



SUMMARY OF THE EMBEDDED PRIMARY CARE PROVIDER'S ROLES

POPULATION MANAGEMENT

A population-based approach to achieve the best outcomes in overall health care delivered in the Health Home (HH) requires analyzing aggregate data as well as evaluation of individual charts for selected patients. This data will serve as a basis for establishing HH priorities for disease management, identifying trends and critical issues in addition to developing plans for improving overall health status. HH data to use in the analysis may include benchmarks, metrics, registries, cost and pharmacy utilization claims data in addition to other tools available to collect various outcomes.

COLLABORATION

Build collaborative relationships with in-house staff including psychiatric providers, care managers, case managers and others so the team can effectively work together to address deficiencies in care discovered by data analysis and reach desired outcomes. Ensure effective working relationships with community-based PCPs and hospitals outside the HH to create opportunities for smooth transitions between care sites, timely sharing of information, and to make sure established treatment goals are being met. The PCP works to develop and maintain these relationships and emphasizes how the HH supplements and does not interfere with or duplicate the treatment provided by other healthcare professionals. The PCP provides quality control in this unique position, using data to look over the shoulder of both the psychiatric providers and community-based PCPs. Without these collaborative relationships, the PCP may struggle to influence the care provided by others, thwarting the efforts to significantly improve the overall health status of the HH population.

CASE CONSULTATION

Meet with Care Manager (CM), qualified health home specialists (QHHS), and other members of the HH team to regularly review the registry and available data to determine patients in need of immediate attention, those that are not improving and those new to the HH. Other staff may request consultation regarding specific patients, including psychiatric providers and community based PCPs.

EDUCATION

Provide education to all behavioral health staff to establish a shared base of knowledge about common chronic medical illnesses in the HH population. This ranges from basic knowledge for case managers, peers, and therapists to more advanced education for care managers and psychiatric provider staff. Development of education materials for patients is part of this effort. Educational topics may be generated from issues discovered by data review. Reviews for community-based PCPS may be included.

PATIENT CARE

In-person examination and treatment may occur at some sites. The PCP may also meet with individual patients to explain test results, treatment course, etc. Home visits may be necessary in some instances. The PCP could help link individuals who do not currently have a PCP to colleagues in the community.