The medical home is really about creating relationships with our patients through planned outreach and relationship building. The physician and the team are seen as the "owners" of the patient health care.

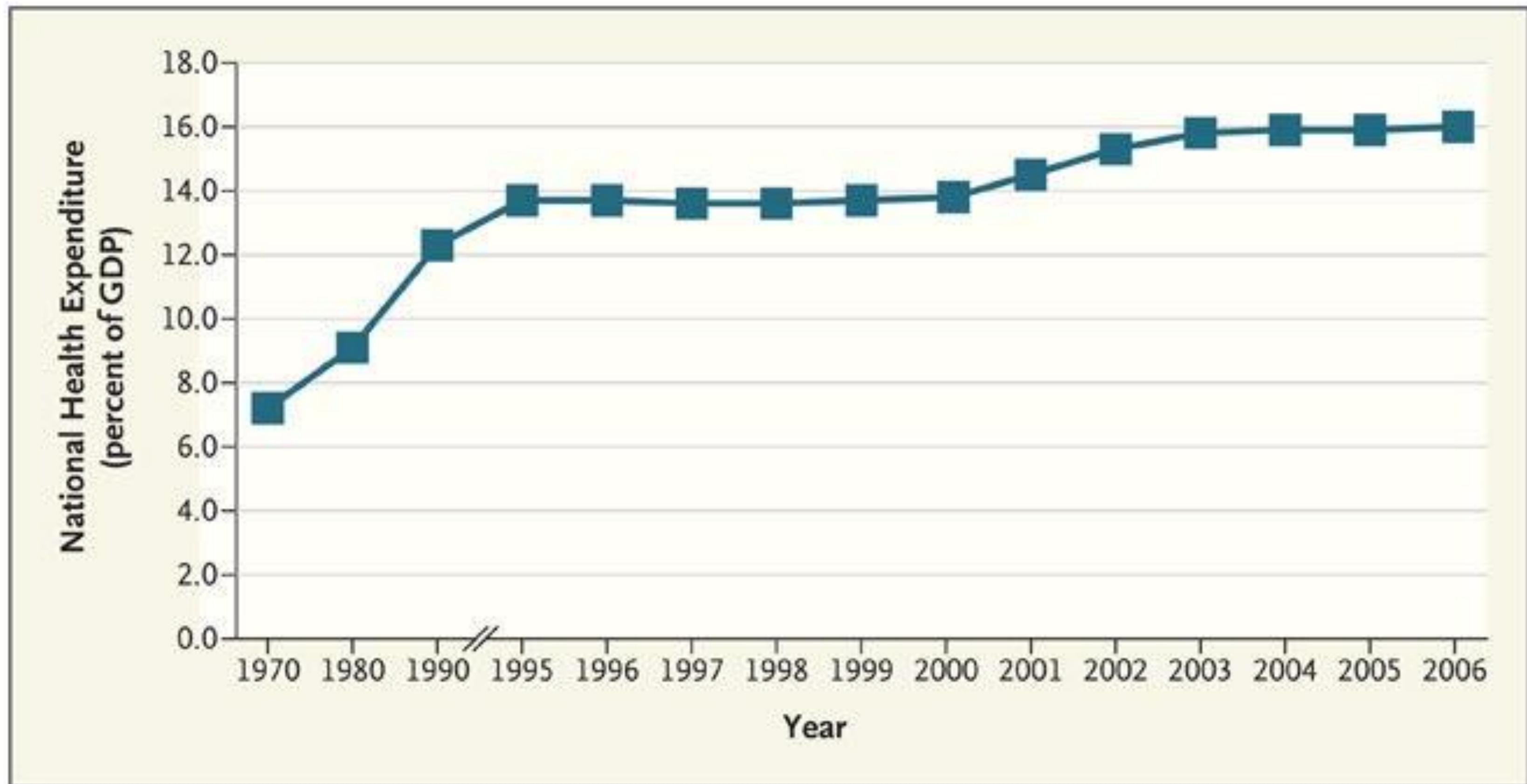
Design Principle

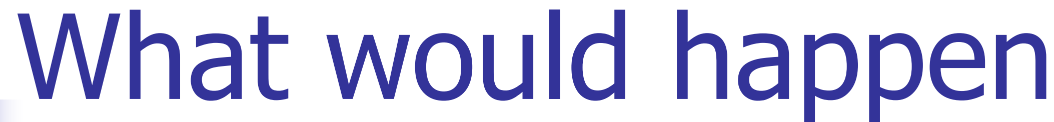
- The relationship between physician and patient is the primary relationship and all aspects of the delivery system will align to promote and sustain this primary relationship
- Care is patient centric

Why do we need a Medical Home?

- In U.S. medical costs soaring
- For that $$$ we are still getting care that is episodic, poorly coordinated
- Despite the highest monetary output per patient we rank poorly in outcomes

Costs as function of GDP





- If we replaced our "come and get it model" which hasn't resulted in good outcomes with organized proactive care?

5 Chronic Diseases drive costs

- CAD
- COPD
- Diabetes
- Depression
- Asthma

Medical Home

- Care on a continuous care platform not episodic
- Leverage I.T./internet
- Care “proactive” not “reactive”
- Patients become activated with Self

Management tools

Characteristics of the New Model

- Patient-centered approach
- Elimination of barriers to access
- Electronic Medical Record
- Redesign of a more patient centered office with the Team
- Focus on quality and outcomes

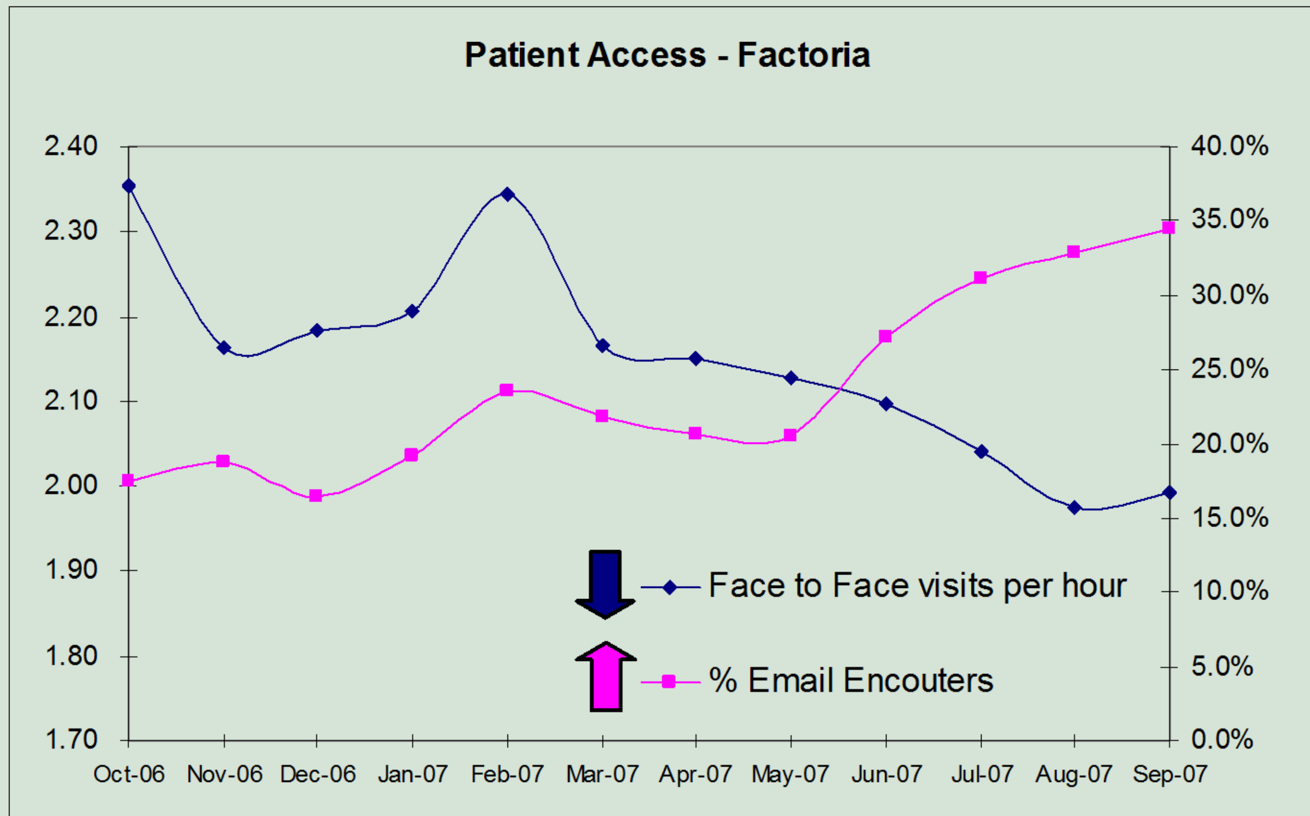
How might that look practically

- 1. Reduced panel counts from 2300 raw to 1800 raw
- 2. Longer appointment times: 30 min. to do the Chronic care work
- 3. Build a team: PA,MD, RN/LPN, team Pharmacist
- 4. Leverage the tools we have EMR; e mail communication directly; Phone interaction
- 5. Strategic proactive care for Chronic illnesses
- 6. Strategic “outreach” for quality
- 7. Strategic “outreach” following E.D. visits/hospitalization

30 minute visits? Shape demand

- Leveraging e mail or phone.
- Use of the team
- Set expectations of illness in AVS
- Care plans
- Using followup visits in the form of secure messaging or phone message
- Offering patients a phone visit instead of face to face
- Fishing proactively

Early Results – Access



Proactive population management

1. Proactive population management: need to know the needs of your patients: this is the population YOU have in your practice: female, geriatric, HIV etc.

We must change how we practice!

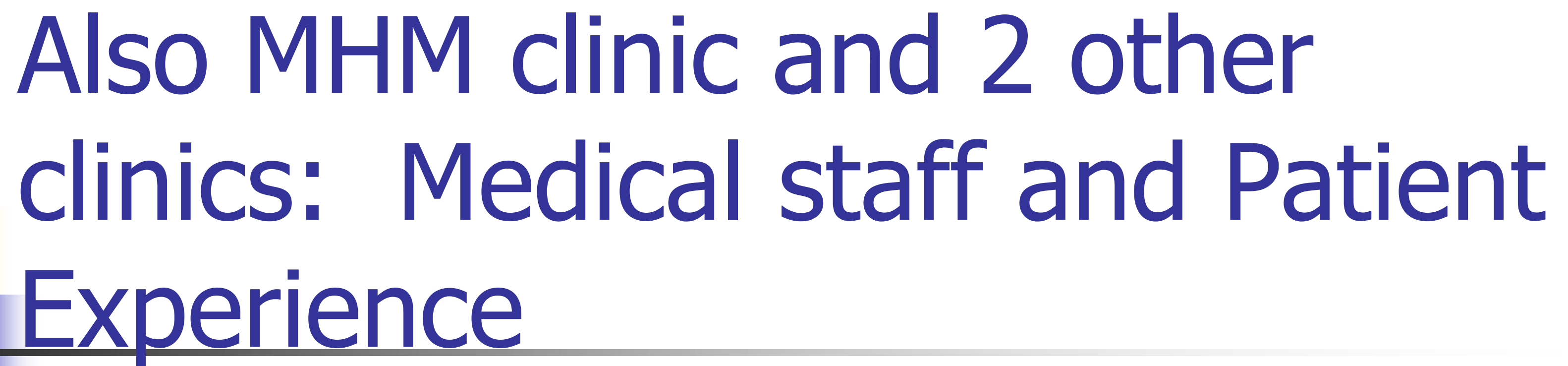
- We need to get the patient involved to take care of themselves. How about Access to their own medical record
- Identify their own goals
- We have to go after chronic illness strategically
- We need to get the Relationship back into the mix.

What do we need for a MHM?

- A working team
- EMR
- A way to give resources to patients
- Registries to identify who has the chronic illness
- Proactive approach to Chronic Illness

Results: MHM clinic and 19 other clinics

- Secure e mail message tracks
- Consulting nurse calls
- Group visits
- Self management support opportunities
- Emergency Room follow-up either by face to face or phone



Also MHM clinic and 2 other clinics: Medical staff and Patient Experience

- A five scale Ambulatory Care Experience survey called ACES
- 2 scales from the Patient assessment of Chronic Illness Care PACIC

The ACE measures

- shared decision making
- coordination of care
- helpfulness of staff
- quality of the doctor patient interaction
- access

PACIC: Patient assessment of Chronic Illness Care
Patient-reported activation

- Involvement with goal setting
- Care tailored to their needs
- Whether patients were more likely to use group visits
- Self management support workshops
- eHRA
- Previsit outreach and
- ED f/u

RESULTS

- ED visits: 29% lower
- In clinic: 6 % fewer face to face visits
- 8 percent more specialty visits
- Hospital Admissions did not change but
- were 11% fewer hospitalizations for ambulatory care sensitive conditions

Staff Burnout

- lower staff burnout measured by the MBI Maslach Burnout inventory
- which measures emotion exhaustion/depersonalization/ lack of personal accomplishment

Quality of care HEDIS markers

- 22 showed improvement:
- 13 chronic illness markers
- 4 medical markers