GE-NMF PRIMARY CARE LEADERSHIP PROGRAM PCLP

"To Improve Is To Change" : CMHS and the Patient Centered Medical Home

Ayana Worthey

University of Illinois at Chicago, College of Medicine

Site Placement: Central Mississippi Health Services, Inc.

Jackson, Mississippi

GE Foundation

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Introduction

- How I chose the Patient Centered Medical Home
  - Comprehensive
  - Far Reaching
  - Already in motion at CMHS
- Why CHMS should be interested in the Patient Centered Medical Home
  - CMHS is already medical home
  - Provider-patient relationships

What is a Patient Centered Medical Home?

- Team-Based
- Proactive, not Reactive
- Quality
  - Coordination and Management
- Access
- Integration
- **$$$$$$$$**
  - ER visits, unnecessary tests and labs
  - Reduced mistskes

6 PCMH Standards

- Enhance Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Provide Self-Care Support and Community Resources
- Track and Coordinate Care
- Measure and Improve performance

Methodology

- 6 PCMH Standards → *MUST HAVE ELEMENTS!*
  - Without these elements in place, we will not reach the October 31, 2014 Deadline
- How We Will be Measured
  - https://www.ncqa.org/Portals/0/Programs/Recognition/PCMH_2011_Data_Sources_6.6.12.pdf
- GA Carmichael Templates

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Methodology

Template Used

G.A. Carmichael Family Health Center

Clinical Protocol: **Team Meeting (Huddle)**	
Date Written: March 2013 Sonja R. Fuqua, PhD, RN	Date Reviewed/ Revised:
Approved By: Executive Director	Approval Date: 3.05.2013

PURPOSE: To communicate and coordinate clinical care management among the members of the team prior to providing daily services. The huddle must result in actions that improve the efficiency of the clinical team for each of the day.

POLICY: G.A. Carmichael Family Health Center's clinical service teams consisting of the LIP, their assigned nursing personnel and a client care coordinator communicate routinely to prepare the clinical team, synchronize staff expectations and assemble information and resources prior to a patient's arrival.

PROCEDURES:

As we are transitioning to paperless documentation, necessary notes/task may be done in the EHR

1. Nurse opens the day's schedule (May be done the afternoon before or morning of service)
   a. Scrubs chart of each patient.
      - Information needed for the visit (new patient, follow-up, reason for visit)
      - Notes health maintenance gaps (immunizations, PAP, etc)
2. Team discusses:
   a. No shows from the day before
   b. Patients scheduled for more than routine care
   c. Contingency plan for walk-ins

Sample Protocol Produced

Central Mississippi Health Services, Inc.
5429 Robinson Road Extension
Jackson, MS 39204

Protocol Title: Same Day Appointments

I. PURPOSE: To ensure that patients may obtain a same day appointment by either calling in or walking in to the clinic during regular business hours.

II. POLICY: Providers at Central Mississippi Health Services, Inc., Southwest Clinic will ensure space in their schedules for same day appointments.

III. PROCEDURE:
   1. Each provider leaves three open appointments per morning for patients who call or walk in the clinic requiring same day services during business hours.
   2. Scheduling staff will contact patients by telephone to confirm scheduled appointments no later than 48 hours before.
      a. Cancelled appointment spaces will also be left open for same day appointments.

Results: Technology use is our *greatest weakness*

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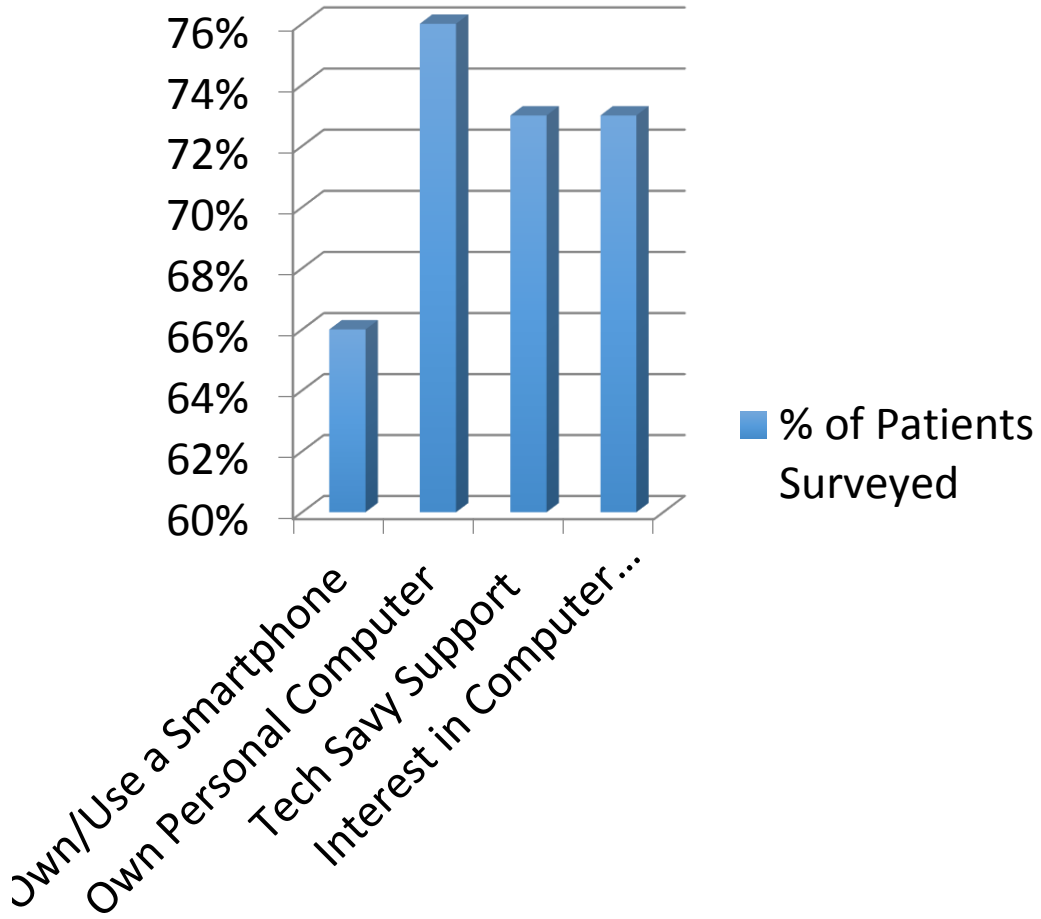
- PCMH 1, Element A: Access During Office Hours
  - Providing timely electronic Clinical Advice During Office Hours
- PCMH 2, Element D: Use Data for Population Management
  - Registries are currently limited; explore this in the new version of the EHR
- PCMH 3, Element C: Care Management
  - Follows up w/patient/families who have not kept important appointments
- PCMH 4, Element A: Support for Self-Care Process
  - Uses EHR to identify patient-specific resources and provide them to more than 10% of patients, if appropriate.
- PCMH 5, Element B: Referral Tracking and Follow Up
  - Demonstrating the capability for electronic exchange of key clinical information (e.g. problem list, medication list, allergies, diagnostic test results) between clinicians.
- PCMH 6, Element C: Implement Continuous Quality Improvement

Recommendations:

HIPAA Compliant Text Messaging: Patient Readiness Survey

- 47 Patients Surveyed
- 31 Patients reported owning/using a Smartphone
- 36 Patients report owning/using a personal computer
- Of the 11 patients that do not own a smartphone or computer, 8 reported having a tech savvy individual in their household or immediate family.
- Of those same 11 patients, 8 reported that they would attend clinic based computer training to access their medical information online and communicate with providers



Discussion: Mobile Health (mHealth) & PCMH

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- Agency for Healthcare Research and Quality
- HRSA-15-016: Affordable Care Act New Access Point Grants Department of Health and Human Services Health Resources & Services Administration
  - Our Buy-In: Black Males
- **Don't forget: Next Year's GE Scholars!!**

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Bernie Monegain, Editor

Bernie Monegain is the Editor of *Healthcare IT News*. Bernie covers hospitals and IDNs, industry trends and is responsible for overall coverage decisions.

Diabetes texting program gets a boost

BOSTON | October 19, 2011

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The Center for Connected Health has received a research grant from the McKesson Foundation's Mobilizing for Health initiative to integrate a text-messaging program into an existing program at Massachusetts General Hospital to help diabetes patients better manage their condition.

The goal of Mobilizing for Health is to improve health outcomes among under-served patients with chronic diseases using mobile health (mHealth) technologies that have proven successful. The grant program

Conclusion

- If the PCMH measures and protocols that have been drafted are adopted and implemented, and the identified weaknesses addressed, CMHS Southwest Clinic will be on track to reaching the October 31st deadline for Level III PCMH Certification.
- If the CMHS community fully engages with the PCMH model, and in becoming a driving force in the future of community health care delivery, there will be a tangible difference in patient outcome and experience.

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Acknowledgements & References

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