HAWAI'I PRIMARY CARE ASSOCIATION

PATIENT-CENTERED HEALTH CARE HOME

COMMUNITY HEALTH CENTER PILOTS

Partners

- Kalihi-Palama Health Center
- Wai'anae Coast Comprehensive Health Center
- Waimanalo Health Center
- West Hawai'i Community Health Center
- AlohaCare
- Hawai'i Primary Care Association

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Core Values

WHOLE PERSON APPROACH

- Patient-driven and Family-centered
- Barrier-free access to care
- Team-based care delivery
- Integrated and holistic care

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Health Care Home Roadmap

Leadership

Common Purpose

Systems

Access & Communication

Registry

Quality Improvement

Patient- & Family-Centered Care

Processes

Care Plans

Care Coordination

Team Care

Implementation Plan

ICSI

Institute for Clinical Systems Improvement

PCHCH Implementation

July 2008	Healthcare Safety Net Visioning Session with HPCA and AlohaCare
Sept 2008	All-HPCA Strategic Planning meeting
Jan 2009	HPCA Patient-Centered Medical Home Conference featuring CareOregon
March 2010	PCHCH Kick-Off meeting for CHC Pilots
Oct 2010 to April 2011	PCHCH Learning Collaborative (3 F2F Learning Sessions)
May 2011	PCHCH Full Implementation

PCHCH Transformation

- Organization wide culture change
- Patient centered assessments
- Team based care and innovation
- Redesign of workflows: value stream mapping
- EMR template changes and registry implementation

PCHCH Transformation

- New positions and roles
- Improved communication, collaboration and integration: warm handoffs
- Care coordination and management: care plans
- Motivational interviewing and self management support

Unique Features

- Patient engagement
- Complexity tool
- Eligibility / Activation into Health Care Home
- Quality metrics
- Steering committee and monthly calls
- Partnership

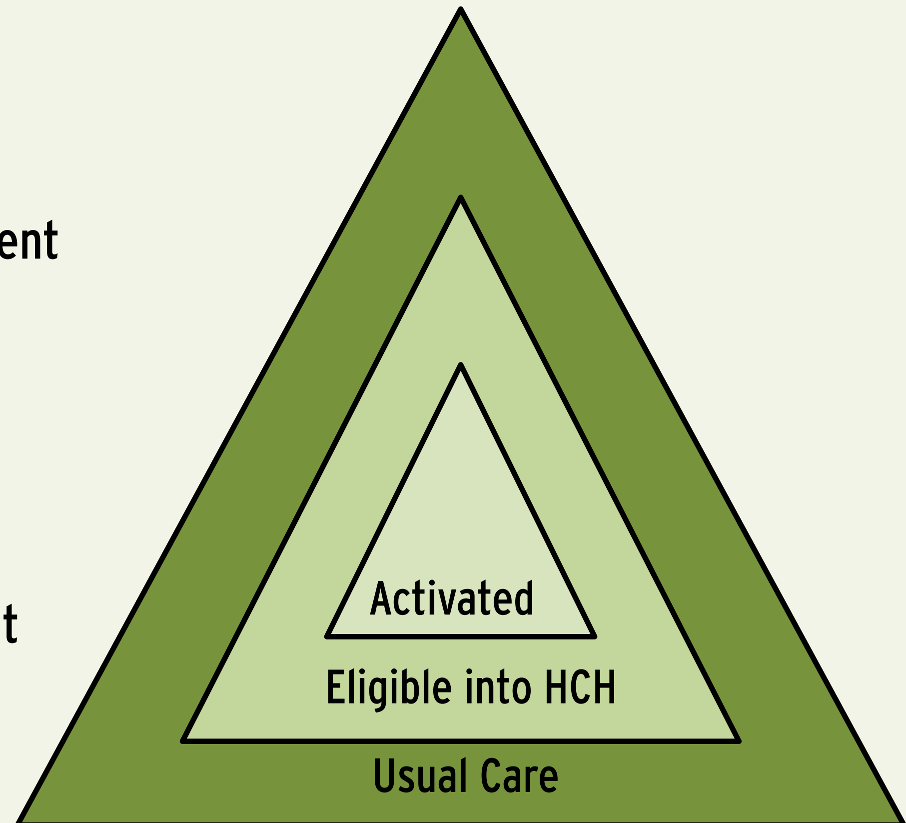
Metrics

DIABETES

- Diagnosis of 250.xx
- Eligibility into HCH: A1c > or = 8
- Activation into HCH: Patient agreement

DEPRESSION

- Diagnosis of 296.2x, 296.3x, 300.4
- Eligibility in HCH: PHQ9 > 9
- Activation in HCH: Patient agreement



Metrics

PROCESS MEASURES

- Activation Rate
- Diabetes: A1c test, Eye exam, Foot exam, Self Management Goal
- Depression: PHQ9 usage, PHQ9 follow-up rate

OUTCOME MEASURES

- Improvement in diabetes outcomes (A1C, BP, and LDL)
- Depression response and remission (PHQ-9)

FUTURE MEASURES

- Patient experience: Exploring patient experience surveys to determine common measures
- Return on investment

Opportunities

- Spread efforts
- Ongoing measurement
- NCQA PCMH Certification
- CMS Advanced Primary Care Demonstration Project
- HRSA Supplemental funding
- Health Home State Plan Amendment
- Community centered health homes

Challenges

- Staff and provider buy-in
- Standardization
- Change not easy - Transformation even harder
- Flow of information for improved care transitions
- Demand for care coordination greater than the capacity
- Patient acuity/complexity

SUSTAINABILITY

Appropriate payment structure

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