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Riding the Wave.....

Objectives

- Leverage Patient Centered Medical Home (PCMH) as a framework to leverage Quality Payment Program (QPP)
- Utilize PCMH process to ease providers and staff into Value Based Performance
- Develop strategies to align PCMH and other VBP initiatives

The Beginning.....

Small practice

Limited Resources

An overwhelming number of programs for a small staff

Limited buy-in

Solution: Give the Providers and Staff one way to do the right thing and show them their financial viability depends on it



PCMH Facilitation Process

- Gather Information: survey, interview and observe
- Analyze and identify strengths and opportunities
- Work with Providers and staff to set goals

PCMH Stages



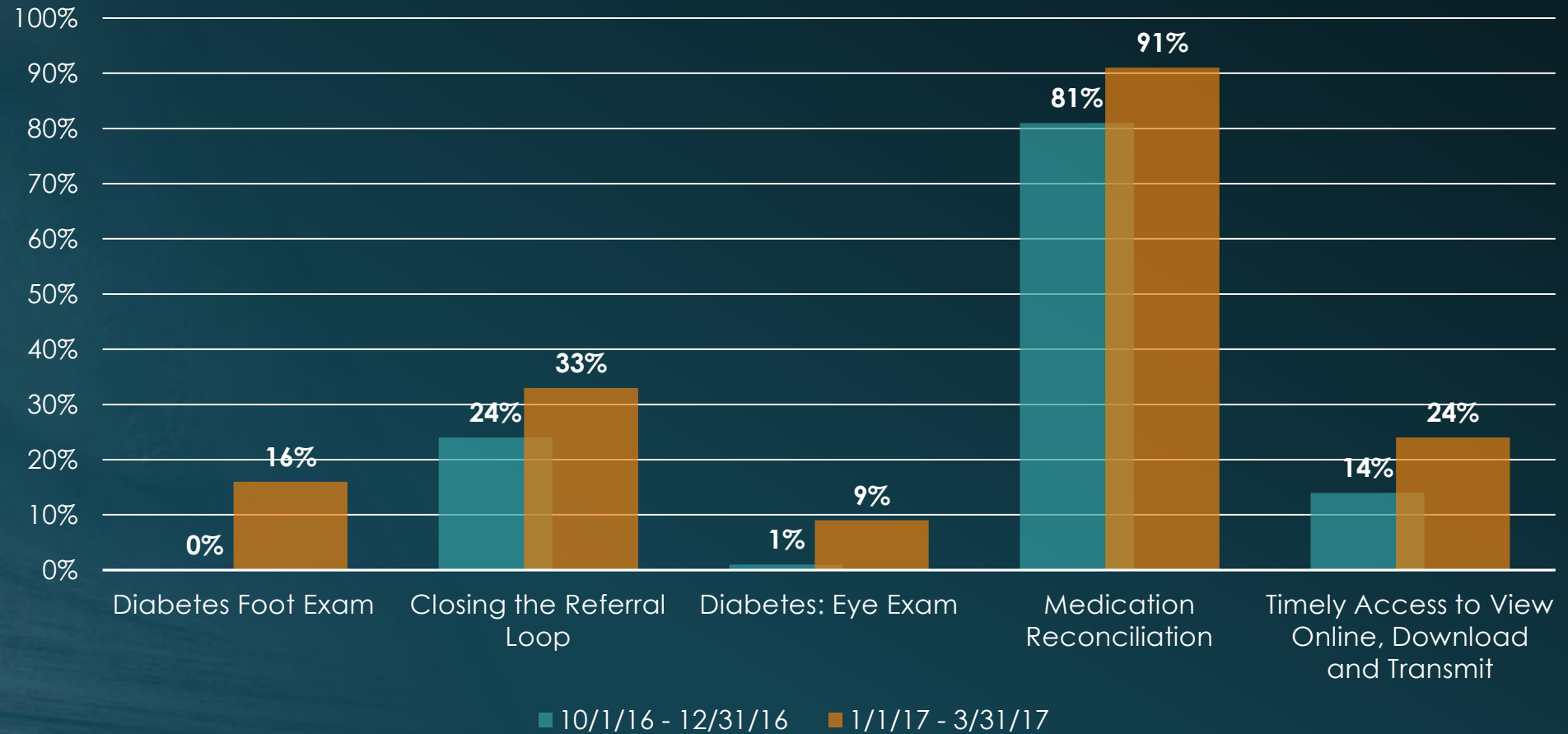


Stage 2 Organizational Building Capacity

Utilization of Reliable data and understanding of measures

- Data was used to determine areas of clinical concern and thus the areas of focus
- Selected same chronic conditions to track, with an outcome of improved health and specific quality outcomes
- Integrated within the EHR

Clinical Quality Measures



Now, see what we've working on?

	FFS Environment	PCMH Environment	VBP Environment
Availability of Appointments	Am I seeing enough patients?	Do I measure my appointment availability?	Do I offer the right amount of appointments to meet the needs of the patient population?
Uses Shared Decision Making Aids		I sometimes discuss shared decision making aids	I know patients engaged when they are informed and able to participate in the decisions.
Measures affecting health care costs	Cost/patient-internal	I monitor at least 6 measures and strive to improve on 4	I measure and monitor 6 measures and implement interventions to achieve appropriate utilization and cost



PCMH as the Driver to Value

- PCMH is its entirety is your Population Health Management Intervention
- Cross Alignment of competencies create your value based outcome
- Assessing your application against intent is your blueprint

Questions

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