CCOs in Practice: Integrating the patient-centered care model to reach the Triple Aim

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Agenda

- The role of Occupational Therapy services in the integration of the patient-centered care model within Oregon's CCOs
- What does this look like?
- What outcomes are expected?
- What is the current and future impact on OT?

- Discussion throughout presentation

Quick Discussion

- What setting do you currently work in?
- Have you heard about CCOs in your current position?
- Have you heard about the patient-centered medical home model?

CCOs Elements Recap

- Local control
- One point of accountability
- Expected health outcomes
- Integrating physical and behavioral health
- Focus on prevention
- Reduced administrative overhead
- Community health workers
- Global budget
- Electronic health records
- **Patient-centered primary care homes**

Patient-centered care models

Patient-centered medical homes/primary care model

- Reduce fragmentation of care
- Improve efficiency and outcomes
- Reduce health care costs

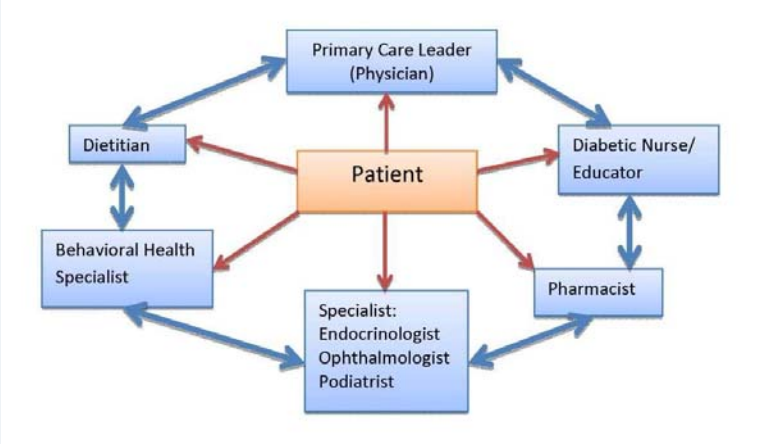
Medical Homes

What does this look like?

- Physician-directed practice
- Personal physician
- Accountable for providing and coordinating the entire spectrum of patient's care needs, including:
  - Physical and mental health
  - Prevention and wellness
  - Acute care
  - Chronic disease and disability management

Patient-centered Medical Home

Diabetes Management example



PCMH Joint Principles

Joint Principle	Characteristic Description
Personal physician	An ongoing relationship with a physician who is considered the patient's first point of contact.
Physician directed medical practice	The physician directs the team-based model of care for the practice.
Whole person orientation	The physician is responsible for all stages of life care including chronic care and preventive services.
Coordinated Care	Patient care is coordinated and integrated across the entire health care system including the community, with an emphasis on information technology.
Quality and Safety	Decision making is based on evidence and utilizes clinical decision support tools. Patients are active decision makers in their own care. Physicians use performance measures for continuous quality improvement.
Access	Utilizes open scheduling, extended practice hours to provide improved access.
Payment	Payment for added value and achieved quality improvements.

PCMH Principles

- Patient-centered
  - Partnership between practitioners, patients and families
  - Patients have education to make decisions
  - Patients participate in their own care

PCMH Principles

- Comprehensive
  - Prevention and wellness
  - Acute care
  - Chronic care

PCMH Principles

- Team-based
  - Interprofessional team
  - The team approach is also considered to be patient-centered, with the patient as an essential component of the team.

PCMH Principles

- Coordinated
  - Just as it says – care is organized across all elements of health care

PCMH Principles

- Accessible
  - Access to services with shorter wait times
  - 24/7 access
  - Communication through Health IT

PCMH Principles

- Focused on Quality and Safety
  - Quality improvement
  - Use of protocols and standards

Care Coordination

- "Occupational therapy practitioners bring a unique skill set and expertise that can and should be a vital component of any new or existing care coordination models" (AOTA, 2010)

PCMH Success Stories

Does it work?

- **Alaska Native Medical Center, Anchorage, AK**
  - 50% fewer urgent care and emergency room (ER) visits
  - 53% fewer hospital admissions
  - 65% reduction in specialist utilization
- **Group Health of Washington, Seattle, WA**
  - 15% fewer inpatient stays
  - 15% fewer hospital readmissions
  - Estimated costs savings of $15 million (2009-10)
  - 18 - 65% improvements in medication management

http://www.pcpcc.net/content/results-evidence

PCMH Success Stories

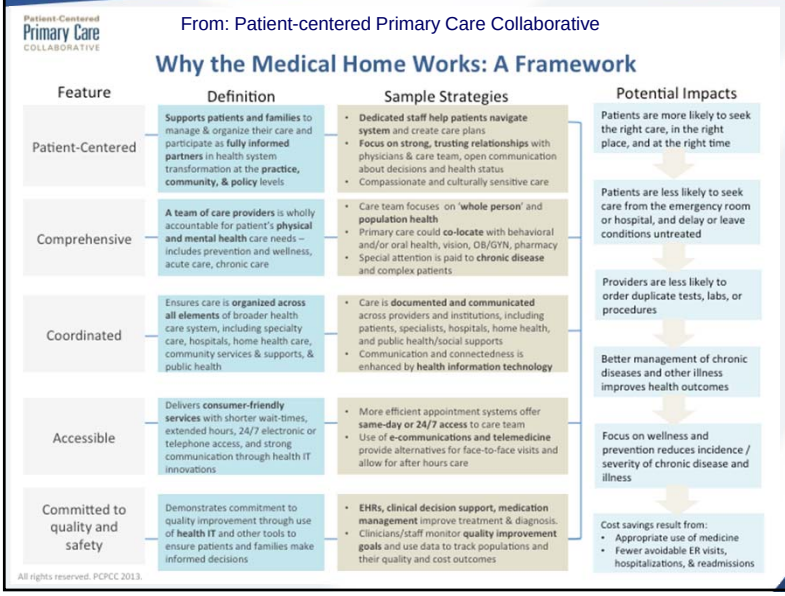
Does it work?

- **Geisinger Health System, Danville, PA**
  - 25% fewer hospital admissions
  - 50% fewer hospital readmissions
  - 7% lower cumulative total spending
- **HealthPartners, Bloomington, MN**
  - 39% fewer ER visits
  - 40% fewer hospital readmissions
  - Reduced appointment wait time from 26 days to 1 day

http://www.pcpcc.net/content/results-evidence

PCMH Success Stories

From: Patient-centered Primary Care Collaborative



Discussion

- Discuss the PCMH Principles and how each is important.
  - Personal physician
  - Physician directed medical practice
  - Whole person orientation
  - Coordinated Care
  - Quality and Safety
  - Access
  - Payment
- Do you see these currently included in your practice?

Discussion

- Do you see the PCMH model as a good fit for CCOs?
- Where does OT fit into this model?
  - Part of the PCMH team?
  - PCMH Neighbor?

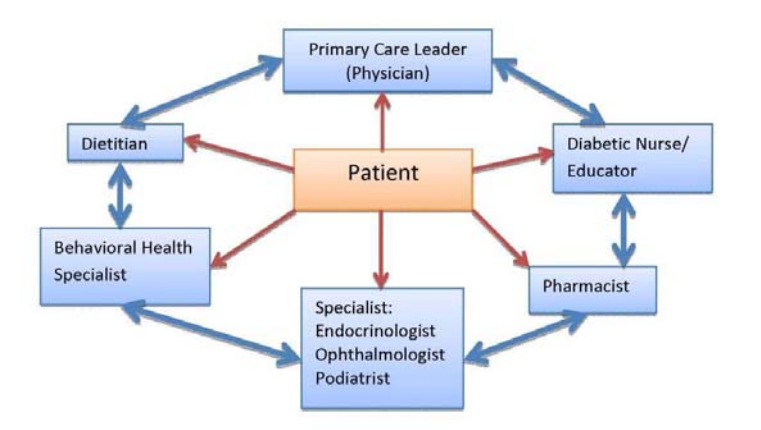
PCMH Example

Diabetes Management example

- Nearly 26 million Americans have been diagnosed with diabetes (CDC, 2011)
  - Another 79 million have pre-diabetes
- Over $200 Billion spent on care
- According to the CDC, preventable care practices can also reduce the incidence of diabetes and complications, such as heart disease, stroke, hypertension, blindness, kidney and nervous system diseases and amputations.

PCMH Example

- Where would OT fit in?



Discussion

- In order to promote successful prevention and management, what are some adaptations to daily routines and lifestyle you would include?
- How would you promote the OT services for treatment of diabetes?
- How would you convince the other providers in the team or health professionals within the CCO to use OT services?

PCMH Implementation Measures

- In-person Access
- After Hours Access
- Telephone & Electronic Access
- Performance & Clinical Quality Improvement
- Preventive Services
- Medical Services
- Mental Health, Substance Abuse & Developmental Services

Implementation Measures

- Comprehensive Health Assessment & Intervention
- Personal Clinician Assigned
- Personal Clinician Continuity
- Organization of Clinical Information
- Clinical Information Exchange
- Specialized Care Setting
- Population Data Management

Implementation Measures

- Electronic Health Record
- Care Coordination
- Test & Result Tracking
- Referral & Specialty Coordination
- Comprehensive Care Planning
- End of Life Planning
- Language/ Cultural Interpretation
- Education & Self-Management Support
- Experience of Care

Oregon Health Authority Oct. 2011

Challenges/Barriers

- Do you currently use an electronic health record?
- How do you see EHRs working within CCOs?
- What do you see as some of the major barriers to implementation of a team-based patient-centered medical home model?

Impact on Providers

- Increased accountability
- More emphasis on reporting/ data collection
  - May or may not have a visible impact
- OTs must be able to clearly articulate:
  - their program of care,
  - the cost of that care,
  - their role on the team, and
  - the expected outcomes of their care.
- Changing role – emphasis on prevention

Discussion

- Scope of practice changes as more emphasis on prevention?
  - How do you see the role of OT changing?

References

- American Diabetes Association [Online]. 2011 [cited 2011 Apr 16]; Available from: URL:http://www.diabetes.org/diabetes-basics/diabetes-statistics/
- Centers for Disease Control and Prevention. Number of Americans with diabetes rises to nearly 26 million. [Online]. 2011 [cited 2011 May 12]. Available from: URL http://www.cdc.gov/media/releases/2011/p0126_diabetes.html
- Patient Centered Primary Care Collaborative. Joint principles of the patient centered medical home. [Online]. [2007?] [cited 2011 May 12]. Available from: URL http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home
- Why the Medical Home Works: A Framework. Patient-Centered Primary Care Collaborative, Washington, D.C. March 2013http://www.pcpcc.net.

More Information

- Understanding the 2013 PCPCH Standards
  – May 7, 2013 - 12:00pm to 1:00pm
- http://www.pcpci.org/resources/webinars/understanding-2013-pcpch-standards

- Questions? Comments?
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