



Executive summary: Vizient Chronic Disease Medical Home Playbook

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A breakthrough approach to managing care for the chronically ill population

A chronic disease medical home (CDMH) is a team-based model of care designed to improve patient outcomes and lower health care costs by providing holistic, comprehensive, coordinated care for patients with one or more chronic illnesses. The 84-page Vizient™ Chronic Disease Medical Home Playbook is a guide for organizations that are considering or implementing a CDMH. The playbook covers a broad range of issues, including crucial roles, interactions, information flow, handoffs and infrastructure, and describes lessons learned from three pilot-program sites and other research on institutions with chronic disease management programs.

How the playbook was developed

The Vizient Research Institute™, in collaboration with Axiom Consulting Partners, first collected data from three health systems serving as pilot sites about their efforts to successfully manage patients with complex chronic illnesses. Next, findings were synthesized to identify common themes and unique practices associated with different care models. The third step was to test assumptions through conversations with pilot-site project leaders and compare the early findings with established theories and research.

The playbook includes case studies with operational examples, guiding principles with tips and best practices for specific CDMH elements, and lessons about what worked best at each pilot site.

Highlights from the Playbook's five chapters follow.

The business case for a different care delivery approach

A CDMH contributes to the “six aims” for improving health care — safety, timeliness, effectiveness, efficiency, equity and patient-centeredness — for the chronically ill. These aims go beyond treating disease to address psychosocial and other environmental determinants of health in a holistic manner. At one pilot site discretionary funds were used to resolve problems that prevented patients from achieving better health outcomes — for example, by purchasing an air conditioner for a patient or hiring a snow-shoveling service.

Sample stakeholder value propositions and guiding principles included in the Playbook will help institutions create a CDMH value proposition that is right for their specific situation.

The playbook also examines how different institutions address the economic requirements for implementing a CDMH from clinical, operational, and financial perspectives. At one pilot site, slightly higher spending on outpatient care and care coordination led to significantly lower inpatient spend, reducing the overall cost of care. Another case quantifies the value of working closely with uninsured and underinsured patients to determine if they are eligible for insurance coverage. In this case, 91 percent of

patients were uninsured at their first clinic visit but with intervention, only 64 percent were uninsured at their most recent clinic visit.

Foundational elements of a CDMH

A successful CDMH must be built on a foundation that supports the institution's goals for population health and reinforces the patient and provider value propositions. The Playbook details seven foundational elements and includes case studies, important lessons, guiding principles and details for each:

1. Clinic infrastructure
2. Key interactions
3. Target patient population
4. Team-based approach to care
5. Roles and responsibilities
6. Workforce composition and staffing model
7. Tools and technologies

In studying various tools and technologies needed for a successful CDMH, such as electronic medical record alerts and patient educational materials, the researchers concluded that investment and utilization should be guided by several principles:

- Consider crucial interaction needs both within the CDMH and across the institution
- Equip providers with a means to communicate in real time
- Build on current institutional systems to minimize costs associated with new technology
- Design or use patient materials that are simple and straightforward, and ensure that patients understand them, both during onboarding and across the care continuum
- Standardize care-team touch points to address issues, highlight successes and assess the CDMH's progress toward its goals

The desired patient journey

To successfully engage chronically ill patients in a team-based care model, it is important to consider each patient's unique diagnoses, motivators and personal circumstances and needs. The Playbook examines four typical phases of most CDMH patient journeys, from patient qualification and onboarding to the initial planning and ongoing management of care. "Experience maps" for patients and the care team document potential concerns, goals and actions from both perspectives to promote productive engagement.

Because governance and decision-making must be clearly defined in a team-based approach, the Playbook also applies the Recommend, Approve, Consult and Inform (RACI) model to clarify decisions associated with primary accountabilities and the leaders involved in making those decisions.

Ongoing assessment of performance

The CDMH approach supports the Institute for Healthcare Improvement's Triple Aim initiative, an approach to health system design that focuses on simultaneously improving the patient experience of care (quality and satisfaction), improving population health and reducing per-capita health care costs. The Playbook outlines how to set appropriate metrics for measuring progress toward the Triple Aim and includes three case studies describing quality, clinical and financial outcomes.

Sustaining success

The Playbook provides an “align-equip-sustain” model to address the risks of implementing a CDMH strategy and synthesizes the research into eight principles that apply to all CDMH approaches:

1. It is essential to align the CDMH's strategy with the institution's overarching goals and approach to population health management.
2. The combination of patients' psychosocial, educational and financial challenges requires an agile team that can adapt to unanticipated needs.
3. Increasing health literacy and improving other social determinants of health can significantly improve patients' compliance with the care plan and reduce costs.
4. It is critical to identify and leverage patients' relationships with care team members to build trust and increase engagement in the care plan.
5. Roles and responsibilities must be defined, but team members' ability to work as a fluid unit and manage handoffs determines success.
6. In a fast-paced clinical environment, information sharing takes place through both formal and informal channels.
7. Enhanced information technology systems tailored for care coordination can improve efficiency, support team communications and ensure a consistent understanding of each patient's needs across the health system.
8. Data analytics is critical to understanding successes and opportunities, deciding where resources should be allocated and sharing results and best practices to build buy-in for the CDMH.



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