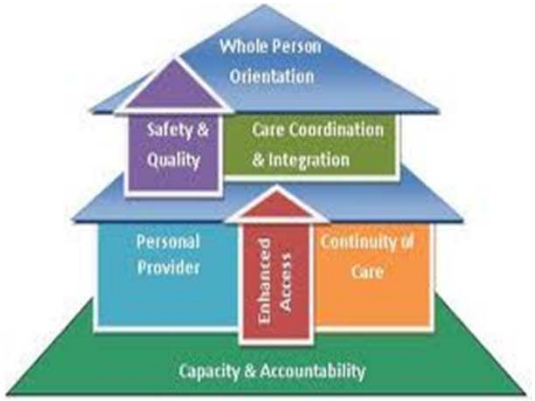


Patient Centered Medical Home

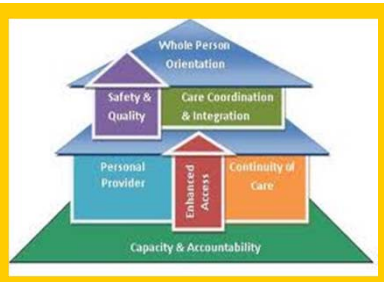
The poster child for Interprofessional collaboration

5th Annual Emswiller Interprofessional Symposium

Susan Miller MD FAAFP PSF
Joanna Fowler MHA

PCMH History

- Started in 1967 in **Pediatrics**
- The **Future Of Family Medicine** project in 2002 and the **TransForMed** project in 2006 **brought the AAFP into the conversation**
- The Patient Centered Primary Care Collaborative (**PCPCC**) **Business interests**
- In 2007 **The Joint Principles** of PCMH were released by **AAP, AAFP, ACP, AOA**
- In 2007 **The Medical Homes Act** was passed into law by the 101st Congress in the **Medicare Improvement Act**
- In 2010 **Demonstration Projects** funded in 2007 produced data about PCMH



What did they show?

- Redesigned PCMH care showed
  - higher patient satisfaction,
  - fewer hospitalizations and ED visits,
  - better chronic disease and preventive care quality markers.
- In some cases it showed an overall **lower cost**.
- PCMH requires **time and money** to redesign care and implement **new roles** to manage populations.
- **The foundation of the redesign is the creation of the interprofessional team that meets the needs of the population being cared for.**

The 6 standards

1. **Patient-centered access**
2. **Team-based care**
3. **Population health management**
4. **Care management and support**
5. **Care coordination and care transitions**
6. **Performance measurement and QI**

The PCMH Pilot Project

Funded by the Office of Health Innovation under Sheryl Garland

Co-led by Dr. Miller as clinical lead and Joanna Fowler as administrative lead

Consulting support from Community Health Solutions

Each clinic had an MD lead and an RN lead

IT support from VCUHS

VCU Psych Dept. helped with Integrated Behavioral Health program

VCU Dept. of Social Work embedded social workers

Nutrition Dept. helped find resources to embed in clinics

Four VCUHS Pilot Clinic Sites:

Center for Advanced Health Management

Complex Care Clinic

Hayes E. Willis Health Center

Nelson Family Medicine

1.Patient-Centered Access

- Requires 24/7 availability of physicians with access to electronic health record
- Ability of patients to be seen in a timely fashion
- Communication via phone, and electronically by portal

2. Team-Based Care

- Define new roles, develop policy and procedures, standing orders
- Train for patient centered care: Care coordination, patient and family support, patient empowerment
- Team does care planning daily (Huddles)
- Team meets regularly and participates in QI
- Population management skills

3. Population Health Management

- Means know who your patients are and what they need
- Risk stratification: “hot spotters” report
- Developed the Diabetic registry
- New role of Population Nurse
- New resource embedded behavioral health: C&L psychiatry fellow, clinical psychologist, social worker

4. Care Management and Support

- Interdisciplinary care plans
- Nurse care management in collaboration with rest of care team
- New community collaboration: YMCA diabetes prevention program
- Social worker developed list of resources and took on “warm handoffs,” crisis intervention, and advanced care planning
- Clinics were pilots for the Honoring Choices project in Richmond

5. Care Coordination and Care Transitions

- New reports of ER visits and hospitalizations on a daily basis and referral report to track specialist visits
- New role for RN to make calls, do medication reconciliation and schedule appts

6. Performance Measurement and Quality Improvement

- Measuring quality data
  - Chronic condition: diabetes
  - Preventive care measures: mammograms and colorectal screening
  - Immunizations: tetanus and pneumonia
- Patient satisfaction survey results
- QI projects

Questions?


Whole Person Orientation
Safety & Quality
Care Coordination & Integration
Personal Provider
Enhanced Access
Continuity of Care
Capacity & Accountability