Primary Care Practice Transformation

The Foundation For Success In Accountable Care

Bruce Bagley, MD
President and CEO
TransforMED

Jay W. Lee, MD, MPH, FAAFP
Associate Medical Director
MemorialCare Medical Group
Learning Objectives

- Clarify the current status of PCMH and primary care transformation projects
- Understand the importance of the integration of primary care into the medical neighborhood
- Examine the elements of a solid primary care foundation that lead to success for any integrated system or accountable care organization
- Share actual experience in practice transformation with results
Brief environmental scan for context
Current status of patient centered medical home
Clinical integration and collaboration in the medical neighborhood
Medical neighborhood as the foundation for a successful ACO
“My practice/group is implementing the PCMH model.”

1. No way!
2. No, how?
3. Thinking about it.
4. Yes, we are in the process.
5. Yes, we are recognized/certified.
“The Problem”
“The Remedy”

- People/Organizations/Integration/Work- TEAM
- Technology and Connectedness
- Patient Engagement and Self-management Support
- Payment Reform and Incentives
- Community Involvement in design and execution of new models of care

- Patient Centered Medical Home
- Medical Neighborhood
- Accountable Care Organizations
1. Although medical cost growth has slowed, the cause is a complex calculus
2. Current payment provides perverse incentives
3. Fee for service payment drives volume without regard to quality or necessity and it must be reduced to part of a balanced blended model
4. Clinical, financial and information technology integration is essential for efficiency
5. Value based purchasing requires performance data on metrics for service, cost and clinical quality
6. Distribution of resources will mirror value contribution
The PPACA has changed the conversation:

- More emphasis on **wellness** and **prevention**
- The importance of the **community** of care
- **Access** redefined as addressing patient’s needs when and where they have the need rather than a conversation about appointment availability
- **Strategic distribution** of the work (team care)
- Consolidation, **integration** and market forces for greater efficiency and effectiveness
- Many practices and systems are already **successful** in making transformational change
Technology and Connectedness

- We must apply the great technology we already enjoy in our everyday lives to health care delivery

- Knowledge management, communication and information exchange
  - Electronic health records
  - Patient portals
  - Community wide Health Information Exchange (HIE)
  - Email with patients and e-visits
  - Video visits

- Systems for tracking, care management and care coordination
  - Registries (chronic illness care, high risk patients, preventive services etc.)
Population Health Management

- Focus on the single patient **AND** a sub-set of the practice panel (e.g. diabetics)
- Identify the high risk/high needs patients
- Risk stratified care management and care coordination
- Reduce cost by focusing on complex patients and high reliability systems to help them
“Block-buster drug of the 21st Century”
- Patient/Family/Caregiver engagement
- Patient Self-management Support
  - Motivational interviewing
  - Health coaching
  - Shared goal setting
  - Informed Medical Decision Making
  - Home monitoring and between visit contact
- Care coordination across the medical neighborhood
- Home care as needed
- Digital engagement **required!**

www.patientfamilyengagement.org
Research and Development at TransforMED

Providers

Patients

Payers

Health Systems

ACO Learning and Diffusion

Comprehensive Primary Care (CPC)

HCIA Medical Neighborhood

Best practices
Strategic Questions

How has the practice environment and payment environment changed in your locale and what are you doing about it?

What is motivating you and your group to change right now?
Patient Centered Medical Home

Continuing, Comprehensive and Personal Care In The Context Of Family And Community
Patient-Centered Medical Home

American Academy of Pediatrics Medical Home (MHCSHCN)  
Future of Family Medicine Report  
1990's

Wagner Chronic Care Model  
IHI ID-COP  
1970's

Patient-Centered Primary Care Collaborative  
NCQA PCMH Recognition Program  
2004

AAFP National Demonstration Project (NDP) > TransforMED  
Joint Principles  
2005

CMS CPCi Health Plans, ACOs & Value Based Purchasing  
2008

ACA in place  
Cost Moderation Mkt. Consolidation  
PCMH Central to Value Creation  
2012

Future of Family Medicine Report  
2014
Primary Care Role in Health System Redesign

- Individual patient care
- Population health
- Stewardship for health care resources

The Triple Aim is About “Right-sizing Health Care”

30%
US uses 30% more laundry detergent than needed for clean clothes
P & G introduces Tide-Pods premeasured soap
Total market size reduced by 30% ("Right-sized")
P & G able to charge a premium for soap
Market then grows with real increased need
Patient Centered Medical Home Demystified

PCMH - Nothing less than an extreme make-over for primary care practices to make them:

- More **Service Oriented** for patients
- More **Effective** for better patient outcomes
- More **Efficient** for better profit
- More **Fun** to go to work for all
5 Reasons Why the PCMH Literature is Not Compelling

- No standard yet established for how best to study PCMH
  - RCT not applicable
  - Studying social change in complex adaptive system
  - ROI elusive because of lack of change in payment
- Heterogeneity of implementation methodologies
- One size does not fit all practice types
- Applicability to general population vs. specific populations
- Payer-mix
Healthcare Delivery System Trends

- Physician leaders
- Information technology enabled
- Clinical integration
- Prepaid global payment system

"80% of the strategies for managing population health and controlling total healthcare costs are related to Primary Care activities."

-Robert Pearl, MD –CEO, KPMG
Practice & Payment Redesign in the CPC initiative

- Access and Continuity
- Planned Care for Chronic Conditions and Preventative Care
- Risk-Stratified Care Management
- Patient and Caregiver Engagement
- Coordination of Care
Critical Elements For PCMH

- True team approach to care and change
- Quality measures and a culture of improvement
- Patient and family engagement with patient self-management support
- Care management and care coordination
- IT enabled for the core business, clinical, education and communication functions
Patient Centered Medical Neighborhood

Creating a Shared Sense of Responsibility for Service, Cost and Quality
Criteria For Good Citizenship In The Neighborhood

- Shared responsibility for service, cost and quality
- Willingness to discuss process and interactions
- Efficient transfer of clinical information
- Multi-level accessibility
- Commit to a high level of service
- The patient is always the central focus
PCMH Role

- Patient advocate
- Central repository of personal health information
- Center for preventive services and wellness advice
- Comprehensive care
- Continuity of care
- Care management
- Care coordination
- Integrator
Sub-Specialty Care Role

- Special expertise in knowledge and/or procedures
- Timely access that matches the patient need
- Recommend changes in the care plan
- Partner with primary care
Emergency Room Role

- Triage level of intervention required
- Get clinical and health status information from PCMH
- Be aware of community capabilities for follow up
- Appropriate use of hospitalization
- Offer definitive testing
- Return of care to PCMH
Hospital Role

- Acute care
- Access to specialty services
- Specialized equipment not available elsewhere
- Surgical support
- Safe return to community of care
Administration Role

- Leadership
- Governance
- Data transfer support
- Financial health
- Allocation of resources
- Appropriate incentives
- Support integration
- Communication
Community Resources Role

- Education
- Support groups
- Behavioral health
- Healthy community
- Family/caregiver support
- Volunteerism
Common Themes About Cost/Utilization

- **High needs/high cost patients** require special attention
  - Risk stratified care management and care coordination
  - Care plan, registry, team approach, clinical integration
  - Patient/family/care giver engagement and support
- The “**community footprint**” is real and requires leadership and comparison data to change
  - Quality data
  - Cost of care data, down to the NPI level
  - Shared sense of responsibility for service, cost and quality
- **New tools** required
  - Population health management and RSCM support
  - Collaborative agreements or service contracts
  - Development of a supportive community of care
Accountable Care Organizations

Clinical, Financial And IT Integration For Better Care, Better Quality And Better Service
ACO Puzzle Pieces

- Global Payment
- Financial Metrics
- Clinical Performance Metrics
- Internal Incentives
- Patient Engagement
- Care Coordination
- Team Approach

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ACO Success Rules

- Patient engagement and partnership
- Align payment and incentives with aims
- Primary care is central and capable
- Culture of quality improvement
- Clinical, financial and IT integration
- Designed for the long term
Patient Engagement And Partnership

- Patients must be encouraged to choose and use a PCMH
- Center of care management and care coordination
- Family/care-giver involved
- Self-management support
- Superb access to care
- Continuity over time
Align Payment Incentives With Aims

- Pay for what you want to happen
- Payment and incentives should foster integration and cooperation
- Reward quality and outcomes
- Support infrastructure to accomplish the goals
Primary Care Is Central And Capable

- Primary care is supported and valued by the system
- Accessible
- Comprehensive
- Continuity assured
- IT enabled
  - Clinical information
  - Communications
  - Education and outreach
  - Financial data
Culture Of Quality Improvement

- Performance **measurement** is routine
- **Systems** approach to improvement
- Quality **goals** known to all
- **Team** work is the norm
- Patient **outcomes**
- **Service** oriented
Clinical, Financial And IT Integration

- Must eliminate fragmentation and waste
- Internal financial incentives are key
- Platform for data exchange
- Efficient management
- Service agreements
Designed For The Long Term

- ACOs must be set up for the **right reasons**
- Strong organizational **leadership** and integrity
- Optimize **outcomes** of care
- Community orientation
- Shared governance
- Patient centered
Key ACO Ingredients and Functions
Michael Leavitt’s List

1. Ability to change patient & physician behavior
2. Positive brand in the market place
3. Access to capital
4. Ability to aggregate lives
5. Capacity to manage risk
6. Large (geographic) clinical footprint
7. Collaborative IQ to bring all together
“After this environmental scan…”

1. No way will I implement PCMH.
2. I better understand PCMH but will not be implementing it.
3. Still thinking about it.
4. The evidence may be mixed, but I will begin the process.
5. So what if the evidence is mixed? I will prove the naysayers wrong.
MemorialCare Health System is a not-for-profit integrated delivery system which includes six Hospitals, a health plan, and a Medical Foundation:

MemorialCare Medical Foundation
Greater Newport Physicians
Independent Practice Association (IPA)

MemorialCare Medical Group

MISSION: “To improve the health and well-being of individuals, families and our communities through innovation and the pursuit of excellence.”
Problem and Causes

THE PROBLEM
Unclear strategy for leading organizational change following merger of 4 physician groups to become MemorialCare Medical Group

THE UNDERLYING CAUSES
- Merger of at least 4 distinct cultures
- Geographical fragmentation
- Focus on growth via acquisition (versus via innovation)
- No incentive for change from volume to value
SMART Objectives

**Outputs**
- 16 sites by FY15

**Outcomes**
- 10%
  - Clinical Operational Experience
Outputs Achieved

- Formed leadership dyads (clinical + operational)
- Rebranded PCMH -> Practice Transformation
- Negotiated $100,000 commitment x 1 year for Innovation Center by MCMG Physician Executive Committee
- Developed balanced set of metrics (clinical, operational, and experience)
- Accessed available data streams; identified new data streams
- Standardized training modules
- Planned scale up of practice model from Long Beach to San Clemente
- Received approval of operational budget and for new analyst and administrative assistant
The Triple Aim + 1

1. Value (quality/cost)
2. Patient experience
3. Population health
4. Physician/patient care team fulfillment aka “Become the physician you wrote about in your personal statement”
Building Blocks

1. Engaged leadership
2. Data-driven improvement
3. Empanelment
4. Team-based care
5. Patient-team partnership
6. Population management
7. Continuity of care
8. Prompt access to care
9. Comprehensive-ness and care coordination
10. Template of the future

Practical considerations

- PCMH accreditation: To be or not to be?
- Does this align with your/your organization’s mission?
- Readiness for change/transformation.
- Evaluate your financial resources/adaptive reserve.
- Do you play well with others? Consider a consultant vs a collaborative.
- Shall we play a game? Have a strategic game plan.
Grumbach: PCMH is not a pill (JAMA 2013)

- To justify FDA approved, would need to demonstrate safety and therapeutic benefit
  - No luck for PCMH: not enough to be non-harmful and demonstrate some degree of efficiency
- Pharmaceutical products can be manufactured with uniform specifications and delivered in a standardized manner
  - PCMH is a multi-faceted intervention
    - Changes in organization, structure, process, culture and financial model of practice
    - More in common with CQI than rigid clinical trial protocol
- Research limitations: sufficient analytical power, heterogeneity of methodology, appropriate timeframe
Grumbach: PCMH is not a pill (JAMA 2013)

- PCMH being judged on whether or not it is a “3-run homer achieving the triple aims of better health, better patient experience, and lower costs.”
- Policymakers must not wait for incontrovertible scientific evidence that PCMH is “a magic triple aim pill with a large and immediate financial return on investment.”
- Organizations must make strategic decisions based on best available information using a collage of scientific evidence, case studies and their own hunches.
“The best way to predict the future is to invent it.”

Peter Drucker
Discussion Topics

- Who will lead in your community?
- Do you have the data that you need to do this work?
- What is the “Collaborative IQ” of your organization?
- How are patients involved in redesign efforts?
- Are you and your organization ready for transparency?
“If We Build It...They Will Come” – Field of Dreams

“If We Build It With Them... They Will Already Be There”

- Christine Bechtel
  - National Partnership for Women and Families
Questions

For more information:
- www.transformed.com
- www.delta-exchange.net
- bbagley@transformed.com
- Follow @TransforMEDCEO

CONTACT:
Jay W. Lee, MD, MPH
jwlee@memorialcare.org
@familydocwonk