Patient Centered Medical Home and Accountable Care Organizations

Health Information Technology

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Healthcare Reform

Coverage for All

Payment Reform
- Align incentives
- Pay for Value
- Strengthen Primary Care

Health Information Technology

Tools to Rebuild and Restructure Health Care
The Vicious Cycle

The interconnected nature of health IT, payment reform, and care delivery

Lack of health IT cripples the ability to move to new payment methods that reward providers for health, care quality, and care efficiency, utilizing data supplied by health IT

Lack of Provider Payment Reform

Lack of Health IT Adoption

Lack of a business case for care delivery innovation cripples demand among providers for health IT as an enabler of key care innovations

Lack of Care Delivery Innovation

Lack of payment reform cripples the business case for innovations that improve health, care quality, and care efficiency
Reform initiatives aim to promote alignment of incentives between payers and providers

► Effective January 1, 2011, provides states the option of enrolling Medicaid beneficiaries with chronic conditions into a patient centered medical home

► Beginning no later than January 1, 2012, allows providers organized as accountable care organizations (“ACOs”) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program

► From January 2012-2016, establishes a demonstration project in up to eight states to study the use of bundled payments for hospital and physician services under Medicaid
Accountable Care Organizations

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

- Accountable Care Organization
- Bundled Payments
- Medical Home
- Partial Capitation
- HIT
- Accountability, Performance Measurement, Shared Savings
HIT-Enabled Health Reform
HITECH & “Meaningful Use” - an iterative approach

2009 2011 2013 2015

HIT-Enabled Health Reform

HIT-Enabled Health Reform

HITECH Policies

Data capture and share data

Advanced care processes

Improved Outcomes

Nation-wide regional extension program to assist primary care providers achieving ‘meaningful use” of HIT
Center for e-Health Information Adoption and Exchange
“Meaningful Connections” (April 2009)

- Identifies health IT as a “critical platform” of the PCMH.
- Conceptualizes health IT as an e-platform and set of tools.
- Health IT functional priorities to support a PCMH.
- Critical capabilities to engage consumers with health IT.
- Explores the current use of health IT by primary care physicians.

It is apparent that many EMR’s do not have HIT capabilities which are critical to patient centric care or medical home activities such as quality improvement activates
PCMH Adoption of EHRs

Significant Challenges Reported

- Poor cross-system communications and response times
- Costly implementations and interfaces
- Failure to support *role-based* access, teamwork, and shared decision making
- Huge challenges in managing medication lists, problem lists, and care plans across HIT platforms
- Inefficiencies caused by non-integrated, “bolt-on”, and silo’d applications and databases
- Failure to meaningfully engage the consumer²,³

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² Bates, DW, Bitton A. The Future Of Health Information Technology In The Patient-Centered Medical Home, Health Affairs, 29, no. 4.
A foundational shift in Health Information Technology (HIT) *must occur* in order to drive widespread adoption of the Patient Centered Medical Home (PCMH) model, and support the Accountable Care Organization (ACO)
The Nature of the Problem

Anchoring the EHR in the traditional visit based care delivery model limits the potential of the medical home to generate paradigm shifting care delivery transformation and positive outcomes\(^1\)

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\(^1\) Zayas-Caban, T., Finkelstein, J., Kotharim, P., Quinn, M., Nace, D. “Cyberinfrastructure for the Patient Centered Medical Home: Current and Future Landscape” (in press)
Health Information Technology

Enabling Practice Transformation

HIT as an *enabler* of Access, Care Coordination and Payment Reform

To support PCMH (practice) and ACO (enterprise) practice transformation, an interconnected HIT network with key capabilities acts to optimize engagement, coordinate care, and implement value based payments.
Capabilities of HIT

Enabling Access

- Secure Messaging
- Telephonic / Cellular (routing, texting, twitter, etc.)
- Same Day / Convenience Scheduling
- Access to Team Members
- Remote Monitoring
- PHR / EHR Access (Patient-centric Record)
- Access to Care Plan (Shared)
- Patient / Family Feedback to Practice (QI)
- Patient Engagement Tools
Capabilities of HIT

Enabling Coordination of Care

- Reminders / Outreach
- Team Coordination
- Referral Management
- Diagnostics Results Management
- Care Transitions Management
- Holistic Care Coordination (360 degree)
- Case / Condition Management
- Care Plan / Medication Adherence
- Shared Decision – support Tools
Capabilities of HIT

Enabling Payment Reform

- Tracking of Non-FFS Activities
- Quality and Efficiency Measurement
- Pay for Performance Reporting
- Integrated Clinical / Practice Management Information
- Gain Sharing Contribution Tracking
- Episode of Care Tracking
- Risk and Acuity Measurement
- Predictive Modeling
- Comparative Effectiveness Analytics
Transformation Value Creation

Four Essential Factors

Expanded Access
Care Coordination
  - Dedicated Care Managers

Payment Reform
  - Value, not Volume

Health Information Technology
  - Clinical and Financial Data for Population Health Management
  - Transparency on “Movable” Performance Metrics
    - Care Transitions
    - Care Plan Adherence
    - Experience of care

1 Daniel Fields, Elizabeth Leshen, and Kavita Patel; Driving Quality Gains And Cost Savings Through Adoption Of Medical Homes, *Health Affairs*, May 2010; 29(5): 819-826
PCMH Practice Transformation

Technology Support for Practices

- **Access**
  - Patient Portal
  - Asynchronous or RT Communication

- **Data and Information**
  - Facilitate Data Flow and Access
  - Data Analysis, QI, Reporting

- **Registry Function**
  - Monitoring, Tracking, Gaps in Care, Guidelines

- **Care Coordination Services**
  - Regional Care Coordination Programs
  - Community Health Extension Services
  - 24x7 Nurse Lines

- **Patient Engagement**
  - Educational Content and Tools
  - Multimedia, Interactive, Social Media
  - Experience of Care Surveys, Feedback Loops
Accountable Care Organizations
New IT Capabilities Required

**Internal**

- **Integration of owned provider ecosystem**
  (hospital, employed physicians, outpatient services, long-term care, rehab, home health, outside labs, etc)
  - Clinical, administrative and workflow systems
- **Care management capabilities**
  - Data to manage - patient-specific information
  - Care management tools – clinical and financial – integrated into workflow
  - Analytics for performance management
- **Clinical + administrative systems capabilities**
  - Improve throughput and cost per episode
  - Clinical and workflow tools that deliver care management
  - Early avoidance of patient safety issues that will impact quality and potential financial exposure

**External**

- **Integration of affiliated provider ecosystem**
  (affiliated physicians, labs, outpatient facilities, rehab, home health, etc)
  - Clinical and workflow systems
  - Contracting and payment systems
- **Direct to state exchange and employer capabilities**
  - Data integration – clinical and administrative
  - Analytics and performance reporting – clinical and administrative
  - Consumer tools (multimodal communication)
- **Health plan capabilities**
  - Data integration
  - Clinical, administrative and workflow integration
  - Transactional automation
ACO Technology Needs

Understanding and Using the Data is Foundational

<table>
<thead>
<tr>
<th>Type of analytics</th>
<th>Application examples</th>
<th>Questions addressed</th>
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<tbody>
<tr>
<td>Stochastic optimization</td>
<td>Behavior change</td>
<td>How can we achieve the best outcome including the effects of variability?</td>
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<tr>
<td>Optimization</td>
<td>Diagnostic and therapeutic approaches</td>
<td>How can we achieve the best outcome?</td>
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<tr>
<td>Predictive modeling</td>
<td>High-risk patients</td>
<td>What will happen next if?</td>
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<td></td>
<td>Early detection</td>
<td></td>
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<tr>
<td>Forecasting</td>
<td>Public health issues</td>
<td>What if these trends continue?</td>
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<tr>
<td>Simulation</td>
<td>Clinical trials and Patient conceptual model</td>
<td>What could happen?</td>
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<tr>
<td>Alerts</td>
<td>Drug interactions</td>
<td>What actions are needed?</td>
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<tr>
<td>Query/drill down</td>
<td></td>
<td>What exactly is the problem?</td>
</tr>
<tr>
<td>Ad hoc reporting</td>
<td></td>
<td>How many, how often, where?</td>
</tr>
<tr>
<td>Standard reporting</td>
<td></td>
<td>What happened?</td>
</tr>
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Hudson Valley Project

Achieving Care Coordination and Outcome Measurement

Value-Based Purchasing:
Reimbursement Tied to Performance on Value (quality, appropriate utilization and patient satisfaction)

Value/Outcome Measurement:
Reporting of Quality, Utilization and Patient Satisfaction Measures

Operational Care Coordination:
Practice Embedded RN Coordinator and Health Plan Care Coordination

Primary Care Capacity:
Patient Centered Medical Home

HIT Infrastructure:
EHRs and Connectivity

Achieve Supportive Base for ACOs and Bundled Payments with Outcome Measurement and Health Plan Involvement
We’ve been here before…
… but we think it’s different this time

• Healthcare costs as a percentage of GDP is dramatically higher than in the 90’s and is projected to increase

• Government is driving reform with both the carrot (financial incentives) and the stick (reimbursement pressure)

• Technology availability, adoption, and cost make it feasible and increase the chance of success
What is needed to ensure success

- A standard and consistent set of aligned performance metrics for tracking and monitoring the success of PCMH and ACO transformation projects

- Performance metrics to assess key ACO / PCMH components

- Public / Private alignment of payment reform initiatives

- Accreditation organizations (NCQA, URAQ, Joint Commission, etc.) aligning standards with the requirements for PCMH, HITECH, and ACO’s

  - PCMH-specific criteria embedded in the EHR certification and Meaningful Use criteria
Summary

A workable primary care model is essential – the patient centered medical home!

Principles of population health management are core to PCMH and ACO activities

Health Information Technology is a critical foundation of the PCMH and ACO

Incentive alignment is essential to reforming the system
Summary

- Health information technology has enormous potential to improve primary care, and plays a pivotal role in implementing both the PCMH (micro) and ACO (macro) models.

- In order to promote development of an HIT infrastructure that unlocks the potential of technology in transforming the quality, efficiency, and safety of clinical care, HIT will have to address multiple barriers on several levels.
“Meaningful Connections”
Capabilities and Functionalities Foundational to the PCMH

**Exchange**
- Ability to collect, store, exchange and manage relevant PHI.
- Ensure that relevant health information is accessible at the point of care (anytime, anywhere).

**Measure**
- Ability to measure and report on processes of care.

**Collaborate**
- Ability for team members to communicate among themselves.
- Team access to information during the process of care delivery.

**Enable**
- Enable decision support for evidence-based treatments and tests.

**Participate**
- Facilitate consumer access, education, empowerment, and participation tools for decision-making related to their health and medical condition.
• Patient Centered Medical Home v. HIT enabled PC clinics
  ▪ Initial Implementation of advanced HIT alone was problematic
  ▪ PCMH transformation in one clinic - decrease panel, longer visits, dedicated time to PCMH activities, MI trained staff, co-located team members, morning “huddles”, patient care plan access, ER and hospital follow-up, etc.

• Despite significant investment, all costs were recouped within the first year
  ▪ 29% decrease in ER visits
  ▪ 11 % decrease in hospitalizations
  ▪ 6 % decreased office visit, with increased use of secure e-mail, telephone, etc.

► Patients received better care and were more satisfied!

\(^1^\)Reid, Robert J. et al, Am Journal of Managed Care, vol.15, no.5, p.71-87, 2009
ACO’s and PCMH: Moving Toward a More Accountable Coordinated System

Cooperating in new efforts to better coordinate care
- Patient Centered Medical Homes
- Community health teams
- HIT

Working with innovative reimbursement structures
- Bundled payments
- Expanded pay-for-Quality
- Readmission incentives
- Outlier reductions

Improving health outcomes
- Prevention (primary and secondary)
- Chronic disease management
- Patient engagement and education
- Data transparency