Jamaica Plain, MA

Brigham and Women's Hospital PCMH Pilot

Andrew Schutzbank MD, MPH

9.15.2011 Site Visit

Created by a group at BWH dedicated to Primary Care innovation, this practice is the result of collaborative efforts between physicians, nurses, medical assistants, social workers, and pharmacists. At the time of initial visit, this practice had been seeing patients for six weeks.

Care Model

The practice consists of 4 core Care teams to care for panels of patients. The teams have two doctors, an "anchor" doctor working 6 sessions per week and a part time doctor at 2 sessions per week, a PA, 2 MAs, 1 LPN and 1 Social worker that work together to care for their panel. Tasks are delegated in a license appropriate fashion. Teams are collocated in huddle rooms as described below.

The entire practice shares additional expertise in 2 RN care managers who oversee patients with advanced needs within the practice. There is one nutritionist, six full time administrative scheduler/receptionist staff, 1 population manager, 1 community resource manager and 1 pharmacist.

The population manager is a unique role, working behind the scenes to use data to lead improvements in the practice. Currently the population is undergraduate trained with an interest in health care and a quantitative background. At the time of first visit, he was studying claims and clinical data for the practice patients to determine demographics and possible outreach strategies. The next project just starting was looking at visit data to change the practice schedule and schedule software provided by Brigham and Women's to better suit patient needs.

The community resource manager works works with patients to obtain goods and services from the community/public domain. Examples include: connecting patients with Masshealth resources such as ordering and obtaining durable medical equipment, insurance eligibility, transportation needs through MBTA ("The Ride"), dealing with

insurance paperwork, letters of medical necessity, location and directions to social supports in the community such as AA, community groups, etc.

The Clinical Pharmacist has both direct patient care and education roles, working on complex medication reconciliation and optimization, new medication teaching, prior authorization assistance, medication safety, stocking, and treatment protocol creation. The pharmacist ideally is introduced to patients via warm handoff at the end of the visit into an immediate follow up or a closely scheduled follow up visit.

Team Rooms & the Huddle

Each of the 3 teams has its own section of the clinic with multiple exam rooms surround a team room. Teams are co-located in team offices with a white board dedicated both to patients coming into the practice that day, but also patients that are ill, high-risk or currently hospitalized. Theses white boards in the team rooms serve as the guide for the pre-session huddles, happening 2-3 times daily.

The huddle is designed to get the team in sync for the session, think about the team's panel at large, and ensure appropriate capacity for doing the day's work. The huddles, led by the Medical Assistants, begin before every clinic session; on the day of my observation they started at 8am and 1pm. The huddle is visit-preparation based, with additional focus on high-risk hospitalized or active patients. Progress is followed through an Access Database for quality metrics, and this record provides opportunities to for individualized team training. I observed rapid cycle training in which an MA learned a new lab draw technique because it came up during the huddle. The information shared between team members was brief but valuable, focusing on conditions, expected needs for the day, social dimensions of care, and barriers to care.

The Schedule & Visits

The schedule is based on 15-60 minutes depending on visit status (new, follow up) but the practice's population manager is currently working with BWH to transform the scheduling software, and thus the schedule of the practice. MAs room patients with vital signs, and will handle health maintenance screening and medication reconciliation. The physician portion of the visit incorporated electronically prompted safety/screening questions to ensure these data were collect. Exams proceeded smoothly and the rooms were stocked thoughtfully and identically to make locating supplies and inventorying seamless. Due to the number of skillful providers in the clinic, most visits end with a Warm Handoff between providers.

The Warm Handoff

The Warm handoff is one of the highlights of the practice. Arranged mid visit by the Physician via Page to the appropriate team member- Social Work, Community Resource Specialist, Pharmacy, Nutrition; the visit then dovetails into a meet and greet with the allied provider. Based on patient and team member availability either a full visit or a scheduled future visit will occur. Patients seemed to have a much better understanding of various team member roles, even if those roles are currently defined.

Conclusions

This very young practice is heading in the right direction for Primary Care innovation. The magic of the practice thus far is best seen in the collocation of the teams with huddles and awareness of total panel population. The quality of care is obvious, combining the best of guideline based care with personalized and intelligent clinical work, integrated Mental health via social work and psychiatry, and comprehensive support with LPNs, RN Case Coordinators, translation, phlebotomy, nutrition and community resource support. The Population Manager is a unique role, starting as master of the reports, but will hopefully expand to proactively guide care with data, rather than simply report on care activities retroactively.