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# The Pt-Centered Medical Home in the California Safety Net

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# The Patients We Serve

Very high social and medical complexity

- Chronic disease, poverty, language and educational barriers, mental illness, substance abuse
  - High utilization of fragmented and expensive care: frequent ED use, frequent readmissions
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# Early Efforts To Date

- Patient Visit Redesign
  - Chronic Disease Management – CI
  - Frequent ED Users
  - Hospital Readmission Prevention
  - Cultural Competence/ Language Access
  - Specialty Care Access
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# Clinical Example

- RH is a 62 y/o homeless laid-off printer with severe diabetes
  - poor control of diabetes due to homelessness
  - 6 months of multiple hospitalization for foot infections
  - partial amputation of one foot
  - interventions: diabetes case manager, job counselling, housing assist
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# Our System Goals

1. Care is tailored to the patient
  2. A Team is responsible, not just MD
  3. The patient decides together with team
  4. Care is continuous and coordinated
  5. Driven by measurement, supported by IT
  6. Patient has full access: UC, advice line
  7. Culture, language, education is
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# Lessons and Challenges

- System change is slow
  - Hard to change tires while going 60
  - Funding has to support these expanded preventive efforts vs. paying for more utilization
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