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# MANY ROADS LEAD HOME

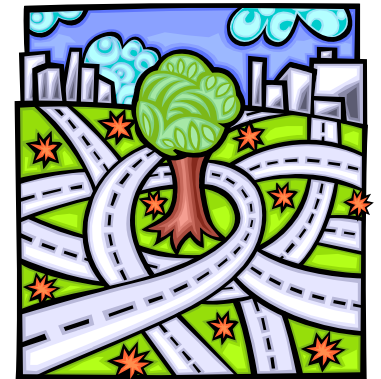
## The Genesys Integrated Group Physician Model

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Flint Michigan



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# Many Roads Lead Home

- Where we started
    - Genesys Physician Group has a history of successful managed care performance
      - 15 Plus years
    - Consider Patient Centered Medical Home = Managed Care on Steroids
      - Have considered managed care about prevention and health maintenance not gate keeper or withholding care
      - Dr. Bedi already functioning with many of the key initiatives required of a patient centered medical home
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# Many Roads Lead Home

- Administrative Staff First Steps
    - Evaluated the PCMH expectations against current practices
    - Hand picked a core group of pilot physicians
      - Needed highly visible and influential, respected physicians to lead and initiate this transformation project
        - Lends credibility
        - Sustainability
  - Process of Physician Engagement
    - Identified physicians
      - Well engaged with PHO organization and successful with managed care
      - Strong patient relationships
    - Utilized core group to develop and solidify office best practices, reporting, work on problem resolution
    - Reviewed the initiatives and divided into two categories
      - PCP
      - Administrative
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# Many Roads Lead Home

- In process of identifying core 11 physicians went through each of the initiatives with physician and staff
  - Resounding response was two fold
    - Nothing overly problematic/nothing they weren't already doing
    - All 11 docs admitted areas existed where they could do better
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# Many Roads Lead Home

## ■ Primary Care Physician

- Provider Agreement
- Patient/PCP relationship
- Access
- Care Management
- E-Prescribe
- Extended Access
- Test Tracking






## ■ Administrative

- Patient Registry
  - Performance Reporting
  - Care Management
  - E-prescribe
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# Many Roads Lead Home

## ■ PCP

- Provider Agreement  
    - Prior to PCMH: Patient and PCP agreements were in place, but not a formalized process for ensuring each patient educated
    - Post PCMH: Single practitioner – need to solicit Medical Assistant help in process
      - Medical Assistant Responsibilities
      - PCP Responsibilities
  
  - Patient/PCP Relationship   
    - Patients followed PCP across county when office moved, demonstrating strong relationship. High PCP Satisfaction Scores
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# WELCOME HOME!

## Genesys PHO

### Patient Centered Medical Home

A medical home is a team approach to providing comprehensive healthcare to patients in a high quality and cost effective manner.

A Patient Centered Medical Home is based on a continuous relationship with a personal physician. The physician leads a team of medical professionals who together take responsibility for a person's care through all stages of life.

#### Your Role As the Patient...

- Take part in planning your care
- Learn about wellness and how to prevent diseases
- Tell me (your Primary Care Physician) your health concerns and needs
- Follow the care plan that is agreed upon and receive the recommended treatment
- Tell me (your Primary Care Physician) any prescribed or over the counter medications you are taking
- Have all other physicians who take part in your care to send me (your Primary Care Physician) a report regarding your visit to them

Contain health care costs

Improve individual experience of healthcare

Improve the health of the population

Self Management

Health Navigator

Physician

Patient

Patient/ Doctor Sets Health Goals

Shared Medical Appointment

Satisfaction



#### My Role As the Physician...

- I will be your "Medical Home"
- I will know about you and your health status to enable me to coordinate your care
- I will respect you as an individual and respect your privacy
- Provide you with the care that meets your needs and fits with your goals and values
- Provide you with care that is based on quality and safety

Care is Coordinated and Integrated

Quality and Safety

Enhanced Access To Care

Electronic Medical Office

TURN OVER FOR MORE INFORMATION!

YOUR health is precious to US! Part of our work in supporting you is transforming our practice into a **Patient Centered Medical Home** to better support you and your family.

A patient-centered medical home is an approach to providing comprehensive primary care for people of all ages and medical conditions. It is a way for a physician-led medical practice, chosen by the patient, to integrate health care services for that patient who confronts a complex and confusing health care system.

Here's what that means for you:

### **What does it mean to have a Medical Home?**

- You have a relationship with your doctor who knows you and your family.
- You and your doctor set a health goal that you both agree upon to work on for the next year
- You rely on your doctor's office to coordinate all your medical care in a timely manner – from regular check-ups to specialty care
- Your doctor uses health information technology so that your records are accurate and easily accessible to all of those involved in your care
- Your care is comprehensive and considers all aspects of your health and well-being
- Your care is consistent with your needs and values

### **What are the benefits for me?**

- Improved communication between your doctor and you based on trust, respect and shared decision-making
- More focus on health and prevention which may lead to earlier identification and management of health problems
- Lower per person costs, fewer unnecessary tests and procedures, and less use of the emergency room
- Higher satisfaction for both patients and family doctors









### **What can I do to support the Medical Home?**

- Talk to your doctor about ways to improve your health and the Medical Home
- Set a health goal each year and discuss it with your health care team

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# Many Roads Lead Home

## ■ PCP

- Care Management   
    - Prior to PCMH - Coordinated care with specialists as able
    - Single Practitioner – solicit office staff to assist with coordination
    - Office Staff Responsibility
    - PCP Responsibility
  
  - E-Prescribe     
    - Began E-prescribing in March 2008 and progressed to full EMO/point of care documentation from there
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# Many Roads Lead Home

## ■ PCP

- Access 
  - PCP carries pager 24/7 when in town. Responds to after hour calls personally, is directly accessible to patients.
- Extended Access 
  - As above with access, with addition of extended hours one weekend a month, and one weekday per week, and coverage through Genesys Physician Group owned after hour clinics
- Test Tracking 
  - Electronic Orders Management
    - PHO Staff providing outstanding labs for labs not completed for office to “stalk” patient
  - Organization working on consistent compliance to test tracking policy
  - Recall system for paps, recheck mamms or abnormal testing follow up

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# Many Roads Lead Home

- Challenges to Individual Physician
    - Everyone in the office must be vigilant to processes and expectations
    - Must have strong communication between PCP and Office Staff
    - Ongoing oversight of staff
      - “Everything goes under my nose”
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# Many Roads Lead Home

- Challenges to Individual Physician
    - Patient Retraining takes time
      - Patients don't always comply with medical advice the first time
        - Example – when and how to contact physician after hours
      - Patients more likely to participate in own health care when asked what is important to them
        - Allows patient to feel proactive regarding health status
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# Many Roads Lead Home

- Challenges to Individual Physician
    - ❑ Lots of patient support needed
    - ❑ Hired centralized staff called “Health Navigators” to provide follow up with patients relative to meeting health goals and managing chronic illness
    - ❑ Health Navigators trained to use motivational interviewing techniques
    - ❑ Are seen and treated as part of PCP’s team
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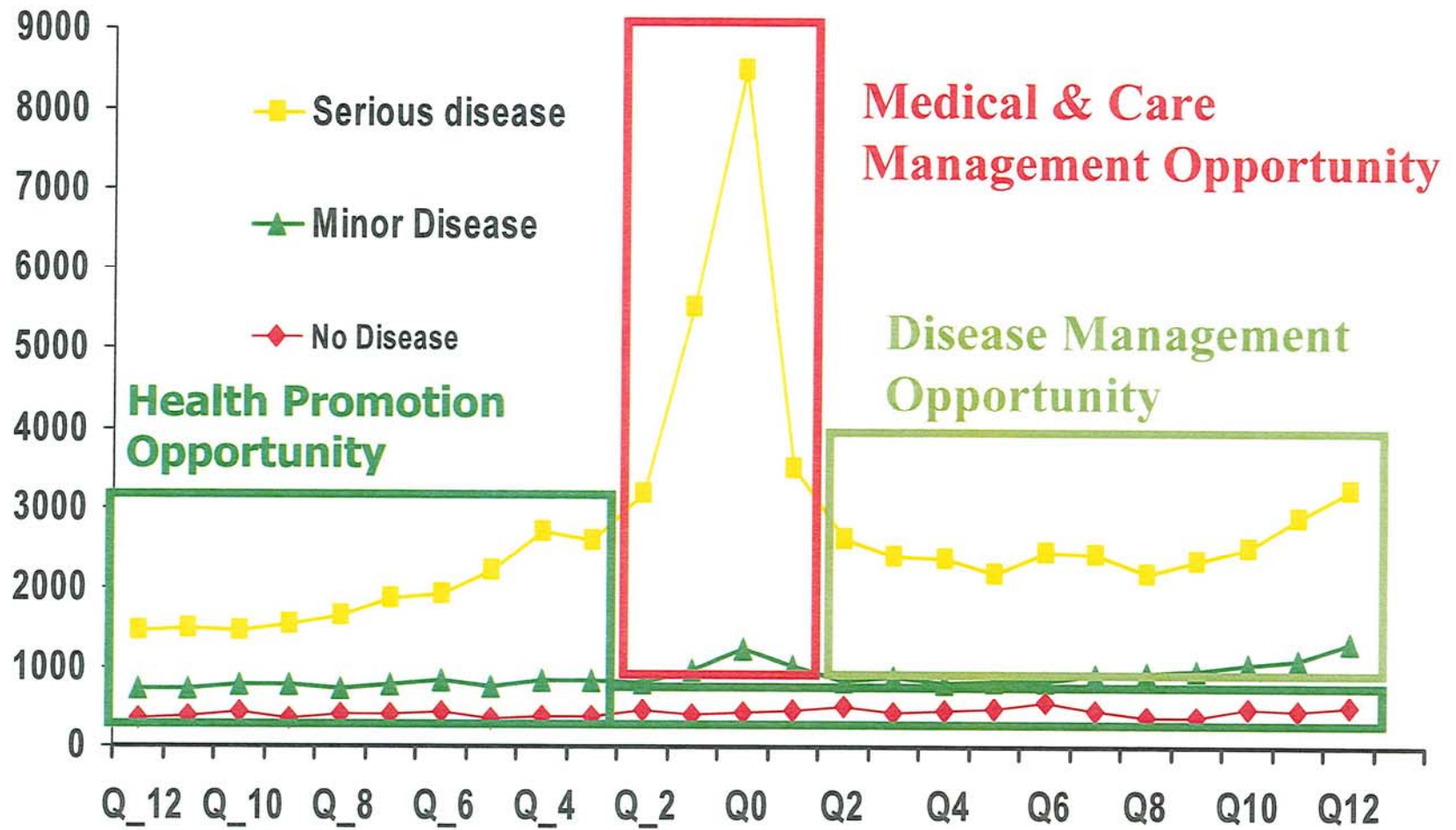
# Many Roads Lead Home

- Time spent up front can save time long term

## Patient Education

- After hour access
  - Health goals
  - Role of Health Navigator
  - Expected contact from Health Navigator
  - Office staff compliance
  - Technology
    - Communication tool for entire team
    - Reports compliancy at population level
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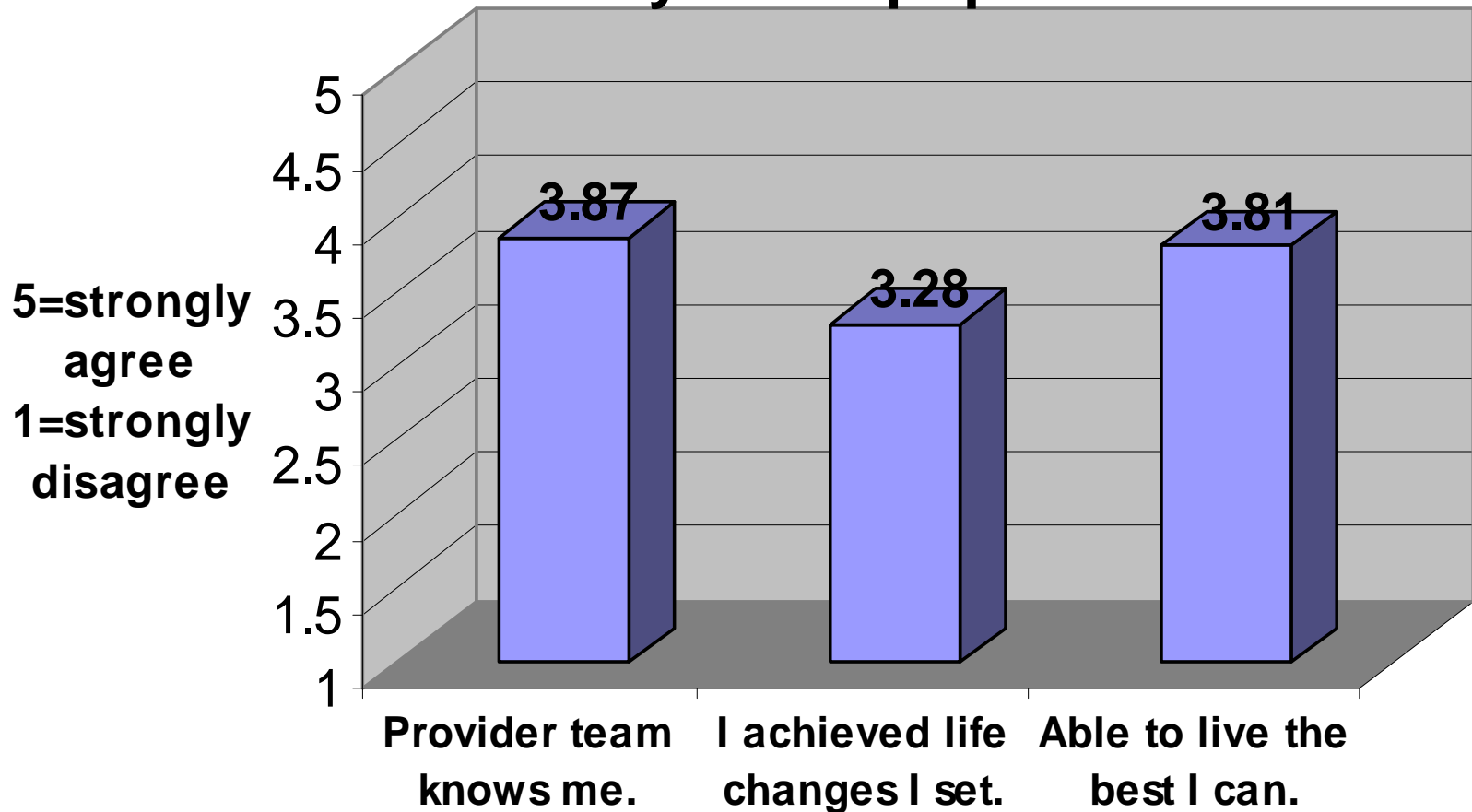
# Where are Additional Opportunities for Population Health Management



Medical and Drug Costs only

# Patient Centered Medical Home

## Baseline Patient Experience Data 2007 Total Genesys PHO population



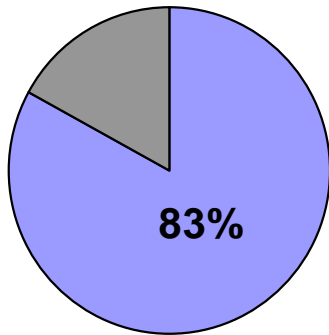
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# Patient Centered Medical Home

## Patient Survey Results

### Specific to patients working with Health Navigators

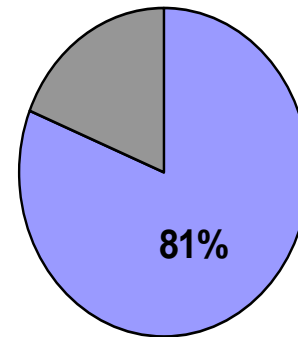
My doctor helps me to be as healthy as I can be.



■ Agree, Strongly Agree  
■ Neutral, Disagree, Strongly Disagree

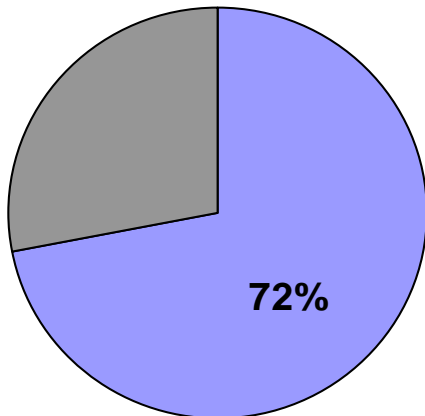
83%

My doctor cares about me.



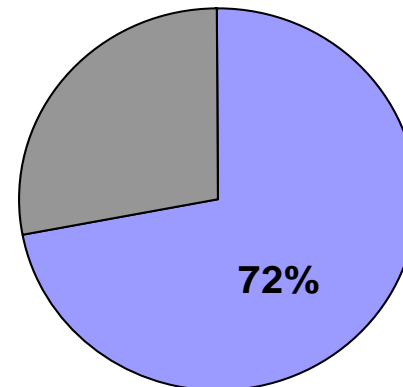
81%

My doctor knows me well.



72%

My doctor helped me set a health goal at a doctor's visit.

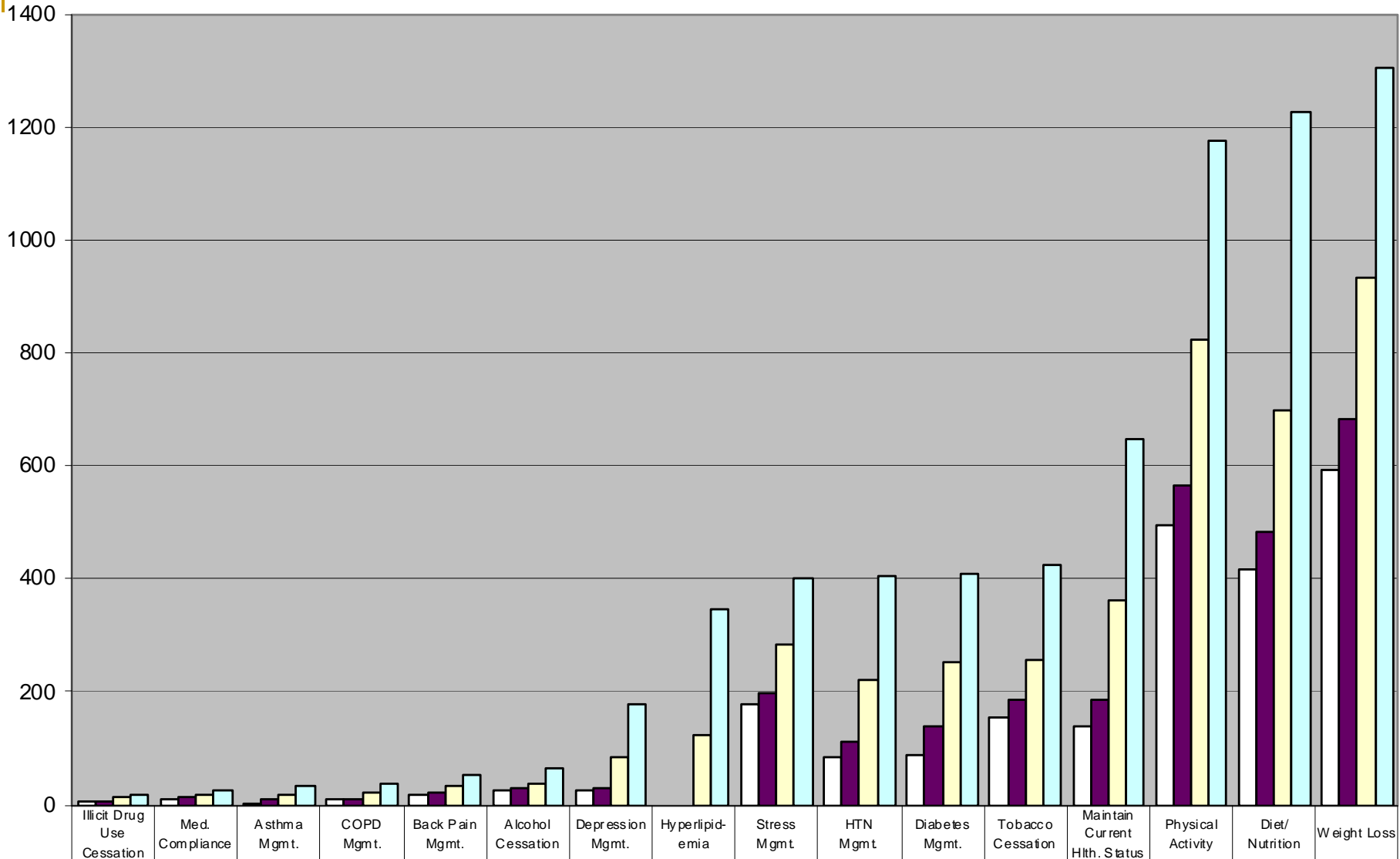


72%

# GENESYS PHO

## Health Goals by Category

□ 3/31/09 YTD
■ 4/15/09 YTD
□ 5/15/09 YTD
□ 7/15/09 YTD

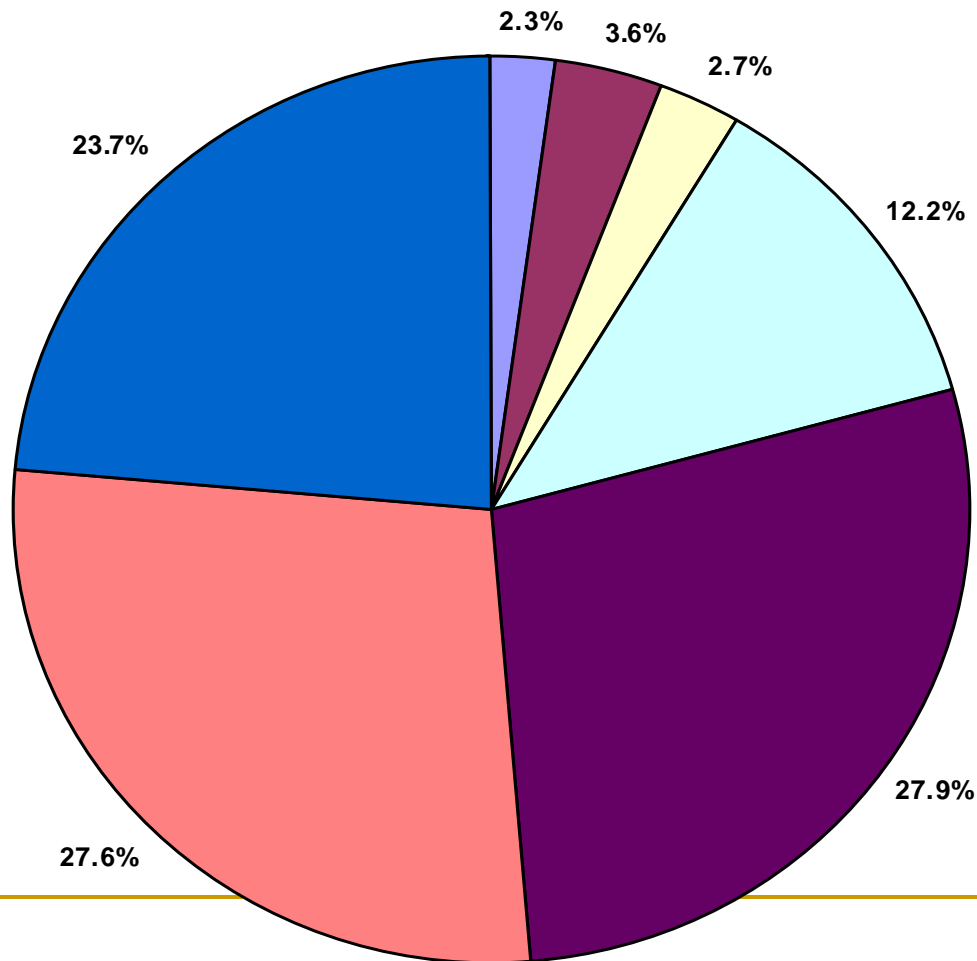


	3/31/09 YTD	4/15/09 YTD	5/15/09 YTD	7/15/09 YTD
Illicit Drug Use Cessation	7	7	14	18
Med. Compliance	9	12	18	27
Asthma Mgmt.	4	8	19	33
COPD Mgmt.	8	10	22	39
Back Pain Mgmt.	17	20	33	53
Alcohol Cessation	27	28	39	63
Depression Mgmt.	27	31	85	179
Hyperlipidemia	124	348	124	348
Stress Mgmt.	178	197	284	401
HTN Mgmt.	86	112	220	404
Diabetes Mgmt.	87	138	252	409
Tobacco Cessation	154	185	255	423
Maintain Current Hlth. Status	140	186	363	647
Physical Activity	497	566	825	1178
Diet/Nutrition	418	484	698	1228
Weight Loss	592	684	933	1306

# GENESYS PHO

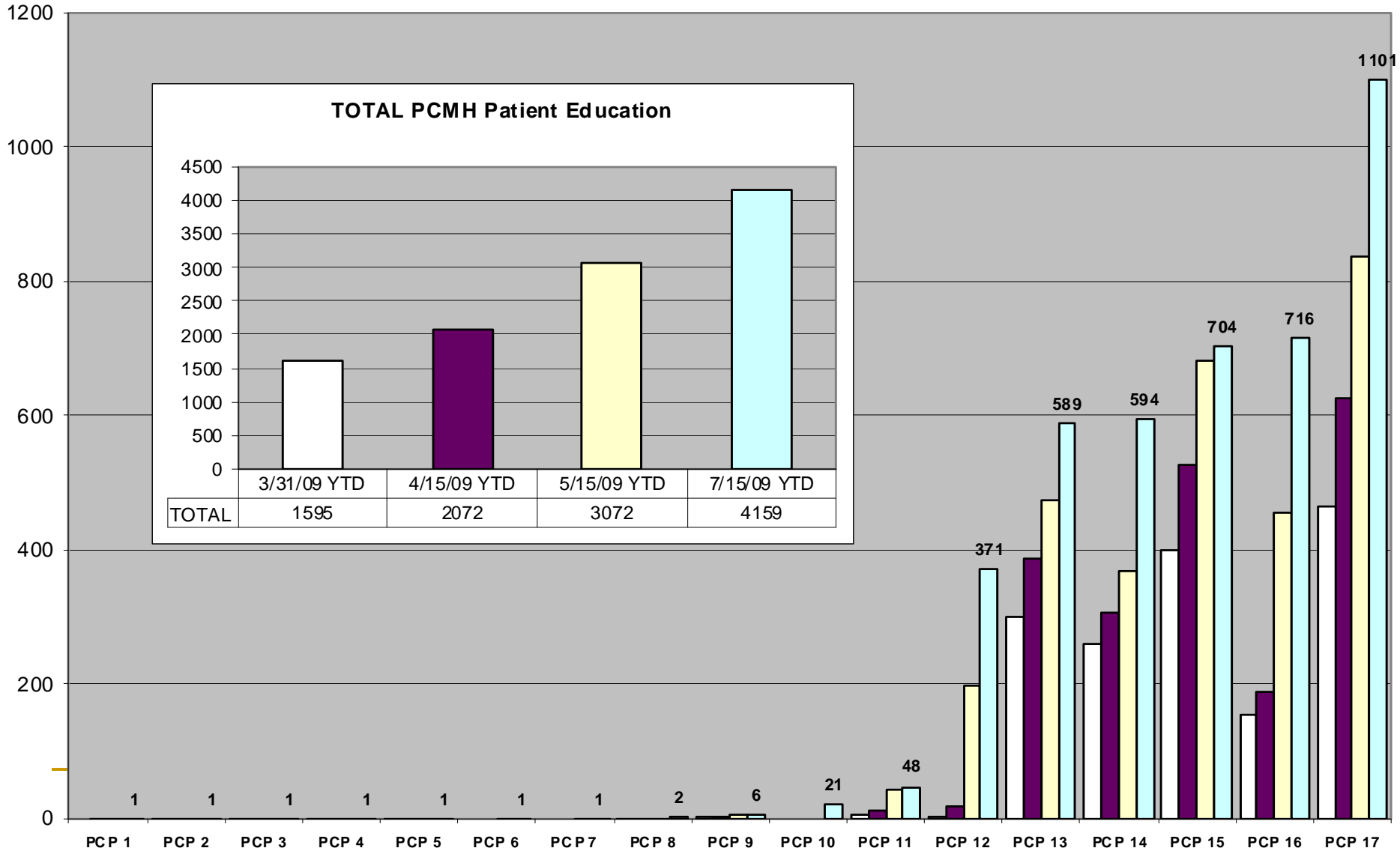
## Percent of Total Chronic Care Health Goals

Asthma Back Pain COPD Depression Diabetes HTN Hyperlipidemia



# GENESYS PHO PCMH Patient Education

□ 3/31/09 YTD
■ 4/15/09 YTD
□ 5/15/09 YTD
□ 7/15/09 YTD



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# Many Roads Lead Home

## ■ Lessons Learned:

### □ PCP/Stakeholder involvement

- Need early adopters to become champions of project
  - Set clearly defined expectations (the “what”) with frequent follow up on office implementation and compliance
  - Allow flexibility for implementing the expectations (the “how”)
  - Use provider feedback loops to identify best practices and communicate this within early adopters
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# Many Roads Lead Home

- Lessons Learned:
  - Deeper not wider
    - First attempt at implementation
      - Employer specific
        - Two employer groups totaling approximately 2,500 patients across 150 offices
      - Lacked significant volumes in any one office to create change
      - Overall failed to gain traction
    - Current process
      - Eleven PCPs representing seven offices selected as Pilot Sites
      - Patients of Pilot Sites are all part of Medical Home, with slight “enhancements” for two pilot employer groups
      - 11 PCP offices averaging 2,000 patients each (total of estimated 220,000 patients)
      - Each PCP met with individually and explained expectations regarding this model of care. Physician commitment was obtained prior to their engagement in process
      - Physicians meet regularly to review their rates of patient engagement and office compliance to required outcome measures (peer pressure and open dialogue regarding operations)

**Take home message is – PCMH will only work if implemented across entire practice**

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# Many Roads Lead Home

## ■ Current Process

- PCPs participating are engaged in ensuring that every patient has a health goal, regardless of health status
    - This includes the chronic care patient (diabetes, COPD, low back pain, etc.) as well as the young healthy adults
    - Patients are “met where they are at”
    - Change in strategy from Paternal relationship to Partnership in health
    - Availability of Health Navigators to further investigate patients’ strategy for meeting health goals and ongoing follow up
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# Many Roads Lead Home

## ■ Current Process

- Use of Electronic Medical Record Crucial for our implementation
    - Ability to now track the number and types of health goals
    - Future reports to track ability to change patients' behavior, lifestyle choices and the associated health status
    - Example, if goal weight loss, how does weight and BMI track over time? If patient also a diabetic, what are the associated HbA1c's and LDLs as patient improves weight?
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# Many Roads Lead Home

- Current Process
    - Ability of PCPs to forward patients who need Health Navigator assistance electronically
    - Health Navigator can review goal set with PCP and other pertinent information prior to contacting patient
      - Strengthens team approach
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# Many Roads Lead Home

- Patient education must be ongoing and repetitive
  - May not “get it” the first time
  - May not remember



# Many Roads Lead Home

- QUESTIONS?

