

Kansas Patient Centered Medical Home (PCMH) Initiative



The initiative is administered through the Kansas Academy of Family Physicians.

Objectives

Describe Patient Centered Medical Home

What is a PCMH?

Why PCMH?

Describe the Kansas PCMH Initiative

Elements of the Initiative

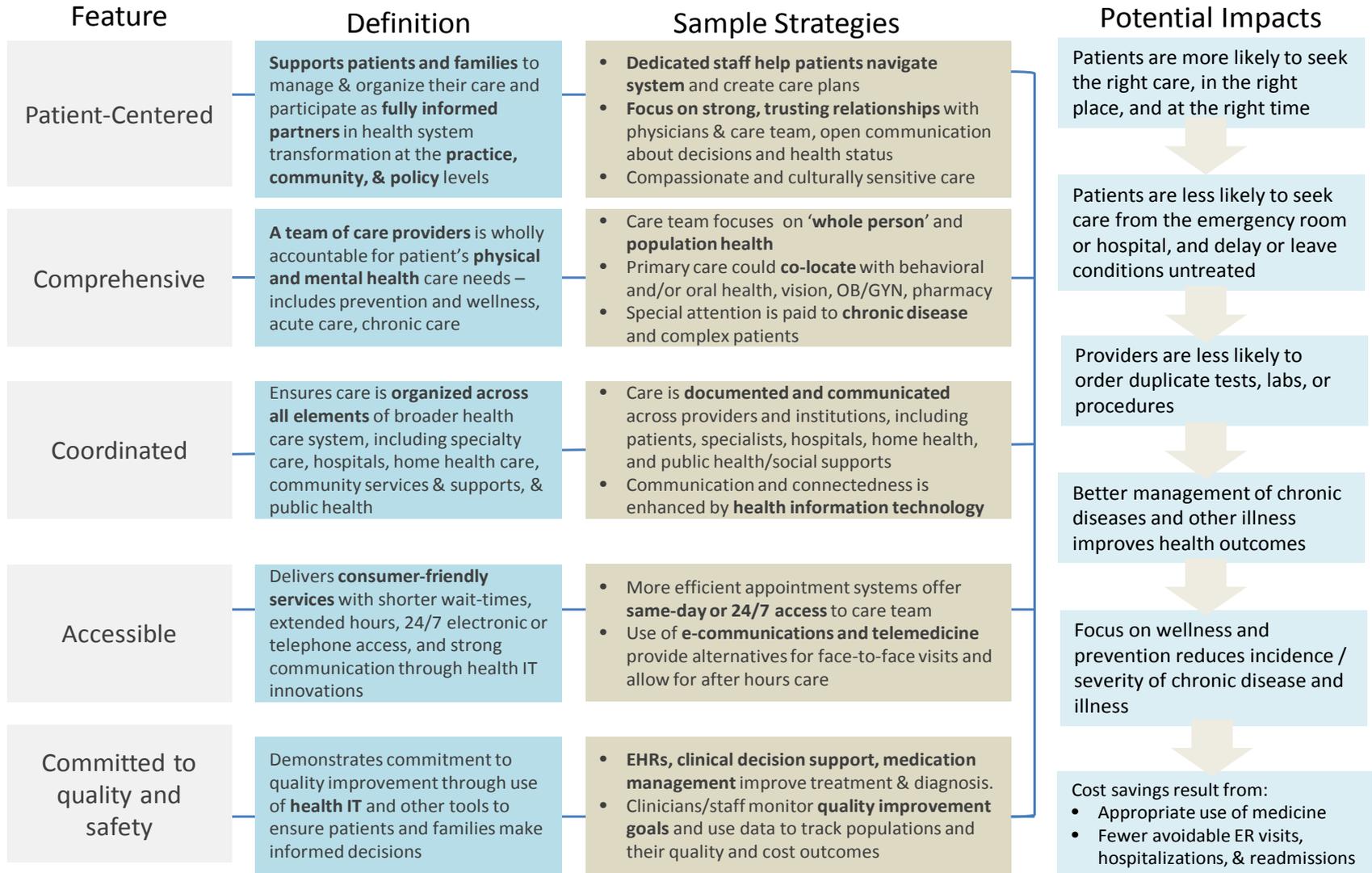
TransforMED model

Outcomes

What does a Patient Centered Medical Home (PCMH) do?

*The PCMH puts patients at the **center** of the health care system, and provides primary care that is “**accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.**”*

Why the Medical Home Works: A Framework



The PCMH model of care provides:
higher quality, better coordinated, more
efficient care.

Improved Outcomes

Quality

Chronic Disease care

Transitions in care

Satisfaction (patient/provider)

Communication

Efficiency (cost savings)

Elements of the Kansas PCMH Initiative:

1. **PROVIDER EDUCATION:**

- a. KAFP Annual Meeting: June 13th – 15th, Wichita Kansas
- b. PCMH Summit: November 1st – 2nd, Wichita Kansas

2. **PUBLIC RELATIONS:**

- a. Radio spots, social media, news releases, rack cards, exhibits, presentations etc...

3. **PILOT PROJECT:**

- a. Eight practices across Kansas
- b. Systematic and all-encompassing effort to become Patient Centered

TransforMEDSM

The TransforMED Patient-Centered Model A Medical Home for All



**A continuous relationship with a personal physician
coordinating care for both wellness and illness**

• Mindful clinician-patient communication:
trust, respect, shared decision-making

- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care

Access to Care and Information

- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

Practice-Based Services

- Comprehensive care for both acute & chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Care Management

- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies

Care Coordination

- Community-based resources
- Collaborative relationships
 - Emergency Room
 - Hospital care
 - Behavioral health care
 - Maternity care
 - Specialist care
 - Pharmacy
 - Physical Therapy
 - Case Management
- Care Transition

Practice-Based Care Team

- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Practice Management

- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Health Information Technology

- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

Quality and Safety

- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Initial PCMH Outcomes

Note: These are the 1st year's improvements for 3 quality benchmarks
Based upon aggregate figures from all practices in pilot.

Metrics Spreadsheet	Average across Providers/ Practice	Average across Providers/ Practice	Change
Description	2011	2012	
Same Day Availability	19.80%	30.27%	10.47% 
Breast Cancer Screening	55.13%	58.01%	2.88% 
HbA1c Control	56.07%	65.72%	9.65% 

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