Chronic Care Model to Patient Centered Medical Home (PCMH) – the Road to Nirvana

Presented by:

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Intended for:

The Jackson Physicians Alliance

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Current State

People are good

The system is broken

Chronic Illness in America

- More than 125 million Americans suffer from one or more chronic illnesses and 40 million limited by them.
- Despite annual spending of more than $ 1 trillion and significant advances in care, one-half or more of patients still don't receive appropriate clinical care.
- A much larger percentage receive little useful assistance in their self-management
- Gaps in quality care lead to thousands of avoidable hospitalizations and deaths each year..
- Patients and families increasingly recognize the defects in their care.

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Chronic Illness and Medical Care

- Primary care dominated by chronic illness care
- Clinical and behavioral management increasingly ineffective and increasingly complex
- Inadequate reimbursement and greater demand forcing primary care to increase throughput—the hamster wheel
- Nurses are becoming an endangered species in primary care
- Unhappy primary care clinicians leaving practice; trainees choosing other specialties
- Loss of confidence in primary care by policy-makers and funders
- But, there is a growing interest in changing physician payment to encourage and reward quality

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Starting From the Ground Up

Building on a New Foundation
The Chronic Care Model

The Footprint for the
Patient Centered Medical Home

Chronic Care Model Impact on Cost and Health Care Indicators

- Evidence of Effectiveness
  - Decreased Length of Stay – 10%
  - Decreased Inpatient Days/1000 – 26%
  - Pharmacy Cost Increased – 16%
  - Overall Cost of Care Decreased – 11%
- Health Care Indicators (over 10 year period)
  - Diabetic Eye Exams – improvement from 43% to 75%
  - Foot Exams – improvement from 10% to 85%
  - Microalbumin Screening – improvement from 1% to 89%

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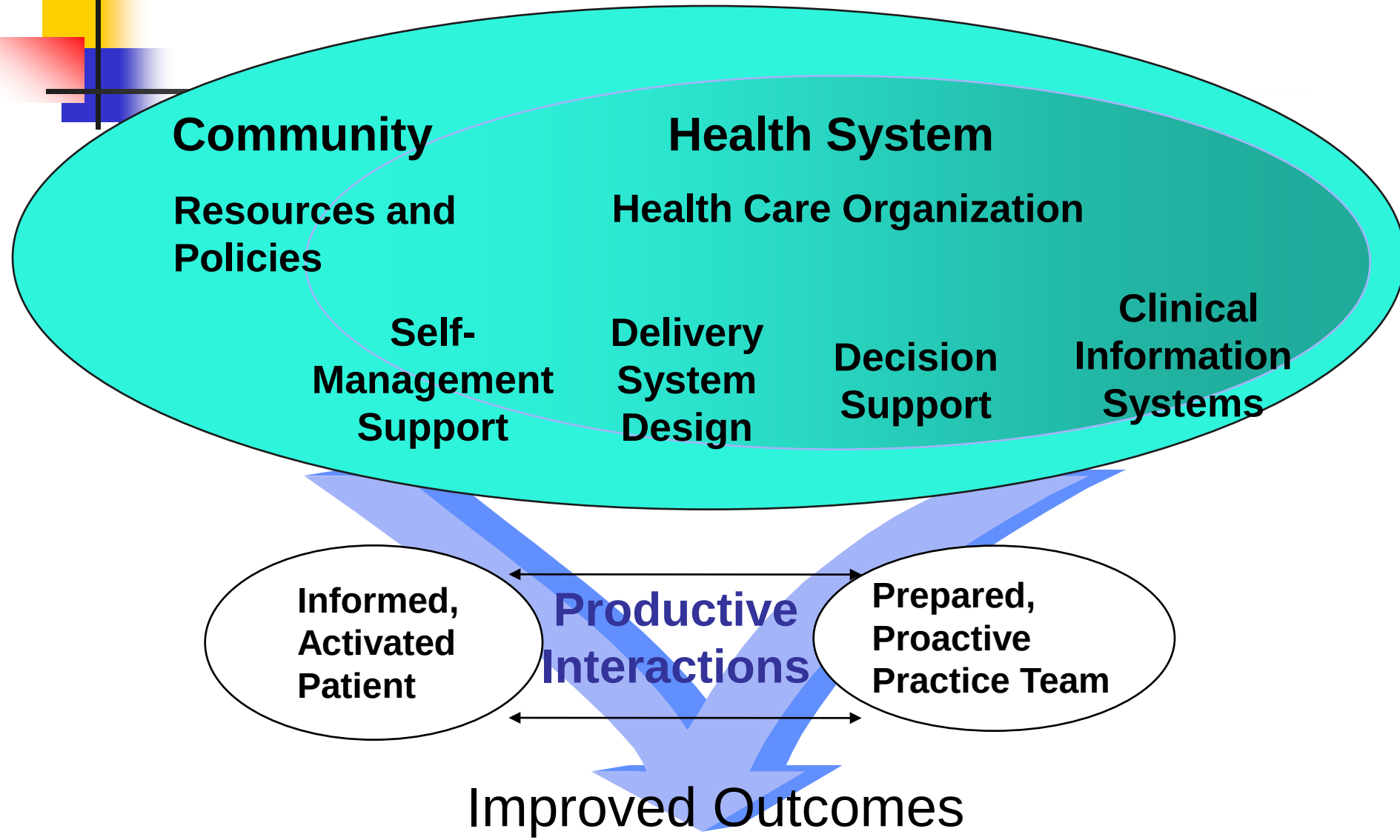
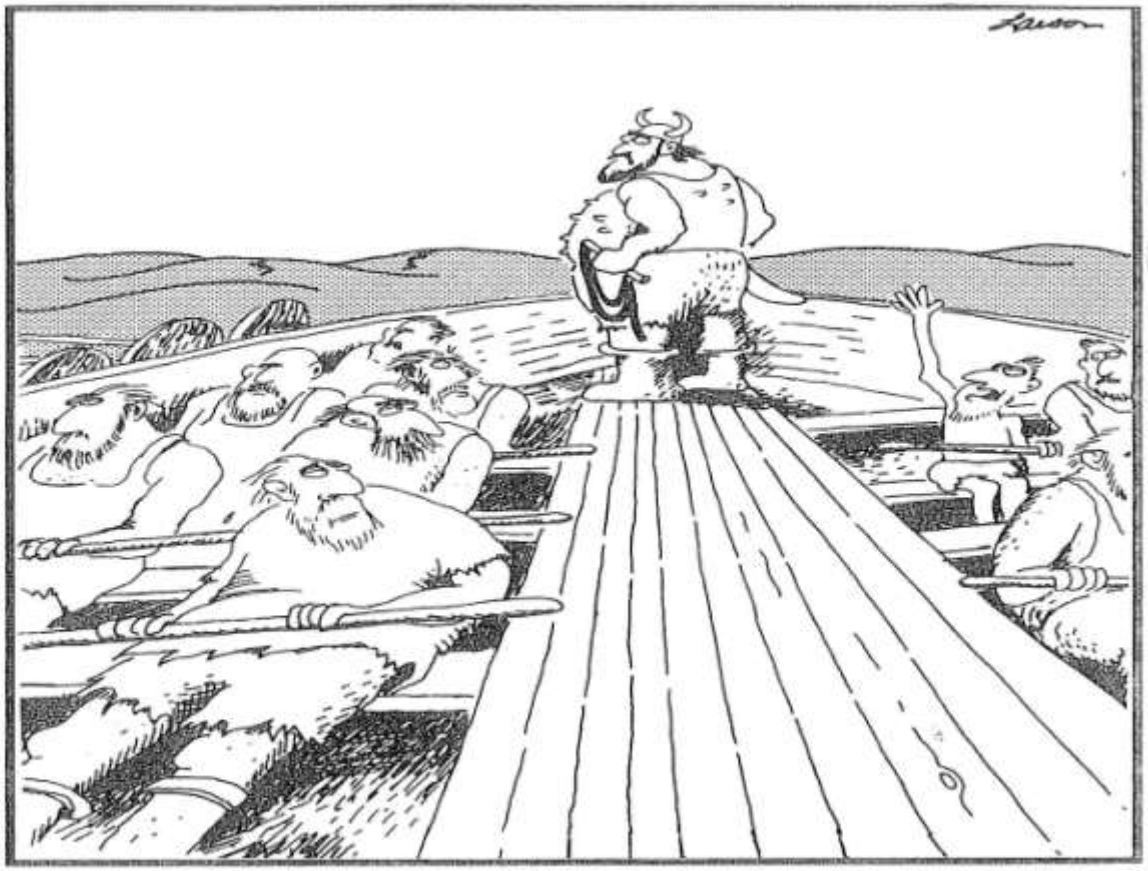
Chronic Care Model



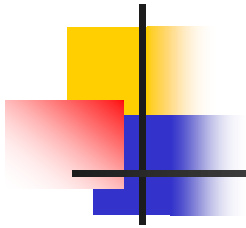
Health System

- Visibly support improvement at all levels of the organization, beginning with the senior leader
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of errors and quality problems to improve care
- Provide incentives based on quality of care
- Develop agreements that facilitate care coordination within and across organizations

Delivery System Design



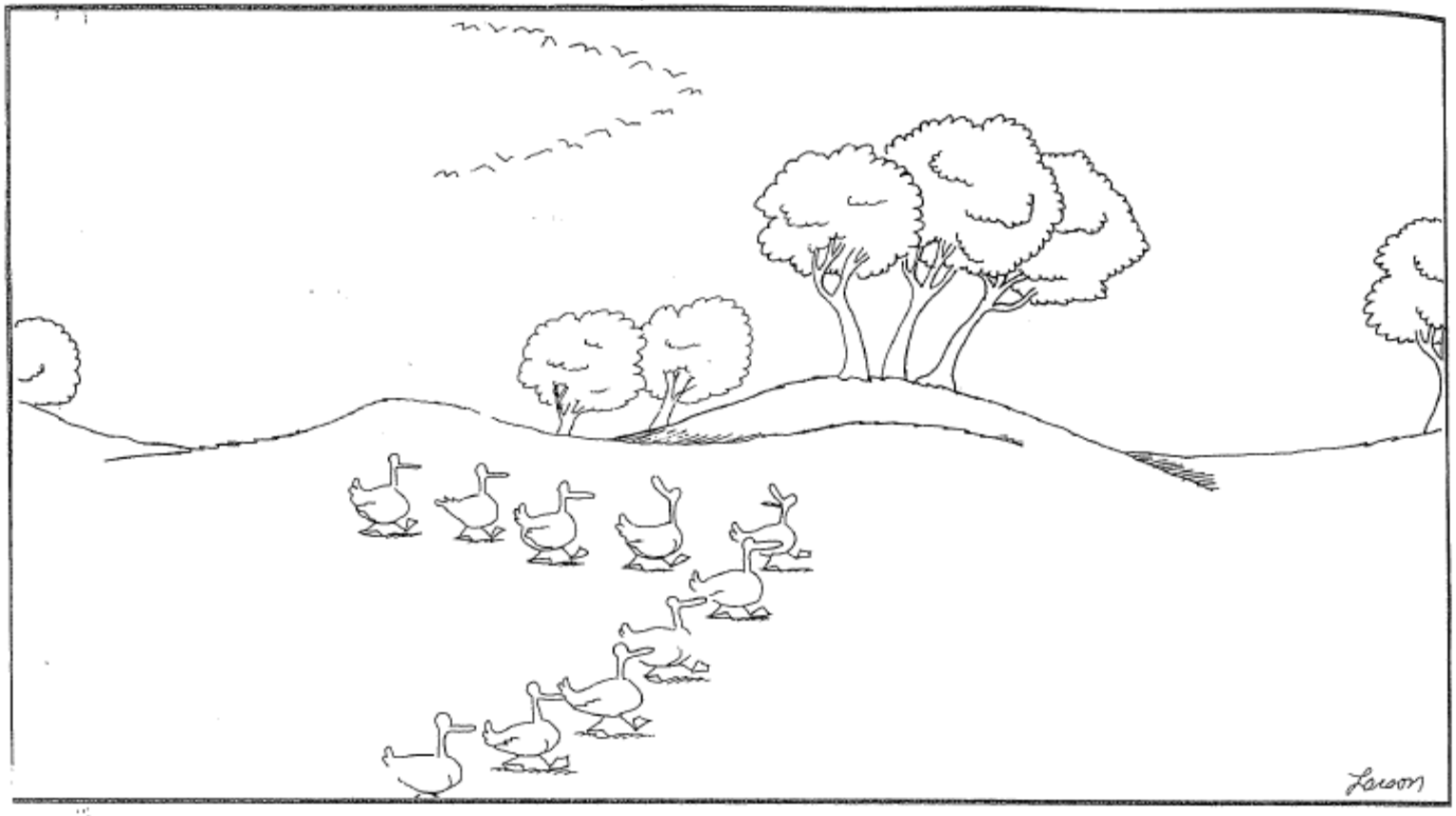
"Yoo-hoo! Oh, yoo-hoo! . . . I think I'm getting a blister."



Delivery System Design

- Define roles and distribute tasks among team members
- Use planned interactions to support evidence -based care
- Provide clinical case management services for complex patients
- Ensure regular follow-up by the care team
- Give care that patients understand and that fits with their cultural background

Decision Support

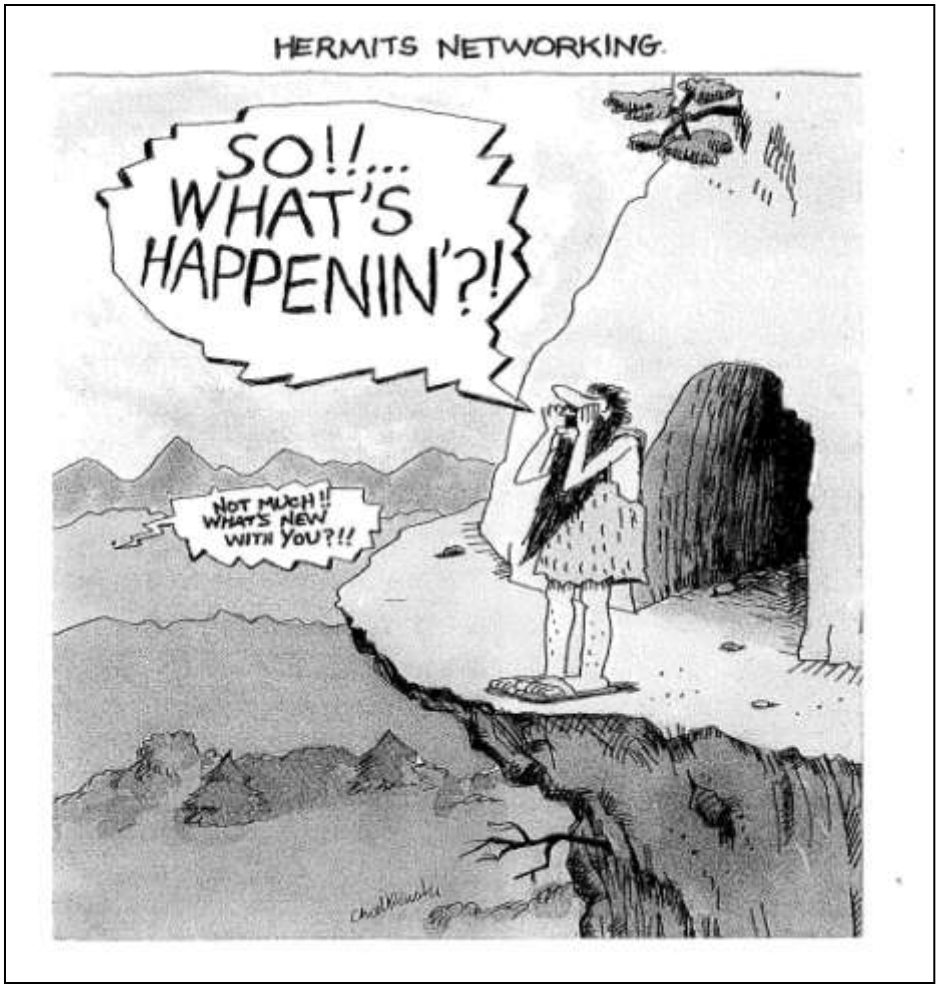


"Say . . . Look what THEY'RE doing."

Decision Support

- Embed evidence-based guidelines into daily clinical practice
- Share evidence-based guidelines and information with patients to encourage their participation
- Use proven provider education methods
- Integrate specialist expertise and primary care

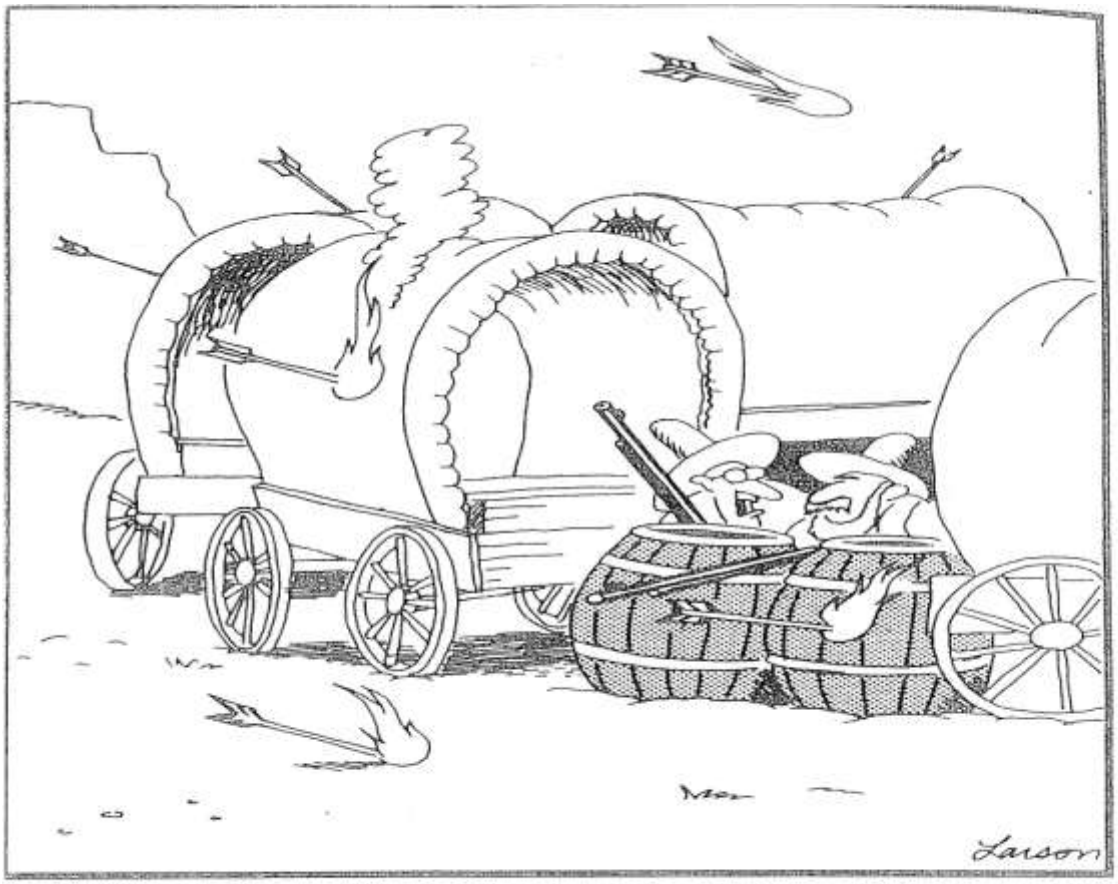
Clinical Information Systems



Clinical Information Systems

- Provide timely reminders for providers and patients
- Identify relevant subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with patients and providers to coordinate care
- Monitor performance of practice team and care system

Self Management Support

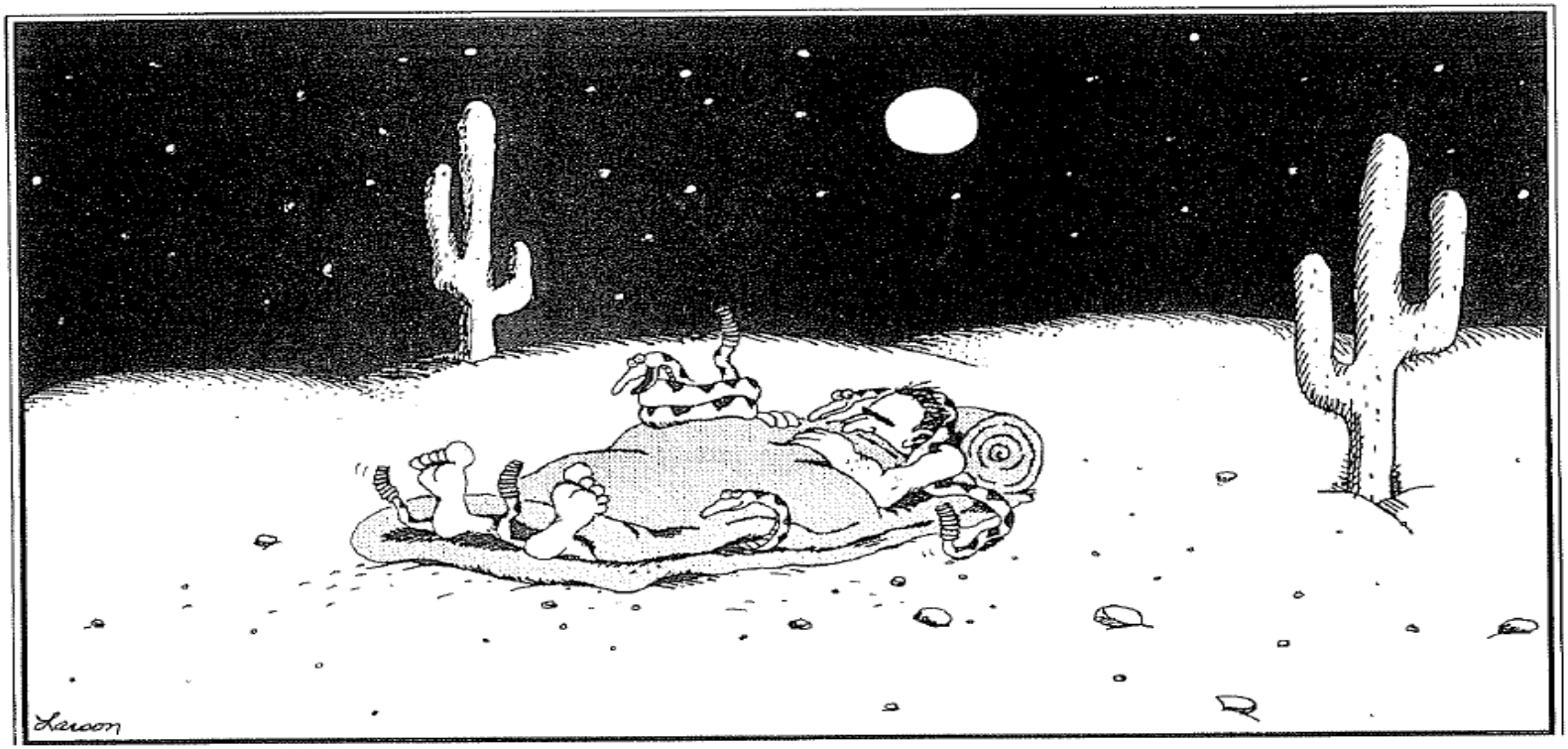


"Hey! They're lighting their arrows! . . . Can they DO that?"

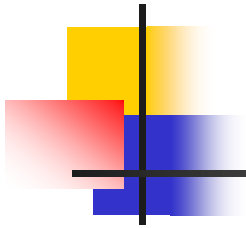
Self Management Support

- **Empower and prepare patients to manage their health and health care**
  - Emphasize the patient's central role in managing their health
  - Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving, and follow-up
  - Organize internal and community resources to provide ongoing self-management support to patients

Community Resources



"Okay . . . On the count of three everybody rattles."



Community Resources

- **Mobilize community resources to meet the needs of patients**
  - Encourage patients to participate in effective community programs
  - Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
  - Advocate for policies to improve patient care

From Chronic Care Model to Patient Centered Medical Home

Patient Centered Medical Home Guiding Principles

- Physician coordinates the team care (*delivery system design)*
- Importance of care coordination (*delivery system design*) across all elements of the complex health care system and the patients' community *(health care organization, community resources and policies*)
- Care is facilitated by registries, information technology (*clinical information systems)*

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Patient Centered Medical Home Guiding Principles

- Patients obtain indicated care when and where they need it (*decision support - evidence based guidelines*)
- Patients actively participate in decision making (*self management*)
- Advanced Access (*delivery system design*)
- Payment reform appropriately recognizes the added value to patients with a PCMH (*resources/policies, health care system)*

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TODAY'S CARE		MEDICAL HOME CARE
My patients are those who make appointments to see me	→	Our patients are those who are registered in our medical home
Patients' chief complaints or reasons for visit determines care	→	We systematically assess all our patients' health needs to plan care
Care is determined by today's problem and time available today	→	Care is determined by a proactive plan to meet patient needs without visits
Care varies by scheduled time and memory or skill of the doctor	→	Care is standardized according to evidence-based guidelines
Patients are responsible for coordinating their own care	→	A prepared team of professionals coordinates all patients' care
I know I deliver high quality care because I'm well trained	→	We measure our quality and make rapid changes to improve it
Acute care is delivered in the next available appointment and walk-ins	→	Acute care is delivered by open access and non-visit contacts
It's up to the patient to tell us what happened to them	→	We track tests & consultations, and follow-up after ED & hospital
Clinic operations center on meeting the doctor's needs	→	A multidisciplinary team works at the top of our licenses to serve patients

Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma

Let's compare the 2 models of care:

Biomedical	Behavioral
Practitioner centered	Patient centered
Information giving	Information exchange
"Save" the patient	Patient "saves" self
Dictate behavior	Negotiate behavior
Compliance	Adherence
Authoritarian (Parent-Child)	Servant
Motivate the patient	Assess motivation
Persuade, manipulate	Understand, accept
Resistance is bad	Resistance is information
Argue	Confront
Respect expected	Respect earned

Adapted from Berger BA. *Case Manager*. 2004:15:46=50.

PCMH-on the Ground Reality

So, it's in our hands~

Thank you !

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Next Webinar

Evidence Based Care Measures

Part 1 – General Guidelines

Thursday, September 9, 2010

12:00 PM – 1:00 PM