Person Centered Health Home Foundation of Transformation.

@Paul_PCMH
Away from Episode of Care to Management of Population with Data

System Integrator

- Creates a partnership across the medical neighborhood
- Drives PCMH primary care redesign
- Offers a utility for population health and financial management
Key principles

- **Personal healer** – each patient has an ongoing personal relationship with a physician for continuous, comprehensive care

- **Whole person orientation** – physician is responsible for providing all the patient’s health care needs or arranging care with other qualified professionals

- **Care is coordinated and integrated** – across all elements of the complex healthcare community

- **Quality and safety are hallmarks of the medical home** – Evidence-based medicine and clinical decision-support tools guide decision-making

- **Enhanced access to care is available** – systems such as open scheduling, expanded hours, and new communication paths between patients, their physician and practice staff

- **Payment is appropriate** – added value provided to patients who have a patient-centered medical home
Smarter Healthcare

36.3%  Drop in hospital days
32.2%  Drop in ER use
12.8%  Increase in chronic medication
-15.6% Total cost
10.5%  Drop in inpatient specialty care costs
18.9%  Ancillary costs down
15.0%  Outpatient specialty down

24 April 2016, Michigan patient-centered medical home program shows statewide transformation of care YEAR 6

ROI 8.64 CMS CMMI Medicare patients ---savings $336,014,971

- 9.9% Decrease in adult ER visits
- 27.5% Decrease in adult ambulatory care sensitive inpatient stays
- 11.8% Decrease in adult primary care sensitive ER visits
- 8.7% Decrease in adult high-tech radiology usage
- 14.9% Decrease in pediatric ER visits
- 21.3% Decrease in pediatric primary-care sensitive ER visits

4,022 primary care doctors at 1,422 practices around the state in its sixth year of operation. These practices care for more than 1.2 million BCBSM members.
Payment reform requires more than one dial

Fee for...

health  value  outcome  process  belonging  service  satisfaction
Driving factor 1: **Unsustainable Cost** (USA 2012)
Driving factor 2: Data
Leveraging Watson for Knowledge- and Data-Driven Insights: Support **business continuity and growth**

- Medical literature
- Clinical guidelines
- Key textbooks
- Social determinants

- Claims data
- Health risks & behaviors
- Community-based data
- HR workforce data

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Closing the **translational knowledge gap**

Enabling new **personalized and population health insights**

**Knowledge/Data-driven Insights for Better Health Decisions and Prevention of the Next 20% Who Could Cost 80%**

NOND-1162025-0001
Driving factor 3: Communication
Smart Integration, Customization, and Engagement:
Improve the overall health and vitality of our employees and their families

5 Dimensions of Health:
- Physical
- Mental
- Financial
- Social
- Purpose
Practice transformation away from episode of care

Preventive medicine  Chronic disease monitoring  Medication refills  Acute care  Test results

Master Builder

Case Manager  Behavioral health  Medical Assistants  Nursing

Source: Southcentral Foundation, Anchorage AK
New model of care – putting the patient first

Source: Southcentral Foundation, Anchorage AK
Future healthcare transformation

Data driven

Every person has a plan

Team based

Managing a population down to the individual
<table>
<thead>
<tr>
<th>Today’s Care</th>
<th>PCMH Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those making appointments to see me</td>
<td>Our patients are the population community</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today</td>
<td>Care is determined by a proactive plan to meet patient needs with or without visits</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory/skill of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained</td>
<td>We measure our quality and make rapid changes to improve it</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates all patients’ care</td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them</td>
<td>We track tests &amp; consultations, and follow-up after ED &amp; hospital</td>
</tr>
<tr>
<td>Clinic operations centre on meeting the doctor’s needs</td>
<td>A multidisciplinary team works at the top of our licenses to serve patients</td>
</tr>
</tbody>
</table>

Source: Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma
Defining the care centered on the patient

- Superb access to care
- Patient engagement in care
- Clinical information systems, registry
- Care coordination

Team care
Communication/Patient Feedback
Mobile – easy to use and available information
Benefit redesign – Patient engagement
Different strategies for different Healthcare spend segments

- Those with severe, acute illness or injuries
- Those with chronic illness
- Those who are well or think they are well

% Total healthcare spend

% of members
PCMH 2.0 in action

A coordinated Health System
Health IT Framework
Global Information Framework
Evaluation Framework
Operations

Nurse Coordinator
Social Workers
Dieticians
Community Health Workers
Care Coordinators

Public Health Prevention
HEALTH WELLNESS
Call & Check Providing support and care for all in the community