“Patient Centered Care Teams”

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Transformation Coach
• What is a PCMH?
• The Practice Team
• Connect care team training with NCQA PCMH standards
• Understand application of PCMH principles in OUR practice
What is a PCMH?

• Delivers “whole person” coordinated care to transform our practices into “what patients want it to be”

• Encourages clinician-patient relationship to keep patients healthy between visits
What is a PCMH? (continued)

• Supports “team based” – allowing us to work at our highest level of training

• Aligns use of information technology - helps providers support the Triple Aim (better quality, experience and cost) and improve population health
Benefits of a PCMH

• Improved cooperation with obtaining recommended preventative services
• Better chronic disease management resulting in fewer ER and hospital visits
• Improved healthcare quality and patient satisfaction
Managing patient care is a team effort that involves clinical and nonclinical staff interacting with patients and working as a team to achieve stated objectives.
• A patient advocate
• Essential members of the PCMH team
• Sharing ideas to improve patient care
• Dedicated to working at your highest level of education and ability
• Care coordination
• Support patients in self-management & behavior change
• Manage the patient population
• All with the goal of improving clinical performance
Care Coordination

• Deliberate, organized patient care activities
• Shared information among all participants involved

GOAL: achieve safe, appropriate and effective care

(AHRQ – Agency for Healthcare Research and Quality)
Examples of Care Coordination

• Obtaining test and referral results
• Communicating with community organizations, health plans, facilities and specialists
• “Close the referral loop” when patients are referred out
  ✓ ensure patients keep appointments
  ✓ ensure results are received back from specialists
The help given to patients with chronic conditions that enables them to manage their health on a day-to-day basis

Provides support and inspiration to patients to learn more about their conditions and to take an active role in their health care
Self Management Tools

• Communication
• Shared decision making
• Motivational interviewing
Strategies to Improve Patient Understanding

• Focus on “need-to-know” & “need-to-do”
• Use teach-back method
• Use clearly written education materials
What do patients need to know when they leave the exam room about:

- Taking medicines
- Self-care
- Referrals and follow up visits
• Ensure agreement and understanding about the care plan

• “I want to make sure I explained it correctly. Can you tell me in your words your understand of the plan?”
• Use plain language
• Limit information to 3-5 key points
• Be specific and concrete
• Demonstrate, draw pictures
• Repeat, summarize
• Be positive, hopeful, empowering
Examples of Plain Language

- Annually = yearly or every year
- Arthritis = pain in joints
- Cardiovascular = having to do with the heart
- Diabetes = elevated sugar in the blood
- Hypertension = high blood pressure
When a health care provider and patient work together to make a health care decision that is best for the patient.

The decision should consider evidence-based information about options, the provider’s knowledge and the patient’s values and preferences.

(AHRQ – Agency for Healthcare Research and Quality)
SHARE Approach

- Step 1: Seek your patient’s participation
- Step 2: Help patient explore and compare treatment options
- Step 3: Assess patient’s values and preferences
- Step 4: Reach a decision with the patient
- Step 5: Evaluate patient’s decision

A form of **collaborative conversation** for strengthening a patient’s own **motivation** and **commitment** to change. “Change Talk” is any speech that favors movement in the direction of change.
D = Desire for change
A = Ability to change
R = Reasons for change
N = Need for change
• Open-ended questions
• Reflections
  ➢ Simple
  ➢ Double-sided
  ➢ Reframe
✓ How is your exercise plan working out?
✓ Tell me about how and when you are taking your medications.
✓ What concerns you most right now about your health?
Patient: “I know I said I’d work on losing this extra weight, but I just don’t have time to exercise.”

PCMH Team Member: “You are really busy right now.”
Patient: “I know I said I’d work on losing this extra weight, but I just don’t have time to exercise.”

PCMH Team Member: “You’d like to figure out some other ways to lose weight that will fit into your busy schedule.”
Patient: “I know I said I’d work on losing this extra weight, but I just don’t have time to exercise.”

PCMH Team Member: “You are really busy right now, and you still intend to lose weight.”
Unhealthy behaviors like smoking, inactivity, unhealthy diets, non-adherence to prescribed therapies and ineffectively managed stress significantly contribute to illness and escalating healthcare costs.

Population health management focuses on preventing illness.
Assess and manage the health needs of a patient population, such as defined groups of patients (e.g., patients with specific clinical conditions such as hypertension or diabetes, patients needing tests such as mammograms or immunizations)
Domains of Population Health

- Identify subgroups of patients that will benefit from additional services or have gaps in care
- Create reminders for patients and providers
- Ensure patients receive the services identified
- Focus: *improving health*
An ongoing quality improvement strategy that includes regular review of performance data and evaluation of performance against goals focused on:

- Preventive care
- Chronic or acute conditions
- Patient experience
Continuous Improvement

• Plan, do, study, act, repeat to improve:
  o Workflows
  o Clinical performance
  o Patient experience
o How is *our* Care Team structured?

o What is *our* workflow around care coordination?

o How do *we* support patients in self-management & behavior change?

o How do *we* manage patient populations?

o What are *our* areas of focus for clinical quality improvement?
• PCMH recognition is a process, not an event
• Standards work to achieve Triple aim (better quality, experience and cost)
• Practices must show they follow PCMH standards consistently
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