Impact of a Patient-Centered Medical Home Model on Correctional Care Performance and Pt Outcomes

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National Commission on Correctional Health Care
National Spring Conference
Atlanta, Georgia
April 12, 2022

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Learning Objectives

- Summarize the elements of patient-centered medical home models
- Examine how to apply quality improvement, performance monitoring, and patient satisfaction to practice management
- Explore population health management evaluation analytics

Correctional Health Care Delivery

- Varies by site, but traditionally
  - Sick Call
  - Chronic Care
  - Urgent Triage
  - Infirmary
  - Medical Emergency Responses

A system designed for episodic treatment of acute illness is incapable of delivering high-value healthcare that meets the needs of patients (paraphrased from Crossing the Quality Chasm: A New Health System for the 21st Century Institute of Medicine (US) Committee on Quality of Health Care in America Washington (DC): National Academies Press (US); 2001

Our history

- female facility
- highest level of security
- Highest level of medical complexity
- Reception
  - Patients enter with a history of
    - Poor access
    - Poor utilization
    - Poorly controlled comorbidities
    - General lack of prioritization for health
    - Limited experiences enhancing education and self-efficacy
- Asthma/COPD, hypertension and diabetes prevalence similar to national rates
- Clinic utilization 5-6 times higher than national after copay suspension

Our history

- We found many opportunities for improvement in effective care delivery and coordination
  - Access
    - Are we getting people to care as effectively as possible?
  - Personnel Utilization
    - Are we utilizing staff (and teams) to the maximum of their competence and certification?
  - Care transfers
    - Is information moving effectively and do we facilitate coordination?
      - Across units?
      - Within visit types?
  - Patient engagement
    - Are patients participating in shared decisions and enhancing their health and wellness?

So let's get better!

- All patients deserve the best care we can deliver
- A culture of quality improvement demands improvement
  - Better Outcomes
  - Better Safety
  - Better Service
  - Better Direct/Indirect & Non-financial/financial costs
- i.e., CONSTANTLY IMPROVE VALUE!!

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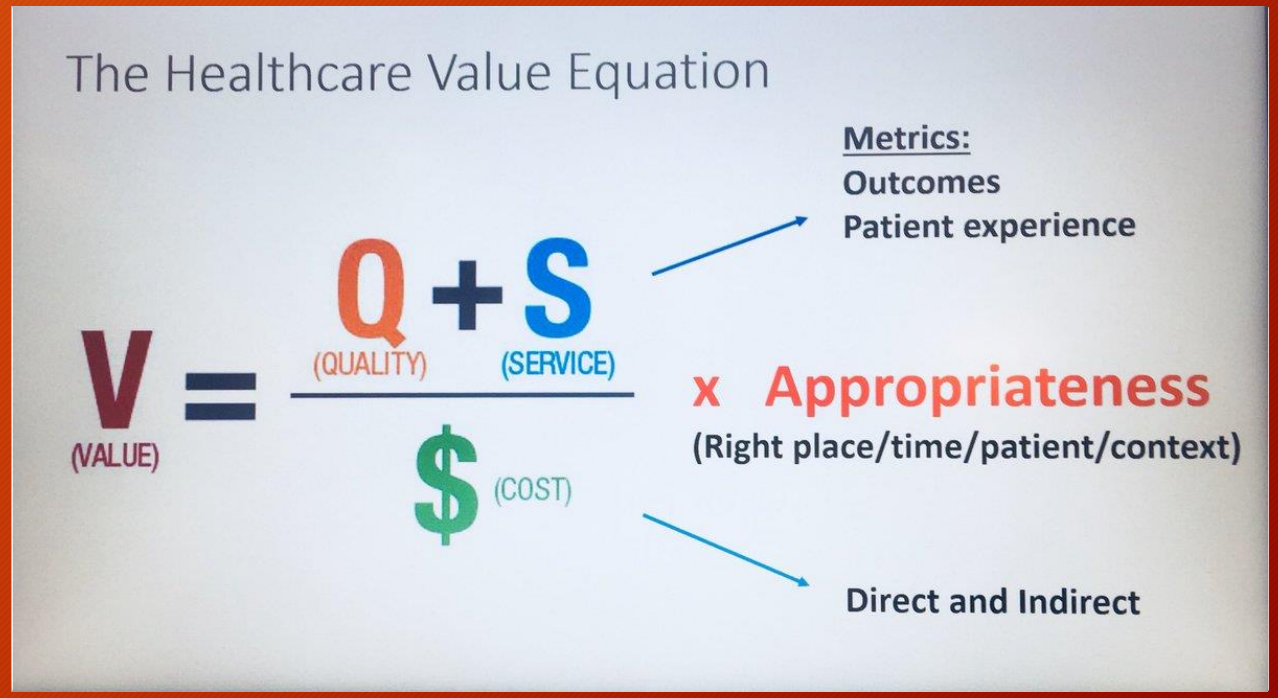
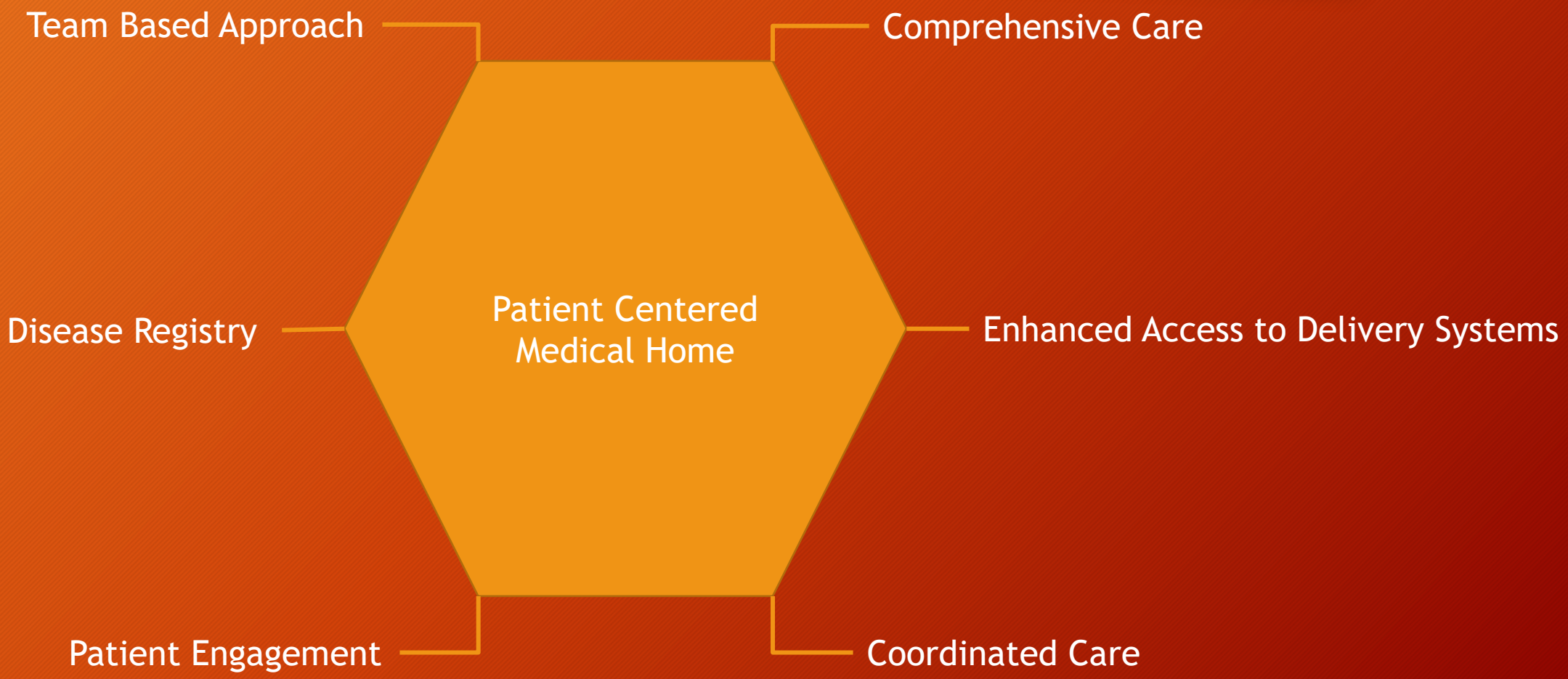


But how?

The patient-centered medical home (PCMH) model is **an approach to delivering high-quality, cost-effective primary care**. Using a patient-centered, culturally appropriate, and team-based approach, the PCMH model coordinates patient care across the health system.



What makes a PCMH?

- Each patient has an ongoing relationship with a personal physician trained to provide continuous and comprehensive care.
- The physician leads a team at the practice level who collectively take responsibility for ongoing care of their patients.
- There is a whole-person orientation.
- Care is coordinated and managed across all elements of the complex health care system and the patient's community.
- Quality and safety are central to health care delivery.
- Enhanced access to care is available to patients through new systems and communication options.
- Payment appropriately recognizes the added value provided to patients in a PCMH.

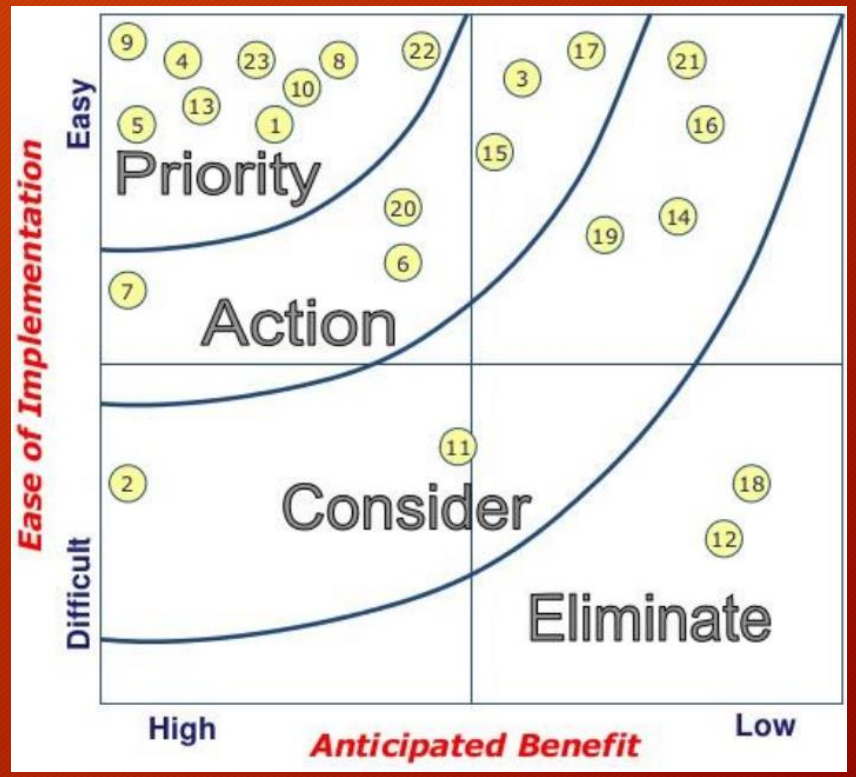
What could be the benefit of a PCMH in a correctional setting?

- Gender responsive and trauma informed
- Enhances continuity and care coordination
  - Aging correctional patient population
  - Similar or higher prevalence of comorbidity than community settings
  - Patients with a history of poor access and utilization
- Routinizes process and procedure but allows for patient and provider individualization
- Cost and time reductions with fewer handoffs
- Better communication across medical units since core team is always the same
  - Infirmary to clinic
  - Chronic care
  - Care for patients in restorative, incentivized and mental health housing

Can it be done? We've bought in, now what?

- Clinical and patient education and training (and lots of Gemba Walks!)
- Alignment of the practice prioritization matrix with advances towards the PCMH model

Urgency	Impact: HIGH	Impact: MID	Impact: LOW
HIGH	1	2	3
MID	2	3	4
LOW	3	4	5



What does that really mean?

- Establish metrics
  - Team task performance – patient flow and visit volumes
  - Care delivery - Chronic disease management, preventive service
  - Coordination – post-infirmary or consult visit access, treatment plan documentation and follow-up
  - Utilization – consultations and avoidable outcomes
  - Superutilizer management – proactive care
  - Shared decision making – patient engagement (care participation and receipt – no shows, preventive services, etc) and records documentation
  - Cost? – medical complexity, visit intensities
- Empanel Patients
  - Establish teams and longitudinal home
    - Determine how to allocate panels equitably for medical complexity

What does that really mean?

- Implementing and monitoring
  - Communication with patients
  - Missed meds, chronic disease metrics, emergency grievances and written complaints
  - Pain management?
  - Coordination with outside consultants
  - Preventive service and vaccine delivery

What were our steps

- Educate, train, get buy-in and communicate throughout…a lot
- Establish Metrics
  - Medical Leadership, Staff Queries, Convention (NCCHC, NQF, AHRQ, etc)
- Empanel
  - Estimate comorbidity and medical complexity, provider FTE, accommodate training and experience to start
- Support access and flow with process
  - Standardize rooming and discharge, centralize scheduling to improve coordination across units, adjust for “no shows”, stagger staffing, combine visit types, schedule nonvisit care
- Monitor Processes and Collect Data
  - Time studies, process fidelity, patient communications, staff satisfaction
  - In addition to the performance and outcome measures of interest
- Re-educate, Retrain, get more buy-in and re-communicate…a lot

Have we established the elements of a PCMH?

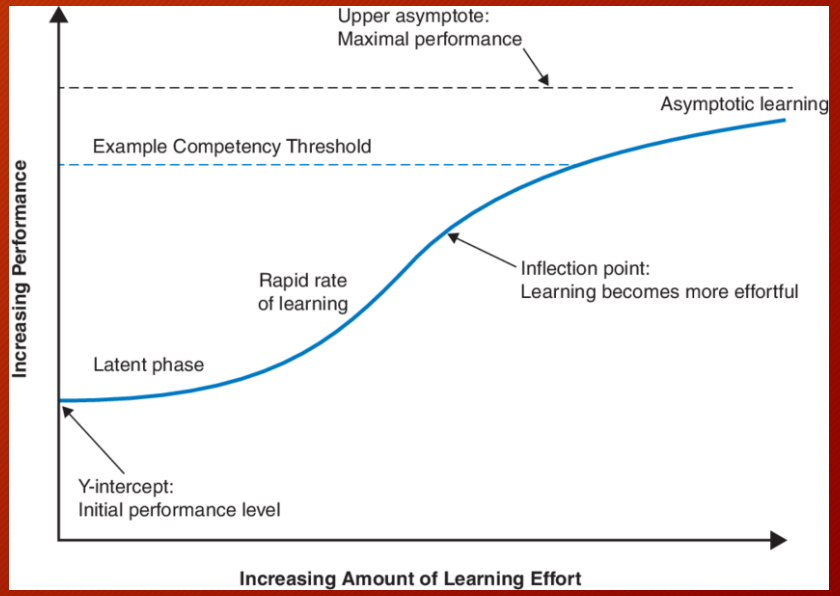
- Team-based approach
  - CNA rooming, LPN clinic assistance, RN CDM, Provider continuity, Scheduler discharge, Patient discharge instructions for internal follow up
- Disease Registries
  - Chronic Disease Management is registry-based
  - Current Superutilizer Initiative
    - Comorbidities, multidisciplinary health needs, avoidable events, intensive care
    - Can drive trauma informed and gender responsive innovations to the current model
- Coordinated and Comprehensive Care
  - Longitudinal coverage from reception through infirmary and to any housing
  - Establish and adhere to documented treatment plans
- Patient Engagement
  - Multimedia patient education, health campaigns, extended wellness programs
- Enhance Access
  - Multiple interventions to the clinical settings to improve access and performance

Have we seen improvement?

- Reduced no shows by 17%, higher reduction with acute care visits
- Scheduling
  - Established 20/40 minute appointment slots for provider visits
  - Time specified for clinic visit versus mass appointments – ~20% increase in access
  - Coordinate visit types and combine – ~10% increase in access
  - Centralize scheduling and coordinate to facility clock – ~20-25% increase in access
- Removed RN sick call clinical visit – saved >1 RN FTE and reduced time to provider visit
  - 64% at baseline, 79% by end of 2020 and >91% by end of 2021
- Improved provider volume productivity 2.5 fold since 2019 (accumulation of increments)
  - Recent intensive pilot for chronic care appts showed 120% visit increase from baseline
- Nonvisit care and remote visits (established during COVID) reduce unnecessary face to face encounters
- Target Diabetic control at population level improved by >25% and exceeds national average
- Vaccine Receipt exceeds national averages by 30-60%, consistent with provider endorsement impact
- Reduced medication misses (multifactorial but improved communication/patient engagement)
- No demonstrable increases in hospitalization or emergency transportations (123 in 2019 to 106 in 2021)

What's next?

- Quality care is "that care that has the capacity to achieve the goals of the physician and the patient" (Steffen GE: Quality medical care: a definition. JAMA. 1988, 260(1):56–61.)
- Enhance trust and credibility in patient-provider dyad
- Better staff (patient?) onboarding and education
- Improve fidelity and consistency
- Build on in house procedures as part of team care
- Incorporate EHR to drive surveillance
- Build promotoras wellness models



Thank you!

- Facility Staff
  - Nurses
  - Medical Team
  - QI Committee
  - Facility Leadership and Operations
  - Security Partners
- Patients
- Other stakeholders and colleagues
  - Input from emergency medical staff, nursing home staff, community members, local EMS, academic experts, and others

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