Lessons from PCMH Implementation

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Key Factors in PCMH ROI: Avoiding Disappointment

Pamela Ballou-Nelson, RN, PhD

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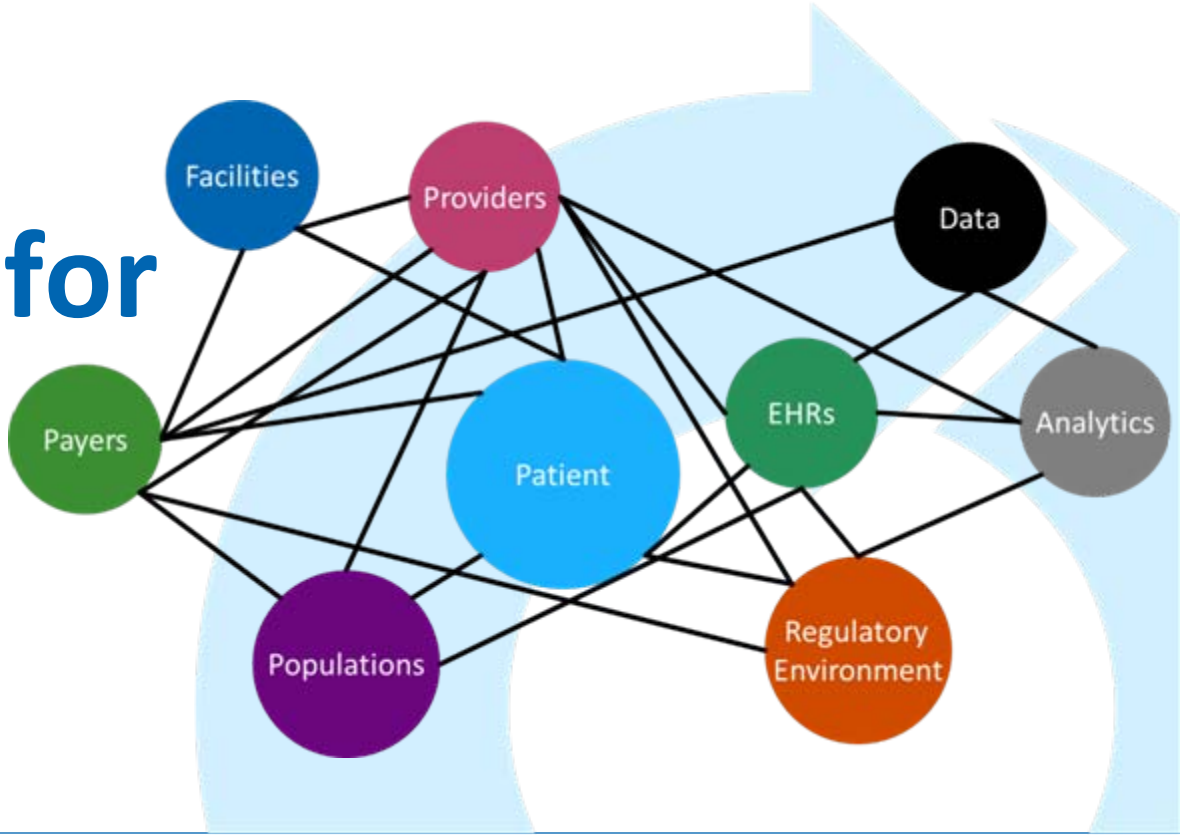
Learning Objectives
Factors in PCMH ROI: Avoiding Disappointment

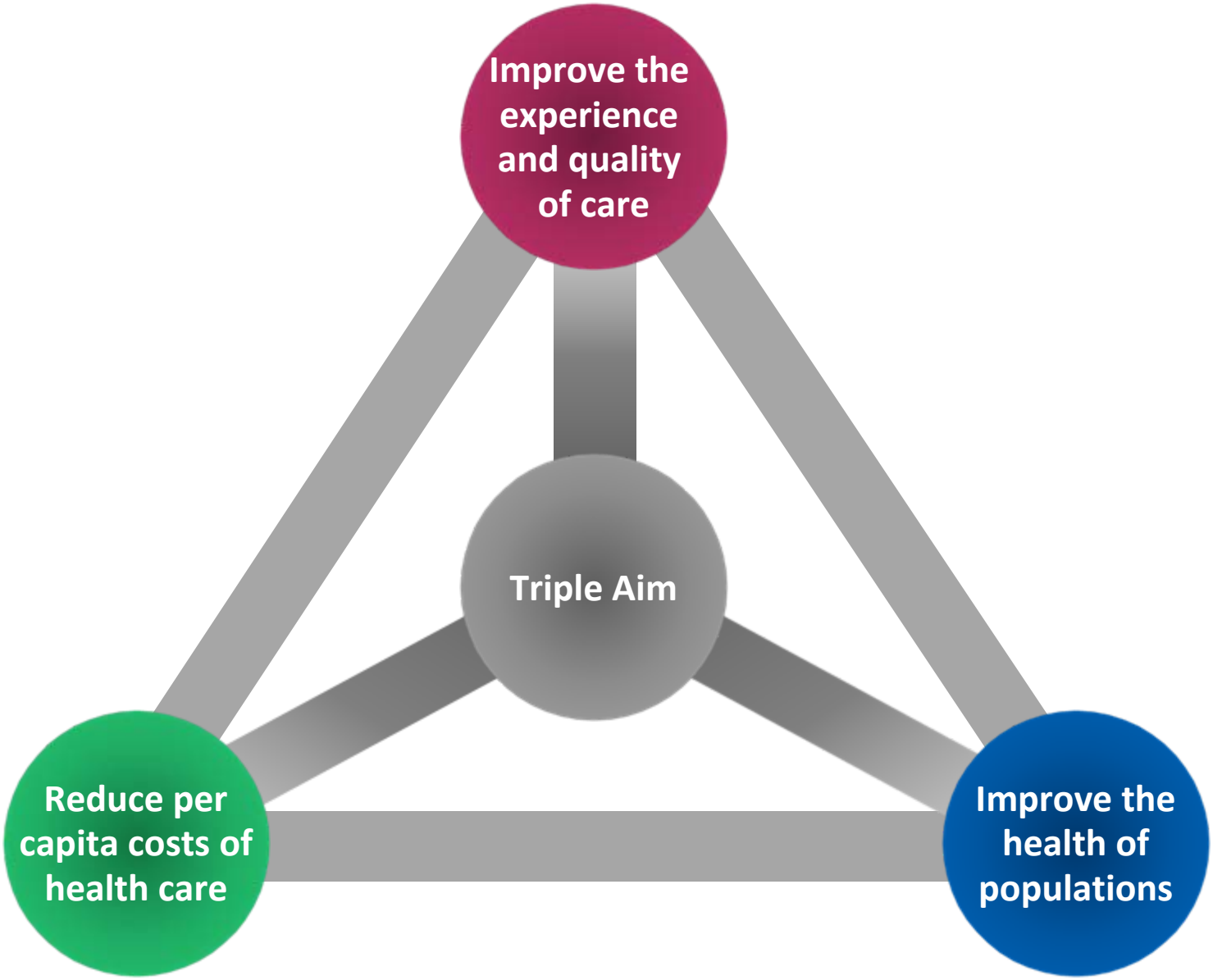
- Create a successful leadership team for PCMH transformation
  - Harmonizing people, process and technologies
- Become a data-driven health system
  - Data drives optimization
- Detail the goals of population health; integration of clinical medicine and public health, healthy lives for all
- Analyze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

Theoretical Framework for PCMH



—Henry Ford

Reminder



National Quality Strategy

Better Care

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

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

Medical Home Care	Medical Home Care
A personal clinician who has an ongoing relationship with patients and follows them through the care process.	Clinician-directed medical practices where the MD captains a team of care providers who all share responsibility for treating a patient.
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.	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.
Quality and safety are the top goals and patients have an active say in all decisions made about their care.	Enhanced access means that patients have greater ability to make appointments and that spots are held open for patients to meet needs.

Leadership

Harmonizing People, Process and Technologies

Continuous Quality Improvement vs. Transformation

Continuous Improvement

- Incremental in nature
- Tactical
- Small improvements over time that make a big difference to an organization
- Continuous improvement is a mindset

Transformation

- Is breakthrough in nature
- Disrupts
- Includes elements of strategy, people, process and technology
- Must begin at the top where strategy is set

Creating Data-Driven Organizations

Characteristics of a Data-Driven Organization

Technology

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

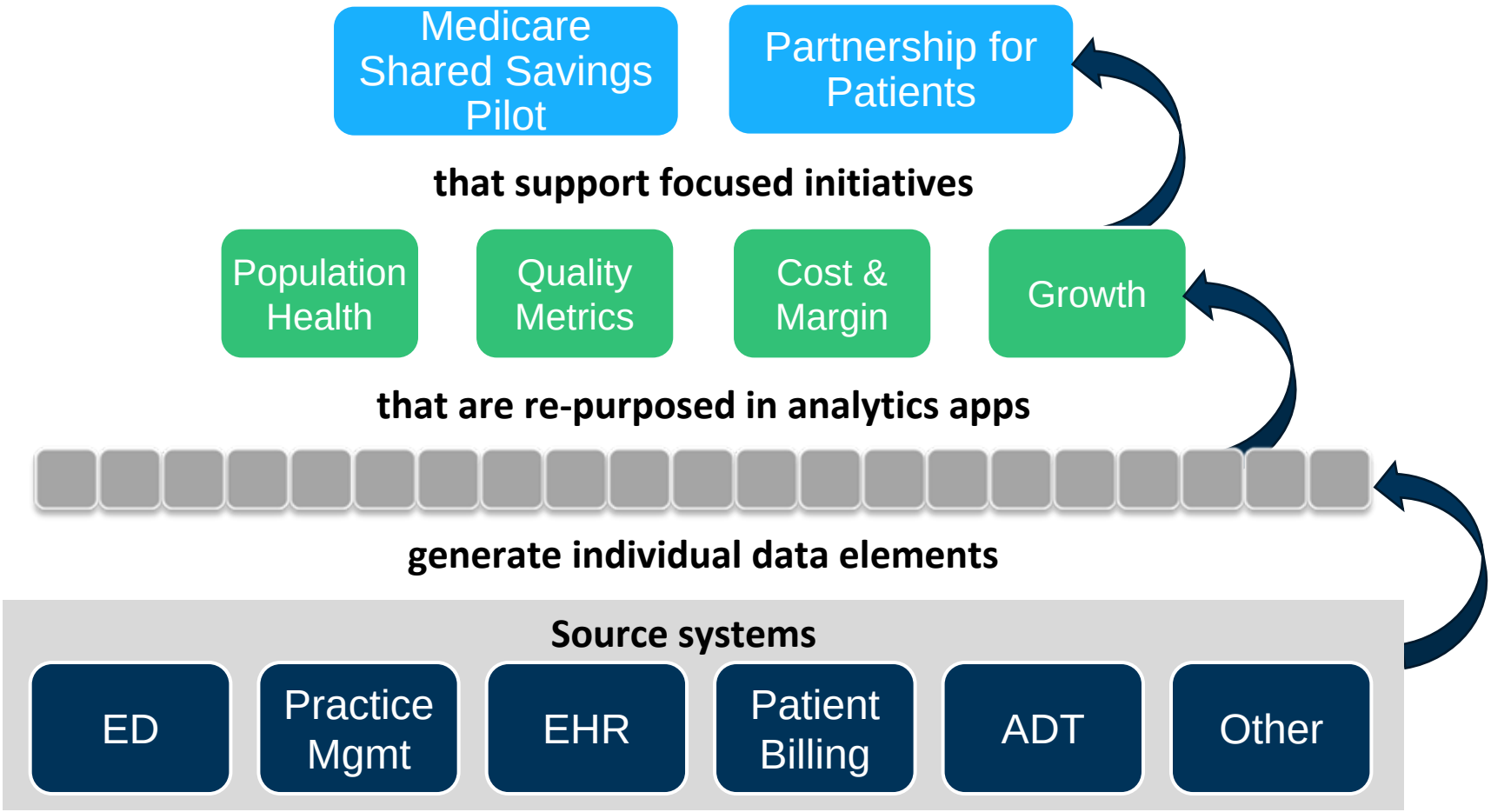
Processes

- 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



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.

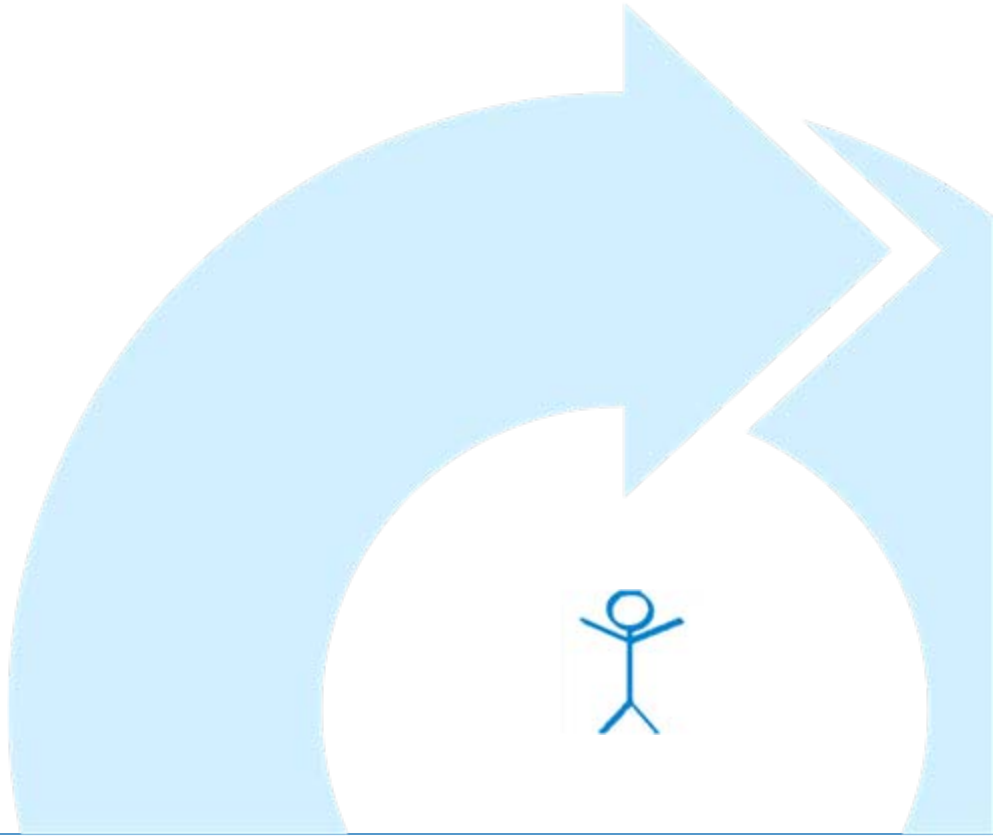
Sources: Schroeder, S. We Can Do Better – Improving the Health of the American People, New England Journal of Medicine, Sept 20, 2007; and The World Health Organization, Commission on Social Determinants of Health Final Report

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

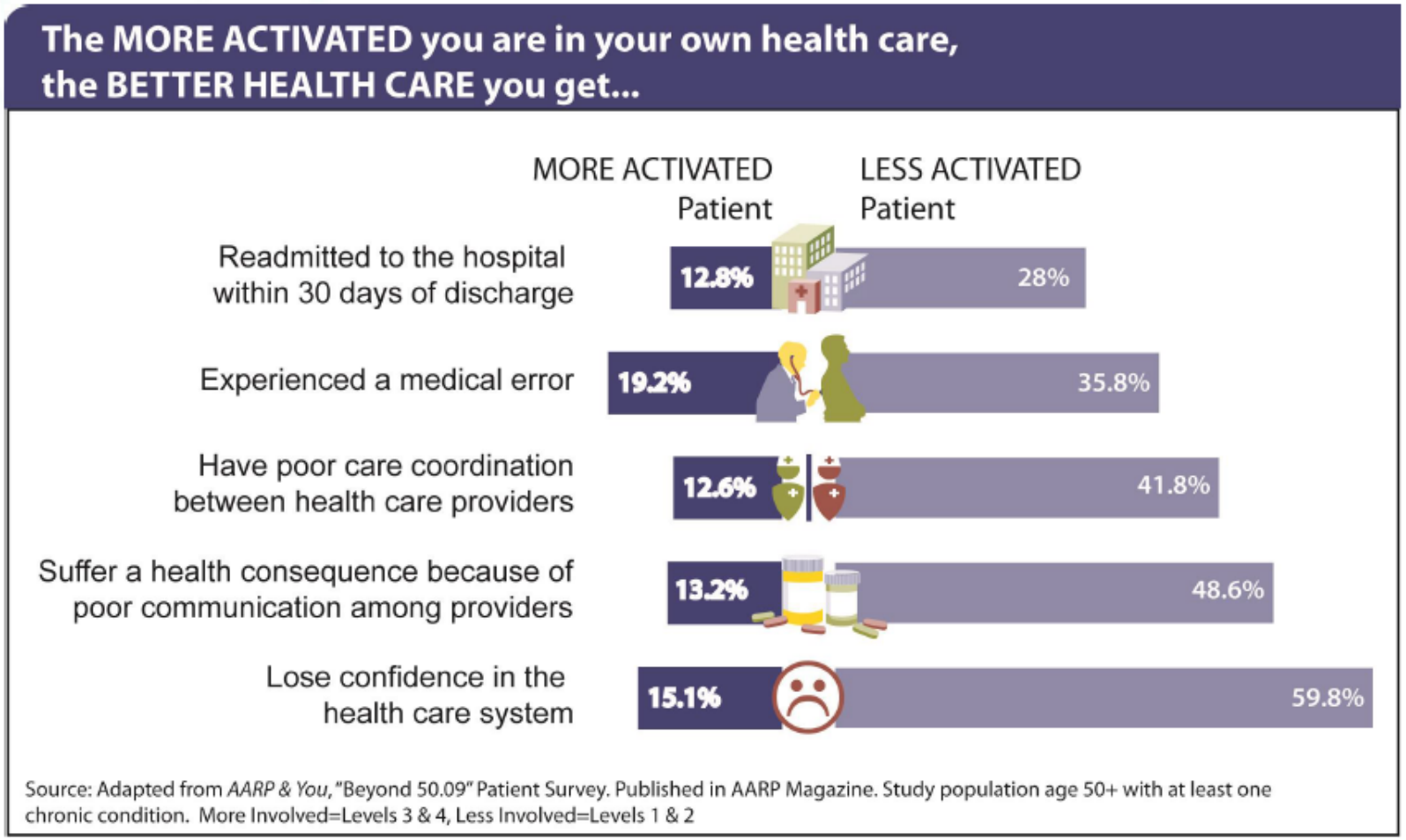
Patient-Centeredness

Patient Engagement-Health Literacy



Low Activations Signals Problems

(and Opportunities)



Source: Patient Activation and Care Transitions; Judith H. Hibbard, D.Ph.; Health Policy Research Group; University of Oregon ©2008.

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:

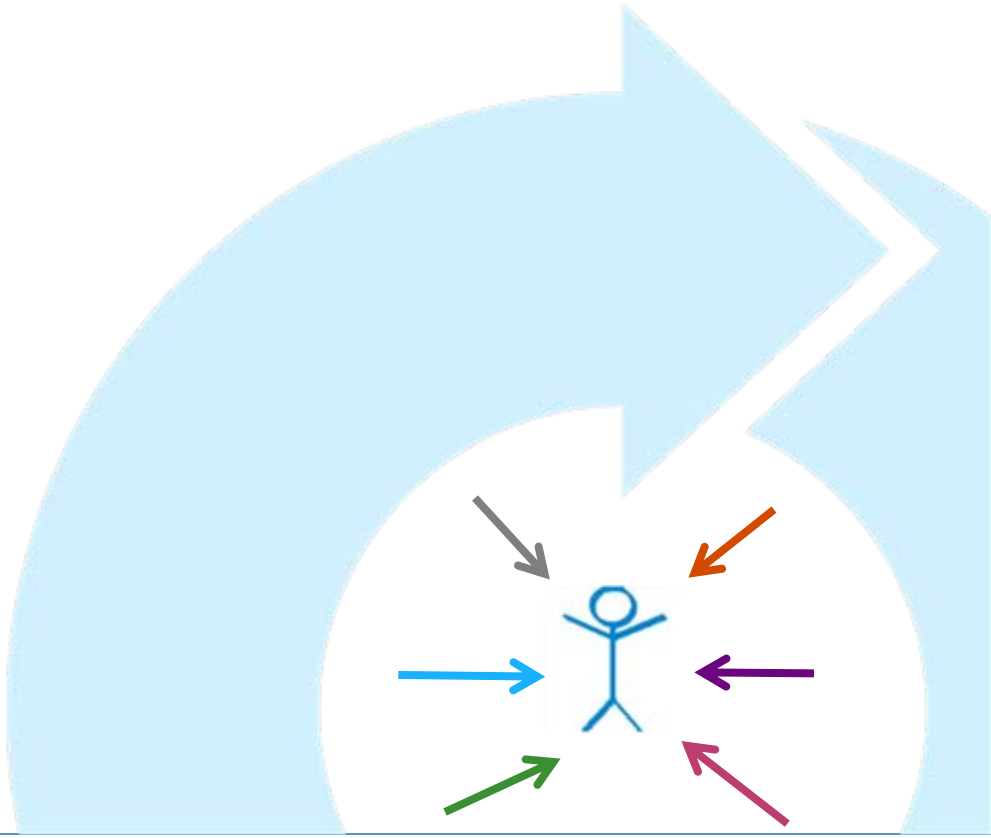
  http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html

Patient-Centered Interactions

continuum of care

care coordination

care management



A Patient's Perspective

For Transformed Care

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.

Pamela Ballou-Nelson, RN, PhD, PCMH CCE
| Value Performance Advisory
NCQA PCMH Certified Content Expert
Encore, A Quintiles Company
pballounelson@encorehealthresources.com
Cell: 630-294-1072
www.encorehealthresouces.com

Thank You!