Primary Care Practice Facilitation Curriculum

Module 24: Introduction to the Care Model

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IMPROVING PRIMARY CARE

Primary Care Practice Facilitation Curriculum

Module 24. Introduction to the Care Model

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Module 24. Introduction to the Care Model

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge in the Care Model

Time

- Pre-session preparation for learners: 115 minutes
- Session: 60 minutes
- Post-session for learners: 30-90 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the key elements of the Care Model.
2. Identify the key elements of a patient centered medical home (PCMH).
3. Understand how the Care Model and PCMH relate.

Exercises and Activities To Complete Before and During Session

Pre-session preparation. Ask the learners to review information in items 1-4. (115 minutes)

1. The content of this module.
2. Ed Wagner's *Improving Chronic Illness Care Across the Population* online video. Available at https://www.youtube.com/watch?v=jJe7Y9-cRgw.
3. Building Blocks of Primary Care: Webinar featuring Thomas Bodenheimer, M.D. Available at http://vimeo.com/93514997.

During the session. Presentation (15 minutes)

1. Present key concepts from this module.
2. Review the Building Blocks of Primary Care Assessment (BBPCA) with learners and read through instructions for completing the assessment. Available at http://www.annfammed.org/content/suppl/2014/03/04/12.2.166.DC1/Bodenheimer_Supp_Apps.pdf

Discussion. Ask questions and explore answers with learners. (45 minutes)

1. What are the core elements of the Care Model?
2. What are the core elements of the PCMH?
3. What is the relationship between the Care Model and the PCMH?
4. What does research say about the effects of implementing the Care Model or the PCMH in safety net practices on patient outcomes? Patient experience? Costs of care for the practice? Costs of care for the payer?

Post-session. Activity for learners (range of 30-90 minutes, depending on number of persons

completing the assessment and delivery)

1. Ask learners to schedule a meeting or at least email a contact from a participating site to complete the BBPCA.
2. The learner will explain the purpose and provide instructions to the person(s) completing the assessment. Ideally, more than one person from the practice would complete the assessment to arrive at greater perspective, but this is not always the case.
3. Follow up with the practice to provide feedback from the BBPCA.

Note: the person(s) completing the assessment should be well versed in both back- and front-end functions of their primary care organization.

Module 24.

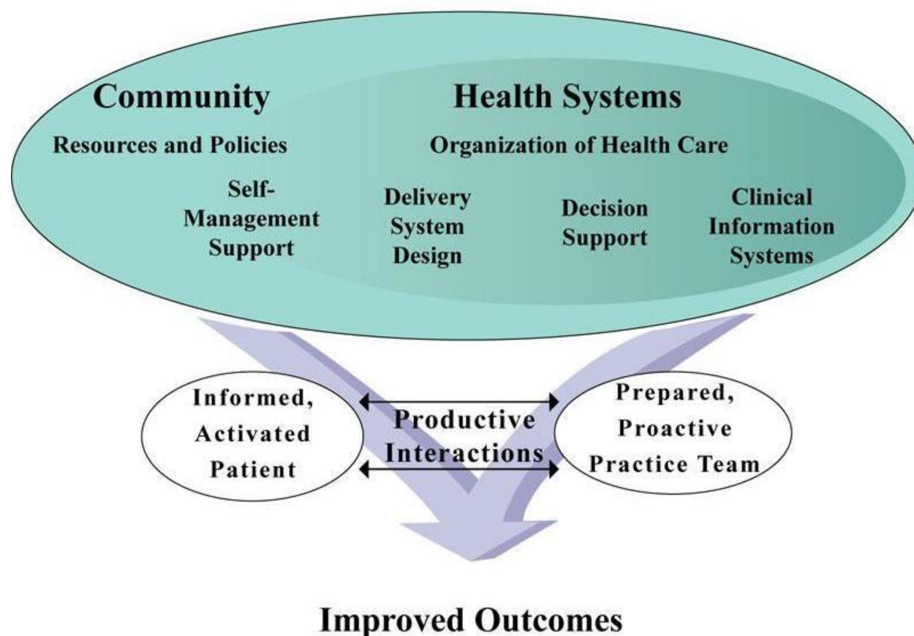
Practice facilitation has frequently been used in disease-specific or other discrete quality improvement projects. Increasingly, facilitation is being used to effect a transformation of the primary care setting.

Currently the U.S. health care system is organized to deliver short-term medical treatment for an acute health condition, not to promote health and well-being or management of chronic health conditions. The Group Health Cooperative of Puget Sound, with funding from the Robert Wood Johnson Foundation, developed the Care Model (originally called the Chronic Care Model) as an alternative to the acute care-focused delivery system (Wagner, et al., 2001).

The Care Model

As shown in Figure 24.1, the Care Model depicts three overlapping spheres in which chronic care takes place: community, health systems, and provider organization (Bodenheimer, et al., 2002). The Care Model consists of five core elements: health systems, delivery system design, decision support, clinical information systems, and self-management support. These in turn produce productive interactions between informed, activated patients and prepared, proactive practice teams.

Figure 24.1. The Care Model



Developed by the MacColl Center for Health Care Innovation. ®ACP-ASIM Journals and Books. Used with permission.

The Care Model calls for an organized and planned approach to improving patient health. This approach focuses on particular patient populations (e.g., individuals with coronary artery disease) to ensure that every patient receives optimal medical care. It also encourages a shift from care

delivered mainly by the physician to one that encourages care delivered through teams. Each team member brings unique and needed expertise to the table.

The Care Model has gained international recognition for identifying the essential elements of a health care system that encourages high-quality care. Numerous studies suggest that redesigning care using the Care Model leads to improved patient care and better health outcomes (Coleman, et al., 2009).

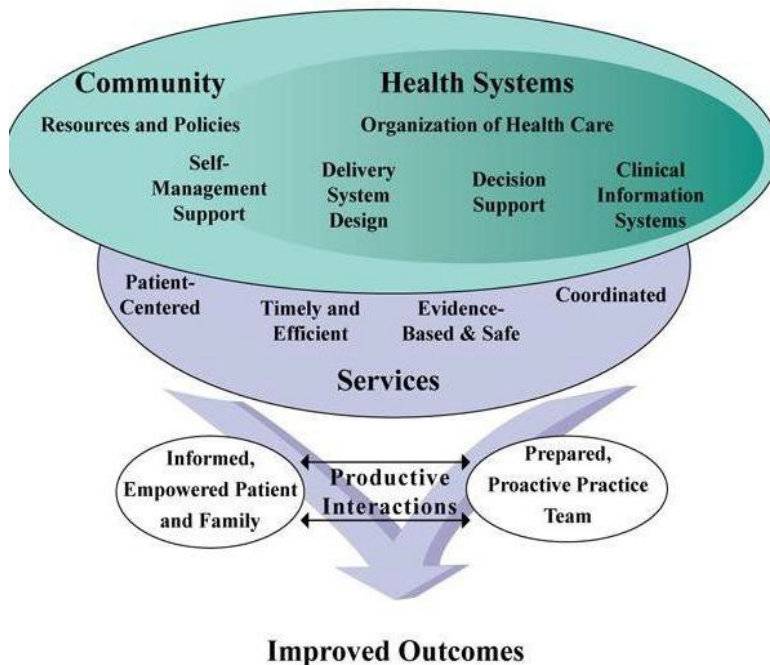
Patient Centered Medical Home

The Care Model was formative in the development of the patient-centeredness movement. Over the past decade the patient-centered medical home (PCMH) has become a popular framework for transforming primary care. Briefly, the Agency for Healthcare Research and Quality has characterized the PCMH by five functions and attributes:

- Comprehensive care
- Patient centeredness
- Coordinated care
- Accessible services
- Quality and safety

To underscore the compatibility of the two approaches, the Care Model has been expanded to explicitly include elements of PCMH (see Figure 24.2).

Figure 24.2. Expanded Care Model



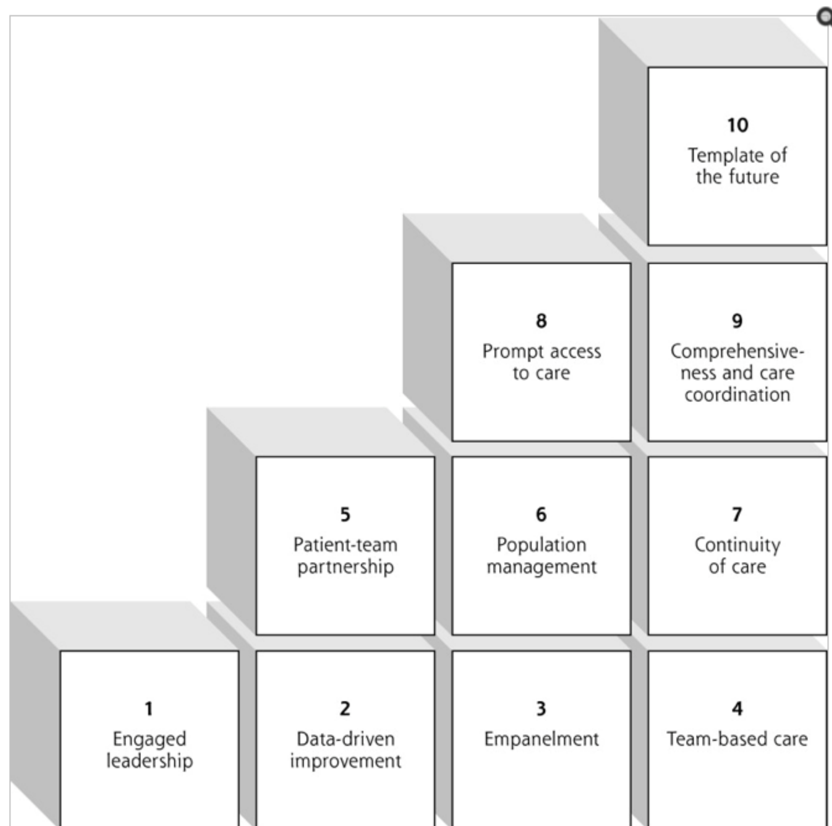
Source: 1996-2011 The MacColl Center for Health Care Innovation. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacColl Center for Health Care Innovation. Used with permission.

Many organizations that seek to become a PCMH use the Care Model to operationalize the broad principles and the aspirational vision of the PCMH. Facilitators assisting practices striving to attain PCMH status can rely heavily on the tools that have been produced to aid in Care Model implementation.

The Ten Building Blocks of Primary Care

Ten areas in primary care were identified by Bodenheimer, et al. (2014) as the building blocks for high performance. These areas are shown in Figure 24.3; the blocks incorporate both the Care Model and PCMH principles. When working with your practices in quality improvement work, consider this model and how each building block forms a foundation to a high-performing practice.

Figure 24.3. The ten building blocks of high-performing care



Ten Building blocks of high-performing primary care.

Source: Bodenheimer T, Ghorob A, Willard-Grace R, et al. The 10 building blocks of high-performing primary care. Ann Fam Med 2014;12(2):166-71. Reprinted with permission.

Note: this module is based on Module 16 of the Practice Facilitation Handbook. Available at: https://www.ahrq.gov/ncepcr/tools/pf-handbook/index.html

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