A continuous relationship with a personal physician caring for the whole person

CARE MANAGEMENT

within the

PATIENT CENTERED MEDICAL HOME

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Care Management

'is a web of components that, when done right, creates a strong network of efficient, effective health care for an individual or population.'

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Care Management :

- Evidence-based, integrated clinical care
- Best done within the Patient Centered Medical Home
- Patient-specific to insure every patient has coordination of care and services
- Care plan developed collaboratively by the care team (which includes the patient)
- Care plan designed and executed to optimize the patient's health status and quality of life

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Patient Centered Medical Home

Access to Care & Information
- Health care for all
- Same-day appointments
- After-hours access coverage
- Lab results highly accessible
- Online patient services
- e-Visits
- Group visits

Practice Management
- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Practice Services
- Comprehensive care for both acute and chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic & support services
- Ancillary diagnostic services

Health Information Technology
- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication: *trust, respect, shared decision-making*
- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care

Care Management
- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Care coordination
- Patient engagement and education
- Leverages automated technologies

Quality and Safety
- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Continuity of Care Services
- Community-based services
- Collaborative relationships
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management

Practice-Based Care Team
- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Primary Care-- Value

- The greater the supply of primary care physicians the lower the total mortality-- heart disease, stroke & infant mortality.
- The higher the percentage of primary care physicians to population the greater the incidence of prevention and screening.*
- Lower ER and hospital utilization rates
- Higher patient satisfaction**

*Macinko, J. Starfield, B. Shi, L. Int J. Health Ser, 2007;37 (1) 111-136.

**Greenfield S, et al JAMA 1992;267:1624-30; Forrest CB. Starfield B. JFP:. 1996;43(1):40-8.
Macinko J. Starfield B. Shi L. HSR. 2003;38(3):831-65.

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Primary Care-What Happened?

Primary Care- Reimbursement

- Fee for Service
- RBRVS System
  - Procedure vs. Cognitive value
- RUC Committee Role

Primary Care Viability

Financial – Salary

FM salary declines 10% over 10 years (inflation adjusted)

Specialty salary increased by 16-36%

Primary Care Residents

US Graduates to FM decline by 50%

Supply

Access

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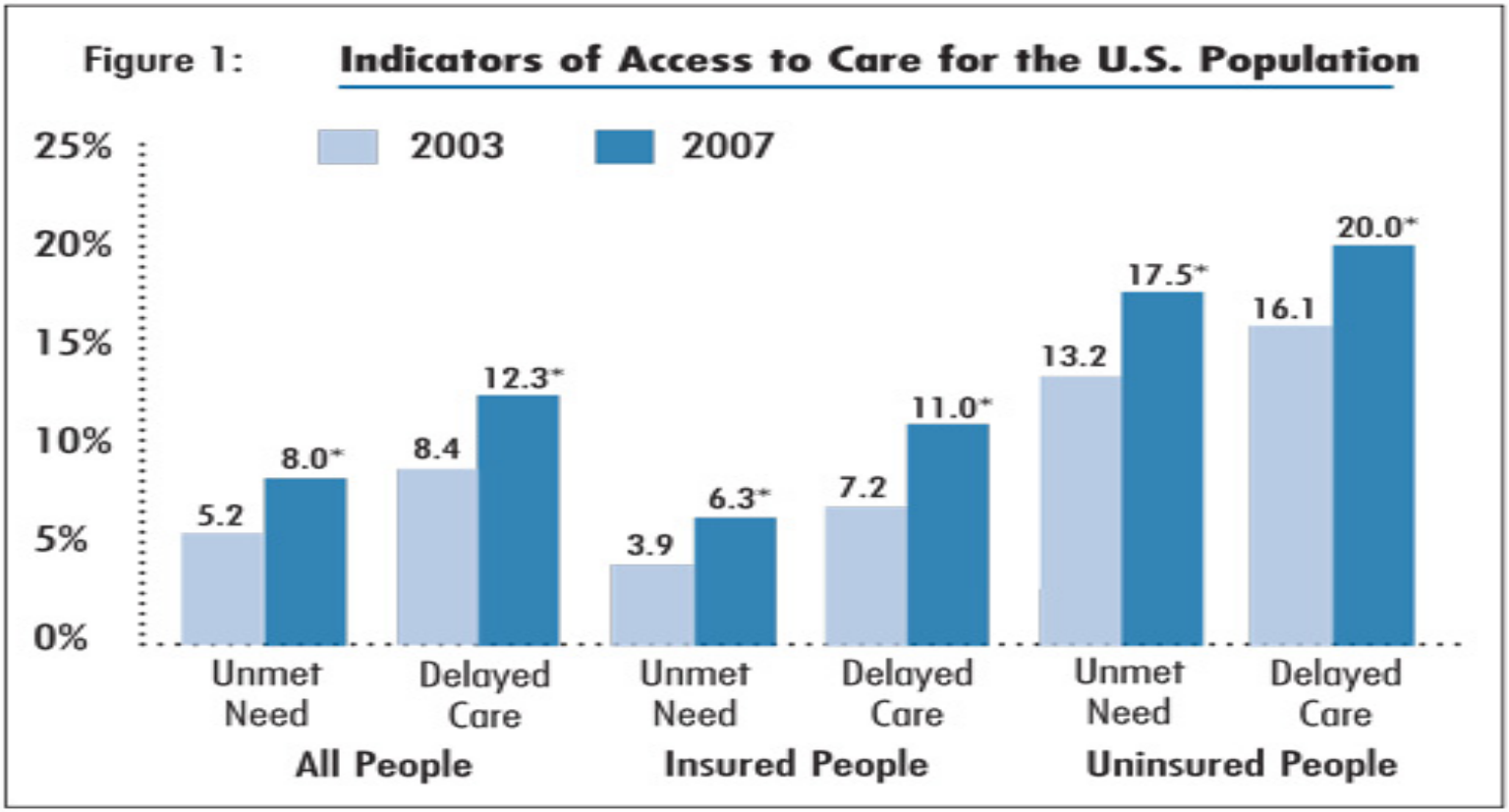
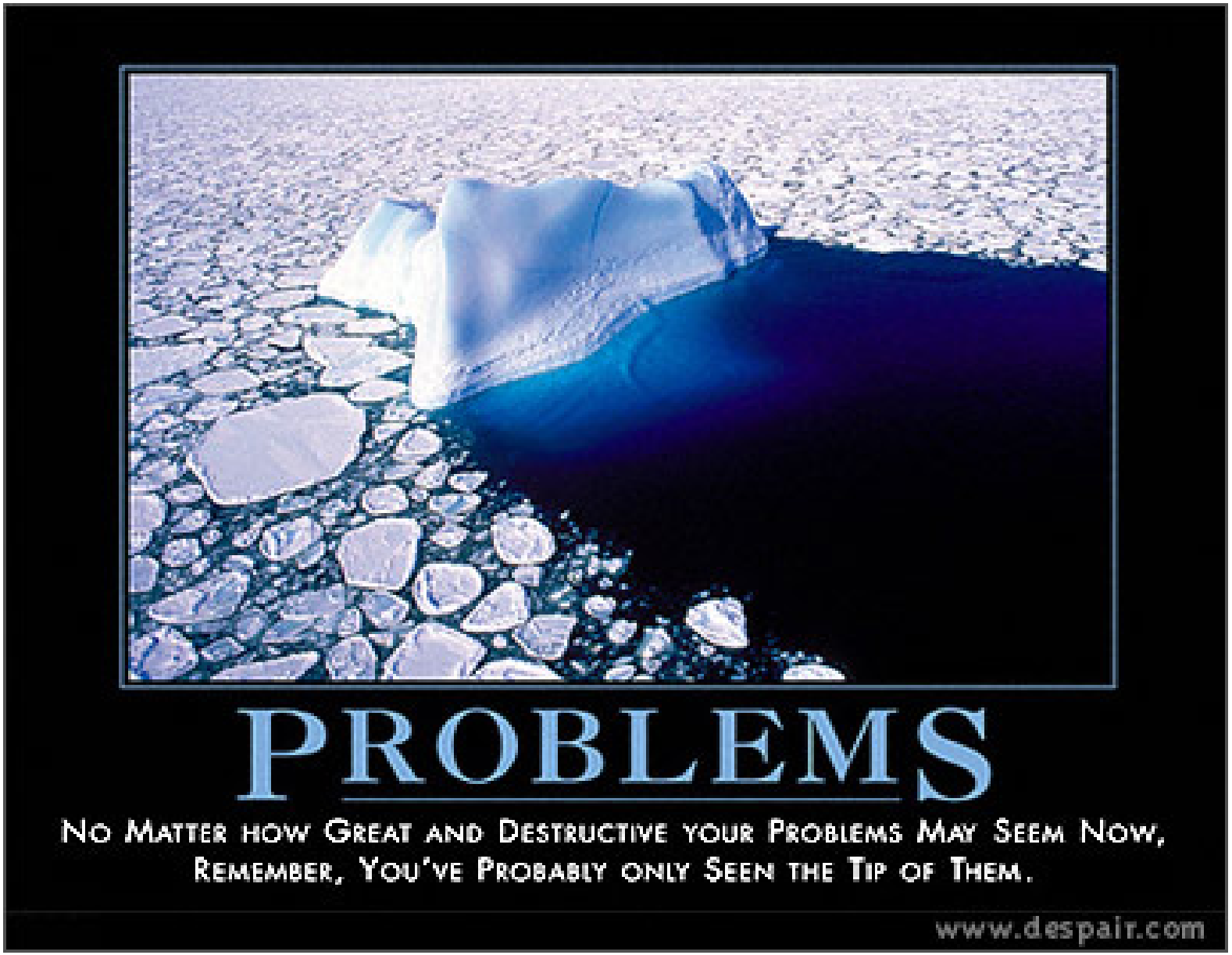


* Change from 2003 to 2007 is statistically significant at $p < .05$.

Sources: 2003 HSC Community Tracking Study Household Survey; HSC 2007 Health Tracking Household Survey

Cunningham, Peter J., and Laurie E. Felland, *Falling Behind: Americans' Access to Medical Care Deteriorates, 2003-2007*, Tracking Report No. 19, Center for Studying Health System Change, Washington, D.C. (June 2008).



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Health Care Costs

- 2008 estimated health care spending

  $2.39 trillion

- $420 billion increase from 2005
- $7,868 per person

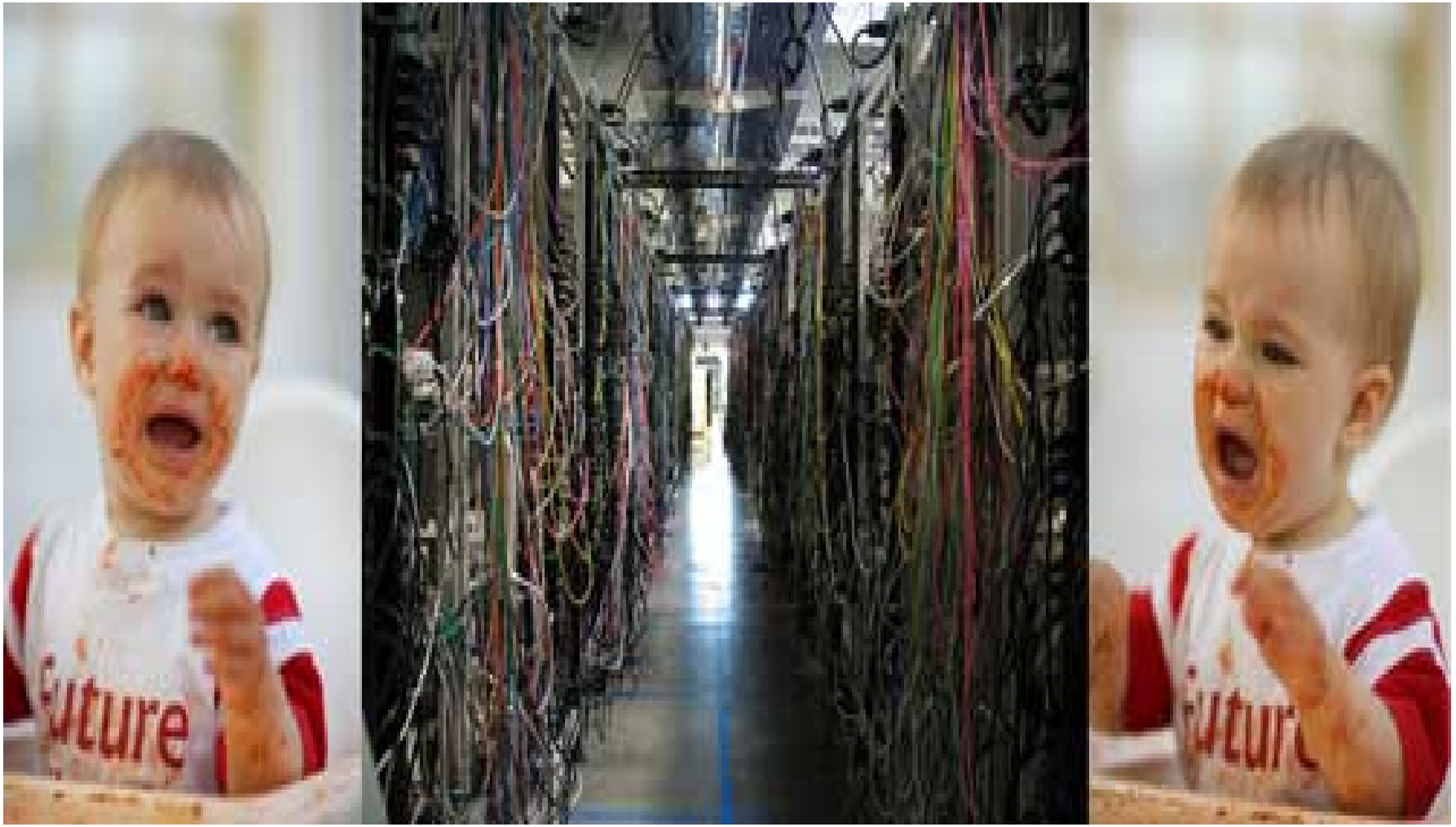
  Increase from $2000-$4600 in 1980-2000

Quality – Outcomes

Commonwealth Report – Quality in US

Evidence Based Medicine Outcomes

Primary Care Role



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Paradigm change for Primary Care

‘***from acute episodic care to integrated, coordinated whole person care’***

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PCMH—Care Management

Improved outcomes

Cost savings

Increased reimbursement

Physician – patient -- staff satisfaction

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Pilots --Care Management alone

- CMS Care Manager project
  - 15 sites
  - Varied models
  - Only 5 showed cost neutral or savings

- CMS Care Management Pilot – 2006
  - Utilized outside disease management
  - Ending early – no cost savings

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PCMH Pilots – Care Management

Clinica Campesina

- Community Health Center – Denver
  - Primary care teams
  - Chronic disease registry
  - Patient self-management

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PCMH-Care Management

Two year results-Diabetes Initiative

HgbA1C – reduction from 10.5 – 8.7

2 HgbA1c/yr – increased from 11% to 71%

Self-management goals –increase of 3% to 65%

Bodenheimer T,Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. *JAMA.* 2002;288(14):1775-1779.

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PCMH-Care Management

Geisinger Medical Home Initiatives

24/7 access

Care coordination -- nurse

Disease Management –

CHF, Diabetes, Hypertension

Self Management

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PCMH -- Care Management

Cost Savings

Hospitalizations reduced by 20%

Hospital readmissions reduced by 48%

Overall healthcare cost savings down 7%

www.commonwealthfund.org/publications/publications_show.htm?doc_id=704008

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Community Care of N. Carolina

Started in 1999

Grown to 15 networks

3500 physicians

1000 Medical homes

Focus:

care coordination

population/case management

case/care management fee paid

Savings for State -- $231 million/2 yrs

www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20071011ccnccutscosts.html

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PCMH-Care Management

Current Pilots – Physician Reimbursement

- CMS Medical home pilot-2009
- BC/BS Michigan
- Geisinger - Pennsylvania
- CDPHP – New York
- Community Care of N. Carolina

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PCMH --Care Management

- **Care Coordination**
- **Population Management**
- **Patient Engagement-Education**

PCMH --Care Management

Care Coordination

- Coordinate health care services not provided within the PCMH at the point of care
- Take responsibility for gathering information about all services/providers involved in the care of the patient
- Information available in a timely manner

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PCMH -- Care Management

Collaborative relationships-specialists

Coordination w hospital services

Community services

Technology – efficient communication

PCMH -- Care Management

Population Management:

A set of activities aimed at improving the health and clinical outcomes of a population of patients defined by specific parameters—preventive or disease based

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Population Management Disease Management

- Technology-ease of reporting data
  - Identify populations
  - Mechanism to identify high acuity populations
- Care manager role in the office
  - Guided care – Health care coach model
  - Differs from case / disease management from payer
- Implementation EBM into clinical practice
- Regular reporting w physician-staff coaching

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Patient Engagement --providing the patient with the resources and information that is culturally and educationally appropriate to insure that they can actively engage in management of their health

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PCMH-Care Management

How to do it

- Team Care
- Access
- Technology
- Process
- Commitment

"Look at the world around you. It may seem like an immovable, implacable place. It is not.

With the slightest push--in just the right place it can be tipped."

Malcolm Gladwell, The Tipping Point