The Role of Primary Care in Care Redesign

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The Role of Primary Care in Care Redesign

- Care Redesign in Primary Care: Getting ready for bundled payments, prepaid care, capitation, ACOs etc.

  – The Why

  – The Who

  – The Where

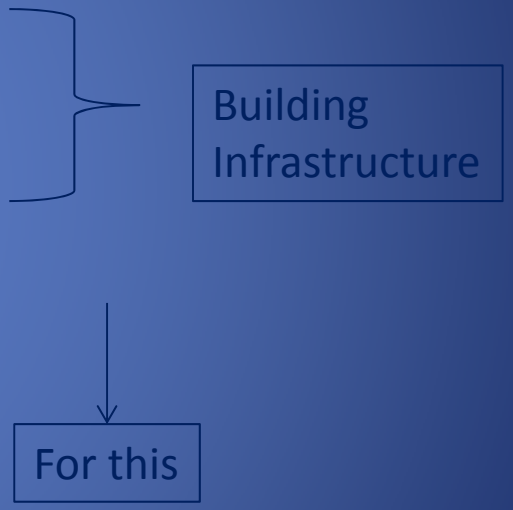
  – The What

  – The When

The Why

Payment Mechanisms

Stage 1	Fee for Service	Volume Based
Stage 2	Performance Quality	Fee for Service + Bonus
Stage 3	Outcomes management	Fee for Service + Bonus
Stage 4	Care Management	Per Member per Month Payment
Stage 5	Bundled Payments Global Risk ACO	The “tipping point”



The Why

Strategic Role of Primary Care in Different Markets

Fee for Service	Hybrid	Global Budget
• Downstream Referral generation (inpatient admissions, outpatient ancillary services) $8 dollars for every $1	• Increasing coordination of care and services for defined panel of patients • Securing referral channels	• Growth of covered or attributable lives • Coordination of care across continuum • Management of total medical expenditures $M plus

"Primary Care is the cornerstone of the clinical delivery Model under Accountable Care"

Source: The Chartis Group

The Why

Changing Role of the PCP

Traditional Role

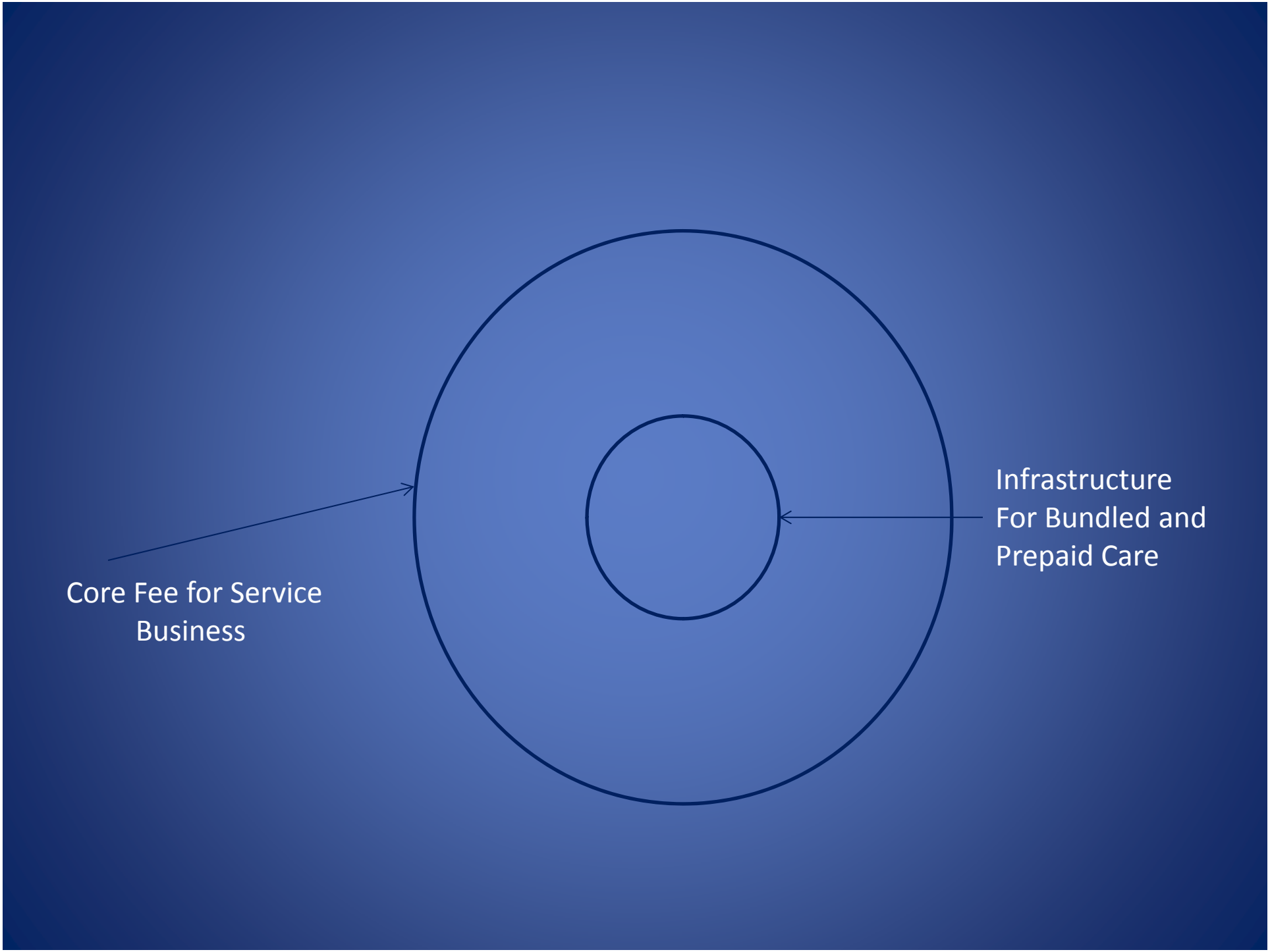
- Care Provider
- Episodic Care
- Treatment
- Supervising staff
- Individual practitioner
- Face-to-face patient care
- Contract negotiation
- Payment for service
- Production
- Patient treatment

Future Role

- Care coordinator
- Health across continuum
- Treatment and prevention
- Managing a team
- Team-based patient care
- Group visits, e-visits, etc/.
- Provider-payor partnering
- Pay for performance
- Accountable for outcomes
- Patient empowerment

Source: Health Strategies and Solutions, Inc.


CABIN CREW TO WELDING GEAR...
INFLIGHT PLANE REDESIGN PROGRAM


Core Fee for Service Business
Infrastructure For Bundled and Prepaid Care

The Why

Primary Care Infrastructure Needs in Advanced Markets

- Care Management/Coordination
- New Delivery Models that leverage larger number of support staff
- Enhanced IT connectivity between all sites of care
- New finance, budgeting and risk management capabilities

Source: The Chartis Group

The Who

- Penn State – Hershey owned Practices
  - 8 in South Central PA (Hershey)
  - 3 in Cental PA (State College)
    - 250,000 visits per year
- PA Spread Practices – 17 practices
  - Central Pennsylvania
  - Northwest Pennsylvania

The Where

PA Spread Practices

Penn State Owned Practices

The What
At Penn State

- Pre-planned activities
  - NCQA Medical Home
  - Medical and Staff Engagement
  - Lean Training
  - Primary/Subspecialty care hotspot management
  - Medical Home Curriculum for Medical Students
- Unplanned Opportunities
  - PA Governor's Chronic Care Initiative
  - Pay for Performance Programs with Payors

Governor's Chronic Care Initiative

- Established in October 2007 by executive order
- Collaborative multi-payer approach essential for practice-wide transformation using Medical Home Model
- Teach Chronic Care Model (CCM) using rapid cycle testing approach while implementing key elements of the PCMH
- Elements:
  - Practice facilitation
  - Regional learning collaboratives
  - Monthly performance reporting
  - Practice-based care management
  - Enhanced payments
  - Regional rollouts
  - Emphasis on diabetes and/or childhood asthma

The When: Penn State PCMH Activities

- 2005: began regular meetings of office managers and medical directors
- 2007: Family Medicine Department strategic plan includes PCMH
- 2008: NCQA diabetes certification for FCM offices
- 2009-2012: Governor's Chronic Care Initiative
  - involved 4 of our offices out of a total of 16 in our region.
  - Forced tight schedule to develop care manager program, regular use of diabetic registry, tracking system for consultations and high end testing, and new polices and procedures for PCMH.
- 2009-2011: All FCM offices certified as level 3 PCMH
- 2010 - now. P4P programs yield increased revenue.

Primary Care Extension Service

- Center for Medicare and Medicaid Innovation Center Funding for Model Design and Testing
  - Funding to Governor's Office
  - Model Design:
    - Promote development of ACOs
    - Motivate and support accountable provider entities through gain sharing models
    - Reduce cost and disparities in care by developing community based teams for hot spots
    - Extension Service as a means for practice transformation using AHEC infrastructure

Medicare Bundled Payment Program

CMS program

- All bills rolled into single fee.
- Episode triggered by an “anchor event” (i.e., hospital admission) and includes 90d post-discharge care.
- Penn State Projects: CHF and Stroke

PSHMC Program Partners:

- PSH Rehab Hospital; VNA-CP, Spring Creek NH

Care Redesign Interventions in progress or planned

- Expanded post-discharge phone calls; home visits; care management for 90days, etc

PCMH Interface

Medical Home Curriculum

- Funded by $1.46 million HRSA grant
- Started as a pilot in July 2011
- Offered to 3rd and 4th year students
- Becomes part of the curriculum 2015

- Provide a longitudinal experience to enhance medical education
- Teach the concepts of chronic care model and chronic disease management
- Prepare students to practice in the changing medical environment by introducing the concepts of the Patient Centered Medical Home