

Team Approach to Care/Experience using Coaches a product of health care redesign

Mott Blair, MD

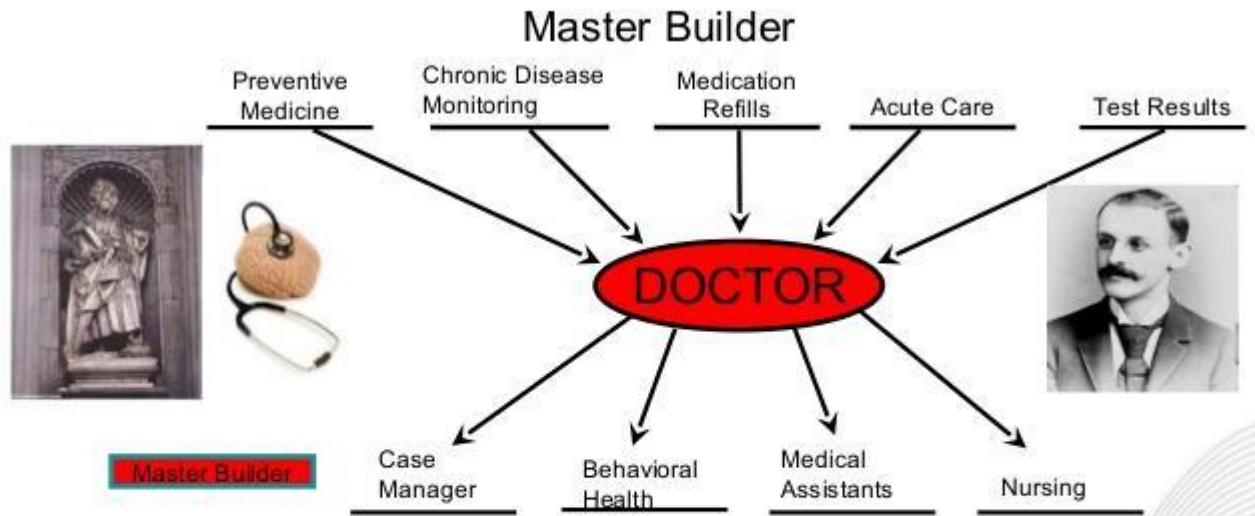
Vidant Family Medicine Wallace

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Practice transformation away from episode of care



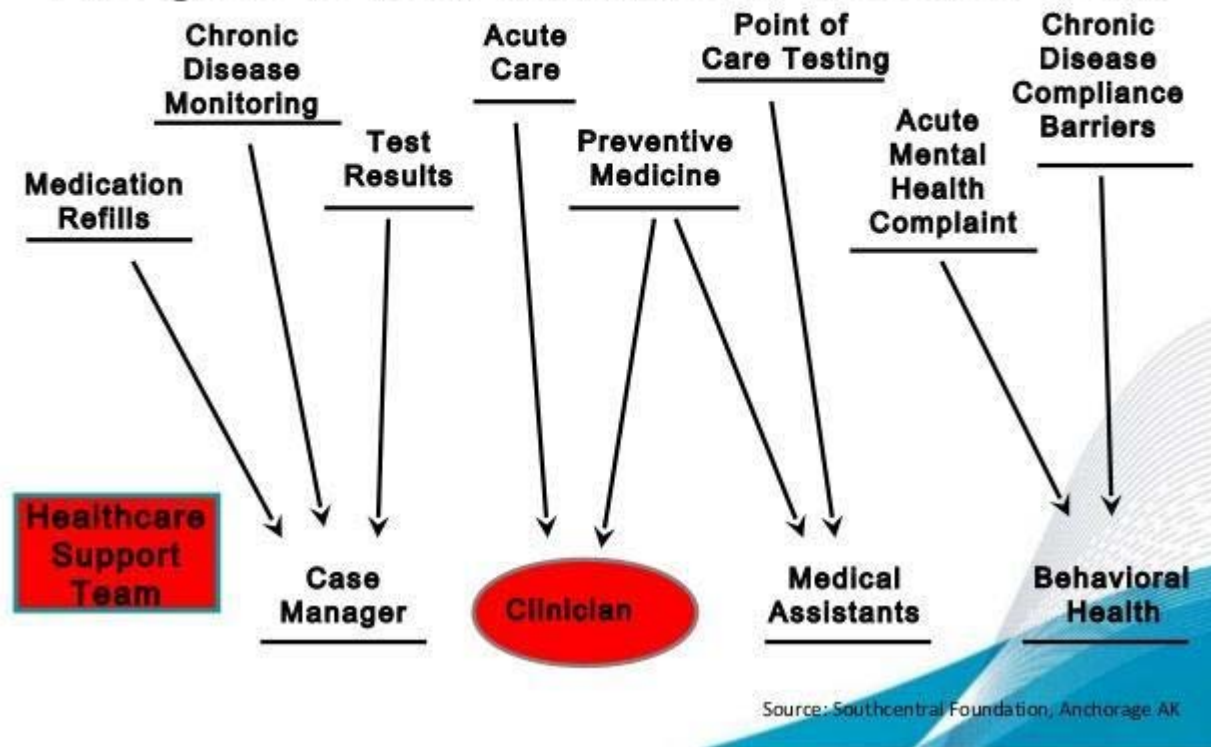
Source: Southcentral Foundation, Anchorage AK



The Cowboy - All Alone out there Stamping out Disease!

PCMH Parallel Team Flow Design

The glue is real data not a doctors Brain





Rural Practice-Where research
and theory hit the road

The Joint Principles of the PCMH

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access to care
- Payment to support the PCMH

Team-based care:
Patient/Family
NP/PA
RN/LPN
Medical Assistant
Office Staff
Care Coordinator
Nutritionist/Educator
Pharmacist
Behavioral Health
Case Manager
Social Worker
Community resources
DM companies
Others...

Joint Principles: adopted by AAFP, AAP, ACP and AOA



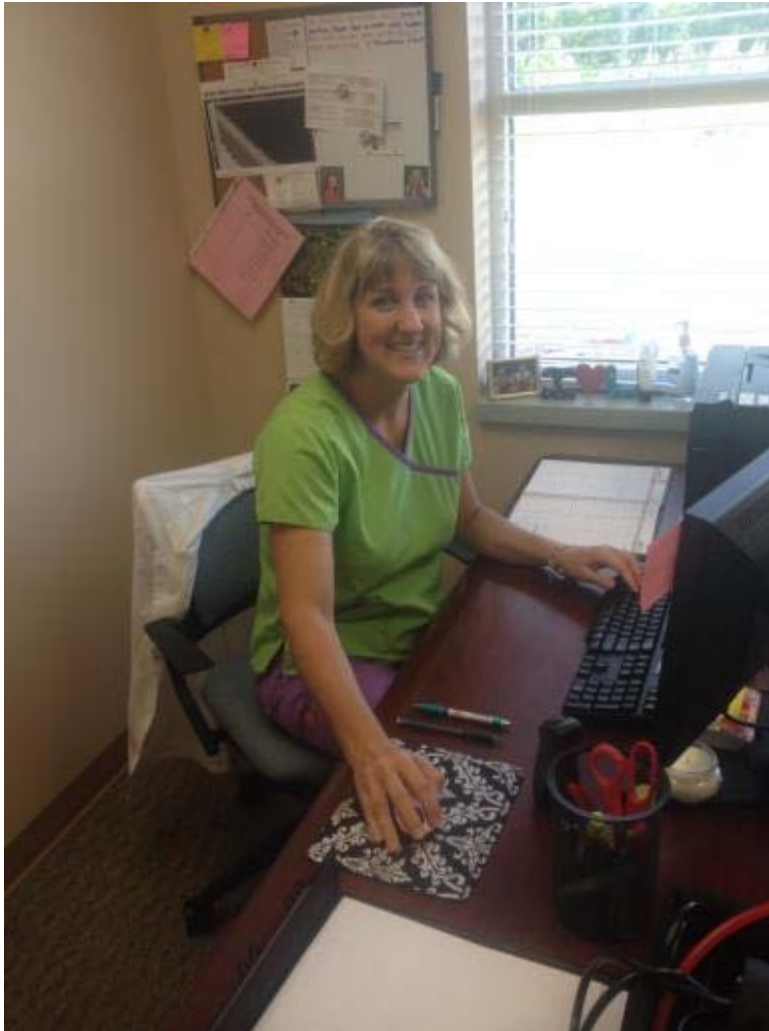
The Health Care Team

Vidant Family Medicine Wallace PCMH Recognition Level III

Trajectory to Value Based Purchasing: Achieving Real Care Coordination and Outcome Measurement



Patient Care Manager and Health Coach



Health Coach for chronic illness

Tracks high risk groups and identifies for follow up

Makes contact after Hospital Discharge and arranges for follow up

Makes Previsit contact to high risk populations-reviews medications for compliance

Janice Thigpen, RN

Case Study

J.E. is a 67 year old male with longstanding Type II diabetes. He has coexisting hypertension and coronary artery disease. His recent Hemoglobin A1C was 8.4. He had no interest in taking any additional medications.

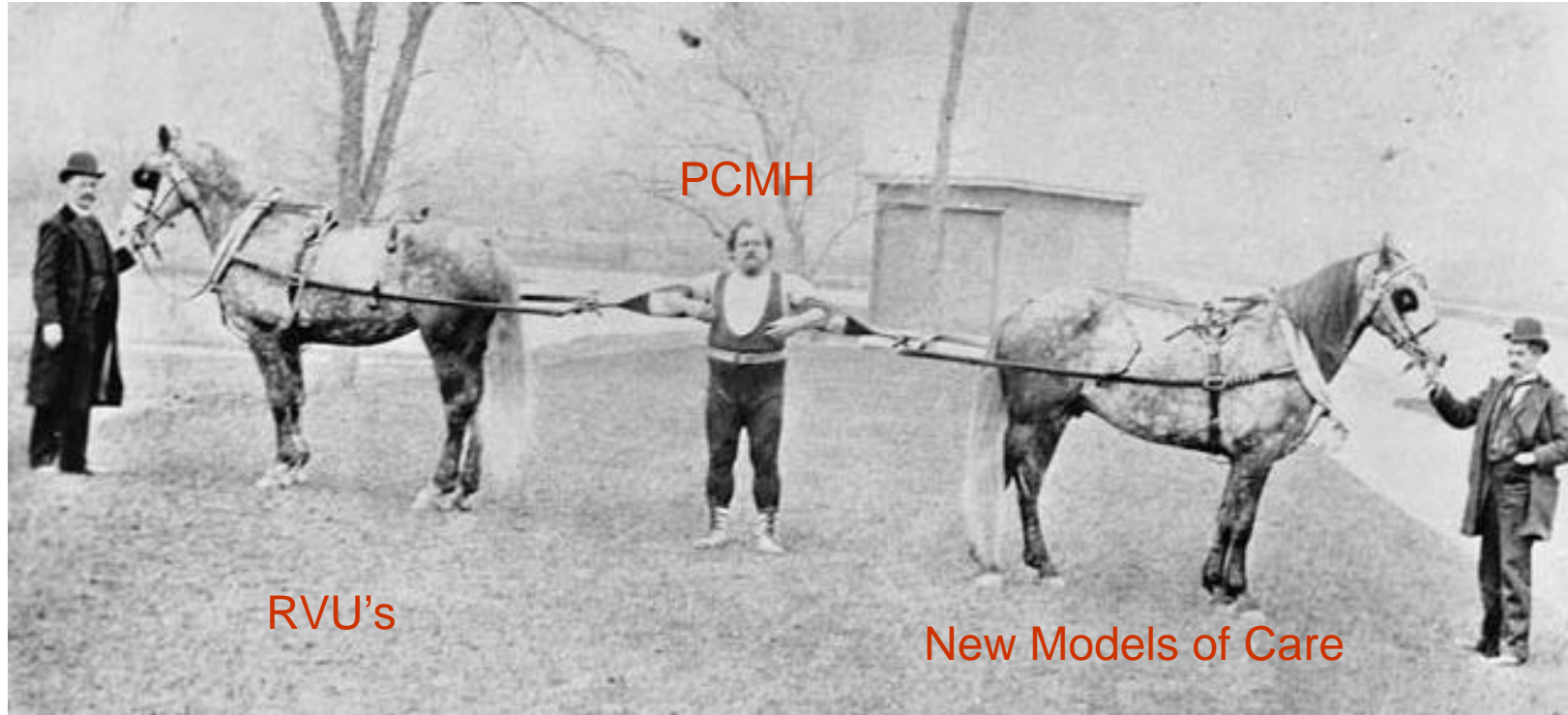
Through intensive intervention via health coach and utilization of community resources, 3 months later his HgbA1C is 6.4!

Case Study

H.M. presented acutely with several week hx of polyuria, blurring of vision with weight loss. He was able to get a walk in appointment that day (open access appointment). Initially screening blood sugar was >350. He was introduced and met with the health coach on that day and intensively followed up with education and appropriate medications. Initial Hemoglobin A1C was 13.7 and 4 months later it is 6.3!

PCMH and new model of care

- Data Driven
- Every patient has a plan
- Team based
- Managing a Population Down to the Person

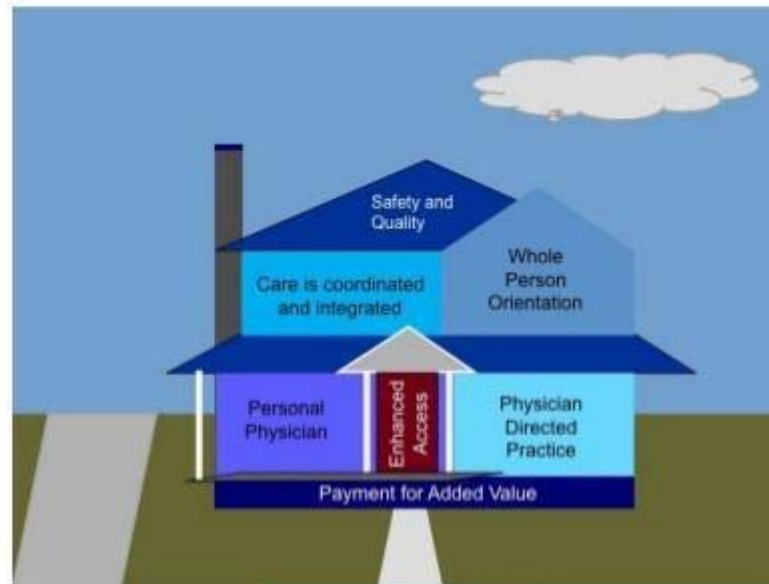


PCMH as the Foundation

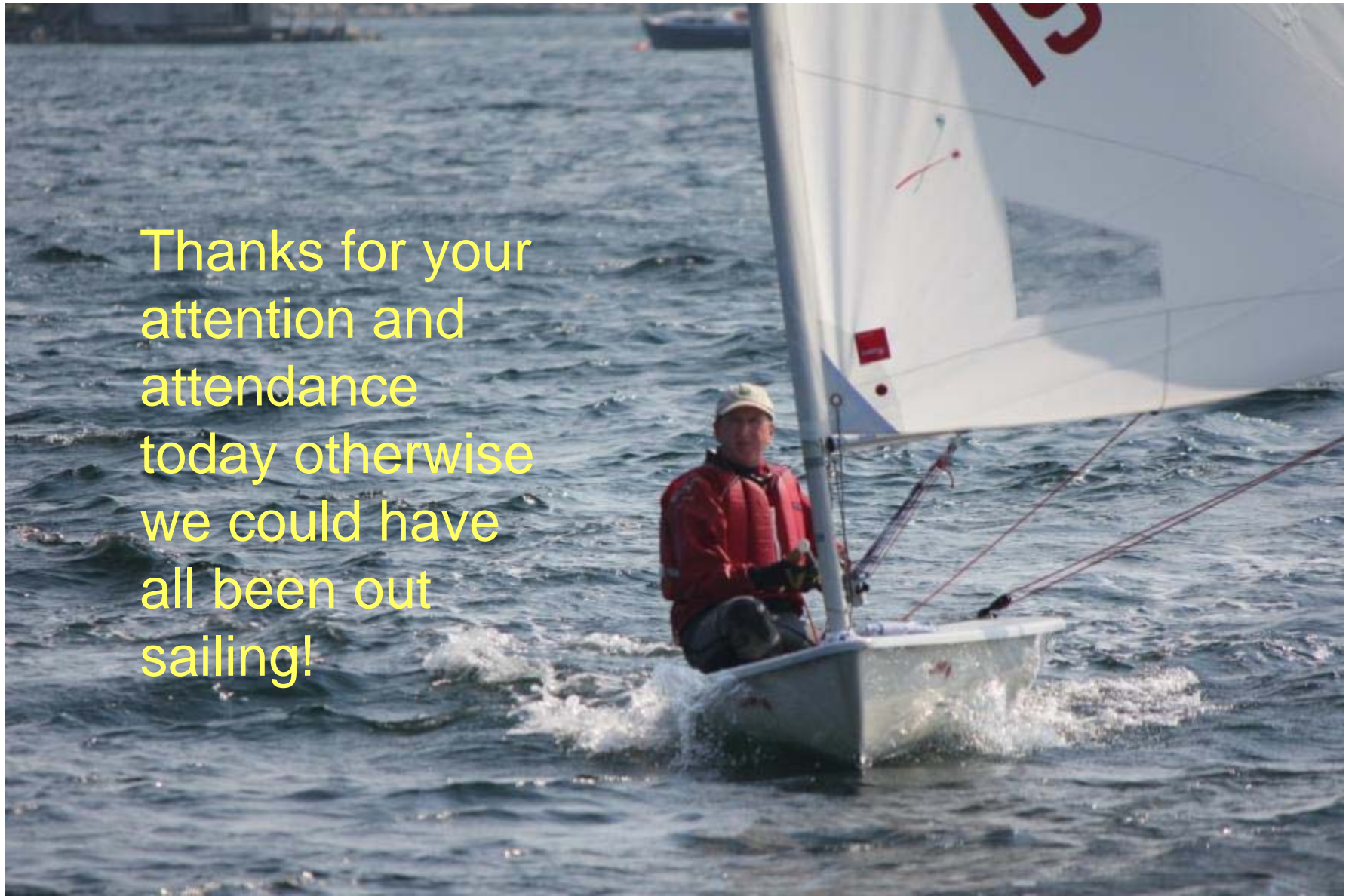
The right care foundation

The right time

The right price



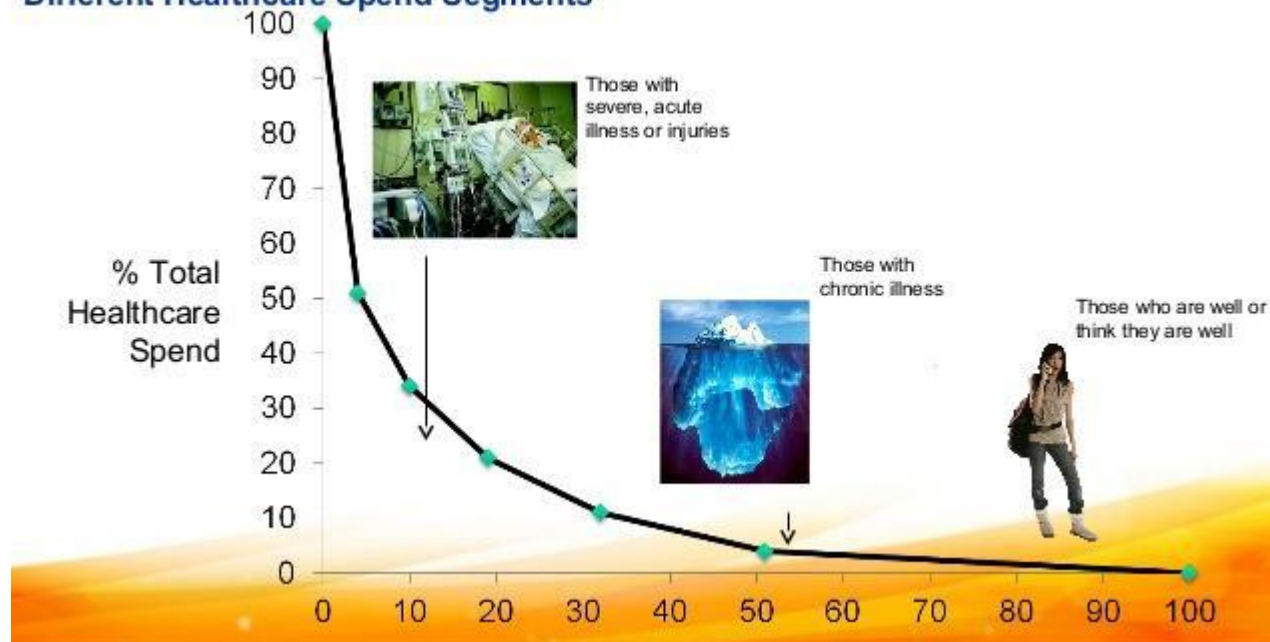
Thanks for your
attention and
attendance
today otherwise
we could have
all been out
sailing!



The Institute of Medicine's 2012, 385-page report,
Best Care at Lower Cost:

Primary care providers are the **only** healthcare professionals who can effect transformation in health care. The systems and structures which will fulfill the Triple Aim (IHI) can **only be designed** and **implemented** by **primary** Healthcare Healers.

Benefit Redesign - Patient Engagement Different Strategies for Different Healthcare Spend Segments



Slide from Paul Grundy, Feb 2013