Patient-Centered Medical Home

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USUHS
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BUMED
Disclosure

Presenter has no financial interest to disclose.

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Learning Objectives

1. Understand the structure and function of the PCMH model

2. Show how the principles of PCMH align with the goals of the MHS

3. Understand the collaborative care model as it relates to primary care
Overview

• Patient-Center Care
• Health Crisis and Health Care
• PCMH Model
• HRO
• Team Based Care
• Access: Traditional and Enhanced
• Continuity
• Enrollment
Patient-Centered Care

ATTENTION

IF YOU ARE 10 MINUTES LATE FOR YOUR APPOINTMENT YOU WILL BE RESCHEDULED

It’s Obvious When You See It!
Patient-Centered Care

And When You Don’t!
Behaviors and Health

- Over 1/2 of Americans do not meet the recommended aerobic activity level\(^1\)
- 1/3 of US population is obese\(^2\)
- 1 in 5 Americans smoke cigarettes\(^3\)
- 1 in 4 ages 18 or older engaged in binge drinking in the past month; 7.1% engaged in heavy drinking in the past month\(^4\)

4. SAMHSA. 2012 National Survey on Drug Use and Health (NSDUH). Table 2.46B—Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month among Persons Aged 18 or Older, by Demographic Characteristics: Percentages, 2011 and 2012. Available at: [http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2012/NSDUH-DetTabs2012/HTML/NSDUH-DetTabsSect2peTabs43to84-2012.htm#Tab2.46B](http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2012/NSDUH-DetTabs2012/HTML/NSDUH-DetTabsSect2peTabs43to84-2012.htm#Tab2.46B)
Putting it in Perspective

Top 10 US Public Health Achievements

- Vaccination
- Motor vehicle safety
- Safer workplaces
- Control of infectious diseases
- Decline in deaths from coronary heart disease and strokes
- Safer and healthier foods
- Healthier mothers and babies
- Family planning
- Fluoridated drinking water
- Recognition of tobacco as a health hazard

Health care has had little to do with increased life expectancy over time.
Study evaluated performance on 439 indicators of quality of care for 30 acute and chronic conditions as well as preventive care using medical records from a two-year period of a random sample of adults living in 12 metropolitan areas in the United States.

Participants received 54.9% of recommended care:

- Proportion of recommended preventive care provided (54.9%).
- Proportion of recommended acute care provided (53.5 percent).
- Proportion of recommended care provided for chronic conditions (56.1%).
- Among different medical functions, adherence to established care processes ranged from 52.2% for screening to 58.5% for follow-up care.
- Quality varied substantially according to the particular medical condition, ranging from 78.7% of recommended care for senile cataract to 10.5% of recommended care for alcohol dependence.

To fully satisfy the USPSTF recommendations, 1773 hours of a physician’s annual time, or 7.4 hours per working day, is needed for the provision of preventive services\(^1\)

- Competing priorities and system limitations
  - Acute Care
  - Chronic Care
  - Access and Enrollment
  - HIT…..others

- If *lucky*, PCMs can address other secondary physical complaints
- If *really lucky*, PCMs can meaningfully address health behaviors
- If *really, really lucky*, PCMs can address subclinical corroborating/comorbid psychological problems

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Here We Are

The Consequences

- Episodic model of disease care
- A growing prevalence of preventable chronic diseases—75% of direct health care costs

Our continuing failure to proactively monitor and improve the overall health of our population has facilitated the growth of our current disease model of care.
Here We Are

Test and prescribe vs. prevention and healing.
Here We Are

Current Healthcare Model

Episodic

Uncoordinated

Primary Care Is Devalued

Disease Model

Primary Care Is Devalued

Current Healthcare Model
**HRO Principles**

**Preoccupation with failure:** Identification of risk, viewing near-misses as evidence of systems that should be improved rather than as proof that the system has effective safeguards.

**Reluctance to simplify:** Simplistic explanations for why things work or fail are risky. Avoiding overly simple explanations of failure (unqualified staff, inadequate training, communication failure, etc.) is essential.

**Deference to expertise:** Willingness to listen to the insights of staff who know processes and the risks patients face.

**Sensitivity to operations:** Constant awareness by leaders and staff of the state of systems and processes.

**Resilience:** Leaders and staff need to be trained and prepared to know how to respond to system failures.
“Destructive organizational habits can be found within hundreds of industries and at thousands of firms. And almost always, they are the products of thoughtlessness, of leaders who avoid thinking about the culture and so let it develop without guidance. There are no organizations without institutional habits. There are only places where they are deliberately designed, and places where they are created without forethought.”*

*Charles Duhigg, *The Power of Habit: Why We Do What We Do in Life and Business*A

We need deliberate design to drive organizational culture
Joint Principles of PCMH

• Personal physician
• Physician directed medical practice
• Whole person orientation
• Care is coordinated and/or integrated
• Enhanced access
• Quality and safety
• Payment reform
Medical Home Model

- Holistic Approach
  - Partnership with Patients and Families
- Comprehensive
  - Spectrum from wellness to end of life
- Coordinated
  - Team Approach
  - Across Specialties
- Patient-Centered
  - Enhanced Access
  - Consistent PCM Continuity
Team Based Care

• Team Composition:
  • Internal/Family Medicine, Advanced Practice RN, PA, RN, LPN, HM/Medic, Clerical Support

• Collaborative:
  • All members engaged in preventive and chronic care
  • Team members with expanded skills and training

• Integrated care model
  • Behavioral health
  • Clinical Pharmacist
  • Dieticians
  • PT
  • SW/CM
Team Formation

- Policy
- Process
- Team Building
- Execution
  - Roles & Responsibilities
  - Check lists
  - SOP’s: Standard Work
  - Monitoring and Feedback
- Change Management!

Why we fail:
- Must involve people
- Systems approach
- Standards not Standardization
- Clearly defined outcomes
- Timely feedback
- Visual dashboards
Outcome Measures

The Bottom Line

- Care delivered by primary care physicians in a patient-centered medical home is consistently associated with:
  - Better outcomes
  - Reduced mortality
  - Fewer hospital admissions
  - Lower utilization
  - Improved patient satisfaction
  - Lower Cost
Variable success.....why?
What is access?

Is access proportional to available appointments?

How should we measure access? acute vs. routine
Enhanced Access

- In-person encounters
- Telephone
- Automated medication refills
- Relay Health
- NAL
- Telemedicine
- Open access preventive care
• Reducing artificial demand
  • Scrubbing schedules:
    • Impact of call centers
  • Removing barriers
• Chronic/preventive care
  • Process based management: standard work
  • Proactive appointing and asynchronous visits
• Open access
  • Patients are seen right setting right time
• Template management
Continuity

• Trust
  • Affability/Availability/Accessibility/Accountability
  • Communication
  • Time
• Acute care vs. Chronic care
  • When does continuity matter?
• Transitions
Enrollment Increases as PCMH Matures

Acuity based enrollment:
- Understanding your population

<table>
<thead>
<tr>
<th>Area</th>
<th>Startup</th>
<th>Today</th>
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<tr>
<td>IM</td>
<td>600</td>
<td>860</td>
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<tr>
<td>FP</td>
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<tr>
<td>PA/NP</td>
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Recent study in FM suggests 1,600 Patients/FTE
Lessons Learned

- Culture change: don’t underestimate
  - Training, team building
- Measuring for success
  - Persistent and Predictive
- Productivity: Beyond RVU’s
  - How do we measure non-traditional care?
- Staffing model: what is optimal?
- Transformation: where to start?
  - HRO Principles
- Wellness focus: population health has to be at the center of all elements of care
Discussion

You need a new health care system. Your old one is shot. Unfortunately, your insurance won’t pay for it.
Back Up
### Continuous Enrollment Impact (quarterly utilization and cost)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Chronic</th>
<th>Non-chronic</th>
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<td>Average use</td>
<td>Cont enr impact</td>
<td>Change</td>
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<tr>
<td><strong>IP adms</strong></td>
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<td><strong>IP days</strong></td>
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<td>$83.42</td>
<td>$3.52</td>
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<td><strong>PMPQ</strong></td>
<td>$481.51</td>
<td>-$38.09</td>
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### WRB Medical Home Impact (quarterly utilization and cost)

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<th>Total</th>
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<th>Non-chronic</th>
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<tr>
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<td>Average use</td>
<td>PCMH impact</td>
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<td><strong>IP adms</strong></td>
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### WRB Medical Home Impact by Condition

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<tr>
<th>Outcome Measure</th>
<th>Diabetes</th>
<th>Hypertension</th>
<th>Hyperlipidemia</th>
<th>COPD</th>
<th>CAD</th>
<th>Mental health</th>
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<tbody>
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<tr>
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<td>ER visits</td>
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<td>-0.5%</td>
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<td>3.4%</td>
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<tr>
<td>Primary care</td>
<td>40.3%</td>
<td>32.0%</td>
<td>32.1%</td>
<td>46.3%</td>
<td>49.3%</td>
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<td>Pharmacy</td>
<td>-17.0%</td>
<td>-16.1%</td>
<td>-17.0%</td>
<td>-10.3%</td>
<td>NA*</td>
<td>-1.4%</td>
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<td>Ancillary</td>
<td>-16.2%</td>
<td>-19.1%</td>
<td>-15.2%</td>
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<td>-24.1%</td>
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<td>PMPQ</td>
<td>-10.5%</td>
<td>-11.1%</td>
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<td>NNMC enrollees</td>
<td>1,595</td>
<td>7,098</td>
<td>7,207</td>
<td>960</td>
<td>659</td>
<td>2,426</td>
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### Cost Impacts Associated with Chronic Enrollees

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<th>Chronic</th>
<th>Non-chronic</th>
<th>Total</th>
<th>Change attributable to chronic</th>
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<tr>
<td><strong>Estimated costs per enrollee</strong></td>
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<tr>
<td>PMPY without PCMH</td>
<td>$3,136</td>
<td>$750</td>
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<tr>
<td>PMPY with PCMH</td>
<td>$2,803</td>
<td>$697</td>
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<tr>
<td>Change</td>
<td>-$333</td>
<td>-$53</td>
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<tr>
<td>Change</td>
<td>-10.6%</td>
<td>-7.1%</td>
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<tr>
<td><strong>Average PMPY change by percent chronic</strong></td>
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<tr>
<td>40%</td>
<td></td>
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<td>-$165</td>
<td>80.7%</td>
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<td>50%</td>
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<td></td>
<td>-$193</td>
<td>86.2%</td>
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<tr>
<td>60%</td>
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