Cheyenne Regional

Wyoming Institute of Population Health

Building Bridges Between Health Care Delivery Systems, Patients and Communities

PCMH 101 and Telehealth Implications

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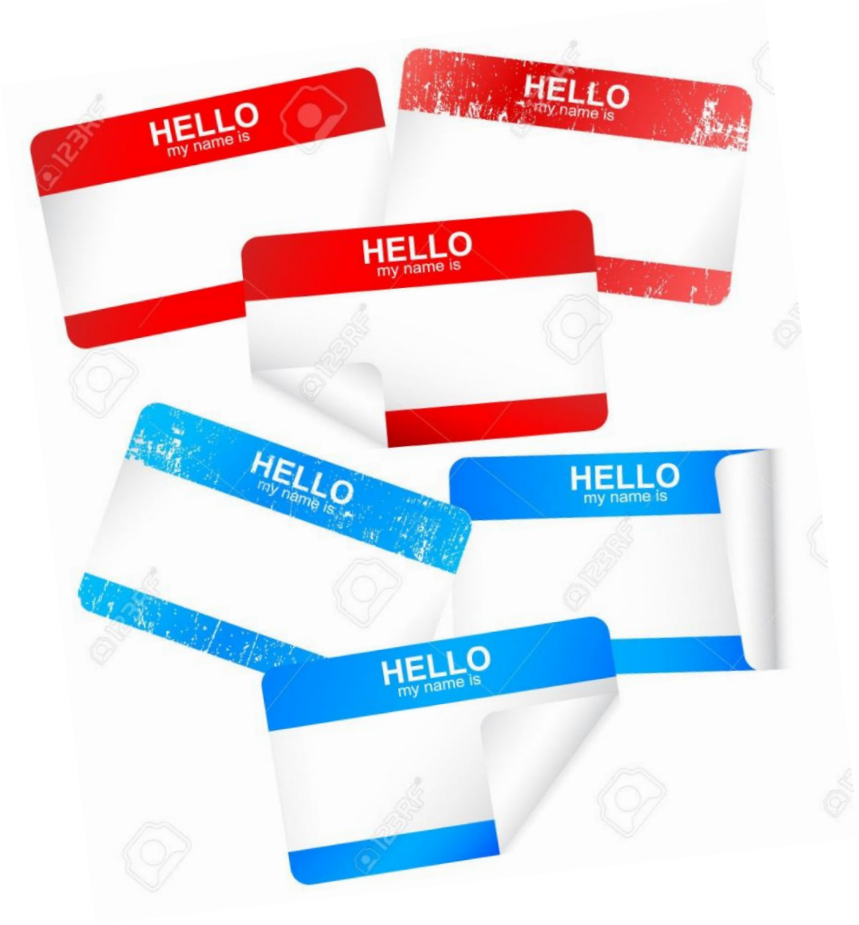
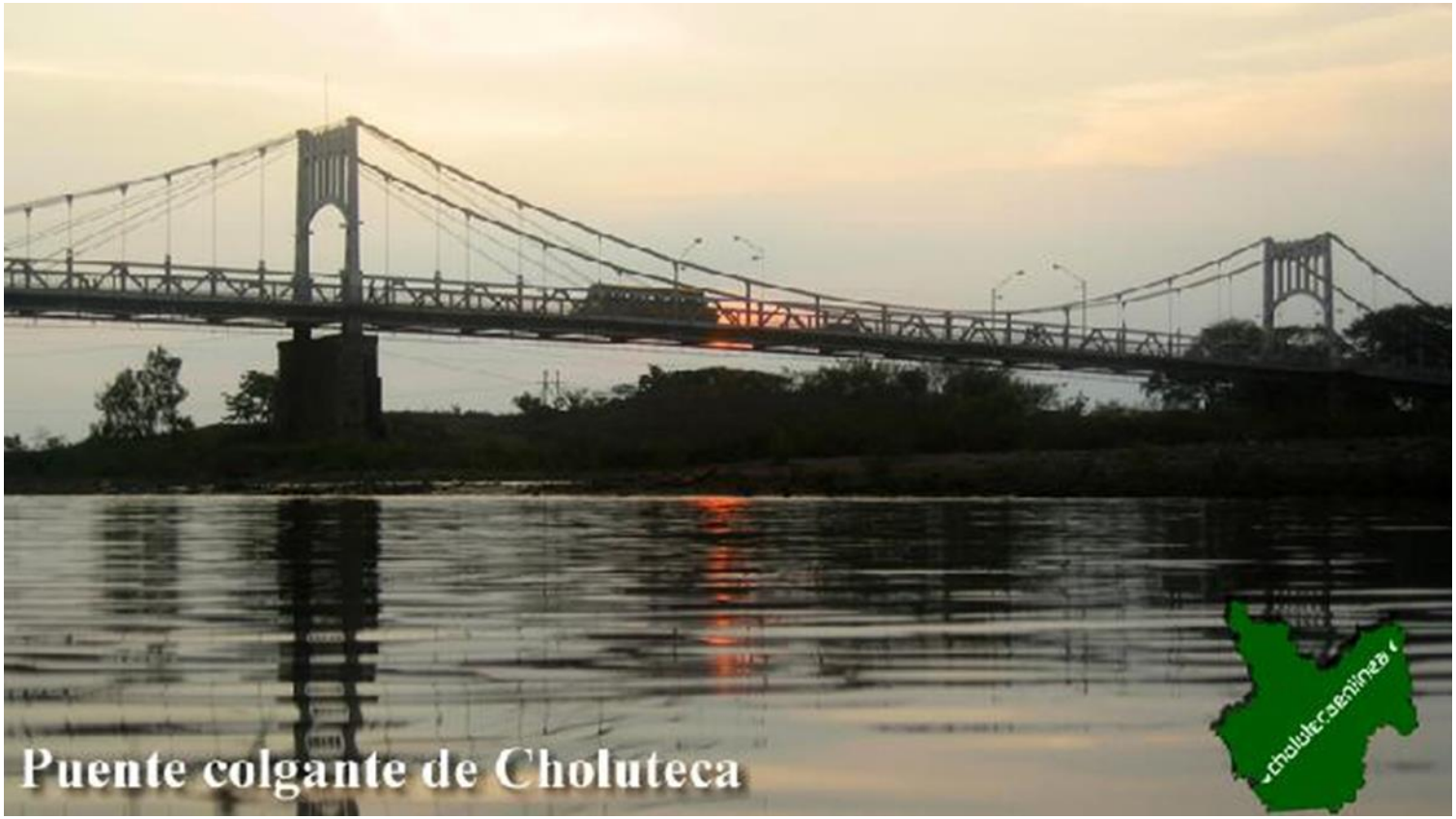
Our Passion
Inspiring and creating models that change the future of health care.

Introduction

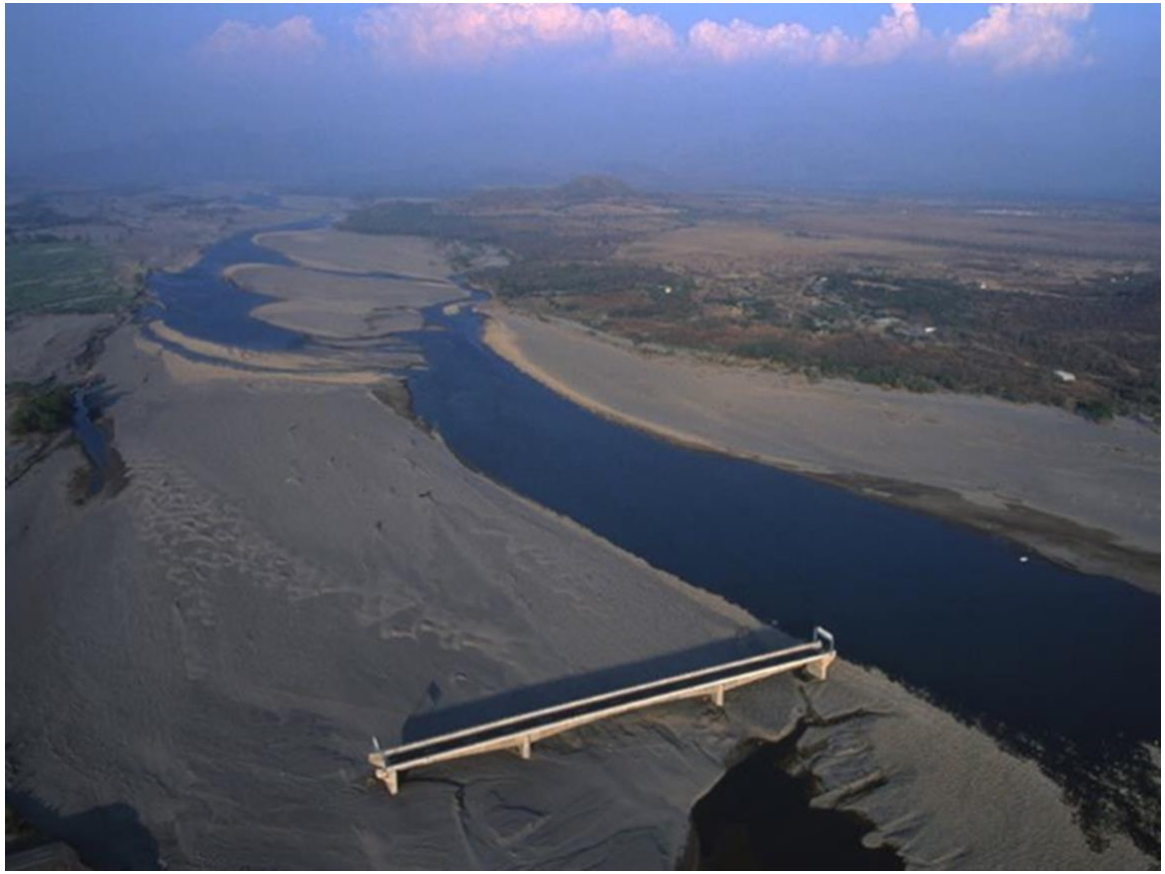


Healthcare is an Ever Changing Industry

Choluteca Bridge in Honduras…



…Now the Bridge to Nowhere



The River isn't Moving, it has Moved

- Getting on board before you get behind
  - Accountable Care Act
  - Alternative Payer Models
  - Meaningful Use
  - Physician Quality Reporting System (PQRS)
  - MACRA
  - National Committee on Quality Assurance (NCQA)

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Health Care was Designed for a Different River

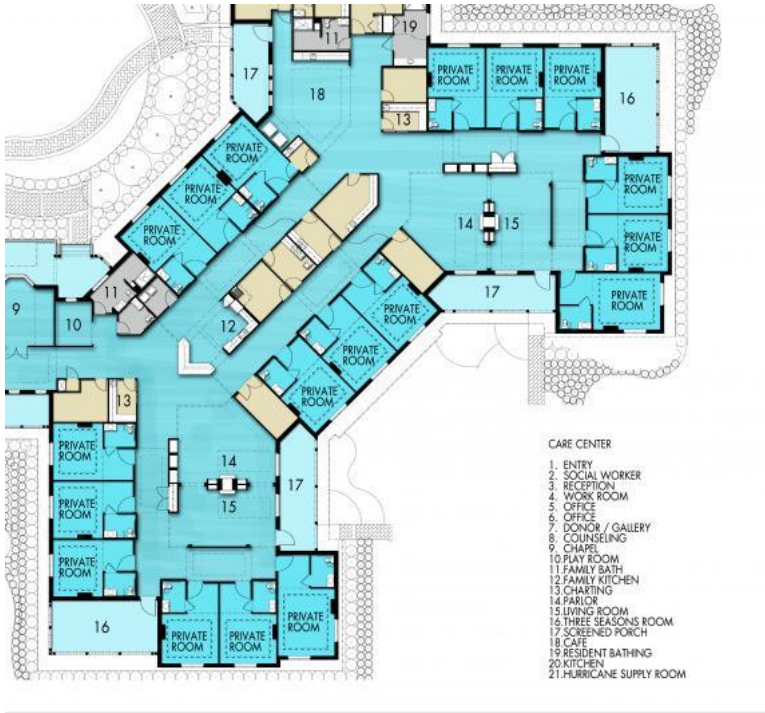
Fee-for-service

- Objective is volume driven
- Care is reactive, and acute patient needs
- Care coordination is not efficient
- Care management is not a priority

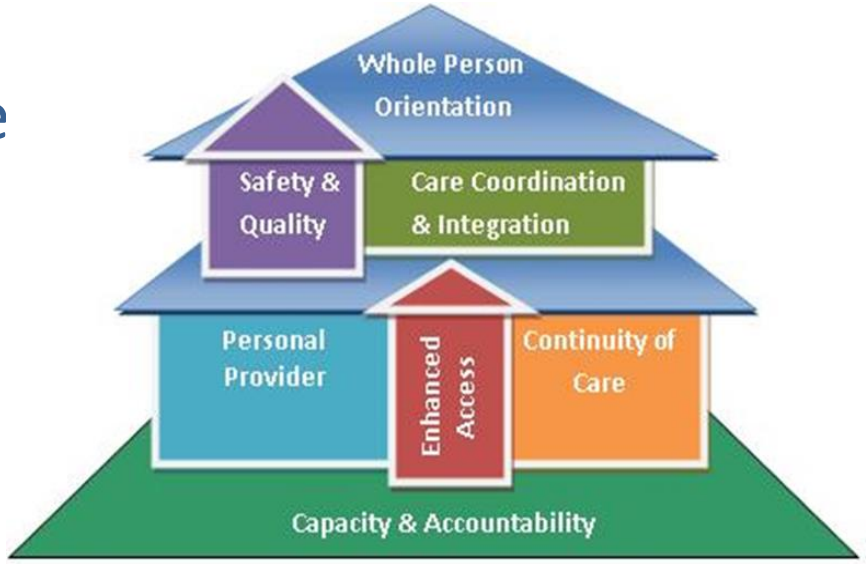
Pay for Performance

- Objectives is outcome driven
- Care is proactive, and total patients needs
- Coordination of care is delivered
- Care management is expected

Why PCMH Redesign?



- Joint Principals of the PCMH
  - PCMH is an approach to providing comprehensive primary care for all ages
  - PCMH is a health care setting that facilitates partnerships between individual patients, and the personal physicians



Principals

- Personal Provider
- Provider directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Payment

Evidence based care model – *it's the right thing to do*

- Focused on preventative care
- Reduction in ED use and re-hospitalization
- Increased health of patient panels
- Patient, employee, provider satisfaction and engagement
- Advanced access to care

Right *Care*, Right *Place*, at the Right *Time*

- Emergency Department (ED)
  - An emergency is when a condition arises that you deem severe, oftentimes a life or death situation. Good examples are heart attack symptoms, stroke or a compound fracture — a bone break that protrudes through the skin.
  - The ED is set up with the resources needed to effectively diagnose and treat life or death situations.
  - Role of a PCMH is to follow up after an ED visit

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- Urgent Care (UC)
  - UCs clinics can be thought of a as middle ground between the patient and their PCP.
  - Patients should utilize UCs when they feel their ailment cannot wait until the next day, and cannot get into their regular PCP for treatment.
  - UCs should not be used for primary care, or for follow up from an ED or hospital encounter.

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- Primary Care Clinic
  - Primary care providers (PCPs) is who patients should call to schedule checkups and other non-urgent medical appointments.
  - PCPs should be the link to specialty care, and refer patients to where they feel the best care will be given to meet the individual patient's need (care management/coordination)
  - Remember that primary care providers know the patient's medical history, what medications they are on, and provide continuity of care for the entire family.
  - Not all Primary Care clinics are Medical Homes…

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Primary Care Clinic v.s. *PCMH*

- It's not a Place…It's a partnership with your primary care provider.
  - PCMH puts *the patient* at the center of their care, working with the *health care team* to create a personalized plan for reaching their goals.
  - The *primary care team* is focused on getting to know the patient and earning their trust. They care about the *whole patients health*.

Medical Neighborhoods and PCMH Navigation

- Medical Neighborhood
  - Specialists (i.e. Cardiology, Endocrinology)
  - Non-Physician Specialty care (i.e. Podiatry, Dentistry)
  - Educational Resources (i.e. Diabetes Education, Nutrition)
  - Social Support (i.e. Food Banks, Housing)

PCMHs are the drivers within the medical neighborhood

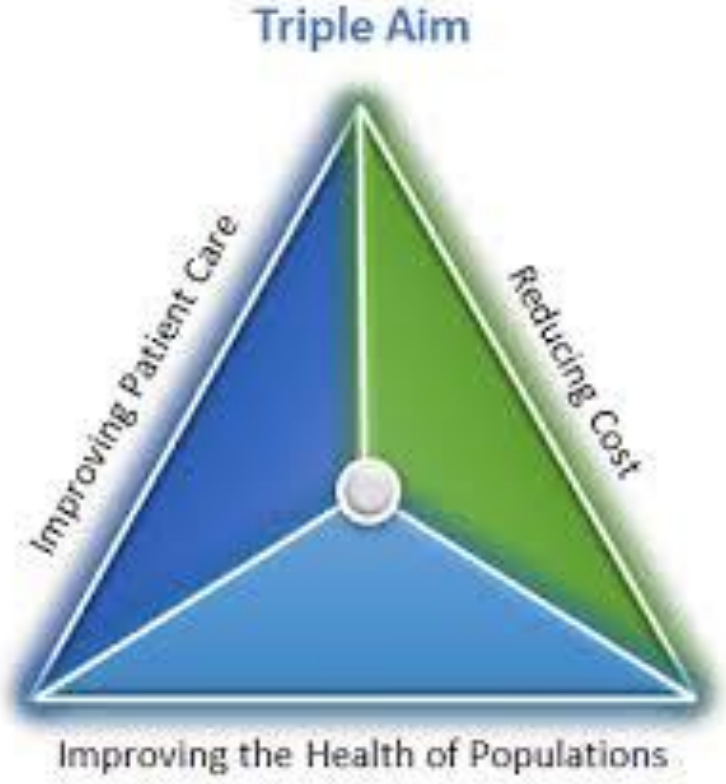
- Facilitate care agreements with specialists to increase communication
- Assists patients to find the most appropriate care outside the Medical Home
- Follow up on referrals to complete the loop
- Increased continuity for patients and care teams

Alternative Payer Models

- Medicaid
  - Per Member Per Month (PMPM) PCMH Program
- Medicare
  - Chronic Condition Management (CCM)
  - Transitions of Care Management (TCM)
- Private Payers
  - Starting to adopt similar models

Methodologies Behind PCMH

- Triple Aim
  - PCMH is a stepping stone to improve health care by focusing on the Triple Aim.



The Triple Aim can be achieved by…

- Care coordination
- Care management
- Team based care
- Preventative care
- Health IT
- Relationships

Adapting to the Medical Home Evolution Through Technology

- Consumer Driven Health Care
  - Access to Care
  - Alternative Encounters
  - Price Transparency

Role of Telehealth in the PCMH Standards

- Patient Centered Access and Continuity (AC)
  - AC 06: Alternative Appointments: Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms.

Access to Care

- Reduction In ED Utilization
- Reduced Readmissions
- Increased Outcomes
- Patient Satisfaction
- Reduction in Cost

Alternative Encounters – Virtual Visits

- Connectivity
  - Smart Phone, tablet, computer encounters
- Convenience
  - Virtual visits drive patients to away from box store medicine
- Availability
  - Virtual visits provide care in rural locations
  - Specialty Outreach

Price Transparency

- Patients Shopping for Health Care
- Lower Operational Costs
- Affordable Delivery of Care

Growing Pains

- Adapting to the New Delivery Mode
  - Providers
  - Patients
- Comfort and Experience
- Compliance
- Rural Connectivity

Does it pass the Triple Aim test?

- Does it improve the health of the population?
- Does it increase experience and outcomes?
- Does it reduce the cost of care?

YES!

Questions?