

Community Primary Care

“The Importance of a Medical Home”

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Access to Primary Care



- **Availability of Care Providers**
- **Cost**
- **Insurance Coverage**
- **Immigration Status**
- **Cultural Barriers**
- **Location**
- **Literacy**

Impact



- ED Utilization
- Continuity
- Compliance
- Perception
- Prevention
- Morbidity/Mortality
- Wait Times
- Cost
- LWOBS
- Crowding

Community Partnership Project



Community Partnership Project

- Deficit Reduction Act of 2005 provides \$50 Million in grant funding to states for the establishment of alternative non-emergency service providers
- Partnership created between NJ Department of Human Services , Division of Medical Assistance and Health Services , NJHA, HRET and NJPCA
- Two demonstration projects were selected after a competitive bid process
- Goal is to develop most appropriate , efficient and cost effective program

Monmouth Community Partnership

- **ED Impact**

- Project Director
- APN - PCA
- IT infrastructure
- IS infrastructure
- Transportation

- **FQHC**

- Primary Care Physician
- Case Manager
- Care Coordinator
- Data Analyst
- PCA
- Nursing Hours

Community Project Focus:

- Express Primary Care Services
- Patient Education
- Access
- Primary Care Capacity
- Outcome Evaluation



Patient Throughput Process

Patient
Registration
ED



Triage

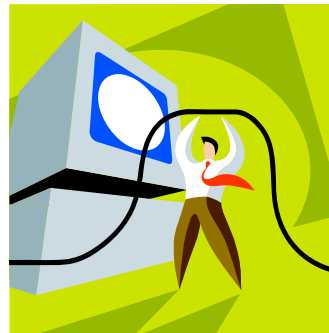


APN
Assessment,
Treatment,
Schedule Appt.,
Transportation
Evaluated

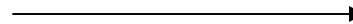
EDIM- Power
Chart data



Appointment
at MFHC,
Follow Up
Care, Patient
Education



Case
Management
Follow Up /
Education



Primary
Care
Team at
MFHC
Engages
Patient

Medical Home – Core Elements

- Personal Physician
- Physician Directed Care
- Whole Person Orientation
- Coordinated and Integrated
- Quality and Safety
- Enhanced Access and Communication
- Patient Tracking and Registry Function
- Care Management
- Referral Tracking
- Patient Self Management Support
- Performance Reporting and Improvement
- Care Coordination Through a Multi-Disciplinary Team
- Patient or Family Education for Patients with Chronic Diseases
- Home Based Services
- Culturally and Linguistically Appropriate Care

Project Data

	March 2009	April 2009	May 2009	Total
Number of Patients Referred	116	200	176	392
Number of Appointments Made	93	164	120	377
Show rate – 1 st Appointments Kept	68%	59%	67%	
Number of Appointments Rescheduled	11	12	4	27
Patient Education and Case Management Services	199	384	268	851

Key Observations

- Case Management
- Electronic Information Sharing
- Hospital-FQHC Communication
- Patient Education on Medical Home
- Cultural and Linguistic Sensitivity
- Physician Specialty Access
- Patient Compliance

