Patient-centered care - from buzz word to meaningful reality

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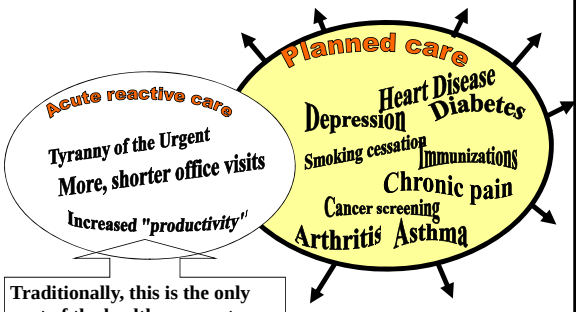
Current Health Care System



Traditionally, this is the only part of the health care system that is being supported.

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A Patient View of the Ideal Health Care System – a Patient Centered System

I have useful interactions with my health care team whenever and however I need to.

I get delighted and surprised by my health care team on a regular basis when they anticipate my needs

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Two Options For the Chronically Ill

- Improve Medical Care

The IOM Quality Chasm report says:
"The current care systems cannot do the job…trying harder will not work. Changing care systems will."

- Work around a deficient medical care system

Direct-to-Patient Disease Management

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Two specific initiatives

- Chronic Care Model
- Patient-centered Medical Home Model

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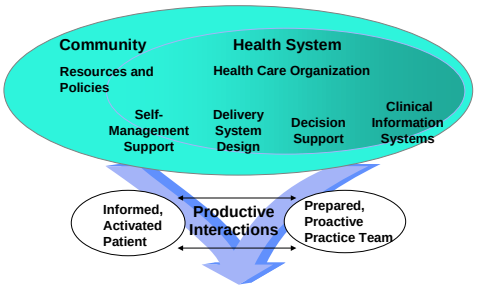
Chronic Care Model



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Can Busy Practices Change in Accord with the CCM ?

- More than 1,500 different health care organizations and various diseases involved to date
- HRSA's Health Disparities Collaboratives- 600+ community and migrant health centers, now academic medical centers & small practices
- Now, regional, state-based, and facility-specific initiatives to improve care.

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Evaluations of CCM Interventions

RANDHealth

- Practices can change - organizations made average of 48 changes in 5.8/6 CCM areas
- Process measures may improve – CHF, asthma, diabetes
- Outcome measures may improve – better glycemic control in diabetes

Chin, et al. & Landon, et al.

- May take more than 1 year to see outcome changes
- Cost-effective

Randomized Controlled Trials

- All but one shows implementation of the CCM significantly improves process and outcome measures compared to controls

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CCM Developments

- Guides several state programs
- Adaptations undertaken by U.K.'s National Health Service, World Health Organization, and several Canadian provinces.
- Foundation for NCQA and JCAHO certification for chronic disease programs.
- Several practice assessment tools now available for large and small practices.
- Fundamental part of the Patient Centered Medical Home proposed by AAFP and ACP.
- Assessments now used in some pay for performance programs (NCQA's PPC-PCMH)

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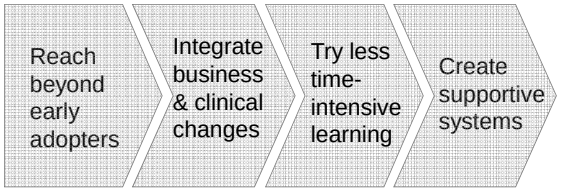
What's next?



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Why promote a Medical Home Model for care?

- More loyal patients
- More sustainable medical costs
- Physicians and clinical care teams who have sustainable and satisfying jobs
- Relationship-centered care more likely to meet the six aims of the Institute of Medicine (care which is safe, effective, patient-centered, timely, efficient, and equitable)
- Better clinical outcomes with more appropriate utilization of services

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A Formula for Success

Activated patients *In relationship with* *Prepared physicians and teams* = *Lower cost trends & more predictable / better outcomes*

Patient (in the red sweater) surrounded by her Factoria health care team

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Defining the Medical Home Model

- The medical home is a philosophy and a system of care---not a physical space.
- It is a set of systems that enables and enhances the patient experience and relationship with their PCP, resulting a better health well-being outcomes.
- It is a collaborative relationship between an engaged, activated patient and supportive physician-led primary care team.
- It does mean that every health care experience (visit, referral, phone call, etc.) connects the patient back to their PCP in a way that enhances their health care experience and clinical outcomes.
- Not just a Primary Care model – Specialists are changing their roles through:
  - Real time consultation (Secure messaging / phone)
  - Focused patient education
  - Collaborative effort with patients on care options

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Design Principles

- PCP-patient relationship at the core
- Delivery system and organization support PCP-patient relationship
- PCPs lead the clinical teams to:
  - Coordinate and integrate services
  - Create collaborative care plans with patients
- Proactive 'continuous healing relationships' that encompass all aspects of health and illness
- Patients will be actively informed about and encouraged to participate in all aspects of their care
- 24/7 access centered on patient needs, available by various modes and maximizes use of available technology

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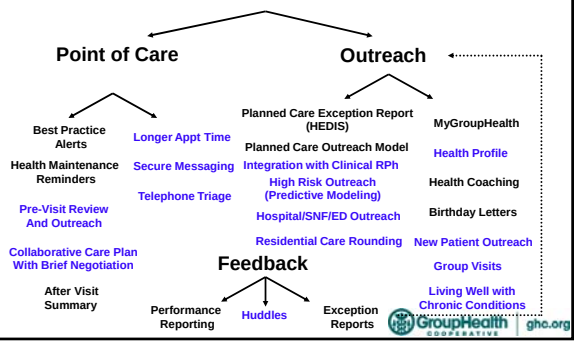
Defining the Medical Home Model:
Integrated Patient-Centered Care



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The Core of MHM:
The PCP/Patient relationship

- Here are ways Factoria supports that relationship:
- Added MD FTE
- Reduced panel size to 1800 for 1.0 FTE
- 20% investment for panel size reductions
- Re-configured teams to support PCPs
- PAs support designated PCPs
- Team RNs co-located with PCPs
- Clinical Pharmacists with the Team
- Team Huddles

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The Core of MHM:
The PCP/Patient relationship

- Here are ways Factoria supports that relationship:
- Patient Outreach
- Patient Access
- Phone visits
- Group visits
- Secure messaging
- Longer face-to-face visits
- Patient Activation
- Collaborative Care Planning

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Expected Outcomes

- Reduced unnecessary ED/UC visits
- Reduced unnecessary hospital admissions
- Reduced unnecessary Specialty visits
- Improved clinical quality performance
- Improved patient experience outcomes
- Improved physician & staff satisfaction

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Early Outcomes Summary

- ⇧ **Higher patient activation rates – Health Profile**
- ⇧ **Higher secure messaging rates**
- ⇩ **Lower referral rates in selected specialties**
- ⇩ **Lower face to face visit volumes**

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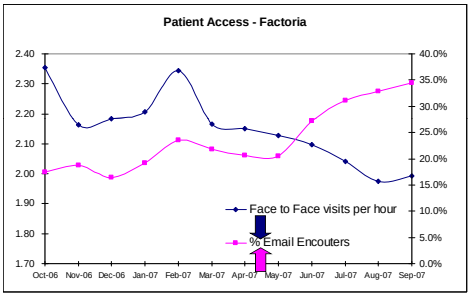
Early Results – Access



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Patient Experiences

"Not only today, but continually, no matter when we come, we are treated promptly, courteously, cheerfully, and efficiently. In recent visits we are aware of an extended time with the doctor, no longer a sense of rush. To everyone from the front door till the end of our visit… thank you! Keep up the great work!!"

Thank you!

-Factoria Medical Home Patient

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Patient Experiences

"When the pilot program at Factoria was started, I wasn't sure about how it would work. Because of the team's effort, I have lost some pounds, getting help controlling blood pressure, blood work, and some issues that I had no knowledge I had! Thank you to all involved!"

-Factoria Medical Home Patient

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Provider Experiences

"This program is critical to the future of primary care medicine and marks an enormous change in the approach and strategy regarding the use of resources in patient care delivery at the primary care level."

"Across the board, [there have been] dramatic increase[s] in provider satisfaction in a short period of time"

- Dr. Bergman re: "The Implementation of the Medical Home Pilot at Factoria"

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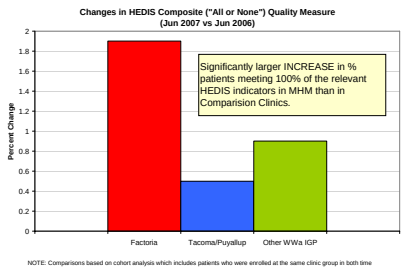
Center for Health Studies
6 Month Evaluation – Quality of Care



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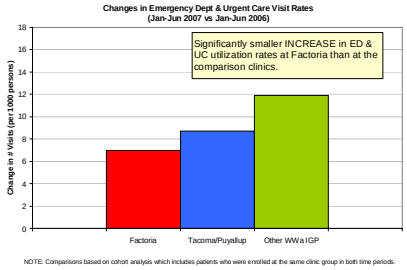
Center for Health Studies
6 Month Evaluation – ED/UC Utilization



NOTE: Comparisons based on cohort analysis which includes patients who were enrolled at the same clinic group in both time periods.

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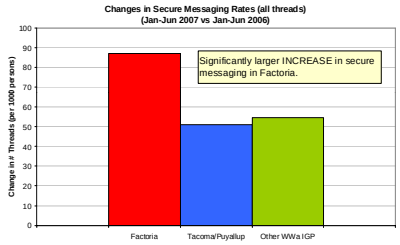
Center for Health Studies
6 Month Evaluation – Secure Messaging



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Aim for Where We Want To Be

- "If you think you can do a thing, or think you can't do a thing – you're right"

  Henry Ford

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