PCMH Transformation

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Where we were, and where we need to go…

Our Practice

- Suburban New Jersey
- 7 Family Practice Physicians and 4 Physician Assistants
- Established practice – over 25 years
- EHR for 4 years
- Extended office hours 6 days/wk
- Inpatient care by hospitalists

The Realization

- As we worked our way through the tedious reporting requirements of the NCQA PCMH recognition process it became apparent that the primary underlying theme is that we need to become more active managers of our patients healthcare needs. Almost everything else we did was a downstream tool or implementation.

Our Map

Where we were:

- Primary care focused
- Good availability
- Good relationships with patients and community
- Episode based management
- No significant data driving clinical care

Where we're going:

- Primary care focused
- Expanded availability
- Good relationships with patients and community
- Population based management
- Data driven
- Improved communications
- Expanded disease management
- Improved discharge and transition handoffs
- Better ways to manage our patients with access issues

The Starting Point

- Horizon's decision to use diabetes as a fulcrum for PCMH development helped up focus on a smaller number of patients, reports, processes and tools that could later be expanded.

What We Did

- Retooled our computer system processes to create alerts for incomplete diabetes and preventive care services
- Hired a part time certified diabetes educator to teach Diabetes Self Management classes as well as individual counselling. In the process our office became a Diabetes Education Center.
- Recognizing that insulin therapy is a weak spot in primary care, we got our staff and physicians additional training in patient education for insulin administration.
- Ran an in-house diabetes education program for our providers, led by a diabetologist and focused on insulin therapy and using case studies of our most poorly controlled diabetic patients.
- Revamped our web site and added a patient portal through which patients can access their medical record and communicate with the office.

What We Did (cont'd)

- Assigned a staff member to do part-time case management followup of the patients in the Horizon project.
- Started a monthly e-mail newsletter to keep patients informed about relevant healthcare topics and initiatives within our practice.
- Added patient educational TV programming to our 2 waiting rooms.
- Improved our communications with our hospitalists and have worked with hospital IT to have a practice hospital census sent to us by secure e-mail every AM and distributed to all our providers.
- As we worked our way through our case management of our Horizon project patients we realized that there were a significant number of elderly patients who had difficulty getting to our office. With that in mind we started a home visit program which has been we received by those patients and their families.
- Horizon also provided us with a list of our patients who would be considered high risk for hospitalization. We identified those patients in our computer system so that providers and staff would be more sensitized in their contact with this cohort of patients.

What We Did (cont'd)

- At biweekly staff meetings we talk about the philosophy and mind set behind PCMH and then specifically about our current initiatives.
- Similarly at monthly provider meetings we review our progress and goals re PCMH.
- We are currently implementing a Point of Care global management tool that gives us a summary of all the patients comorbidities, risk factors and actionable goals.

What We Learned

- The practice as an active manager.
- Improve communications with patients
- Start with a narrow clinical focus and develop the reporting and processes to understand what you are currently doing and what you will need to do.
- Get the entire practice involved, providers and support staff.