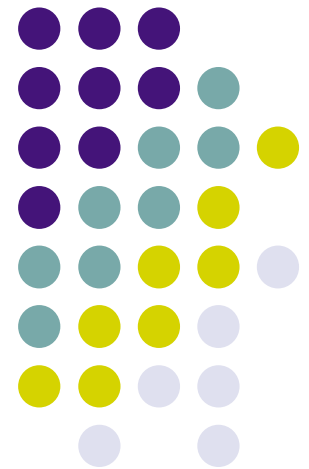
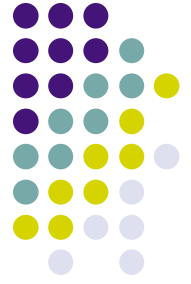


# Expanded Roles for Staff in the Medical Home

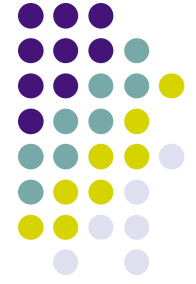
Paul Kaye, MD  
Chief Medical Officer  
Hudson River HealthCare  
May 28, 2009



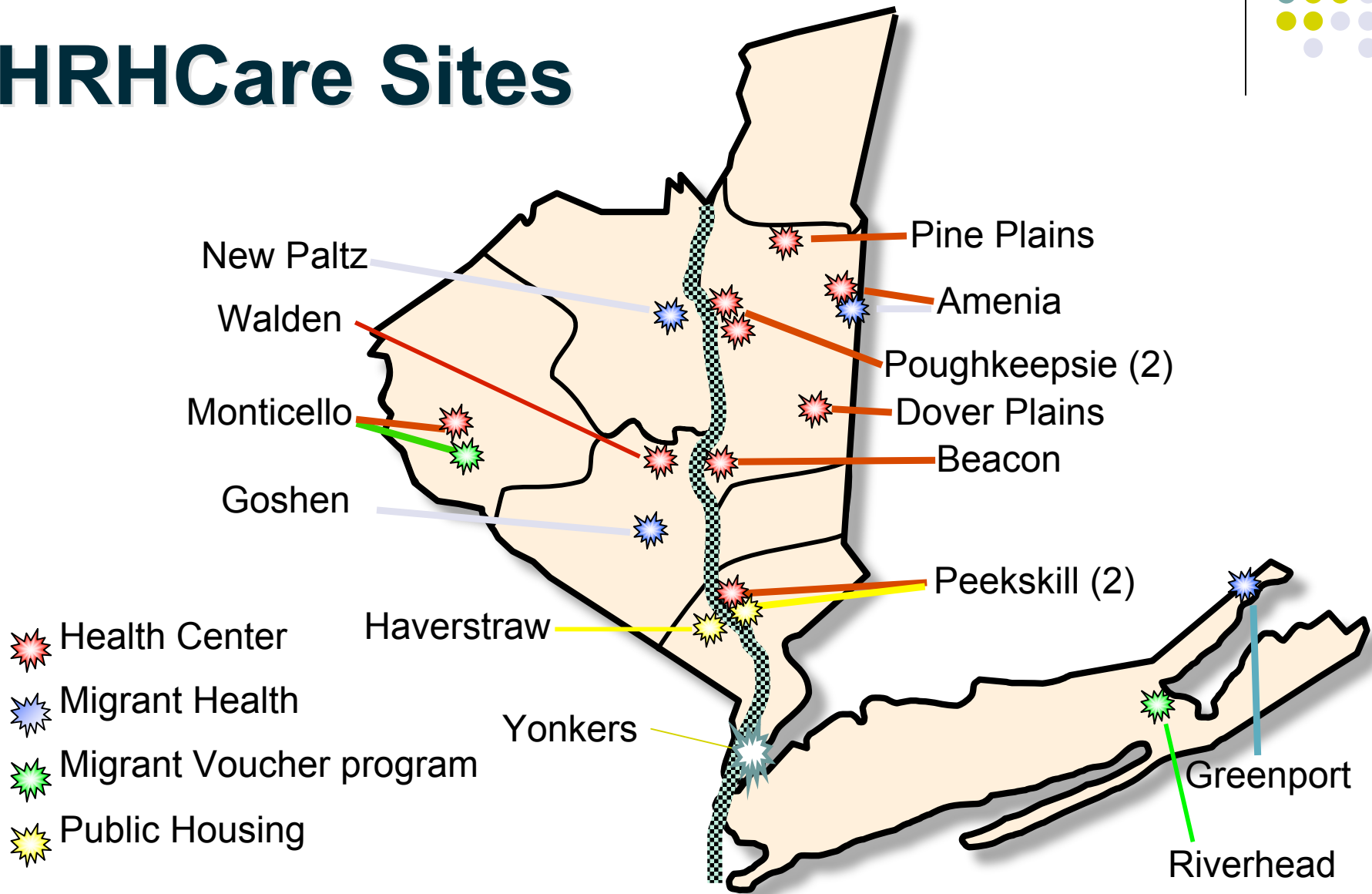






# Hudson River HealthCare

- 16 practice sites in 6 counties of NY
- 75 primary medical care providers
- 225,000 visits/year
- Urban, migrant, homeless, public housing, and Ryan White funding
- JCAHO 1998, 2001, 2004, 2007
- Open Access(IHI),Diabetes, HIV, Prevention Pilot Collaboratives



# HRHCare Sites



-  Health Center
-  Migrant Health
-  Migrant Voucher program
-  Public Housing

# CHC Program Requirements



- **Primary care**
- **After Hours availability**
- **Hospitalization coverage**
- **Case management services**
- **Diagnostic laboratory and radiologic services**
- **Referrals to other providers**
- **Formalized Quality Improvement Program**
- Preventive services including prenatal care
- Cancer and other disease screening
- Well child services

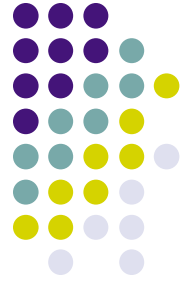
# CHC Program Requirements



- Services to assist the health center's patients gain financial support for health and social services
- Enabling Services
  - Outreach
  - Transportation
  - Interpretive services
- Education of patients and the community regarding the availability and appropriate use of health services

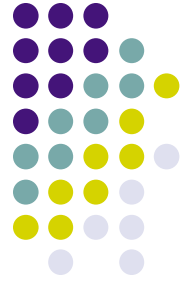
# Hudson River Healthcare's Quality Journey

1993	Together for Tots
1996	Reengineering
1998	IHI Access and Efficiency
2000	Diabetes Collaborative
2000	Introduction of EMR
2002	HRSA HIV Collaborative
2004	Prevention Collaborative
2005	Patient Visit Redesign
2005	IHI Planned Care
2006	Harvesting Meetings
2006	Strategic Aims



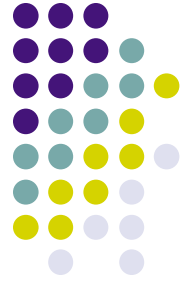
# Common Themes

- Integrated Teams
- Everyone does the highest level of work possible
- Consistent support staff with defined roles
- Work centered around the patient
- Planning of visits
- Daily huddles
- Standing orders
- All tools readily available in every patient room



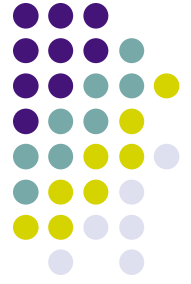
# Ideal Team Composition

- 2 Providers
  - 1-2 Nurses
  - 2 Medical Assistants
  - 1 Patient Care Partner
  - 0.5 FTE Social Worker
  - 2 Patient Representatives (front desk)
  - 1 Health Information Worker
  - 0.5 FTE Care Solutions/Financial Access Specialist



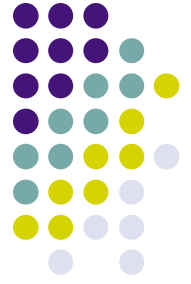
# New Roles for Staff

- Care Coordination
- EHR/Registry Management
- Health Coaching
- Medical Translation



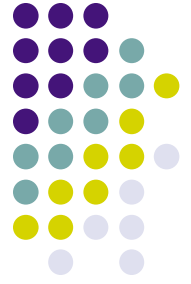
# EHR/Registry Management

- Registry Technical Tasks
  - Data entry
  - Generation of reports
  - First level troubleshooting
- Panel Management
  - Identify patients who have not been seen
  - Identify patients with chronic illness for specific interventions that are due
  - Produce and disseminate quality and access reports



# Care Coordination

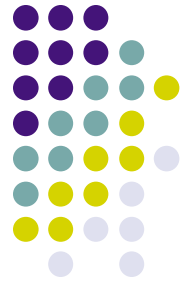
- Referral Management
- Lab and Xray Followup
- Linkage to resources
- Identification and management of patient panels
- Responsibility for all patients-including those who don't come in on their own



# Health Coaching

- Concept grew from a Staff Wellness Program
- Self selected
- Trained on basics of healthy lifestyle
- Received instruction on motivational interviewing
- Help set self management goals
- Provide encouragement and support towards goals
- Monitor and record progress towards goals

# Medical Translation Services



- Non clinical bilingual staff trained in medical interpretation
- Providers also trained formally in appropriate use of medical translators
- At least one per site
- Monitor translator use-may interfere with other job duties when volume is high



# Medical Assistants

- Expedite rooming and patient flow
- Assess learning and communication issues
- Data entry into registry/EHR
- Run registry reports
- Manage followup as directed by provider
- With additional training serve as
  - Health Coaches
  - Medical Translators

- Admin
- Practice
- Registry
- ent Recall
- Encount...
- Registry
- stry Reports
- ty Measures
- ic Care R...
- tics Reports
- eferrals
- essages
- ocuments
- Billing

Progress Notes

TEST, TEST

Social History (TEST, TESTY - 09/17/2008 09:00 AM, ROV) \*

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PEAS

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Practices.

ROS:

Objective:

- Social History
  - Career/Work
  - Education
  - Alcohol
  - Genesis
  - General counseling
  - PEAS
  - Tobacco Use:
  - Sexual Hx:
  - Drug/Alcohol:
  - Household:
  - Misc

PEAS

Social History Verified

Social Info	Options	Details
Language Barriers	Yes	Spanish speaking only
Cultural Practices	No	
Religious Practices	No	
Emotional Factors	No	
Physical Factors	No	
Special Learning Needs	No	
Preferred Learning Style		Auditory/Hearing
Primary Language		Spanish

Notes

Browse ...

Select Default

Clear All

Text area for notes

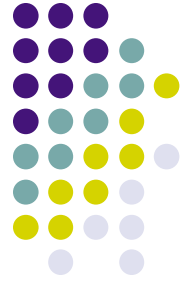
Family History

Custom

ROS

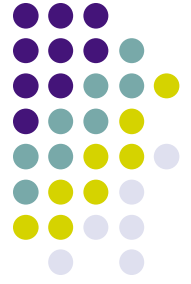
Allergies

- Penicillin
- Sulfa



# Patient Care Partners

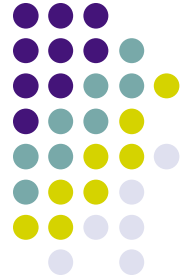
- Make and coordinate referrals
  - Arrange transportation
  - Call to remind patient of appointment
  - Follow up receipt of results
- Reinforce nurse/PCP instructions
- Arrange home care and DME
- Pharmacy Assistance Programs
- Link patients to community resources
  - Smoking and Weight Control groups



# Access Assistants

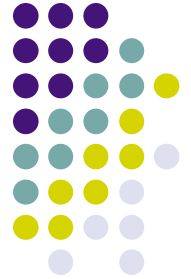
- Access Coordinator-Financial Counselors-Care Solutions Representative
- Aid patient in selection of primary care provider/team
- Assure accurate entry of PCP into EMR
- Review Patient Rights and Responsibilities
- Provide enrollment assistance into public benefit programs, public insurance
- Review after hours communication information

# Patients as Team Members

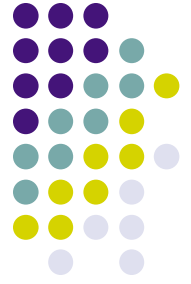


- Group visits-reinforcing goals
- Healthy cooking classes taught by great cooks
- Peer based HIV testing and counseling

# Community: The Missing Piece of the Medical Home Puzzle

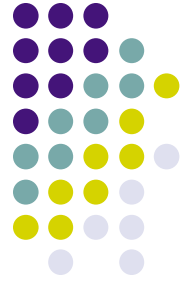


- Linking to other providers of care
- Linking to economic and social resources
- Outreach Workers
- Community Care Partners



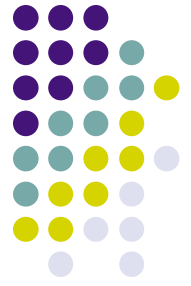
# Outreach Workers

- Combine community activities with self management goals
- Farmworker Women's Walking Group
- Outreach visits to migrant camps with scale and height measurement to calculate BMIs, referrals to nutrition, diet and cooking advice
- Access EMR/registry for data entry of BMIs
- Recall/reminder and overdue testing management



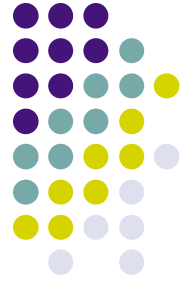
# Community Care Partners

- Stationed in ER, community locations, shelters, laundromats
- Schedule followup visits after ER visit with PCP and make reminder calls
- Integrate into ER team and workflow to provide care coordination and translation
- Provide advice on future access to after hours care



# What are the skills needed?

- Good interpersonal communication
- Genuine empathy
- Willingness to learn
- Manual dexterity and keyboarding skills
- Attention to detail
- Knowledge of the community
- Knowledge of the culture

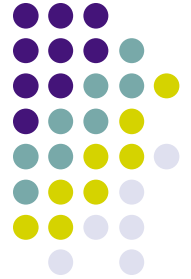


# Helpful Past Experiences

- Hospitality and service businesses
- Child care
- Home care
- Personal grooming
- Medical transcription
- Artists and musicians
- Personal experience with chronic health condition

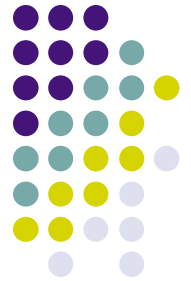
# Lessons Learned

(Things we wish we knew when we started)



- Train and retrain and retrain
  - Core job competencies
  - Software competencies
  - Patient centered philosophy
  - Confidentiality standards
- Plan regular support and guidance
- Audit data entry accuracy
- Manage team relationships
- Be careful of the wrong metrics
- Incentivize teams, not individuals
- Celebrate together

# Hudson Valley Community Transformation Project



- Partnership of THINC RHIO and Taconic IPA
- 6 Health Plans participating and paying
- 210 Physicians aiming towards NCQA Level 2 PPC-PCMH recognition by December 2009
- TransforMed and MassPro assisting
- 3 Community Health Centers
- 4 Large Private Practice groups
- 6 small practices
- Sharing job descriptions, policies, and skills