Transforming Practice, Patients and Population in the Patient Centered Medical Home

Actions for Change

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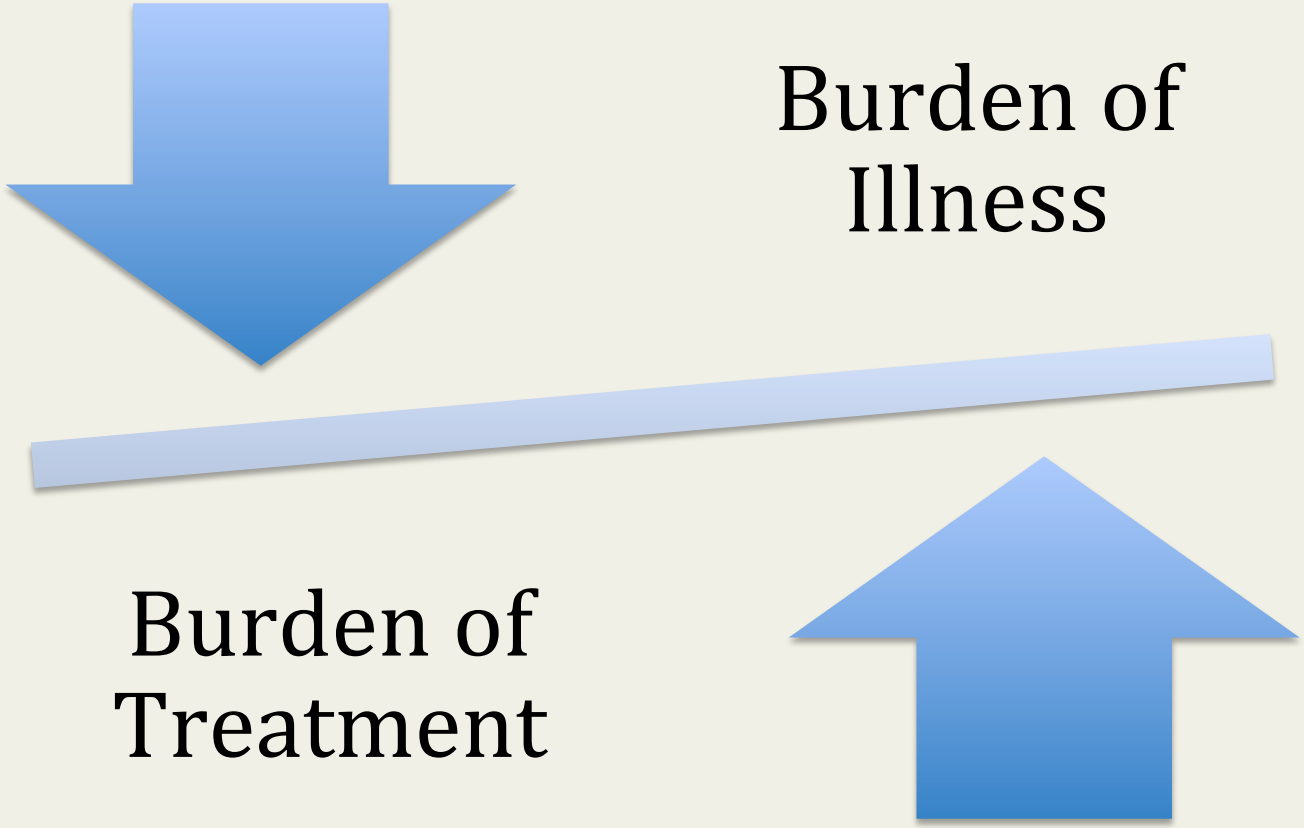
What is the Matter with You?

WHAT MATTERS TO YOU?

Minimally Disruptive Health Care


Burden of Illness
Burden of Treatment

A Patient Centered Health Home is not a place but an approach

association of clinicians for the underserved

Welcoming environment

Comfort and support

Community outreach

Patient Empowerment

Care Coordination and integration

Access and Navigation

Sociocultural competence

Respect for Patient values and needs

Building a Patient Centered Health Home

ACCESS

HEALTH LITERACY

Rx MANAGE-MENT

CARE COORDINATION

PATIENT TRACKING

COMMUNICATION

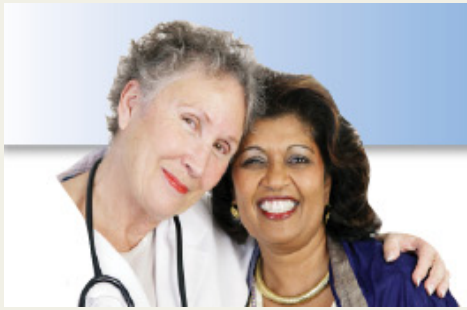
acu association of clinicians for the underserved

Special Considerations for Safety Net Populations

- Transient patients and part time or volunteer providers challenge continuity of care
- Limited health literacy/limited English proficiency
- Cognitive dysfunction/ TBI
- Uninsured access to specialty care
- Care coordination/patient care teams need trained staff
- Insufficient inadequate technology

High leverage activities that yield high outcome

- Identification and management of mental illness/addiction/cognitive dysfunction
- Management of transitions of care (respite)
- Care coordination and Team based care
- Complex co-morbidities
- Identification and management of the socially frail/ isolated individual
- Pharmacologic Management including optimizing medication and adherence



Safety Net Medical Home Initiative

QUALIS HEALTH

THE COMMONWEALTH FUND

MacColl Institute at
Group Health Cooperative

Implementation guides

Empanelment
Team Based Healing Relationships
Patient Centered Interactions
Engaged Leadership
QI Strategy
Enhanced Access
Care Coordination
Organized, Evidenced Based Care

1. Engaged Leadership

- Provide visible sustained leadership to lead culture change and support quality improvement strategies
- Ensure health team have time to conduct activities beyond patient care consistent with PCMH model
- Build values of PCMH into staff hiring and training processes

2. Patient Centered Interactions

- Respecting patient and family values and needs
- Engaging patients in self management, decision making, and health behaviors "*shared decision-making*"
- Language, culture and literacy sensitivity
- Provide self management support at every visit through goal setting and action planning

For patients with chronic conditions, does your practice routinely encourage patient self management?

3. Enhanced Access

- Promote continuous access to health care teams 24 hrs/day, 7 days/wk via phone, email or in-person visits
- Provide patient and family centered scheduling options (evening/weekend)
- Schedule visits with personal clinician
- Help patients attain and understand health insurance coverage (patient navigators)

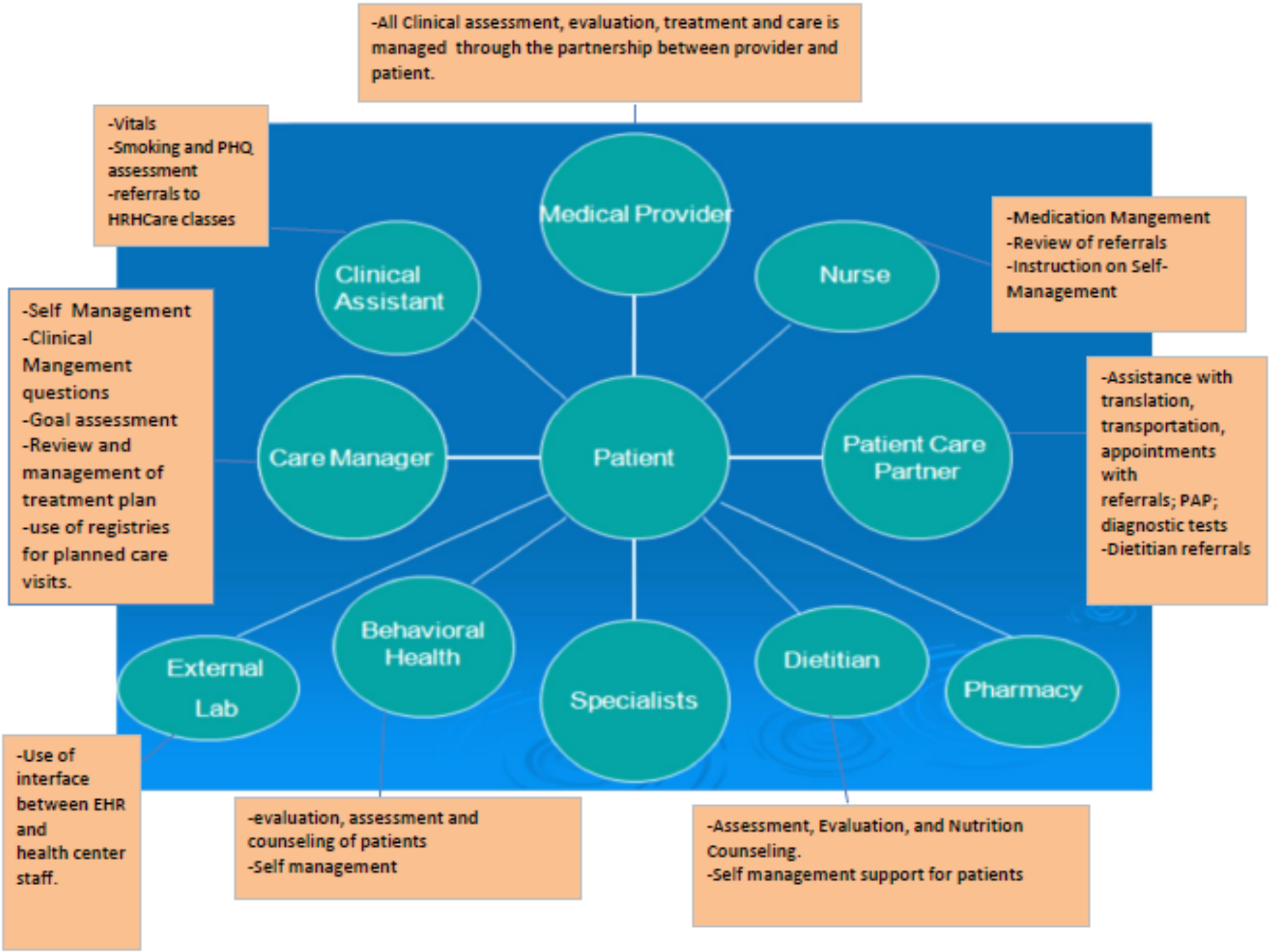
Does your practice have standardized processes to support patient access and communications with the practice?

4. Empanelment

Explicitly defined link between the patient and the provider care team

5. Continuous Team based healing Relationships

- Establishing and supporting care delivery teams
- Linking patients to a care provider and team
- Defining roles and tasks among care team to maximize skills, abilities and credentials
- Cross training care team to ensure patient needs are met


-All Clinical assessment, evaluation, treatment and care is managed through the partnership between provider and patient.
-Vitals
-Smoking and PHQ assessment
-referrals to HRHCare classes
Medical Provider
Clinical Assistant
Nurse
-Medication Mangement
-Review of referrals
-Instruction on Self-Management
-Self Management
-Clinical Mangement questions
-Goal assessment
-Review and management of treatment plan
-use of registries for planned care visits.
Care Manager
Patient
Patient Care Partner
-Assistance with translation, transportation, appointments with referrals; PAP; diagnostic tests
-Dietitian referrals
External Lab
Behavioral Health
Specialists
Dietitian
Pharmacy
-Use of interface between EHR and health center staff.
-evaluation, assessment and counseling of patients
-Self management
-Assessment, Evaluation, and Nutrition Counseling.
-Self management support for patients

6. Organized Evidenced Based Care

Receiving the Right Care

at the Right Time

✓Planned care

✓Point of Care reminders

✓Protocols

Are pre and post visit planning and individualized care management plans routinely used in your practice?

7. Care Coordination

- Link patients with community resources to facilitate referrals and respond to social service needs
- Identify and provide care management services for high risk patients
- Integration of behavioral health and specialty services through co-location or referral protocols
- Tracking and follow up (ER, hospitalization, referrals)

Does your practice have a system outside of the paper medical chart for tracking tests and referrals?

8. Quality Improvement

- Changes you make related to things gone wrong
- Relies on knowledge, asks value (taking waste out of steps)
- Add something new (new and improved)

Quality Improvement

- Choose formal model for quality improvement
- Establish and monitor metrics to evaluate efforts to outcome
- Obtain feedback from patients and families using patient/family centered surveys, involvement in quality improvement activities
- Optimize use of health IT

“What Matters to You?”

Barriers

- Fear
- Communication
- Status Quo
- Inadequacy
- Control (personal agendas)
- Inconsistencies
- Cost $$$