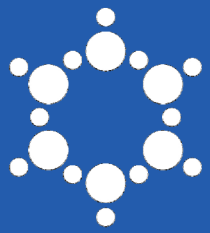
Total Health Management

Integrated Primary Care in Bloomington



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Current U.S. Model- Dartmouth Study

- 1 million Colon Cancer/Hip Fracture/Heart Attack patients
- Higher spending regions spent 60% more money
- Higher use of tests, procedures, specialist care and admissions
- High use of higher reimbursed, less of low reimbursement

However:

- Survival
- Ability to resume work or activities of daily living
- Satisfaction with their care
- Access to care
- Immunization rates
- ALL SAME OR LOWER !!

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RAND/McGlynn Study

- 30 Acute and Chronic conditions
- 439 quality indicators
- 6700 charts reviewed
- 54.9% received recommended care (overall)
- Prevention 54.9%
- Acute care 53.5%
- Chronic conditions 56.1%
- Best= cataract 78.7%
- Worst= alcohol dependence 10.5%

NEJM Vol 348:2635-45 2003

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Quality/Cost= Value

- National quality indicators improving 3.1%/year
- Insurance Costs increasing 11-15 %/year
- Most quality/safety data is institution based
- The National Business Coalition on Health (5/07) noted 30% of health expenses attributed to overuse, underuse, & misuse

Four Recommendations:

1 Community based & standardized performance measures

2 Reported to public

3 Reform payment system to reward what you want

4 Informed choice for customers and buyers

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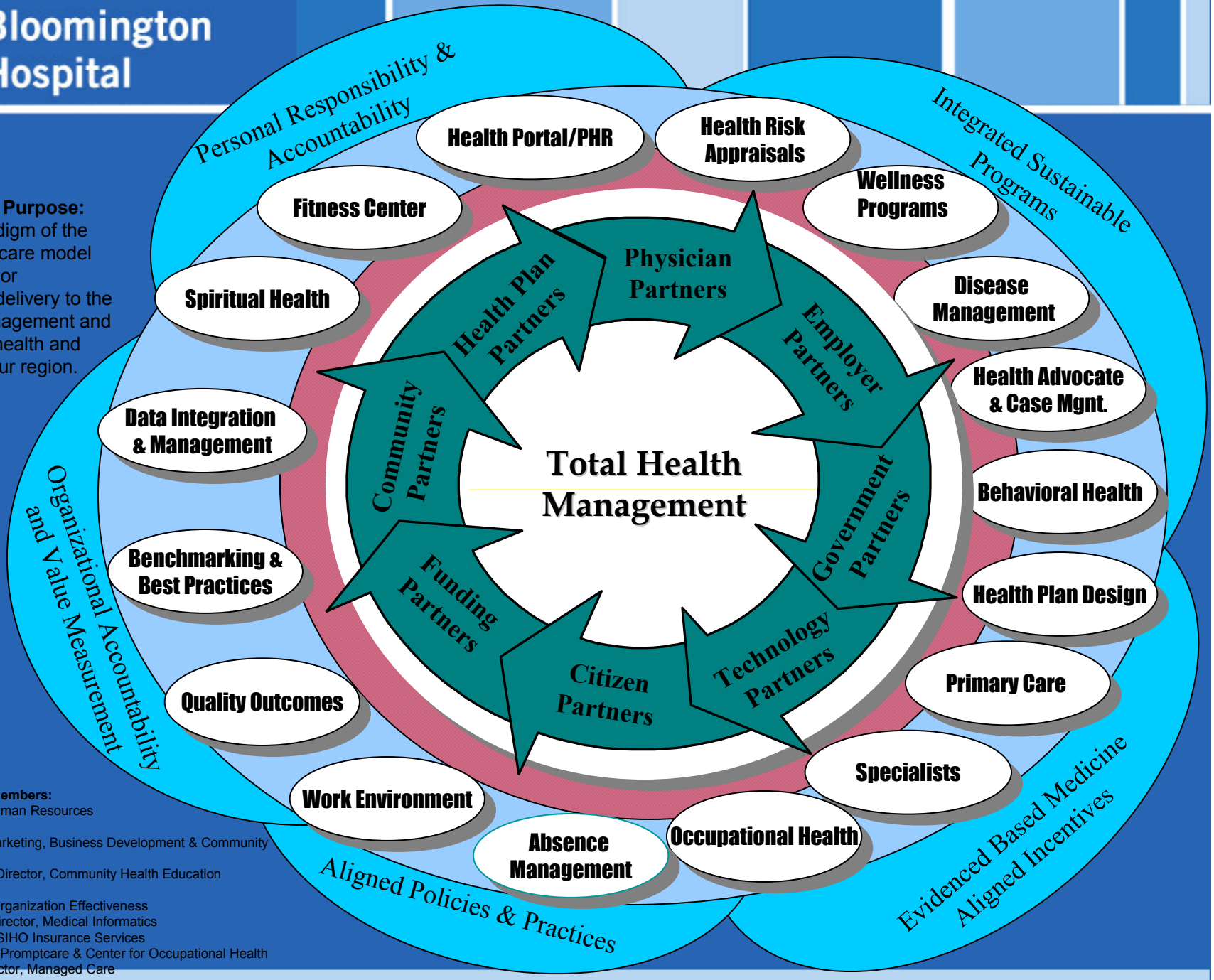
Statement of Purpose:
Shift the paradigm of the current healthcare model from episodic or transactional delivery to the proactive management and promotion of health and wellness for our region.



Steering Committee Members:
Steve Deckard, V.P. Human Resources
Larry Bailey, C.O.O.
Brian Whitman, V.P. Marketing, Business Development & Community Relations
Carol Weiss-Kennedy, Director, Community Health Education
Lee McKinley, M.D.
Rick Barton, Director, Organization Effectiveness
Todd Rowland, M.D., Director, Medical Informatics
Paul Van cleave, V.P., SIHO Insurance Services
Thomas Kuhn, Director Promptcare & Center for Occupational Health
Mary Ann Valenta, Director, Managed Care

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Patient Centered Medical Home

Joint Principles:

1. Personal physician
2. Physician lead team of individuals who take collective care of the needs of the patient
3. Whole person orientation
4. Coordinated and integrated across all elements of care
5. Quality and safety is paramount
6. Enhanced access
7. Payment reflects coordination, quality instead of quantity, and is adjusted for disease severity

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Data driven medical practice

- Collect data on physician-sensitive process and outcomes
- Patient satisfaction feedback to practice and referral physicians/hospitals/labs/radiology
- Track source of referrals to clinic
- Secondary/Tertiary care to best providers, not “who is on-call”
- Pharmacy Medication management
- PBM data from insurers
- IT/Management support
- Decision support for individuals and populations

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Quality & Safety

- Continuous care, especially post acute settings
- Continuous data on: PQRI, HEDIS,IT,CMS, Anthem, Crimson indicators
- Employer based Wellness, chronic disease, IHAP
- Remote EMR access
- Staff education on safety culture, team dynamics and self care

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Is there Return on Investment?

- 36 National Demonstration projects revealed:
- decreased overall costs at 1 year
- Improved patient and physician satisfaction
- Decreased use of ER for low acuity problems
- Improved access and preventive care
- Decreased use of tests, specialists and procedures

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This is all very nice but…..

#1 No incentive for specialists/hospitals to help in the effort to reduce overall costs (still volume based)

#2 No arrangements which allow primary care practices to share in the savings (i.e. see less patients per hour but manage individuals and a population cost effectively)

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Accountable Care Organizations

- An employer who is self insured and can re-align incentives to match needs to benefits and decrease waste
- A Clinical Integration organization composed of physicians who want to offer a population improved quality with lower overall costs
- A federal program which rewards quality management over quantity.

Without one of these Patient Centered Medical Homes
are not sustainable

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Bloomington solutions?

- Provide an evidence based model of care delivery
- Look at a patient centered approach, increase access
- Provide a model for physicians-in-training to experience*
- Improve post hospitalization care
- Clinical Integration-Partnership with payers and other providers (Clarian Quality Partners)
- Attract new physicians to primary care & decrease burnout for those remaining in practice
- Convince Local companies to re-align health plans to reward new behaviors

* IU/Clarian Bench-Bedside-Community-World curriculum -stresses continuity of care experience and community service

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References

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Joint Principles of the Patient Centered Medical Home
(AAFP,AAP,ACP,AOA , 2007)

Ritterhouse, et al NEJM 12/10/2009 361; 24

National Business Coalition on Health May 2007