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at COLUMBIA UNIVERSITY HEALTH POLICY AND MANAGEMENT

Patient-oriented care in the US – a partnership of equals or a business imperative?

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Outline

- The Setting and the History
- The Emergence of the Empower Consumer
- Keys of Care Coordination
- Patient Centered Medical Home
- Care Coordination Techniques
- Best Practices for Population Management
- Discussion

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The land of "unlimited" possibilities…

- Who plays the game?
- Who does what and with whom?
- Who defines and how does it evolve?
- Who pays and who benefits?
- Whose turf is ambulatory care?
- Was it always like this?
- What does "integrated care" really mean?
- Managed care part 1 – damaged care
- Managed care part 2 – coordinated care
- The future is here to stay?!

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This is not one country…

- Being a patient in New York
- Being a patient in Massachusetts
- Being a patient in California
- Being a patient in Texas

Recent changes in legislation created incentives for physicians and patients to better coordinate care, lower costs, and improve quality.

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The patient became a consumer

- The patient as the co-producer in healthcare delivery
- Demand for flexibility and free choice ("Lite Managed Care")
  - Increasing financial involvement of the patient
  - More information available and easily accessible
  - Consumers influenced by other industries
- "My health care, my way" became the imperative

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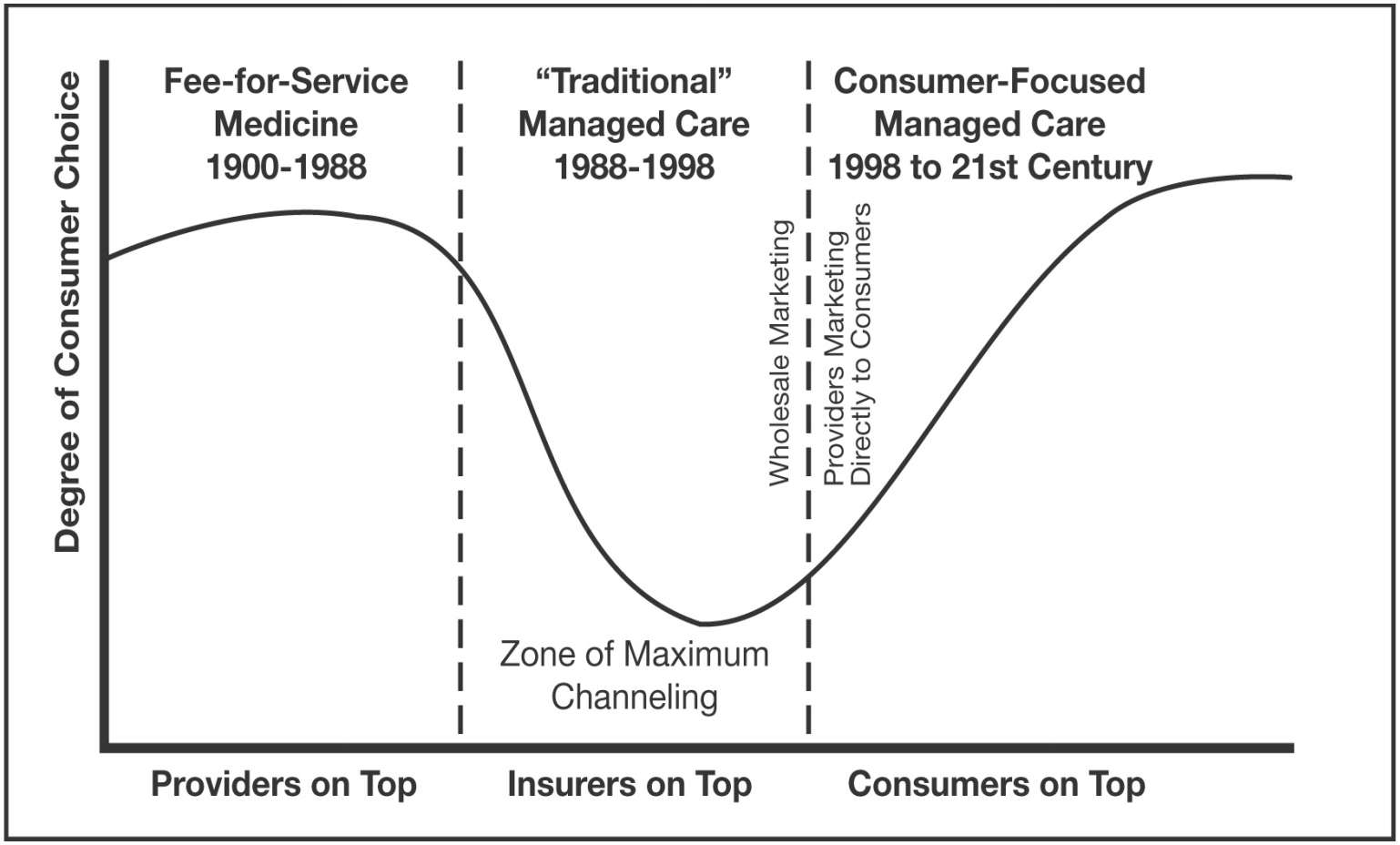
Emergence of the empowered consumer



Source: Health Care Advisory Board (1996c), pp. 10-11, 52-53

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Emergence of the empowered consumer

- Increased demand for flexible solutions and move from HMO to PPO products
- HMO penetration in California:
  - 1999: 65.3%
  - 2000: 64.0%
  - 2001: 50.2%
  - 2012: 42.9%
- PPO penetration: increase from 79.6 Mio. to 106.8 Mio. from 1995 - 1999
- Demand for quality indicators and more value for money => role changes among stakeholder (i.e. PBMs)
- Risk-shifting towards the patient (copayments, deductibles, co-insurance, high deductible health plans, flexible savings accounts)

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Keys for Care Coordination

- Collect data (Hawthorne effect)
- Integrate data – EHR (consistent data)
- Provide meaningful, specific feedback to physicians
  - P4P, Patient Satisfaction, other quality metrics
  - Kaiser uses hundreds of data points
- Focus on your disease burden and high costs
- Invest in information technology
- Invest in PCP resources - PCMH
- Invest in Ambulatory ICU's
- Understand the goals of each party
- Work toward common goals
- Share benefits of savings

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Patient Centered Medical Home – A model for change

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Patient Centered Medical Home

- Care team managing the health of a population
- Use of EMR to identify high risk patients
- Nurse Care Coordinators outreaching to patients who need more care
- Nurse Practitioners providing low level care
- Physicians managing process and seeing sickest patients
- Use of Huddle and care planning each day
- 6000 patients per practice
- Care Coordination with Specialists and Hospital

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Care Coordination techniques

- Engagement of patient. Notification of health alerts at check in
- Written report to patient at end of each visit… follow up with email reminders
- Written detailed report on appropriate pharma use mailed to every patient using the drug
- Patient Satisfaction surveys on many visits
- Patient use of apps to manage their own care

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More Care Coordination

- Warm hand off between outpatient to inpatient with PCP visit within 24 hours of discharge
- Analysis of Data to identify high risk patients that need attention
- Changed incentives for Hospitalists… paid based on episodes of care
- Examples:
  - Kaiser Back Clinic
  - Incentives for Quality and Care Coordination
  - Keeping patients out of the ER trough incentives and advice nurse triage

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Patient engagement

- KP online and app
- Lab results, appointments, pharma, education, emails
- Alert reminders, vaccines, tests, chronic disease management
- Outreach for high risk patients
- More Home visits less telephonic coaching

- What about regulation and cultural issues?

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Back Clinic

- All patients with back pain are referred to 2 hour group visit with PT, education, evaluation, exercise techniques
- Appropriate referral for Orthopedic Surgery, MRI or Injection
- 10 week intensive back strengthening program
- “Spinezone” as an example

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Incentives for Care Coordination

- Use of advice nurse to triage care
- Incentives to physicians to keep patients out of the hospital
- Reporting surgical outcomes to PCPs
- New payment incentives for physicians and care teams to change behavior
- Case rate for Hospitalist to manage episode of care
- PCP FFS plus quality incentives and outcomes
- Requirement that PCP sees patient within 24 hours of discharge
- Increased use of homecare instead of telephone follow-up

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Contact

Thanks for listening & sharing!

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