LakeCounty
Health Department and
Community Health Center

PCMH 2.0 Implementation Update

Board of Health

February 22nd, 2017

The Nurse Care Coordinator

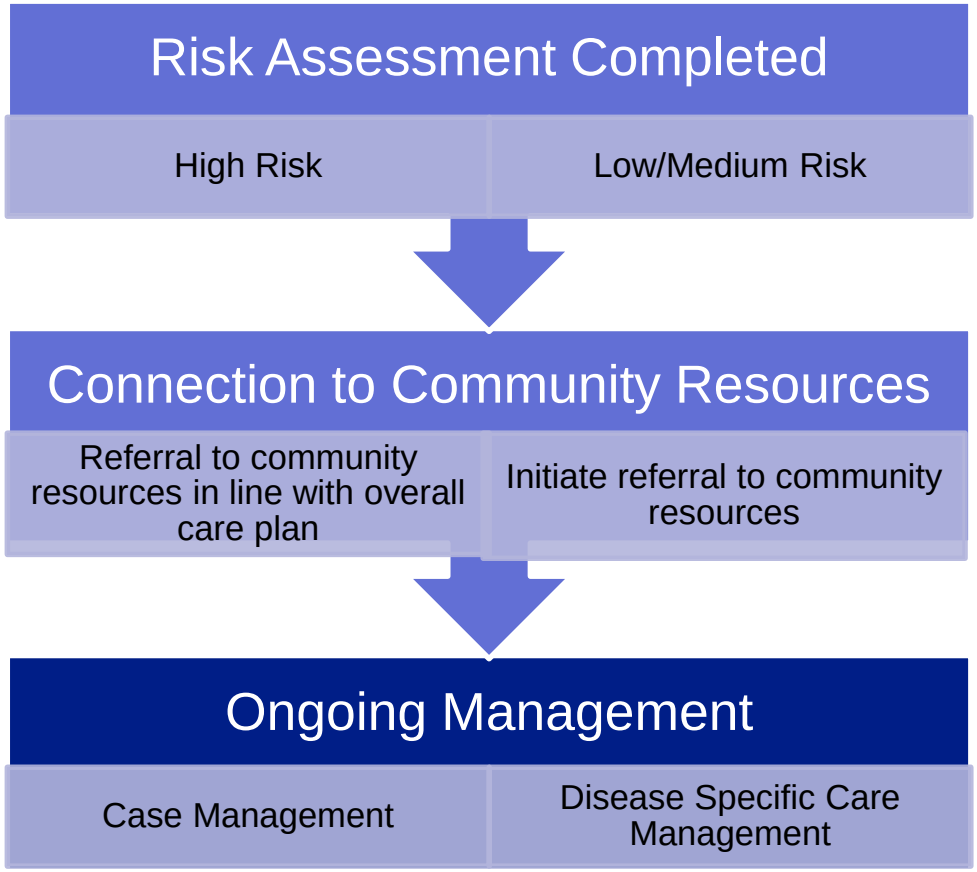
- Promote timely access to appropriate care
- Increase utilization of preventative care
- Reduce emergency room utilization and hospital readmissions
- Increase comprehension through culturally and linguistically appropriate education
- Create and promote adherence to a care plan
- Increase continuity of care by managing relationships with specialists, transitions in care and referrals
- Increase patients' ability for self management and shared decision-making
- Connect patients to relevant community resources

Essential Duties

- Serve as the contact point, advocate, and informational resource for patients, care team, family caregiver, payers, and community resources
- Work with patients to plan and monitor care
  - Assess patient's unmet health and social needs
  - Develop a care plan with the patient family/caregiver and providers
  - Monitor adherence to care plans, evaluate effectiveness, monitor patient progress in a timely manner, and facilitate changes as needed
  - Create ongoing processes for patient and family/caregiver to determine and request the level of care coordination support they desire at any given point in time
- Facilitate patient access to appropriate medical and specialty providers
- Educate patient and family/caregiver about relevant community resources
- Assist with identification of high risk patients

New Patient Intake Visit

- Provide overview of PCMH model
- Assess medical and surgical history
- Complete initial assessments – CRAFFT, AUDIT, PHQ2
- Medication reconciliation
- Assess Social Determinants of Health (SDoH)
- Calculate Risk Level
- Initiate case management or disease specific care management based on risk level

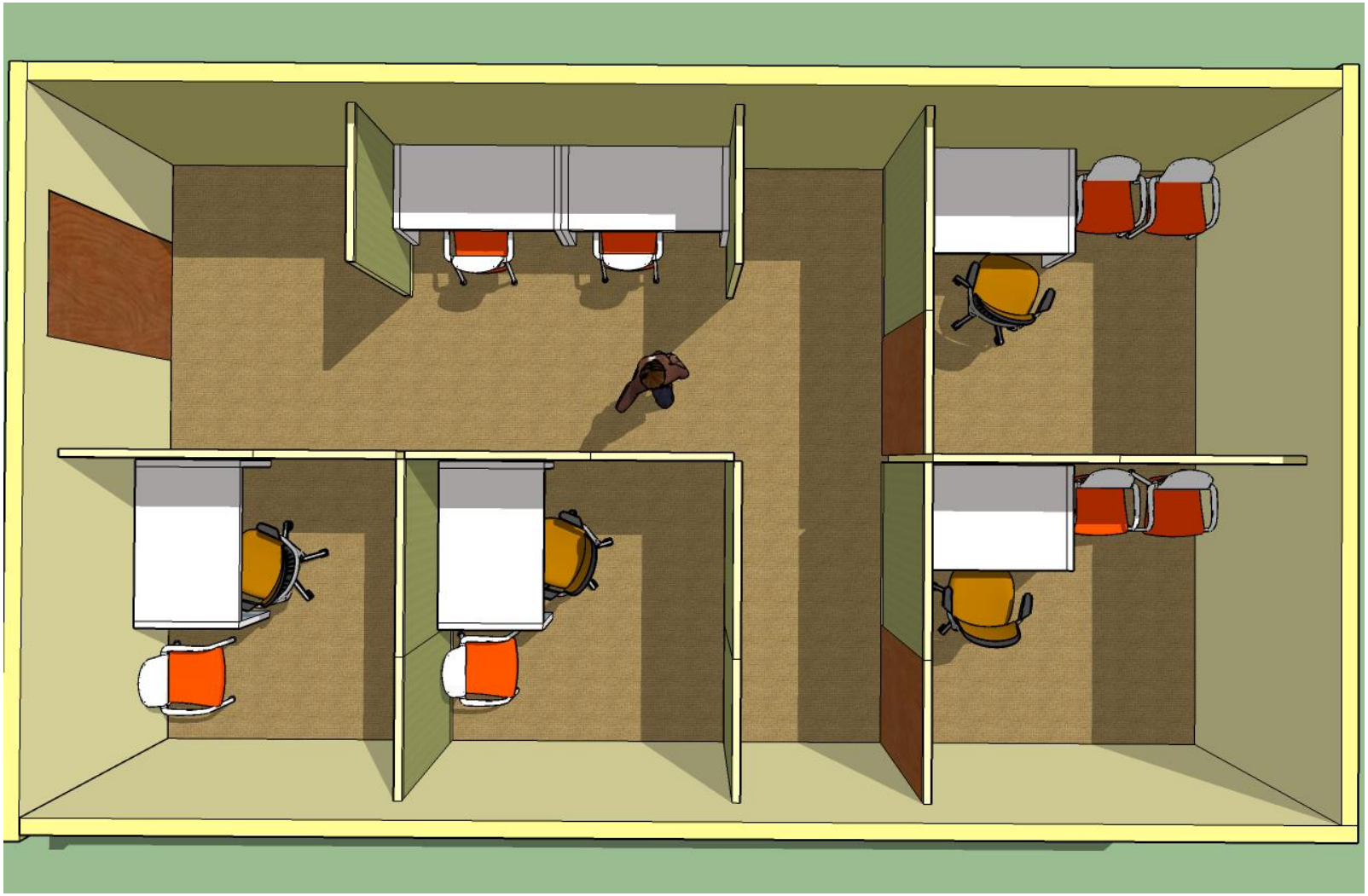


Case Management Follow-up

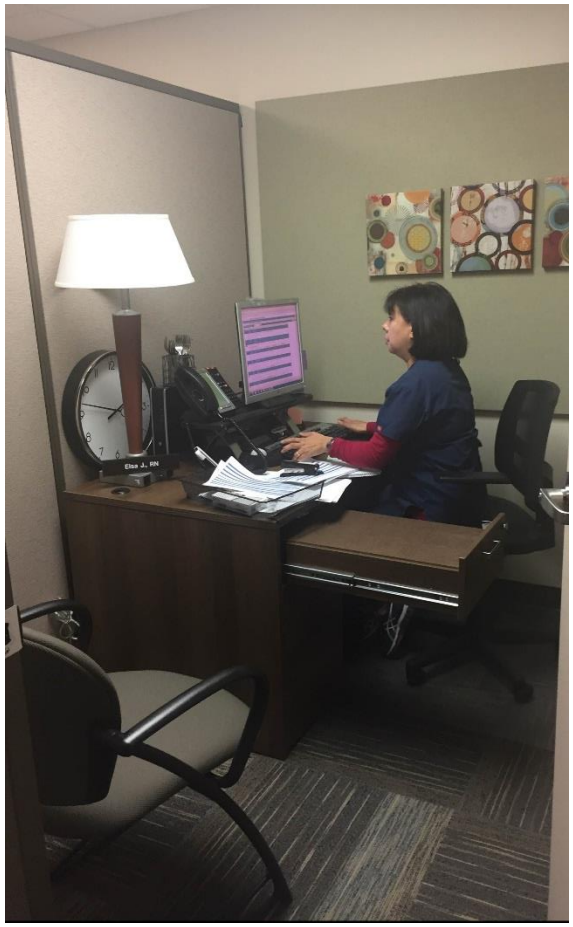
Identify and focus on highest risk population (~5%)

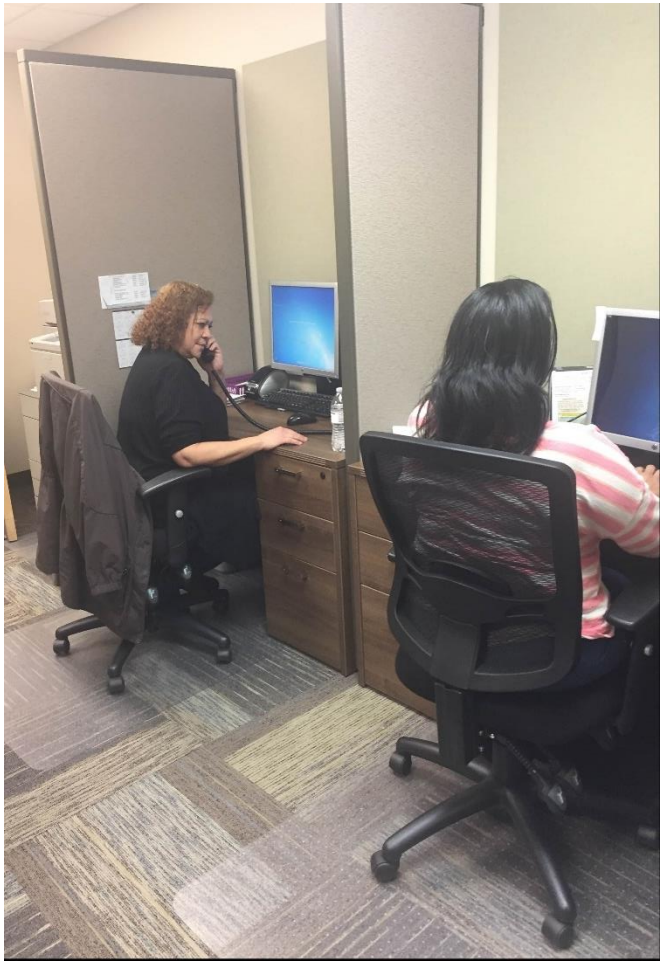
- In-person or telephonic
- Follow-up on status of care plan
  - Inquire on status of referrals (medical and community resources)
  - Evaluate home monitoring results and provide support and tools
  - Identify and help patient resolve barriers
  - Coaching and compliance support
- Conduct patient education

New Functions, New Spaces

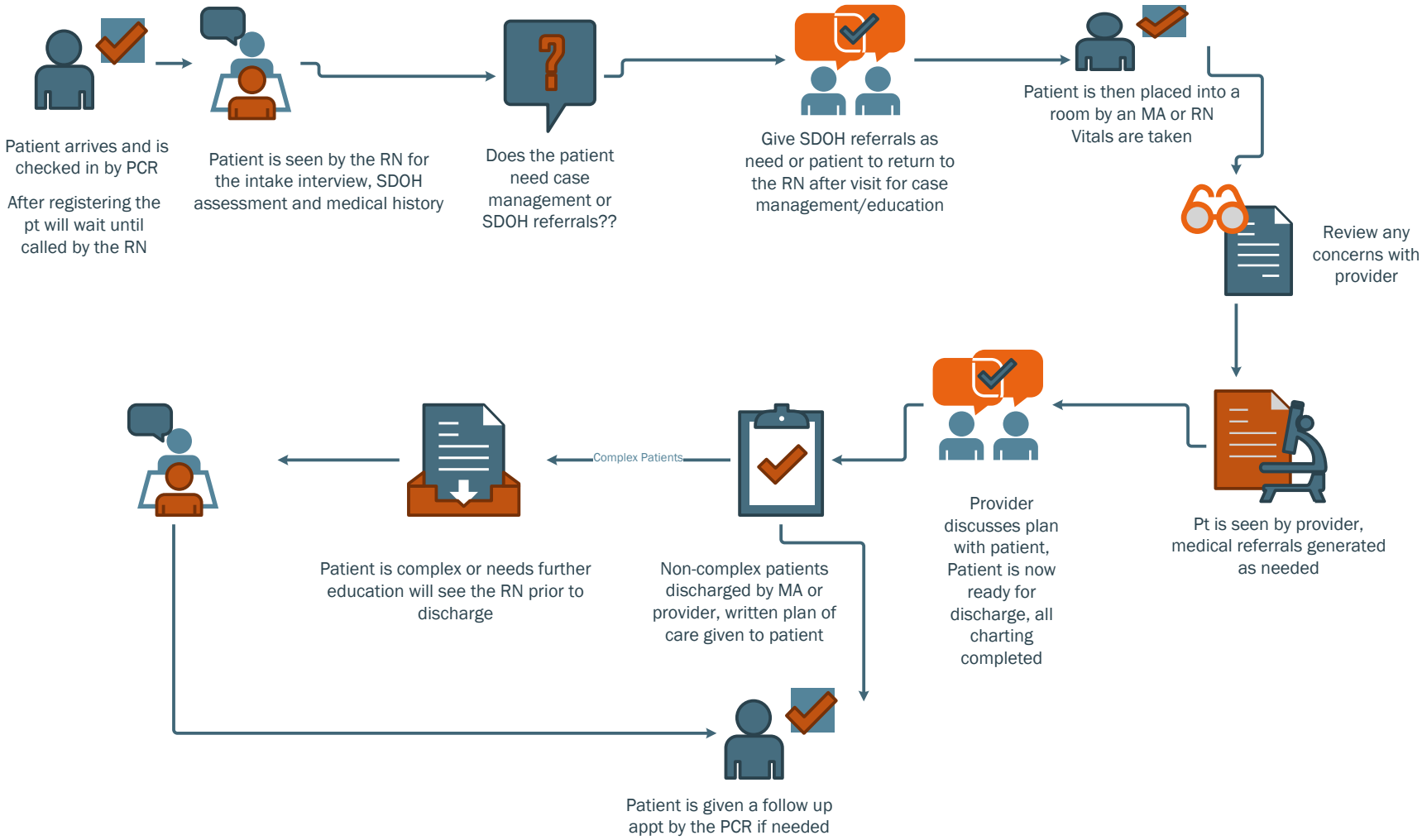


New Functions, New Spaces





PCMH Workflow

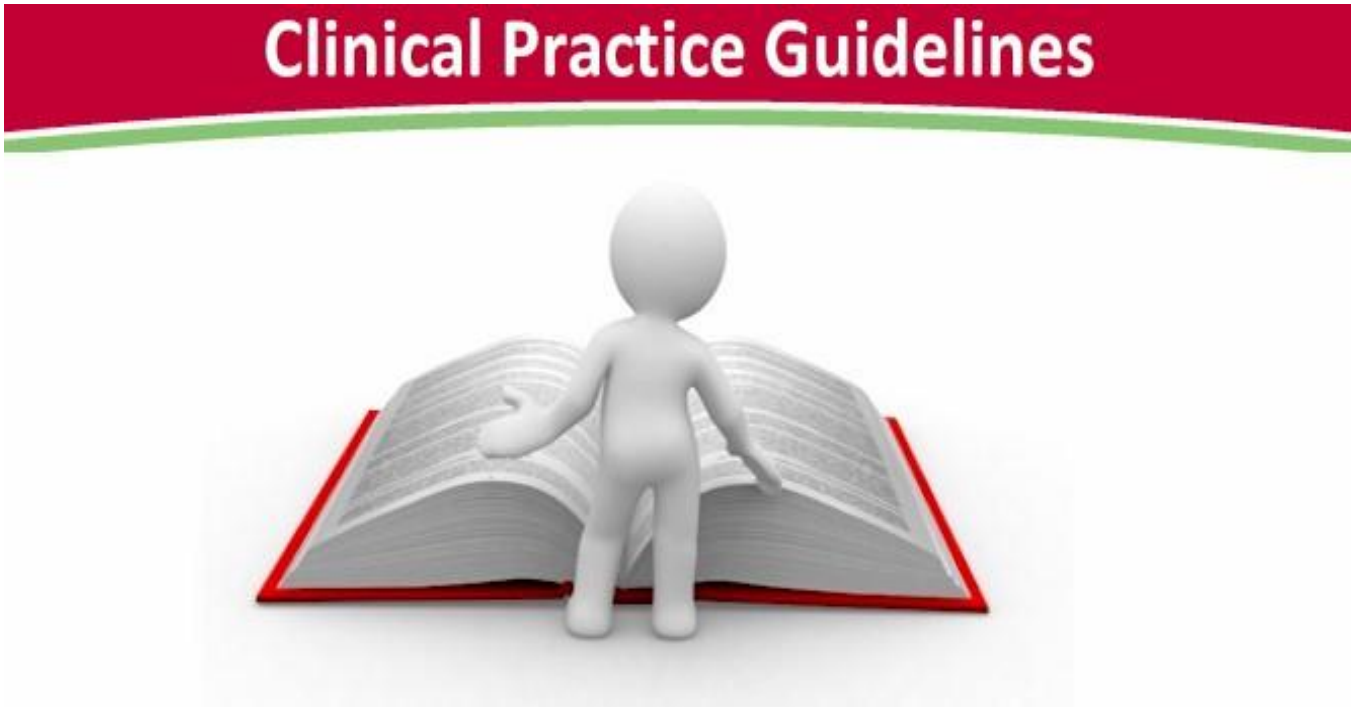


What Have We Achieved

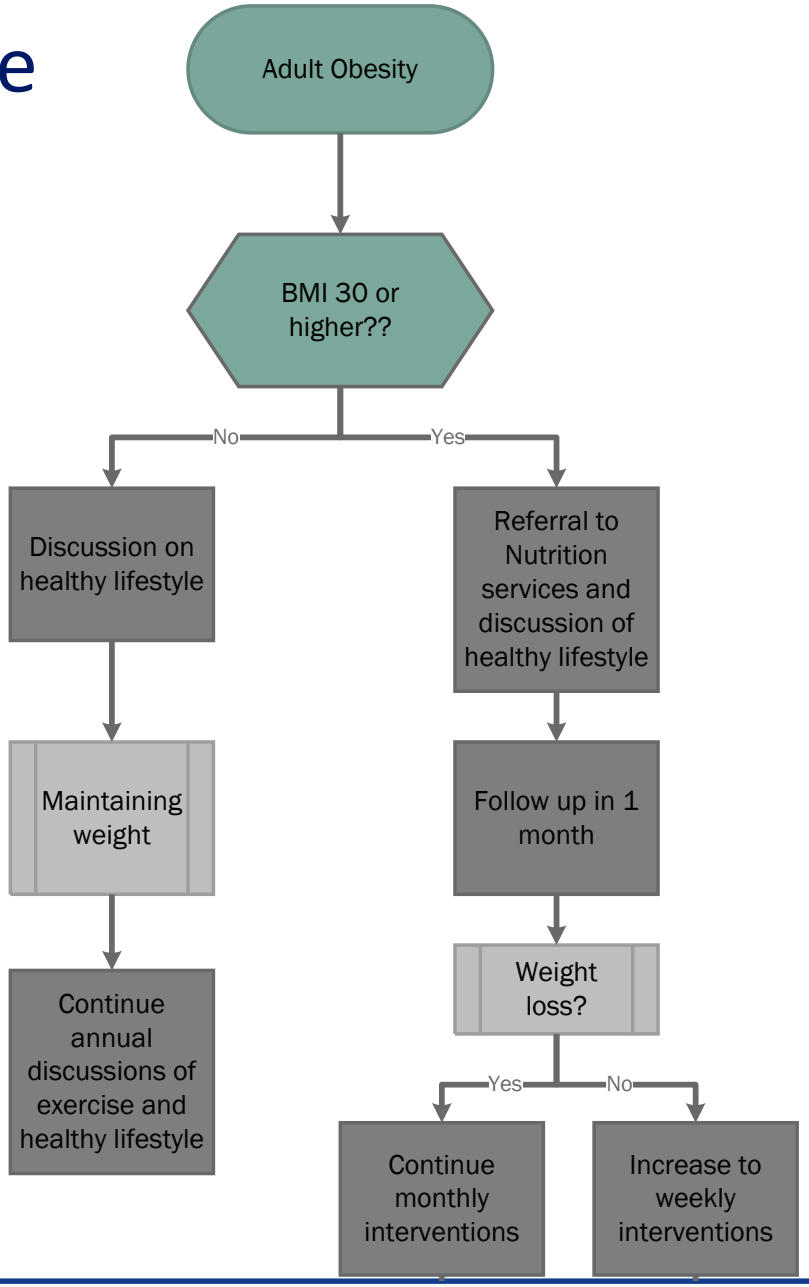
- North Chicago went live January 15th 2017
  - Dr. Alesna's team went first
- Challenges
  - Removing the number system
  - Patients roomed immediately in the correct order of appointment
  - Provider charting in the room (computers on wheels)
  - Patient health care information post visit by the provider
  - Check out process out of the room
  - Nurses difficulty in navigating system created longer than 30 minute per patient nurse visit
  - Administrative tasks had to be moved away from the clinical staff
- Next phase: Implementation of Standard Practice Guidelines

Standard Practice Guidelines

- Obesity and Hypertension



Standard Practice Guideline



How will we measure success?

- Compare to baseline and to non-care managed population
- Evaluation Metrics
  - Improvement in clinical outcomes
    - Weight loss
    - Blood pressure control
  - Provider satisfaction
  - Patient satisfaction
  - Utilization – show rate
  - Completed SDoH referrals

LakeCounty
Health Department and
Community Health Center

3010 Grand Avenue Waukegan, Illinois 60085
847.377.8180 phone
http://www.lakecountyil.gov