Welcome to the sixth module

in the

New Business of Medicine Series,

From Good to Great: Moving from Disease Management to Improved Care for Your Entire Practice

Which measurements of patient experience are good indicators of quality of care?

A. Time spent waiting while at the visit
B. Ease of making an appointment
C. PCP understanding of patient’s barriers to care
D. PCP understanding of patient’s emotional issues
E. All of the above
F. None of the above
Which of the following is NOT evidence for the effectiveness of primary care?

A. Reduced all-cause mortality and mortality caused by cardiovascular and pulmonary diseases
B. Less use of emergency departments and hospitals
C. Better preventive care
D. More testing and lower patient satisfaction
E. Better detection of breast cancer, and reduced incidence and mortality caused by colon and cervical cancer
F. All of the above

Good collaborative care with patients embodies:

A. Relationship over time
B. Comprehensive scope of services
C. Coordination of care
D. Bridging the clinician/patient divide
E. All of the above
Which of the following is a FALSE statement about comprehensive primary care?

A. Eliminates barriers to care  
B. Reduces the work load of personal physicians  
C. Enables and enhances self management  
D. Provides a broad array of services  
E. Coordinates care across a continuum

What is the definition of disease management?

A. A system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.  
B. It refers to the work of health care professionals who act as a first point of consultation for all patients.  
C. A system for financial incentive for eligible healthcare professionals to participate in a voluntary quality reporting program.
Which of the following is NOT a benefit of effective comprehensive primary care to patients and practices?

A. Patients report less problems with their medications
B. Reduced preventative care maintenance
C. Improved patient follow through on recommendations
D. Improved access to care
E. All of the above

Which of the following are barriers to effective comprehensive primary care introduced by the current fee for service payment model?

A. Clinically appropriate telephone, email and virtual visits are not rewarded.
B. Change management to enable improved technology solutions is not compensated.
C. Some physicians have asked patients to pay out of pocket for the time and services required to deliver more comprehensive primary care.
D. All of the above
Module 6

From good to great: moving from disease management to improved care for your entire practice

Objectives

• Explain the differences between disease management and effective primary care
• Describe the core components of effective primary care
• Review the potential benefits to patients and practice derived from improving effectiveness at the level of delivery of primary care
• Address the barriers inherent in our current payment system
Importance of Primary Care

More than two decades of accumulated evidence reveals that having a primary care-based health system matters:

- **Evidence of Effectiveness**
  - Reduced all-cause mortality and mortality caused by cardiovascular and pulmonary diseases
  - Less use of emergency departments and hospitals
  - Better preventive care
  - Better detection of breast cancer, and reduced incidence and mortality caused by colon and cervical cancer

- **Evidence of Efficiency**
  - Fewer tests, higher patient satisfaction, less medication use, and lower care-related costs

- **Evidence of Equity**
  - Reduced health disparities, particularly for areas with the highest income inequality, including improved vision, more complete immunization, better blood pressure control, and better oral health

Phillips RL, Starfield B. Why Does a U.S. Primary Care Physician Workforce Crisis Matter? Am Fam Physician Volume 70(3) 1 August 2004 pp 440-446

Comprehensive Primary Care

- First point of contact
- Relationship over time
- Comprehensive scope of services
- Coordination of care
- Eliminate barriers to care
- Enable and enhance self-management
- Provide a broad array of services
- Coordinate care across the continuum

World Health Organization 1978 Alma Ata Conference
Milstein A, Gilbertson E. American Medical Home Runs: Four real-life examples of primary care practices that show a better way to substantial savings. Health Affairs 2009;28(5):1317–26
Key Attributes of Comprehensive Primary Care

- Continuity
  - Poor continuity predicts increased hospitalizations
- Access
  - Poor experience of access or wasted time in the office predict “no show”
- Relationship building through Efficiency, Information and Confident Self-Care
  - Poor relationship predicts lack of follow up with preventive recommendations and chronic disease management


Good Collaborative Care Shows Results

<table>
<thead>
<tr>
<th>Past treatment has made:</th>
<th>Good collaborative care</th>
<th>Poor collaborative care</th>
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<tbody>
<tr>
<td>pain much better</td>
<td>34.7%</td>
<td>9.6%</td>
</tr>
<tr>
<td>emotional problems much better</td>
<td>34.8%</td>
<td>12.5%</td>
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<tr>
<td>Pts with HTN, CAD, DM report their systolic BP&lt;140</td>
<td>74.8%</td>
<td>64.6%</td>
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<td>Reports of problems from their medications</td>
<td>6.6%</td>
<td>20.1%</td>
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<td>Spent at least one day at home because of illness in past 3 months</td>
<td>26.9%</td>
<td>31.6%</td>
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<tr>
<td>Physical or emotional problems limiting capacity to work in past 2 weeks</td>
<td>18.0%</td>
<td>33.4%</td>
</tr>
<tr>
<td>Hospitalized in past year with common chronic diseases</td>
<td>12.3%</td>
<td>14.2%</td>
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Exactly the care...

Need Both

- Clinical information
  System: registries

- Patient experience measures,
  SMS tools

Healthcare system: What is the Matter?

Patients: What Matters to Me?

Clinician Patient Divide

Necessary Ingredients for Effective Care

- Room to breathe
- A method for improvement
- Ideas that work
- Ongoing feedback on performance
- Supportive technology
Patient Experience Measurement

- To obtain a true view of the quality of your practice, you must measure the patient’s experience.
- Measuring the patient’s experience with your practice (e.g., ease of getting an appointment, connection with a PCP and time spent waiting while at the visit) offers powerful information regarding real or perceived barriers to care, which ultimately affect quality of care.
- Inquiring about the characteristics that increase patients’ likelihood of declining health and measuring patients’ responses can offer valuable insight into a practice and create the opportunity to reform delivery of care in response to meaningful information.

Guinn, N. Moore LG. Practice Measurement; a new approach for demonstrating the worth of your work. Family Practice Management February 2008, pp. 19-22

Practice Improvement Techniques

- Eliminate barriers to access
- Eliminate wasted time
- Create a reminder system
- Adopt a reliable approach to unmasking patient needs and segmentation
- Adopt a patient engagement strategy
- Embed it all in the workflow
Outcomes example using HIT Enhanced PCCC

- % Having a PCP: 97.47
- % Having Perfect Care: 77.22
- % Having Very Easy Access: 72.15
- % Having Confidence in self-management: 69.23
- % Seldom Wasted Time: 97.44
- % Get Exact Care Needed: 67.95
Payment Policy and Practice

- Payment policies predict behavior
  - When revenue = 'office visits' we encourage office visits and suppress other modes of communication
  - When revenue = specific identifiable behaviors we will see more of that behavior over time
- All systems can be gamed
- Do we have the best system of payment or should we explore other systems?

Summary: Going from Good to Great

- Understand the difference between disease management and effective primary care
- Good collaborative care with patients embodies
  - Relationship over time
  - Comprehensive scope of services
  - Coordination of care
  - Bridging the clinician | patient divide
- Technology applications facilitate efficient collaborative care
- Simple pilot programs with technology result in better outcomes than trying to design the ultimate program
- Build a solution to scale to the size of your practice
Patient Centered Care References

- Sevin C, Moore LG, Shepherd J, Jacobs T, Hupke C. *Transforming Care Teams to Provide the Best Possible Patient-Centered, Collaborative Care*. Journal of Ambulatory Care Management Jan-March 2009:32;1 pp 22-30

Additional References

Additional References

- www.HowsYourHealth.org
- www.IdealMedicalHome.org
- www.IMPCenter.org
- www.IHI.org