Redesign for Patient-Centered Care
Key Changes to Create Value

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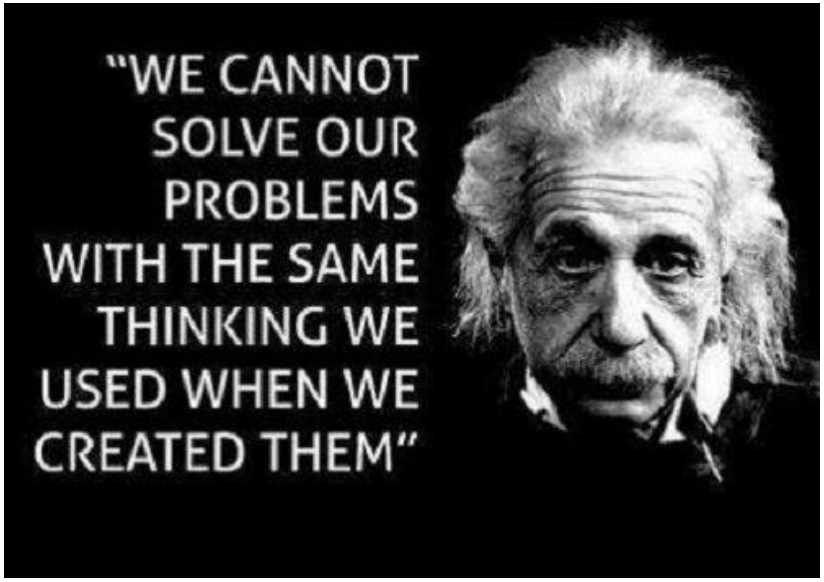
Advancing Healthcare
Improving Health

Start Here: Re-Imagine the Practice and Think Different

Build around this: What does the patient need and want? How can we deliver that?

From “What’s the matter?” to “What matters to you?”



Why Is Clinical Transformation So Hard?

"Change is hard enough; transformation requires epic whole-practice re-imagination and redesign."

- Practices are complex, adaptive systems with interdependent and interacting processes and systems; a change to one aspect (e.g., a staff role) affects other staff and practice processes.
- Medical practice is inherently stressful, and established routines and patterns limit stress even if flawed.
- Clinical transformation asks physicians and other staff to change their roles and identities, the way they deliver care, and how they relate to one another.

Nutting et al. Ann Fam Med. 2009; 7:254-260

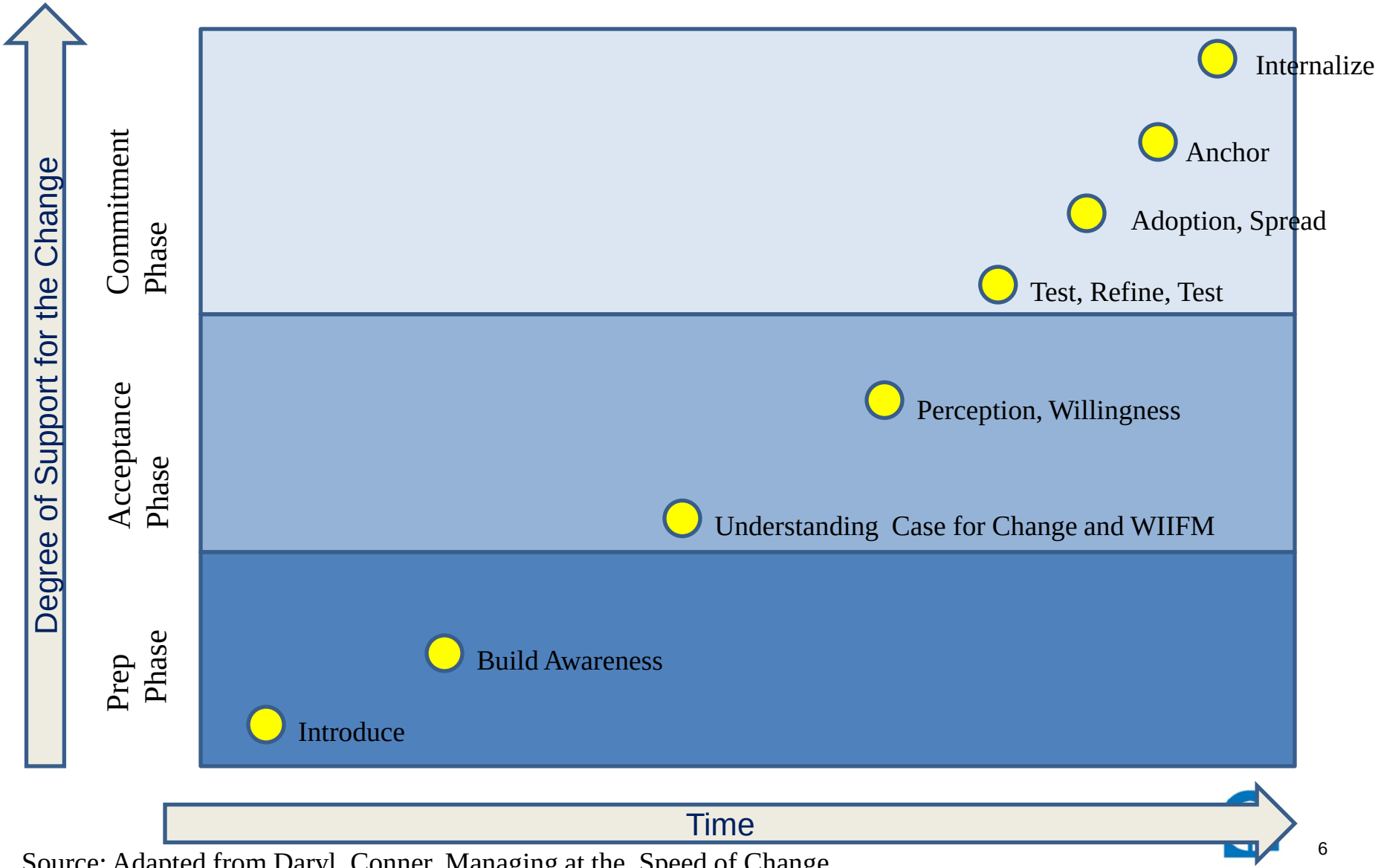
Use a Framework and Sequence Changes

Change Concepts for Practice Transformation

Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The Changes Involved in Patient-Centered Medical Home Transformation. *Primary Care: Clinics in Office Practice.* 2012; 39:241-259.

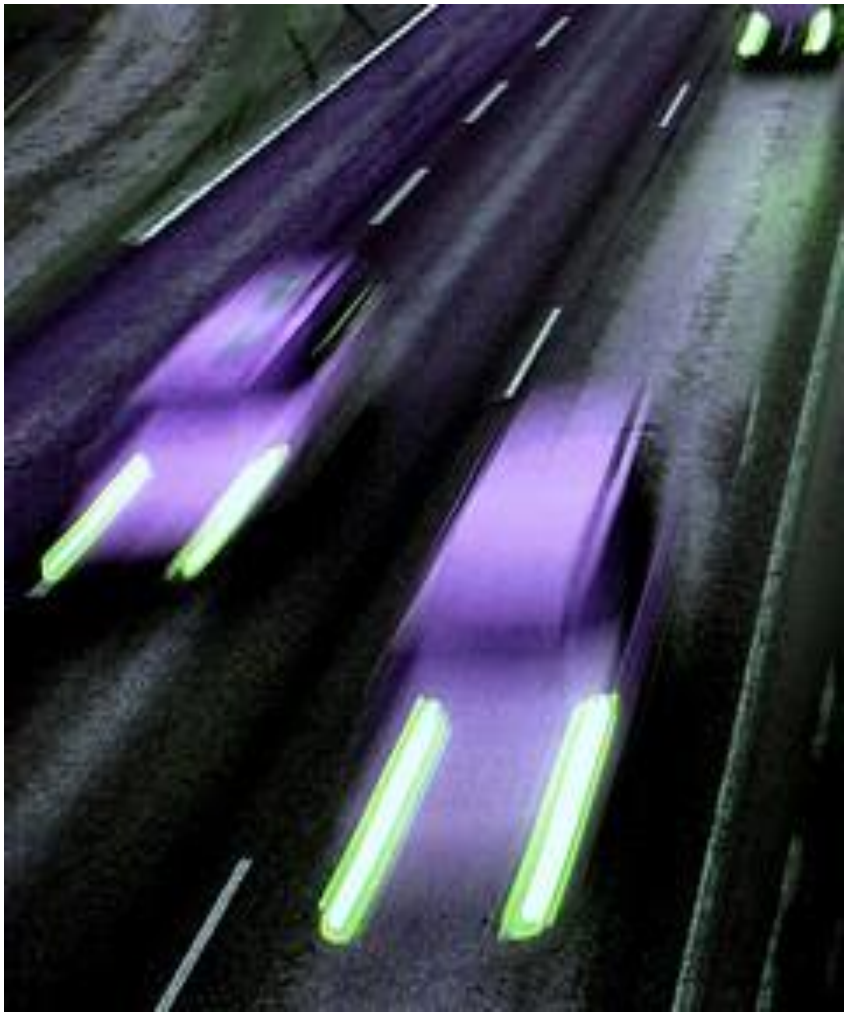
Attention on Four Fronts

Building Commitment for Change, Redesign



Source: Adapted from Daryl Conner, Managing at the Speed of Change

Provide the Foundation for Transformation



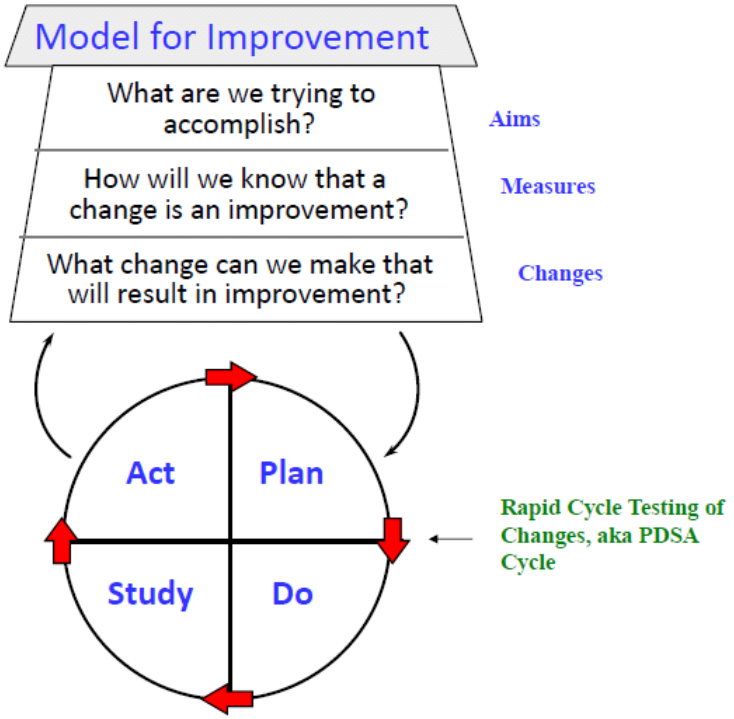
Create Organizational Fitness for Speed and Demands of Change (adaptive reserve)

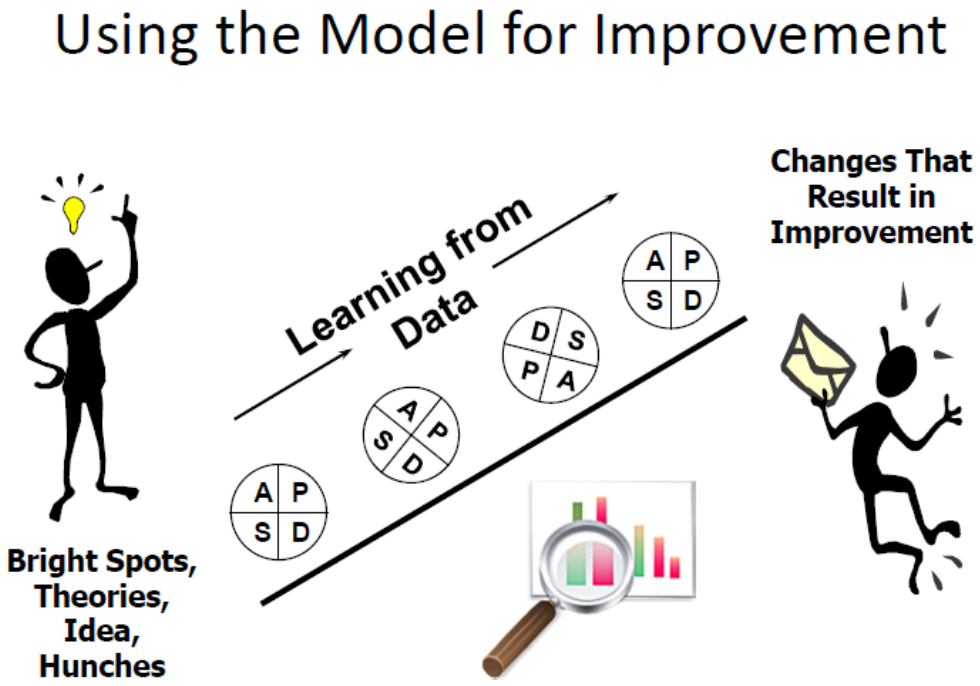
- Confusion → Clarity
- Resistance → Resilience
- Compliance → Commitment

System Design

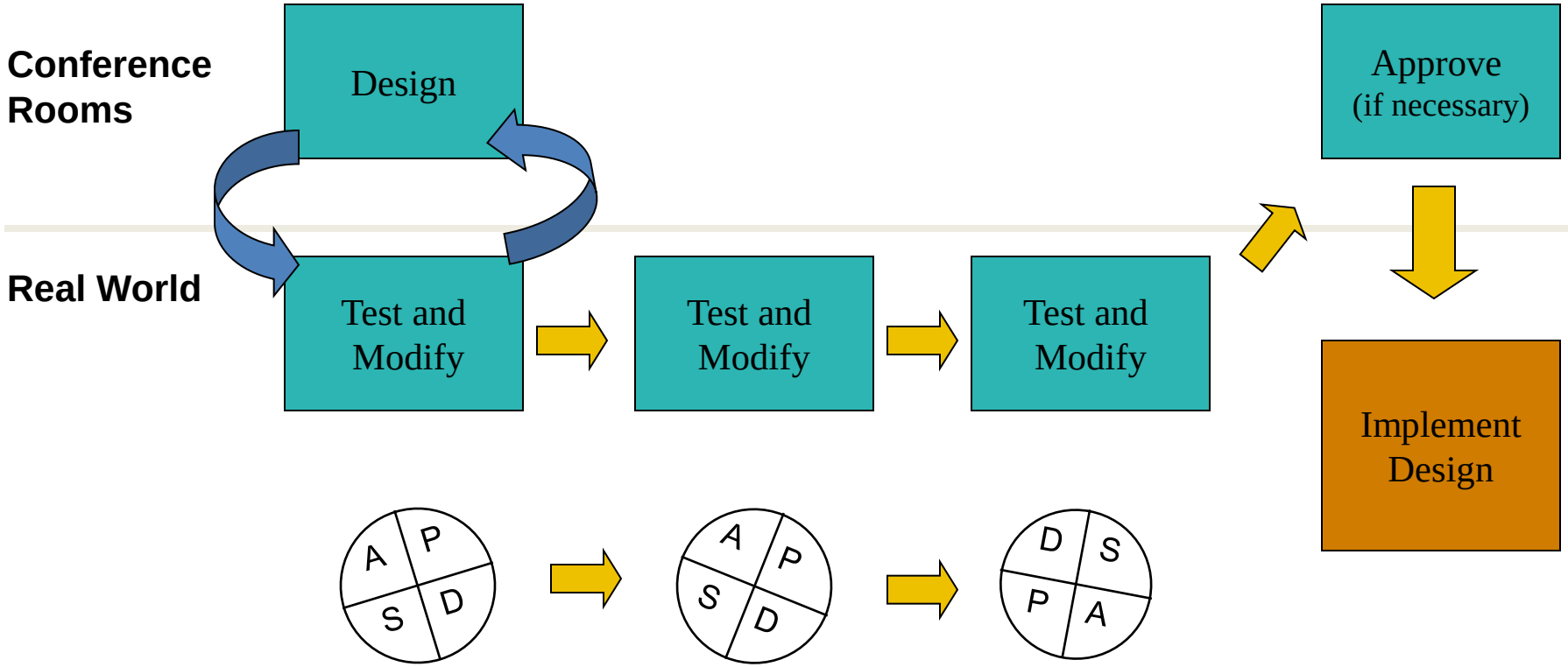
Every system is ***perfectly designed*** to produce the results that it produces.

Choose and Use a Quality Improvement Approach



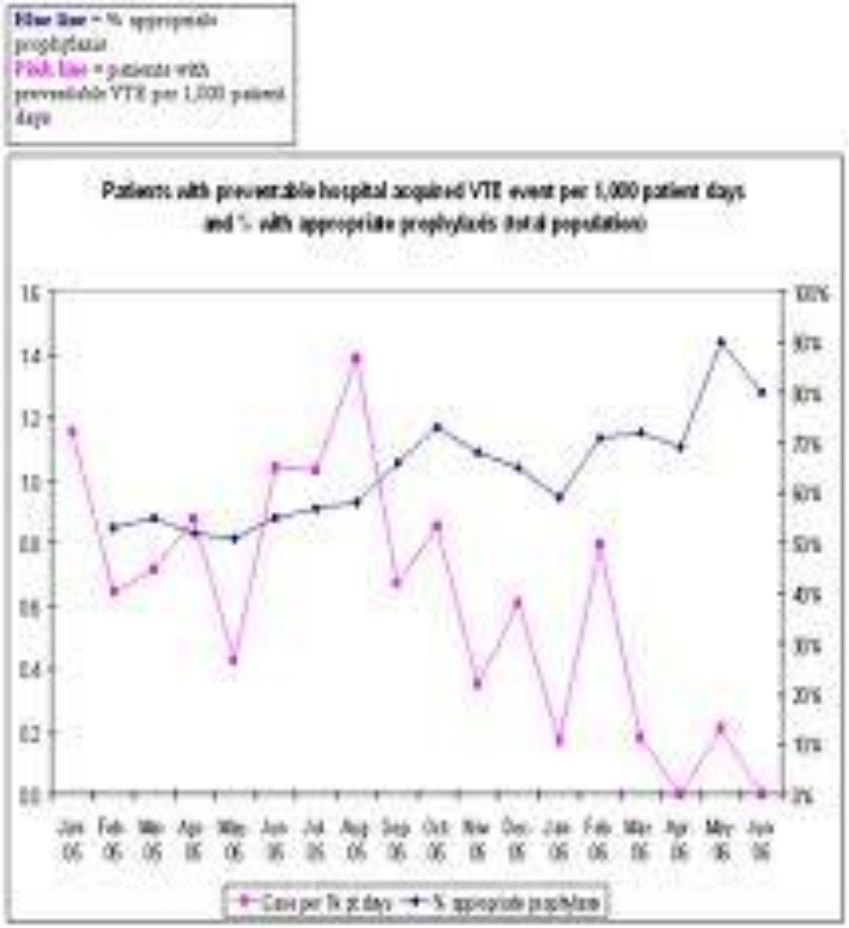


Refine the Design for the Local Setting Using Small Tests of Change

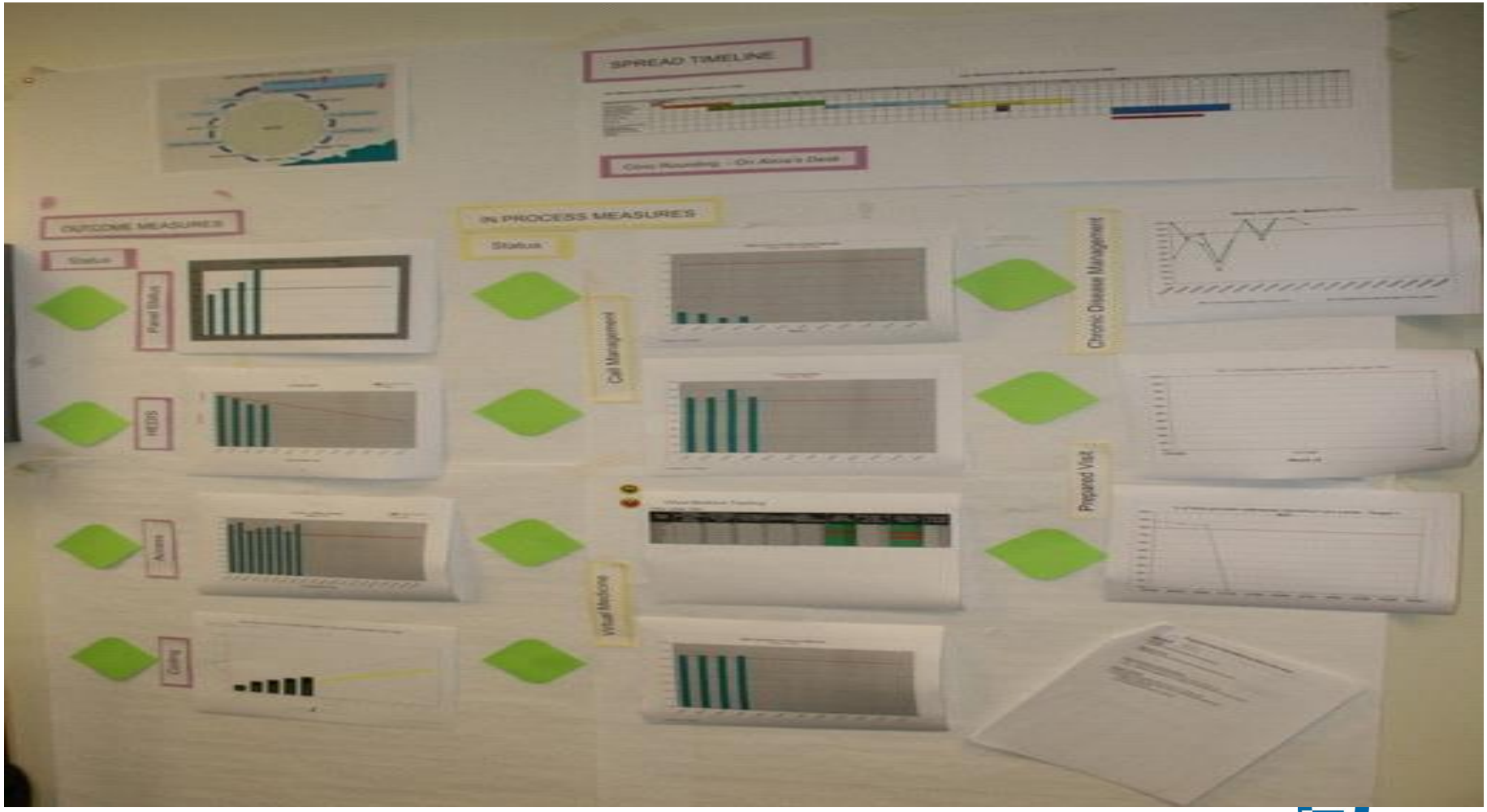


Concept Source: Reinertsen JL, Bisognano M, Pugh MD. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition).* IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2008. (Available on www.IHI.org)

Meaningful Use of Data



Visible, Transparent Display of Results



Connect Patients to Their Care Team*

Basis for Relationships & Continuity

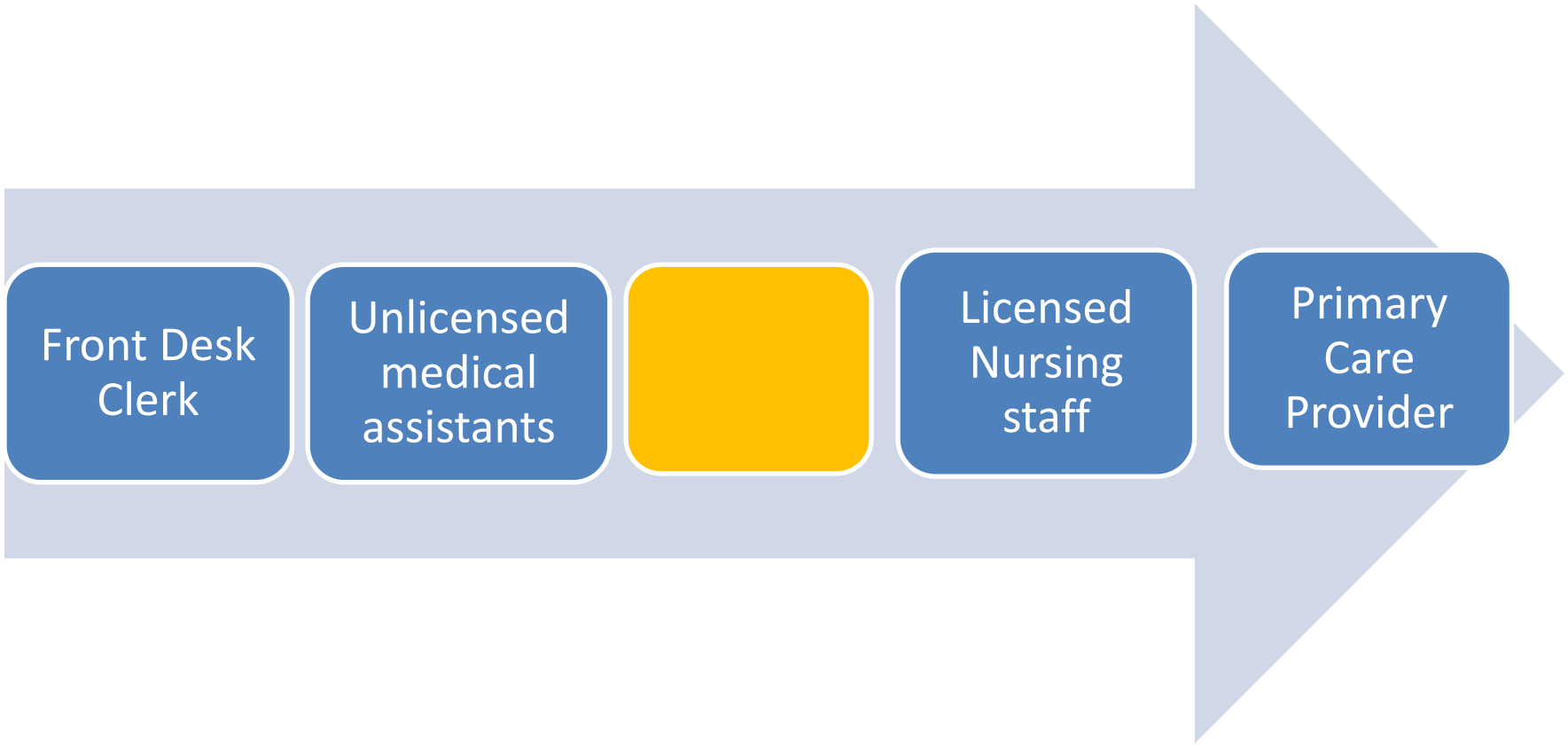
Whose Patient Is It?

My Patients

New Goals, New Thinking, New Opportunities

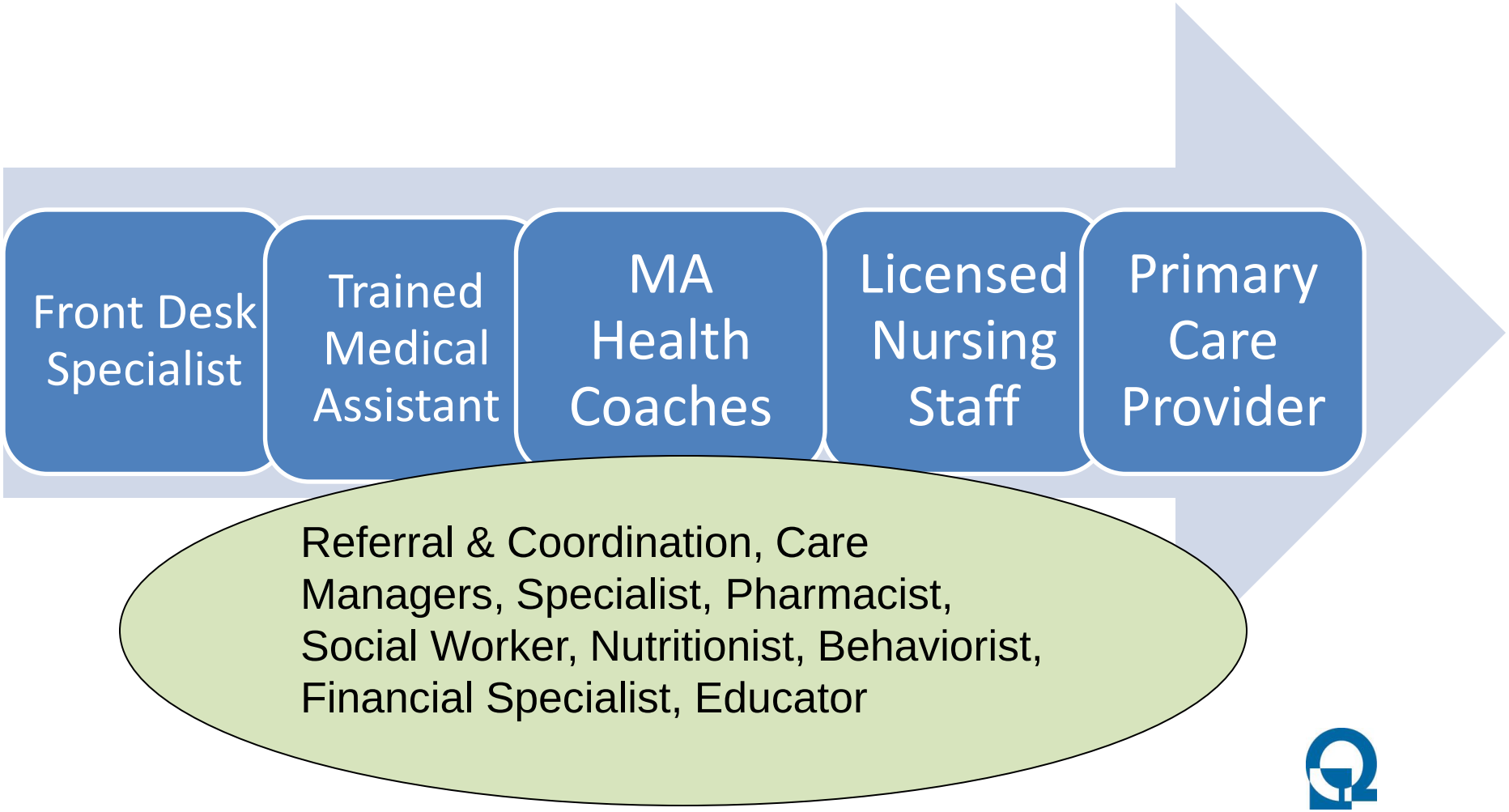
* a.k.a., Empanelment

Build and Develop Care Teams



Challenge: Bridge the Gaps in the Core Care Team

New Model: Continuous Capability in Team & Aligned Resources



Referral & Test Tracking, Registry & Panel Management, Self Management Support

Self Management Support, Medication Reconciliation, Clinical Issues

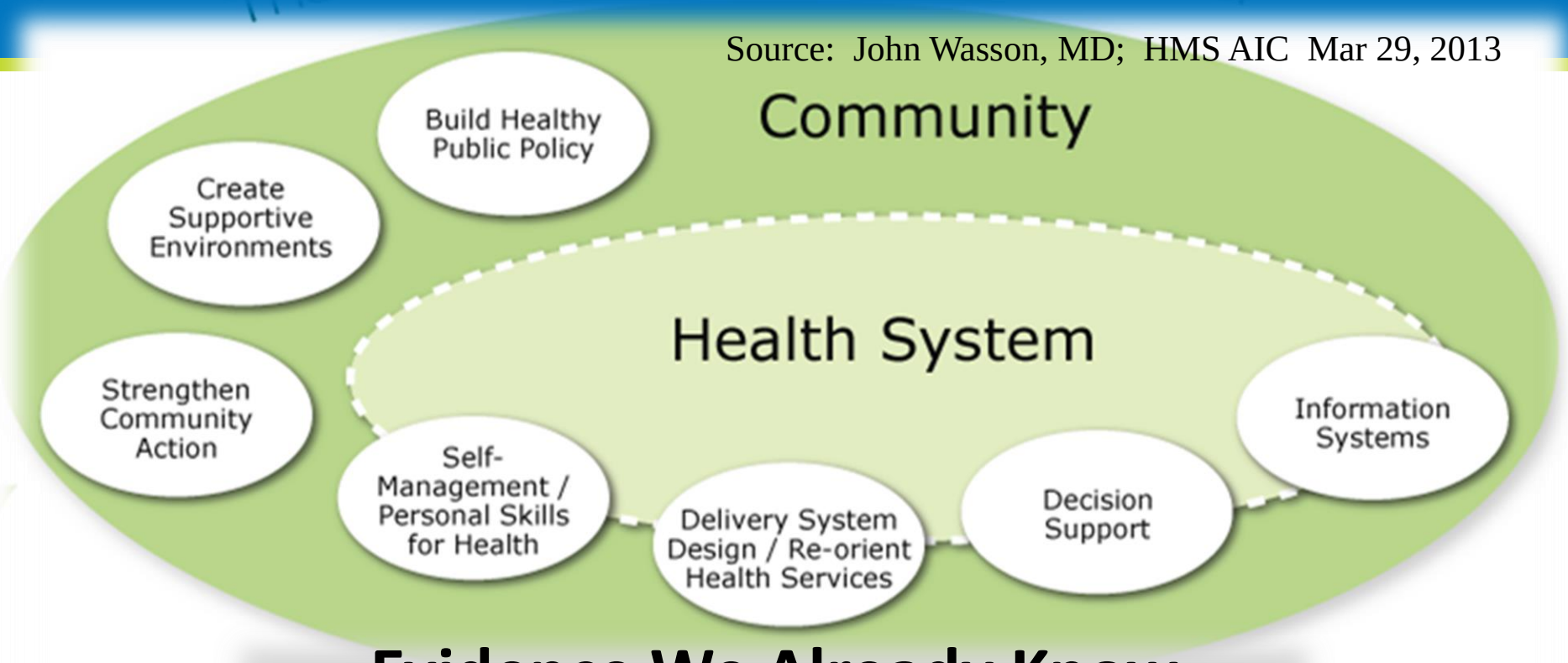
Medical Assistants → Health Coaches → CDEs, Licensed Nurses

Increasing Complexity of Patients Care Needs

Now We Are Ready

- For really patient-centered, high value care focus on patient-centered interactions that are critical to outcomes
  - Population health management
  - Planned and proactive care
  - Self-management support
  - Care management, Clinical follow-up, Care Coordination

Source: John Wasson, MD; HMS AIC Mar 29, 2013



Evidence We Already Know

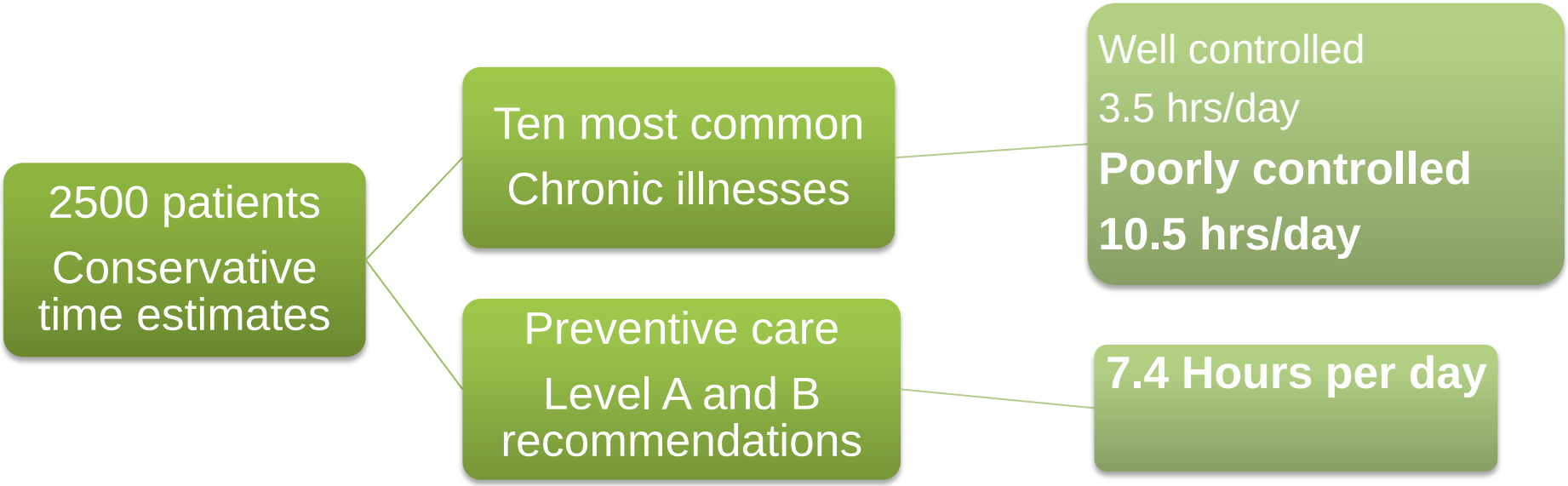
Engagement = Reciprocal Tasks

Proxy = Patient-reported Health Confidence

Desirable Outcomes, Value

Time Demands in Primary Care

Am J Public Health. 2003;93:635–64; Ann Family Med 2005;3:209-214.



Add the 60 % of patients with acute problems,
plus paper work, phone calls and charting **= 24 hours / day**

Cut panel size to 1250 **= 12 hours / day**

Source: Larry Mauksch, M.Ed., University of Washington

Team-Based Care Influence on Panel Size

If portions of preventive and chronic care services are delegated to non-physician team members, practice panels of larger size are possible

Type of Delegation	Prevent/Chronic Delegation NONE (% = 0/0)	Prevent/Chronic Delegation LOW (% =50/25)	Prevent/Chronic Delegation MED (% = 60/30)	Prevent/Chronic Delegation HIGH (% = 77/47)
Panel Size	983	1,387	1,523	1,947
% Increase from Base		41%	55%	98%

Source: Altschuler, et.al., Estimating a Reasonable Panel Size for Primary Care Physicians with Team-based Task Delegation. Annals of Family Medicine, Vol 10, No. 5; September/October 2012

Population Health Management

- Team focus on panel of patients
- Registries to identify which patients need what
  - gaps in chronic, preventive services
  - missed appointments
- Pro-active follow-up with patients to address care needs (use planned care approaches)
- In practices where assessment of needs was linked with outreach, quality improved (Source: Ed Wagner, HMS, AIC LS3, Jan 2013 Presentation)

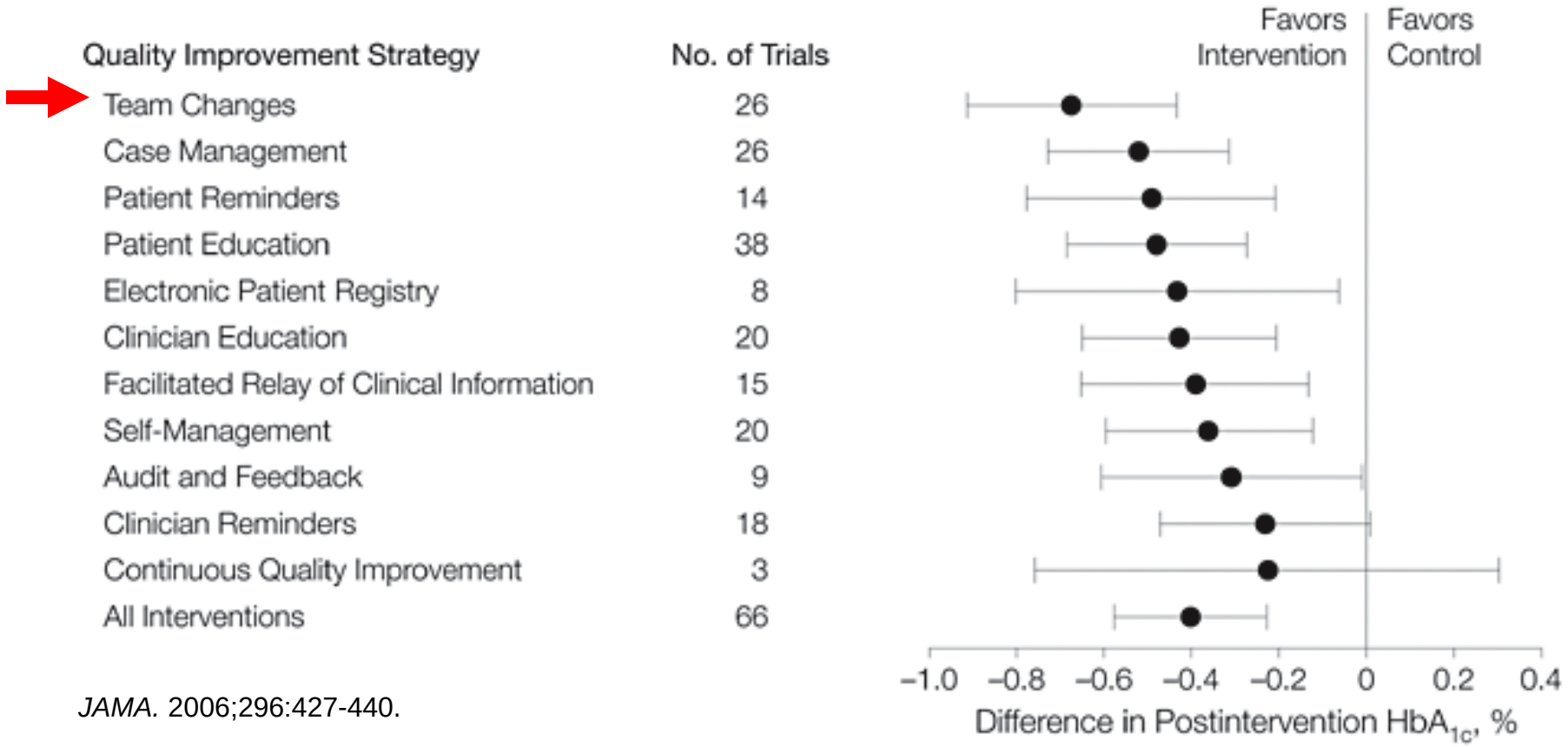
Planned Care

- Proactive vs. reactive
- Use evidence-based guidelines
- Ready access to patient information to identify patient needs
- Team, time, tools, processes redesigned to anticipate, plan and deliver care needed
  - Pre-visit planning & prepare for each day (huddle)
  - Identified role of each team member in care
  - Visit structure ensures all team members and allies available to deliver all needed care
  - Plan, structure for follow-up (connect to care coordination, care management as needed)

Care and Outcomes Improve

Team involvement in the care of the chronically-ill is the single most powerful intervention.

Effects of QI Strategies for Type 2 Diabetes on Glycemic Control



JAMA. 2006;296:427-440.

Proactive Teams Engage Patients

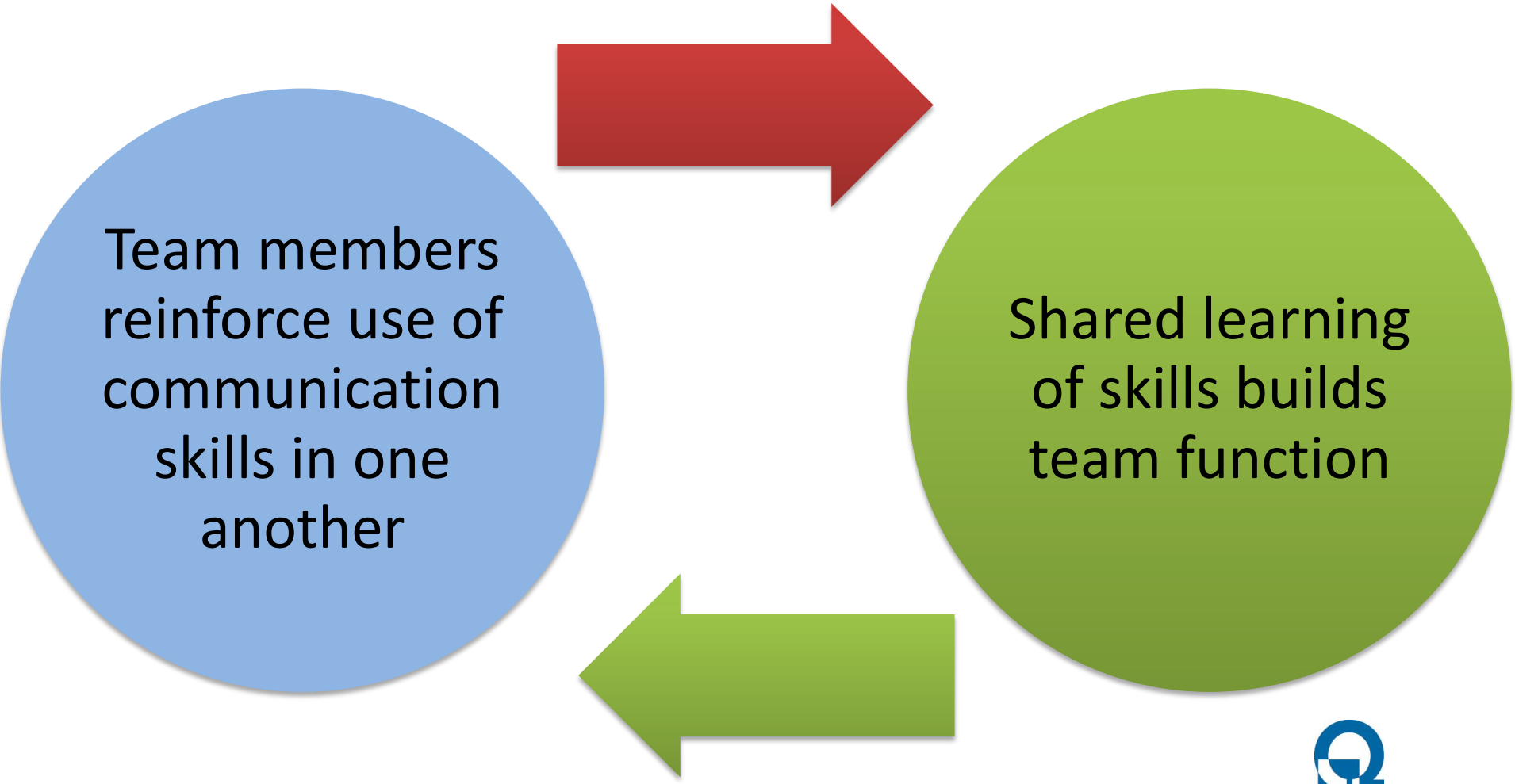
- Hard-wire processes for reliability
- Prepare, anticipate care needs
- Have the skills and know how to use them
  - Communication skills – training
    - Motivational interviewing
    - Five “A’s” for Behavior Change
    - Teach Back
    - Ask Me Three
- Have the resources to engage
  - Time to listen (it’s not a task, it’s a relationship)
  - Patient preferences, values and needs
    - Language
    - Culture
    - Literacy

What It Takes

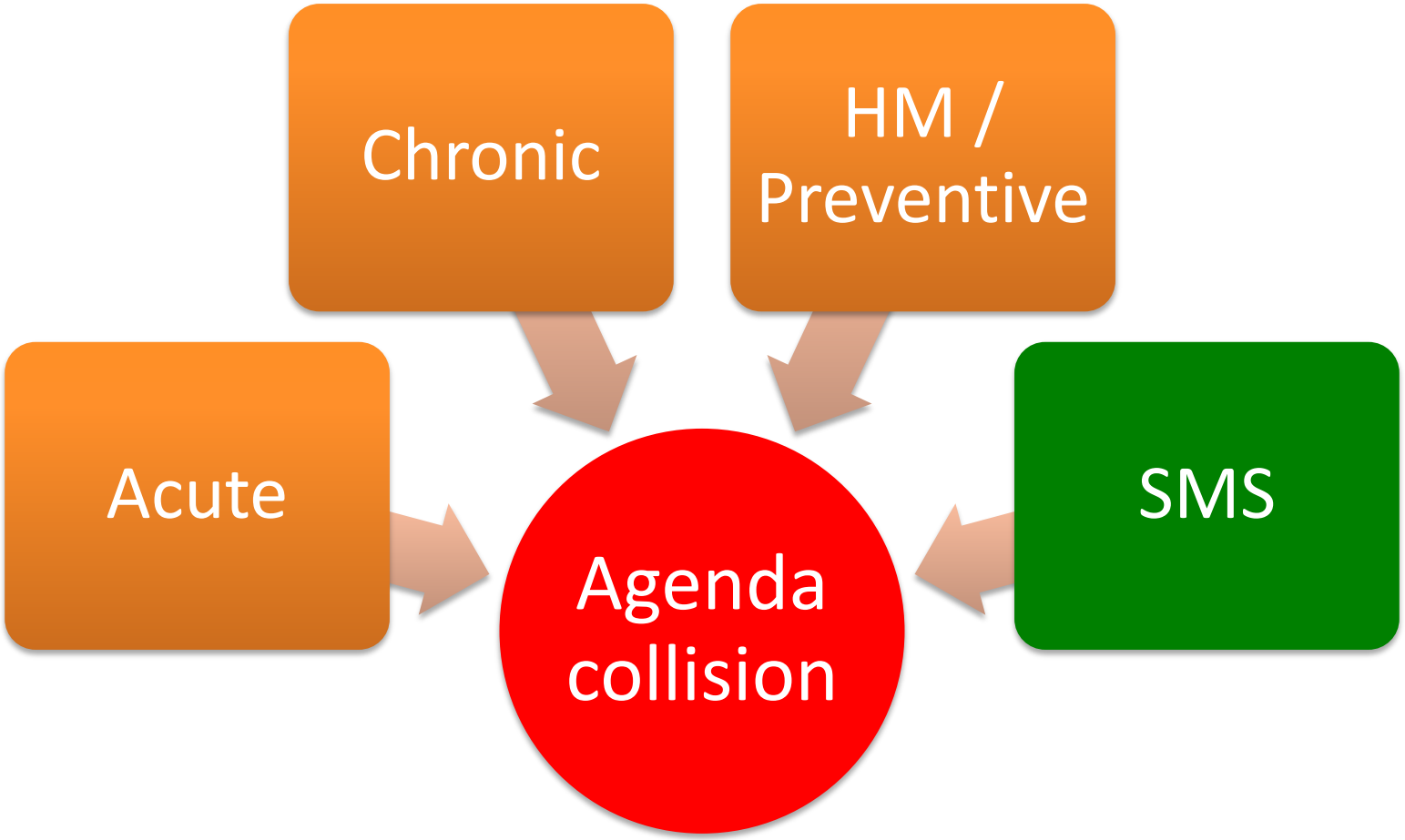
- Protected meeting time to reflect produces mindfulness
- A learning culture that supports efforts to make sense of experience; support, coaching for learning
- Respectful interactions
- Leadership
- Teamwork

Crabtree BF, Nutting PA,, et al. Primary Care Practice Transformation Is Hard Work: Insights From a 15-Year Developmental Program of Research. *Med Care.* Sep 17 2010.
Jaen CR, Crabtree BF, et al. Methods for evaluating practice change toward a patient-centered medical home. *Ann Fam Med.* 2010;8 Suppl 1:S9-20; S92.
Nutting PA, Crabtree BF,. Journey to the patient-centered medical home: a qualitative analysis of the experiences of practices in the National Demonstration Project. *Ann Fam Med.* 2010;8 Suppl 1:S45-56; S92.

Team Communication Training



Need a Better Design to Include the Patient



Source: Larry Mauksch, M.Ed, University of Washington

Upfront Collaborative Agenda Setting

Brock, Mauksch, et al. JGIM, Nov, 2011; Mauksch et al, Fam, Syst, Health, 2001

- **Identifies patient's priorities**
- **Organizes the visit**
- **Decreases chance that patients or providers will introduce "oh by the way" items**
- **Screens for mental disorders**
- **Facilitates shared decisions about time use between acute, chronic, and health maintenance care**
- **Does not lengthen the visit; protects time for planning**
- **Decreases clinician anxiety**

How It Helps

- MD
- “I feel less anxious and more able to be present”
- “I have fewer ‘oh by the ways’”
- “I am using my time better… on time more of the time”
- Medical assistant
- “This helps us stay on time”
- “The physician is less likely to be caught off guard”
- “Decreased my stress”

Source Larry Mauksch, M.Ed, University of Washington

Levels of Activation

Hibbard et al Health Services Research 2007, 42(4) 1443-63

Level of activation **(age 45 or older, 2.9 chronic conditions)** **diabetes, HTN, lung, cholesterol, arthritis, heart**	**Percent (cumulative)**
May be overwhelmed and unprepared to play an active role in their own health	12
May lack knowledge and confidence about self management	29 (41)
Taking action but may lack confidence and skill to support self management	37 (78)
Mastered self management but may not maintain behaviors at times of stress	22

Source: Larry Mauksch, University of Washington

Self-Management "CARE"

CHECK (Engagement)
Addressable measures to assess the patient's or caregiver's self-management capacity and impediments for optimal patient engagement and care.
ACTION **(Individualized Self-Management)**
Patient preference and understanding guides individualized information.
REINFORCE **(Enhance Self-Management Skills)**
The frequency and intensity of electronic or personal contacts is individualized to reinforce self-care behavior changes.
ENGINEER **(Health System Reliability)**
The health care workforce and community resources are designed into a reliable system that seamlessly connects Checking, Action, and Reinforcement.

Source: John Wasson, MD; HMS AIC Mar 29, 2013

The Engaged Patient's CARE

CHECK **(Engagement)**
What Matters to Me? **I need to understand my health care needs and how I can help in managing my problems and concerns.**
ACTION **(Self-Management)**
What I will do, what others will do, and what others will help me do.
REINFORCE **(Enhance Skills)**
The health care team and helpers in the community help me do the right things at the right time.
ENGINEER **(Health System Reliability)**
I am setting up a system of care and support that will make it very difficult for me to "get into trouble." I have a clear plan including a plan for if I am too sick to speak for myself.

Source: John Wasson, MD; HMS AIC Mar 29, 2013

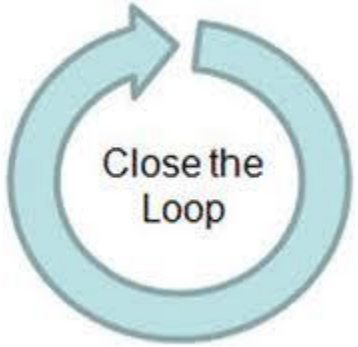
It's Not a Task; It's a Relationship

- Assume that in isolation any of the following will improve outcomes (task vs. engagement orientation):
  - Merely contacting the patient.
  - Performing a health risk assessment.
  - Presenting the patient with an already completed care plan.
  - Prescribing tele-monitoring

In contrast, continuity of provider care and telephone interactions by a clinician or "plugged in" care team member or care manager (in lieu of an office visit) are effective solitary interventions that can improve outcomes…presumably by enhancing "engagement".

Adapted from: John Wasson, MD; HMS AIC Mar 29, 2013

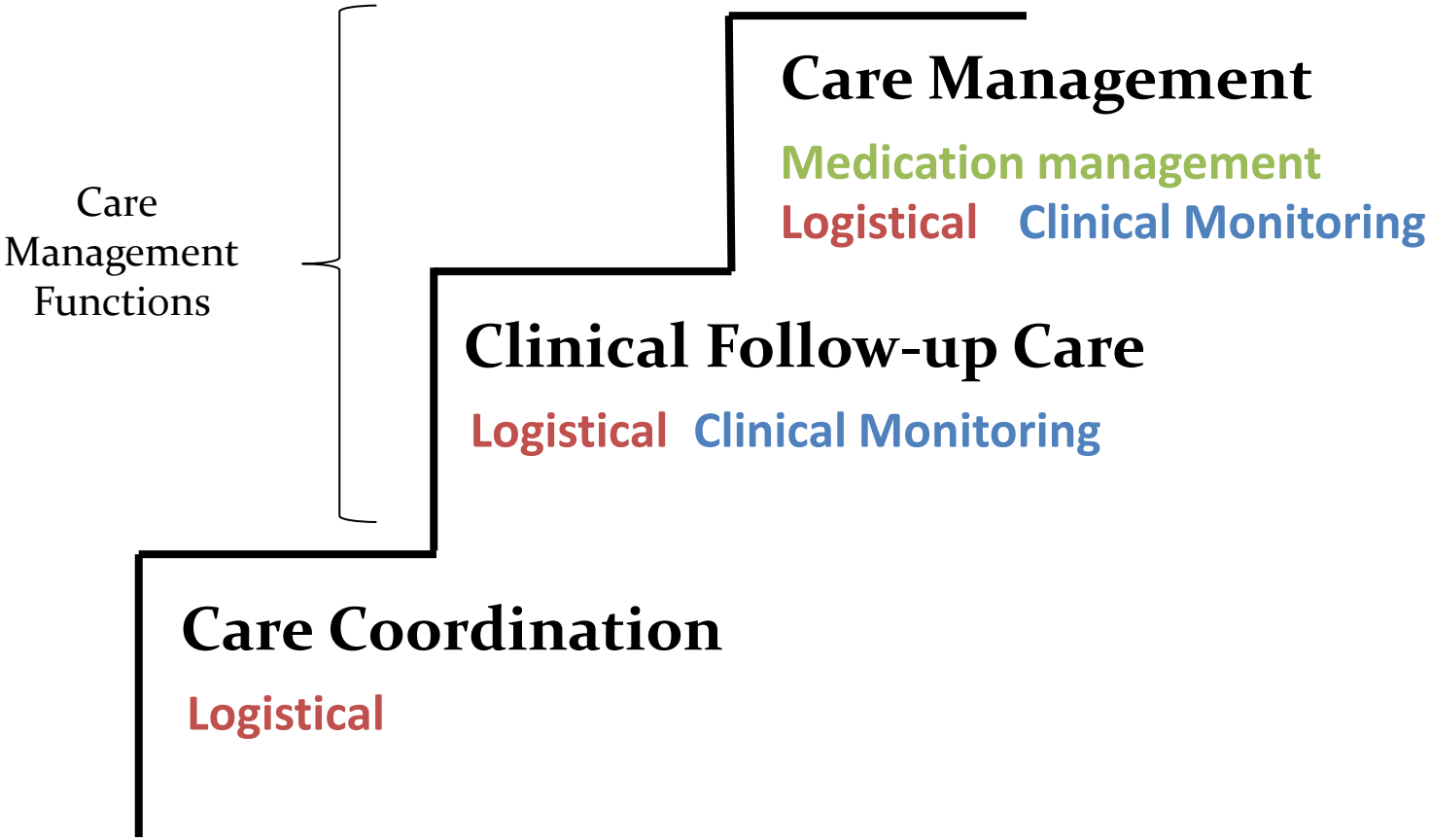
Monitor and Support Patients Care Coordination and Care Management



- Many patients need services beyond what can be done in office visits
- Many patients need services beyond what can be provided in the clinic
- Some patients may need clinical care management beyond what can be done in office visits

Source: Ed Wagner, AIC LS3, Jan 2013

Relationship Between Care Coordination & Care Management Activities In Primary Care



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Tyranny of Typical Schedule

Time	Primary care physician	Medical assistant	Nurse	Nurse Practioner	Medical assistant
8:00	Patient A	Assist with Patient A	Triage	Patient H	Assist with Patient H
8:15	Patient B	Assist with Patient B		Patient I	Assist with Patient I
8:30	Patient C	Assist with Patient C		Patient J	Assist with Patient J
8:45	Patient D	Assist with Patient D		Patient K	Assist with Patient K
9:00	Patient E	Assist with Patient E		Patient L	Assist with Patient L
9:15	Patient F	Assist with Patient F		Patient M	Assist with Patient M
9:30	Patient G	Assist with Patient G		Patient N	Assist with Patient N

5PM Patients still waiting, most staff gone, limited support for provider, some work, charting not complete. Exhaustion, frustration

Source: Bodenheimer et al

Redesign for Value

Time	Primary care physician	Medical assistant	Nurse	Nurse Practitioner	Medical assistant
	Teamlet 1			***Teamlet 2***	
8:00-8:10	Huddle and make plan for the day's work				
8:10 AM	Telephone and e-mail visits -***12 pts***	Panel management	RN diabetes visits	Drop-in patients- ***4 patients***	Assist with drop-in patients, close the loop, phone follow-up
9:00 AM	***Patient D***				
9:30 AM	Coordinate with specialists and hospitalists. Consult with team members	Health coach visit with ***pt J***	Group visit for chronic care – ***12 patients***	***Patient K***	
10:00 AM		BP clinic- ***3 patients***		Join group visit for chronic care	Panel management
10:15 AM	***Patient H*** and ***Patient B***		Phone outreach	Telephone and e-mail visits – ***6 pts***	

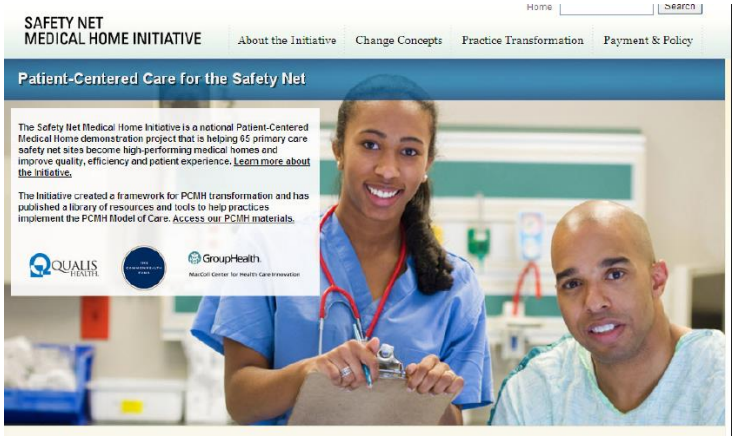
5PM home… Team signs out to overnight coverage and goes today's work done today

Source: Bodenheimer et al

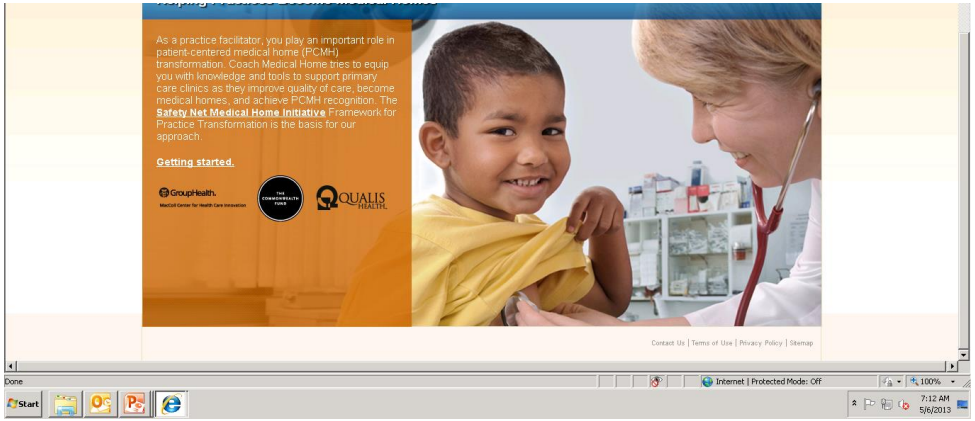
Anchor Changes (Leaders)

- Reinforce changes in the organization
  - Training, skill development
  - Policies, procedures
  - Measure to evaluate, assess and take action
  - Hiring, evaluation, promotion, incentives
- Be vigilant of the pull of deeply ingrained cultural beliefs and past practices that can overtake changes if you are not watching
  - Persistence in measurement
  - Quick action if progress falters, slips back
  - No excuses

www.safetynetmedicalhome.org



www.coachmedicalhome.org



Resources include:

- Implementation Guides
- Webinars
- Key Activity Checklist
- PCMH-A

Six Modules each with Facilitator's guide and PPTs to use and modify

1: Getting Started
2: Recognition & Payment
3. Sequencing
4. Measurement
5. Learning Communities
6. Sustain & Spread

PCMH Implementation Resources

- Patient-Centered Medical Home Assessment (PCMH-A) Find it at: http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf
- 13 Implementation Guides provide implementation strategies, tools, and case studies. Find it at: http://www.safetynetmedicalhome.org/change-concepts
- 23 tools that can be used to test or apply the key changes, including an NCQA PMCH Recognition Crosswalk. Find it at: http://www.safetynetmedicalhome.org/sites/default/files/NCQA-Change-Concept-Crosswalk.pdf
    - Downloadable registry of tools and resources. Find it at: http://www.safetynetmedicalhome.org/resources-tools
- 38 webinars (find these on each change concept page on the SNMHI website – see Implementation Guides link above.)
- 3 policy briefs on medical home payment and health reform. Find it at: http://www.safetynetmedicalhome.org/recognition-payment

Questions or More Information

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