Transitioning to a Patient Centered Medical Home

Bowdoin Street Health Center

The Problem

- High costs of health care combined with an increasing shortage of primary care physicians have prompted national and regional insurers to explore development of a patient centered medical home that emphasizes patient involvement, care coordination and integration, a personal relationship with a clinician who leads a TEAM who collectively take responsibility for the ongoing care of patients, quality measures, and responsibility for an identified panel of patients. The expected outcome being improved quality and reduction of cost.
- It is anticipated that reimbursement for care will be based on the successful implementation of a patient centered medical home

Aim/Goal

Our goal is to gradually transition to a medical home model of care for both our adult and pediatric patients eventually meeting the quality standards developed by NCQA and positioning ourselves to maximize reimbursement in a changing health care environment.

The Team

Francine Azzara, MPH, RN, Operations Manager Harvey Bidwell, MD, Medical Director

Blue Sky Team- H. Bidwell, MD; K. Barry, ANP; G. Leddy, MD; J. Lincoln, FNP: J. Driscoll RN; M. O'Sullivan, RN; T. Nguyen, T. Pereira. S Prevost, MA'S; A. Louro, Interpreter; A. Brow, MSW; T. Tran, CRS.

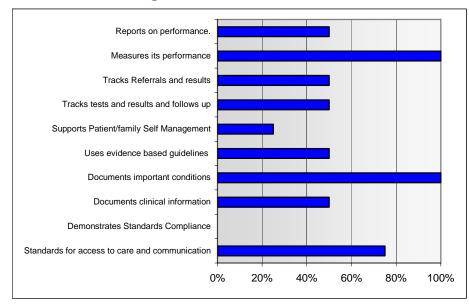
Sunshine Team- J. Alves, MD; J. Ingelfinger, MD; A. Phan, MD; K. Sheehan King, RN; D. Tatum, LPN; R. O'Brien, RN, CNS; R. Pereira, A. Pires, M. Spinola, MA's; A. Mett, Interpreter; C. Palmer, MSW; K. Banovic, MSW; A.C. Spencer, CRS; M. DaCruz PSR.

<u>Green Team</u>- B. Anderson, MD; A Bonacci, MD; H. Delgado, MD; K. Cook, PNP; J. Brown, RN; M. Sanders, LPN; K. Le, D. Lherrison, D. Marcel, M. Perez, MA's; R. Amado, Interpreter; M. Driscoll, MSW; R. Graciani, CRS; R. Amezquita, PSR. EVERYONE ELSE who is not specifically named here!!!!

The Interventions

- Completed a self assessment of current state utilizing NCQA's standards for a medical home and identified areas for development.
- Convened Multidisciplinary meetings- all invited- to discuss model and to identify target populations and clinically significant conditions.
- Created clinical teams responsible for identified patient panel.
- Established regular weekly team meetings to discuss implementation strategies

The Results/Progress to Date



Bowdoin Streets progress towards Achieving Critical "Must Pass" Items (Practice must meet a minimum of 50% elements to Qualify for Patient Centered Medical Home.)

Lessons Learned

Shifting the culture of care in an organization requires:

- Dedicated time for team meetings
- Dedicated resources to achieve goals
- Involvement of all affected from the beginning of planning
- Availability of data to support measurement of goals
- > A positive attitude and willingness to change.

Next Steps/What Should Happen Next

- Develop Written Protocol to define clinical practices and expectations for adherence.
- Complete panel identification and assignment in CCC.
- > Conduct baseline chart reviews to document adherence to guidelines.
- Develop capacity to create practice wide reports from OMR with IT support to facilitate patient tracking, reminders, and care management needs.



