• Discuss drivers of health care reform and patient care
• Define a Primary Care Medical Home
• Signature Care initiatives supporting PCMH
• What does a Primary Care Medical Home mean for you?
Health Care Reform and Patient Care

• Move to Quality Care
• Patients as Consumers
• Drive to Value Care
Elements of Quality at Duke

**Safe:**
Avoid injuries to patients from care that is intended to help them.

**Effective:**
Provide services based on scientific knowledge to all who could benefit, and refrain from providing services to those not likely to benefit.

**Timely:**
Reduce waits and sometimes harmful delays for both those who receive and those who give care.

**Efficient:**
Avoid waste, including waste of equipment, supplies, ideas and energy.

**Equitable:**
Provide care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

**Patient-Centered:**
Provide care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

Source: Institute of Medicine (IOM): *Crossing the Quality Chasm: A New Health System For the 21st Century* (March 2001)
Patient as Consumers

• Patients have more choices
• Patients have more responsibility
• The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey is a standardized tool to measure patients' perception of care provided by physicians in an office setting.
• More satisfied patients are more engaged in their healthcare and healthier
Value Care

• Value = Patient Quality/ Cost

• Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare

**Medicare Fee-for-Service**

**GOAL 1:**
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

30%

**GOAL 2:**
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

85%

**STAKEHOLDERS:**
Consumers | Businesses
Payers | Providers
State Partners

Set internal goals for HHS

Invite private sector payers to match or exceed HHS goals
Joint Commission and PCMH

- Principles developed and endorsed in 2007
- Introduced in 2011 for accredited ambulatory care organizations
- Consistent with health care reform efforts to improve patient care and outcomes
- Focuses on educating the patient and encouraging self management the patient
- Provides a framework of care to improve access, outcomes and coordination of care
- Not a place but a model of care
PCMH core functions

- Patient centered care
- Comprehensive care
- Coordinated care
- Superb access to care
- Systems based approach to quality and safety
Patient Centered Care

• Relationship-based care focuses on the whole person
• Understanding and respecting each patient’s needs, culture, values and preferences.
• Supports patient learning to manage and organize care at the level the patient chooses
Patient Centered Care

- Duke My Chart
- Learning Assessment
- Health Literacy Assessment
- Lifestyle goal setting
Comprehensive Care

• Accountable for meeting the majority of a patient's physical and mental health care needs, including prevention and wellness, acute care and chronic care.

• Teams, either in practice or as a virtual team may include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, mental health workers, social workers and others work to meet each patient's
Comprehensive Care

- Registered nurses
- Nutrition counselor
- Exercise physiologist
- Health psychologist
- Signature Care Newsletter

- Psychiatry access*
- Dental resources*
Coordinated Care

• Care is coordinated across all elements of the broader health care system, including specialty care, hospitals, home care and the provision of community and support services.

• Emphasis during transitions between sites of care, such as when patients are discharged from the hospital.
Coordinated Care

• Nurse Triage
• Front desk handing/scheduling of consultation
• Internal and external referrals
• Electronic communication and follow up with consultants through Maestro InBasket and MyChart
Access to Care

- Patients have access to services with shorter waiting times for urgent needs, enhanced in-person hours, around the clock telephone or electronic access to members of the care team, and alternative methods of communication
Access to Care

• 24/7 access to Duke Signature Care
• Duke MyChart messaging
• Covering answering service
• Direct physician contact
• Telemedicine pilot
Systems based approach to quality and safety

• Use of evidence-based medicine and clinical decision support tools

• Engagement in performance measurement and improvement, measures and responds to patient experiences and satisfaction, practices population health management, and publicly shares robust quality and safety data and improvement activities.
System based approach

- Electronic measure capture and reporting
- Organizational safety reporting
- Clinic specific quality improvement projects
Impact on patient safety and quality care

Aggregated Outcomes from the 30 Studies

21 of 23 studies that reported on cost measures found reductions in one or more measures; two found cost increases

23 of 25 studies that reported on utilization measures

30 total studies

- 17 peer-reviewed studies
- 4 state government evaluations
- 6 industry reports
- 3 independent evaluations of federal initiatives

The Patient-Centered Medical Home’s Impact on Cost and Quality


Published February 2016

Authors:
- Marc Nielsen, PhD, MPH
- Elisabeth Buehl, MPH
- Katrina Peltz, MD, MS
- Len M. Nichols, PhD, MS, MA

Made possible with support from the Milbank Memorial Fund
Impact on patient safety and quality care

• Collectively, studies find greater impacts of PCMH interventions on chronically ill populations (in both public and private settings)

• There is a large variation in the ways in which PCMH is being implemented such as differences in:
  – Team composition
  – Populations
  – Payment models

• There is a dose-response element to PCMH – the longer the initiative is implemented, the more impressive the results
How does this change our relationship?

• We continue to strive to provide individual care in a unhurried manner

• PCMH will act as a framework for improved and expanded care and services in a patient centered care manner