Patient Centered Medical Home in Practice

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Medical Home Model

The Personal Medical Home

A continuous relationship
that cares for the whole person

Access to Care and Information

- Same Day Appointments
- After-hours Care Coverage
- Online Patient Services
- E-Visits
- Lab Results Via Phone & Web
- Nurse-Line or "Ask A Doctor"
- Culturally Sensitive Approach to Care

Information Systems

- Affordable Electronic Health Record
- e-Lab and e-Prescriptions
- Disease Management Software
- Evidence-based decision support
- Population-based management software
- Point-of-care reminders
- Web-based patient history / PHR
- Website / Patient portal
- Interoperable / Adheres to standards

Continuity of Care Services

- Community Connected
- Coordinated Ancillary Services
- Collaborative Referral Relationships
- Comprehensive Care
- Hospital and Urgent Care
- Maternity Care
- Hospice Care
- Mental Health Care
- Services for All Stages of Life

Practice Management

- Disciplined Financial Management
- Change Management
- Optimized Office Design/Redesign
- Cost-Benefit Decision-Making
- Revenue Enhancement
- Optimized Coding & Billing
- Personnel
- Facilities Management

Quality and Safety

- Evidence-based Best Practices
- Patient Safety Focused
- Medication Management
- Patient Satisfaction Feedback
- Evidence-Based Outcomes Analysis
- Quality Improvement
- Risk Management
- Regulatory Compliance

Point of Care Services

- Acute/Chronic Care
- Disease Prevention and Management
- Wellness promotion
- Procedures

Team-Based Care

- Physician Leadership
- Inter-disciplinary Care Team
- Collaborative Staff Relationships
- "Just-Right" Staffing
- Effective Communication
- Front/Back Office Shared Vision

Critical Success Factors

- Today's Realities
- 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

- Practices need to provide what patients demand
- Practices need to be positioned to provide what payers are willing to pay for
- Practices need to be complete Medical Homes

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National Demonstration Project

- 8 M project funded from AAFP reserves
- 36 practice from around the country were selected
- Practices committed to implementation of as much of the full model as was realistic or feasible in their environment in a 24 month period
- 18 practices were aggressively facilitated, 18 were “self-directed”
- All practices studied equally and independently
- The facilitation component of the project ends May 31, 2008, the evaluation component ends December 31, 2008.

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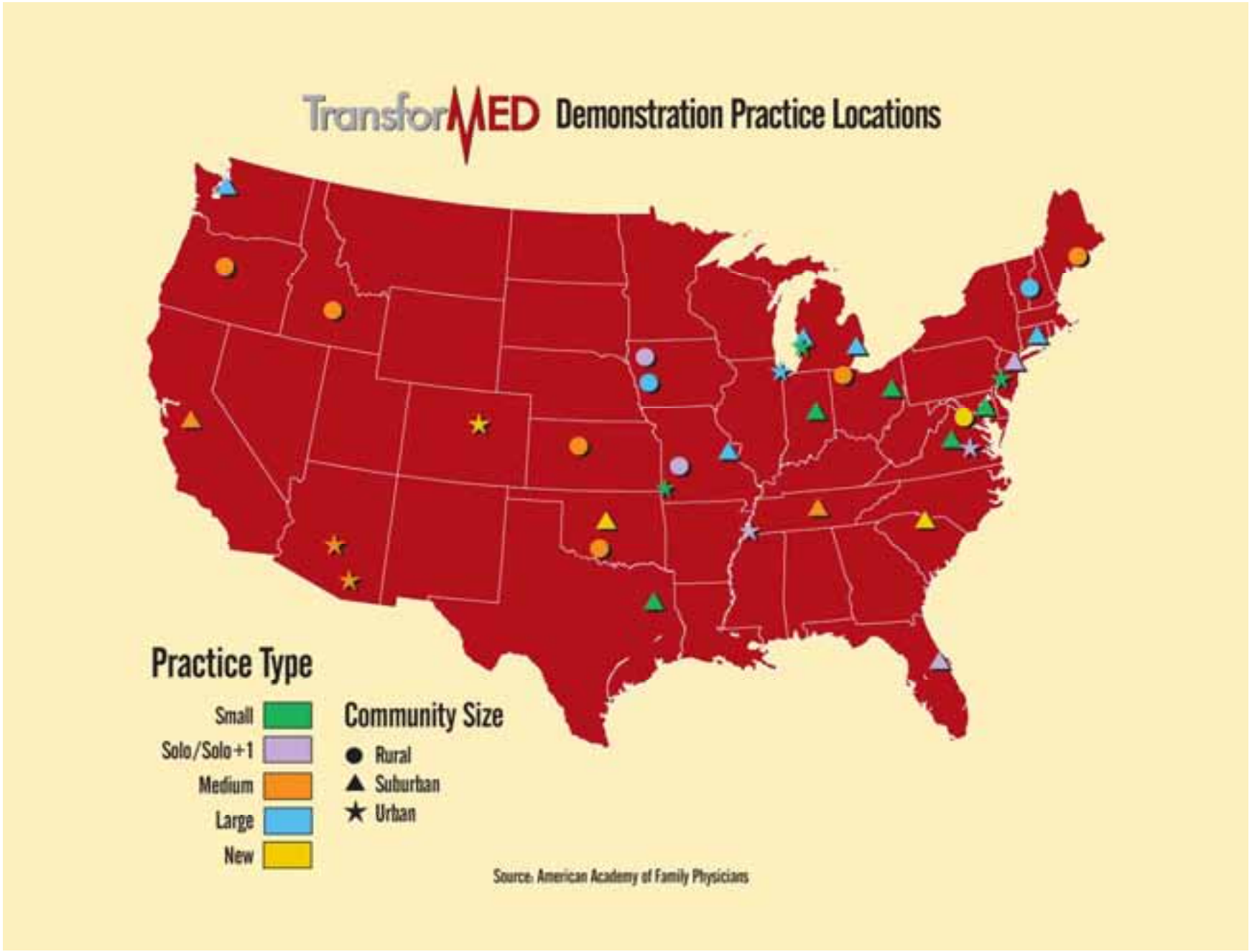

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P 4

- Preparing the Personal Physician for Practice
- Over 80 Residencies applied
- 2 collaborative meetings to date
- Research component by the University of Oregon

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P4—Preparing the Personal Physician for Practice

- Studying ways for residency programs to better educate Family Physicians
- Does not replace the need for FM residency out patient departments to become medical homes.
- FM residents must learn and practice in medical homes.

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Current Status of the NDP

- The 24 month project ends May 31, 2008
- The project will be completed at current budget projections with an approximate $900K contingency in reserve
- To date, one practice has implemented all of the components of the new model
- Final collaborative meeting will bring the facilitated and self directed practices together for the first time April 10 – April 14.
- Evaluation component of the project ends December, 2008

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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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What has been learned about the "Bottom Line"

- Thinking "inside the box"— typical business principles are lacking
- A primary care practice is not economically viable at 2.4 patients per hour (AAFP data)
- 3 patients per hour is the minimum and 4 creates economic stability
- Eliminating the operational inefficiencies in a practice translates into revenue
- Practicing good evidence based medicine generates revenue from more volume and Pay for Performance Programs
- Group visits are not a "cash cow" but can pay for themselves.
- Midlevel providers are poorly utilized in practices

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Thank You!

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