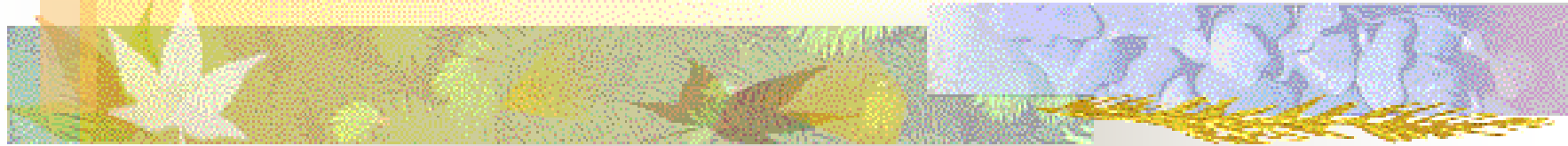




OHSU FAMILY MEDICINE
AT SCAPPOOSE

WINDING WATERS
CLINIC, PC

Implementing the Patient Centered Medical Home in Rural Primary Care



26th Annual Oregon Rural Health Conference
November 6, 2009
Gleneden Beach, OR





Speakers

- Melinda Davis, MA - Oregon Rural Practice-based Research Network
- Winding Waters Clinic, PC
 - Keli Christman – Practice Manager
 - Renee Grandi, MD – Clinician/Partner
- OHSU Scappoose Rural Health Clinic
 - Diane Hutson – Practice Manager
 - Bruin Rugge, MD – Medical Director
 - Kar-ye Wu, MD – Clinician

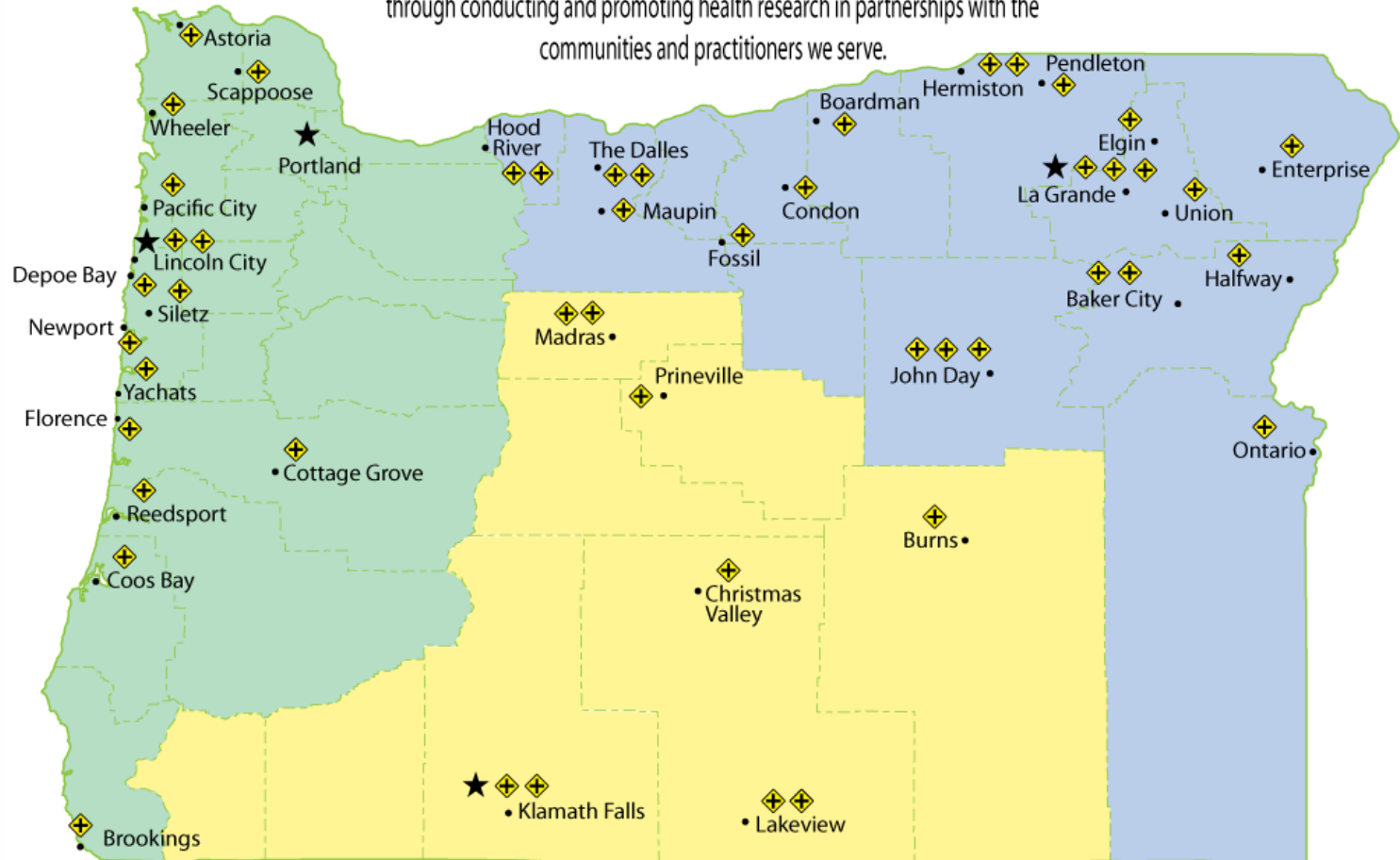


Session Overview

- Overview of the Patient Centered Medical Home & ORPRN Research
- Stories from the field
 - Winding Waters Clinic, PC
 - OHSU Scappoose Rural Health Clinic
- Participatory discussion (i.e. Q&A)
- Summary & Conclusions

Oregon Rural Practice-Based Research Network

The mission of ORPRN is to improve the health of rural populations in Oregon through conducting and promoting health research in partnerships with the communities and practitioners we serve.



www.ohsu.edu/orprn

◆ Member Clinic

★ ORPRN Office



ORPRN & The Patient Centered Medical Home (PCMH)

- Dr. David Dorr's Care Management Plus
- FIMDM - Shared Decision Making
 - Network wide baseline survey
 - Participatory implementation in 4 clinics
- Qualis/Commonwealth Safety Net Medical Home Initiative

What is the PCMH?? How do we know when we get there?



Joint Principles of a Medical Home

AAFP, AAP, ACP, AOA

- Personal Physician (Provider?)
 - Team care
- Whole person orientation
- Integrated & coordinated care
 - Quality & Safety
- Enhanced Access
 - Payment Reform





NCQA: PPC – Patient-Centered Medical Home Recognition

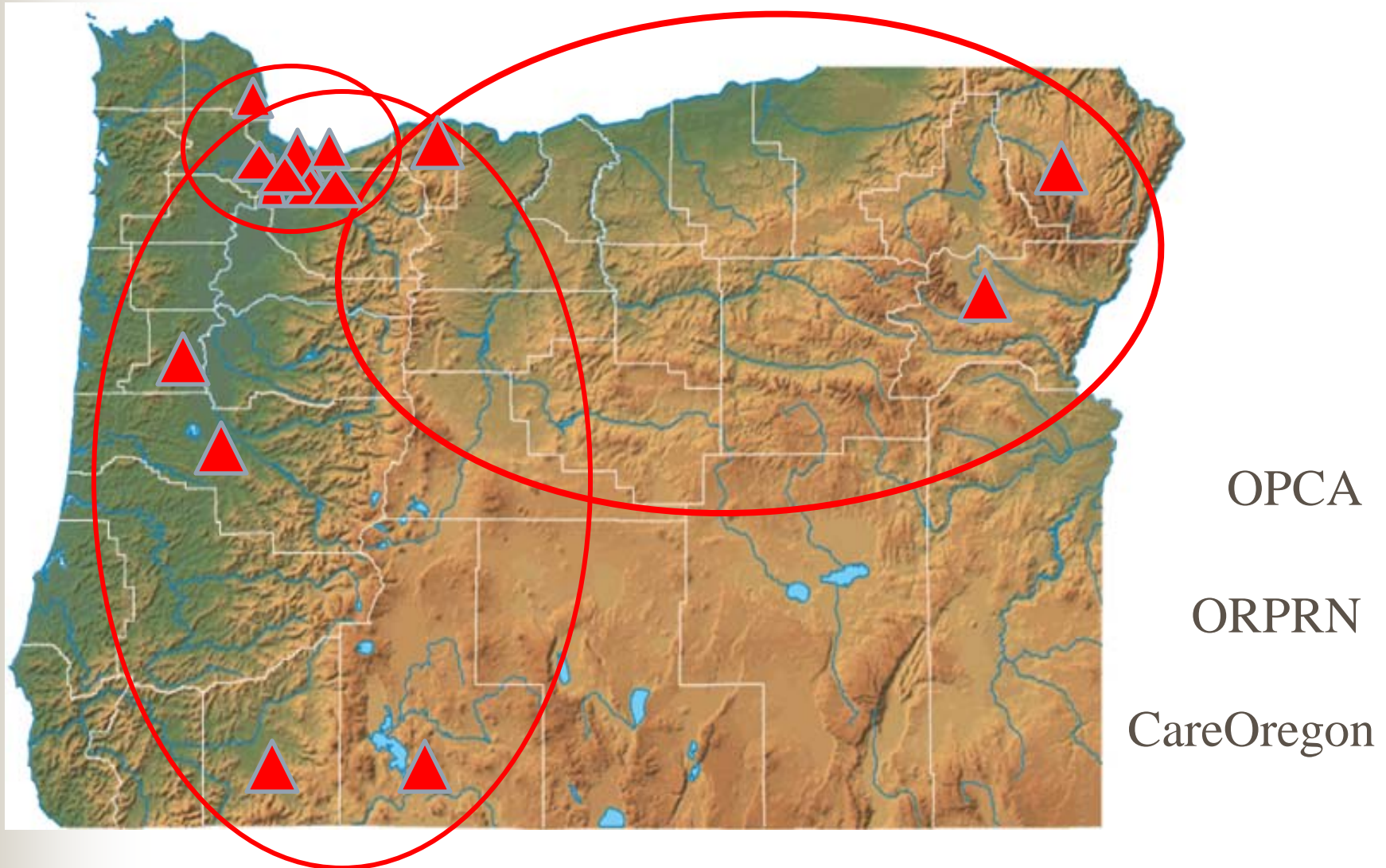
- Tool for assessing PCMH “ness” based on Joint Principles
- 9 PPC-PCMH standards, including 10 “must pass” elements
 - ex. Access & Communication, Care Management, Referral Tracking, Performance Reporting & Improvement...
- Recognition possible at 3 levels



Safety Net Medical Home Initiative (“the Initiative”)

- Sponsors: Commonwealth Fund, Qualis Health, & the MacColl Institute for Healthcare Innovation
- 5 Regional Coordinating Centers (RCC)
 - 12-15 safety net clinics within each RCC
 - 1 Medical Home Facilitator per RCC
- 4 year project: April 2009 – April 2013

Oregon RCC – three collaboratives into one





SNMHI Activities to date

- Baseline assessment (June 09):
 - NCQA PCC-PCMH
 - Assessing Chronic Illness Care (ACIC) version 3.5 + Medical Home Supplement
 - Anne Beal/FQHC Survey
- Oregon RCC Kick Off Meeting (July 09)
- “Change Package” - Prioritization & Action
- QI Data Reporting (Sept 09)



change·con·cept

(cheynj kon-sept) *n.*, **1.** A general idea — with proven merit and a sound scientific or logical foundation — that can stimulate specific ideas for changes that lead to improvement

SNMHI Change Concepts

- Engaged leadership
- Quality improvement strategy
- Empanelment
- Patient-centered interactions
- Organized, evidence-based care
- Continuous, team-based healing relationships
- Care coordination
- Enhanced access






And now for the stories...



...Winding Waters Clinic, PC

...OHSU Scappoose Rural Health Clinic



Q & A: What do you want to know or share?

- Empanelment?
- New/Old staff orientation to PCMH concept
- Change management & leadership
- Prioritization of tasks
- Facilitating/building teams
- Nurse care management & care coordination
- Data reporting/tracking
- Team coordination/leadership

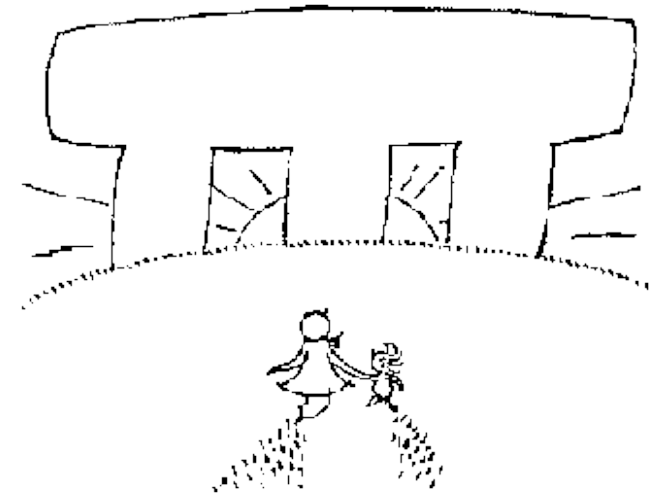


Summary/Conclusions

- Culture change and tasks occur simultaneously
- Clinics with and w/o EHR can start on this journey of transformation
- Start in small steps (doesn't have to be a total overhaul)...slow & steady
- Clinician leadership and staff champions are vital to moving the activities forward!
- Have fun!

T.T.T.

Put up in a place
where it's easy to see
the cryptic admonishment
T.T.T.



When you feel how depressingly
slowly you climb,
it's well to remember that
Things Take Time.

Grooks by Piet Hein