Patient-Centered Care in Rural Settings

Lessons Learned

Patient-centered care in rural settings delivers improved outcomes and patient engagement.

Performance Challenge

Rural primary care practitioners need to meet a variety of health and social needs through a single practice. Small, independent providers have difficulty determining care priorities and focusing resources to ensure effective and achievable clinical outcomes.

Practice Solution

A rural practice should focus on patient-centered care design to improve health outcomes in a cost-effective manner that values patient dignity. In addition, they should actively focus on population health goals to deliver improved outcomes in patient satisfaction and engagement in care. Lastly, coordinating care across the medical neighborhood will improve quality and reduce risk to patients managing complex medical concerns.

Change Steps

Practices can introduce patient-centered models of care to prioritize and support patients' needs. Practices should also focus on the patients' socioeconomic and clinical needs.

- Identify all services needed by the person at their point-of-care, such as lab work, diagnostic tests, and pharmacy consults to create a seamless care experience.
- Standardize referral follow-ups for patients using a medical home model with support from EHR and care coordinators.
- Employ case management using navigators and coordinators prior to the patient's visit to helps optimize their experience.
- Optimize care teams across the medical neighborhood for improved patient engagement and outcomes.

Practice Spotlight

Family Nurse Practitioner (FNP), Judith King, owns and operates a health center in rural Southwest Oregon. Her practice's care team includes a pharmacist, two community health workers, two medical assistants, a psychologist, and an office manager, as well as Ms. King herself. Together, they serve over 1,000 patients, most of whom are elderly, in a struggling community.

Challenge: The goal of the practice is to serve the local community's health needs in a cost-effective manner within one practice that serves the patient population across the lifespan. It was difficult determining care priorities and focusing limited resources to ensure effective and achievable clinical outcomes.

Actions: To ensure patients' needs were being met the practice adopted patient and family-care design strategies that focus on patient population health goals. With a consistent focus on creating patient-centered spaces, the practice incrementally expanded their services to patients and community. Mitigating barriers to access was a high priority and the practice added a flu testing lab in their outpatient setting, and brought an EKG machine to the office for point-of-care imaging and an A1 lab machine was purchased so the results could be processed in the clinic.

Outcomes: Results were immediate, care coordination was accelerated, and patients were served in a more timely fashion. Care teams are essential to meeting patient needs over time. Team roles are optimized to focus on patient experience and health outcomes including care team workflows, daily huddles, monthly team meetings, and regular medications management session for patients. Team members understand their roles across the care continuum: episodic care, risk management, longitudinal care, and medication management. Care coordination is standardized and documented in the EHR. All re-

Authors: National Nurse-Led Care Consortium, Judith King, FNP

Lessons Learned

Change Tactics

Successful practice transformation tactics fall under person- and family-centered care, sustainable business operations, and quality improvement:

- *Team-based relationships*: Expand team membership to include specialty and community-based staff; optimize continuity of care both inside and outside the office setting.
- *Enhanced access*: Create patient-centered spaces with onsite services (testing, lab) to reduce travel times, and make use of CHWs to provide community-based services.
- *Coordinated care delivery:* Manage care transitions, including ER discharges and specialty referrals, in coordination with partners and proactively manage medication reconciliation.

Resources

National Nurse-Led Care Consortium's Team Based Care training is a four hour workshop using the train-the-trainer model. This workshop session will provide attendees with skills to build interdisciplinary care teams. Attendees learn how to define care teams roles and responsibilities to optimize efficiency, outcomes and accountability.

PCPCC's Bite-Size Learning Modules: Tactical Ways My Practice Can Effectively Engage Patients and Families features a 10 minute video for clinicians and practice staff.

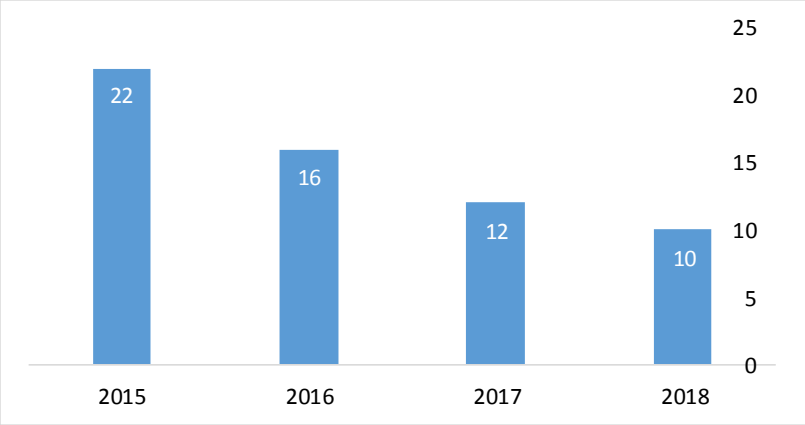
Improving Primary Care's Team Guide Presents practice advise case studies and tools from Primary care practices that improve care, efficiency and job satisfaction through team-based care delivery.

Practice Spotlight

ferrals are tracked from their origin, to communication with consulting offices, to appointment scheduling, to delivery of consult notes for pre-visit follow up planning. Coordinated patient centered care resulted in increases in patient screenings, increasing wellbeing. In the last year, 91.2% of all eligible patients had a A1C below 9.0. Improved care coordination resulted in improved diabetic care management.

Next Steps: Data is collected from partner agencies and notifications are used to alert for any high cost care utilization, like ED visits. Collective data from the Care Organization and Medicare Comprehensive Primary Care Plus (CBC+) are used to address patients who frequently visit the ED to determine a more effective health care strategy. Cost data from CPC+ is used to evaluate effectiveness in influencing patients' appropriate use of the emergency room. As a result, ED visits costs are down 30%.

Figure 2: Results of patient-centered approach to uncontrolled HgA1c



Person and Family Engagement

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