HACKLEY COMMUNITY CARE CENTER
Patient Centered Medical Home

A model of care where each patient has an **ongoing relationship** with a personal physician who leads a **team** that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient’s health care needs and, when needed, arranges for appropriate care with other qualified physicians.  

- [www.ncqa.org](http://www.ncqa.org)
Structure = Function

- A.T. Still
Traditional Methods of Managing Work Flow

Patients

Preventive Med Intervention
Chronic Disease Monitoring
Medication Refill
New Acute Complaint
Test Results

Case Manager
Dietician
MA
Clinical Pharmacist
Behavioral Health
Referral Specialist

 PROVIDER
Parallel Work Flow Design

- Test results
  - Chronic Disease Monitoring
  - Medication Refills
- Preventative Med Intervention
  - Point of care testing
  - Mental Health Concern
- New acute complaint
- Patients

Clinical Pharmacist  Case Manager  Dietician  Provider  MA  Behavioral Health
What do Chronically Ill Patients Need to Optimize Outcomes?

- A continuous healing relationship
- Clinical therapy that gets them safely to the therapeutic goals
- Services to meet major clinical and other needs, and coordination of those services
- Preventive interventions at recommended time
- Evidence-based monitoring and self monitoring
- Follow-up tailored to severity
Continuous and Team – Based Healing Relationships

Goal:

- To develop skilled and well organized care teams, and ensure that patients are able to see their provider and care team consistently over time.
Continuous and Team – Based Healing Relationships

PCMH practices:

- Establish and provide organizational support for care delivery teams that are accountable for the patient population and panel.
- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.
- Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
- Ensure that patients are able to see their provider or care team whenever possible.
Why are effective teams so critical?

- Team involvement in the care of chronically ill folks is the single most powerful intervention.
- Involvement of non-physician care team members in care has been associated with a 0.75% reduction in HbA1c and a 13mmHg reduction in BP.
- A physician alone would need 17 hours every practice day to meet guidelines for prevention and chronic care!
- Some clinical functions may be better performed by a trained staff person- e.g., self management support.
Why is continuity of relationship such a big deal?

- Patients who have a continuity relationship with a personal care physician have better health process measures and outcomes.
- Continuity of care increases the likelihood that the provider is aware of psychosocial problems impacting health.
- Continuity has been shown to achieve quality at a lower cost.
- Relationships generally enhance career satisfaction.
Patient-Centered Interactions

Goal:

• To encourage patients to expand their role in decision-making, health-related behavior change, and self management and to communicate with them in a language and at a level they understand.
Patient- Centered Interactions

PCMH practices:

- Respect patient and family values and expressed needs.
- Encourage patients to expand their role in decision-making, health-related behaviors, and self management.
- Provide self-management support at every visit through goal setting and action planning.
- Obtain feedback from patients and families about their health care experiences and use this information for quality improvement.
What characterizes an “informed, activated patient”?

They have goals and a plan to improve their health and motivation, information, skills, and confidence necessary to participate in decision-making and to manage their illness well.
What is Planned Care?

- Planned care uses guidelines, patient data, team and practice organization to assure that all patient needs are met (productive interactions).
- Can be patient-initiated or practice-initiated
- Pre-visit planning (huddle) ensures that patient needs are met; post-visit huddle organizes follow-up.
The Importance of Planned Care

- Only half of recommended services are delivered
- Care is often reactive, even though many patient needs are predictable
- Planned Care creates an agenda for encounters
Population Management

- Maintain a database (Registry) that includes key information on important patient groups within a practice population.

- Monitor the database to identify and reach out to those needing service.

- Use the database to plan care.
US Health Care

Shortage of primary care

- 35% of US physician workforce is primary care
- System organized around episodic care
- Payment system rewards procedures

Successful countries: 50% Primary Care
Primary Care Crisis

U.S. primary care is in crisis

- Primary care physicians must care for more and more patients, with more and more chronic conditions, in less and less time, for which they are compensated far less than subspecialists.
They must absorb increasing volumes of medical information and complete more paperwork than ever, as they try to function in a poorly coordinated health care system. As a result, their ranks are thinning, with practicing physicians burning out and trainees shunning primary care fields.
“...It would take a primary care doctor 18 hours per day to provide all the recommended preventive and chronic care services to a typical patient panel. As a result, only half of the evidence based medical care is provided.”

-- Bodenheimer, T.
Everyone who touches the process is a member of the team

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<thead>
<tr>
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<tbody>
<tr>
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Team Building

- New attitudes
- Leadership
- Communication
- Standardized care
- Redefined roles
- Restructured processes
Communication

- Share Data
- Define goals
- Improve processes, safety, quality
- Report on Progress
- Ask for and receive feedback
- Safety
Critical Success Factors in Managing Practice Transformation

1. Leadership
2. Teamwork
3. Communication

BUY IN
Transformation

Teamwork does not necessarily follow from professionals working alongside one another. Structural, historical and attitudinal barriers can and do contribute to difficulties which inhibit teamwork. Problems can arise from competing demands, diverse lines of management, poor communication, personality factors, plus status and gender effects.
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