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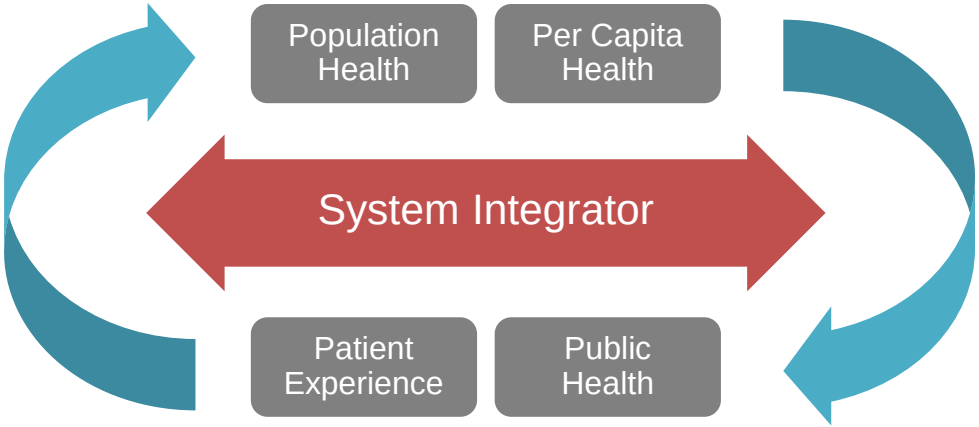
A Foundation for Transformation.

New Mexico Academy of Family Physicians

@Paul_PCMH

Away from Episode of Care to Management of Population with Data



Community Health

The System Integrator

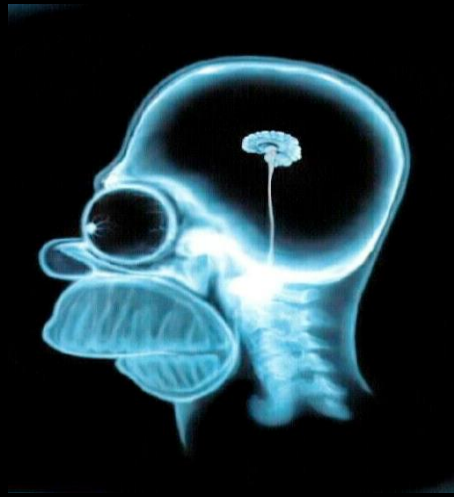
- Creates a partnership across the medical neighborhood
- Drives PCMH primary care redesign
- Offers a utility for population health and financial management

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 -- a no Brainer

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



Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the US – PCPCC Oct 2012

July 2017, Michigan patient-centered medical home program shows statewide transformation of care YEAR 8

19%	Decrease in adult ER visits
23.4%	Decrease in adult ambulatory care sensitive inpatient stays
20.1%	Decrease in adult primary care sensitive ER visits
12.7%	Decrease in adult high-tech radiology usage
17.2%	Decrease in pediatric ER visits
22.7%	Decrease in pediatric primary-care sensitive ER visits

4,692 primary care doctors at **1,638 practices** around the state in its eight year of operation. These practices care for more than **1.4 million** BCBSM members.

http://www.mibluesperspectives.com/2017/07/14/patient-centered-medical-homes-michigan/

Association between elements of the PCMH model and clinical quality in the Veterans Health Admin

JAMA -May 1, 2017

http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2623525


I
HERDING
CATS


I WANT TO THANK
PURINA
Friskies
Feed The Senses
NO ONE.
Facebook/Friskies

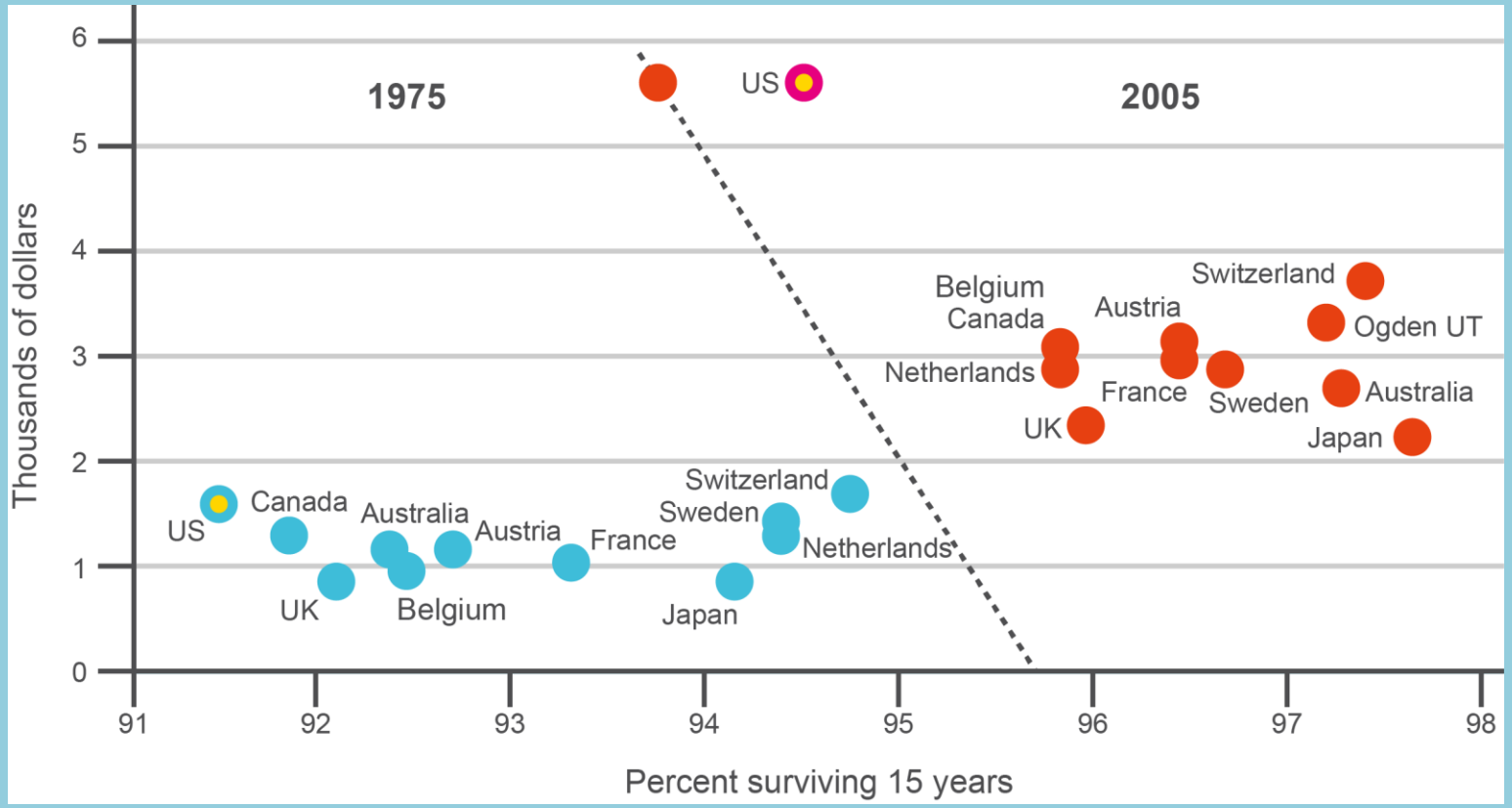
Payment reform requires more than one dial

Fee for...

health value outcome process belonging service satisfaction

Driving factor 1: **Unsustainable Cost**

(USA 2012)



Driving factor 2:
Data

"The idea of cognitive healthcare – systems that learn – is real, and it's already mainstream," said IBM CEO Ginni Rometty in her opening keynote address to a packed auditorium at the 2017 HIMSS Convention and Exhibition. “ IT can change almost everything about healthcare."

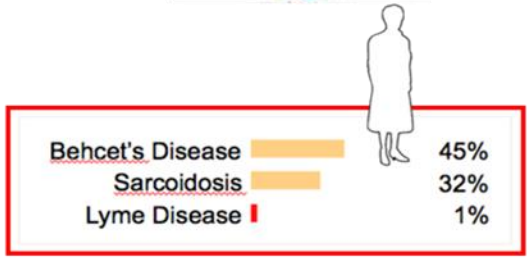
Leveraging Watson for Knowledge- and Data-Driven Insights:

*Support **business continuity** and **growth***

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

Published Knowledge

WATSON



*Closing the **translational knowledge** gap*

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

Observational Data

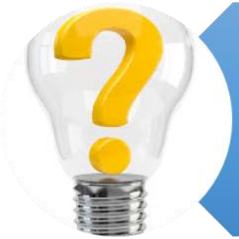
Patient Care & Insights

*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%.*

Real world evidence results from the systematic analysis of real world data

Evidence: Findings from real world data that rise to the level of medical evidence, currently include results from observational studies and case studies.



Insights: Findings that do not rise to the level of medical evidence, but which may be used for non-clinical decision making, potentially helping to inform hypotheses for further analysis or for initiation of RCTs

Predictions: Predictive models and Risk Factor identification may result from analysis and modeling using predictive techniques.

Analytic Life Course

Current Analytic Practice Timeline

2-3 **MONTHS** 3-24 **MONTHS** 2-3 **MONTHS** 3-9 **MONTHS** 2-3 **MONTHS** 2-3 **MONTHS** 2-3 **MONTHS**

Total Time
18 months-3 years

Watson Health Analytics Timeline

2-3 **DAYS** 2 **DAYS** 2-3 **DAYS** 1-7 **DAYS** 1-2 **DAYS** 2-3 **DAYS** 2-3 **DAYS**

Total Time
2-3 weeks

Key factors to time reduction:

- Data is in a ready and usable state
- Feature Library already defined
- Analytics Catalog has support research

VALUE BASED CARE COMPONENTS

Risk Analytics

- Actuarial Cost Analytics
- Contract Management
- Quality and cost reporting

Practice Analytics

- Physician Efficiency profiles
- Episode Efficiency profiles
- Drug profiles
- Cost of care analysis
- Imaging
- Leakage

ANALYTICS

Case Management

Manage high-cost patients (top 5%)

- Predictive modeling
- Patient risk stratification
- Readmissions
- ER usage
- Medication management
- Referral management

Population Management

Manage entire population

- Patient Stratification
- Preventive/Chronic gaps
- Visit compliance
- Rx / Lab compliance
- Self management
- ER, Hospital, Readmissions

CARE DELIVERY

DATA FOUNDATION

Diagnosis

A

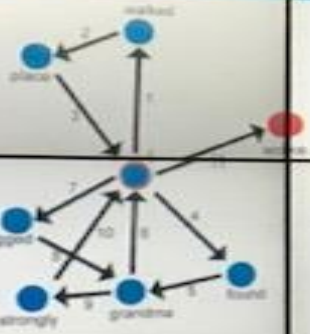
I / walked / into a place, / and I / found / my grandma. / I / hugged / her / strongly. / I / woke up.

About dreaming

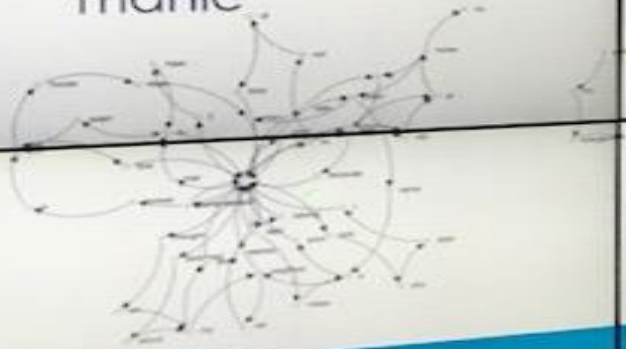
About waking

control

B

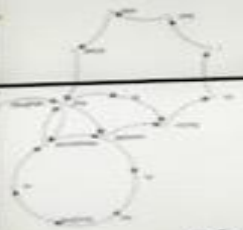


manic



AUC > 0.9

schizophrenic



PLoS ONE (2012)

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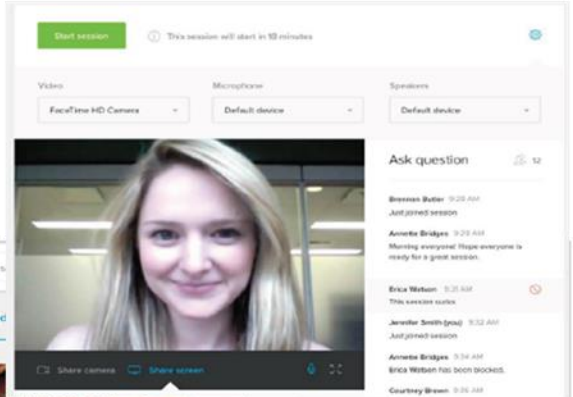
Driving factor 3: **Communication**

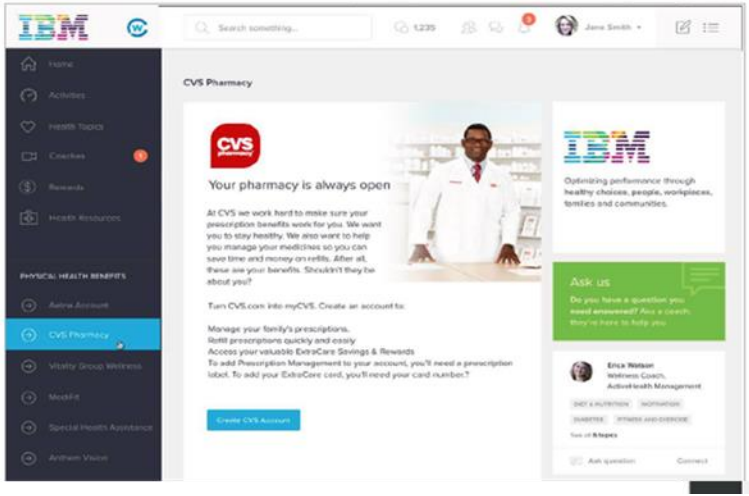
Smart Integration, Customization, and Engagement:

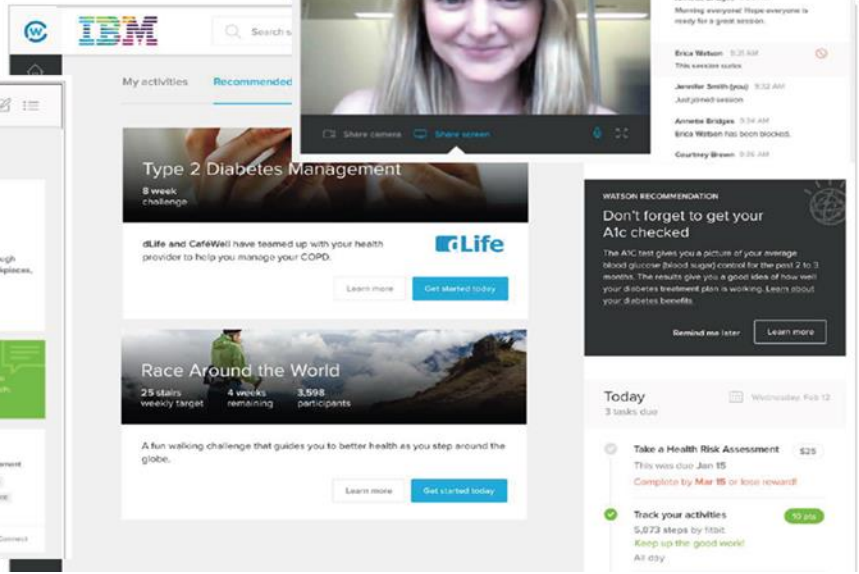
*Improve the **overall health and vitality** of our employees and their families*

5 Dimensions of Health:

- *Physical*
- *Mental*
- *Financial*
- *Social*
- *Purpose*

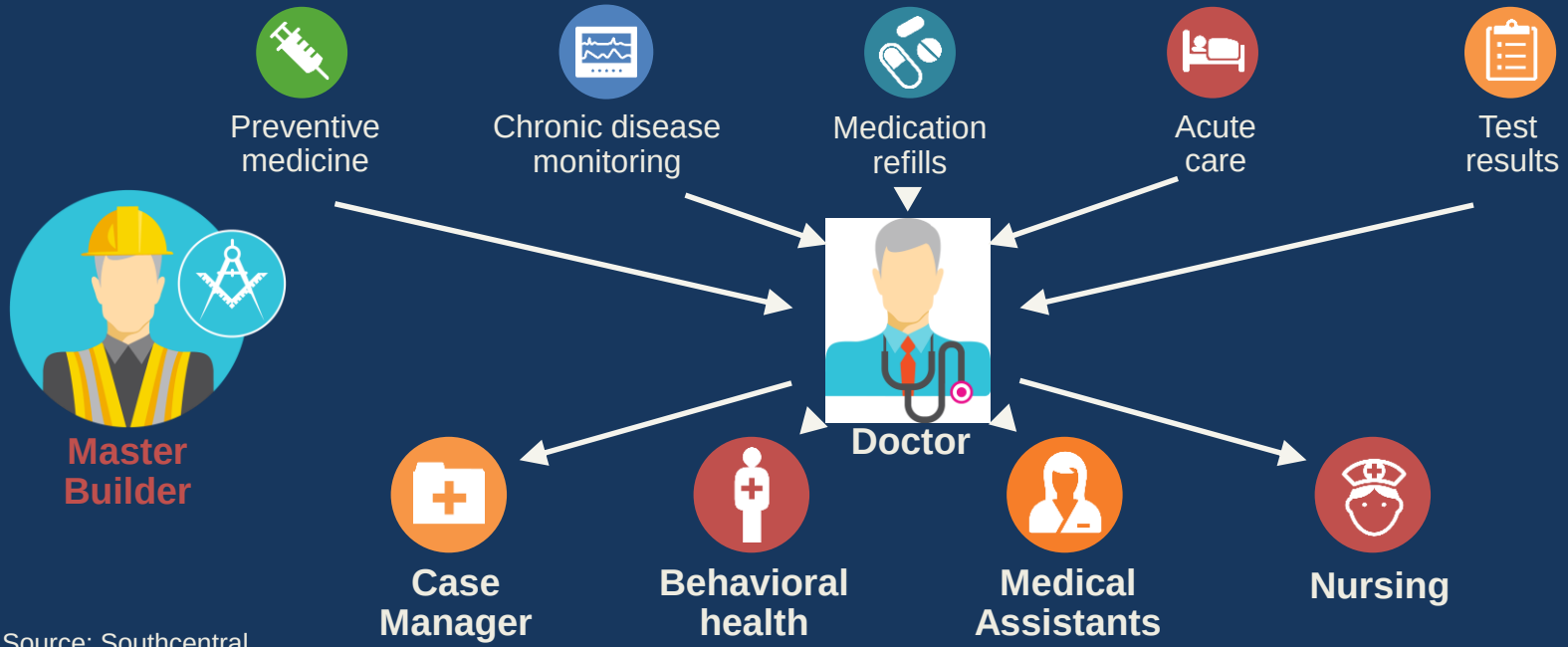






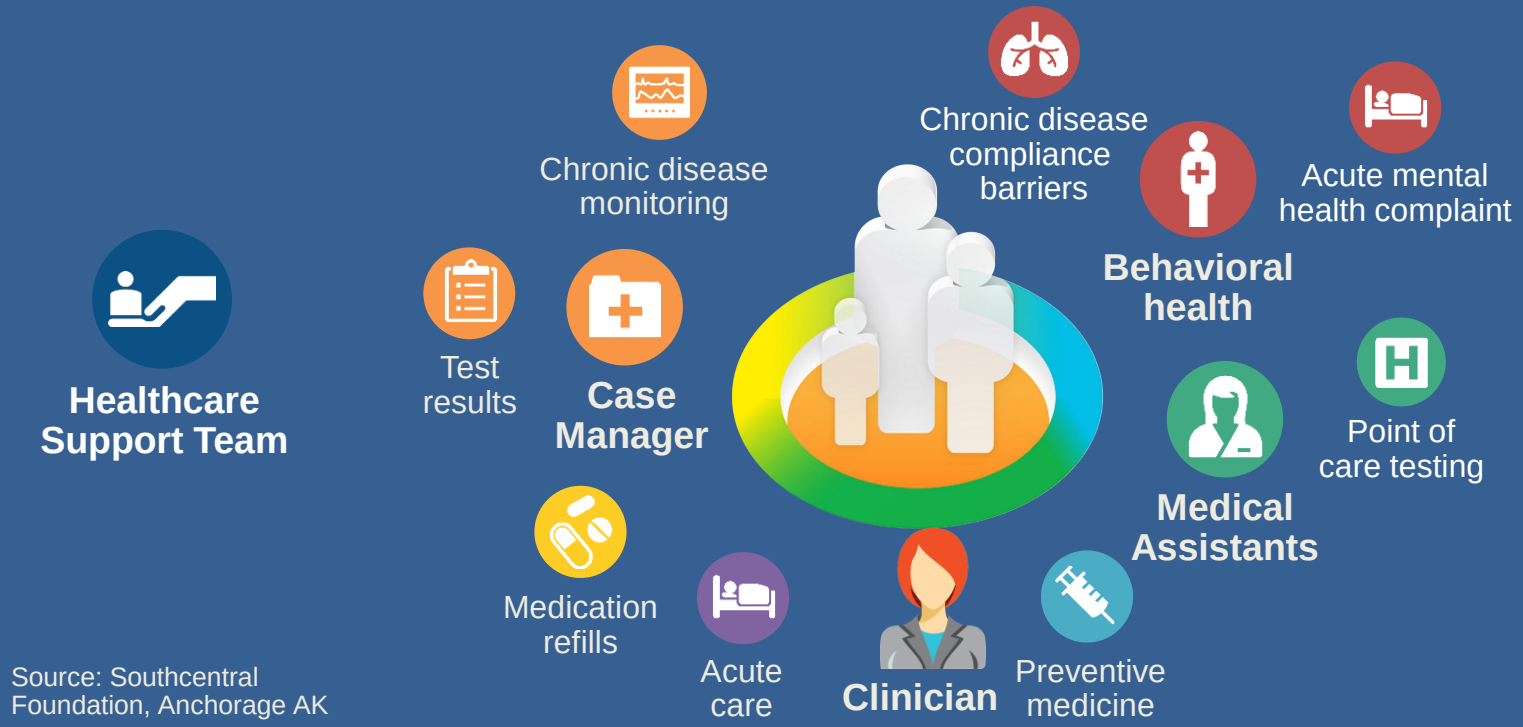
Proprietary

Practice transformation away from episode of care



Source: Southcentral Foundation, Anchorage AK

New model of care – putting the patient first



Source: Southcentral Foundation, Anchorage AK

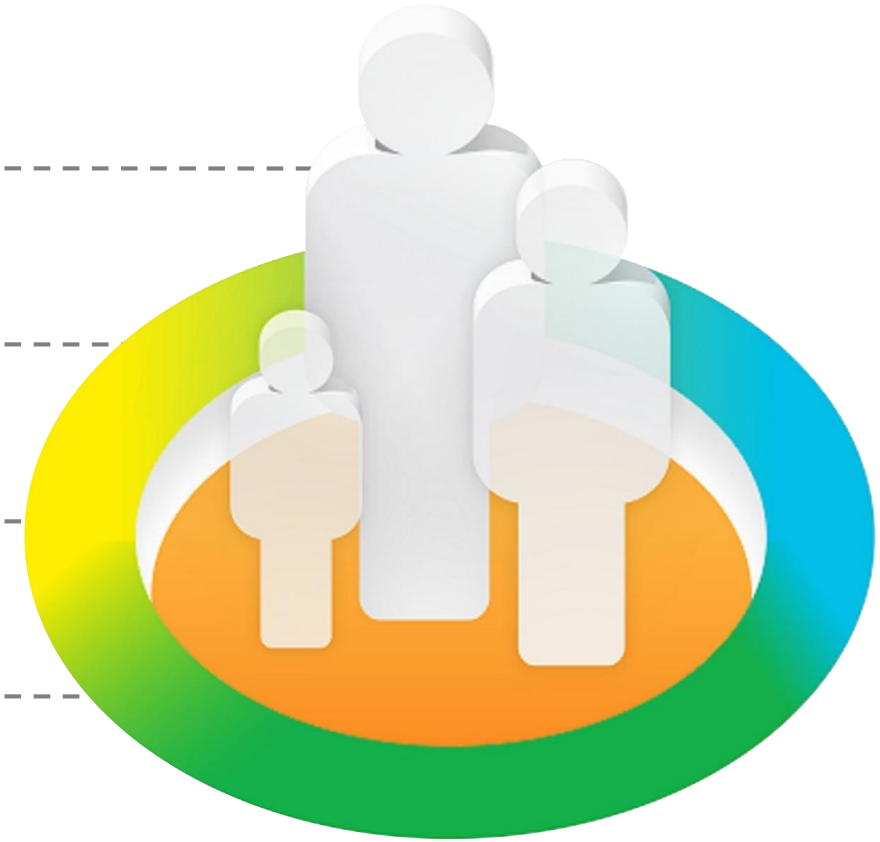
Future healthcare transformation

Data driven

Every person has a plan

Team based

Managing a population down to the individual



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

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

PCMH 2.0 in action