PCMH Patient Success Story at Absarokee Family Medicine

Karen Gray-Leach, RN, Medical Home Coordinator

1149 patients—4013 patient visits in 2015

Our Providers

Bradley Fouts, MD

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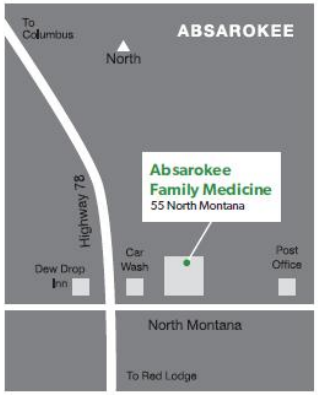
Contact Us

Office Number
406-328-4497

Office Hours:
Monday-Thursday - 8:00 am to 5:00 pm

After Hours:
In an emergency, call 911.

For non-emergent questions after hours, please call Ask-A-Nurse at 1-800-762-8778 or 406-237-8778.



St. Vincent HEALTHCARE | SCL Health

55 North Montana
Absarokee, Montana 59001
406-328-4497 | svh.org

Absarokee Family Medicine

St. Vincent HEALTHCARE | SCL Health

Population statistics:

- 70+ years = 210
- 60-69 = 203
- 50-59 = 185
- 40 -49 = 119
- 30-39 = 90
- 20-29 = 49
- 18-19 = 32
- 13-17 = 114
- 2+ - 12 = 124
- 0-2 = 23

Females = 623

Males = 526

Race and Ethnicities = white/nonhispanic

NCQA Level 2 Recognition PCMH 2011

June 2015

Absarokee Patient Story

53 years old male with a 35 year history of smoking ¾ pack of tobacco daily and type 2 diabetic for the last 2 years. Actively employed in construction work with private insurance as payer source and is married.

In 2013 had cardiac stent placement and underwent a second procedure for another stent placement in January 2015.

PCMH workflows that assisted patient towards an improved health status:

- 2/2015 “Readiness to Quit” tobacco letter was sent out to all tobacco users at the practice. (PCMH Population Health activity.)
- 2/2015 In response to the letter above (which encourages the patient to make an appointment with their provider to discuss strategy to quit tobacco) he met with his PCP and together they set the goal and developed a plan to quit smoking. MT Quit Line brochure and Quit Kit were given to patient. (PCMH Support Self-Care and Shared Decision-Making activity.)
- Follow up nurse visits were scheduled and kept to provide health coaching and monitor progress. (PCMH Integration of Behavioral Health.)

PCMH workflows that assisted patient towards an improved health status:

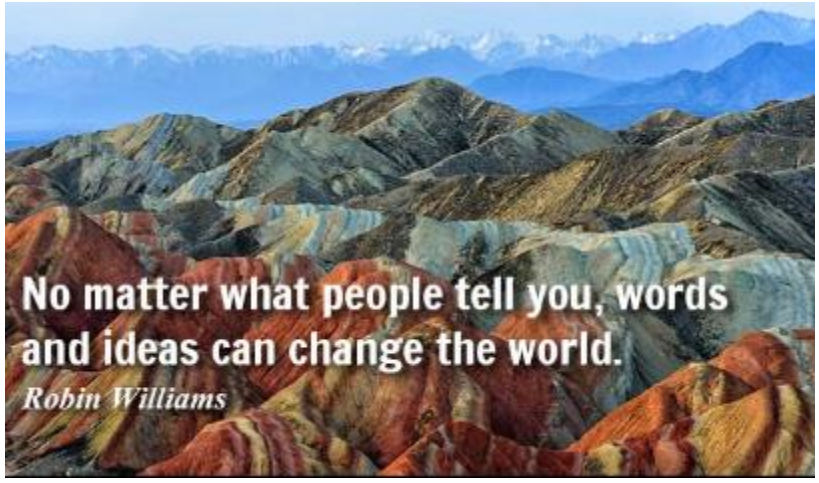
- Follow up provider visit May 2015, labs done with results of Hgb A1c @ 11.6%. Referral made with Diabetic Educator. (PCMH Team Based Care.)
- Diabetic Educator monlty visits done via telemedicine with specialist located in Red Lodge and patient in Absarokee. (PCMH alternative appointment availability.)
- Letter sent out to patient stating he was due for Hgb A1c repeat. (PCMH Care Management/Chronic Disease.)
- Hgb A1c went from 11.6% to 6% in a 6 month period.
- Estimated average glucose went from 295 to 126 mg/dL as well.

Patient Interview:

- What influenced his decision to make choices to change his life? "I decided to live."
- What parts of the clinic and process was most helpful to support this change? "The team approach, telemedicine visits with the diabetic educator, the reminder letters and phone calls, and the follow up visits."

Staff interview:

- *"Have seen a complete 180 degree change in him regarding his attitude and thoughts about health in the last year."*
- *"The biggest driver for change was 'him'…we just all needed to be there to help him along the way and make sure that this momentum for changes doesn't get wasted!"*
- *"Telemedicine component is crucial: we can do everything big clinics do with just an alternative way of providing care."*
- *"An important piece of PCMH in the rural setting is personal relationships. Our patients say they come to our clinic and feel like a person, not a number. We remember our patients and personal things about them and ask about them…like their dog, their kids."*


No matter what people tell you, words and ideas can change the world.
Robin Williams