# Bright Spots

## ... in primary care

### Re-Imagining the PCMH:
### An Innovative Approach to Primary Care

Nathan Stern, MD

**West County Health Centers**
Sonoma County, CA
September 2016

Since my recent visit to West County Health Centers (WCHC) in Sonoma County, CA, I have been thinking about the purpose of the patient-centered medical home (PCMH). Often cited as a solution to the towering primary care provider shortage in this country, many PCMHs try to create teams to offload tasks traditionally performed by providers, tasks that could be capably done by other healthcare professionals. In many PCMH practices, having more team members increases access to care and might provide care in a more patient-friendly manner, but the provider remains in the center. The traditional model of provider-driven primary care is enhanced, but remains intact.

WCHC takes a different approach. This primary care "bright spot" embraces the PCMH as a new model of healthcare that can revolutionize both how primary care is delivered and the role of the primary clinic in a person's health. WCHC puts the patient at the hub, with a small group of diverse team members arranged like spokes on a wheel, surrounding and supporting the patient. Providers no longer occupy the hub.

## Take Away Messages

- WCHC has consistent teams from both a patient and provider perspective involving the Core Four: provider, medical assistant, front office staff, and RN.

- All team members have a high degree of autonomy and ownership of their responsibilities, especially RNs, allowing the teams to adapt to the needs of individual patients.

- The focus on non-provider care team members empowers the teams to more ably address the social determinants of health to "move primary care outside the four walls".

**Current Team Structure**

WCHC cares for a medically and socially complex population in mostly rural West Sonoma County in Northern California. Between their 4 primary clinic sites, they serve almost 14,000 distinct patients, 82% of whom have either public insurance or no insurance at all. Ninety-seven percent of the low-income residents in their catchment area receive care at WCHC. To serve this challenging population, WCHC has designed a unique Care Team model. The patient/family always comes first, followed by the Core Four: Medical Provider, Medical Assistant, Care Team Representative (front office staff), and Nurse Case Manager. The Care Team is stable from both patient and provider perspectives – which is to say that the patient always interacts with the same Core Four and the provider always works with the same MA/Care Team Representative/RN. Behavioral health is co-located and integrated into primary care, and community health workers support several teams.

- Medical Assistants manage the office experience for both the patient and provider. They run the daily huddles, which involve all team members, prepare the teams for patient visits, and assist the provider during the visit. They often know the patients and the team members better than anyone and are the glue that holds the teams together. If that were not enough, they also utilize standing orders and a user-friendly data system to coordinate the population management and preventive care for their panels. As one MA told me, "We do it all here – not just responsible for rooming and vitals."

- Care Team Representatives are the front line staff. Like the other team members, they receive customer service and motivational interviewing training because they are often the first team member a patient will meet. They are seen as important members of the team, and give valuable input during team huddles. They also perform much of the population management outreach.

- Nurse Case Managers have the most diverse and variable role on the team. Their level of involvement with a patient depends on that patient's particular needs. Focusing on the most complicated and complex patients, they can be found providing many unique and invaluable services, including: giving clinical advice and triage to their patients, managing chronic diseases, refilling medications, providing health education, assisting with hospital transitions, assisting with adjustment to new diagnoses, and filling in gaps identified by the team. With the assistance of community health workers, their visits can take place anywhere from the clinic to the patient's home or in the hospital. The RNs embody WCHC's mantra of "moving primary care outside the four walls" by focusing on "non-medical determinants" in addition to management of medical problems. RNs also form the backbone of care for the patients who most utilize the healthcare system. By having one RN on each team, this complex case management is embedded into the function of the teams, rather than being a referral or a separate team. The Nurse Case Managers have an impressive degree of autonomy and flexibility to carry out these tasks.

To achieve this level of continuity and complexity, the staffing ratios per full-time-equivalent provider are staggering: 1.75 MA, 1.75 Care Team Representative, 1.2 RN, 0.33 Community Health Worker and 1 Behavioral Health clinician. That's 5 full-time staff members per full-time medical provider, plus 1 full-

time Behavioral Health clinician. This allows for a relational care approach based on "touches." A patient interacts with a small team of 4-6 people, having more "touches" with the team members who are most able to help them. The frequency, intensity, and type of "touches" are based on the patient's needs. Because all team members have some level of autonomy and diversity of training, they are all capable of providing certain aspects of a patient's care, and can refer to other team members without going through the provider.

For example, a MA would use her population management time to get on the clinic's intranet, where she can access Quality Dashboards that have been generated by Tableau, an user-friendly data visualization software. She can easily pull her panel's registry for a variety of conditions and identify who is overdue for certain things. She might ask the Care Team Representative to make outreach phone calls to schedule appointments. During one of the calls the patient may tell the Care Team Representative that she has not made it in for the pap smear because of transportation barriers and that she's been feeling depressed about her sister's passing. The Care Team Representative will provide support and possibly some motivational interviewing about trying to make it into the clinic. After the phone call the Care Team Representative will likely discuss what happened with the Nurse Case Manager, who will either reach out to the patient or delegate to the Behavioral Health clinician and the Community Health Worker. When the patient finally comes for her pap smear, the provider will be prepped on her depression during the team huddle, and will likely perform a warm hand-off to the Behavioral Health clinician, if they have not met already. This model operationalizes team members to work at the top of their licenses, freeing up providers to focus on provider-only duties, i.e. diagnosis and management of medical conditions. Providers can have that old-school relationship with their patients, despite the time constraints of modern healthcare, without spending time on things other members of the team can just as easily manage. The system adapts to each patient's needs, so that the care is individualized for every patient.

**The Journey**

It has taken over 10 years for WCHC to arrive at their current model, and they are constantly tweaking the process to provide better patient care. They started by using one of their clinics, Sebastopol Community Health Center, as a test site for innovations. When something worked well there it would be expanded to the other 3 sites. Now all 4 sites operate similarly and each can serve as a test site. The WCHC innovation process consists of a few key principles.

- Culture of Innovation – Using human-centered design processes and techniques, WCHC goes far beyond traditional healthcare models to bring primary care outside the four walls. They are proud of having a "DNA of being on the edge." Jason Cunningham, the WCHC Medical Director, told me that "early on, leadership drank the Kool-Aid on innovation," promoting an inclusive environment of idea-sharing and rapid, effective change.

- Focus on Human Resources – When WCHC finds a staff member whose skills they like and fits with their ethos, they invest heavily in that person. If that person's skills seem to be better suited for a different position in the organization, they will get that person the training they need. For

UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

example, the current Innovation Project Coordinator started out in data entry but showed aptitude for innovation work and has received a wealth of training through the Center for Care Innovations. The current data team consists of a former Medical Assistant and an Assyriologist (someone who studied the cuneiform writings of ancient Assyria).

- Using Data to Guide Innovations – Rather than using data to see how well current processes work, WCHC takes a more proactive approach. They received a Reimagined Care grant through the Center for Care Innovations to create a data lake, which combines EHR utilization, health plan claims, publicly available data like the Census, and surveys on social determinants, among other sources. They use this information and data visualized through Tableau to guide their innovations towards the major health needs of the community.

- "Focused on Care not Cost" – Many of their "touches" do not provide immediate revenue. Much of the work of the MAs, Nurse Case Managers, Community Health Workers, etc., is not reimbursable, but if these services are important for providing high-quality primary care to a medically and socially complicated population, then WCHC finds a way to pay for them. Rather than waiting for payment reform, they extend the spirit of creativity and innovation to financing appropriate care. They have found ways to be financially viable in the present, with the assumption that better primary care now will lead to even more cost savings in the future.

## Summary

WCHC is an inspiring place – one of the brightest of bright spots. They combine innovative design techniques, mission-driven staff and leadership, a dauntless attitude toward embracing new ideas, and big data to create a unique and comprehensive approach to primary care, regardless of how it has been done in the past. However, what stood out most during my visit were the joy and pride people have in their work at WCHC. Passion for their mission and a feeling that their work was important and valued were the common threads throughout all my interviews. WCHC embraces the spirit of the patient-centered medical home by putting patients in the center and creating a diverse, well-trained team that is able to extend the medical home beyond the walls of the clinic. The staff and providers realize that they are at the forefront of a revolution in primary care. Not only do they enjoy working at WCHC, but they feel how well this model works for patients.

UCSF
Department of Family &
Community Medicine
Center for
Excellence
in Primary Care