Business plan on day to day operations of patience centered medical home

Health & Medicine, Healthcare

With the ever increasing cost and demands of the health system in New Mexico, health providing institutions should devise a mechanism of combating these demands while providing reliable and affordable health services to its users. XYZ clinic is one such institution located in the North West Albuqueque Metropolitan area, in the New Mexico area. The clinic is instituting a proactive approach to deal with the volatile healthcare state. XYC targets federal-funded patients as well as other groups and insurance plans. The Medicaid population is primarily made up of women and children below the poverty level. The clinic tries to serve those in moist need including patients with complex and co-morbid multi-diseases. As a result, the use of a proactive approach towards an integrated model of healthcare is necessary. A Patient Centered Medical Home is what the clinic strives to offer to its range of patients. PCMH model will integrate a multidisciplinary care team and an innovative program that improves healthcare through a coordinated system. Through integration with information technology, the system will foster partnerships between the patients, care givers, doctors and the patient’s families. Collaboration will be between the registry department, information processing departments, health information exchange between doctors, physicians and nurses and managerial departments to provide health services to those they need at the fastest instance possible. Family members are brought into the equation because the clinic acknowledges the importance of patient history in diagnosis and treatment.

PCMH comprises of health information technology, workforce and finance. All the three components work hand in hand to provide safe, high quality health

care. This is achieved through decision support tools, evidence based and shared decision making. Sharing of quality data leads to an improvement of the services offered as well as system level commitment to quality.

In a day to day basis the patients reporting to the clinic go through the registry. Using clinic information systems the staff gets the patient details in the system or updates the details for revisiting patients. The data required include the name, address, next of kin and their contact information, place of work and the current illness. Once the information is availed, the patient is booked to see the physician or doctor.

Health IT is tasked with the collection, storage, and management of personal health information. The data is aggregated and shared to improve processes and outcomes. In a day to day operation, the Health IT is tasked with;

- Collection of patient records through the admission desk or the registry.
- Review Medicare or private health insurance card and make necessary arrangements for reimbursement.
- Set up regular sponsor and improvement team building meetings with IT management and other leaders highlighting success and challenges in financial and information related reports.
- Assuring the organization that data reporting capabilities including the use of billing systems and system level measurements are up to date. This is to determine if they are agreement with the desired transformation.
- Utilizing data on a day to day basis to communicate effectively with other departments to measure success and continue the transformation in the PCMH facility.

These steps recognize that data need various audiences such as board

members, support staff and front line staff. Support and front line staff need to recognize how many patients are handled by the facility. This is on a day to day basis, and how collaboration impacts their intervention. Segregating the audience and delivering the data to the respective users for quick delivery of services to patients is the fundamental role of health IT.

Workforce is an vital component of the PCMH through which services is delivered to the intended patient. Strong primary care workforce includes physicians, physician assistants, nurses, nutritionists, social workers, care managers, medical assistants among others. These workforces are trained to provide care based on the elements of the PCMH model. In a day to operations, the workforce;

- Provide visible and sustainable leadership to lead overall culture change including other strategies to oversee the improvement of quality and lead a sustainable change.
- Establish a quality support team that meets regularly to give guidance and create changes. The team creates changes, test the changes, oversee which changes have impacts and redesign other changes.
- Involving family members in the management of sick patients is one of the pillars of PCMH service models. Family cooperation is necessary in order to ensure than patients adhere to the set standards of clinic schedules and drug prescriptions. Physicians and nurses should provide a follow up of the patient’s conditions through family contacts to enhance recovery and well being.
- Workforce management would also gather and report data for fiscal and statistical analysis such as roster validation and preventive care programs.

- The managerial departments of the workforce ensure effective administration of implementation of benefit programs, job description adherence, personnel policies, wage scales and payroll management and practices.
- Ensure that healthcare providers such as physicians and nurses have the necessary resources and time to conduct activities effectively that are in consistency with the medical home model. Physicians record interaction with patients and provide a follow up to be in consistency with the PCMH model. They should also provide a platform for interaction with fellow physicians and nurses to provide a sustainable service delivery.

Financial aspects of the PCMH model ensure that payment policies are adequate to, fully, achieve the PCMH goals. In the scenario where routinely compensation for care coordination is not reliable, XYZ clinic should coordinate its resources in a manner that best utilize access, contribution of the team and delivery of services. Incentives are crafted to minimize duplication of services across the health care platform. This includes;

- Provide timely coordination of provider reimbursements from federal and private sectors to enhance the delivery of service. This is executed by the financial departments with liaison with management.
- The department should craft incentives that persuade the community residents to take health care plans that assist them in healthcare financing.
- Financial departments will perform day to day accounting including preparation of cheques, bank deposits, bank reconciliation, control of all aspects relating to accounts payable and account receivable.

In summary, all the departments should work hand in hand in achieving a

harmonious model of the PCMH model. The participation of both the specialty practitioners and the primary care colleagues is fundamental for the provision and sustenance of timely and high quality home care. The program should work towards the harmonizing of services in order to reduce duplication, improve communication with patients, and enhance service delivery. A Patient Centered Medical Home is what XYZ clinic strives to offer to its diverse patients. This is by ensuring that the neediest patients are served first in a time manner.

Works Cited

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