Inspiring Accountability at the Patient Level

Health Coaching's Value in Accountable Care and Medical Homes

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Presentation Intent

1. Why “Healthcare Version 3.0” is changing practices in PCMHs and ACOs.
2. Why transforming the conversation with patients and transforming the care processes builds population health capacity.
3. What constitutes competency for a Clinical Health Coach.
4. How the Clinical Health Coach is sustainable in your healthcare enterprise.
5. How the Clinical Health Coach accelerates achievement of better health, better healthcare and lower costs.

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How would you describe the nature of your organization in managing those individual with chronic disease?

1. We identify and manage those with chronic conditions most often when they present themselves to us with symptoms.
2. We treat individuals but do not actively manage their chronic conditions.
3. We identify and manage those with chronic conditions fairly well.
4. We identify and manage those with chronic conditions proactively.

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What are your organization's primary challenges in achieving the desired results in managing chronic conditions?

1. Unclear regarding what those desired results actually are.
2. Present structure of reimbursement slows or halts real change needed.
3. Lack confidence in knowing the most effective intervention set to use to achieve desired results.
4. Limited organizational grasp of population chronic condition management.
5. Organizational politics.
6. Other.

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Healthcare's New Version 3.0

Version 1.0 Healthcare professionals are accountable for treating the ill, the sick, and the broken who present themselves. *Historical.*

Version 2.0 Healthcare professionals accept accountability for proactive prevention, education and care management to guide all patients to better health outcomes. *Present Trending.*

Version 3.0 Healthcare professionals inspire accountability at the level of the patient by partnering with them to create a care management plan that prompts improved health behaviors and builds self-care skills. *Future.*

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Opportunity Window

- We have a sick care system when we desperately need a well care system (Harkin)
- Chronic disease accounts for 75-80% of health care spending, 96% of Medicare expenditures and 83% of Medicaid costs (Thorpe)
- Costs associated with in-patient hospital stays and ER visits represent 83% of the cost of chronic disease (IOM)
- Chronically ill patients receive only 56% of clinically recommended health care (Thorpe)
- 80% (and more) of healthcare is delivered in the home—95% of diabetes care is self-care (AHRQ)
- The patient is the greatest untapped resource in heath care (Douma)

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What's responsible for the gap between where we are and where we need to be?

1. A system oriented to acute disease that isn't working for individuals (patients) or professionals when chronic conditions are often most costly and can be managed.

2. The misappropriation of education as an end game when patients benefit most from activation to self care.

3. Lack of patient skill or accountability in self management of chronic conditions which often lead to exacerbations and high cost.

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Strategies for Shift to Healthcare 3.0

- Create real patient centered medical homes.
- Build a true population health capacity.
- Develop robust, differentiated healthcare teams.
- Utilize trained, performance oriented health coaches.
- Activate patients toward self-care, inspire their accountability.

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#1. Transforming the Conversation

- Employ performance oriented health coaching.
- Rely upon the science of behavior change.
- Evoke patient motivations to guide goal setting.
- Partner with patients for self-management support.
- Exhibit empathy, self-efficacy & empowerment.
- Develop whole person strategies, inspire accountability, follow-up, affirm, count upon success.

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#2. Transforming the Care Processes

- Employ population health management practices.
- Align best practice care with patient centered resources.
- Identify and reduce care gaps.
- Increase planned prevention visits.
- Communicate to improve health literacy.
- Connect patients with best community resources.

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Emphasis on Population Health

- Powerful consequence of chronic conditions on the total cost of healthcare.
- Realignment of payment and incentives toward prevention and value versus volume.
- Commitment to technology (EMRs & registries) for tracking quality and outcomes.
- Risk sharing/shifting in Accountable Care Organizations and PCMHs.

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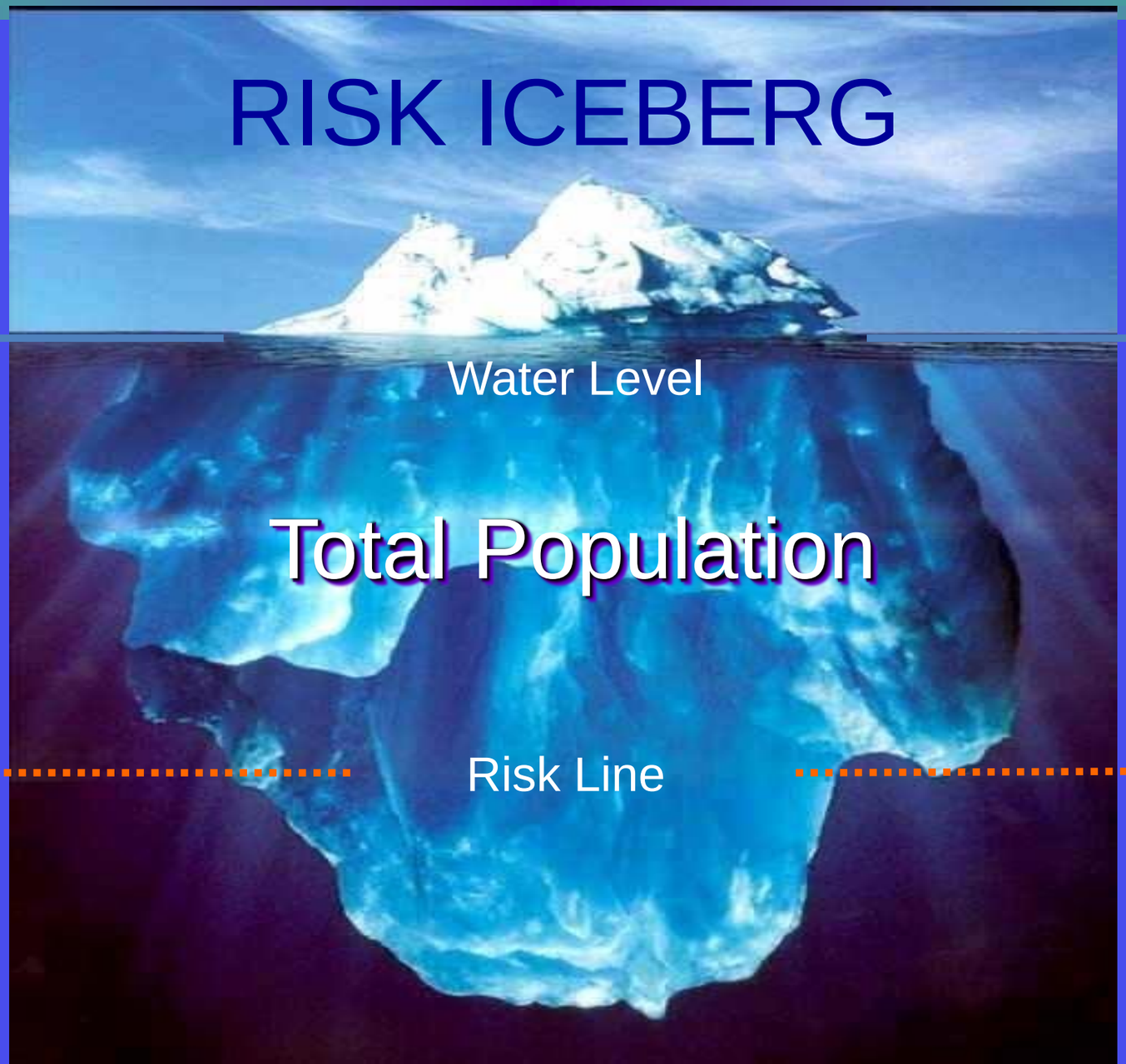
POPULATION HEALTH MANAGEMENT

Population
at risk
who have
filed a claim

Disease & Care
Management



Population
with risk
but not sick

Lifestyle & Health
Behavior
Management

Population with
no known
risk factors

Health
Maintenance &
Promotion

What Is A Population?

- Patient cohort a clinic serves.
- Medicaid beneficiaries in a state.
- All patients with a diagnosis of diabetes.
- Lives covered by a health plan.
- Everyone in a defined community.

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Sequential Steps in Population Health Management

1. Population Identification/Definition
2. Health & Risk Assessment
3. Risk Stratification
4. Targeted Interventions
5. Engagement for Behavior Change
6. Evaluation of Outcomes/Impact

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Why Your Organization Needs a Clinical Health Coach

- Improve clinical and population health outcomes for those you serve.
- Engage and activate your patients toward self-care.
- Lead your market as a medical home or ACO/population health organization.
- Improve patient experience.
- Achieve financial success under any payment model.

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Primary Clinical Health Coach Competencies

- Performance proven health coaching skills that can be effectively used to partner with patients.
- Patient engagement and activation strategies employing a health coaching approach.
- Clinical assessments, tools and resources to support best practice care and patient centered goal setting.
- Population health strategies to identify, stratify and manage large numbers of patients.
- Healthcare communications skills to improve patient health literacy.
- Leadership skills to implement the health coach change strategies.

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Building Clinical Health Coach Competencies

- ❑ Formal training, not just orientation to Motivational Interviewing (MI).
- ❑ Knowledge and skills in transforming the conversation with patients and transforming the care processes.
- ❑ Gestational training, over time, with practice skill building.
- ❑ Guidance in implementing health coaching within the health care team.
- ❑ True performance orientation and assessment.

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How Do We Pay for the Clinical Health Coach?

A Clinical Health Coach will aid in accreditation as a PCMH. Good evidence exists for the value of the Coach. A Coach will drive heath team efficiency and throughput. **Yet, how do we pay for the Clinical Health Coach?**

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Paying for the Coach in Future

- Current evidence affirms value to outcomes of coaching; future evidence will be compelling.
- As payment in PCMH, ACO, shared savings models shift to value, clinical health coaching will become standard practice.
- Care coordination payments by health plans currently exist and will likely expand.
- The Affordable Care Act allows health plans to include spending for quality improvements (coaching is an example) as an allowable cost of care expense.

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Paying for the Coach Now

- Many health plans and Medicaid programs are providing **care coordination payments** for PCMH.
- **Incentive payments for enhanced outcomes** for patients with chronic conditions are often available.
- Accelerating **proactive visits for all patients for physicals, labs and preventative screens** adds revenue in excess of expense.
- **Assessing gaps in care for patients with chronic conditions** prompts additional lower cost office visits. **Group visits** may add value and revenue.

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The Patient is the Great Untapped Resource

- Most healthcare occurs in the homes of patients where their health behaviors play out.
- Most chronic care is self-care.
- Effectively partnering with patients to set goals on best health behaviors is no longer an option in good healthcare, it is the expectation, it is Healthcare 3.0.
- The Clinical Health Coach is effectively trained to guide a PCMH/ACO toward achieving better health, better healthcare and lower costs.

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Questions

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