Patient-Centered Medical Home Success Stories
Transforming and improving the delivery of health care
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Horizon Blue Cross Blue Shield of New Jersey is collaborating with doctors, hospitals and other health care leaders to create a health care system in New Jersey that achieves better health outcomes, a better patient experience and a lower cost of care.

Horizon BCBSNJ’s patient-centered programs, which transform reimbursement from a fee-for-service method to a pay-for-value model, will play an important role in improving care, increasing accountability and accelerating better health outcomes. Horizon BCBSNJ’s patient-centered programs, including our Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs), focus on improving the quality of care patients receive and the vital role doctors and care teams play in care coordination, which is the hallmark of these care delivery and payment reform programs.

A PCMH is a primary care doctor’s practice that coordinates patients’ health care needs and helps ensure that they receive quality care, at the right place and at the right time. This approach provides a personalized and comprehensive health care program that enables patients to become engaged in their health care.

The following includes some real-world success stories of how practices that are part of New Jersey’s largest PCMH program are delivering more coordinated and effective care for Horizon BCBSNJ’s members.
Decreasing Avoidable Emergency Room Visits

A solo-practitioner PCMH practice wanted to reduce patients’ avoidable Emergency Room (ER) visits by improving access and engaging patients immediately about their concerns.

**Solution:** The practice developed a process to give its patients 24/7 access to the doctor. When the office is closed, all phone calls are transferred to the doctor’s personal cell phone, which provides patients the opportunity to discuss their perceived emergency conditions with their doctor before proceeding to the ER. After consulting with the patient, the doctor makes a determination as to whether an ER visit is appropriate.

**Outcome:** The PCMH practice significantly decreased avoidable ER visits as a result of ensuring its patients were informed and understood the new policy around improved access. Ensuring 24/7 access has allowed the doctor to discuss concerns that patients may have over the phone prior to visiting the ER. For example, one patient, a 48-year-old woman with a history of abdominal pain and urinary tract infections, frequently visited the ER for treatment when the office was closed. When it was explained to the patient that she had 24/7 access to the doctor during perceived emergencies, she began contacting the doctor on weekends and the doctor was able to reduce all avoidable ER visits for this patient. This also allowed the doctor to build a stronger relationship with the patient, improve her patient experience and help ensure the patient receives the right care, at the right place, at the right time.
Improving Engagement and Care for a High-Risk Patient

A Population Care Coordinator (PCC) identified a 23-year-old female patient who frequently visited the Emergency Room (ER) and was often admitted to the hospital. The patient had a combination of complex medical and behavioral health conditions, including depression and anxiety. The patient was also on approximately 14 medications.

Solution: The PCC met with the patient’s doctor to discuss her frequent ER visits and hospital admissions. A detailed care plan was developed and implemented by the doctor and PCC that led to improved patient engagement and gave the team the ability to deliver more effective care. The PCC worked in partnership with the patient and the doctor to clearly understand the condition and needs of the patient. The PCC also engaged the patient’s mother to understand her family support system.

Outcome: Two years have passed since the practice first contacted this patient as part of the PCMH program. Care coordination has greatly improved with her specialists. The PCMH practice developed a medical neighborhood specifically for this patient. With this new relationship and improved access, unnecessary ER visits and hospital admissions have been avoided. In addition, the patient’s complex conditions are now controlled, and her doctor was able to significantly reduce her medication regimen. Most importantly, the relationship she has with members of the practice has greatly improved the quality of life for the patient and her family.
Developing, Coordinating and Connecting Patients to Improve Care

A multi-site practice identified that its patients needed improved access to behavioral health resources within their community. The practice could better coordinate care for their behavioral health patients if they achieved a better understanding of the available resources within their medical neighborhood.

Solution: The practice team developed a comprehensive list of providers within a five-mile radius of each of their offices for behavioral health clinicians who deliver treatment, counseling and services for alcohol and substance abuse, depression and family counseling. The team called each local practice to confirm the services they provide, their contact information and the insurance plans they accept. This information was compiled and placed in a town-by-town listing, along with other useful contact information of mental health professionals at nearby hospitals and various support groups. The resource directory was distributed to all practice locations to help doctors and care coordinators deliver better coordinated care to their patients with behavioral health needs.

Outcome: Providing the doctors and care coordinators with this information greatly improved care for their patients. Office staff provided several referrals within the first few weeks of using the directory. For example, practice staff used the resource directory to assist a 60-year-old patient with a history of alcohol and substance abuse and non-adherence to her medical care plans. After significant intervention by the practice, and with the help of information within the resource directory, the patient was admitted to a local inpatient facility, and is now attending an intensive outpatient program in her area. The resource directory made it easier for the offices to refer to local providers for specific services needed by the patients. It has also allowed the office to better engage, educate and empower its patients.
Improving Population-Based Care Through a PCMH

A PCMH practice needed to increase patient compliance for mammography screenings. Research has found that appropriate mammography screenings can help reduce the number of deaths from breast cancer among women ages 40 to 70.

**Solution:** The practice developed and executed a three-month awareness campaign to target women eligible for a mammography, according to evidence-based clinical guidelines. First, the practice developed breast cancer awareness information cards, which were given to all female patients that met the age criteria at the time of check-in. The card specifically asked for the date and location of their last mammography screenings. If a patient needed a mammogram, the practice offered to help coordinate that appointment for the patient. To build momentum around the campaign, the practice decorated its office waiting area in pink. In addition, any patient who completed and submitted the information card was entered into a raffle to win a basket full of pink-themed items, which was on display at the practice.

**Outcome:** The practice received a very positive response from its patients. Due to this intervention, the practice was able to confirm that over 250 women received a mammography within the past two years. The practice was able to build general awareness around the importance of mammography screenings and develop a cost-effective incentive for its patients to fill out the information card and take action. This ultimately reduced the gaps in care for this patient population.
Improving Quality Outcomes in a PCMH

A family practice wanted to improve mammography rates for its patients. The practice wanted to make sure that all of their female patients who were due for their mammograms received one as soon as possible. Believing that a majority of them received mammograms through other providers, the practice wanted to ensure they received this information.

**Solution:** The PCMH practice ensured that charts were flagged to highlight incoming patients in need of a mammogram. A decision aid document, which included evidence-based information to assist patients in understanding the importance of receiving a mammogram was also provided by the practice. In addition, the practice conducted 72-hour pre-visit phone calls to discuss the need for a mammogram. Every contact with the patient was viewed as an opportunity to improve quality. For example, during every “sick” visit in the office and during every telephone medication request, the patient was reminded to close this gap in care. Finally, a pre-printed prescription for a mammogram was developed and sent to patients through the practice’s Patient Portal.

**Outcome:** Within six months, the practice was able to increase its mammography rates by approximately 25 percent for all eligible patients. Using similar techniques and proactive outreach strategies, this practice was able to reach the 90th national percentile for seven quality process and outcome measures, including controlling high blood pressure and increasing colorectal cancer screenings, within nine months.
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