

## **Building a Diabetes Medical Home: The Impact on Practice Work Flow, Patient Outcomes and Healthcare Costs**

PATRICIA DONOVAN: Welcome to HealthSounds: Conversations with Healthcare Innovators. This is Patricia Donovan for the Healthcare Intelligence Network. Today I am speaking with Dr. James Barr, medical director for Partners in Care, a Physician led organization in New Brunswick, New Jersey. Dr. Barr is presenting at HIN's webinar on Building a Diabetes Medical Home: The Impact on Practice Work Flow, Patient Outcomes and Healthcare Costs." Welcome and thank you for speaking with me today Dr. Barr.

DR. JAMES BARR, MEDICAL DIRECTOR FOR PARTNERS IN CARE: Thank you.

PATRICIA DONOVAN: To begin with your diabetes medical home pilot has been called an innovative collaboration between insurers and physicians on funding and information sharing. Can you describe the types of information shared between the doctors and the health plan and how this contributed to the improved compliance and clinical outcomes?

DR. JAMES BARR: The arrangement that we developed in New Jersey was between the Horizon Blue Cross Blue Shield plan and a physician organization called Partners in Care. This is more of a physician data company that brings in information of all types and then delivers it to physicians in a very actionable format so that it fits into their workflow patterns and allows them to be more engaged to the driving of care towards evidence-based guidelines. And at the same time organizing it in a fashion of the patient centered medical home so that the whole person

orientation treated by a physician led team can act on this. The type of information that was shared was the plan delivering eligibility claims, labs, and pharmacy data all to the Partners in Care organization. The Partners in Care organization then goes out to the physician offices and then performs a chart audit through the physician offices looking at the claims lab and pharmacy data then supplementing that or correcting some of that data with their own data from the patients chart. Together then, between the entities you develop a member specific profile for every patient. This then is brought to the medical home with coordination of all other physicians that care for this patient being involved in this member specific profile. Everyone continuously updating the profile and acting on the profile in order to make sure that that patient receives the best care possible.

PATRICIA DONOVAN: I see. So this data gathering is obviously a huge time saver for the practice?

DR. JAMES BARR: Right. The physician in today's world does not have time to perform a lot of these activities. We've found that by having some type of collaboration between the plan and the physician entity we were able to bring that information in that actionable format right to the physician. And it can be done right at the point of care, which is where that physician has their greatest influence with the patient. If you don't put it in this format the multitude of reports that physicians get from various plans and various reporting structures, none of it fits into their workflow and therefore none of it gets acted on.

PATRICIA DONOVAN: Thank you Dr. Barr. As you said physicians are very busy. On average, how much extra time did the

physicians have to spend with the patients in this pilot program as compared to non-participants and was this time tracked in any way?

DR. JAMES BARR: The method of track for the time, and also for compensation, which I'll touch base on, mimicked some of the CMS demonstration pilots that are being performed where we utilize the "G" codes, the 8,000 9,000 "G" Codes where a physician or the office staff member who took the time to look up the patient's information, perform an outreach we'll say to the patient to get them in for some testing that was beyond what the guidelines would allow for, or to arrange a new treatment to get them to the goal of our guidelines. All that extra work along with the physician calling other physicians and coordinating care, all of it was tracked on a per minute basis. The physician or the office staff member then put down what type of goal oriented activity they preformed. They would put down the amount of time it took them to do that, and then they would submit that to the Partners in Care organization, which then worked with Horizon Blue Cross Blue Shield in order to obtain a reimbursement, which was a certain hourly rate, which brought down to that minute for physicians versus a different hourly rate for the office staff. When you first start this program, your time per patient will be a slightly higher. It could end up to being up to 13 to 30 minutes per month on a patient. Some will be larger, some will be shorter. But then as the patients member specific profile starts to become developed it becomes less of a time requirement, especially for those that have been able to reach their goals, whereas others may take some time to keep them going with compliance issues.

PATRICIA DONOVAN: Thank you Dr. Barr. In which cases besides obviously those involving children would it be appropriate in this model to include the patient's family?

DR. JAMES BARR: There's a multitude of areas here where the family needs to be engaged, and I think it's critical that we bring the family into our patient center medical homes. There's areas where there's compliance again of that patient that are of concern. And sometimes it might be a financial issue; they can't afford medications. Maybe the family can assist in that regard. Maybe there's a mental health issue that the patient has again that the family's assistance in helping them work through certain depressions or other states, helping them get their treatments that's critical. And then there's the issue of end of life care, which are poorly addressed in today's healthcare system that certainly would require the involvement of the patient's family. And then in the end, just overall motivation and support. We need to engage patients. Physicians have the best opportunity to do that because they have an established relationship with that patient. And I think if we extend that relationship to the whole family our outcomes will be that much better.

PATRICIA DONOVAN: Well thank you Dr. Barr. Those are all the questions that I have today. Thank you for being with us. And were looking forward to hearing more details on this program during the webinar and also how this model can be applied in other disease management areas. To register or get more information about this webinar, please call the Healthcare Intelligence Network at 1-888-446-3530. This is Patricia Donovan for the Healthcare Intelligence Network.