Field Notes

Palmetto Primary Care Physicians Patient-Centered Medical Home

Problem:

Diabetes and hypertension disease management for urban and rural populations in South Carolina was ineffective and costly.

Project:

Palmetto implemented a patient-centered medical home model that includes patient care coordinators who liaise between patients and the health care team, ensuring delivery of coordinated, patient-focused care for high-risk individuals.

For more information please contact

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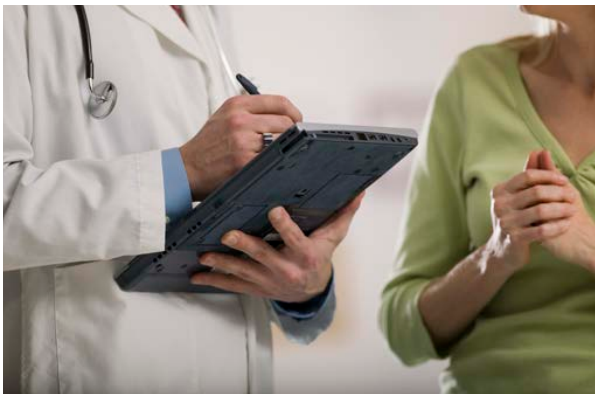
Overview

Palmetto Primary Care Physicians is one of the largest health care networks in South Carolina, with more than 30 locations and 90 providers. In 2009, Palmetto partnered with BlueCross BlueShield of South Carolina to pilot a patient-centered medical home (PCMH) with an aim to reduce health care costs and improve outcomes for patients with diabetes. After successful completion of the pilot, the program expanded to include coverage for patients with hypertension. Several health care insurance providers support the programs through financial reimbursement and incentives to physicians for the delivery of PCMH services.

The National Committee for Quality Assurance certified Palmetto as a Level 3 PCMH in 2010. The Palmetto PCMH model includes three essential components:



1. **Patient care coordination**—Palmetto tailors care coordination to meet the needs of each individual patient. Patient care coordinators (PCCs) collaborate with the whole care team to assess barriers and implement individualized care plans and goals. PCCs play a key role in the PCMH model by

- Contacting patients and conducting assessments.
- Working with patients to set health behavior goals and provide motivational support.
- Identifying patients' health, health education, and social needs and connecting patients to community or clinical resources, such as physician appointments, support care, health education classes, or prescription assistance.
- Maintaining patient contact logs and electronic medical record (EMR) case note entries to document interventions, current condition, and disease management goals.

2. **Monitoring and quality assurance**—Palmetto engages physicians in performance monitoring and improvement to strengthen accountability. Staff actively monitor and use EMR data to improve quality of care and assess provider performance at quarterly meetings. Palmetto offers continuing medical education credits to physicians for participation in these meetings. This approach has resulted in competitive and motivated physicians who are fully engaged in improving the quality of patient care.

3. **Patient and provider education—**Palmetto's PCMH model emphasizes patient and provider education. PCCs facilitate access to health education resources for patients, including print materials and group or individual sessions with certified diabetes educators. Practice administrators strongly encourage continuing education and certification for providers to help ensure staff satisfaction and quality care for patients.

Field Notes (cont.)

Goals and Objectives

The overarching goals of the Palmetto PCMH are to improve chronic disease management for all patients, particularly individuals with diabetes and hypertension. Expected outcomes of the program include better physician adherence to clinical guidelines for chronic disease care, fewer disease-related hospitalizations and readmissions, and lower health care costs.

Intended Participants

Palmetto's target population is patients with diabetes insured by Medicaid or South Carolina's state employee insurance plan and patients with hypertension insured by BlueChoice or the state employee plan. Palmetto plans to expand the patient population to include other insurance providers and other diseases.

Progress Toward Implementation

On the basis of the success of Palmetto's 2-year PCMH pilot for patients with diabetes, the program expanded in 2011 to serve patients with hypertension. Palmetto participates in three payer reimbursement programs using standard processes and procedures from lessons learned during the pilot.

Palmetto's medical director has been deeply involved in creating and implementing the PCMH model at Palmetto and has served as a champion of the model among providers. Program staff and providers accept the model and appreciate the incentives offered and the friendly competition among colleagues.

Community Involvement

Outside the scope of the PCMH model, Palmetto maintains a community outreach program through which providers and health education staff deliver services in local communities, typically through churches in rural areas. Staff conduct screenings and patient consultations, facilitate educational sessions, and encourage follow-up care with a physician as needed.

Reach and Impact

Palmetto serves a diverse population of 130,000 patients who represent all levels of socioeconomic status. As of July 2012, 4,285 patients have participated in the program, including 2,383 individuals with hypertension and 1,902 with diabetes. Palmetto works with South Carolina's state insurance provider to target primarily patients enrolled in the state employee plan.

Palmetto provides data on usage and clinical measures to payers and receives annual reports on PCMH patient outcomes from payers. Improvements include an increased percentage of patients with controlled blood pressure, rising from 34.0% in 2011 to 37.9% in 2012. In 2011, BlueCross BlueShield of South Carolina reported 14.7% fewer inpatient hospital days and 25.9% fewer emergency room visits among PCMH patients.

During the first year of the Palmetto PCMH (2009–2010), BlueCross BlueShield of South Carolina reported a risk-adjusted cost-savings of 15.8%. Nearly 50% of patients rated their provider and care a "perfect 10."

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