The Verden Group | PCS PATIENT CENTERED SOLUTIONS

Your Partner in Practice

PCMH & Your Community

PCC User's Conference - Workshop
July 27, 2016

About This Talk

Being a medical home for your patients means more than just coordinating care. It also requires bringing resources together to ensure that they have access to the right care. In this course you will learn how to connect your patients to services in a number of ways: outreach to specialists, building programs in-house, contracting with other professionals, referring to and helping to build community programs, even connecting with Payers to take advantage of their member programs and services, or to collaborate on creating new ones.

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First, A Bit About Medical Homes ...

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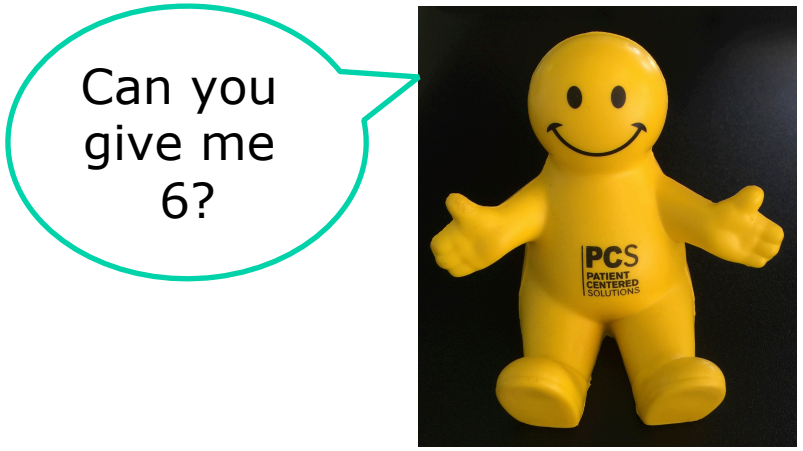
Are You A 'Medical Home'?

You don't have to be NCQA recognized. The medical home is best described as a model or philosophy of care that is:

1. **patient-centered**
2. **comprehensive**
3. **team-based**
4. **coordinated**
5. **accessible, and**
6. **focused on quality and safety**



It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff, so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs.

Patient Centered Primary Care Collaborative:https://www.pcpcc.org/about/medical-home

A Medical Home typically provides:

- ✓ Excellent, accessible communication between providers, nursing staff and patients
- ✓ Full involvement of the patient in the treatment and decisions made regarding their own healthcare
- ✓ Care coordination to ensure that patient needs are met, test results and specialist visits are tracked and followed-up and all staff are knowledgeable about their roles and responsibilities towards the patient
- ✓ After hours access to a provider
- ✓ Technology that enhances the care of the patient through education and data and performance measurement

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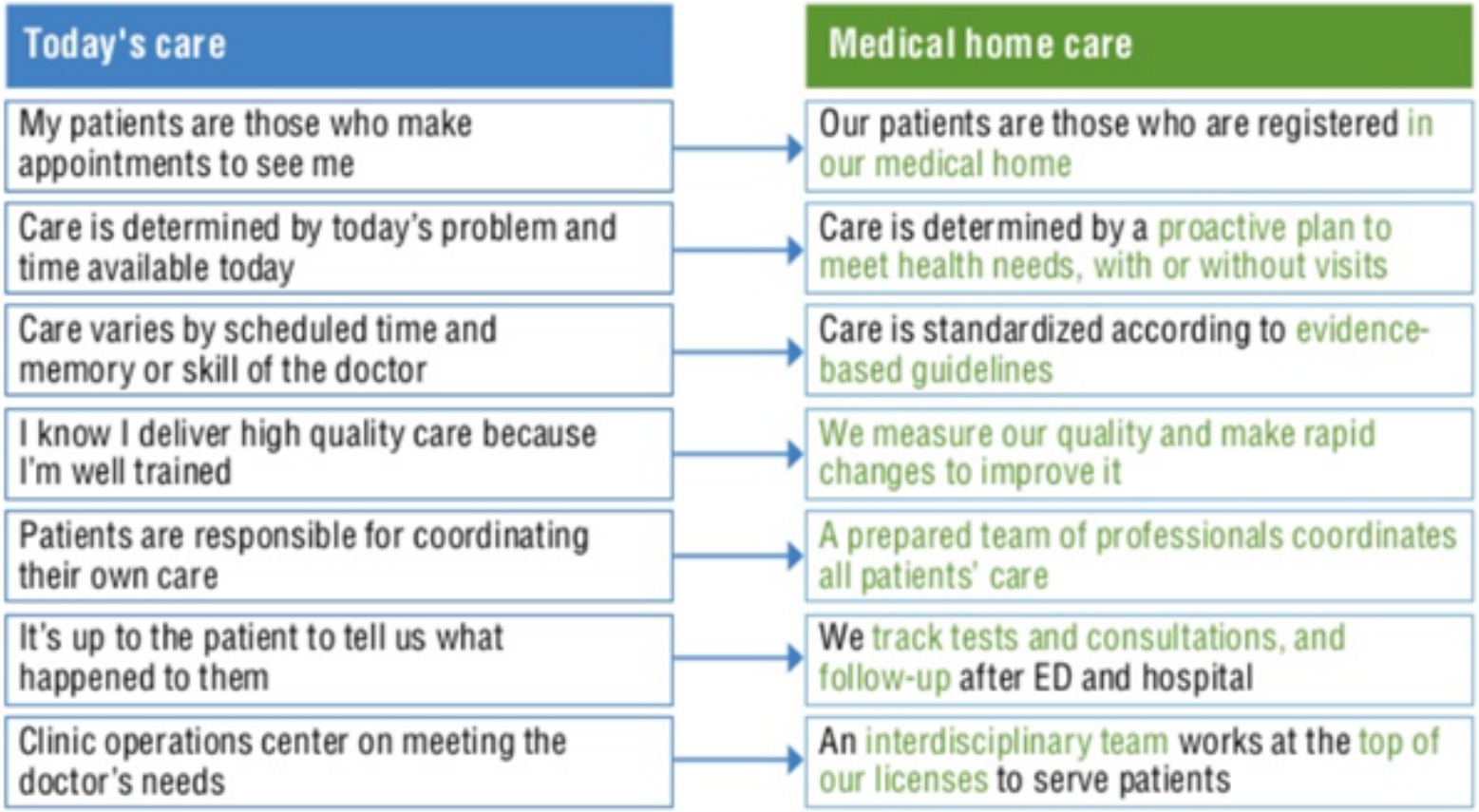
How It Works In Practice:



Patient-Centered Medical Home. What, Why and How? Jim Adams, Paul Grumdy, MD, Martin S. Kohn, MD, and Edgar Mounib:http://www.slideshare.net/fullscreen/DrGrundy/pcmh-what-why-and-how/3

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Does Your Medical Home Offer Services Like These?

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Many Practices Want To Offer More Services, But How Do You Go About It?

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IN-HOUSE: Developing New Services

Create ‘Clinics’ within your practice to meet your patients’ needs

- Adolescent clinics
- Asthma clinics
- Nutrition clinics
- Breastfeeding services
- Even Travel clinics!

➢ Provides excellent marketing opportunities and helps with scheduling

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IN-HOUSE: Developing New Services

What others are doing:

- Asthma clinics
  - Certified Asthma Educator to assist with treatment, education and management of asthma and asthma related diseases including
  - Medication monitoring and compliance;
  - Asthma control and action plan
  - Spirometry and nebulizer treatments
  - Patient centered goals and objectives related to control of the disease

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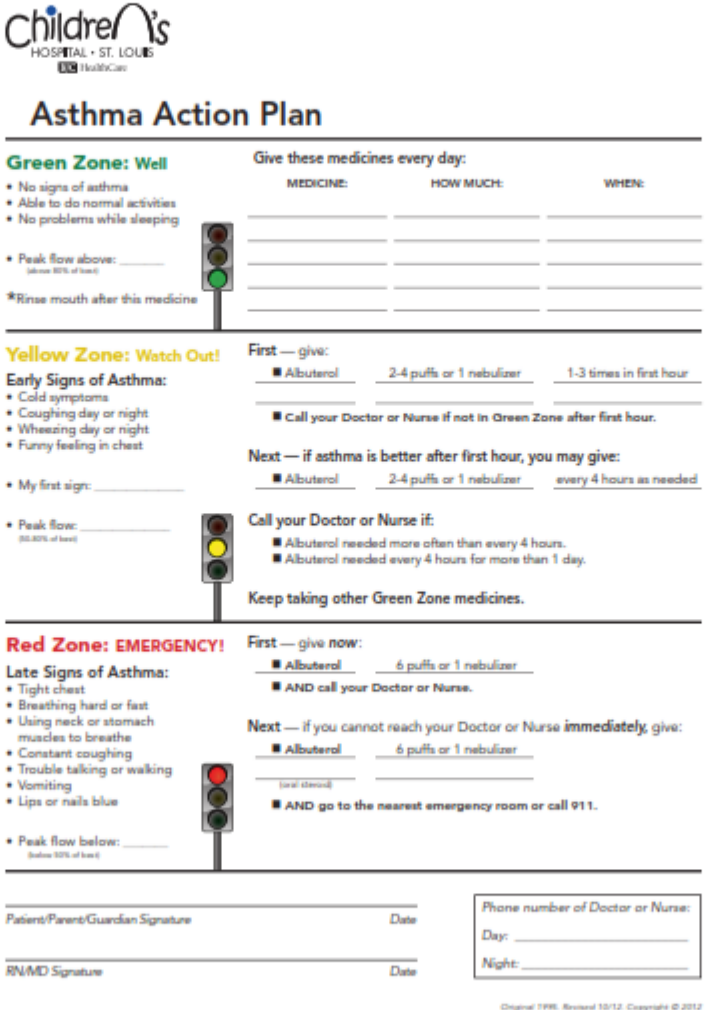
Sample Asthma Plans



Children's HOSPITAL • ST. LOUIS

Asthma Action Plan

Green Zone: Well
- No signs of asthma
- Able to do normal activities
- No problems while sleeping
- Peak flow above: _____ (above 80% of best)

*Rinse mouth after this medicine

Give these medicines every day:

MEDICINE:	HOW MUCH:	WHEN:

Yellow Zone: Watch Out!

Early Signs of Asthma:
- Cold symptoms
- Coughing day or night
- Wheezing day or night
- Funny feeling in chest
- My first sign: _____
- Peak flow: _____ (50-80% of best)

First — give:

■ Albuterol	2-4 puffs or 1 nebulizer	1-3 times in first hour

■ Call your Doctor or Nurse if not in Green Zone after first hour.

Next — if asthma is better after first hour, you may give:

■ Albuterol	2-4 puffs or 1 nebulizer	every 4 hours as needed

Call your Doctor or Nurse if:
- ■ Albuterol needed more often than every 4 hours.
- ■ Albuterol needed every 4 hours for more than 1 day.

Keep taking other Green Zone medicines.

Red Zone: EMERGENCY!

Late Signs of Asthma:
- Tight chest
- Breathing hard or fast
- Using neck or stomach muscles to breathe
- Constant coughing
- Trouble talking or walking
- Vomiting
- Lips or nails blue
- Peak flow below: _____ (below 50% of best)

First — give **now**:

■ Albuterol	6 puffs or 1 nebulizer

■ AND call your Doctor or Nurse.

Next — if you cannot reach your Doctor or Nurse **immediately**, give:

■ Albuterol	6 puffs or 1 nebulizer
(oral steroid)	

■ AND go to the nearest emergency room or call 911.

Patient/Parent/Guardian Signature _____ Date _____

RN/MD Signature _____ Date _____

Phone number of Doctor or Nurse:
Day: _____
Night: _____

Original 1998. Revised 10/12. Copyright © 2012

Pick and choose from various resources, and customize to fit your needs!

Asthma Action Plan from Children's Hospital, St. Louis

Easy for parents to follow, pictures that even the youngest child can recognize.

http://www.stlouischildrens.org/our-services/allergy-immunology-and-pulmonary-medicine/asthma-education

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IN-HOUSE: Developing New Services

What others are doing:

- Nutrition clinics
  - On-site nutritional health evaluation by independently contracted counselor
  - Treatment and counseling services for individuals, families and groups
  - Tie in with community based weight ins and ‘weight watcher’ program at the local YMCA
  - Schedule alongside well visits

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Nutrition example

How about an 8 month visit or a 21 month visit with the nurse to teach proper nutrition habits?

Calculate by forecasting:

- You have three hundred 8 month olds a year
- Nurse payment at $50.00
- Don’t forget the cost of your nurse!

300 x 20 minutes = 100 hours x nurse salary ($25/hr)= $2,500

$15,000 - $2,500 = **$12,500 net profit**

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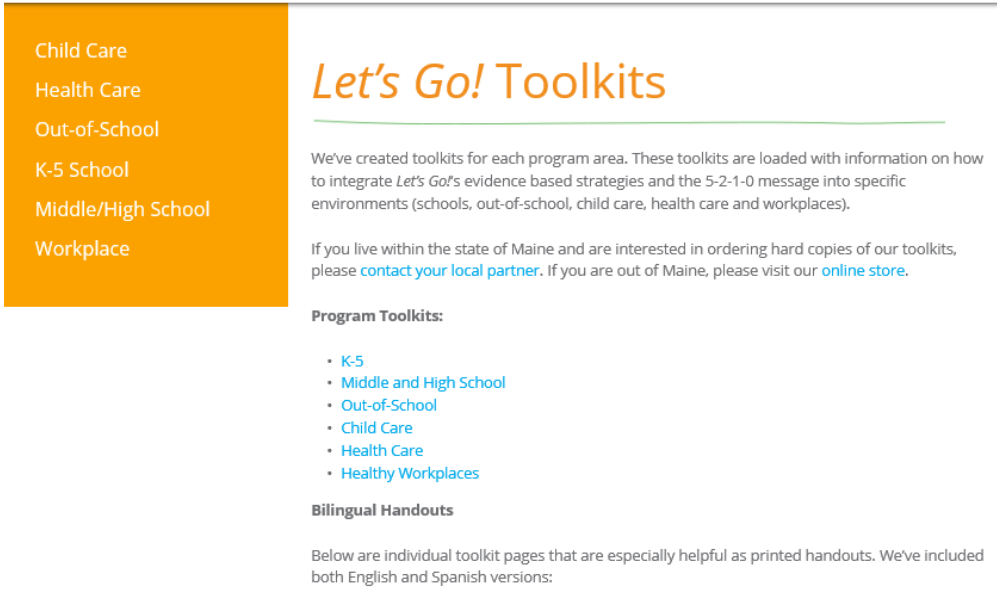
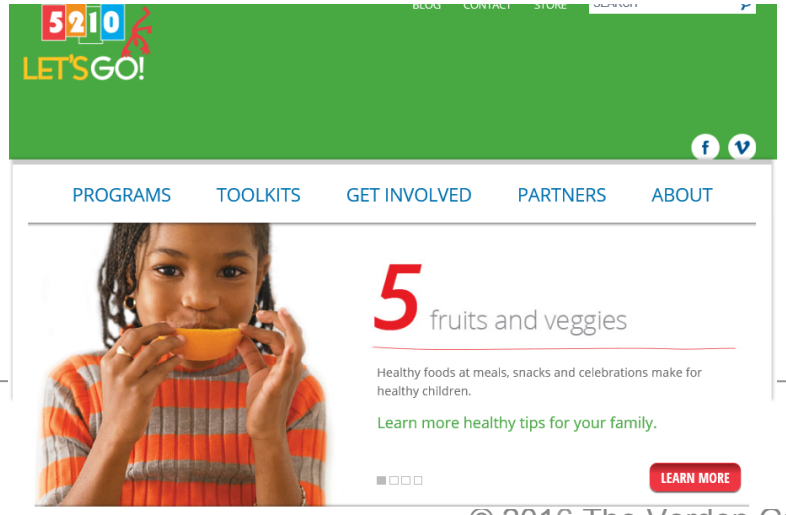
Nutrition Program Example

Example: www.LetsGo.org

Combatting Pediatric Obesity

- Encourages use of their materials
- Allows co-branding of materials and customization





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IN-HOUSE: Developing New Services

What others are doing:

- Adolescent clinics
  - Specific hours for teens (certain days & hours)
  - Specified exam rooms for teens that are age appropriate (not 'kiddie')
  - Teen education programs playing in waiting room
  - Greater emphasis on teen screens and services
- ➢ Adolescent Well Visits including depression and substance abuse screening, may be a new metric coming to Payer plans soon

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IN-HOUSE: Developing New Businesses

Develop Entirely New Businesses

- Lactation / Breastfeeding Center
- Behavioral / Social Health Center
- Urgent Care / After Hours Clinic

- Bringing services in-house either through direct employee contributions or through sub-contracted professionals, extends your reach in the market.
- These can be developed as extensively as you like, with their own tax ID numbers and 'brand', or less extensively as a business within your practice that is financially separate

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IN-HOUSE: Developing New Lines of Business

Lactation / Breastfeeding Center

- Can reside within your pediatric practice footprint or as a separate area altogether
- Some practices designate 2 exams rooms and design as newborn & nursing rooms
- Schedule consultations alongside the newborn visit and / or the 1 month for patient convenience
- Utilize a trained employee or contract with an independent agent
- Great practice builder and new Moms love the newborn / nursing rooms

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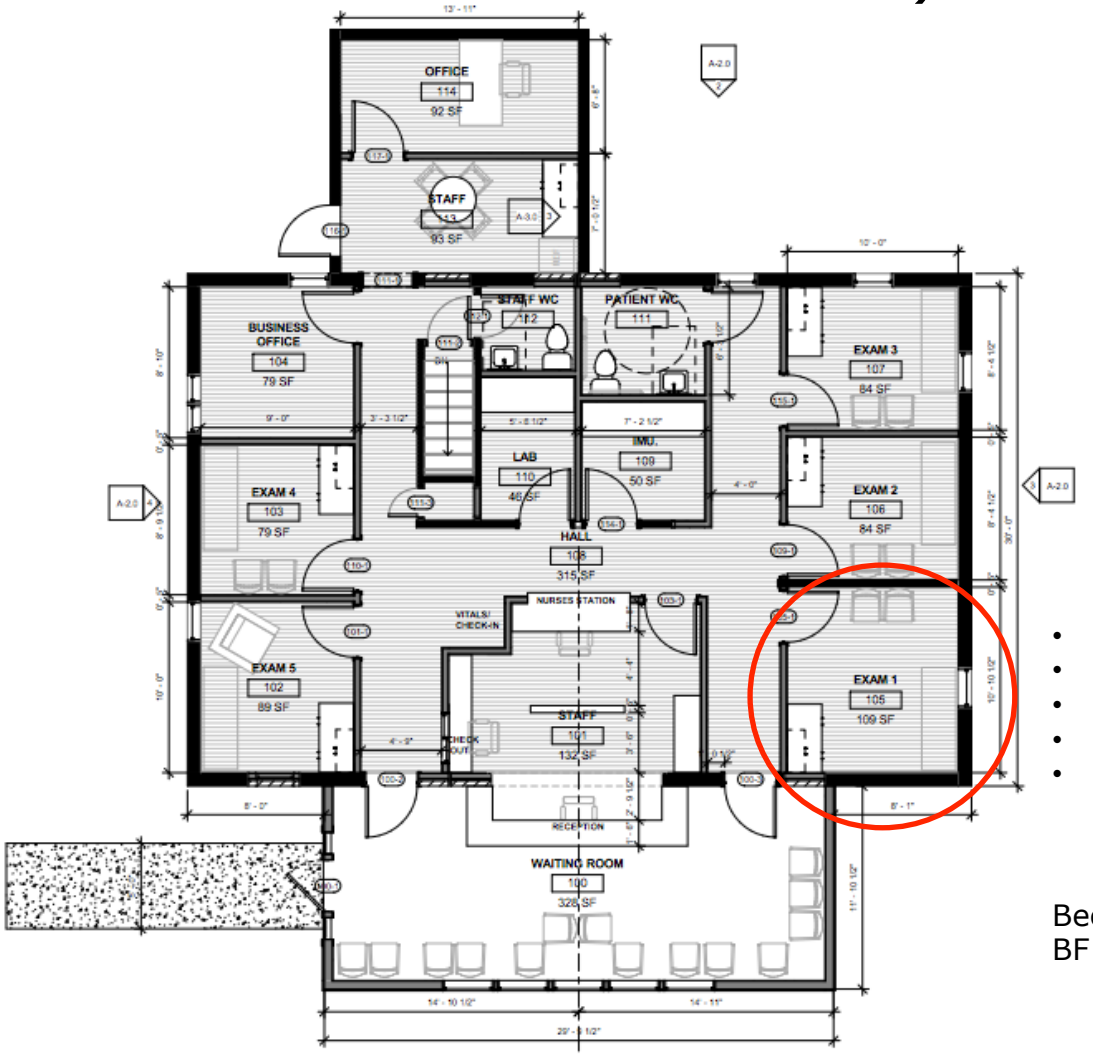
Even a small practice can be a BF center! (new service rather than business for smaller entities)



- Add a lazy-e-boy
- Add a Boppy
- Add a baby scale
- Add a mobile
- Newborns get seen by doc, LC sees Mom for BF consult

Becomes the 'newborn / BF room!

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IN-HOUSE: Developing New Lines of Business

Behavioral Health Center

- Usually resides within pediatric practice footprint
- Staff it with an employee (if practice population supports it) or contract with an independent agent or lease space to therapist / social worker who is building their practice
- Usually defined hours, practice staff manages schedule and can set up appointments without patient having to arrange separately
- Allows for better care, coordination, access
- Even just start with an ADHD program and a qualified / trained nurse

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ADHD Program Tools

The Children's Hospital of Philadelphia
Center for Management of ADHD Health Resources

Videos

Executive Functioning and ADHD

A CHOP psychologist discusses executive functioning in children with ADHD, and provides practical tips for parents.

Helping Teens with ADHD Succeed after High School

This video focuses on the transition to adulthood for teens with ADHD, presented by J. Russell Ramsay, PhD, co-director of the Adult ADHD Treatment and Research Program the Hospital of the University of Pennsylvania.

Helping Your Adolescent With ADHD Succeed

Psychologists from The Children's Hospital of Philadelphia discuss ADHD in the contex adolescence, and suggest strategies to help your teen with ADHD.

Helping Your Child with ADHD Succeed at Home

Dr. **Stephen L. Soffer, PhD**, psychologist in the Center for Management of ADHD at The Children's Hospital of Philadelphia, discusses interventions and treatment options to h children with ADHD succeed in the home environment.

Helping Your Child With ADHD Succeed at School

CHOP psychologists describe the role of parent-school collaboration in success of students with ADHD, and present practical school- and home-based behavior management strategies.

Helping Your Child With ADHD Succeed Socially

A psychologist from The Children's Hospital of Philadelphia discusses the effect of ADHD on peer relationships and ways to help your child improve his social skills and make and keep friends.

Preparing Your Teen with ADHD for Safe Driving

This video discusses the impact of ADHD on teen behavior as it relates to driving and provides strategies for promoting safe driving in teens with ADHD.

For Parents and Caregivers

How to Increase Success at Home for Children With ADHD

As a parent of a child with, you will often need to be the manager of the team that helps your child succeed. Find out how you can help.

http://www.chop.edu/centers-programs/center-management-adhd/health-resources#.V4BM-o3Hz4g

IN-HOUSE: Developing New Lines of Business

Urgent Care Center

- Typically is a separate building, or has a separate entrance to main practice
- Staff with existing providers and staff
- Close practice at 5pm, all after hours care provided at the UC
- Network with small practices to be their preferred referral choice when they are closed (by providing excellent follow up and pass back)
- Compete directly with retail-based clinics
- Many Payers offer separate contracts for UC, but note: higher copays for patients is likely!

Do Your Research Before Undertaking

Ask your patients what they need! You have a captive audience of 100s of patients every week / month coming to your practice – hand them a short survey and ask for their feedback!

Do your market research too:

- Number of annual births (www.cdc.gov/nchs/fastats/births.htm)
- City demographics (citydata.com – it's free)
- Distance to competitors (plot via www.easymapmaker.com of similar free software)
- Competitor offerings (check out their websites)

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Utilizing Community Resources

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Types of Community Resources

- Hospital based baby CPR
- Weight watchers
- Multicultural centers (isolation, language issues)
- Local YMCA (often have weight / diet and health programs)
- Local churches
- Yoga studios (parental stress)
- Local Schools

Referral Resource: 211.org

211 is a free, confidential service to help find needed local resources:

- supplemental food and nutrition programs
- shelter and housing options and utilities assistance
- emergency information and disaster relief
- employment and education opportunities
- services for veterans
- health care, vaccination and health epidemic information
- addiction prevention and rehabilitation programs
- reentry help for ex-offenders
- support groups for individuals with mental illnesses or special needs
- a safe, confidential path out of physical and/or emotional domestic abuse

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Shortage of Community Resources?

Connect the dots and pull together:

- Available apps
- Educational resources
- National / Government / Open programs
- Become an Advocate!

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Mobile Apps – examples:

ADHD Tracker 1.0

Using the Vanderbilt Scales published by the American Academy of Pediatrics, this free app makes completing and submitting a behavioral assessment easier for parents and teachers of children ages 4 through 18 years who have already been diagnosed and treated for ADHD. **Price: FREE**

Child Health Tracker

Child Health Tracker gives you the power of on-demand access to your child(ren)'s health information, needs, and providers and in addition, provides AAP guidance on the vaccinations and milestones you should be expecting with each birthday. Also included are tools like parent handouts for each well child visit. **Price: $4.99**

Download on the App Store

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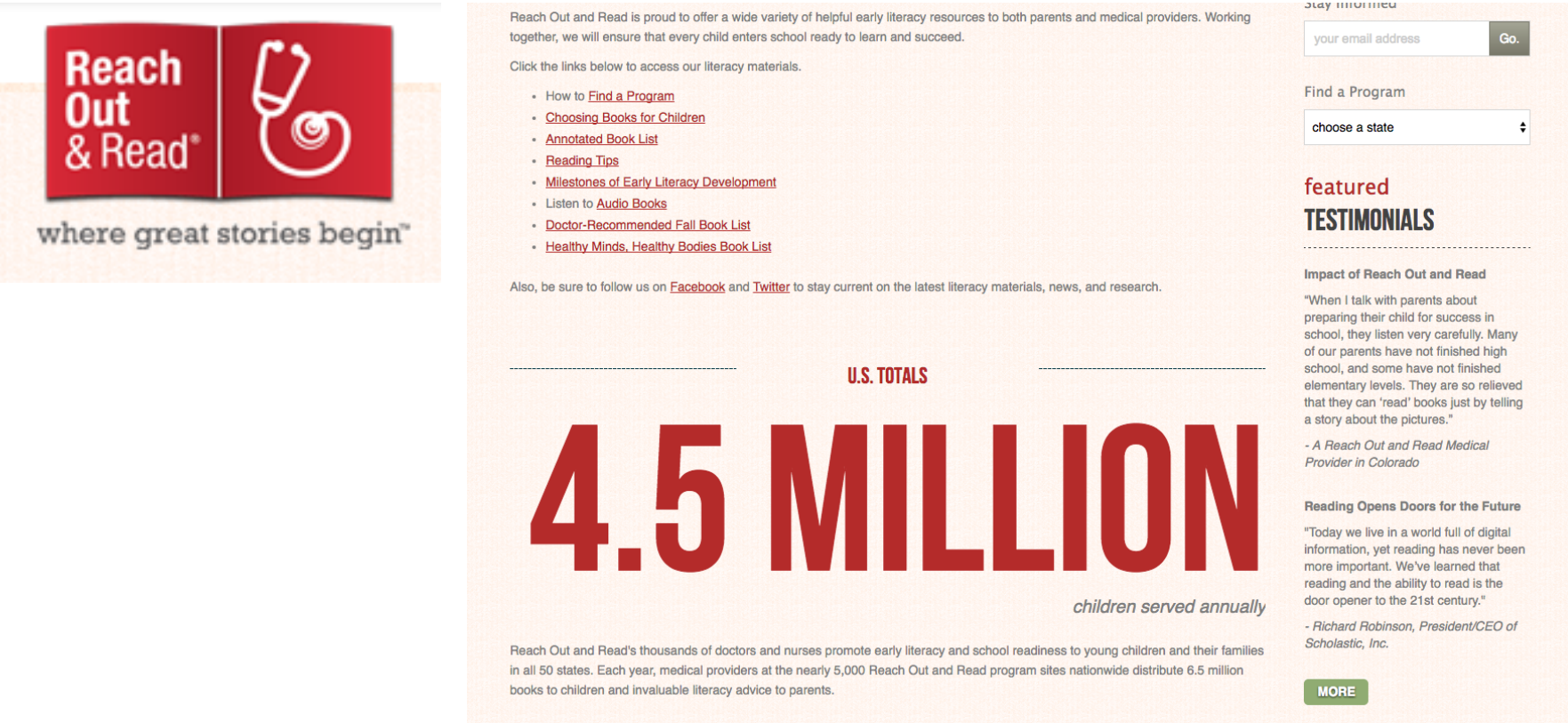
Educational Resources – example:



http://reachoutandread.org/resource-center/literacy-materials/

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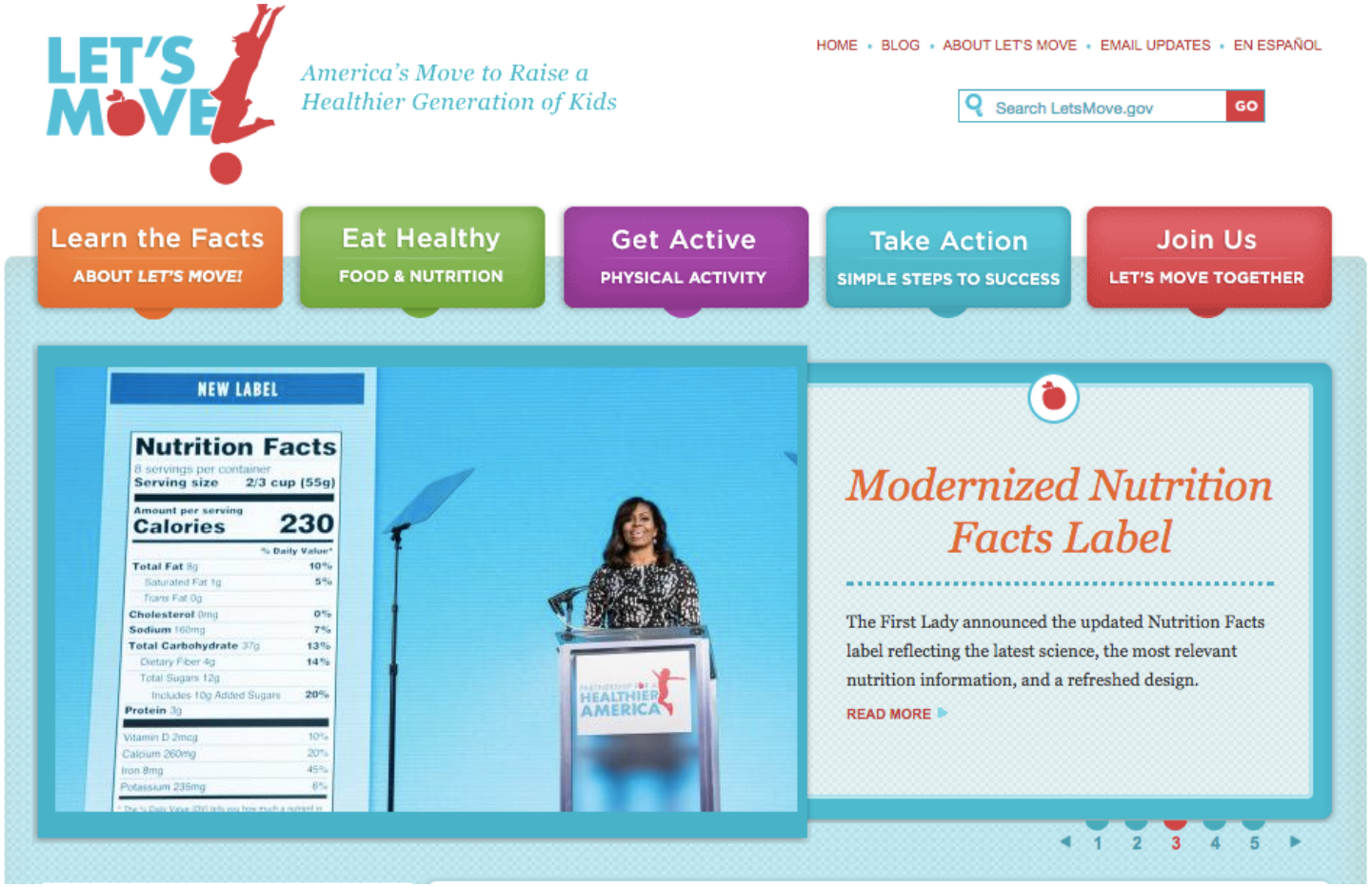
National / Govt. Programs



http://www.letsmove.gov/

Become an Advocate

Some examples of the role that you as a pediatrician could play in community advocacy could include:

- Partner with child advocacy organizations in your area
- Inform community leaders, decision-makers, and elected officials about issues that are affecting children in your community
- Invite decision-makers to visit your professional setting or community project
- Provide testimony and telling your story at community forums, events, and in your local media
- Serve on the board of an organization that supports children's health and well-being or children's interests such as a school board
- Offer medical expertise to schools, youth organizations or institutions, and child care centers
- Ask parents, teachers, and other health care professionals and clinicians in your area to get involved in local efforts to improve children's health and well-being
- Initiate a community project or forming a partnership, alliance, or coalition to address a problem

https://www.aap.org/en-us/advocacy-and-policy/community-advocacy/Pages/Community-Advocacy.aspx

Good opportunity for an NP to build a Program?

Advocacy Training Modules

These training modules and guides were created to help you prepare for and present the legislative advocacy training curriculum in an easy-to-follow and uniform format. A trainer guide accompanies each of the modules and provides prompting questions you can use to encourage participation and input, tips for presenting the training content, and suggestions on timing.

The AAP Advocacy Guide is designed to make it easier for you to advocate for children and pediatricians. It includes tips, tools, and real-life examples from other pediatricians about how you can use your voice to create positive and lasting change as an individual with patients and families, in your community, through your chapter and in your state, and at the federal level.

Please feel free to modify the presentations to fit the needs of your program. The training modules were designed as stand-alone trainings and do not need to occur sequentially. However, starting with the Overview of the Legislation Process module is recommended. This module will help pediatric residents get comfortable with basic skills outlined in subsequent modules. Each module is designed to take about 45 minutes, incorporate "real time" learning, and be fun and interactive.

+ **Training Module 1: Overview of the Legislative Process**
+ **Training Module 2 : Working in Partnerships**
+ **Training Module 3: Working with Decision-Makers**
+ **Training Module 4: Advocacy Communication**
+ **Training Module 5: Voting with Children's Health and Pediatric Resident's Schedule in Mind**

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/CPTI/Pages/Advocacy-Training-Modules.aspx

Help the Un- / Under-insured

Prescription Assistance:

https://healthfinder.gov/FindServices/SearchContext.aspx?topic=696

Non-profit Organizations:

https://healthfinder.gov/FindServices/SearchOrgType.aspx?OrgTypeID=2&show=1

State Health & Human Services:

https://healthfinder.gov/FindServices/SearchOrgType.aspx?OrgTypeID=8&show=1

Insurance Coverage / Medicaid qualification:

https://www.healthcare.gov/

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Utilizing Health Care Insurance Company Resources

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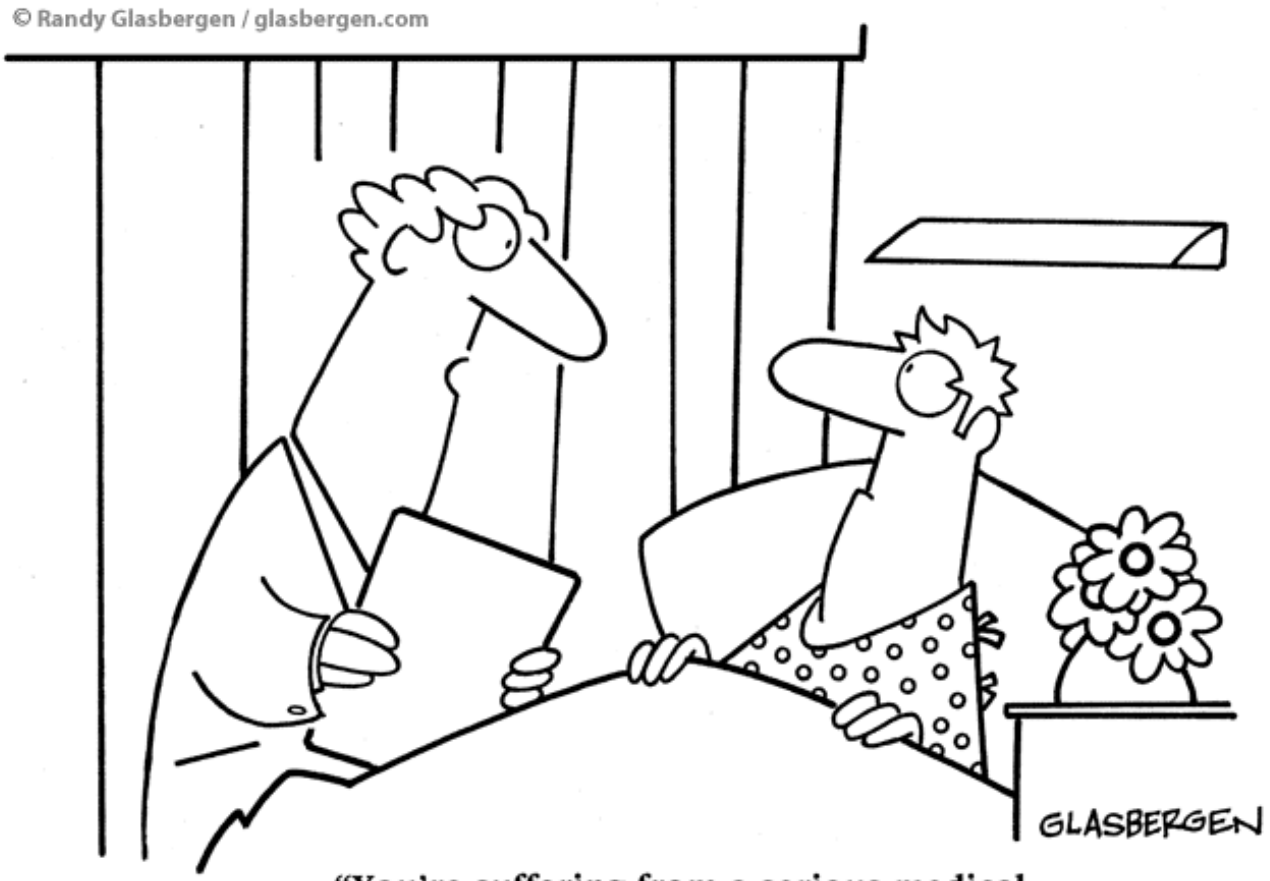

"You're suffering from a serious medical condition called 'lousy insurance'."

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Aetna has a Behavioral Health program and a step by step checklist to help you integrate this into your practice.

Checklist

Aetna Integrated Primary Care Behavioral Health Program

The Aetna Integrated Primary Care Behavioral Health Program offers a collaborative approach that allows the direct provision of behavioral health services to our members in the primary care setting.

When implementing an integrated approach in your primary care practice, consider the following:

❍ **Lease agreement**
- Necessity of lease agreement between primary care physician (PCP) practice and behavioral health clinician/practice

❍ **Location where the behavioral health clinician will see patients**
- Available exam room
- Unoccupied office or room

❍ **Times when room will be available for the behavioral health clinician to see patients**
- Set day(s) and time(s) of the week
- Increase/decrease allotted time, depending on patient volume

❍ **Workflow to confirm patient insurance coverage**
- Aetna medical — for services provided by the physician
- Aetna Behavioral Health — for services provided by the behavioral health clinician
  > Behavioral health clinicians submit their own claims for services provided in the PCP practice, and are reimbursed from the behavioral health benefit
- Non-Aetna coverage
  > Explore available options for behavioral health clinicians to provide services for patients with other insurance coverage

❍ **Workflow for physician to refer patients to the behavioral health clinician**
- Designated contact person in PCP and behavioral health practices to send/receive referrals
- Use of a referral form

❍ **Scheduling appointments**
- Behavioral health or PCP practice to verify patient's behavioral health benefits
- Behavioral health or PCP practice to contact patient and schedule appointment

❍ **Charting and confidentiality**
- Behavioral health clinician's access to the medical record
- Obtaining a patient release

❍ **Behavioral health clinician reports**
- Designated contact person in PCP and behavioral health practices to send/receive written reports about behavioral health intervention

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How the program works

- Primary care physician refers patients, as clinically indicated, to the behavioral health clinician.
- Behavioral health clinician maintains a problem-solution focus and sees patients for up to three sessions* within the primary care setting.
- Behavioral health clinician communicates on a regular basis with the primary care physician and provides written reports about interventions and patient progress.

Behavioral health clinician billing guidelines

Behavioral health clinicians (licensed psychologists, either master's or PhD level; licensed social workers, master's level minimum; or licensed professional counselors, master's level minimum) delivering behavioral health services in primary care offices may submit claims to Aetna for the first three (3) patient sessions using the following codes:

- **Diagnosis code: V40.9** (Unspecified mental or behavioral problem).**
- **Procedure code: 99242** — Office consultation for a new or established patient, which requires these three key components: an expanded problem-focused history, an expanded problem-focused examination and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies is provided, consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Behavioral health clinicians typically spend 30 minutes face-to-face with the patient and/or family.

Behavioral health clinicians will submit claims using their behavioral health office address and provider ID number/tax identification number. Aetna will reimburse the provider out of the behavioral health benefit in the manner set forth in their agreement.

*If additional behavioral health services are required beyond the three initial visits, the patient is referred to a network community provider or continues to see the integrated behavioral health clinician outside the primary care setting.
**Effective October 1, 2015: Submit claims using the following codes: diagnosis code: F48.9 and procedure code: 99242.

And they are upfront about the number of visits, coding and the type of clinician eligible in a primary office.

99242 (Office consultation new / estbd) = 2.9 RVUs
($104.15 CMS National 2016)

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Case Management

Anthem BlueCross

ConditionCare

About the Program

A team of nurses with added support from other health professionals – such as dietitians, pharmacists and health educators – work with members to help them understand their condition(s), their physician's orders and how to become a better self-manager of their condition. Members are stratified into three different risk levels.

Engagement methods vary by risk level but may include:

- **Education** about their condition through mailings, telephonic outreach, and/or online tools and resources.
- **Round-the-clock phone access** to registered nurses.
- **Guidance and support** from nurse coaches and other health professionals.

Physician benefits:

- **Saves time** for the physician and staff by answering patient questions and responding to concerns, freeing up valuable time for the physicians and their staffs.
- **Helps support the physician-patient relationship** by encouraging participants to follow their physician's treatment plan and recommendations.
- **Provides** the physician with updates and reports on the patient's progress in the program.

Nurse coaches encourage participants to follow their physician's plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate the member on options for their treatment plan. Providers may receive a quarterly report for patients who are currently enrolled in the program including the member's current educational goals.

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Humana case management and chronic care programs

Overview of programs

Members who choose to enroll in a Humana case management or chronic care program are assigned a care manager who supports them by phone (eligible members also receive home visits). The manager's goal is to anticipate members' needs and problems, encourage preventive care and prevent costly interventions through home-safety assessments and evaluations of medical, functional and psychosocial status.

Services may include:

- Facilitating conference calls between the member, the physician and the care manager as needed to clarify treatment plans, medication regimens or other urgent issues.
- Monitoring medication adherence.
- Assessing the member's daily living activities and cognitive, behavioral and social support.
- Assessing the member's risk for falls and providing fall-prevention education.
- Connecting members and their families with professionals who can help them address medical, legal, housing, insurance and financial issues facing older adults.
- Helping caregivers access support and respite care.
- Arranging access to transportation.
- Assisting members in obtaining home health and durable medical equipment.
- Referring members to meal-delivery programs and advance directive preparation services.

24 Hour Nurse Line
Oxford On-Call®

When you're worried about someone you love at 2 a.m., you want to talk to someone who can help. That's exactly what you get with *Oxford On-Call*. 24 hours a day, 365 days a year, you can speak with an informed, registered nurse who is available to offer suggestions and guide you to the most appropriate source of care.

Oxford On-Call nurses can:

- Identify caller symptoms and recommend next steps using one of the most advanced patient assessment systems available.
- Pose a series of questions derived from clinically tested algorithms.
- Recommend a visit to an emergency room, suggest an appointment with a physician, or suggest how to care for a problem at home.
- Refer Members directly to specialists when medically appropriate.
- Make follow-up calls to promote continuity of care.
- Keep primary care physicians informed by faxing call records.

If you are a Member and you need to reach *Oxford On-Call*, please call 800-201-4911.

Patient's should call you first….but sometimes they don't. Keep actively engaged with the Nurse Line for continued communication about your patient!

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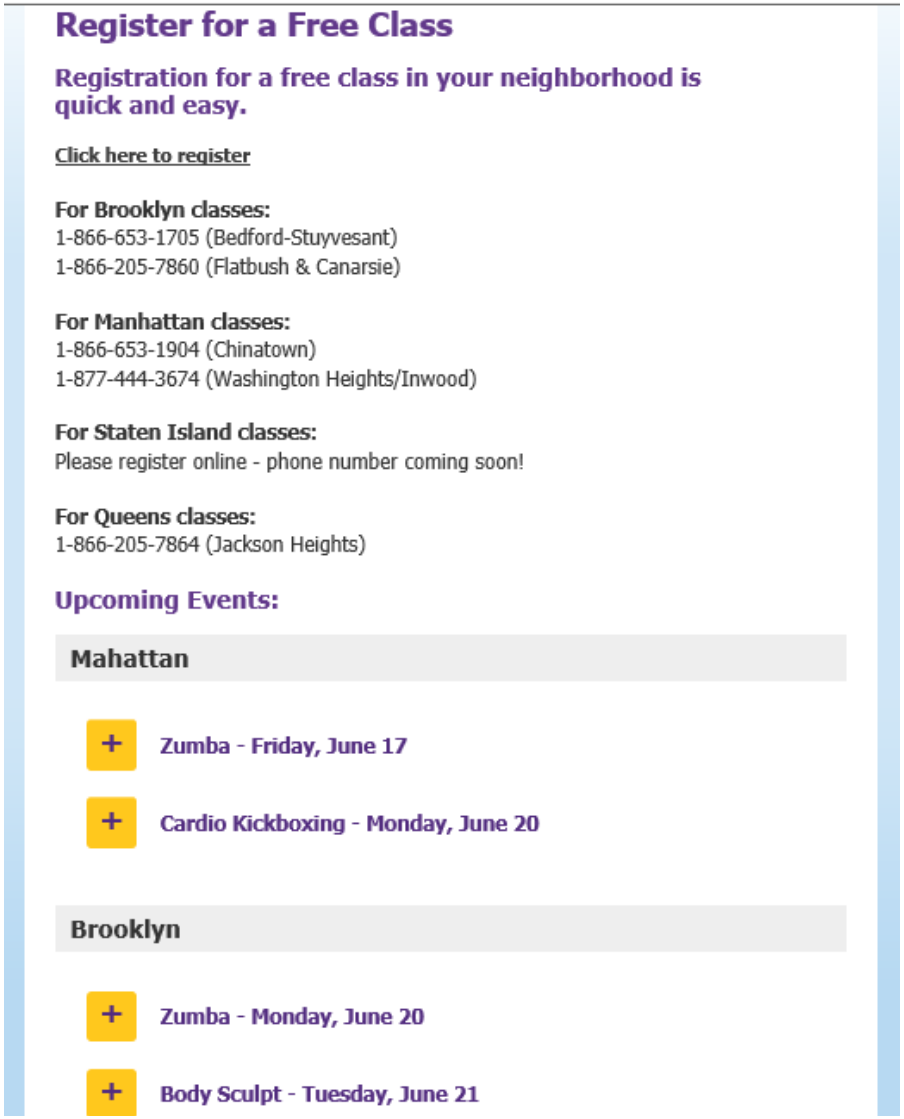
EmblemHealth

Free classes. . .



Register for a Free Class

Registration for a free class in your neighborhood is quick and easy.

Click here to register

For Brooklyn classes:
1-866-653-1705 (Bedford-Stuyvesant)
1-866-205-7860 (Flatbush & Canarsie)

For Manhattan classes:
1-866-653-1904 (Chinatown)
1-877-444-3674 (Washington Heights/Inwood)

For Staten Island classes:
Please register online - phone number coming soon!

For Queens classes:
1-866-205-7864 (Jackson Heights)

Upcoming Events:

Mahattan

+ Zumba - Friday, June 17

+ Cardio Kickboxing - Monday, June 20

Brooklyn

+ Zumba - Monday, June 20

+ Body Sculpt - Tuesday, June 21

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Tools to combat childhood obesity

Funding

Always check to see if there are any grants available to help get a new program off the ground.

Example:
http://www2.aap.org/commpeds/grantsdatabase/

Coming soon – grant match up from the new Independent Practice MSO
(register for more information at www.theverdengroup.com/ipmso)

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Q & A

Contact Information

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