Lessons from PCMH Implementation

Key Factors in PCMH ROI: Avoiding Disappointment
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Learning Objectives
Factors in PCMH ROI: Avoiding Disappointment

• Create a successful leadership team for PCMH transformation
  • Harmonizing people, process and technologies
• Become a data-driven health system
  • Data drives optimization
• Detail the goals of population health; integration of clinical medicine and public health, healthy lives for all
• Analyze patient-centeredness; building individualized care plans with patient engagement, self-management and literacy awareness
Theoretical Framework for PCMH
Coming together is a beginning

Keeping together is progress

Working together is success

—Henry Ford
Reminder

Improve the experience and quality of care

Reduce per capita costs of health care

Improve the health of populations

Triple Aim
National Quality Strategy

Improve the overall quality of care, by making health care more patient-centered, reliable, accessible, and safe

Better Care

Healthy People/Healthy Communities

Improve health of the U.S. population by supporting proven social and environmental health determinants in addition to delivering higher quality of care

Affordable Care

Reduce the cost of quality health care for individuals, families, employers and government
## Enhanced Access...

...to Comprehensive, Coordinated, Evidence-based, Multidisciplinary Care

<table>
<thead>
<tr>
<th>Medical Home Care</th>
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</tr>
</thead>
<tbody>
<tr>
<td>A personal clinician who has an ongoing relationship with patients and follows them through the care process.</td>
<td>Clinician-directed medical practices where the MD captains a team of care providers who all share responsibility for treating a patient.</td>
</tr>
<tr>
<td>Whole-person orientation in which the care team helps the patient plan out goals for all phases of their care needs. The office takes responsibility for facilitating future appointments and appointments with other providers.</td>
<td>Coordinated care that uses a proven system for sharing information (like electronic health records) and information is clearly relayed to patients. Also, patients have the opportunity to receive care when and where they need it.</td>
</tr>
<tr>
<td>Quality and safety are the top goals and patients have an active say in all decisions made about their care.</td>
<td>Enhanced access means that patients have greater ability to make appointments and that spots are held open for patients to meet needs.</td>
</tr>
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Leadership
Harmonizing People, Process and Technologies
## Continuous Quality Improvement vs. Transformation

<table>
<thead>
<tr>
<th>Continuous Improvement</th>
<th>Transformation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Incremental in nature</td>
<td>• Is breakthrough in nature</td>
</tr>
<tr>
<td>• Tactical</td>
<td>• Disrupts</td>
</tr>
<tr>
<td>• Small improvements over time that make a big difference to an organization</td>
<td>• Includes elements of strategy, people, process and technology</td>
</tr>
<tr>
<td>• Continuous improvement is a mindset</td>
<td>• Must begin at the top where strategy is set</td>
</tr>
</tbody>
</table>
Creating Data-Driven Organizations
Characteristics of a Data-Driven Organization

**Technology**
- Possess an IT platform to take advantage of the data available

**Processes**
- Have defined the business processes, workflow and policies & procedures that guide the creation of data

**People**
- Work with SMEs to understand how the data is created. Define a path for operationalization of the data for meaningful initiatives crucial to go after opportunities that will have the highest impact
Anatomy of a Data Element: From Source to Re-purpose

that support focused initiatives

that are re-purposed in analytics apps

generate individual data elements

Source systems

ED  Practice Mgmt  EHR  Patient Billing  ADT  Other
Population Health

The separation between clinical medicine and population health is well- ingrained
Where We Are Today

- A divide exists between clinical medicine and population health
  - Episodic versus whole groups
- Priorities will be similar between clinical medicine and population health
  - Health-related behaviors are powerful determinants of individual health but often ignored in episodic care
- PCMH needs to intentionally train staff and providers
  - Collaborative patient engagement skills, self management, motivational interviewing and literacy skills
Non-Medical Determinants

Research finds that consumer health behavior or self-management, the leading non-medical determinant, accounts for up to 40% to 50% of health outcomes; this rate increases to 70% with the inclusion of environment and social circumstances. Increased individual engagement can mitigate these influencers.

Sources: Schroeder, S. We Can Do Better – Improving the Health of the American People, New England Journal of Medicine, Sept 20, 2007; and The World Health Organization, Commission on Social Determinants of Health Final Report
HALE: Health-Adjusted Life Expectancy

• A simple, understandable measure such as HALE facilitates comparisons
  • Risk modeling tools increasingly enable useful estimates of HALE at the clinical level based on demographic, clinical, and patient-reported data at the point of care (Stine, et al., 2013)
  • Clinicians and researches can compare that to the patient’s potential HALE if he or she were to take specific actions to manage health conditions or behaviors
  • The gap between a patients estimated and potential HALE represents an opportunity for improving health
Patient-Centeredness

Patient Engagement-Health Literacy
## Low Activations Signals Problems
*(and Opportunities)*

The MORE ACTIVATED you are in your own health care, the BETTER HEALTH CARE you get...

<table>
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<tr>
<th>Condition</th>
<th>More Activated Patient</th>
<th>Less Activated Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmitted to the hospital within 30 days of discharge</td>
<td>12.8%</td>
<td>28%</td>
</tr>
<tr>
<td>Experienced a medical error</td>
<td>19.2%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Have poor care coordination between health care providers</td>
<td>12.6%</td>
<td>41.8%</td>
</tr>
<tr>
<td>Suffer a health consequence because of poor communication among providers</td>
<td>13.2%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Lose confidence in the health care system</td>
<td>15.1%</td>
<td>59.8%</td>
</tr>
</tbody>
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Source: Adapted from AARP & You, "Beyond 50.09" Patient Survey. Published in AARP Magazine. Study population age 50+ with at least one chronic condition. More Involved=Levels 3 & 4, Less Involved=Levels 1 & 2

Health Literacy Definition

The degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions. Nearly half of all American adults—90 million people—have inadequate health literacy to navigate the health care system (IOM, 2004).
Health Literacy Resources

• AHRQ Literacy tool kit:

Patient-Centered Interactions

continuum of care

care coordination

care management
He had 2 to 3 years to live. That was a long time ago.

Now, Eric Dishman puts his experience and his medical tech specialist skill together to suggest a bold idea for reinventing (transforming) health care -- by putting the patient at the center of a treatment team.

http://www.ted.com/talks/eric_dishman_health_care_should_be_a_team_sport.html
Summary

How to Avoid Disappointment

Medical home success requires strategic changes to people process and technology in both inpatient and outpatient settings.

Practices/health systems need to be data-driven organizations.

Priorities will be similar between clinical medicine and population health: health-related behaviors are powerful determinants of individual health but often ignored in episodic care.

Patient-centered care begins with the patient.