Cancer Survivors: Coordinated, Interdisciplinary and Enduring* **Objectives** • Describe cancer survivorship definitions and prevalence • Discuss the unique health risks and needs of cancer survivors • Describe the typical pattern of care between primary care and oncology for oncology patients • Outline specific strategies to improve the integration and coordination of the team for cancer survivors, and the role of the patient-centered medical home in survivor care	Cobie Whitten, PhD

TIME/ROOM	TOPICS	PRESENTER
Blue	**B6** Care coordination: Focus on chronic pain **Objectives:** • Discuss the challenges patients with chronic pain face in the current system of care • Outline the ways primary care can use coordination to improve outcomes for patients challenged by chronic pain • Describe the optimal way to work seamlessly with pain clinics and physical medicine consultants to improve patient outcomes	Mary Kay O'Neill, MD, MBA
Purple	**B7** Care coordination: Focus on children *Developmental screening in the medical home, chronic care visits, and care coordination* **Objectives:** • Describe the essential role of well child checks and developmental screening in prevention and early intervention • Compare and contrast the developmental screening tools available • Describe the key coordination strategies that need to link to developmental screening results • Detail methods to follow children with special health care needs and effectively coordinate their care	Chris Olson, MD, MPHA
Orange/Yellow	**B8** Care coordination: Focus on tobacco users *Integrating tobacco treatment into a medical home model* **Objectives:** • Describe the patient and provider benefits that come from treating tobacco use;	Juliet Thompson , BA, Gillian Schauer, MPH

TIME/ROOM	TOPICS	PRESENTER
	• Understand how tobacco use relates to other chronic disease outcomes; • Describe an intervention that can be conducted by multiple staff in a medical home setting to help connect tobacco users with appropriate resources; • Describe appropriate resources for treatment, including the WA State Tobacco Quit Line and roles that a Behavioral Interventionist might play in treatment; • Know how to contact WA DOH Field-based staff for additional support in setting up a treatment and referral-based system	
11:30 - 12:15 Blue	**Lunch**	
11:30 - 1:00 Green	**Lunch meeting for senior leaders**** Question and answer roundtable on the multi-payer medical home reimbursement pilot ***Must be a pilot applicant.*	Moderated by Jan Norman, RD, CDE Steve Lewis Health Care Authority Reena Koshy, MD, MPH Puget Sound Health Alliance
12:15 - 1:00 Blue	***Mini-Plenary*** Health literacy: Challenges and solutions to coordinated care	Lisa Chew, MD, MPH
1:00 - 1:15	**Transition to Workshops**	
1:15 - 2:15	**Workshop C: A mix of repeats from A and new topics**	
Purple	**C1 *New*** Addressing cultural and communication challenges: Advanced directives and end of life care **Objectives:** • Participants will explore the communication and cultural issues that may arise when discussing advance directives and end of life care, particularly with limited English proficient patients • Participants will explore pragmatic strategies to increase	Bria Chakosky-Lewy, RN Kim Lundgreen

TIME/ROOM	TOPICS	PRESENTER
	understanding of advance directives and improve end of life care to particularly for limited English proficient patients	
Blue	**C2 *New*** Health behavior change: Counseling skills for primary care teams **Objectives** • List the key counseling skills that primary care team members can practice • Describe how behavior change can be supported by the health care team • Observe and describe the characteristics of effective interventions using videotaped vignettes	Larry Mauksch, MEd
Teal	**C3 *New*** How to plan and facilitate a patient advisory group or patient members to quality improvement teams **Objectives** • List the key planning decisions that precede recruitment and screening of patient and or family participants. • Weigh the pros and cons of two approaches to recruitment. • Describe the "red flags" that might screen a potential participant out of your group. • Discuss potential team norms. • Describe potential methods to prevent problems or intervene early should they occur.	Marcelle Thurston, MS, RD , CDE
Brown	**C4 *(Repeat of A5)*** Care coordination of Poly-Pharmacy with older adults: An experiment with lean problem solving	Martin Levine, MD Steve Erickson, PharmD

TIME/ROOM	TOPICS	PRESENTER
Green	**C5 *New*** Developing community partnerships **Objectives** • Identify strong community partners. • Use effective strategies to partner with community organizations • Build care capacity in your community	Judith Schaefer, MPH
Red	**C6 *(Repeat of A1)*** Shared decision-making with patients about referrals	L. Gordon Moore, MD
White	**C7 *(Repeat of A2)*** Crafting service agreements for seamless care with our consultant specialists	Berdi Safford, MD
Orange/Yellow	**C8 *New*** Medical Home and Meaningful Use: Reaching meaningful use with a medical home strategy **Objectives:** • Describe the meaningful use program • Define the overlap between patient-centered medical homes and the meaningful use incentive program • Outline the meaningful use Medicare and Medicaid financial incentives	Michelle Glatt, MPH, PA-C
2:15 - 2:30	**Break & Snack** **Transition to Best of the Collaborative**	
2:30 - 4:00 Blue and Red	Best of the Collaborative See Best of the Collaborative assignment chart	Quality Improvement Coaches
4:00	**Evaluations / Adjourn**	

APPENDIX C

Washington Patient-Centered Medical Home Collaborative Webinar Dates

Presentation Date	Topic
October 15, 2009	"The How-To's of Reporting"
November 10, 2009	"Self Management Support in Primary Care"
December 10, 2009	"Improving Performance in Practice (IPIP)"
January 12, 2010	"EHR Information"
February 11, 2010	"Tobacco Use and Chronic Illness 'Why don't they Just Quit?"'
February 17, 2010	"Patient Experience Survey"
April 8, 2010	"Dementia Care in a Medical Home"
May 11, 2010	"Team Nursing Plan: Covington Primary Care"
June 10, 2010	"A Medical Home Includes Childhood Oral Health"
June 22, 2010	"The YMCA Diabetes Prevention Program in WA State"
July 13, 2010	DIAMOND: A Collaborative Care Model for Depression as a Foundation for Medical Home
July 28, 2010	Application Process for the Patient Centered Medical Home Reimbursement Pilot
August 12, 2010	Connecting the Dots: Designing Reliable Care Coordination Work Flows
August 19, 2010	Preparing for the Multi-Payer Medical Home Reimbursement Pilot: Do You Want to Participate?
October 14, 2010	Improving Patient's Experience in Primary Care

Washington
Patient-Centered Medical Home
Collaborative

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The Collaborative News

September 2010 Volume 1 Issue 8

The Health Care Authority Offers Funding Opportunity for Collaborative Participants

On September 1, Senior Leaders and Day-to-Day Leaders of the Washington Patient-Centered Medical Home Collaborative received an electronic mailing with the announcement and application for a new round of health information technology funding. To be eligible for the funds applicants must be a current participant in the Washington Patient-Centered Medical Home Collaborative and be a successful applicant for the Washington State Multi-Payer Medical Home Reimbursement Pilot.

Funds are targeted on efforts to enhance, modify, or expand existing health information technology to create interoperable linkages which support one or more of the following objectives:

- *Reduce avoidable emergency department visits.*
- *Reduce preventable inpatient admissions.*
- *Reduce readmissions to inpatient hospital settings within 30 days of discharge.*

The objectives are strongly aligned with the Multi-Payer Medical Home Pilot as well as the aims of the current Collaborative.

The funding announcement details the deadlines and application process. Successful applicants for the HCA health information technology funding will be announced soon after the communication of successful Multi-Payer pilot participants in early December.

Please Remember...

The Medical Home Index (MHI) has been sent out via electronic mail with instructions. To receive the stipend for Learning Session 3 (LS3) the completed MHI must be returned prior to LS3 or at registration on the first day of LS3. Please bring an additional hard copy of the most recent completed MHI to use for a team meeting activity.

Important Dates

September 10

Diabetes Measures due
Prevention Measures due
Monthly Narrative due

September 20

WAFP closes web registration process for Learning Session 3 at 5:00 p.m. Directions and lodging information will remain available on the site. Late registration questions should be directed to faith.johnson@doh.wa.gov or phone 360-236-3695. The registration web site can be found at:

http://www.doh.wa.gov/cfh/MH-Coll/participants.htm

September 27-28, 2010

Learning Session 3
9900 Willows Rd, Redmond, WA
Focus on care coordination.
Session for Senior Leaders on September 27th.
Session for Senior Leaders of teams that have applied to the Multi-Payer Medical Home Reimbursement Pilot on September 28.

Please note: Monthly webinars are not held during Learning Session months.

The next monthly webinar is scheduled for:
October 15 - 12:30-1:30 p.m.
Topic: Improving the Patient's Experience
Larry Mauksch, MEd

Washington State Department of Health Asthma Resources

The Department of Health's Asthma Program is available to provide free technical assistance about the Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (EPR-3) and a team approach to asthma management.

Home visit programs are available for patients diagnosed with asthma. Home visits are a proven effective means to help educate asthmatics and their families on how to reduce asthma triggers in their living environment. If you are in any of the following areas, please contact the person below to find out more about their asthma home visit programs:

- Seattle-Aileen Gagney, American Lung Association-agagney@ALAW.ORG
- King County-Seattle King County Health Department-Miriam Philby- Miriam.Philby@kingcounty.gov
- Pierce County-Tacoma-Pierce County Health Department-Judy Olsen- jolsen@tpchd.org
- Yakima-Yakima Valley Farm Workers-John Thayer-JohnT@yvfwc.org
- Cowlitz County-Cowlitz County Health Department- Jessica Bell- bellj@co.cowlitz.wa.us

For more information about technical assistance with the EPR-3 guidelines or to incorporate a team approach to asthma management, please contact Keith Zang, Asthma Projects Coordinator with the WA State DOH at 360-236-3631 or **Keith.Zang@DOH.WA.GOV**

Please take a brief survey

The Washington State Asthma Program would like some information about the asthma measures you are tracking. Also, if you are not tracking asthma measures, and would like some free technical assistance on asthma please go to:

http://www.surveymonkey.com/s/HVSCZ8L

Did You Know...

"Medicare beneficiaries with multiple chronic illnesses see an average of 13 different physicians, fill 50 different prescriptions per year, account for 76 percent of all hospital admissions and are 100 times more likely to have preventable hospitalization than those with no chronic conditions." (CMS, January 2008)

Team Stories

We encourage you to visit the data repository and read other teams' reports. The past reports can be found in the folder called Clinic Review < Monthly Narrative Reports.

"Our continued 'aha is that when you peel back the layers of the onion (i.e. the problem) you see the many layers underneath. Adding our Front desk supervisor into the medical home discussion has been a huge success. She brought a wealth of operational issues to the table that we were failing to take into account and the process showed us that more variation in the team increases our chance of long term success"

Lynden Family Clinic, Family Care Network

"We realized that we needed to communicate more with all staff. We started a Monday morning huddle via newsletter to notify the entire staff of upcoming events, changes and what was currently going on with the collaborative. Great response so far. "

Olympic Physicians, PLLC

"It was good to hear from the staff that they needed allotted time to focus on certain parts of our project. We realized that it is really important to be able to focus and practice on one thing at a time to successfully integrate it into the daily routine. "

The Polyclinic

"We have been swapping MAs with our clinic across the street due to us becoming one clinic in March/April 2011. The MAs from over there are seeing the "Teams" in action and are taking back to the other clinic what is working and implementing the changes there. On the reverse the MAs from this clinic are helping them transition across the street. "

Evergreen Clinic-Family Medicine of Redmond

"We know and recently were "refreshed" on the reality that when providers are asked to make "change," change that they want and believe in, still will require quantifiably more time to behaviorally modify and implement than what we expect from our line staff. "

Covington Primary Care Valley Medical Center

"Our weekly care conference calls with home health care agencies & Health Coach improve communication and coordination of care."

Rockwood Cheney

Relevant Education

Spirometry 360 training scholarships available until October 1

Spirometry is now the medical standard for treating patients with asthma and COPD. Some training is needed to use this tool correctly. Peak flow is no longer recommended to diagnose asthma or COPD or to assess severity. Up to one third of patients with persistent or uncontrolled asthma may be missed by history alone.

Spirometry 360™ is an online training and feedback program offered by the interactive Medical Training Resources (iMTRTM) at the University of Washington February 1-May 31, 2011

Spirometry 360™ includes:

- Spirometry Fundamentals: A basic guide to lung function testing.
- Spirometry Learning Lab webinar series.
- Spirometry Feedback: Personalized analysis of providers' spirometric curves.

Details online:

www.spirometrytraining.org

- For all medical staff (M.D., D.O., P.A., R.N., A.R.N.P., M.A., health educator)
- Time Commitment – Six hours of webinars, three months of self-paced learning, practice, and feedback
- CME and CNE credit available
- American Board of Pediatrics MOC Part 4 credit available through Seattle Children's Hospital
- Tuition - $1,200 - $1,500 per team

Institute for Healthcare Improvement (IHI) Offers Transitions in Care Seminar

Hospital readmission payment reductions are scheduled for 2012. Reducing Avoidable Readmissions by Improving Transitions in Care, a two-day seminar from the Institute for Healthcare Improvement (IHI), will focus on creating an ideal care transition for patients from the hospital to home. IHI has a substantial track record working with health care organizations and systems to improve the post-discharge care transition. During this seminar program faculty will share key changes and promising approaches. To learn more about this program visit:

http://www.ihi.org/IHI/Programs/ConferencesAndSeminars/ReducingAvoidableReadmissionsNovember2010.htm

Diabetes Class for Medical Assistants & Office Staff

Swedish Diabetes Education Center will offer a workshop for medical assistants and other clinical staff who work in the ambulatory setting on Saturday, September 18 from 8:00 a.m. to 12:30 p.m. on the First Hill Campus. The four hour class will cover an introduction to diabetes care and problem-solving in the office setting. The course is free, and registration is limited to 15 persons. For questions and registration, please call 206-386-2119.

Chronic Disease Self Management Program (CDSMP) Technical Assistance Conference

On Wednesday, October 20, 2010 the Tukwila Community Center at 1242 42nd Avenue South in Tukwila will host a day long Chronic Disease Self Management Program (CDSMP) Technical Assistance Conference from 8:00 am to 4:00 p.m. Topics include health promotion and disease prevention, recruitment of participants into the chronic disease self-management program called *Living Well with Chronic Conditions,* developed by Stanford University, and other topics related to the Living Well program. Other topics include cultural competence, recruiting and retaining workshop leaders, quality and planning for sustainable work. *Tomando*® is the Spanish version of the *Living Well* program.

The conference is funded by the American Recovery and Reinvestment Act (ARRA) Communities Putting Prevention to Work grant. Registration opened on September 1 , there is no fee to attend, and a box lunch is provided. To learn more about the Chronic Disease Self-Management programs or to recognize outstanding master trainers or lay leaders for the program, go to the Living Well web site at:

http://livingwell.doh.wa.gov/

To register, go to:

http://www.peopleware.net/2697 .

Stanford Patient Education Resource Center

http://patienteducation.stanford.edu

developed the CDSMP materials.

The Collaborative News is a monthly news bulletin which serves the Washington Patient-Centered Medical Home Collaborative, a joint project of the Washington State Department of Health and the Washington Academy of Family Physicians.

Editor: Pat Justis patricia.justis@doh.wa.gov

Washington
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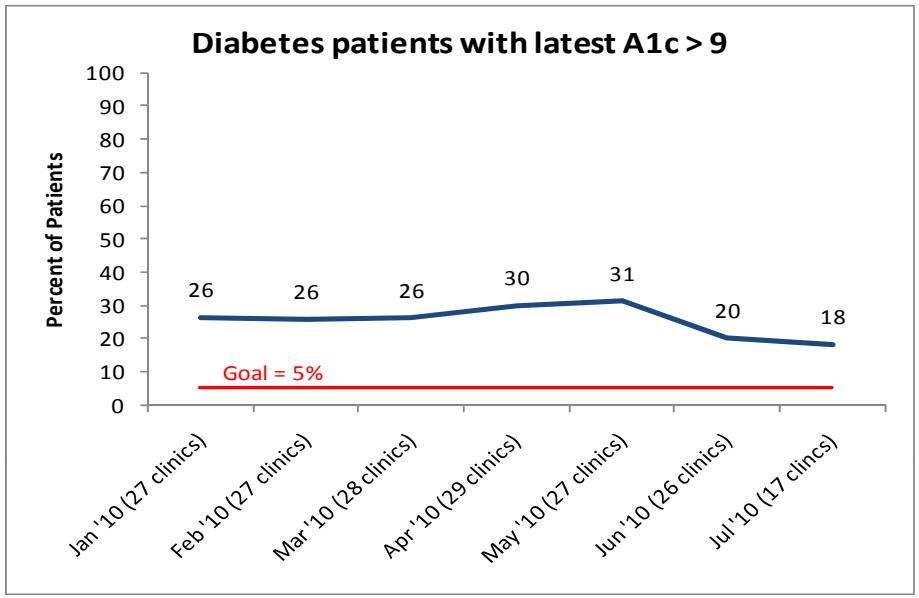
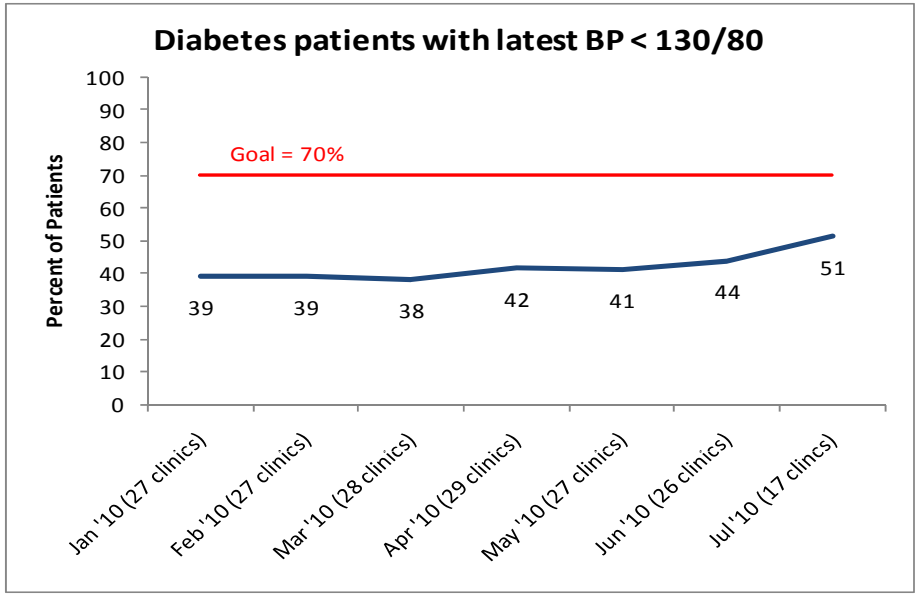
Patient Outcomes and Experience

Presenter:
Dennis McDermot, Research Investigator

Washington State Department of Health

One Year Evaluation--Clinical Measures





Uncontrolled A1c

Note: a lower percent in uncontrolled A1c indicates better performance.

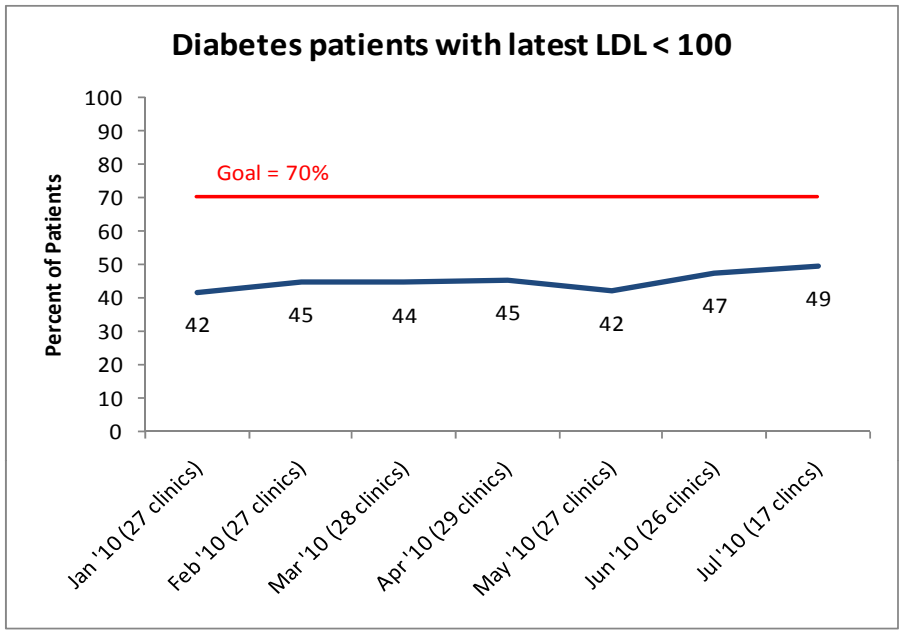
So far, A1c control has exceeded the recommended 30% improvement in year 1 (38% improvement).

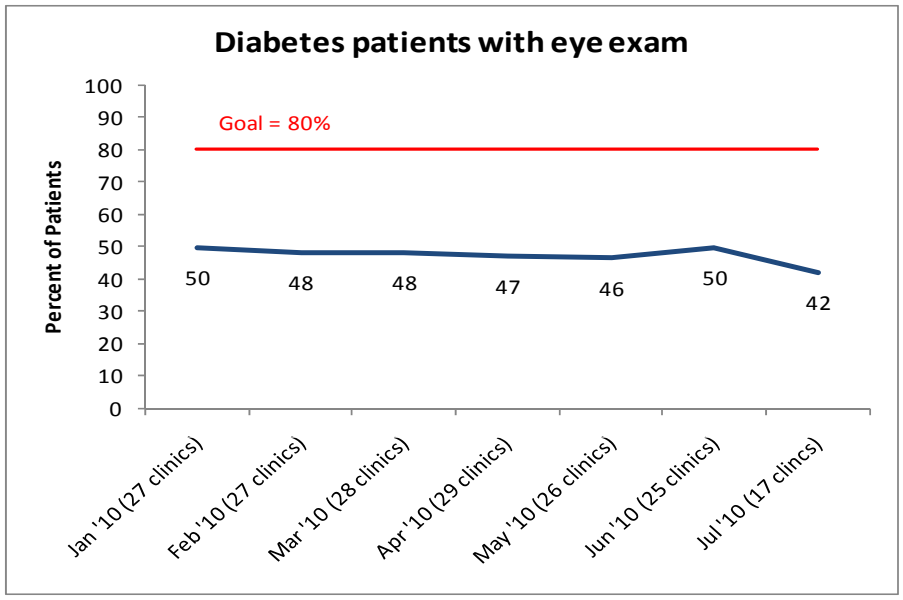
Blood pressure control

Good job closing the gap between baseline performance and goal (39% improvement).

Washington Patient-Centered Medical Home Collaborative

One Year Evaluation—Diabetes Clinical Measures





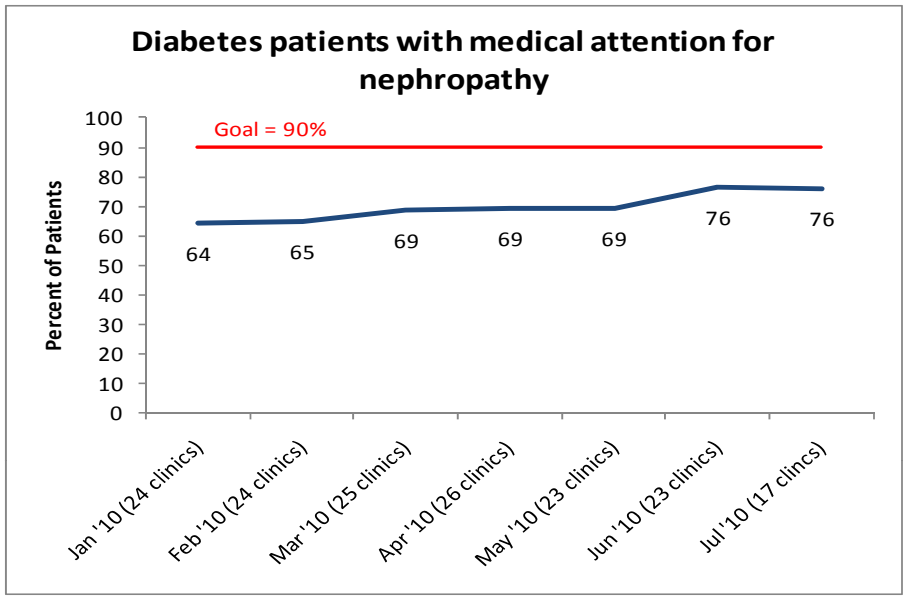
LDL control

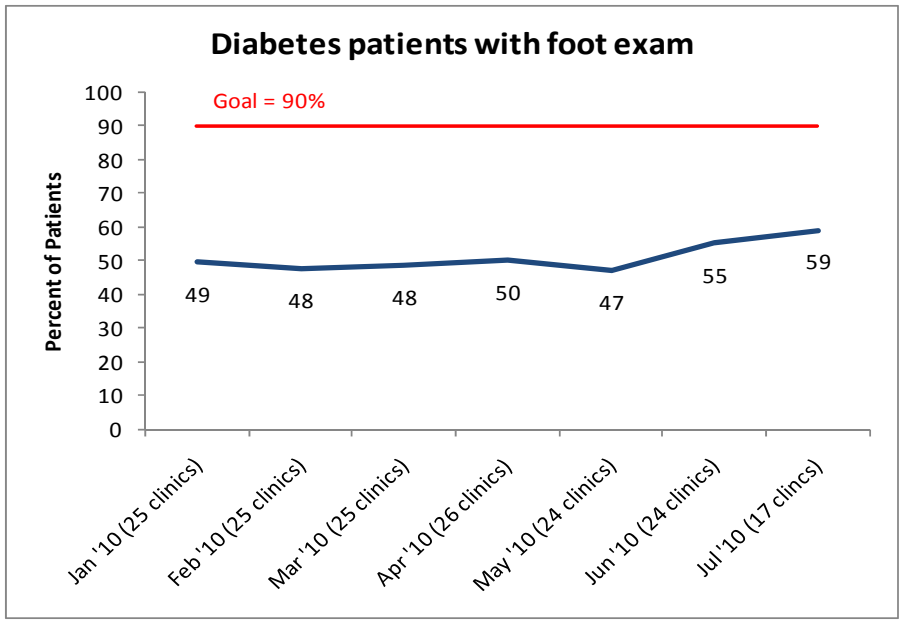
So far, just shy of the recommended 30% improvement in year 1 (27% improvement).

Receipt of eye exams

Does not appear to be improving(gap between goal and baseline widened by 25%).

One Year Evaluation—Diabetes Clinical Measures





Nephropathy screening

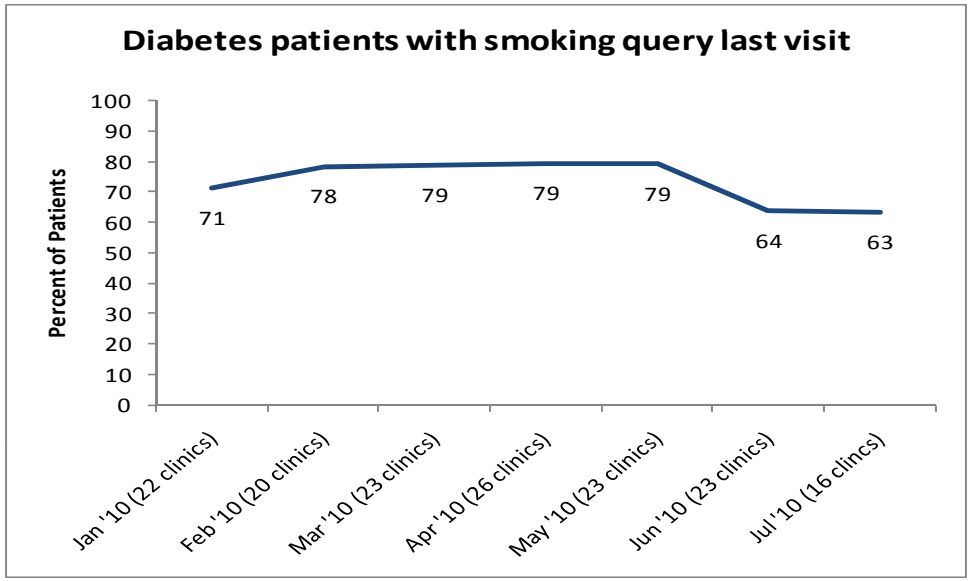
Closing the gap between baseline performance and goal for (45% improvement).

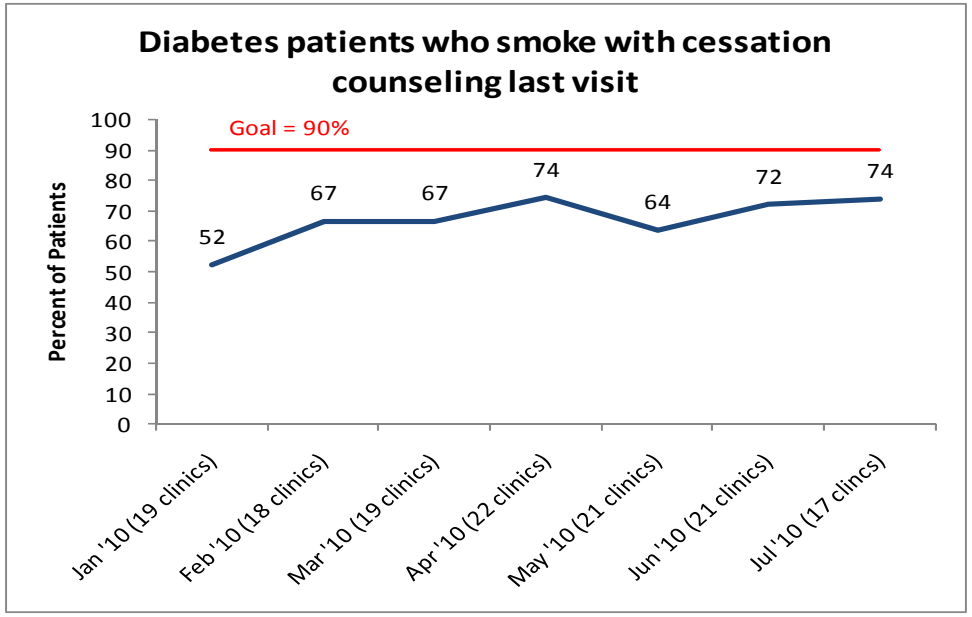
Receipt of foot exam

Still needs to reach the recommended 30% improvement in year one (24% improvement so far).

Washington Patient-Centered Medical Home Collaborative

One Year Evaluation—Diabetes Clinical Measures





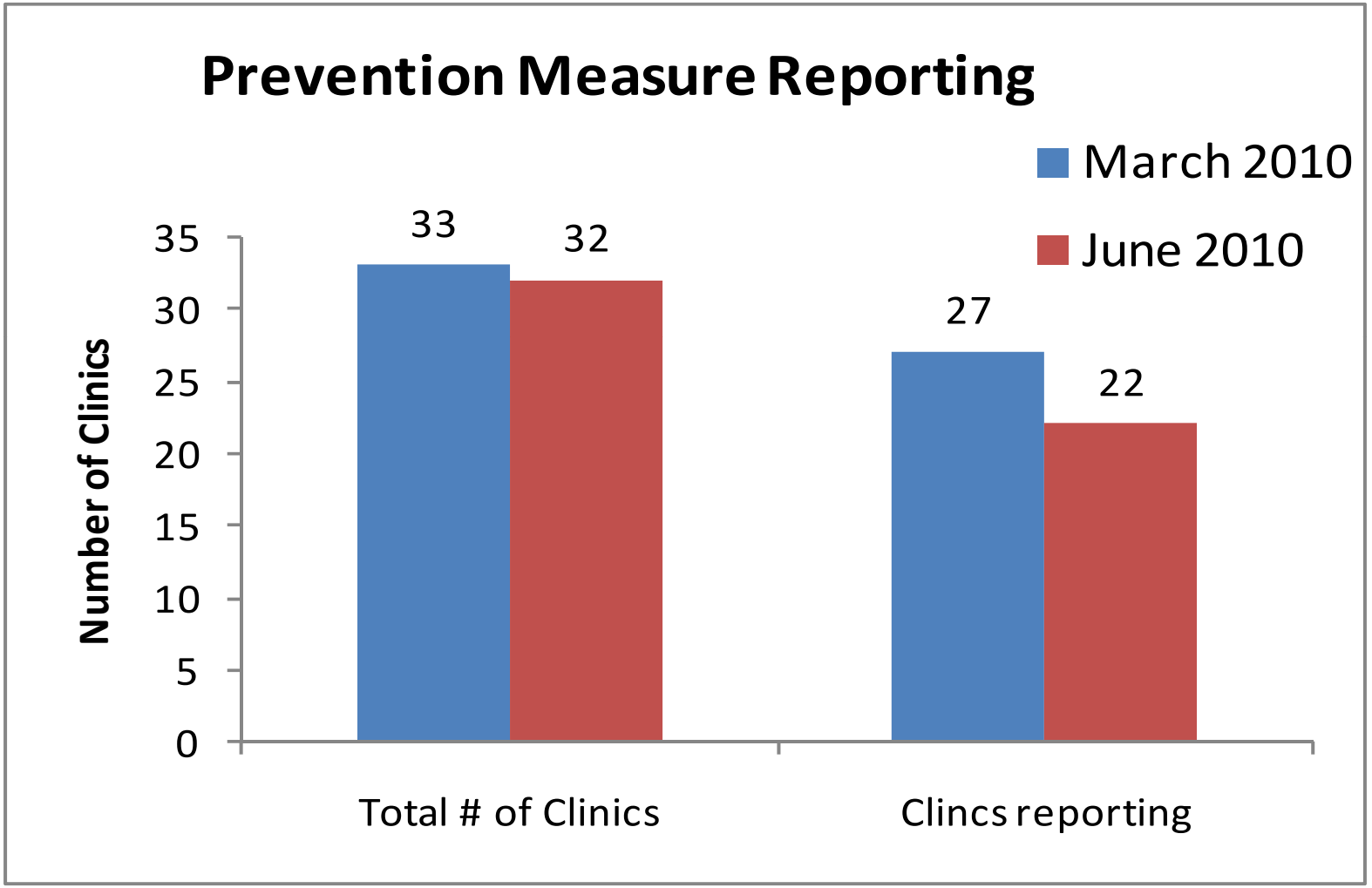
Assessing tobacco use

Decreasing over time—no improvement

Smoking cessation counseling for known smokers

Good job of closing the gap between baseline performance and goal (58% improvement).

Patient-Centered Medical Home Prevention Measure Reporting



Washington Patient-Centered Medical Home Collaborative

Clinical Prevention Measures

	Jan - Mar 2010	Apr - Jun 2010
At least 4 Well Child Visits, Age 12 - 23 months	48 %	44 %
Well Child Visit past 2 years, Age 4 - 17 years	53 %	45 %
Smoking Assessment at most recent visit , Adults age 18+	57 %	65 %
Smoking Cessation Intervention most recent visit *and* within last 4 years, Adult smokers.	28 %	35 %
Screen for Cervical Cancer past 3 years, Females age 21-64	64 %	66 %
Screen for Colorectal Cancer, Adults age 50-75	50 %	57 %
Advance Directive past 2 years, Adults age 65+	16 %	17 %
15+ Active Medications, Adults age 65+	10 %	13 %

Washington Patient-Centered Medical Home Collaborative

Patient Experience Survey—Baseline results

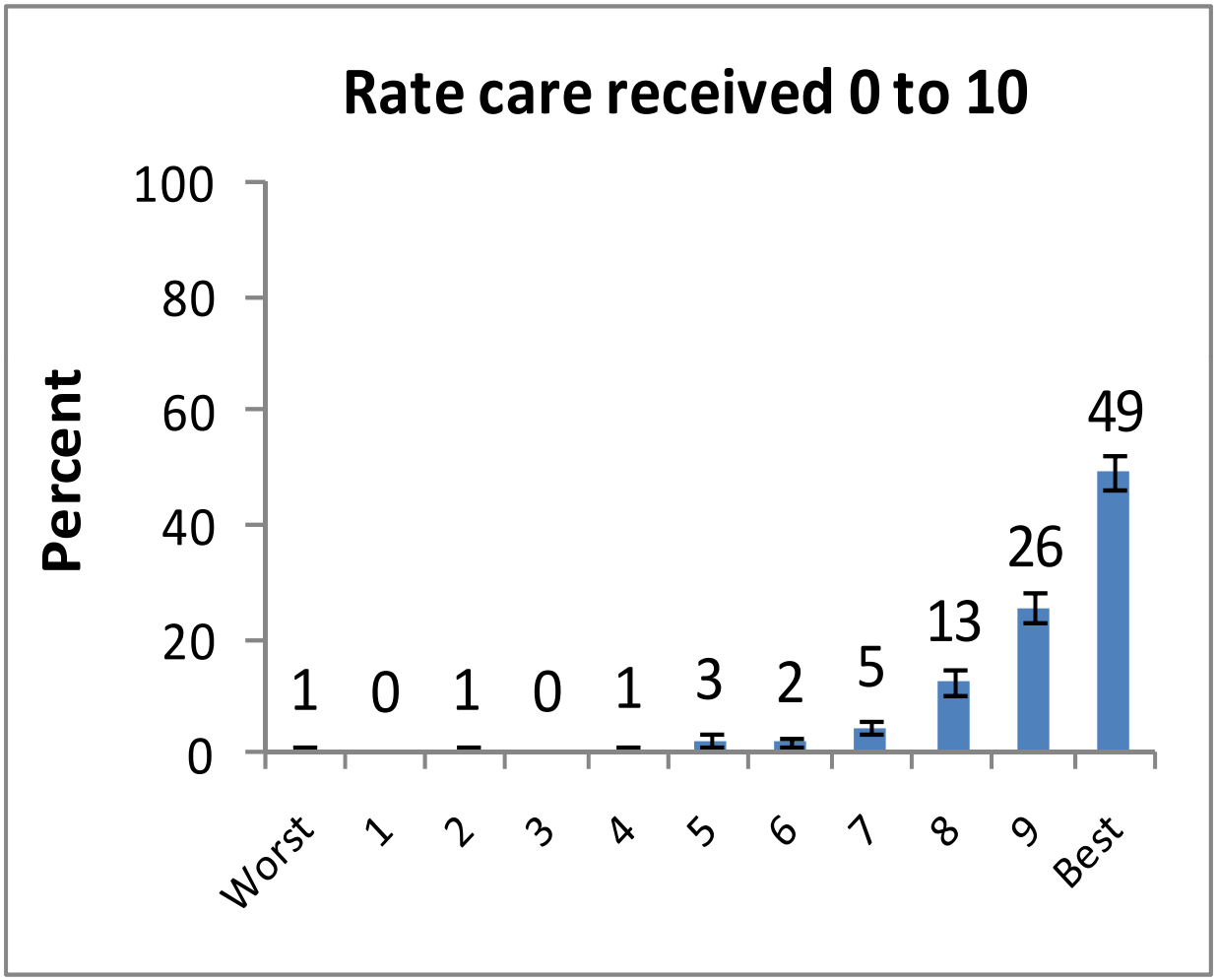
- 38-item survey of experience for patient's seen in the doctor's office within the last 12 months
- 1,121 of 2,800 surveys mailed out were returned— **40% response rate**
- Areas assessed
  - Medical office and scheduling
  - Care from provider in last 12 months
  - Self-management support
  - Shared decision making
  - Care coordination

Washington Patient-Centered Medical Home Collaborative

Patient Experience—Demographics & Health Status

- Age: 11% <35 years, 30% 35-54 years, 25% 55-64 years, 34% 65 years or older
- Gender: 40% Male, 60% Female
- Hispanic Origin: 5%
- Race: 87% White, 5% Asian, 4% Black, 3% Other, 1% American Indian/Alaska Native
- Education: 36% high school or less, 36% some college, 28% college graduate or more
- **Most rated health status at least good: 10% excellent, 31% very good, 38% good, 20% fair, 1% poor**
- **Majority confident they can handle most health problems: 34% always, 53% usually, 12% sometimes, 2% never**

Patient Experience—Overall Rating



Overall patients who responded to the survey were pleased with their provider and care in the last 12 months.

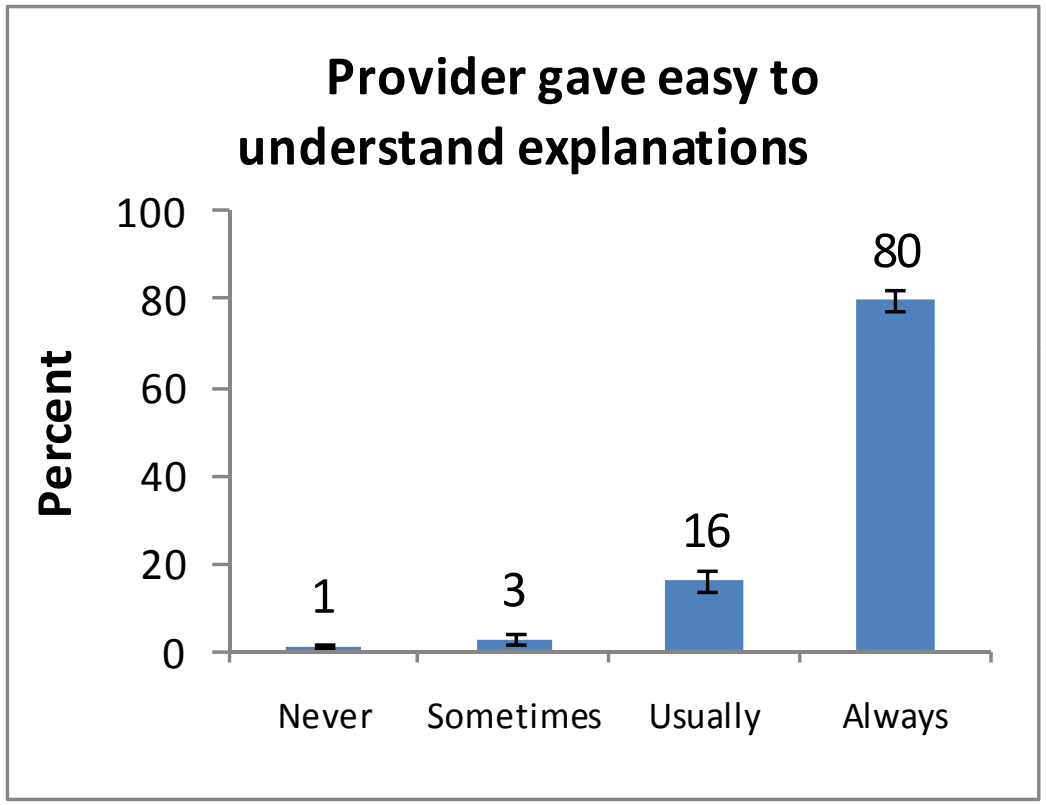
Majority gave a rating of 8 or higher on a scale from 0 (worst) to 10 (best).

Close to 50% of patients gave their provider and care a perfect 10.

Successes

- Patients who responded felt…
  - Office staff were helpful and respectful.
  - Provider gave clear explanations and instructions, listened to patients, and were respectful.
  - Providers were fully invested in their patients.
  - Providers involved patients in decision making process.

Patient Experience—Provider Care (communication)

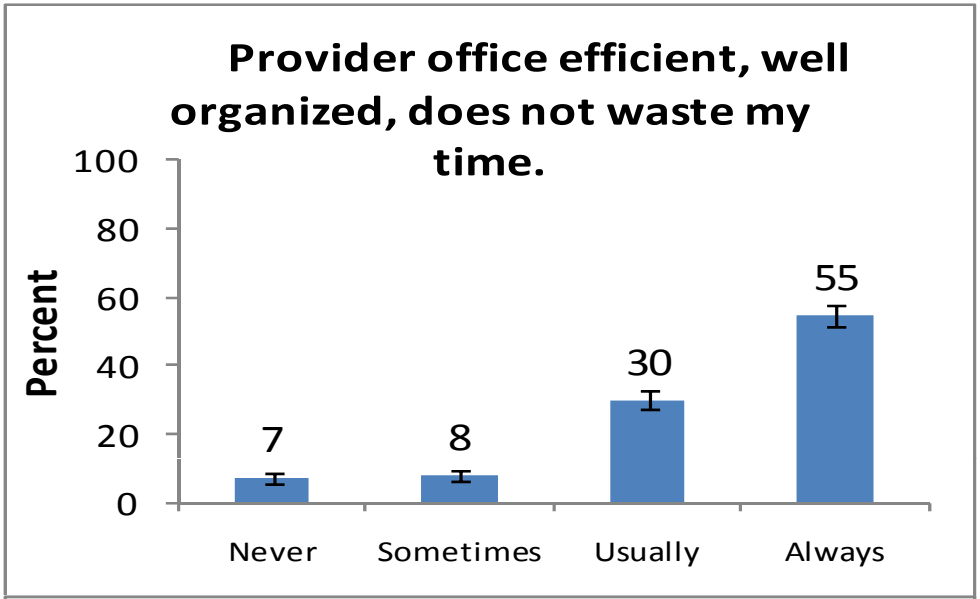


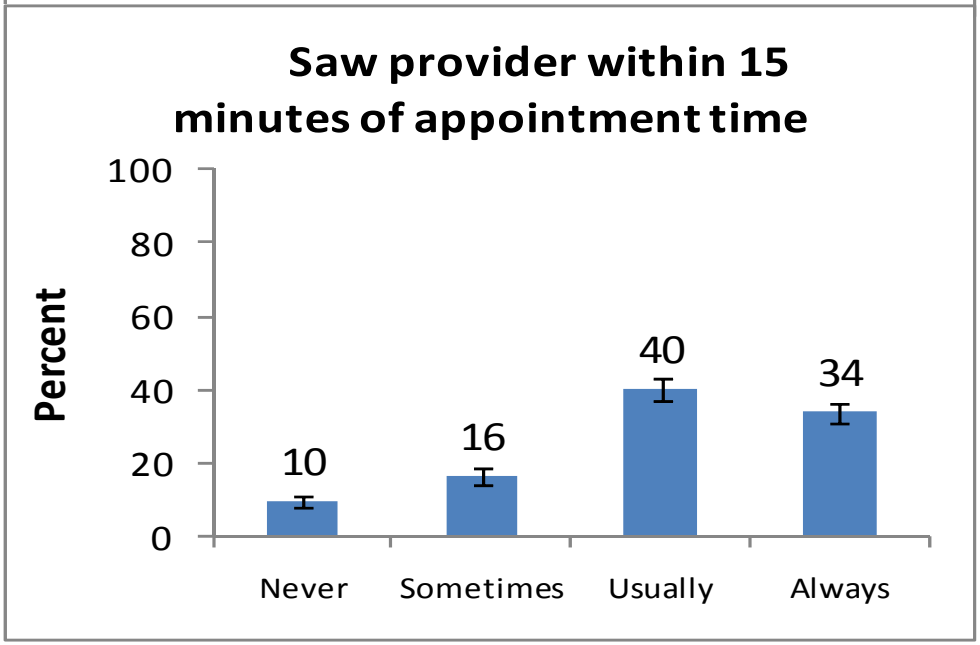
Most patients who responded report their provider always gave easy to understand explanations and instructions, listened carefully, and were respectful.

Opportunities for improvement

- Patients who responded were less favorable about…
  - Office efficiency, especially wait time.
  - Self management support - instructions and feedback
  - Coordination of care with specialists
- Asian patients may have less favorable experiences

Patient Experience—Medical Office (procedures/operations)

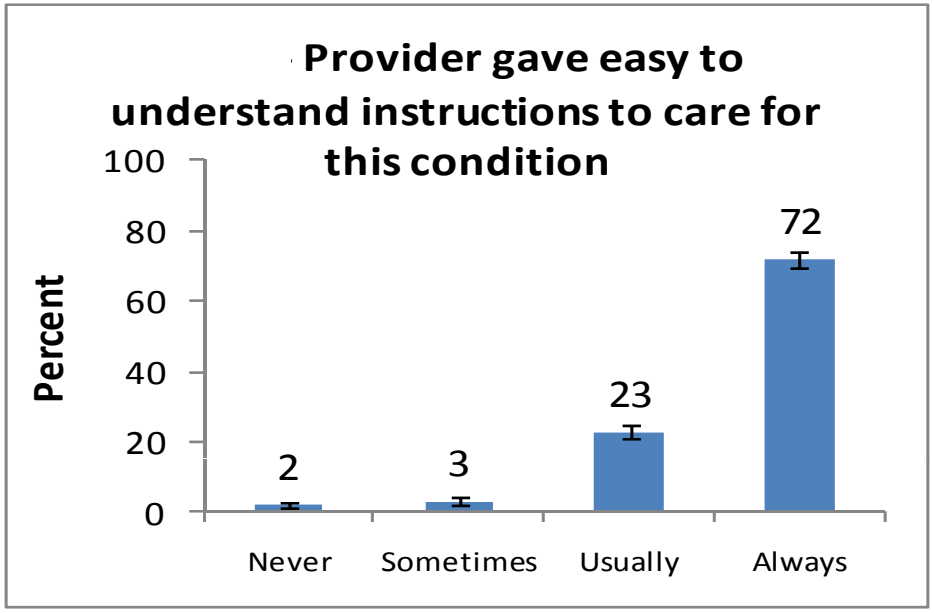


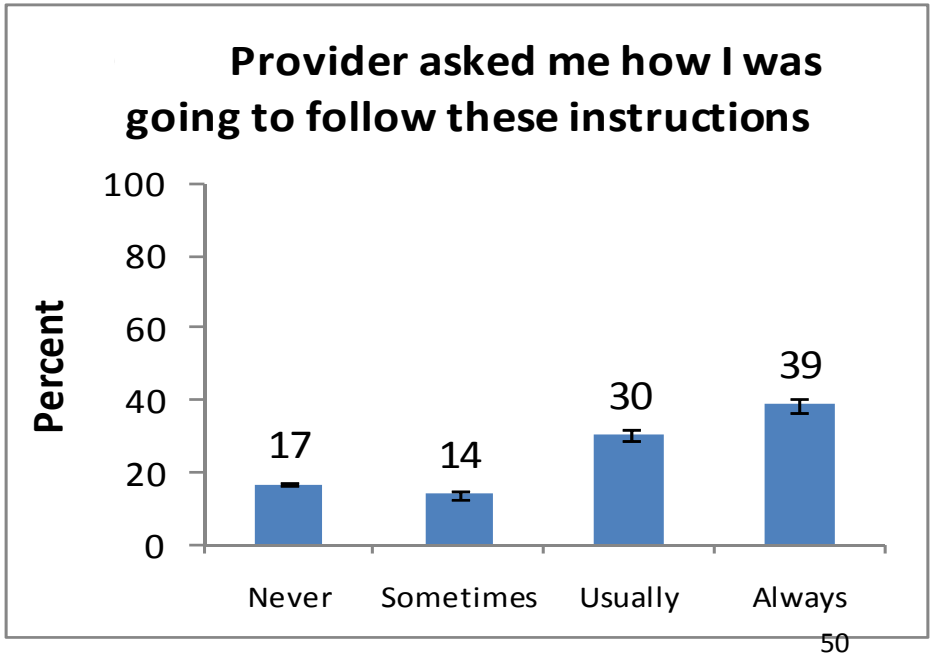


Patients who responded had a less favorable response regarding office efficiency.

This is an opportunity for improvement.

Patient Experience—Self-management support



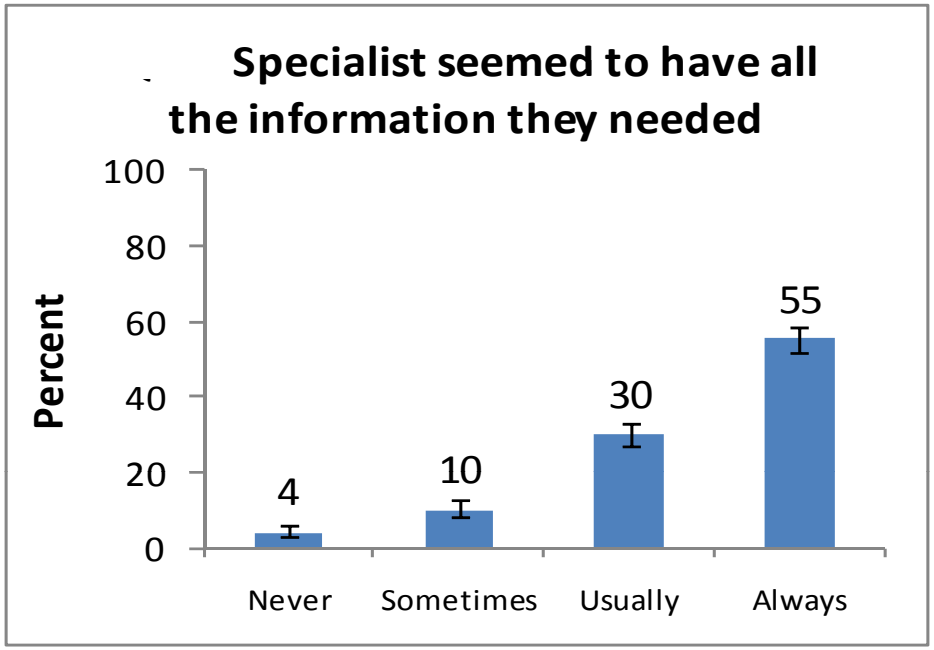


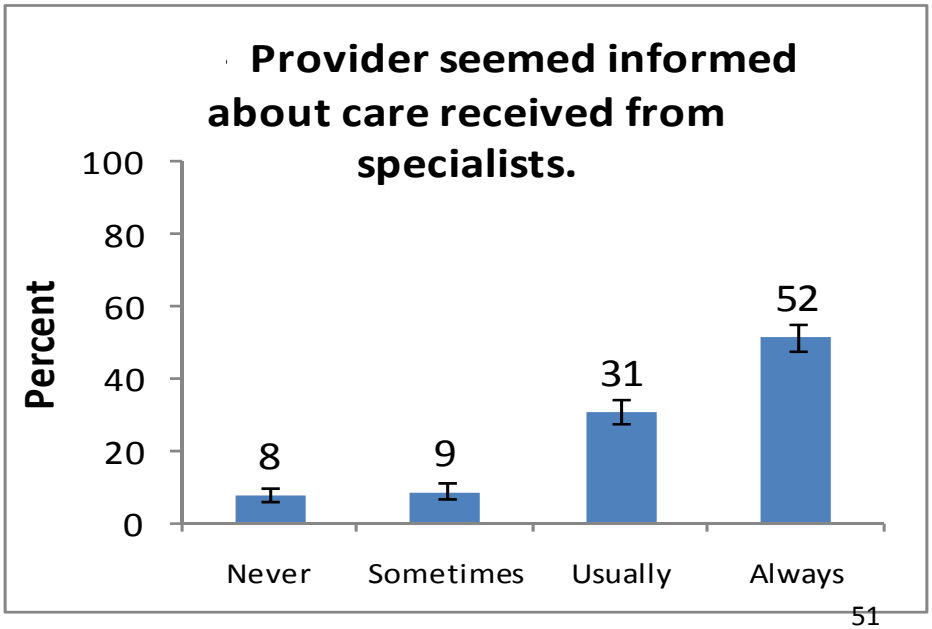
Of the 73%of patients who saw their provider for specific condition…

Most receive clear and instructions from provider, but far less are asked for their feedback to be sure instructions are followed.

This is an opportunity for improvement.

Patient Experience—Care coordination





According to the 61% of patients who saw a specialist…

Fewer report specialists had all the information they needed and that their provider was informed about the care they received from specialists.

This is an opportunity for improvement.

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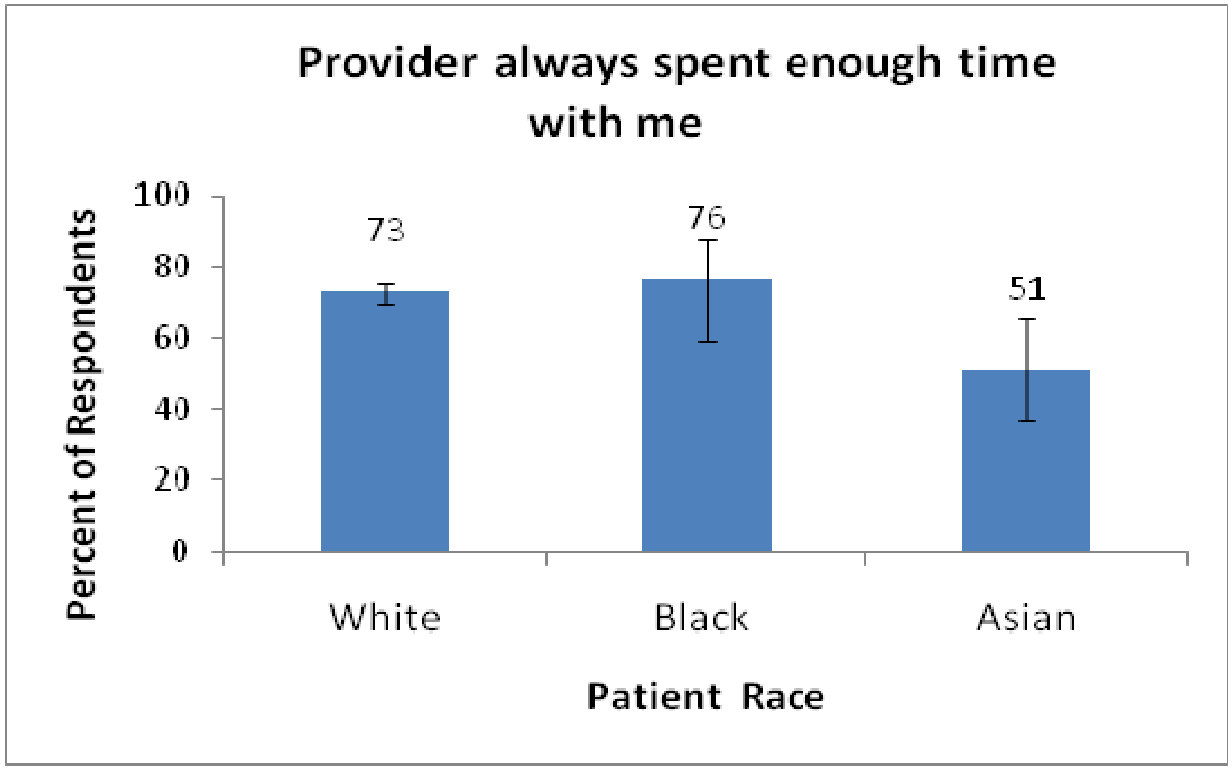
Patient Experience—Differences by Demographics



Patients' experience varied by race.

Asian patients experience less favorable interaction with providers.

Summary to Date

Clinical Prevention and Diabetes Measures

- Remarkable improvements in diabetes outcomes and care
- Continue commitment to accurate data documentation, collection and reporting
- Patient experience positive; identifies opportunities for improvement.
  - Patients who responded may not be representative – need outreach to non-responding patients to assess their experience.

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APPENDIX F

Washington State Collaborative Advisoary Committee	
Name	**Affiliation**
Drew Oliveira	Aetna Healthcare
Mary Kay O'Neill	Cigna Healthcare
Sharon Brooks	Columbia United Providers
Jackie Huck	Community Health Plan of Washington
Christopher Mathews	Community Health Plan of Washington
Sara Davila	Community Health Plan of Washington
Jan Norman	Department of Health
Pat Justis	Department of Health
Barb Lantz	Department of Social and Health Services
Juno Whittaker	Department of Social and Health Services
Eric Troyer	Evercare Washington
Peter West	First Choice Health
Brad Pope	Group Health Cooperative
Ed Wagner	Group Health Cooperative
Steve Lewis	Health Care Authority
Lynn Barker	Kaiser Foundation Health Plan
John Robinson	Molina Healthcare
Craig Carrothers	Molina Healthcare
Rick MacCornack	Northwest Physicians Network
Mary Jo Briggs	Premera Blue Cross
Roki Chauhan	Premera Blue Cross
Larry Mauksch	Primary Care Coalition, UW
Susie Dade	Puget Sound Health Alliance
Sharon Eloranta	Qualis Health
Nicole Bell	Regence Blue Shield
Joe Gifford	Regence Blue Shield
Doug Conrad	University of Washington
Bill Dowling	University of Washington
Freddy Chen	University of Washington
Zena Kinne	Centers
Mary Looker	Centers
Bob Perna	WA State Medical Association Foundation
Lance Heineccius	WA State Medical Association Foundation
Ric Winstead	Washington Academy of Family Physicians
Stan Garlick	Washington Academy of Family Physicians
Karla Graue Pratt	Washington Academy of Family Physicians
Bonnie Burlingham	Washington State Hospital Association