Patient-Centered Medical Home: Future of Diabetes Care?

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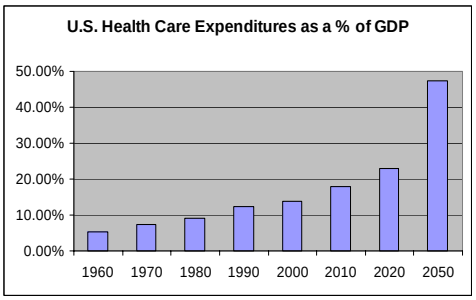
SWEDISH



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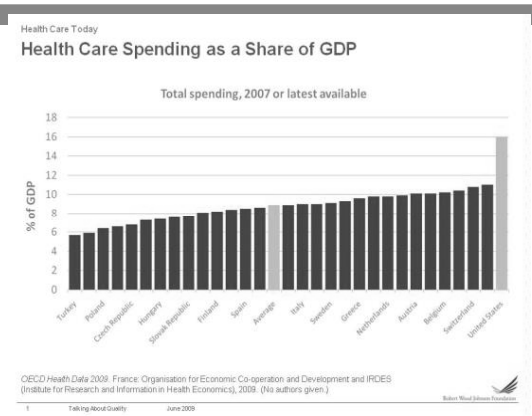

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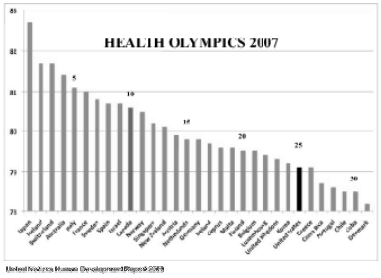
Where we rank



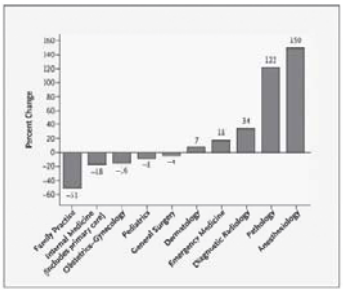
SWEDISH 4

Solution—shift care to the 'front end'

- A study of Medicare patients published in *Health Affairs* in March 2005 found that states with a higher proportion of primary care verses specialty physicians have lower mortality rates and a measurably higher quality of care for a lower cost.
- Data replicated worldwide-- the health status (and costs) of any community is directly correlated with the percentage of primary care providers in the region (Starfield, etc.)

SWEDISH 5

Change in specialty choice United States 1998-2008



SWEDISH 6

What explains this trend?

- **Income—median salaries for some specialties are 2-3 times that for primary care**
  - **Equates to millions of dollars over a career**
  - **Average US medical graduate debt: $150K**
- **Lifestyle—average office visit 15 minutes**
  - **Paperwork, administrative duties, etc**
  - **The dreaded 'treadmill'—the more patients you see in a day, the more money you make**
  - **PCPs must have some of their traditional work 'off-loaded'**

Primary Care Physician Shortage

- Estimated to reach >40,000 by 2020
- No strategy will meet this shortage soon
- We need to re-think the business model of healthcare delivery and financing

Reforming the payment system

- ***Fee for service reimbursement is incompatible with coordinated care/chronic disease management***
- ***New and innovative financing models must be developed to help us achieve the desired outcomes***

What are solutions?

- **Present position of family medicine in US is untenable in the next 10-20 years unless a 'new model' of care is implemented-AAFP, 2004**
- **The patient centered medical home model is based on the premise that the best health care is not episodic and illness-oriented. Rather, high quality care is patient-centered, physician-guided, on-going and cost-efficient. – *AAFP***

The Medical Home

- **It is not necessarily a 'place!'**
- **A vision/continuum; the foundation of coordinated, logical, prevention-based care**
- **Focuses on effective management of outpatient chronic disease**
- **Can appear and operate differently depending on the setting—virtually, electronically, telehealth, etc.**

What *IS* a Medical Home?

- Access and Communication –email and phone
- Patient Tracking and Registry Functions
- Care management; patient self management support
- Electronic Prescribing; EMR
- Test and referral tracking
- Performance Reporting and Improvement
- The foundation of an Accountable Care Organization
- *New financing models needed to support this*

Medical Home

- Effective chronic disease management
- Team approach-utilize MAs, RNs, ARNPs, PAs, etc.
- Encourage work at 'top of licensure'
- *Coordinated care* is key--with hospitals, specialists, pharmacy, nutritionists, behavioral health, community resources, etc

Swedish Community Health Medical Home

- **Opened in March 2009 at Swedish Ballard**
- **Incorporate all features of the patient-centered medical home—MyChart, etc.**
- **2 physician FTEs, 1 ARNP, 2 RN care coordinators, 6 family medicine residents**
- **30-60 minute standard visit; focus on coordination of care and prevention**
- **Recruiting tool for primary care post graduate education**

Payment Structure

- Primary care capitation-fixed fee per patient; financial incentives for quality
- Premera, Molina payers
- Self pay, and low income (no pay) populations

Drivers for Change--$$$

- Employers (purchase/pay for health care for >60% of US population) are clamoring for change to present system
- States, Medicare, and commercial insurance companies are all piloting new models
- Many show costs savings with decreased admissions and ER visits

Where do CDEs fit in?

- **Massive attention/resources will be put toward more cost effective (and clinically effective) diabetes care**
- **More care will be given in the community**
- **Electronic and phone 'touches' with patients will increase**
- **The need for CDEs to help cross train care managers in medical home models (usually RNs) will increase**

Emerging Trends Moving Forward

- Ambulatory ICU—RN case manager responsible for care of patients w/ complex (and costly) medical needs
- Emphasis on preventative health and wellness
- Consumer engagement will increase
- More care will be delivered/managed by nurses, and mid level practitioners (ARNPs, PAs)

Summary

- **The vision of the patient centered medical home will likely steadily grow over the next 5-10 years**
- **Patient education, engagement, and self management will be of paramount importance**
- **Increased funding, support, and education will be given to the role of care managers (RNs)**
- **CDEs will be at the center of this transformation**