# ACO/PCMH and the Role of Clinical Integration in Transitions of Care: Learn How to Successfully Use the Patient Journey Model and Tools for Improving Ratings

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Group Practice Forum

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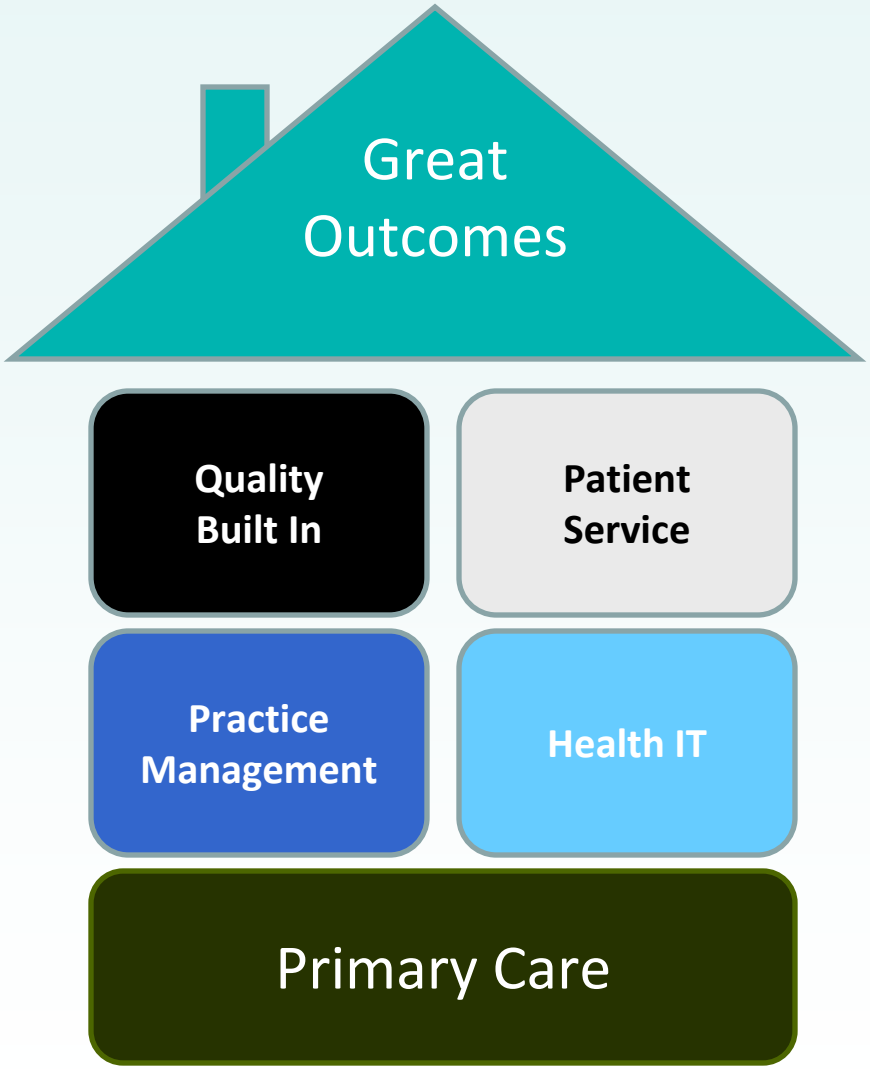
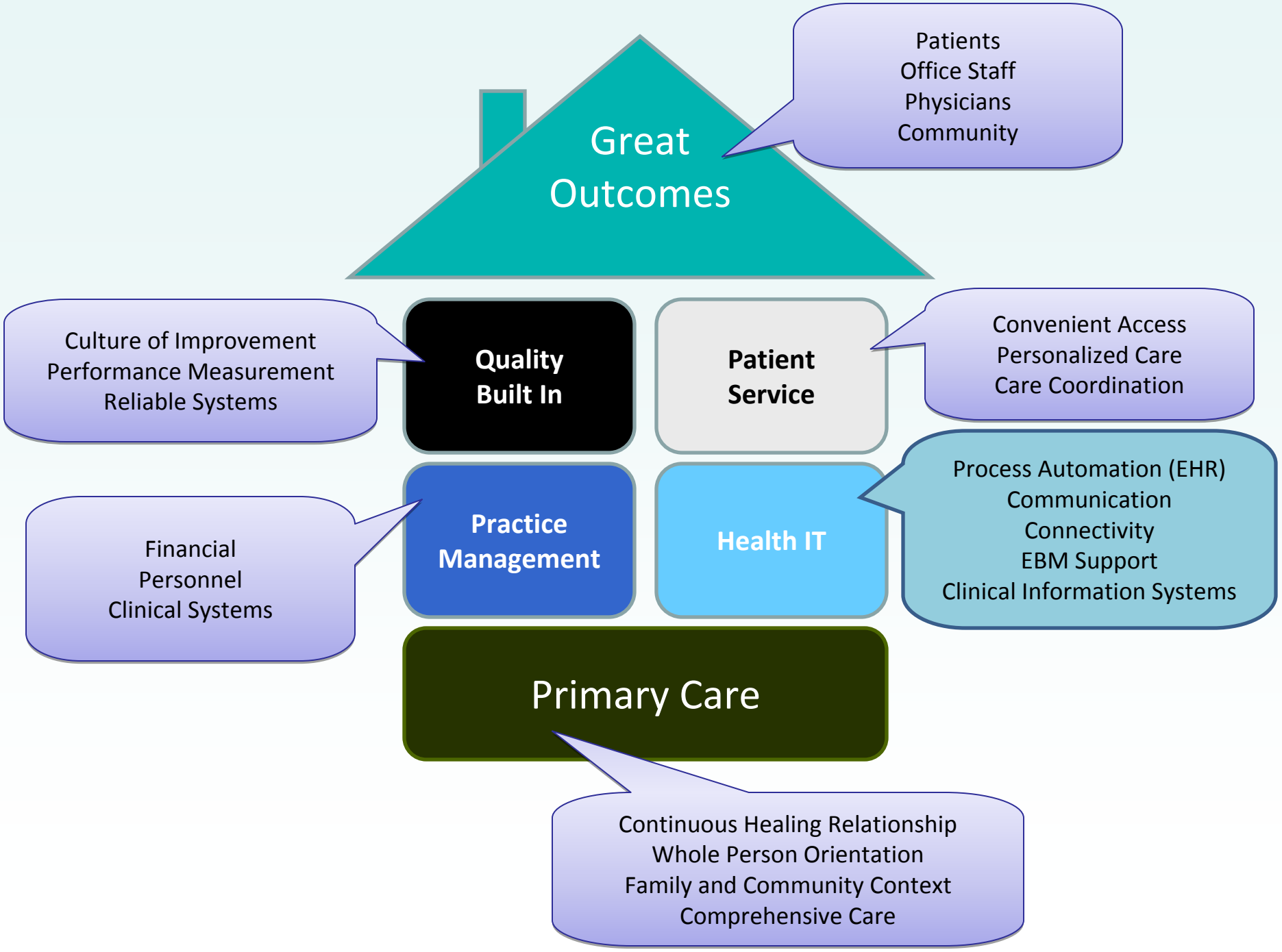
GROUP PRACTICE FORUM


Great Outcomes
Quality Built In
Patient Service
Practice Management
Health IT
Primary Care


Great Outcomes
Patients
Office Staff
Physicians
Community
Culture of Improvement
Performance Measurement
Reliable Systems
Quality Built In
Patient Service
Convenient Access
Personalized Care
Care Coordination
Financial
Personnel
Clinical Systems
Practice Management
Health IT
Process Automation (EHR)
Communication
Connectivity
EBM Support
Clinical Information Systems
Primary Care
Continuous Healing Relationship
Whole Person Orientation
Family and Community Context
Comprehensive Care

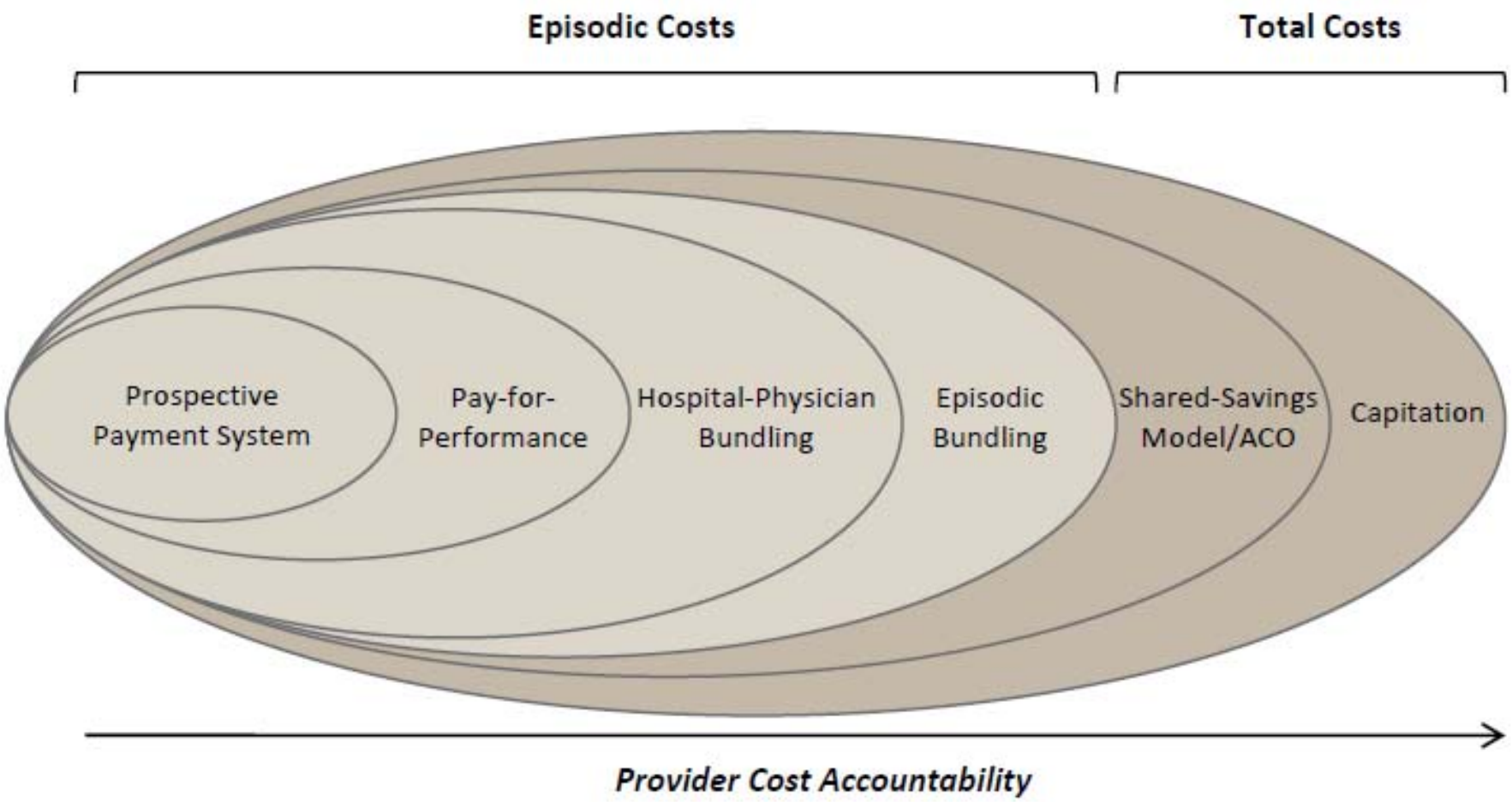
# Principles of The Patient Centered Medical Home/Accountable Care/Clinical Integration

- Personal Physician trained to provide continuous, comprehensive care
- Physician-Directed Medical Practice
- Whole Person Orientation
- Coordinated Care
- Quality and Safety
- Enhanced Access to Care
- Payment appropriately recognizes added value provided to the overall system

"Better patient care for the best price"

# On the Path Toward Accountability

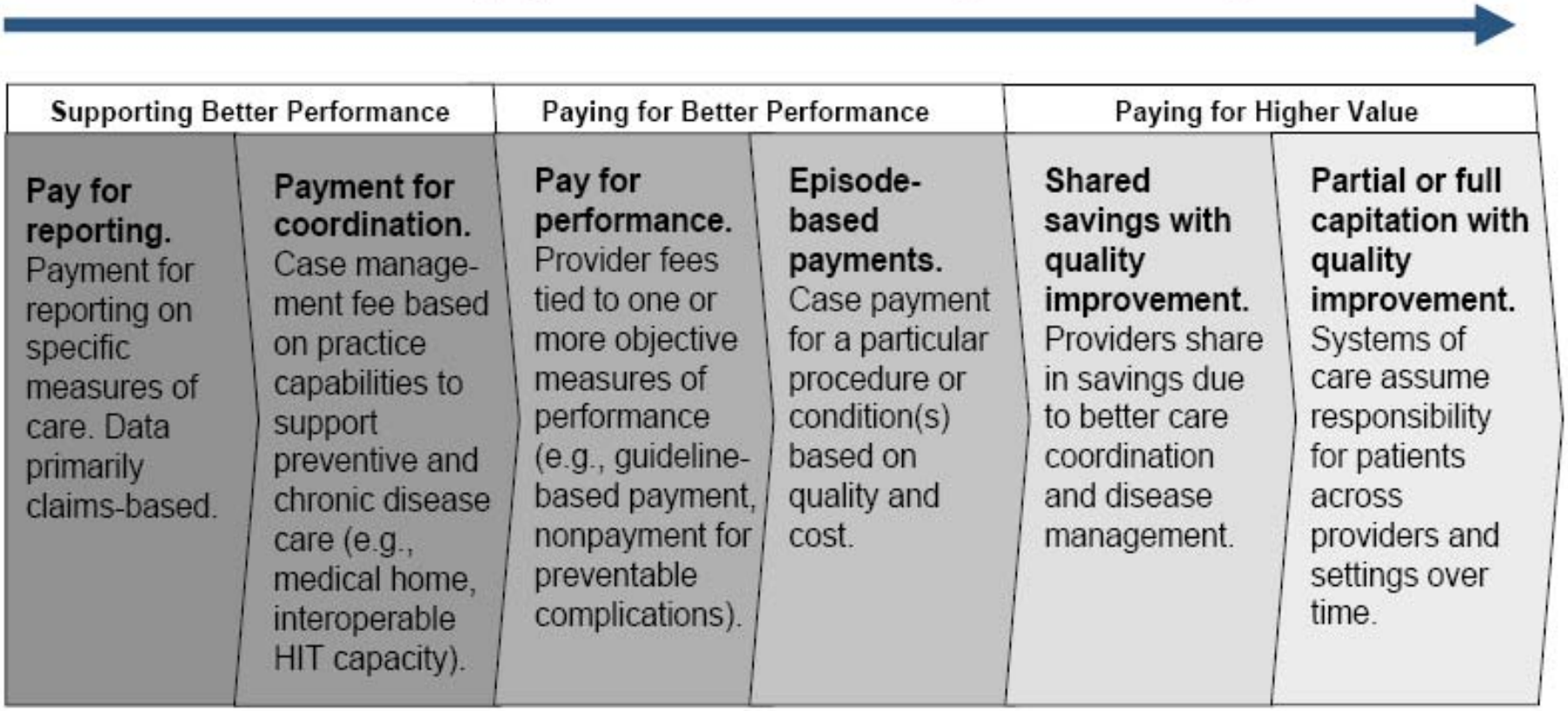
*Uncertainty of Timing, Not Direction, Our Principal Strategic Challenge*




Source: The Advisory Board, 2010

# Evolution of payment reform

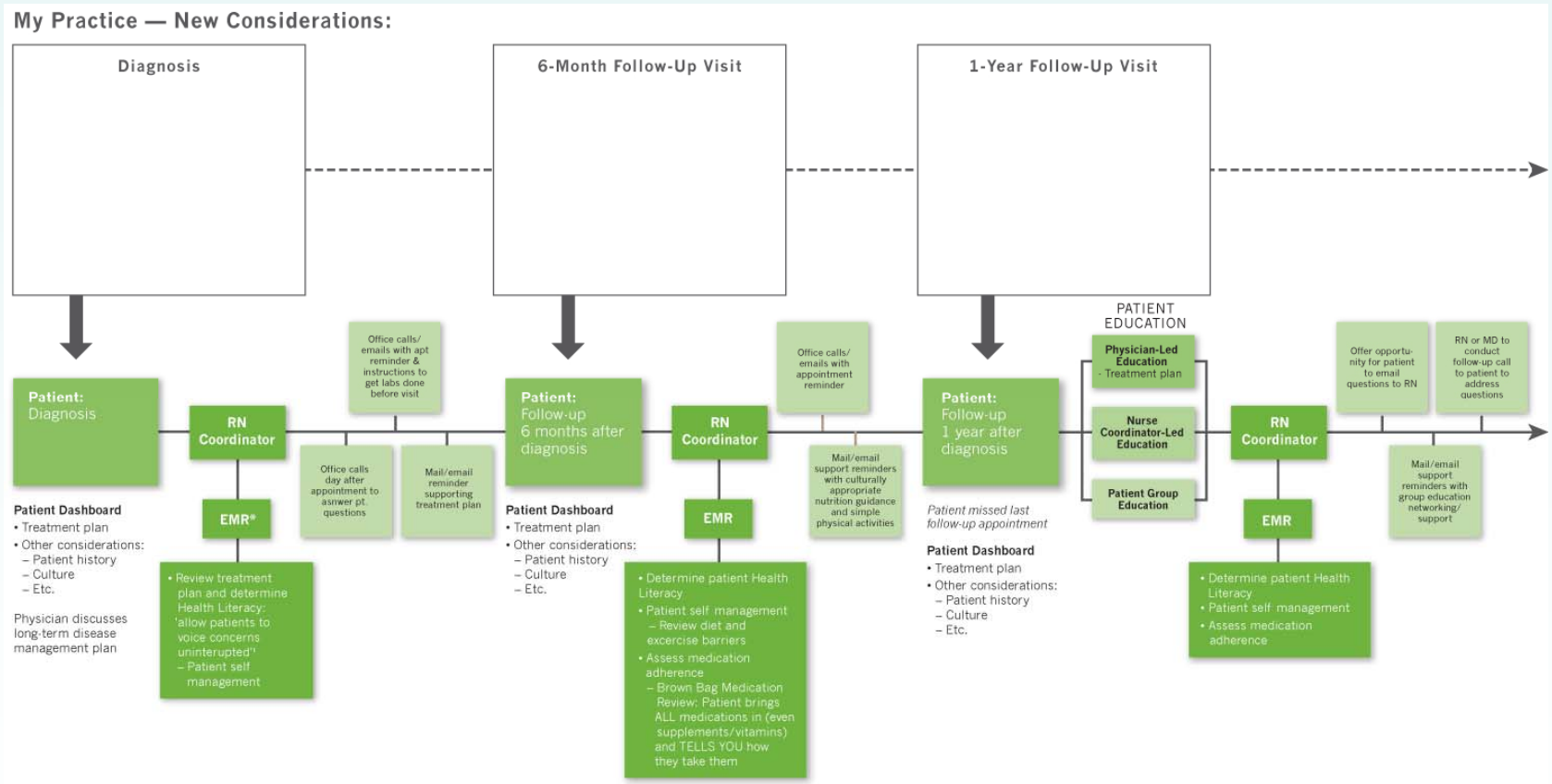
**Past and Emerging Models of Accountability in Provider Payments**



# Making It Real for You: Workflow Redesign

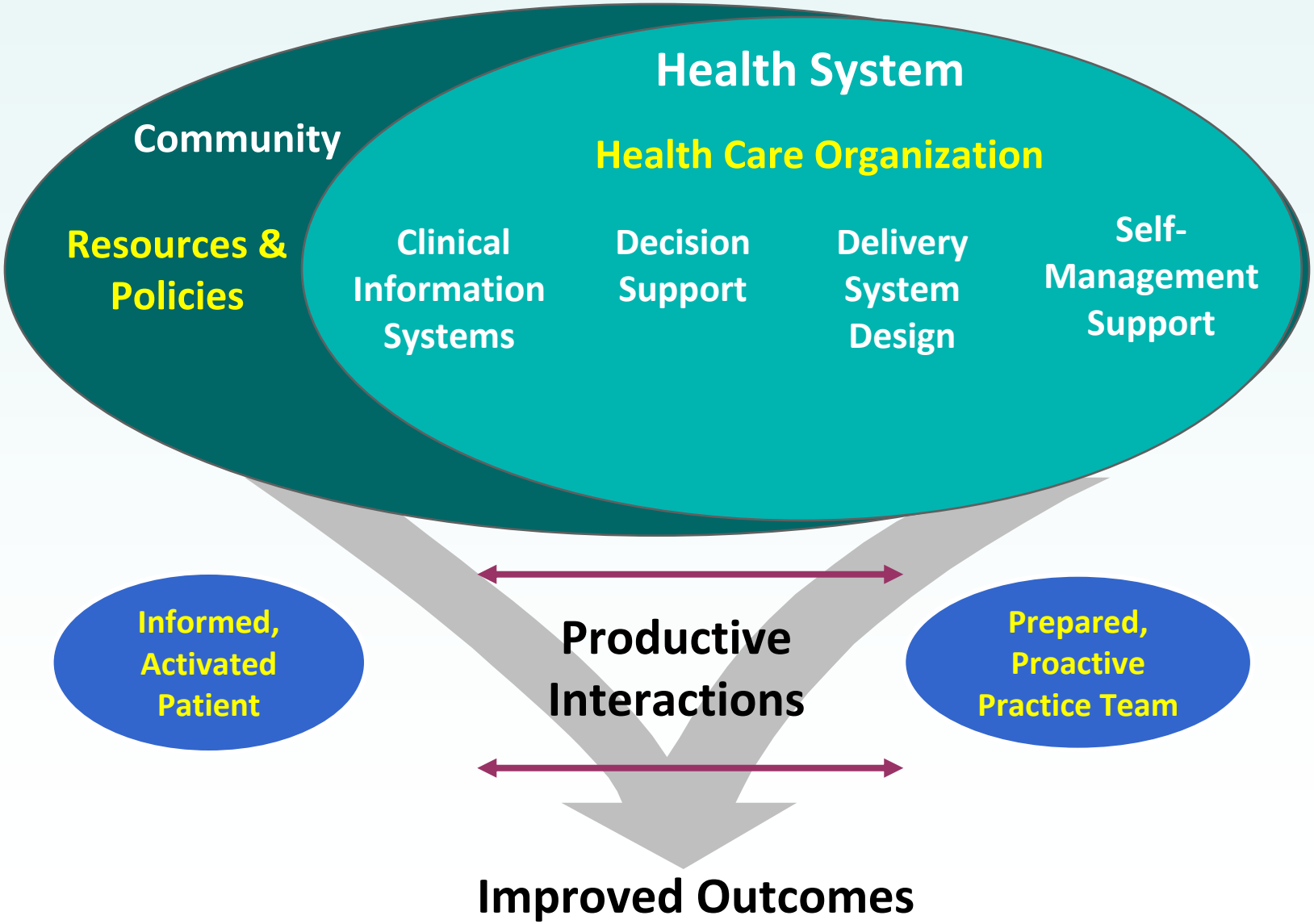
- Prevention and Wellness
- Chronic Diseases
- Population Management
- Care Teams
- Your Patients

# Patient Care Pathway Creates a Map of the Patient Experience through the Healthcare System




| Coordinated care team | Patient empowerment | Health literacy | Patient population management | Electronic medical records |
|---|---|---|---|---|

# Chronic Care Model (CCM)




Slide from E. Wagner

# The Patient Dashboard: A Means to Assess, Monitor, and Modify

**Initial Visit**

**Patient Dashboard**

| Test | Data |
|---|---|
| **Height** | 5´6" |
| **Weight** | 160 lbs |
| **BMI** | 25.8 kg/m$^2$ (overweight) |
| **Average of 3 office BP measurements** | 140/89 mm Hg |
| **Treatment** | • HTN management: ACE inhibitor (ramipril 10 mg qd); (second medication of choice)<br>• Diabetes management: metformin 850 mg bid |

**6-Week Visit**

**Patient Dashboard**

| Test | Data |
|---|---|
| **Height** | 5´6" |
| **Weight** | 155 lbs |
| **BMI** | 25.0 kg/m$^2$ (slightly overweight) |
| **Fasting blood glucose** | 110 mg/dL |
| **Average of 3 office BP measurements** | 127/78 mm Hg |
| **Treatment** | • No change to meds<br>• Continue nonpharmacologic interventions<br>• Focus on lifestyle changes to control blood glucose |

*The information presented in this case is a hypothetical example and not based on an actual patient*

# The Patient Pathway Highlights Team-Based Care Models: Every Member Plays A Part

## Shared Responsibilities to Reach a Common Goal

| | Patient Registry | Motivational interview | Checked medication adherence | Updated EMR | Distributed educational tools | Lifestyle SMBG (diet/exercise) | Outreach to patient after appointment |
|---|---|---|---|---|---|---|---|
| **MD** | | ✓ date | ✓ date | | | | |
| **Nurse/NP/PA** | ✓ date | | | ✓ date | ✓ date | ✓ date | |
| **Office Staff** | ✓ date | | | ✓ date | | ✓ date | ✓ date |
| **Pharmacy CDE** | | ✓ date | ✓ date | | ✓ date | ✓ date | |

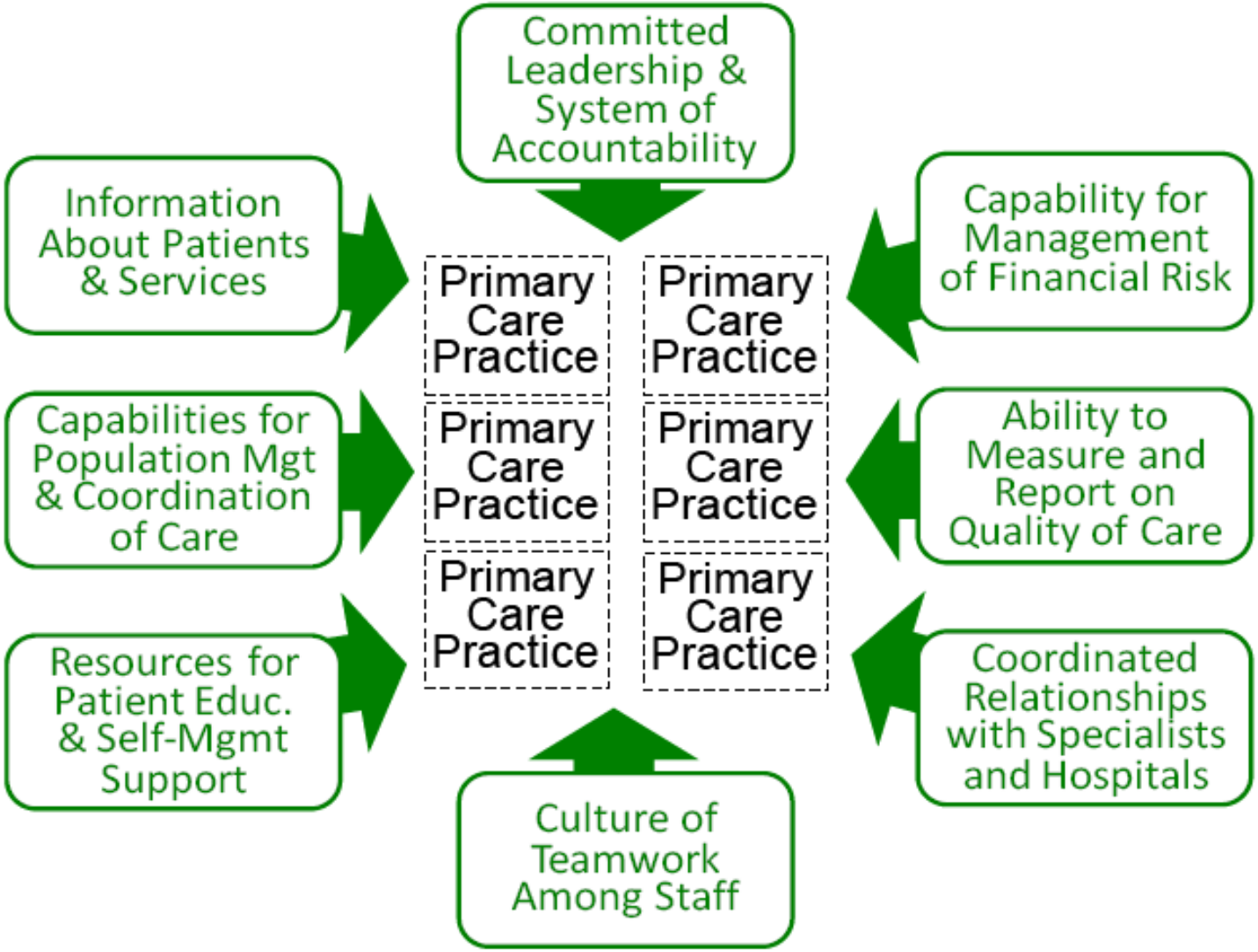
Sample Task List

# Evolution of Expectations for Physicians—Clinical Integration

- Team-based care
- Focus on the top of license/training & interest
- Improved communication
- Improved data flow & access
- Right patient at the right time
- Patient-centered aligned incentives – outcomes, quality, cost
- External accountability – outcomes, quality, cost

# The Virtual Medical Home

# ACCOUNTABLE CARE ORGANIZATION



# The Bottom Line: Volume to Value

- Quality / Cost
  - Maximize the numerator
  - Decrease the denominator

# LEADERSHIP

*The leader always sets the trail for others to follow.*