PATIENT CENTERED MEDICAL HOME

Maximizing

Today's Realities

While Preparing for

Tomorrow's Opportunities

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Associated Press, 9/10/08

- only two percent of graduating medical students say they" were considering practicing as primary-care physicians, the AP (9/10, Johnson

Modern Healthcare, 9/9/08

- Dr. Ebell found that **"family medicine had the lowest average salary ($185,740), and the lowest percentage of filled residency positions (42.1 percent),"** Modern Healthcare (9/9, Robeznieks) noted. And, **"internists, with the third-lowest salary of $193,162, had the third-lowest residency fill rate: 55.9 percent."** In contrast, "radiologists -- whose average salary was $414,875 -- had a residency fill rate of 88.7 percent; and orthopedic surgeons -- whose average salary was $436,481 -- had a fill rate of 93.8 percent." Dr. Ebell wrote that "the correlation between salary and primary-care physician shortages -- which, in turn, may be tied to higher all-cause cardiovascular, cancer-specific, and infant mortality rates -- has persisted since his original research on this issue was published" in 1989.

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USA Today, 9/10/08

- USA Today (9/10, Rubin) reports that "medical students are shying away from careers in general internal medicine, which could exacerbate the U.S. doctor shortage expected by the time the youngest baby boomers head into their senior years," according to a study published in the Sept. 10 issue of the Journal of the American Medical Association.

JAMA, 9/08

- . The data showed that "**paperwork, the demands of the chronically sick, and the need to bring work home are among the factors pushing young doctors away from careers in primary care."** Lead author Karen Hauer, M.D., of the University of California-San Francisco, pointed out that **"it's hard work taking care of the chronically ill, the elderly, and people with complex diseases -- 'especially when...doing it with time pressures and inadequate resources.'"**

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TODAY'S GOALS

Understand the Patient Centered Medical Home

Leadership, communication and managing change in the transformation to a Patient Centered Medical Home

Care Management in the context of Patient Centered Medical Home

Recognizing a Patient Center Medical Home

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WHAT PCMH IS AND IS NOT

- Patient Centered Medical Home is not just about more new money for Primary Care
- It is not about just doing a better job of chronic disease management
- It is about the survival of Primary Care
- It is about redefining and redesigning Primary Care
- It is about increasing the value of Primary Care in today's healthcare system

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The Patient Centered Medical Home

- The Patient Centered Medical Home creates a framework for change
- The Patient Centered Medical Home creates a common language for change
- The Patient Centered Medical Home creates an opportunity for change

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- Infant mortality rate is a crucial indicator of a nation's health care standing
  - US ranks 28th on Infant mortality rate
  - US comes behind Portugal, Greece, the Czech Republic, Northern Ireland, and 23 other nations

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- US healthcare system falls behind other developed countries:
  - Cancer survival (the US ranks behind Italy, Ireland, Germany and others)
  - Diabetes care
  - Only 50% get treatments that scientific studies show to work

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US Healthcare System

In 2006:

- The US health care expenses surpassed $2 trillion
- US health care spending was about $7K/person
  - Highest in the world
  - 20% more than Luxembourg's, the next highest
  - More than twice the average of 30 other wealthy countries
- US health care spending accounted for 16% of the nation's Gross Domestic Product (GDP).
- Total health care spending grew at a 6.7% annual rate, outpacing inflation and the growth in national income.

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Best in the World Myth

- 44,000 – 98,000 estimated annual deaths from medical mistakes in hospitals
- 101,000 estimated annual deaths from “amenable mortality” – deaths preventable by medical care.
- *The US has convincingly demonstrated that more money does not solve health and health care problems*

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Ultimate Issue

The World Has Changed and Primary Care has been slow to change with it.

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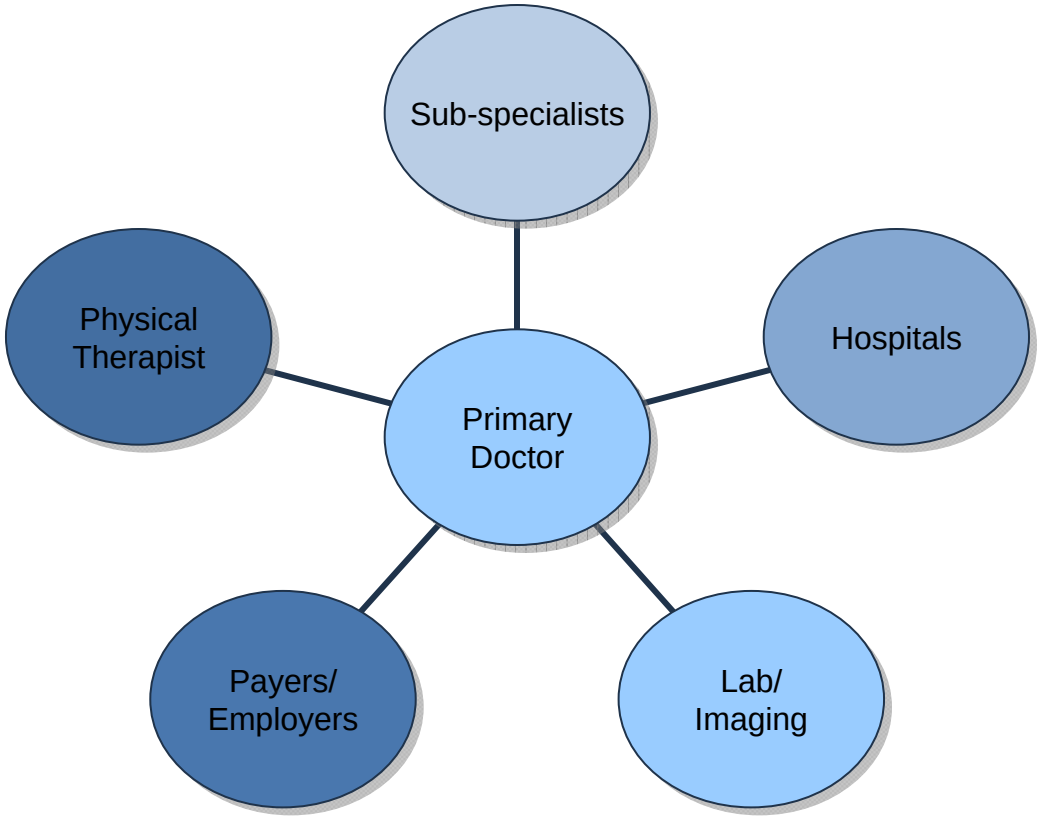
Baby Boomers & Health Care



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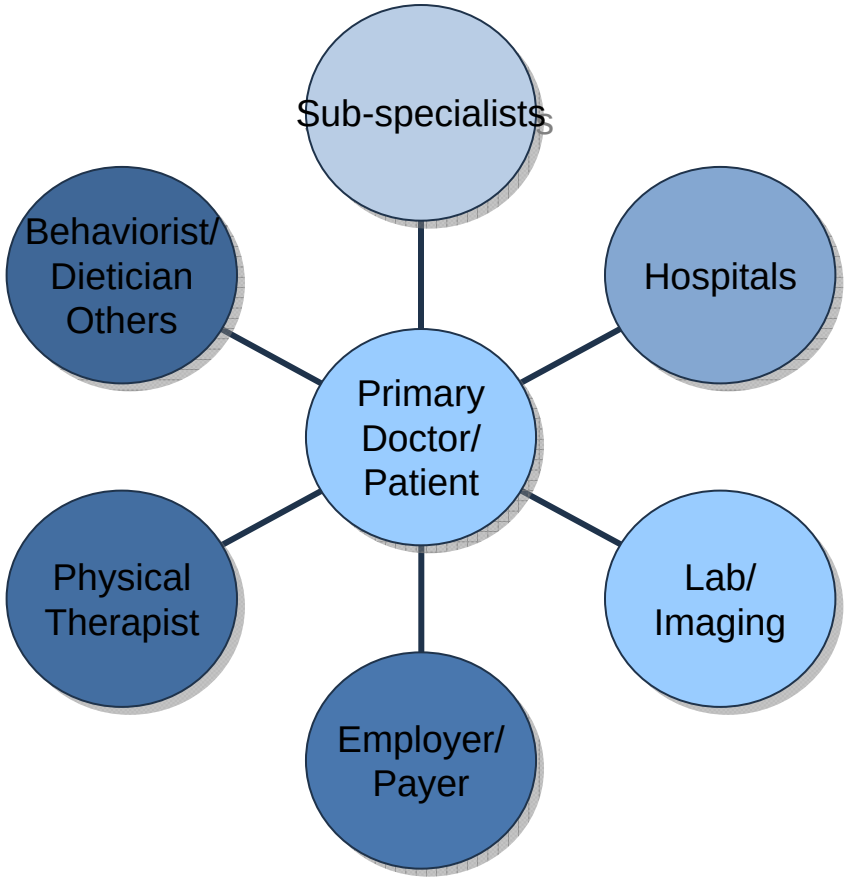
Generation X & Health Care



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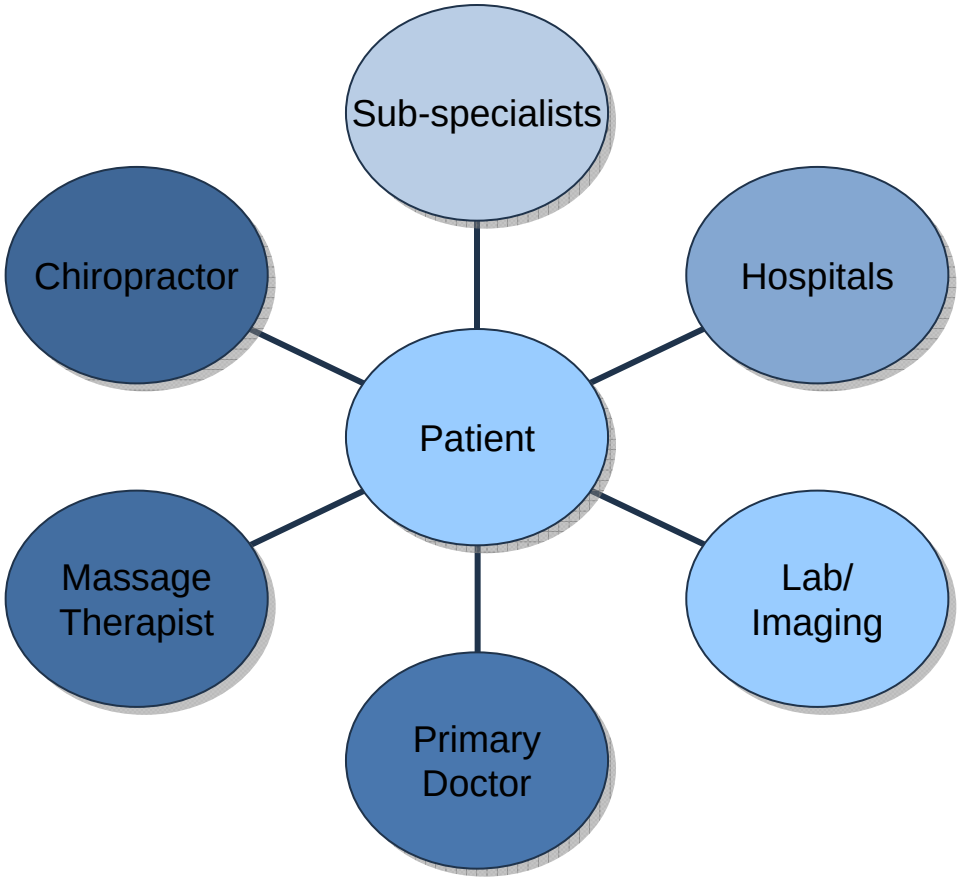
Generation Y and Health Care



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Critical Success Factors

- Maximizing Today's Realities
- Preparing for Tomorrow's Opportunities

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Maximizing Today's Realities

- Practices become economically viable in today's environment
- Practices provide what patients demand
- Practices provide what the US Healthcare system requires
- Improved quality of life for Physicians
- Timeline is short

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Preparing for Tomorrow's Opportunities

- When Primary Care advocacy succeeds
- Practices need to be positioned to provide what payers are willing to pay for
- Practices need to be complete Medical Homes as defined by Primary Care
- CMS Demonstration Project—Level II NCQA to start

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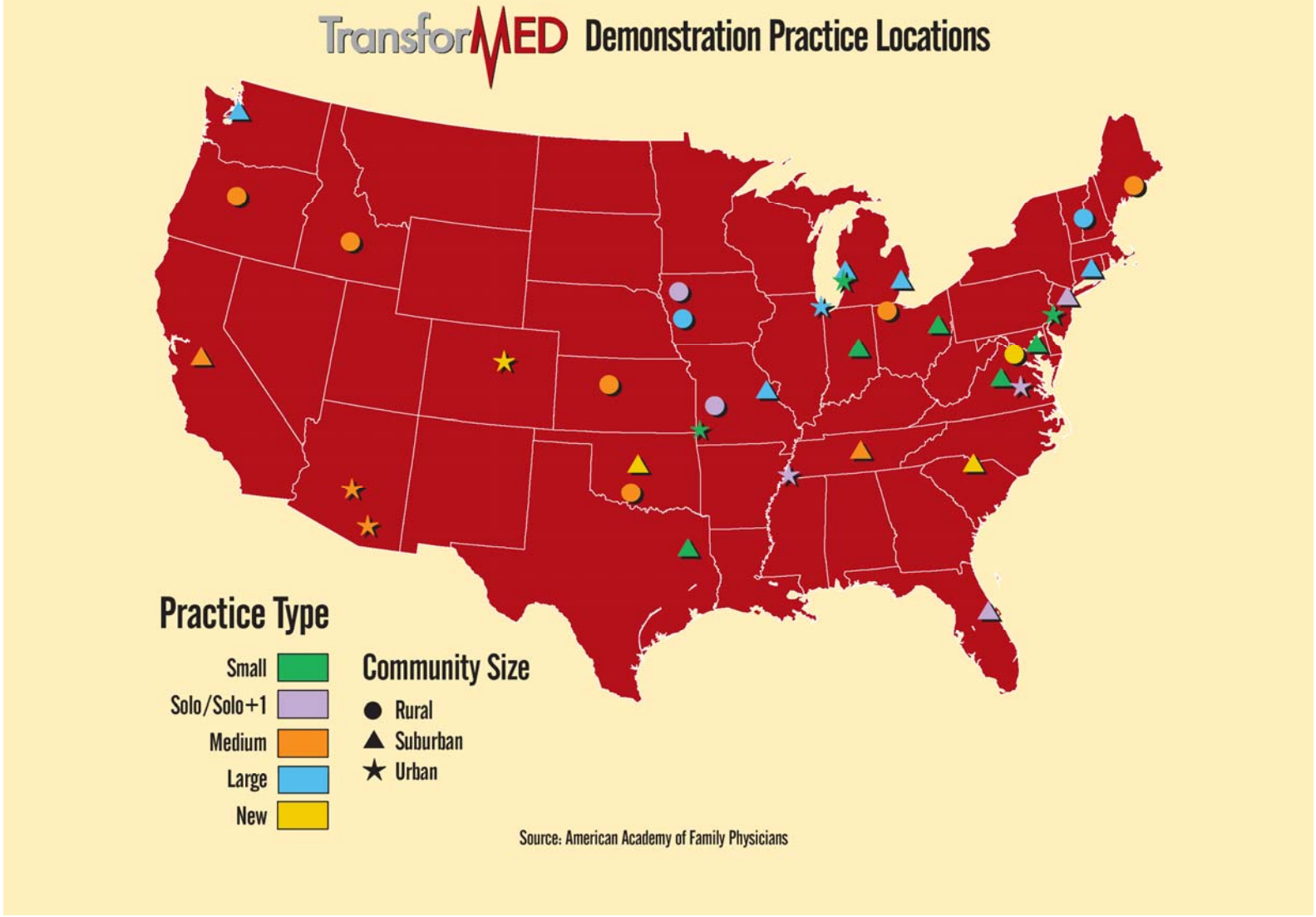

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Challenges Identified from the NDP

- Primary care practices are not prepared to change
- Primary care practices are not motivated to change
- Primary care practices are woefully uninformed
- Leadership at the practice level is lacking particularly around transformation
- Communication within a practice is a major limiting factor for success
- E-visits are not well accepted by patients
- Access and cost are of primary importance to patients — they assume quality; EMR and efficiency are “back hall” issues.
- Chronic care is poorly understood by patients and providers
- Registries are critically important for chronic care, but practices are unwilling or unable to do manual entry of data---registries must be self populating and must be associated with the ability to store and transmit data

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Challenges Identified from the NDP

- The biggest concern about technology implementation is operational not cost
- Most practices think they are providing quality care but most are not
- Safety at the practice level is inadequate
- Understanding and expertise on business issues is sorely lacking
- Practice ownership, particularly by hospitals, limits medical home implementation
- Providers in a practice have lost skills, refer too easily and lack confidence in procedures
- Advanced access scheduling is poorly understood and thus often poorly implemented
- Team care is a difficult concept for Family Physicians to grasp
- The larger the practice, the harder it is to transform

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What are the NDP Positives?

- Population based registries work and are a critical success factor for chronic disease management and patient centered care
- Quality outcome metrics modify behavior
- Team concepts really do work and lead to higher quality, greater productivity and improved job satisfaction by providers and staff
- Practices can do well financially in today's payer environment when operated as a business
- Practice Web sites are popular with practices and patients
- E-visits work but patients need to be better educated and incentives need to change for patients and providers

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What are the NDP Positives?

- Patients and providers like group visits
- Advanced access scheduling really works
- The entire model of care can be implemented
- Point of care evidence based reminders improve quality and provider satisfaction
- The critical success factors for EMR implementation are change management and planning. It does not have to be traumatic
- The components of the new model are interdependent
- Doing “things” does not create a patient centered environment
- There is an inverse correlation between the time the provider spends with a patient and patient satisfaction

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A year ago for the Scientific Assembly approximately 50% of Family Physicians did not understand the concept of Patient Centered Medical Home

A year later a new survey reveals that the number hasn’t changed

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Key Attributes of Patient-Centered Care –Commonwealth Fund

- A high degree of consensus exists regarding the key attributes of patient-centered care. In a systematic review of nine models and frameworks for defining patient-centered care, the following six core elements were identified most frequently:

- Education and shared knowledge
- Involvement of family and friends
- Collaboration and team management
- Sensitivity to nonmedical and spiritual dimensions of care
- Respect for patient needs and preferences
- Free flow and accessibility of information

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Pilots-proving the value/rewarding Medical Homes

- CMS
- Payers
- Employers
- State Medicaid

******Chronic Disease Management and P4P Pilots are not PCMH Pilots*****

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The Pie is not going to get any bigger

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TransforMED℠ 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

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