PCMH: Next Steps for UMass Dept. of Family Medicine and Community Health

Spring Retreat

March 19, 2010

Ashland, MA

A PCMH provides

- Easy **access** to a PCP
- Who is working with a high-functioning **team**
- And a robust **IT** system
- To provide **comprehensive** care to
- **Activated** and **informed** patients and families.

Easy Access to a PCP

- Access
  - Open access scheduling
  - Customized communication
- Interactions
  - Family-centered
  - Personal attention
  - Relationship is key

High-Functioning Team

- Nurse
- Care Co-ordinator
- Social Worker
- Mental Health Provider
- Nutritionist
- Pharmacists

- (Plus learners: students, residents)

Robust IT System

- EMR/Electronic Prescribing
- Decision Support
- Relevant, up-to-date info available at point-of-care
- Tracks Data
  - Registry: Process and Outcomes
  - Satisfaction: Patients, Staff and PCPs

A PCMH is a practice that:

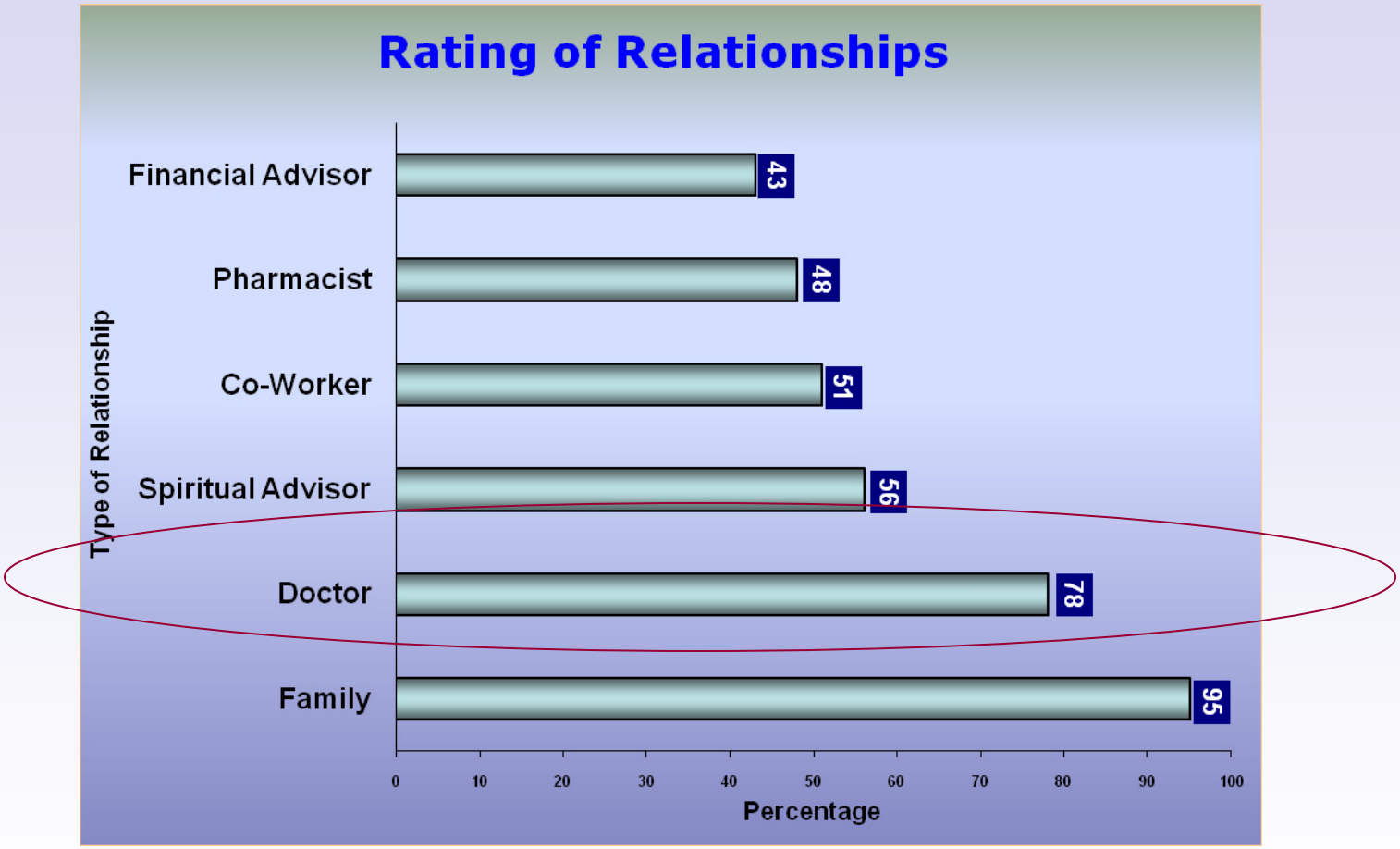
- Offers enhanced **access**
  - To a PCP who fosters a meaningful longitudinal relationship with patients/families.
- Applies the **Chronic Care Model**
  - Features proactive practice teams
  - Supports patient self-management
- Actively engages in continuous **QI**
  - Tracks/reports data to facilitate this
- Provides/coordinates **comprehensive** care

How Connected Are You to Your Primary Care Physician?

"Not surprisingly, those patients with the strongest relationships to specific primary care physicians were more likely to receive recommended tests, medication adherence and preventive care. In fact, this sense of connection with a single doctor had a greater influence on the kind of preventive care received than the patient's age, sex, race or ethnicity."

Atlas, SJ Grant RW, et al. Ann Int Med 2009 :150 :325-335

The Trusted Clinician Can be a Powerful Influence



Source: Magee, J., *Relationship Based health Care in the United States, United Kingdom, Canada, Germany, South Africa and Japan, 2003*

Gap Analysis

- Our current practices provide *some* PCMH elements – but none of us work in a true PCMH.
- How do we build a PCMH?
  - Must be an incremental process
- If you've seen one PCMH, …
  - Practices will choose to prioritize different elements
  - Pace of change influenced by resources committed to it – especially sense of urgency (or not)

Today's Exercise

- Imagine you are offered some additional resources earmarked for PCMH.
- Consider that the resources may be distributed into different "buckets:"
  - Clinical Practice
  - Education
  - Research
- ***The resources are finite!***

- What priorities would you establish?

Your Task

- Develop a proposal to promote PCMH through our department.
- Be specific:
  - Change what, for whom, by when?
  - How would you deploy resources?
  - What is your strategic plan or tactic?
- Consider the department's 5 Priority Areas:
  - Department organization and culture
  - Education --- Clinical Service
  - Community Health --- Research

Patient Centered Medical Home: Next Steps for the Department

Patient Engagement and Activation

University of Massachusetts Medical School

Family Medicine and Community Health

UMassMemorial HEALTH CARE

Two Cornerstones of PCMH

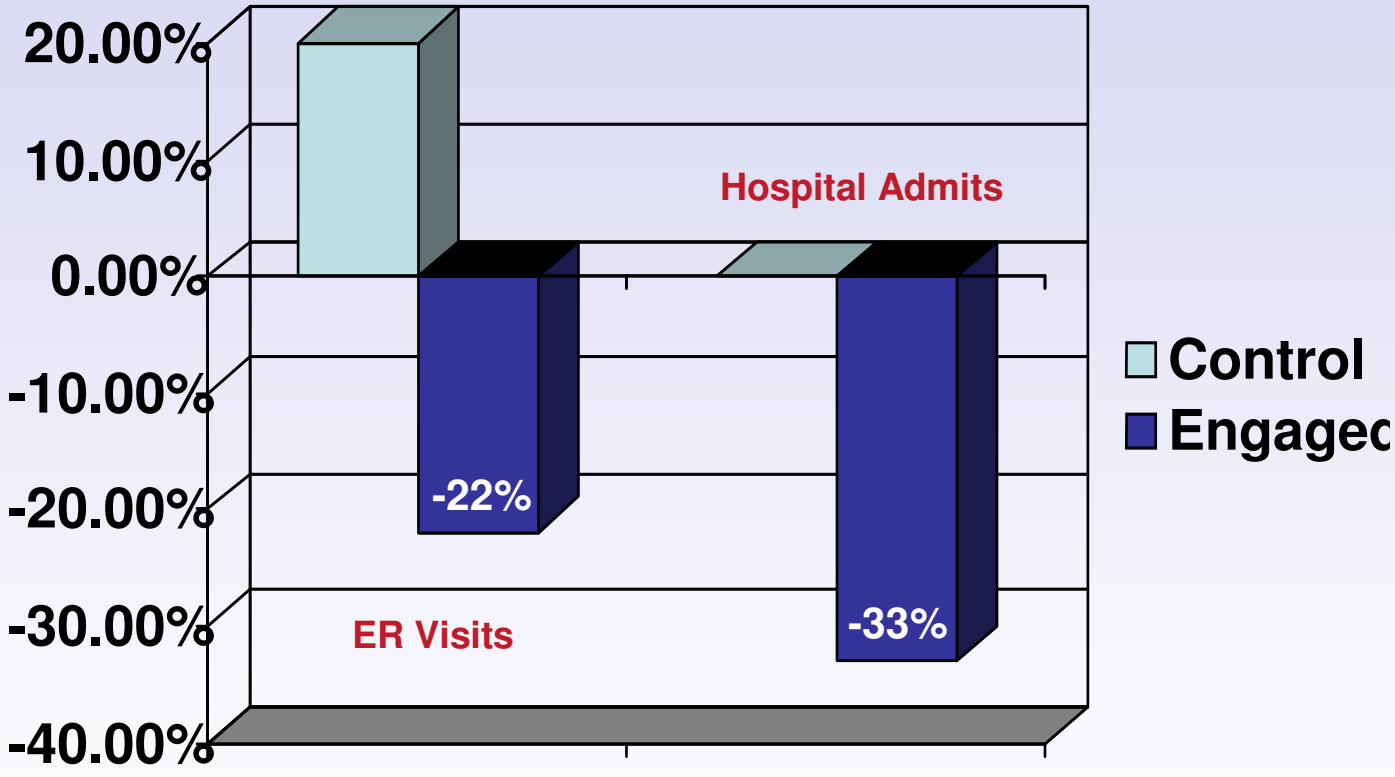
1. Patient-Centeredness (Engagement/Activation)
2. Quality Care (Improvement)

What is Patient Engagement?

Provides patients/families/caregivers with choice in all matters and possesses an ongoing focus on consumer service, with bi-directional feedback

- planning and related activities [goal setting] focused on a patient's specific circumstances, wishes and needs
- Self management

Why Patient Engagement?



Change over 6 month Period

Hibbard, et al

Am J Man Care, Jan, 2009

Patients who are most activated or engaged reported . . .

- 10 x greater patient satisfaction than those who are least engaged
- 5 times more likely to report high quality of life scores
- Significantly higher physical and mental functional status scores

Mosen, et al

J Amb Care Manage, Jan-Mar, 2007

Patients who are engaged . . .

Are more likely to make good decisions about their health

Hibbard, 2004
Lorig, 1999; Von Korff et al, 1997,1998

Use of Shared Decision- Making Aids Resulted in . . .

- More accurate perception of treatment benefits and harm
- Less uncertainty about the decision
- 25% reduction in preference-sensitive surgical treatments !!!!

O'Connor, 2001, Cochrane Reviews

Tactics for Engaging Patients

Goal Setting

Motivational Interviewing

Coaching for Activation

Patient-Centered Interviewing

Shared Decision-Making

Predictive Targeting

Tactics for Engaging Patients

Goal Setting	Elicit, list (chart) and Revisit
Motivational Interviewing	Document Confidence and Importance Rulers in chart
Coaching for Activation	Measure and Stage
Patient-Centered Interviewing	Review ‘chief concerns’ barriers to adherence
Shared Decision-Making	Provide written shared decision-making aids (and discuss)
Predictive targeting	Outreach messaging, coaching for high risk patients

CHCs asked to define goals and identify outcome measures for PCMH

59 goals/outcomes identified

48 (74%) define % DM pts w/Hba1c <7.0

32 (49%) chcs define % hypertensive pts w/ most recent bp<140/90

2 (2%) define pt experience (engagement) but don't yet have a measure

Web Resources

- Insigniahealth.com Patient Activation Measure (PAM) Coaching for Activation (CFA)
- Dartmouthatlas.org Shared decision-making and ‘supply-sensitive’ care
- Healthdialog.com Shared decision-making
- Decisionaid.ohri.ca Shared decision-making

Reliability in Health Care*

- McGlynn et al. studied 13,000 US adults.
- Identified 439 indicators of quality care for preventive care, 30 acute and chronic conditions.
- **Participants received only 54.9% of recommended care:**
  - Preventive: 54.9%
    - Mammograms, Paps, Flu vaccines, Smoking status
  - Acute: 53.5%
    - HIV screening for pt with STI, prohylactic Antibx for hip surgery
  - Chronic: 56.1%
    - ASA for TIA, Controller meds for asthma, Tx high LDL in CAD

*N Engl J Med 2003;348:2635-45.

Reliability in Health Care*

Similar findings among children:

- **Children received only 46.5 % of recommended care:**
  - Preventive 40.7 %
  - Acute: 67.6 %
  - Chronic: 53.4 %

*N Engl J Med 2007;357:1515-23

A Challenge to PCPs

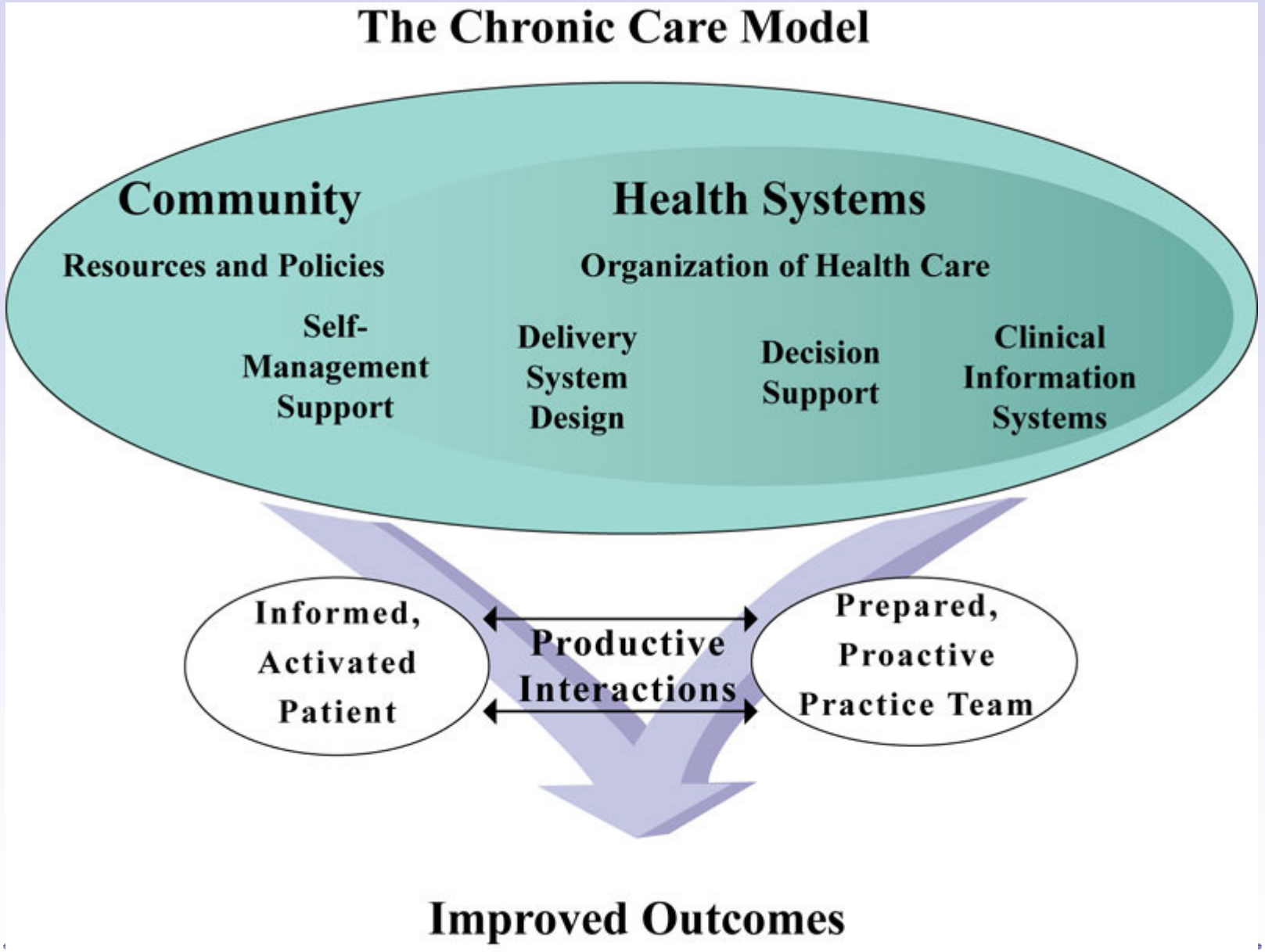
For a typical panel of 2500 patients:

- It takes 7.4 hours per working day to fully satisfy USPSTF recommendations[1].
- It takes 10.6 hours per working day to provide care for the top ten chronic diseases[2].
- Acute care?
- Sleep?
- A life outside of work?

1. ***Am J Public Health.*** **2003;93:635-41.**
2. ***Ann Fam Med*** **2005;3:209-214.**

Working Smarter, Not Harder

- Establish multi-disciplinary teams.
- All personnel working to the limits of their license and training.
- The patient as a resource:
  - The patient is the key “player”
  - Informed and activated patients may require less from the health care team


The Chronic Care Model
Community
Health Systems
Resources and Policies
Organization of Health Care
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Improved Outcomes