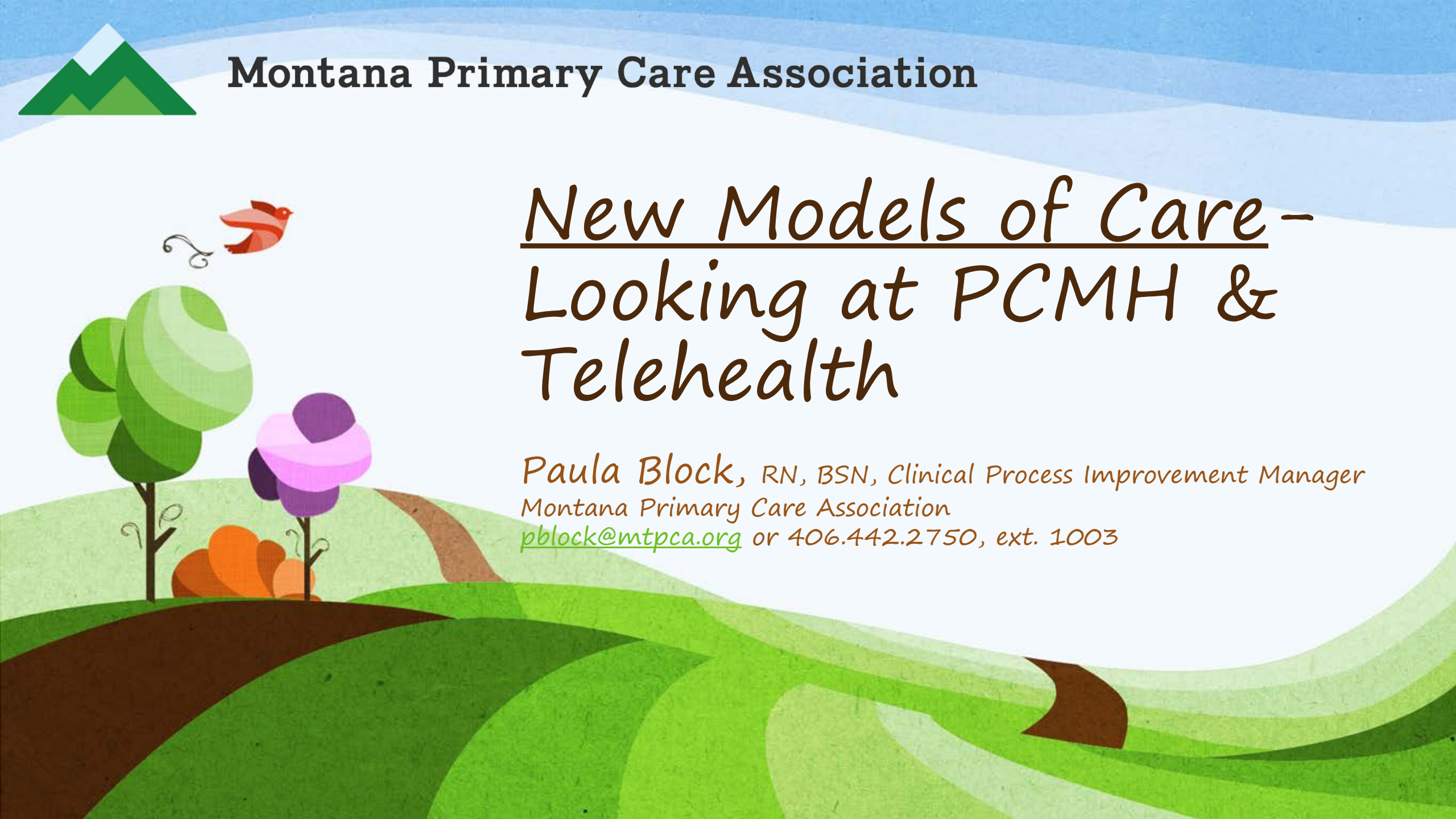
Montana Primary Care Association



New Models of Care – Looking at PCMH & Telehealth

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Agenda

- What is PCMH?
- Theories behind PCMH
- Are we there yet?
- Examples
- Telehealth implications
- Resources

What is a PCMH (Patient Centered Medical Home)?

- AAP (Pediatrics)- introduced concept in 1967
- Evolved today-
  - Cultivated partnership between patient and provider (Doc, NP or PA), in cooperation with specialists and support from community. The patient is the focal point of this model and the care is built around this center and provided by a team. Care is accessible, family-centric, continuous, comprehensive, coordinated, compassionate and culturally effective.

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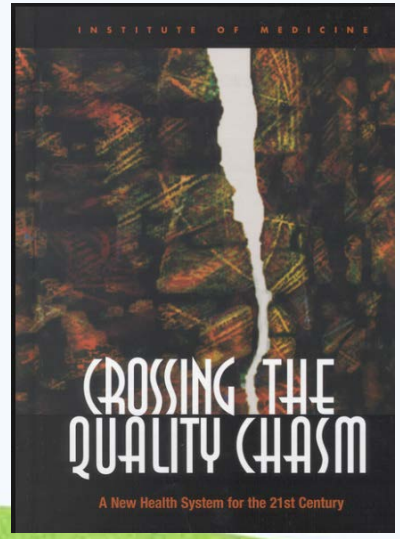
Why Become a PCMH Clinic? Most Important EVER Quality Publication- "Crossing the Quality Chasm: A New Health System for the 21st Century" – 10 rules

- Care- continuous relationships
- Care- based on pt needs / values
- Patient is source of control
- Patient has info so can make decisions
- Evidence based care



- Patient safety
- Transparency of information
- Anticipation of needs
- Continuous decrease in waste
- Cooperation among clinicians

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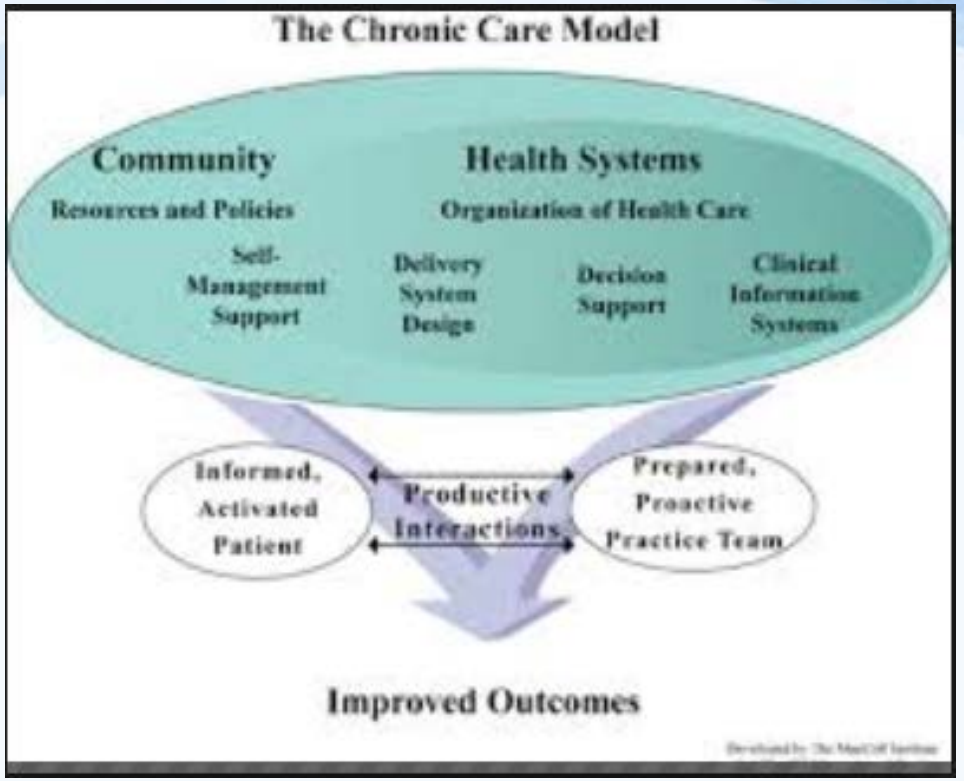
Theories Behind PCMH



- Chronic Care Model- Ed Wagner
  - Clinical Info Systems, Decision support, Pt self management, Redesign, community Linkages
- Patient Centered Care
  - Respect pt values, accessible, coordinated, compassionate
- Cultural Competence
  - Culturally competent, language services, reduce disparities
- Medical Home
  - Personal physician, team care, whole person orientation, Quality, enhanced access

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The Joint Principles of PCMH- Developed by 4 physician groups- ACP, AAFP, AAP & AOA

- Personal Physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated across all health care and community
- Quality and safety integral (care planning; evidenced based medicine; clinical decision support; continuous QI; pt participation & feedback; appropriate HIT)
- Enhanced access
- Payment reform

Are We There?

- 2010
  - 60 million Americans without access to care
  - 20 days- average wait for non emergency
  - 50%- providers accepting new patients
- Primary Care provider needs
  - 7. 4 hours / day doing recommended primary care
    + 10.6 hours doing chronic
    = more than 18 hours/ day or an Unsustainable model
- Costs-
  - 1 in 2 Americans has a chronic condition that is preventable
  - 1 decade, health care costs doubled (2002 – 2012)

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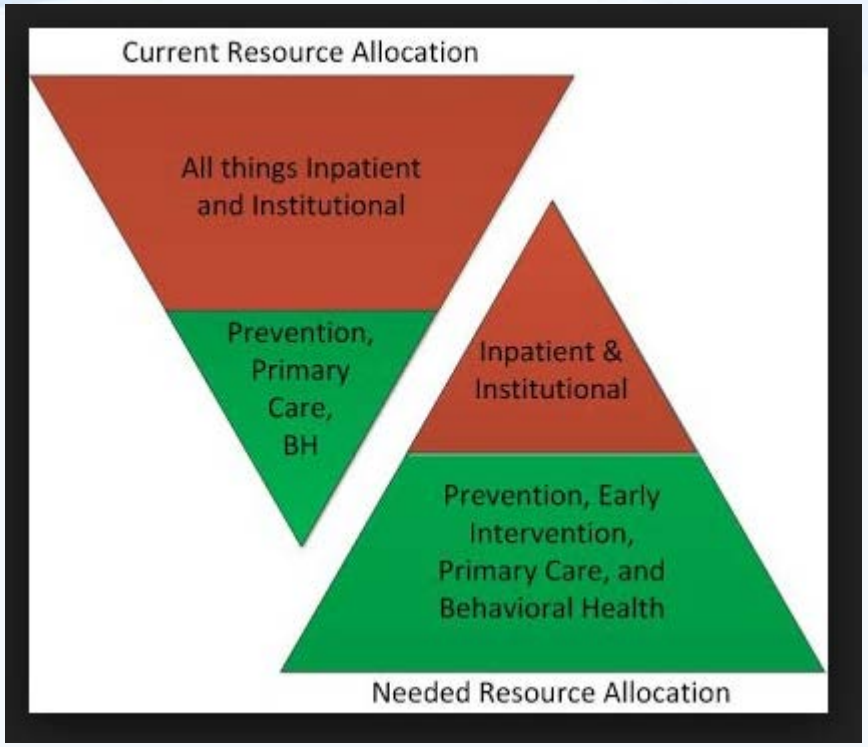
Why Aren't We There?

- Payment system rewards volume over value
- Reactive focus on symptoms rather than proactive and preventive health
- Fragmentation- poorly coordinated care
- Limited transparency and often difficulty in information sharing
- Insufficient resources directed towards primary care
- Treatment decisions not always based on best and latest clinical evidence



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New & Old Models in Health Care

Old Way

- Variable provider- prove you need an appointment. Wait if not sick enough.
- Provider does all care. Overworked, misses things.
- Maybe a registry, little focus on clinic wide needs, reactive.
- Reactive response to care coordination needs. Pt not part of planning care.
- Reactive quality improvement or maybe none at all

PCMH Way

- Personal provider with access, (apt, call, text, email, telehealth).
- Team members planning/doing care (protocols) preventive care & chronic care. ("Work to top of license.")
- Electronic systems- proactively track care needs.
- Care coordination, management & pt involvement in care a big focus.
- Rigorous Quality Improvement part of all aspects of care and patients actively involved

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Examples- PCMH in Montana CHCs

- Group visits for prenatal, behavioral health, pain management
- Same day appointments, ask questions over the portal
- Proactive teams doing routine preventive care test scheduling and ordering routine labs for chronic disease (outreach)
- Huddles
- Proactive care coordination, care management, care planning and goal setting with patient
- EHRs- CDS- Clinical decision support
- REDESIGN
- Patient Advisory Groups

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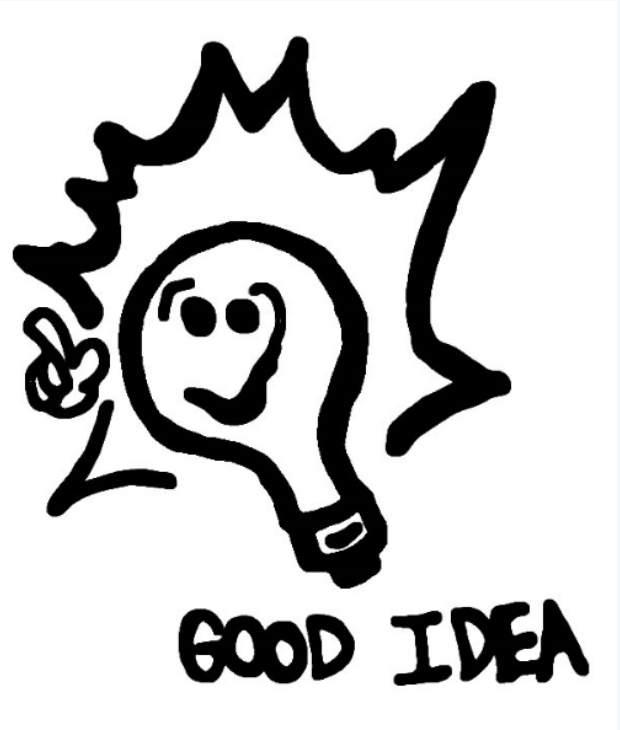
Examples- Other Places

- Telehealth in Idaho
  - Initiative includes tele-health
  - Rural primary care- endocrinologist for DM
  - Derm
  - Cardiac
  - Behavioral / Mental Health (some pts prefer this mode)
- Other places- telehealth
  - MT- Diabetes group education, tele-psych
  - Idea- tele-legal; tele-dental
  - Also, ENT, neurological, VA, home monitoring



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Implications for Telehealth from PCMH

- Care to be available outside of regular business hours.
- Care encouraged to be provided via non-traditional care modes.
- Care team expanded, both in clinic and outside of clinic walls.
- Care to be coordinated & managed for all care needs including specialty care, any referrals. Usually primary care can coordinate & manage.
- Care to be convenient, accessible for the patient.
- Integrating behavioral/mental health into primary care a current focus.
- New care models are rapidly developing.
- Montana is a very rural, low population density state.

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Resources

- NCQA- http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
- AHRQ- https://pcmh.ahrq.gov/
- AAAHC- http://www.aaahc.org/accreditation/primary-care-medical-home/
- Joint Commission- http://www.jointcommission.org/accreditation/pchi.aspx

The End- Questions?