I PiCC: Integrated Patient-Centered Care
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Shifts in healthcare reimbursement have moved funds away from the primary care physician (PCP) to the specialist, which has contributed to a model of fragmented care. The shift in funds, along with other administrative burdens, has led to a lack of PCPs, and an even greater scarcity of geriatric-trained clinicians. This trend puts the vulnerable geriatric client at great risk. Research shows that if primary care practices restructure how they operate (such that they are more accessible, promote prevention, proactively support patients with chronic illness, and engage patients in self-management) they produce better care more efficiently. The name attributed to this conceptualization of primary care is the “Patient-Centered Medical Home” (PCMH).

Integrated Patient-Centered care (I PiCC) is a pilot designed to extend the PCMH and support the more complex geriatric clients in a PCP practice by offering an interdisciplinary team (APN, RN, RPh) that provides structured and scheduled in-home visits between scheduled office visits. These visits will focus on risk reduction, medication optimization and ongoing health education. The target population for this pilot is the 25% of the Medicare recipients who utilize 85% of the Medicare dollars (65+, 2 or more chronic illnesses, five or more medications and identified by PCP practice as “high healthcare user”). Forty patients that meet the pilot requirements will be followed for a period of four months each and receive ongoing comprehensive care as well as transition coaching. Data will be collected and reviewed to measure the impact of each of the disciplines offered to the clients in terms of increased client and PCP satisfaction. NCQA standards for the PCMH will be used to measure the pilot interventions to ensure that the project assists the PCMH in meeting national criteria for PCMH certification.

Please email Karyn with any questions or comments regarding this project.