

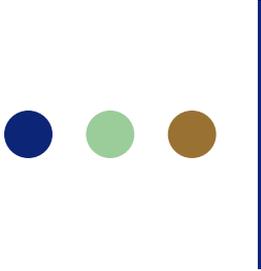
Patient Centered Medical Homes: Improving Care for the Diabetic Patient

Presented by: The Association for Utah Community Health
(AUCH)

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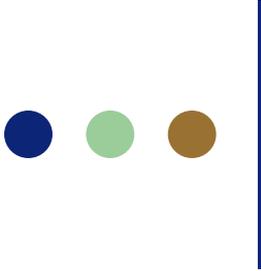
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The Association for Utah Community Health's mission is to support and represent its member organizations and work to increase access to health care for medically underserved populations.



What is AUCH?

- The Association for Utah Community Health (AUCH) is the primary care association for Utah and our members include Federally Qualified Health Centers (FQHC) and other providers who strive to meet the needs of the medically underserved.



What is a Community Health Center?

- Community-based, non-profit organization
- Medically Underserved Area/Population
- Comprehensive health care & enabling services
- Open to all, with sliding fee scale charges based on income
- Governed by community boards
- Rigorous performance & accountability standards



Bear Lake Community Health Center, Inc. ■

Sites: Garden City, Hyrum, Logan



Midtown Community Health Center, Inc. ■

Sites: Ogden (4 sites), Washington Terrace, Clearfield, Kaysville

Community Health Centers, Inc.

Sites: Downtown SLC, Taylorsville, Rose Park, Midvale, Brigham City

Wasatch Homeless Health Care, Inc. ■ ■

Site: 4th Street Clinic (Downtown SLC)

Mountainlands Family Health Center, Inc.

Sites: Provo, Payson

Carbon Medical Services Association, Inc. ■

Sites: E. Carbon, Helper

Green River Medical Center, Inc.

Site: Green River

Wayne Community Health Centers, Inc.

Site: Bicknell, Hanksville

Enterprise Valley Medical Center

Site: Enterprise

Utah Navajo Health System, Inc.

Sites: Montezuma Creek, Blanding, Monument Valley, Navajo Mountain

Family Healthcare

■ Sites: St. George, Millcreek High School, Cedar City

Developed by The Association for Utah Community Health, 2011
Note: Clinic locations are approximate, verify with actual map

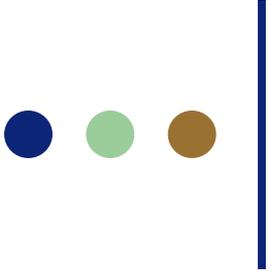


Community Health Centers in Utah



**Association for
Utah Community Health**
Supporting Health Care for the Underserved

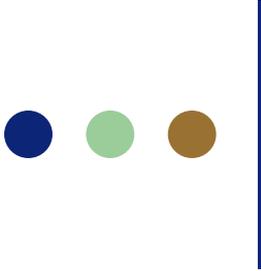




Objectives

At the conclusion of this presentation learners will be able to:

- Define the goals of PCMH Practice Transformation
- List the Eight Change Concepts of PCMH Practice Transformation
- Visualize the Clinical Application of Concepts and Care for the Patient with Diabetes

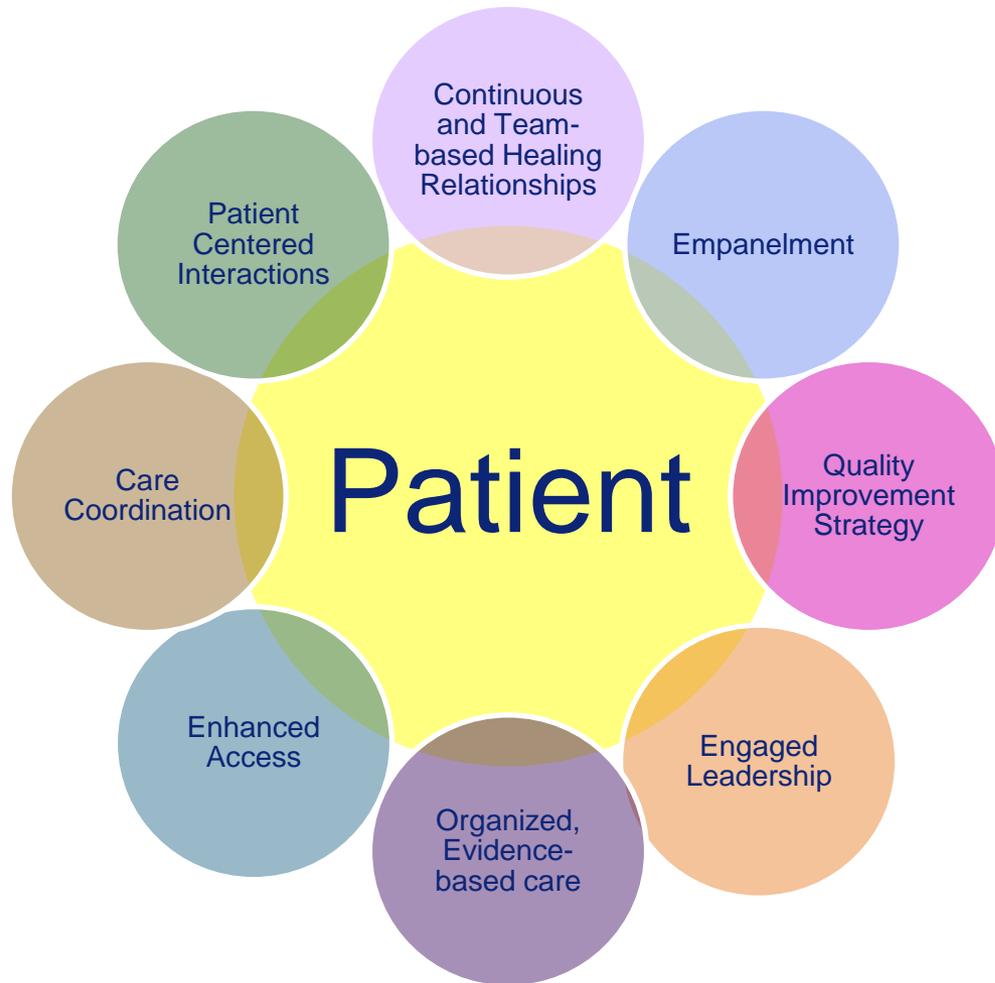


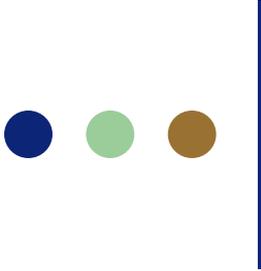
Defining the Patient Centered Medical Home (PCMH)

- PCMH is a team based healthcare delivery approach that provides comprehensive and continuous medical care to improve patient-provider relationships and optimize patient health outcomes

“A Patient-Centered Medical Home puts patients at the center of the health care system, and provides primary care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective” American Academy of Pediatrics

PCMH means the patient is the center of care.





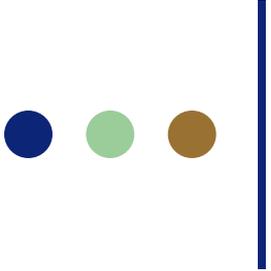
Goals of PCMH Practice Transformation

- Engage patients, communities, and healthcare organizations as partners in prevention, chronic disease management and population health
- To demonstrate improvement, best practices, and innovation in Primary Health Care
- To recognize CHC as providers of choice participating in quality healthcare delivery for patients and families



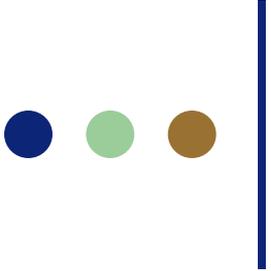
PCMH and Managing Diabetes





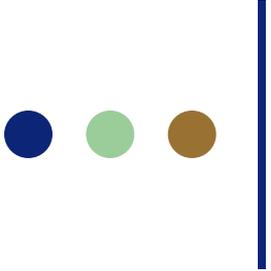
Case Study

A 60 year old woman visits your organization for the first time with the chief complaint of chronic hip pain that has intermittently been bothering her and worsening in the past month. She is inquiring about hip replacement surgery. The patient is from Cuba, Spanish speaking only, obese (BMI >30), a history of Type II Diabetes and has a diagnosed heart murmur.



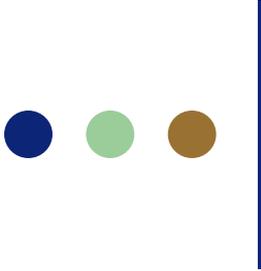
Concept: Engaged Leadership

- Visible and sustained leadership leads to cultural changes that improve the quality of care
- Ensures time and resources for staff success
- Build's the practice values for creating the medical home



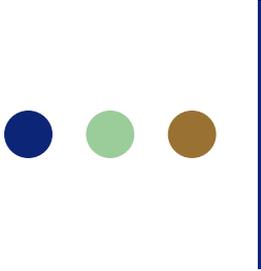
Applied to the case study

- Engaged leaders will ensure this patient will have:
 - A trained care team
 - Care that is coordinated
 - Support for self management, self-efficacy and behavior change
 - A care team that understands population based care
 - A care team that communicates them



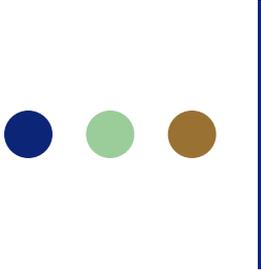
Concept: Empanelment

- Links patients to a “team” of health care providers
- Shifts care from individual patient visits to proactive and planned care
- Addresses acute, chronic and preventive care
- Establishes continuity of care
- Manages supply and demand (access) so patients can see their provider when needed



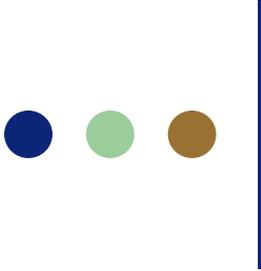
Concept: Continuous, Team-based Healing Relationships

- Establishes care delivery teams
- Links patients and providers as partners in care
- Assures patient they are able to see their provider and team when needed
- Team members have defined roles and responsibilities



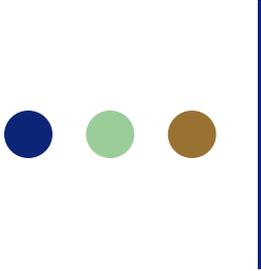
Applying empanelment and continuous, healing relationships to our patient case

- Describing the visit for this patient from her very first call
- Patient works with (clinical visits and communications) with the same “team” of health care providers, at every visit to the clinic.
- The goal is to “engage” her to become a proactive member of the care team



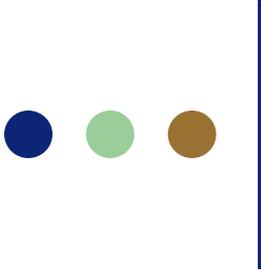
Concept: Patient Centered Interactions

- Respect of patient and family's values and needs
- Encourages patients to expand their role in decision making, health behaviors and self management
- Communication is culturally appropriate
- Self management assessed at every visit
- Organization asks for feedback from families and uses it for continuous quality improvement



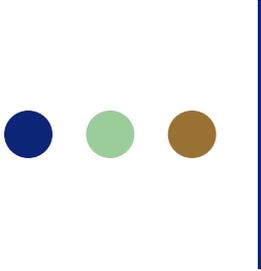
Concept: Quality Improvement Strategy

- A formal model is used for improvement and imbedded in all clinical and business operations
- PCMH organizations are “cultures of data”
- Patients, families, providers and staff are all involved in quality improvement
- Optimization of the use of health information technology



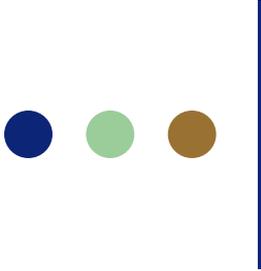
Applying Patient Centered Interactions and the Quality Improvement Strategy

- Educational and instructional materials are provided in Spanish
- Our patient is invited to provide feedback
- An interpreter is utilized
- Health literacy will be assessed (using teach back methods)
- The team will assist in setting mutually agreed upon self-management goals with the patient at every visit (SMART Goals)
- Goals for Diabetes are posted as data that is visible for patients, families and staff



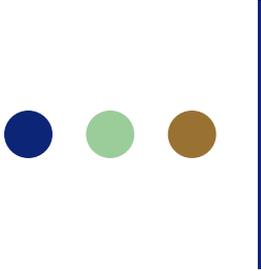
Concept: Organized, Evidence Based Care

- Planned care according to the patient's needs
- Identifies high-risk patients to ensure they are receiving appropriate care and case management
- Uses evidence based guidelines and clinical decision support tools
- Up-to-date information available to providers prior to patient visit



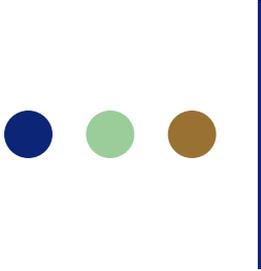
Concept: Enhanced Access

- Established patients will have a method 24/7 to access their care team via phone or email
- Scheduling options that are patient and family centered
- After hours service by telephone to connect with clinician who has the ability to make a clinical decision and triage care



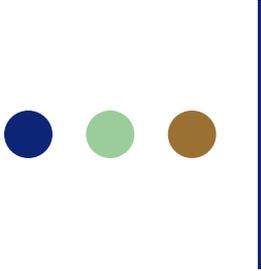
Applying organized, evidence based care and enhanced access to our patient case

- Patient is able to communicate with her health care team after hours (email, patient portal, etc.)
- Clinic uses evidence-based guidelines to manage the patient's diabetes, chronic pain and heart murmur.
- A clinical pharmacist is included in the patient's team of care to assist with complex medication regimens.



Concept: Care Coordination

- Link patients to community resources to facilitate referrals and social service needs
- Integrated behavior health on site or with co-agreements
- Patients needing referrals for outside services are supported and tracked
- ER visits and hospitalizations are followed up within a few days
- Test results and care plans are communicated with patients

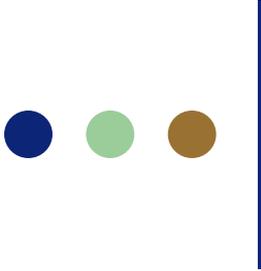


Applying Care Coordination to our patient case

- The clinic has a system that alerts/triggers the team when new information is added to the EMR.
- Test results (e.g. HbA1c) are communicated to the patient by her “team.”
- Patient is referred to a diabetes support group (in Spanish) and an exercise class.

Questions





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