

Patient-Centered Medical Home: Future of Diabetes Care?

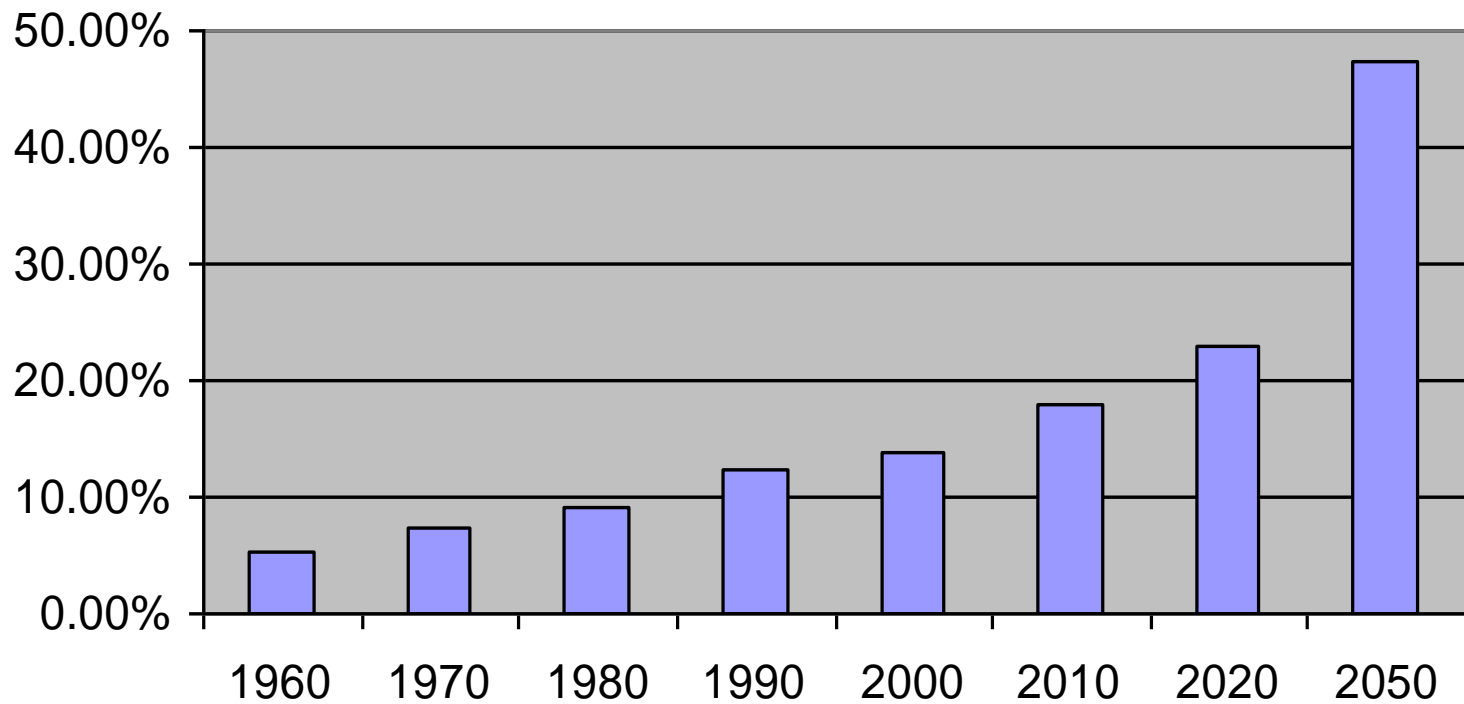
Jay Fathi MD

Medical Director

Primary Care and Community Health

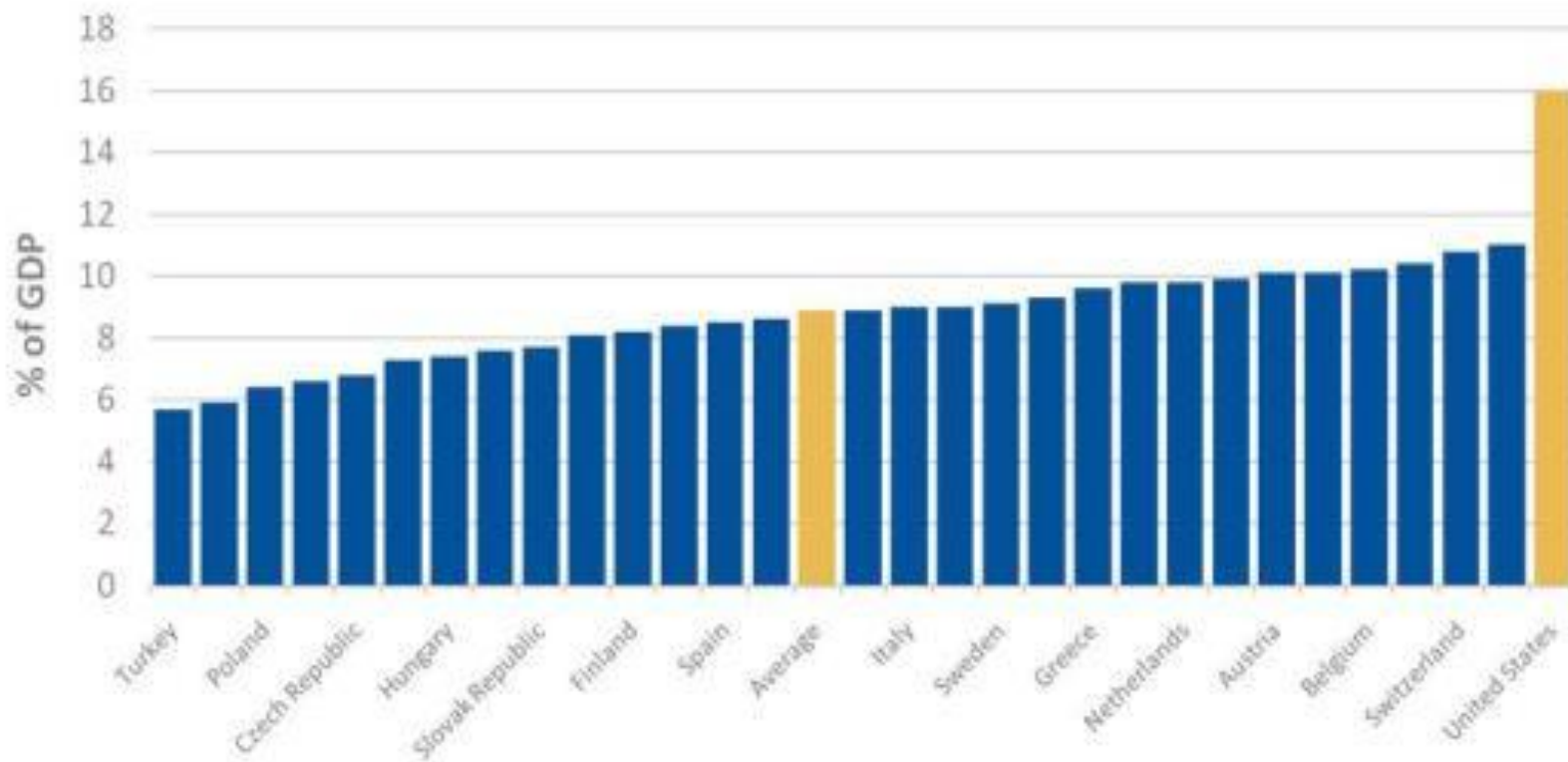
Swedish Health Services

U.S. Health Care Expenditures as a % of GDP



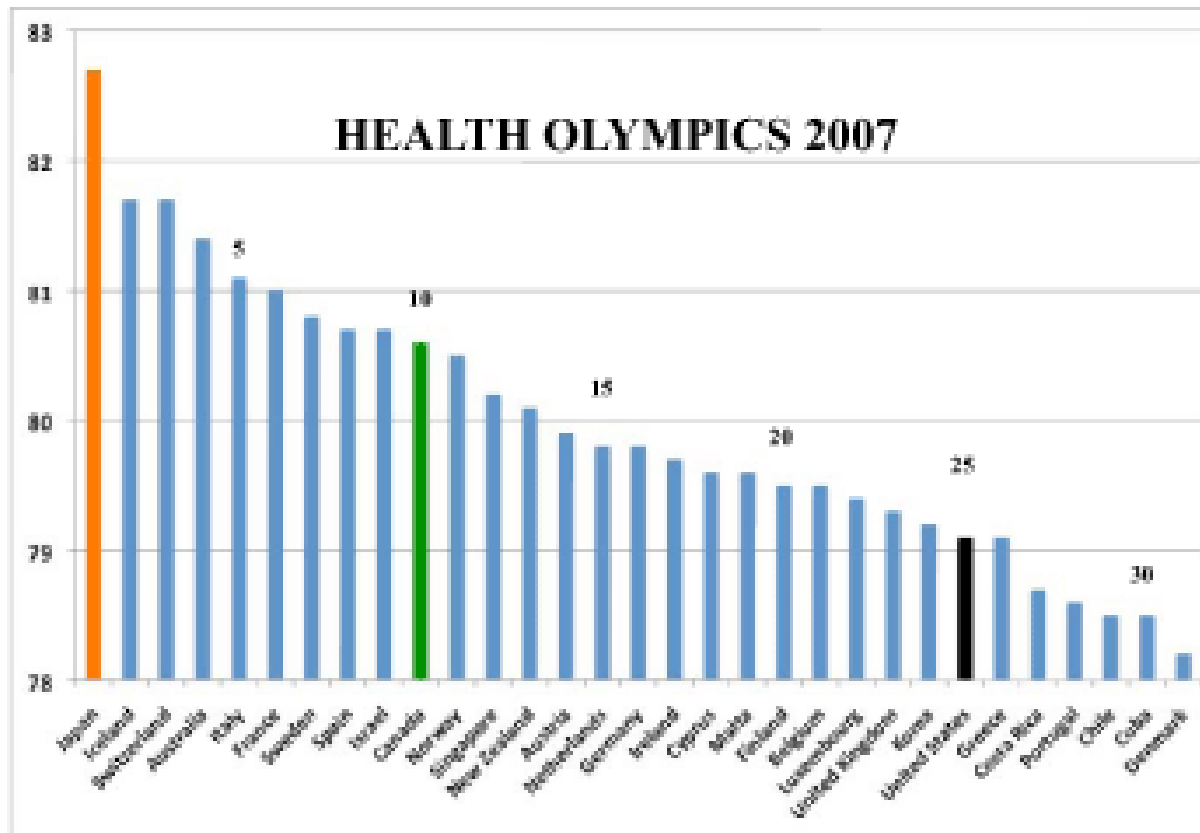
Health Care Spending as a Share of GDP

Total spending, 2007 or latest available



OECD Health Data 2009. France: Organisation for Economic Co-operation and Development and IRDES (Institute for Research and Information in Health Economics), 2009. (No authors given.)

Where we rank

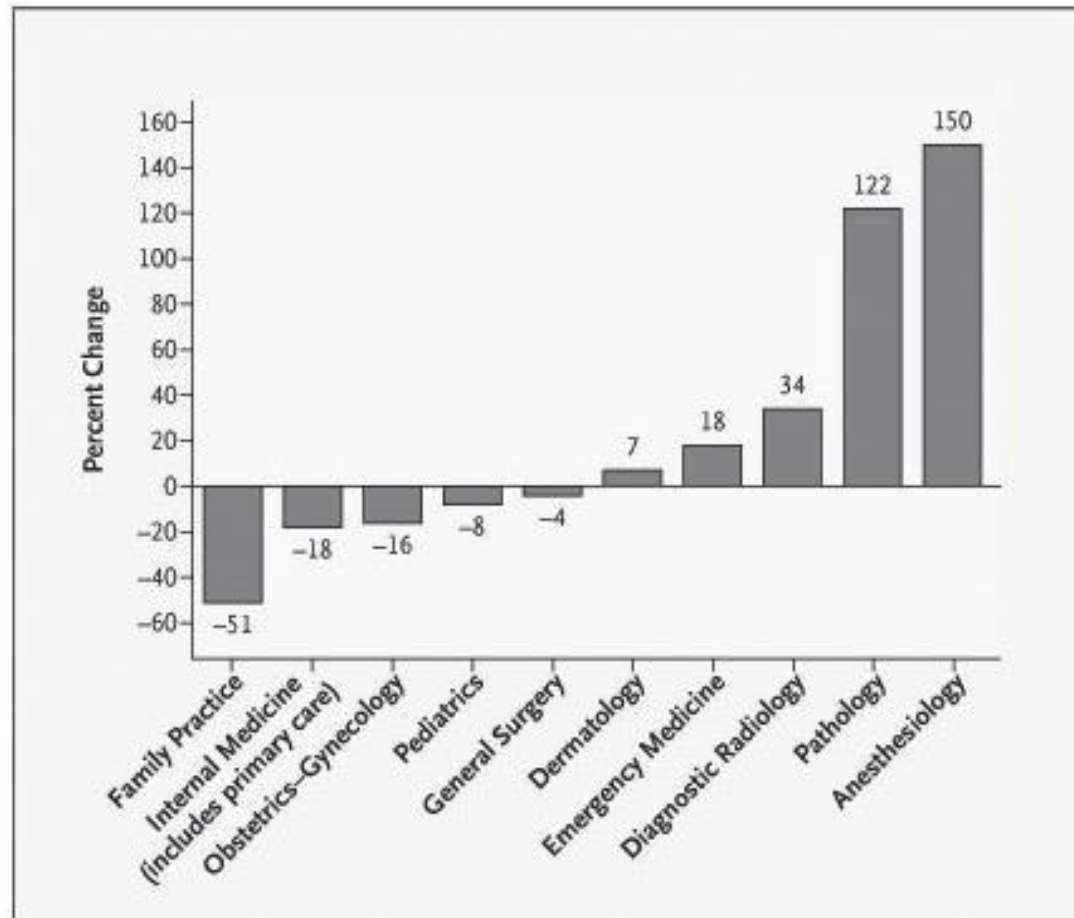


United Nations Human Development Report 2009

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 versus 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.)

Change in specialty choice United States 1998-2008



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**