ACO Accelerated Development Learning Session

Baltimore, MD
November 17–18, 2011

Module 1A: Care Delivery—Primary Care and Care Redesign

November 17, 2011

1:30–3:30 p.m.

Jonathan R. Sugarman, MD, MPH
President & CEO, Qualis Health
Clinical Professor, Departments of Family Medicine and Epidemiology, University of Washington
jonathans@qualishealth.org

Jonathan R. Sugarman, MD, MPH, FAAFP, FACPM: Bio and Disclosure

- President and CEO of Qualis Health (a 501c3 quality improvement, care management, and health information technology consulting firm)
- Past President, American Health Quality Association
- Past President, Washington Academy of Family Physicians
- Executive Committee member, AMA-convened Physician Consortium for Performance Improvement
- Clinical Professor, Department of Family Medicine, University of Washington School of Medicine
- Clinical Professor, Department of Epidemiology, University of Washington School of Public Health and Community Medicine
- Disclosure: Qualis Health holds Medicare QIO and Health Information Technology Regional Extension Center contracts for Washington and Idaho, and consulting and care management contracts with numerous public and private sector firms

Objectives for the Learning Module

- Briefly review the role of primary care as an essential foundation for the success of "newly forming ACOs comprised of independent providers"
- Reflect on the relationship between the patient-centered medical home (PCMH) and ACOs
- Offer ACO leaders a framework for evaluating and enhancing the design of primary care delivery in their ACOs
- Discuss potential challenges ACO leaders need to consider in supporting PCMH transformation, and describe a few resources that may assist in overcoming those challenges

1. Why is primary care a fundamental foundational element for the success of ACOs?

Primary Care- Some "Old" Data

- Persons who receive care in a primary care-oriented model are more likely to:
  - Receive recommended preventive services
  - Adhere to treatment
  - Be satisfied with their care[1]
- Increased primary care to population ratios are associated with reduced hospitalization rates for ambulatory sensitive conditions [2]
- Healthcare costs are higher in regions with higher ratios of specialists to generalists [3]

[1]Bindman and Grumbach. J Gen Intern Med 1996;11:269; Safran et al. J Fam Pract 1998;47:213
[2]Parchman and Culler. J Fam Pract 1994;39:123
[3]Welch et al. NEJM 1993;328:621

Primary Care *continued*

- Adults with a primary care physician rather than a specialist as their personal physician:
  - 33% lower annual adjusted cost of care
  - 19% lower adjusted mortality, controlling for age, gender, income, insurance, smoking, perceived health (SF-36) and 11 major health conditions

Franks and Fiscella. J Fam Pract 1998;47:103

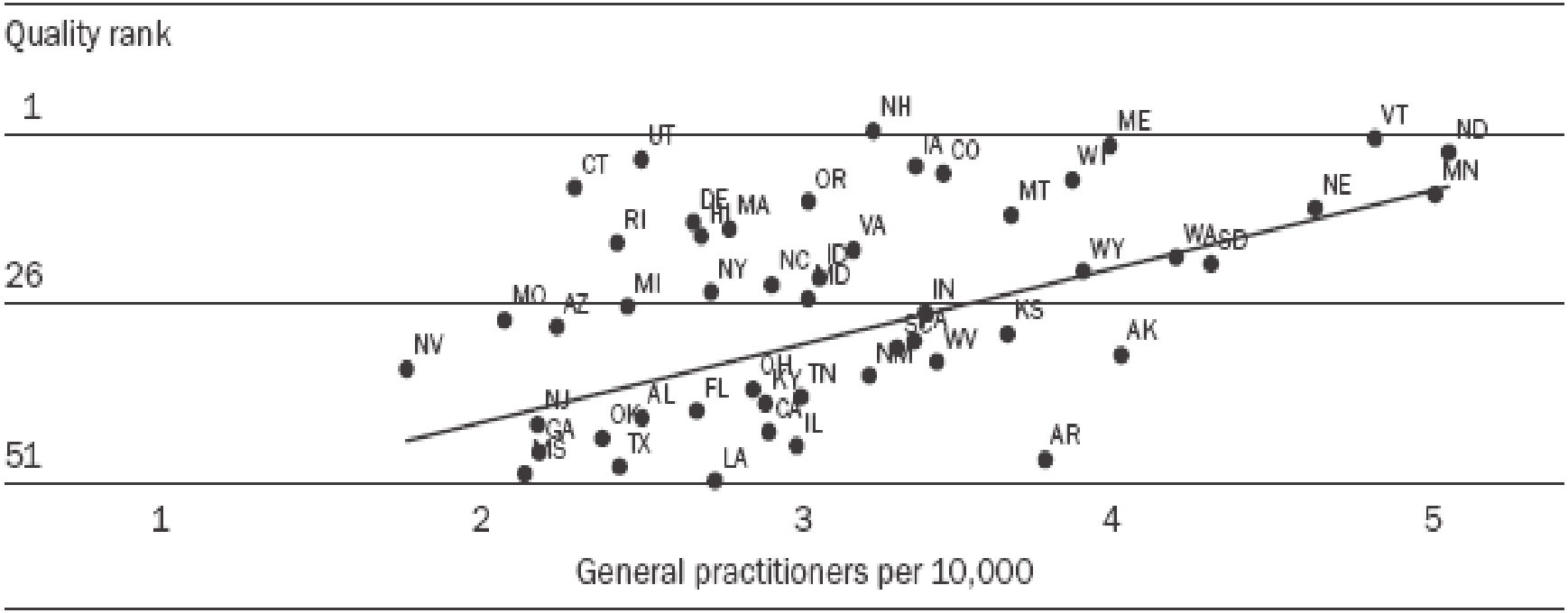
Primary Care *continued*

- Dartmouth Atlas demonstrates that per capita Medicare expenditures in certain regions of the country are far higher than in other regions. These differences are not explained by demographic, socioeconomic, or burden-of-illness factors
- Higher-cost areas tend to have a greater preponderance of specialists; lower-cost areas have more primary care
- Quality of care for certain measures is no better in the higher-cost areas

Fisher et al. Ann Intern Med 2003;138:273, 288
Fisher. NEJM 2003;349:1665

EXHIBIT 8

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



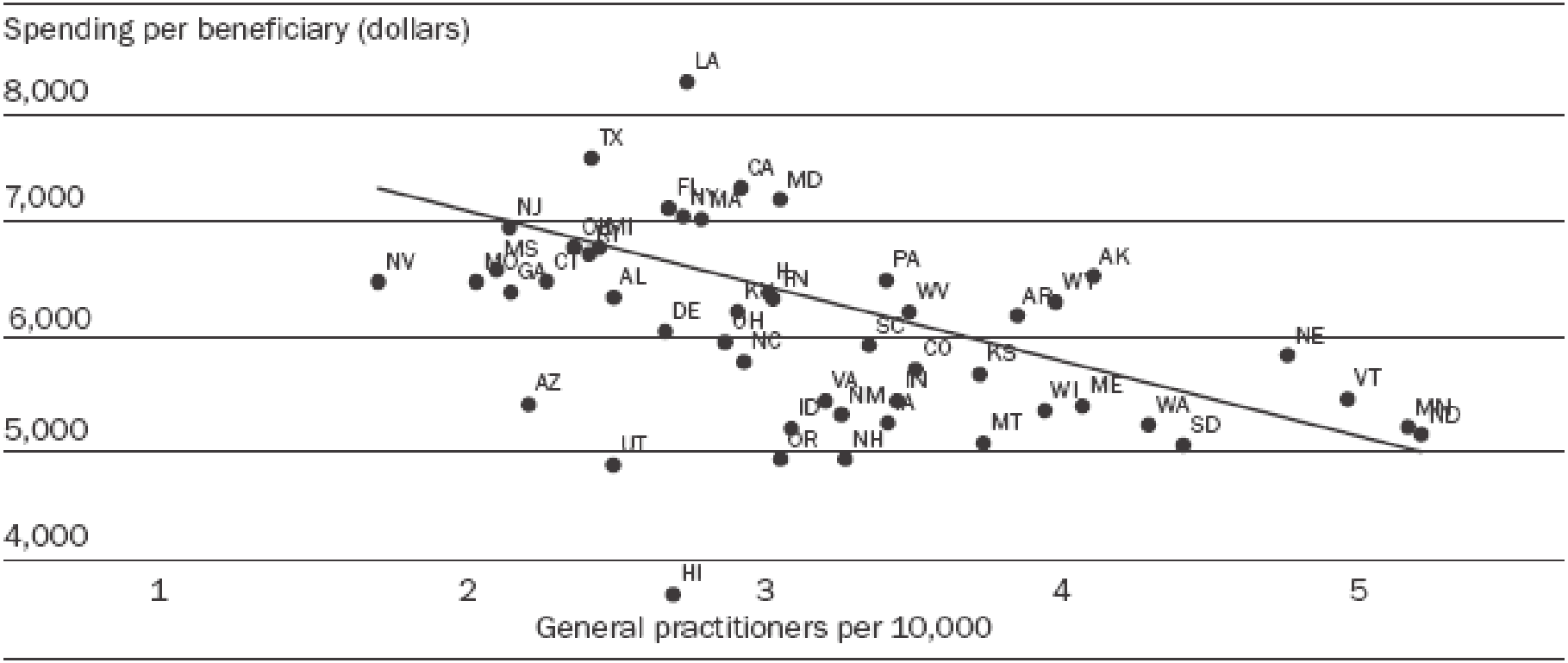
SOURCES: Medicare claims data; and Area Resource File, 2003.

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004

EXHIBIT 9

Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

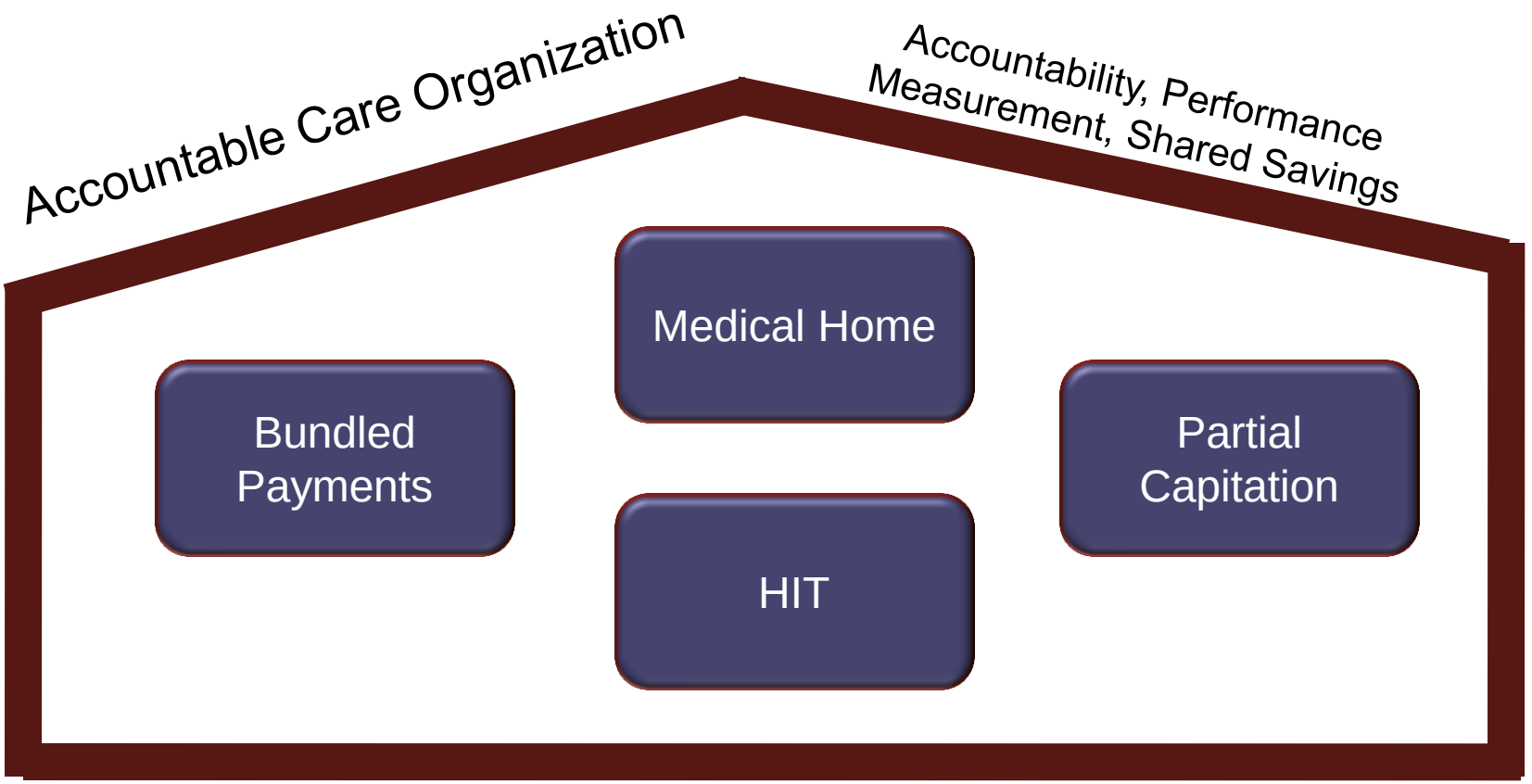
Source: Baicker & Chandra, Health Affairs, April 7, 2004

Emerging evidence that primary care-based "patient-centered medical homes" improve quality, reduce costs, and enhance patient experience

- Group Health Cooperative of Puget Sound[1]
- Geisinger[2]
- and others[3,4]

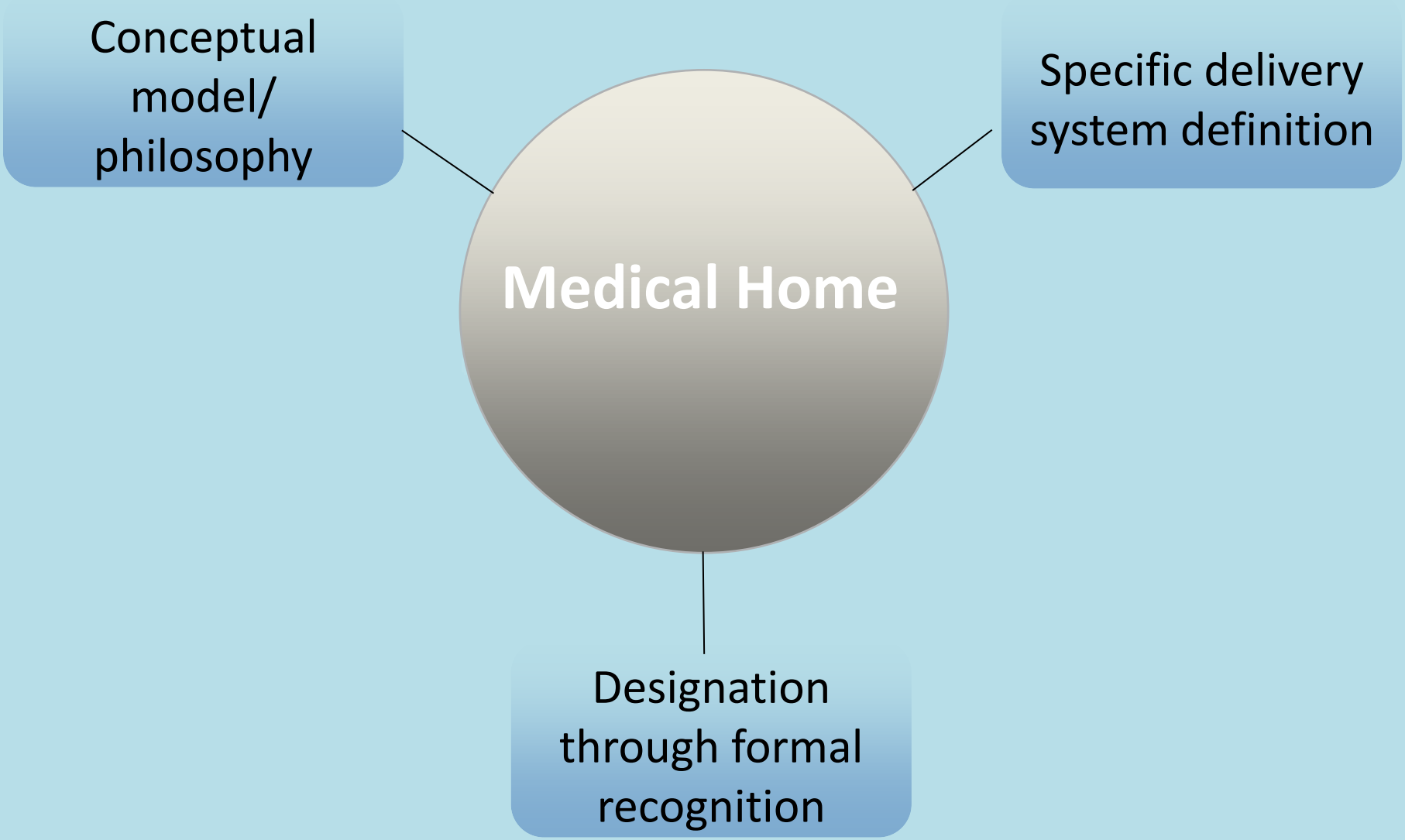
1.Reid RJ et al..The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers. Health Affairs. 2010; 29(5):835-843
2. Gilfillan, RJ et al. Value and the medical home: effects of transformed primary care. Am J Manag Care, 2010. 16(8): p. 607-14.
3. Grumbach K et al. The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies, Patient-Centered Primary Care Collaborative.August 2009.
4. Milstein A, Gilbertson E. American Medical Home Runs: Four real-life examples of primary care practices that show a better way to substantial savings. Health Aff (Millwood). 2009;28(5):1317–26.7

The ACO is the overarching structure within which other reforms can thrive



2. Okay, we have plenty of primary care, so we have medical homes, and our ACO should be ready to go, right?

http://www.xtranormal.com/watch/12676523/medical-home-and-acos-v3



The 4 Cornerstones of the PCMH Model

- Primary care
- Patient-centered care
- New model practice
- Payment reform

Source: Rittenhouse DR, Shortell SM. JAMA 301(19), 2038-2040.

Typical Care	PCMH Care
Providers are responsible for the universe of patients who seek care in the practice.	Patients are paired with a continuity provider who is responsible for a defined panel of patients.
Care is delivered in reaction to today's problem.	Care is determined by a proactive plan to meet health needs, with or without clinic visits.
Providers believe that their extensive training translates to high quality care. Care varies by scheduled time and memory or skill of the provider.	Quality is assured through the measurement of adherence to evidence-based guidelines, and we develop action plans to continuously improve the quality of care we provide.
The productivity treadmill requires providers to work harder and assume longer work days.	The practice aligns appointment capacity with appointment demand, adjusting staffing and other variables to balance the workload.
The provider functions as a solo act, even when support staff are available.	An interdisciplinary team works together to serve patients efficiently and effectively, coordinating care, tracking tests and consultations, and providing outreach and follow-up after ED visits and hospitalizations.

3. Practice Redesign: What needs to happen, and in what order?

The NEW ENGLAND JOURNAL of MEDICINE

Volume 365(219) November 10, 2011 pp. 1753-1756

Making Good on ACO's Promise- The Final Rule for the Medicare Shared Savings Program

Donald M. Berwick, MD

"The dedicated professionals in the U.S. health care system work to deliver the highest-quality health care they can. But as any health care provider can tell you, our system is full of roadblocks, red tape, and frustrations that keep them from practicing the type of medicine that most clinicians envisioned when they chose their noble field."

.

Medical Home Change Concepts: A Framework for Transformation

- Empanelment
- Team-based Continuous Healing Relationships
- Patient-Centered Interactions
- Engaged Leadership
- QI Strategy
- Enhanced Access
- Care Coordination
- Organized, Evidence-based Care

THE COMMONWEALTH FUND

QUALIS HEALTH advancing healthcare • improving health

Improving Chronic Illness Care MacColl Institute at Group Health Cooperative

The Safety Net Medical Home Initiative

19

Two key elements:
Empanelment and Teams

Empanelment- More than a “Regular Doctor”

- Provides a systematic way to allow patients to see their own PCP and team
- Provides a process for sorting patients into populations
- Provides a way to manage supply and demand

PCMH-A Self-Assessment
Sample "Empanelment" Questions

Components	Level D	Level C	Level B	Level A
Patients	…are not assigned to specific patient panels	…are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.	…are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	…are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
Score	1 2 3	4 5 6	7 8 9	10 11 12
Registry or panel data	…are not available to assess or manage care for practice populations	…are available to assess and manage care for practice populations, but only on an ad hoc basis.	…are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.	…are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Team-based, Continuous Healing Relationships

If a primary tenet of the Medical Home is the continuous relationship between a team of providers and an informed patient…

…then we must provide a mechanism for allowing that relationship to happen in our systems

Teams:
A Paradigm Shift from "I" to "We"

- From … How can the clinician (I) see today's scheduled patients and do the non-face-to-face-visit tasks?

Monday	Patients
8:00 AM	Sr. Rojas
8:15 AM	Ms. Johnson
8:30 AM	Mr. Anderson
8:45 AM	Sra. Garcia

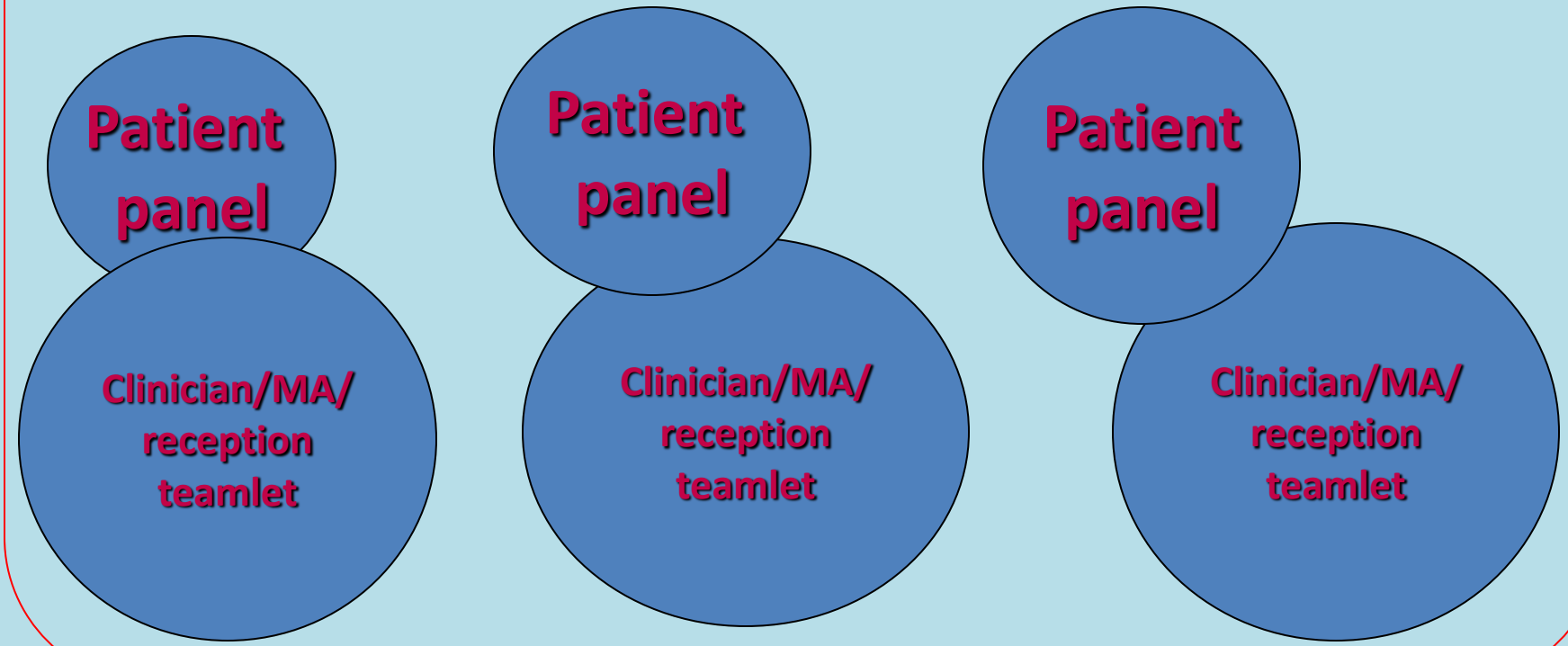
- To … What can the team (We) do today to make the panel of patients as healthy as possible?

The Transformation to Team Care

- 50% of what physicians do could be done by someone else on the team

  Yarnall et al. Am J Public Health 2003;93:635;
  Ostbye et al. Annals of Fam Med 2005;3:209

- However, framing it as "offloading physician work to other team members" alienates non-physician team members
- Share the care
  - –Tasks are redistributed among the team
  - –Each team member feels proud to share responsibility for the team's patient panel
  - –RNs, pharmacists, behaviorists could be the person primarily responsible for a sub-panel



RN, social worker, pharmacist, health educator, nutritionist, care manager, panel manager

1 team, 3 teamlets

Source: Tom Bodenheimer

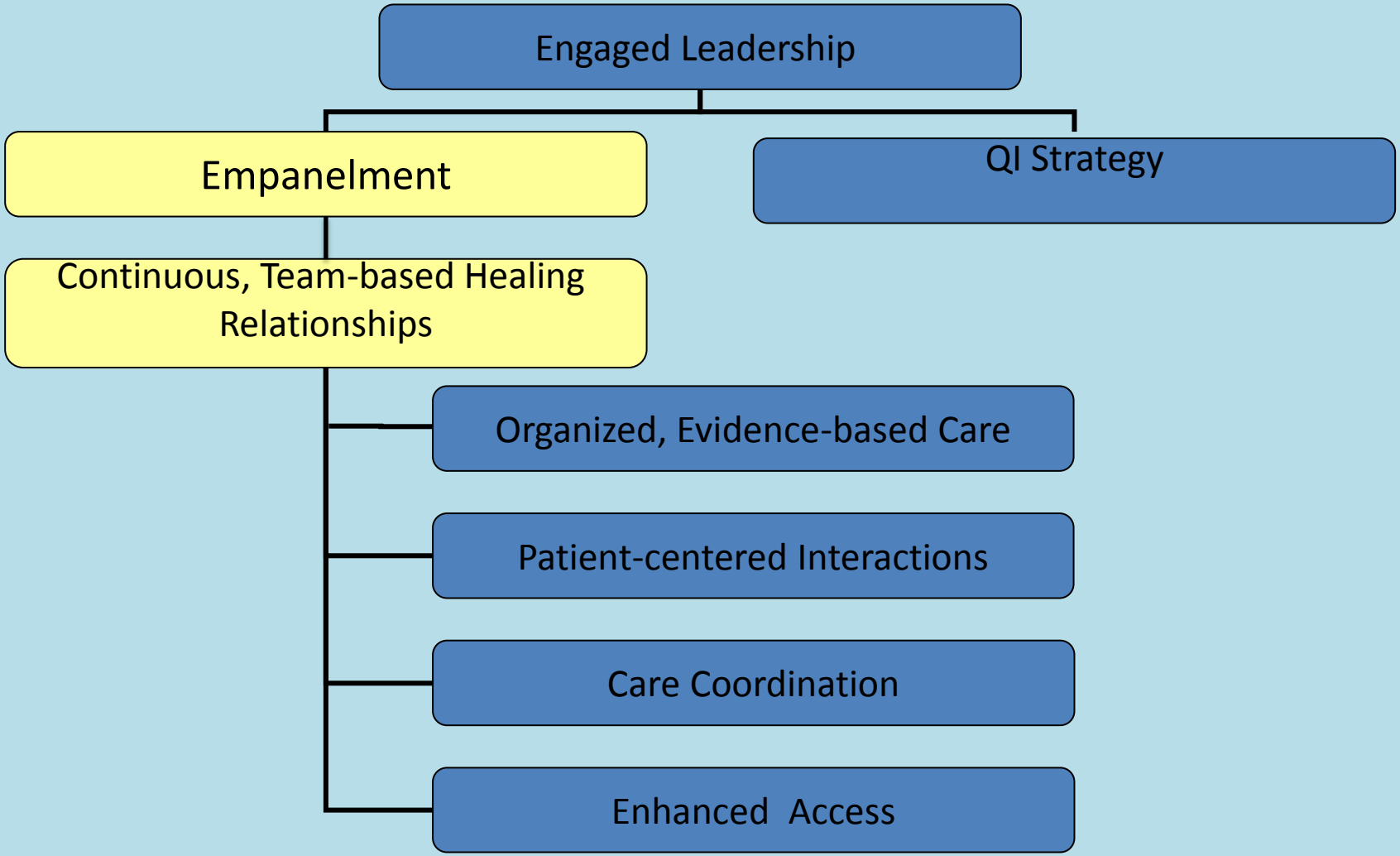
Will Patients Accept Teams?

- Some evidence suggests that this can work for patients if:
  - The same people work together all the time so patients know who is their team
  - Teams are small (teamlets) so patients know and are comfortable with all team members
  - Teams are visible rather than invisible
  - Patients already have a relationship with the team's physician; ideally the physician introduces the team to the patient

Rodriguez et al. Medical Care 2007;45:19;

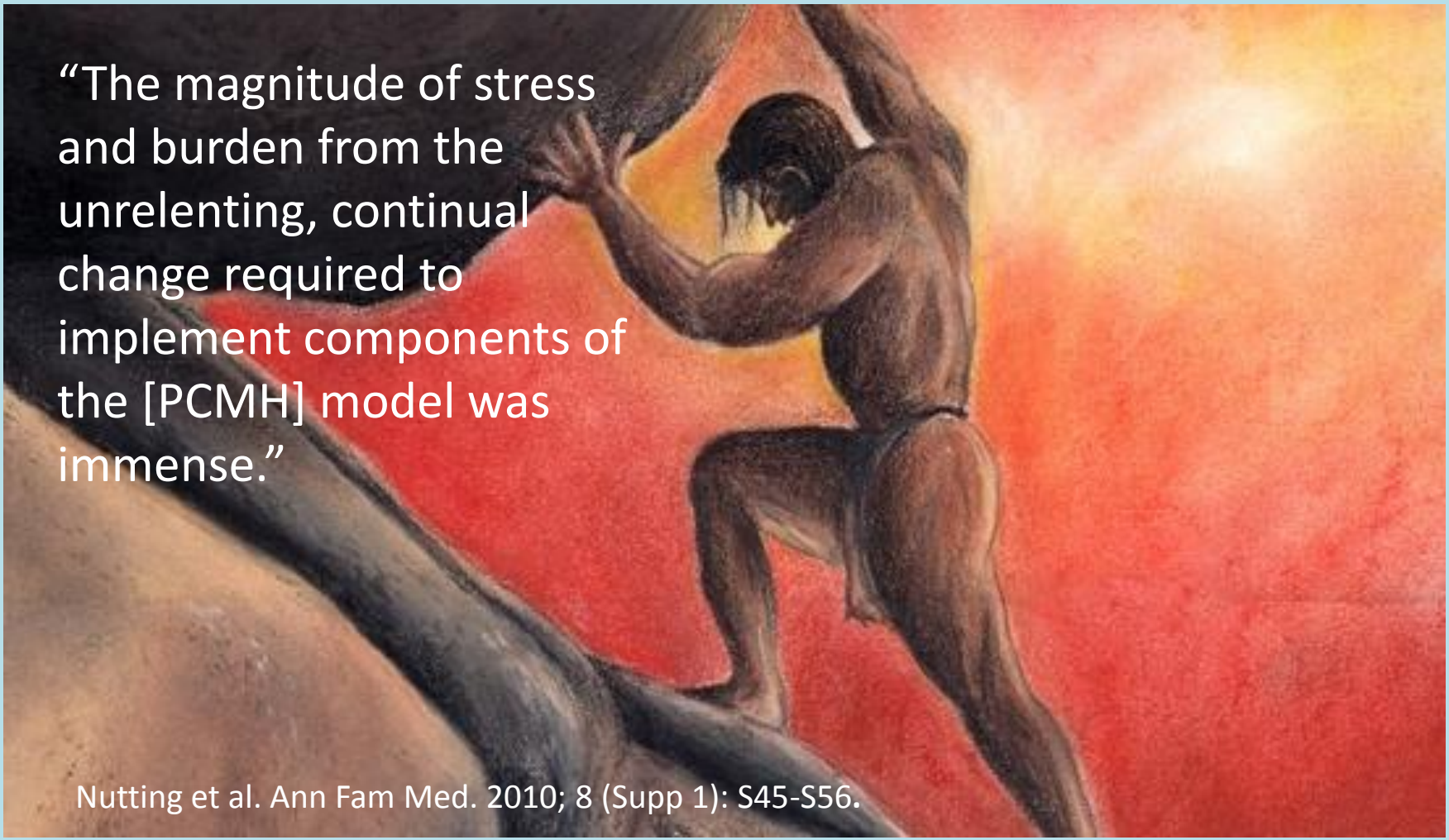
Rodriguez et al. JGIM 2007;22:787

How do the 8 change concepts relate to one another? Why are Empanelment and Team Care so critical?



4. Doesn't sound that complicated, so it should be easy to implement, right?

Practice change is hard



Nutting et al. Ann Fam Med. 2010; 8 (Supp 1): S45-S56.

Why is practice change so hard?

- "Change is hard enough; transformation to a PCMH requires epic whole-practice reimagination 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.
  - Transformation to a PCMH 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

Practice characteristics supportive of transformation

Can the practice function adequately in times of stability?

- Sound financial systems
- Stable leadership and staff
- Stable IT

} **Core structure**

Can the practice change to adjust or improve?

- Facilitative leadership
- Effective relationships
- A learning culture
- Group time

} **Adaptive reserve**

Message: If a practice is broken, it may not be able to make meaningful change unless repaired.

Successful practice transformation

- Recognizes its difficulty and prepares practices for it.
- Includes a focus on the experience of those providing care.
- Assures that routine care delivery is different.
- Involves staff and patients in continuous process change.

What Tools Need to be in the ACO Toolkit to Support Practice Redesign?

A few things to consider…

- Assessment tools
- Coaching or mentoring resources
- An explicit and shared approach to process improvement, and expertise in that process
- Field trips
- Collaborative learning approaches

Assessment and Measurement of "Medical Homeness"

Examples of Assessment Tools:

- PCMH-A
- NCQA PPC-PCMH tools
- MH-IQ
- Medical Home Index

PCMH-A Background & Context

- Developed to measure a practice's progress towards implementing the 8 Change Concepts
- Self-administered assessment
- Aids in the identification of improvement opportunities
- Stimulates conversations with other sites to learn, share, & transform
- Serves as a standardized measure of progress

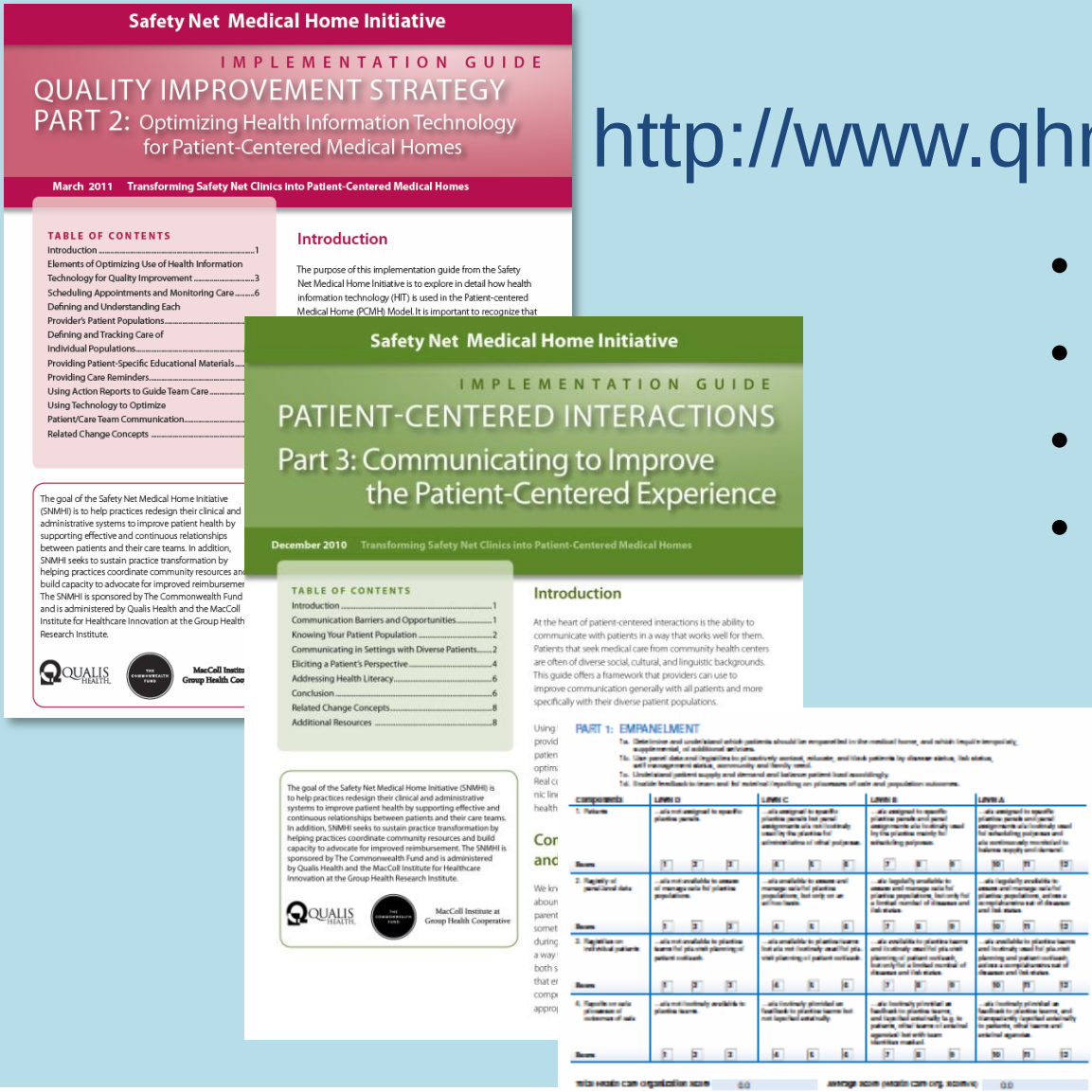
PCMH-A Self-Assessment
Sample "Empanelment" Questions

Components	Level D	Level C	Level B	Level A
Patients	…are not assigned to specific patient panels	…are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.	…are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	…are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
Score	1 2 3	4 5 6	7 8 9	10 11 12
Registry or panel data	…are not available to assess or manage care for practice populations	…are available to assess and manage care for practice populations, but only on an ad hoc basis.	…are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.	…are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.
Score	1 2 3	4 5 6	7 8 9	10 11 12

A Few Places to Start for Tools and Resources

- Patient Centered Primary Care Collaborative. Putting Theory into Practice: A Practice Guide to PCMH Transformation Resources. (www.pcpcc.net/resources , 2011)
- Safety Net Medical Home Initiative implementation guides at www.qhmedicalhome.org/safety-net/publications.cfm
- Bodenheimer and Grumbach, Improving Primary Care: Strategies and Tools for a Better Practice (McGraw-Hill, 2007)
- Institute for Healthcare Improvement (www.ihi.org)

Free SNMHI PCMH Resources:



http://www.qhmedicalhome.org

- PCMH-A
- Implementation guides
- Webinars
- Videos

Module 1A:
Care Delivery- Primary Care and Care Redesign

Jonathan R. Sugarman, MD, MPH
President & CEO, Qualis Health
jonathans@qualishealth.org

Appendix:
Change Concepts for Practice Transformation

Empanelment

PCMH practices:

- Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.
- Assess practice supply and demand, and balance patient load accordingly.
- Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need.

43

Continuous and Team-Based Healing Relationships

PCMH practices:

- Clearly link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
- Assure that patients are able to see their provider or care team whenever possible.
- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.
- Cross-train care team members to maximize flexibility and ensure that patients' needs are met.

44

Patient-Centered Interactions

PCMH practices:

- Assess and respect patient/family values and expressed needs.
- Encourage patients to expand their role in decision-making, health-related behavior change, and self-management.
- Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.
- Provide self-management support at every visit through goal setting and action planning.

45

Engaged Leadership

PCMH leaders:

- Provide visible and sustained leadership to lead overall cultural change as well as specific strategies to improve quality and spread and sustain change.
- Ensure that the PCMH transformation effort has the time and resources needed to be successful.
- Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.
- Build the practice's values on creating a medical home for patients into staff hiring and training processes.

46

Quality Improvement (QI) Strategy

PCMH practices:

- Choose and use formal models for quality improvement.
- Establish and monitor metrics to evaluate improvement efforts and outcome and provide feedback.
- Obtain feedback from patients/family about their healthcare experience and use information for quality improvement.
- Ensure that patients/family, providers, and care team members are involved in quality improvement activities.
- Optimize use of information technology.

47

Enhanced Access

PCMH practices:

- Promote and expand access; ensure that established patients have 24/7 continuous access to their care teams via phone, email, or in-person visits.
- Scheduling options are patient- and family-centered and accessible to all patients.
- Help patients attain and understand health insurance coverage.

48

Care Coordination

PCMH practices:

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Integrate behavioral health and specialty care into care delivery through co-location or referral agreements.
- Track and support patients when they obtain services outside the practice.
- Follow up with patients within a few days of an emergency room visit or hospital discharge.
- Communicate test results and care plans to patients.

49

Organized, Evidence-Based Care

PCMH practices:

- Use planned care according to patient need.
- Identify high risk patients and ensure they are receiving appropriate care and case management services.
- Use point-of-care reminders based on clinical guidelines.
- Enable planned interactions with patients by making up-to-date information available to providers and the care team prior to the visit.

50