

Patient-Centered Medical Home and Team Based Care to Improve Diabetes and Hypertension Outcomes

Diabetes Alliance of Idaho Conference

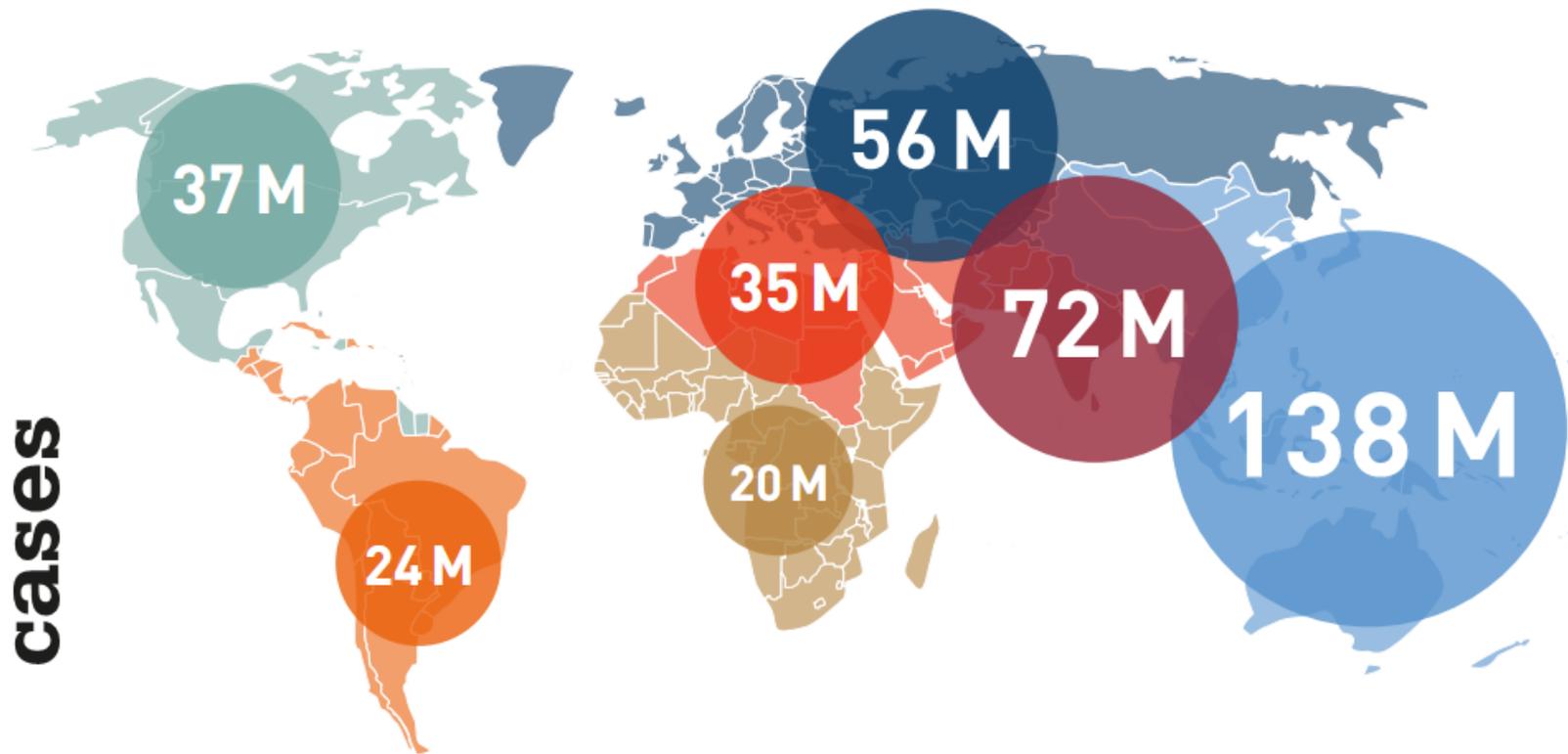
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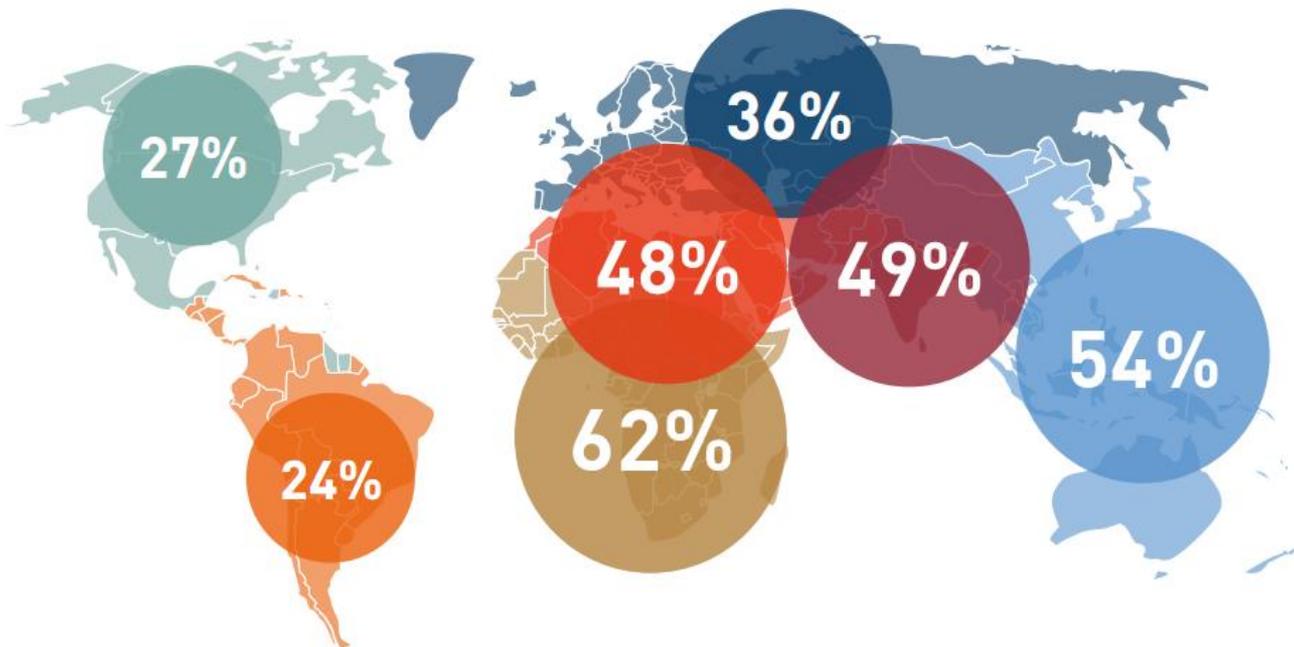
Desired Outcomes

- Understanding of why healthcare is changing (more emphasis on primary care, and PCMH)
- Knowledge of what PCMH is, and how it aligns with and supports HTN and Diabetes care
- Discussion of the importance of team-based care



Number of people with diabetes (20-79 years), 2013

undiagnosed



Proportion of cases of diabetes (20-79 years)
that are undiagnosed, 2013

My Experience with Diabetes...



Is this true?

“Our health-care system is the envy of the world...”



Third Bush-Kerry debate, on domestic policy, 10/13/04 in Tempe AZ



EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

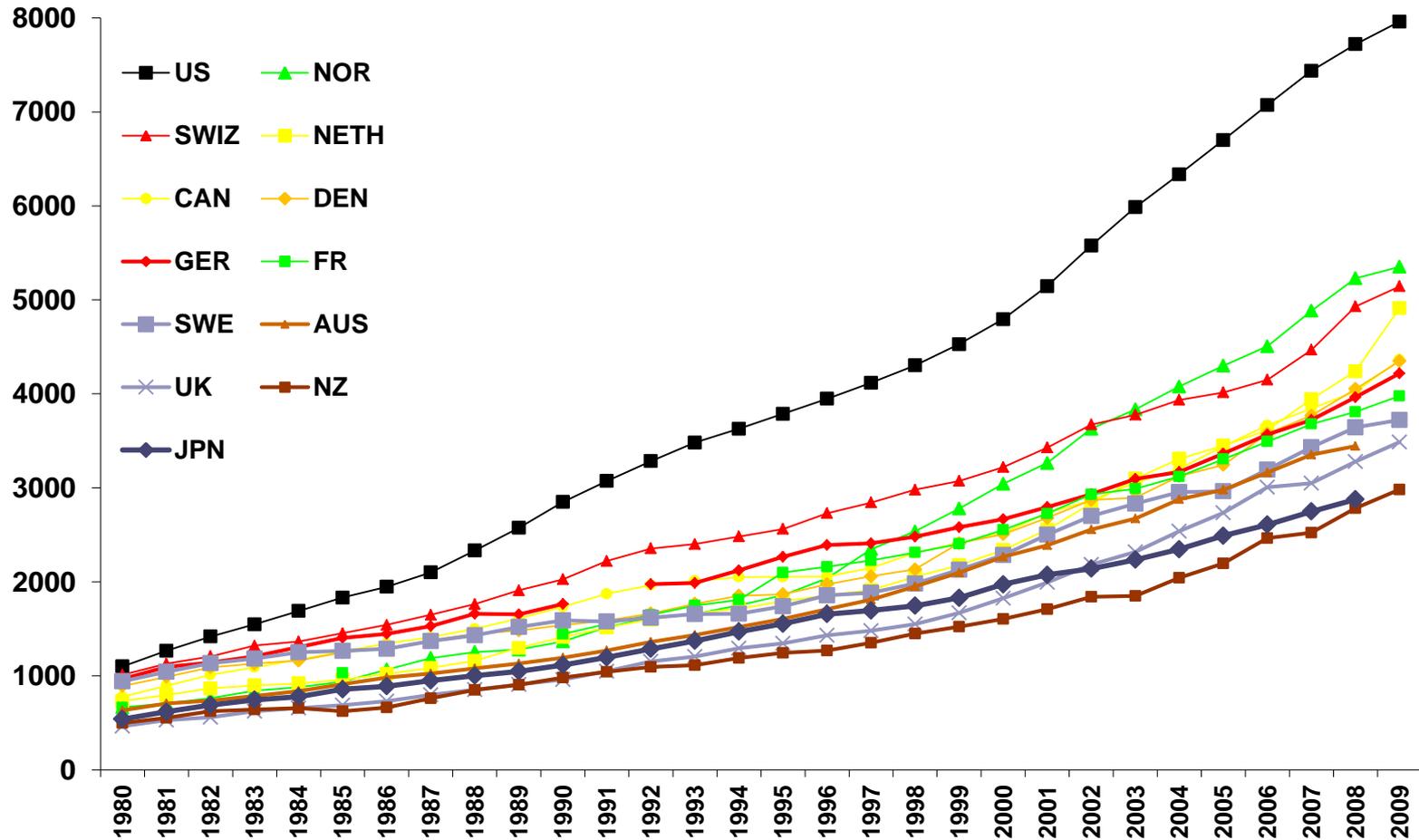


	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508

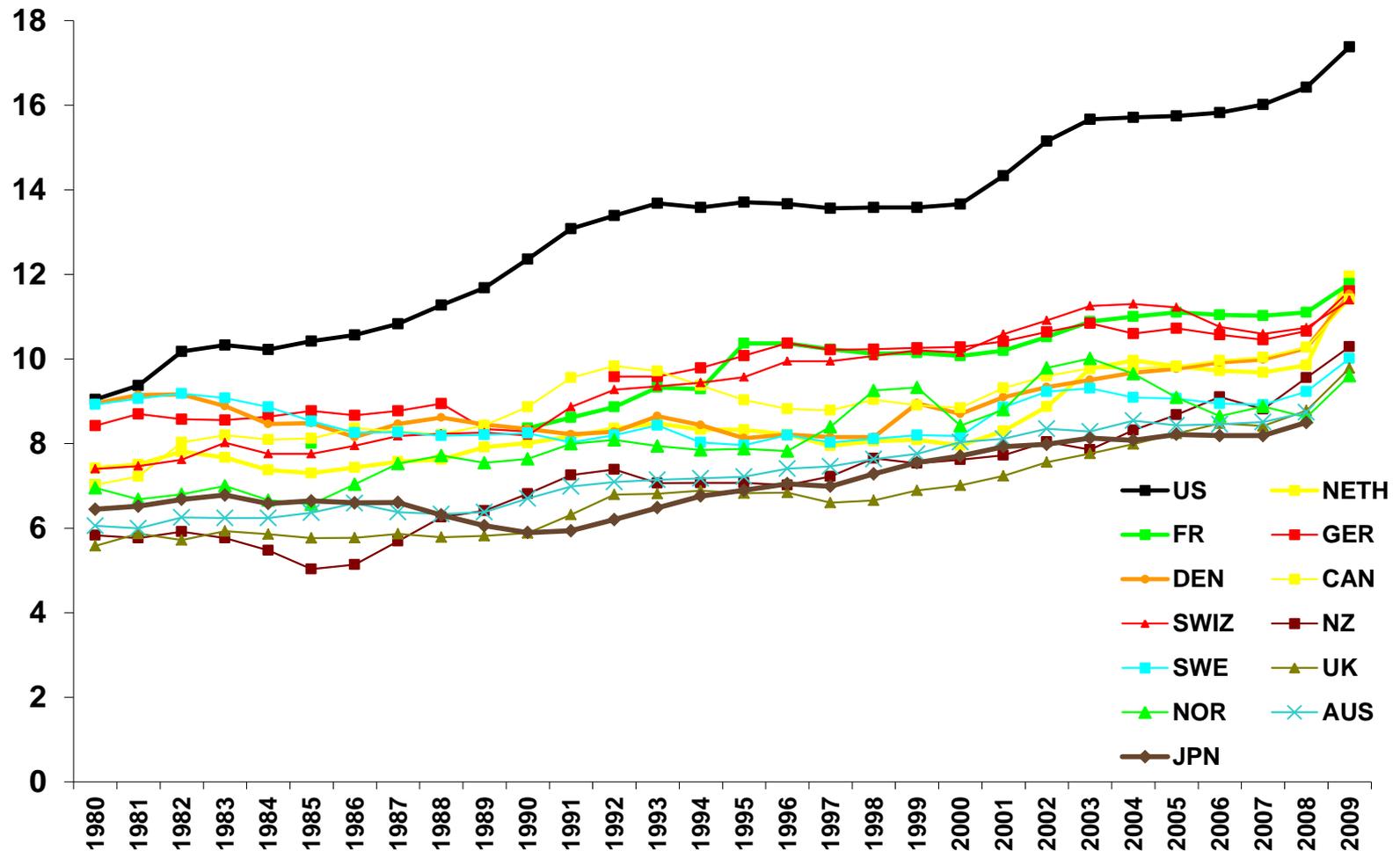
Notes: * Includes ties. ** Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

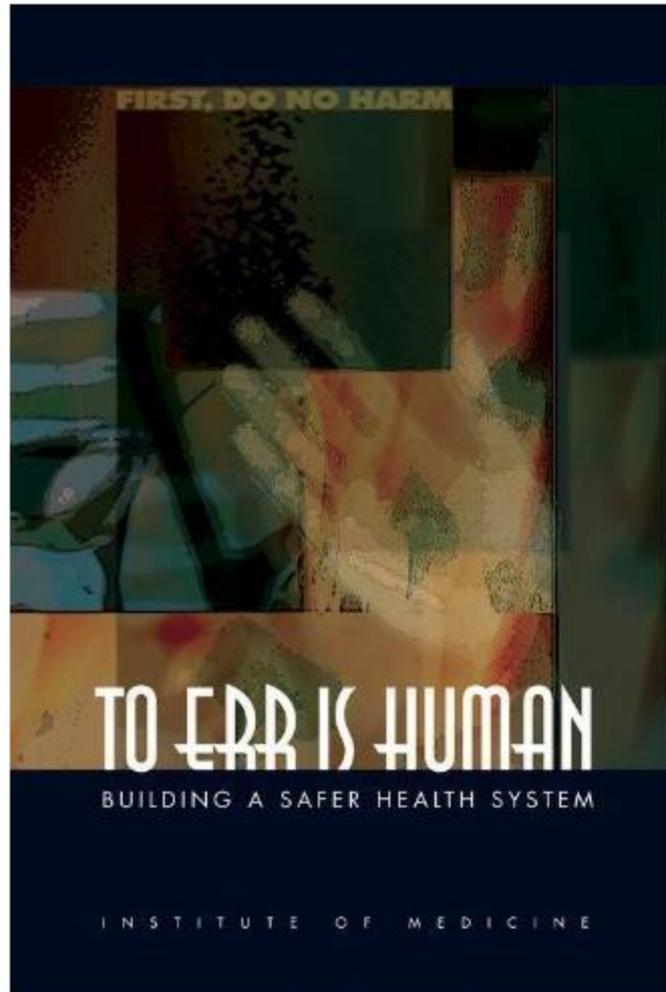
Average spending on health per capita (\$US)

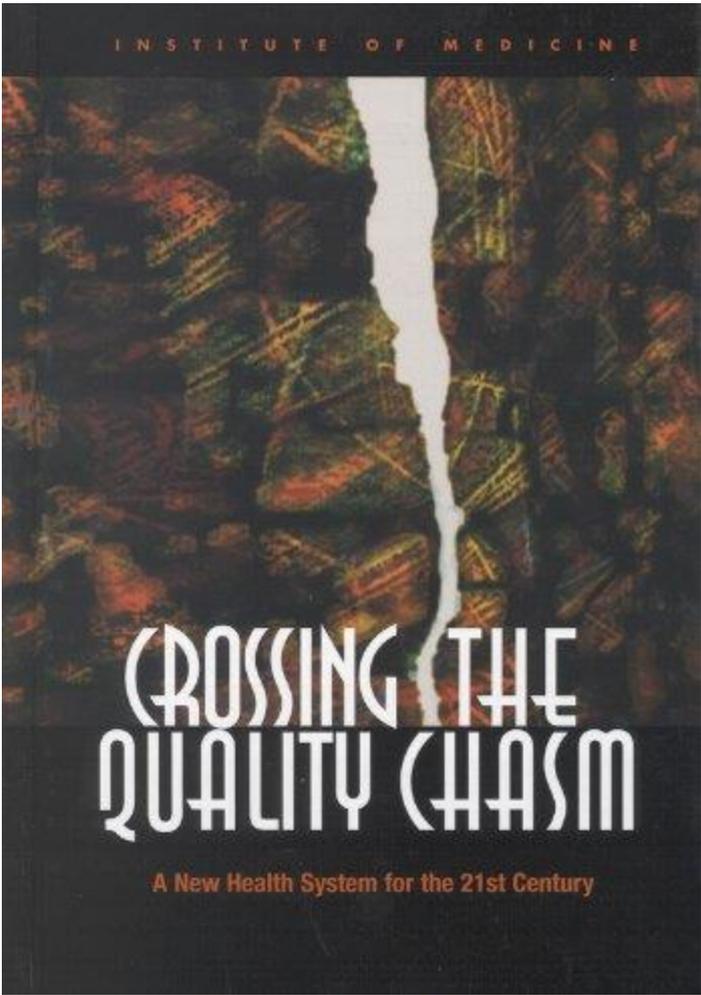


Total expenditures on health as percent of GDP



Source: Squires, DA, Commonwealth Fund May 2012, pub. 1595 Vol. 10





The Chronic Care Model



Improve
individual
experience

The
Triple Aim™

OPTIMIZING HEALTH, CARE EXPERIENCE, AND COSTS FOR POPULATIONS

Improve
population
health

The best
care

For the
whole
population

At the
lowest cost

Control
inflation of
per capita
costs



Our Innovation Models

The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve **better care for patients, better health for our communities, and lower costs** through improvement for our health care system.

Innovation.CMS.gov

Joint Principles of PCMH

“PCMH is an approach to providing comprehensive primary care for children, youth and adults. The medical home is a health care setting that facilitates partnerships between individual patients and their personal providers, and when appropriate, the patient’s family.”

AAP, AAFP, ACP and AOA, March 2007



Principles

- Personal physician/provider
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Payment

Desired Outcomes of PCMH

- Improve health outcomes—esp. for chronic disease
- Provide a more comprehensive and coordinated approach to patient care
- Improve clinic flow/efficiency
- Improve patient, clinician, and staff satisfaction
- Prepare for changes in healthcare industry
- Do the **RIGHT THING** for patients



How does the Patient- Centered Medical Home look different from what we do today?

Today's Care	PCMH Care
My patients are those who make appointments to see me.	Our patients are those who are registered in our medical home.
Care is determined by today's problem and time available today.	Care is determined by a proactive plan to meet health needs, with or without visits.
Care varies by scheduled time and memory or skill of the provider.	Care is standardized according to evidence-based guidelines .
I know I deliver high quality care because I'm well trained.	We measure our quality and make rapid changes to improve it.
Patients are responsible for coordinating their own care.	A prepared team of professionals coordinates all patients' care.
It's up to the patient to tell us what happened to them.	We track tests and consultations, and follow up after ED visits and hospitalizations.
Clinic operations center on meeting the doctors' needs.	An interdisciplinary team works at the top of our licenses to best meet patients' needs.

From the presentation "Patient-Centered Medical Home for Idaho" by Paul Grundy, MD, MPH, IBM Global Business Services, June 29, 2009.



The Safety-Net Medical Home Initiative

- Four year grant (2009-2013) funded by the Commonwealth Fund and eight other co-funders including Blue Cross Foundation of Idaho
- Participating states: Idaho, Oregon, Colorado, Massachusetts and Pennsylvania
- 65 clinics nation-wide; 13 in Idaho
- Technical assistance and support provided by Qualis Health and The MacColl Institute for Healthcare Innovation (Group Health)



SNMHI Goals

- Convene a state-wide learning collaborative of safety net clinics to develop the patient-centered medical home model
- Reduce policy barriers and advocate for reimbursement reform to support medical home services
- Sustain and spread the patient-centered medical home



Personal Physician/Provider

- On-going relationship
- Trained to provide first-contact, continuous and comprehensive care
- Leads the care team at the clinic/practice level
- Team takes collective responsibility for on-going care of patient panel

Whole Person Orientation

- PCP and team take responsibility for all of patient's health care needs
 - OR –
- appropriately arrange for that care with other qualified provider(s)
- ALL types of care and stages of life: acute care, chronic care, preventive services and end of life care



Coordinated and/or Integrated Care

- Across all elements of the complex healthcare system and the patient's community
- Internally within an organization, and externally
- Facilitated by registries, Information Technology, health information exchange, and other means
- CLAS – Culturally and linguistically appropriate services



Does Continuity of Care Improve Patient Outcomes?

Sustained continuity of care improves quality of care, and this association is consistently documented for patients with chronic conditions.

Cabana MD, Jee SH, J Fam Pract 2004 Dec.



Quality and Safety

- Support for the attainment of optimal, patient-centered outcomes
- Use of evidence-based medicine and decision support tools
- Continuous quality improvement through performance measurement
- Patients actively participate in decision-making

Enhanced Access

- Greater access through same-day appointments, expanded hours
- New modes of communication (patient portals, secure e-mail, texting, etc.)
- Telemedicine

Payment

- Needs to recognize the added value of being in a PCMH, including:
 - Care management that falls outside face-to-face encounter
 - Coordination of care within the practice, as well as between consultants, ancillary providers and community resources
 - Additional payments for measureable and continuous quality improvements

The Importance of Team-based Care



Primary Care Providers Can't do it Alone!

- Visit length = 10 to 15 minutes
- Average of 3+ complaints/visit
- Over 3 dozen urgent (but unpaid tasks)/day
- Need 7.3 hrs/day to implement all USPSTF recommendations
- Need 10 hrs/day to implement chronic care recommendations

Source: Mountainview Consulting, Patricia Robinson, Ph.D., Reiter, Jeff, Ph.D. ABPP

Supply and Demand for PCPs

- 12 to 15 million people have gained health insurance through the PPACA
- Need thousands of additional MDs, DOs, NPs, PAs
- Idaho ranks toward bottom of PCP per capita



Practicing “At the Top of Their License”

- Roles and task distribution among team members reflects skills, abilities and credentials of team members
- Efficient/cost effective
- Prevents burnout and increases job satisfaction
- Better outcomes

Care Team Definition

A small group of clinical and non-clinical staff who, together with a provider, are responsible for the health and well-being of a panel of patients.

SNMHI, Improving Care Through Teams, May 2013



Typically Includes:

- Patient – at the center of the care team
- Provider – responsible for leading the team
- Medical Assistant(s)
- Nurse(s), Pharmacist(s), Social Worker(s), Health Educator(s)
- Front office staff

- Sometimes includes: Behavioral Health Consultant, Dietitian

Questions/Comments...



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