POSTS MADE IN MARCH 2012

CHANGES TO HEALTH DELIVERY SYSTEM KEY TO REDUCING CARE COSTS

Leave a reply

With all the talk this week about Obamacare and whether or not the Supreme Court will declare the law constitutional, partially unconstitutional, or take no stand, the law will not have a measurable impact on the cost of health care delivery to patients until significant changes take place in the way the delivery system works.

There are several reasons why the cost of care has risen so radically, and there are measures that can be taken to reduce some of these costs, simply by changing patient and provider behaviors in areas such as medication adherence, fast access to care and preventive care.

Medical Adherence

One-third to one-half of patients in the U.S. do not take their medications as instructed. This leads directly to poorer health, more frequent hospitalizations, a higher risk of death and as much as $290 billion annually in increased medical costs. Non-compliance includes not taking medication on time, not sticking to the proper doses, or simply ignoring the medication by not filling the prescription, or filling it and not taking it. Reasons patients give for their non-compliance include: unpleasant side effects, confusion, forgetfulness, language barriers and feeling “too good” to need medicine.
It is a known fact that patients with chronic conditions such as diabetes and high blood pressure are among the group less likely to follow their medication regimen. Perhaps if more providers were reimbursed based on outcome rather than on their fees for service, they would invest in the time, resources, counselling services, and necessary technology to educate patients and foster better adherence.

A study by researchers at NYU School of Medicine confirms that positive affirmation, when coupled with patient education, seems to help patients more effectively follow their prescribed medication regimen. How does that reduce costs? We know that with adherence comes better management of health issues. With better management of health issues comes fewer visits to the ER. With fewer visits to the ER comes lower cost of care because the patient who gets better by following the treatment prescribed does not need further intervention.

http://medicalxpress.com/news/2012-01-confidence-positive-medication-adherence-hypertensive.html

Access and Information

One of the most significant obstacles to improved patient care, at a reasonable cost, is access. The relative lack of real-time access to care and the absence of comprehensive patient

information at the point of care are essential to improving outcome. Better access to care will lower the cost of care because patients do not have to wait to see their doctors and avoid having their health issues precipitate from an issue to a crisis. An example of that is an elderly woman who called her doctor's office to request an immediate appointment for a rash that was painful and itchy and would not go away with topical medications. The doctor was on vacation and when the patient was finally seen several days later she was diagnosed with Shingles. Instead of a few days on an oral dose of an anti-viral medication, she ended up hospitalized for several days on IV medications, with a very severe case of shingles that had spread to several locations in her body.

The new patient-centered medical home model of care resolves some of these issues, by extending access to patients using the services of nurses, nurse practitioners, physician assistants and other well- trained professionals to deliver many basic health care services. With digital health records as a part of the medical home model, all of the patient's information is available to all of these providers when the patient needs to be seen. This allows the physicians in the practice to focus on diagnosis and deal with the tough issues, while other competent, well trained healthcare professionals handle routine exams, coordinate follow up appointments, deliver counseling, and make sure that screen tests, vaccinations and other milestones for the patient are achieved.

: http://healthland.time.com/2012/01/23/does-better-access-to-health-care-really-help-lower-costs/#ixzz1qENGxXvV

Preventive Care

Prevention is clearly one of the touchstones of health care. To prevent deadly or disabling disease from occurring, or to stop it at an early stage, seems like an obvious way to cut health care costs and improve population health. Early intervention health and wellness programs are available but patients have to be willing receptors of these efforts, and providers have to spend time and energy to make these programs work. It is not an easy task. Some suggestions for carving out programs where preventive care is the focus include:

1. Doctors or their nurse practitioners or physician assistants have to provide patients with education and tools for proper weight control, fitness programs, stress reduction and relaxation techniques because we know that diet and fitness play a huge role in keeping people healthy
2. Immunizations and vaccinations need to be kept current. With the assistance of digital health records, there are no longer reasons why these should not be up to date.
3. Warnings about exposure to certain disease triggers need to be passed along to patients so they are aware of the risks when they travel or expose themselves to certain environments.
4. Doctors and patients have to engage in discussions about family history so they are aware of the genetic make up the of individual that could cause disease. Based on that information the patient needs to be sure to get certain screenings when appropriate.

Current initiatives in patient-centered care medical homes and accountable care organizations are a giant step toward collaborations between patients and physicians to jointly work toward better adherence, more immediate access and availability of information and better preventive care. These efforts will produce reductions in the cost of care but it will be a slow process.

VIRTUAL BOOK SIGNING WITH BEHIND THE STORY

2 Replies

Want to go to a book signing, but the long drive and lines turn you off? Now, the book signing comes to you! With the new *Behind the Story* virtual book signing event, you can experience a free book signing from the comfort of your home, office or wherever the day finds you. Each event lasts one hour and will feature four up-and-coming authors.

To attend our first online event at 2 p.m. EST on Tuesday, March 27, register here to receive your log-in information.

You will also have the opportunity to ask the authors questions during the event, and for attending the virtual signing, **you will receive a free copy of my e-book.**

PATIENT ENGAGEMENT WILL IMPROVE OUTCOME

1 Reply

Engaging patients in managing and monitoring their health by using health information technology has proven to positively change outcomes. In a recent study of over 3,500 patients with diabetes and hypertension, conducted by Kaiser Permanente, (KP) the use of secure patient-physician messaging in any two-month period was associated with statistically significant improvements in their chronic conditions. Results included 2 to 6.5 percentage point improvements in glycemic, cholesterol and blood pressure screening and control.

The study, which was published in the July 2012 issue of **Health Affairs,** concluded that putting patients and their data at the center of care resulted in improvements in health care quality, access and cost. Using *My Health Manager*, Kaiser Permanente members sent over 850,000 secure messages to their clinicians each month.of the study. The clinicians logged in nearly 3.5 million messages between January and April, 2011 to their patients in email exchanges that were focused on helping those patients empower themselves and better manage their health.

http://www.healthcareitnews.com/news/study-doctor-patient-e-mailing-improves-patient-outcomes.htm

There are reasons why the KP project, and similar programs foster patient empowerment and engagement. The availability of a secure portal where patients communicate with their clinicians to ask those questions that they forgot to ask during their face to face visit, or address issues that come up between visits, enables them to stay connected,on top of their health issues, and out of the emergency room. The reward of getting answers quickly and easily without the frustration of telephone tag or the consumption of large amounts of time out of their busy day, encourages patients to engage more. This in turn leads to better management of health issues.

To engage, patients need knowledge, skills and emotional encouragement so they feel confident enough to ask the right questions and become involved. Among the actions that patient who engage must undertake are:

Use technology to communicate with providers
Make treatment decisions
Seek health knowledge, particularly related to their own health issues
Understand health costs and make appropriate choices
Work at preventive health and wellness

These are giant steps toward changing behaviors and moving to patient-centered care. Patient engagement is a cornerstone of the patient-centered medical home. It takes total commitment from patients and providers to accomplish. Without an engaged patient you cannot have a viable team approach to care. Although there are challenges, engaged patients are essential to realizing the needed changes to our health care system that will result in better quality health delivery and cost efficiencies.

PATIENT -CENTERED CARE AND THE MEDICAL HOME

1 Reply

In my last blog post, I talked about Patient-Centered Care, how the concept evolved, and where we are today. A medical home is a model of care delivery that enables patient-centered care. It is a health setting where a specific health care provider /physician leads a team of professionals who take care of you. Does this sound a lot like the old fashioned family doctor that your parents saw 50 years ago? — a doctor who really knew you as a person and followed you from birth until you either died or left the practice only because you relocated?
The 21st century twist is that in today's medical home you, the patient, are a member of the care team, and technology, including email, the Internet, digital health records, smart phones, and secure patient portals, helps facilitate your care and insure personalized care coordination and continuity. The medical home concept also includes a proviso that you have more access to your care team including open scheduling, expanded hours and new options for communicating with your team such as e-visits.

Three trends are building the current momentum around the medical home: (1.) a growing shortage of primary care physicians, thus the need for a team to pick up some of the responsibilities (2.) the increasing prevalence of chronic disease among the population that needs constant managing and monitoring, also enabled by the support of a team of providers,

and (3.) the availability of health information technology (HIT) .

The escalation of health costs and growing numbers of individuals with chronic diseases, validates the medical home model that incorporates primary care physicians who lead multidisciplinary teams that include support staff such as nurse practitioners, physician assistants, pharmacists, nurses, social workers, therapists, and other care extenders. Underlying this assumption is the premise that HIT systems support coordination and continuity of patient care. Government initiatives, including incentives for physicians who adopt of electronic health records, as well as a cultural change in physicians' attitudes toward implementation of health IT such as e-prescribing, web resources, smart phones and smart pads to communicate with patients and electronically monitor chronic conditions, will help the medical home concept gain traction.

Several pilot projects with the patient-centered medical home (PCMH) indicate the success of this approach. All of them employ care teams to coordinate and manage care with primary care physicians leading the teams.They also use health information technology to standardize work flow and to enhance the patient/physician relationship.

One successful pilot was held at Group health in Puget Sound, Seattle Washington. Group Health provides health care insurance and comprehensive care to approximately half a million residents in the northwestern United States, including twenty primary care clinics where patients choose a primary care physician to guide and coordinate their care. These physicians (81.6% family physicians, 3.5% general internists, and 14.9% pediatricians) care for an average of 2300 patients and work in multidisciplinary teams. Between 2002 and 2006, Group Health implemented a series of reforms to improve efficiency and access including same-day appointment scheduling, direct access to some specialists, primary care redesign to enhance care efficiency, and an electronic medical record with a patient Web portal to enable patient e-mail, online medication refills, and record review. The reforms succeeded in improving patient access. Group Health then developed a pilot of a patient -centered medical home (PCMH) redesign in a single metropolitan Seattle clinic serving 9200 adult patients with the goal of spreading lessons learned to other clinics. Structured around a thorough electronic medical record system, frequent patient communication, and regular medical team collaboration, this approach at Group Health improved patient satisfaction and reduced clinician burnout rates and reduced health care costs. With their PCMH, patients had 29 percent fewer emergency visits and 6 percent fewer hospitalizations, resulting in a net savings of $10 per patient per month. For every dollar Group Health invested, mostly to boost staffing, it recouped $1.50.This evaluation prompted Group Health to spread the medical home to all 26 of its medical centers, which it finished doing in January, 2010. http://www.grouphealthresearch.org/news-and-events/newsrel/2010/100504.html

This is just one example of how an implementation of the PCMH results in successful patient engagement in care, coupled with improved working conditions for the physicians and significant cost savings. There is much promise that the PCMH could elevate the quality of health care for everyone and might just be the answer to many of our health care system woes.

PATIENT-CENTERED CARE, THE TIME HAS FINALLY COME

2 Replies

One of the largest health care conferences, HIMSS (Health Information Management Systems Society) took place last week and patient-centered care and the patient role in the care team was a key topic. The realization that patients have more information about their diseases and treatment options and have the right as well as the understanding to be making decisions about their care in conjunction with their health care professionals has finally taken hold in the medical establishment. It is about time.

In 2001 The Institute of Medicine (IOM) published a study that outlined the guidelines for a new health care model, patient-centered care. The report attempted to explain why it is so important that the health care establishment change their approach of treating disease and prescribing medication that most providers learned in their medical training, to an approach that centers on the whole patient and not on the particular disease that needs to be treated. The IOM described patient-centered care as:

"Respectful of and Responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical encounters."

The IOM suggested ten rules that the 21st century health care system should follow. They include:

Rule #1 Care based on continuous healing relationships.
Rule #2 Customization based on patient needs and values
Rule #3 The patient as the source of control
Rule#4 Shared knowledge and the free flow of information
Rule #5 Evidence-based decision making
Rule #6 Safety as a system property
Rule #7 Need for transparency
Rule #8 Anticipation of needs
Rule #9 Waste continuously decreased
Rule #10 Cooperation among clinicians

(**Crossing the Quality Chasm**, National Academy Press, 2001, pages 6,1 66 – 83)
It has taken the entire decade for most health professionals to recognize the importance of this approach and incorporate the rules outlined by the IOM into standard practice. It has taken a decade for the health care system to finally admit that including the patient in the care team. and providing patients with the information to participate in the decision process will result in better, safer, more efficient care delivery and better outcomes, while controlling costs. Hopefully this will resolve some of the problems inherent in our current system.