Patient Centered Medical Home in Small Practices: Lessons Learned

Michael Cantor, MD, JD
Quality Medical Medical Director, NEQCA
Overview

- What is NEQCA?
- Our experience with PCMH: 2008-present
- Lessons learned
NEQCA LOTS of Small Practices (and some large ones)

**NEQCA:**
- ~1,454 NEQCA MDs
  - 474 PCPs
    - 286 Adult
    - 100 Family Practice
    - 86 Pediatricians
- ~100,000+ BCBSMA HMO covered lives
- ~250,000 HMO PPO members

Tufts Medical Center
Formal Hospital Affiliations:
- Jordan Hospital – Plymouth
- Signature Healthcare Brockton Hospital – Brockton
- Quincy Medical Center – Quincy
- MetroWest Medical Center – Framingham, Natick
- Numerous product line specific community hospital relationships (e.g., Lowell, Lawrence General, Morton)
- 1.2 PCPs per AMC Bed
NEQCA is Unique

- Community PCPs - Large number of small practices
  - 82% are Solo to 2 PCP practices
  - 13% are in 3-6 PCP practices
  - Only 5% are in practices of 6+ PCPs

- Community Specialists
  - 78% are Solo to 2 specialist practices
  - 14% are in groups of 3-6 specialist practices
  - 8% are in practices of 6+ specialists

- PCPs are organized into groups called “Local Care Organizations” (LCOs) usually related to a community hospital
  - Mix of IPAs and PHOs
NEQCA’s Goal: Achieve the Triple Aim

- Improved Health of Population
- Improved Experience of Care
- Limited Increase in Cost
NEQCA Approach to PCMH

- Primary care transformation has three pillars:
  - Physician-led teams: nurse care managers, pharmacists, behavioral health, with quality specialists to support practice work flow changes
  - Population health focus
  - Patient empowerment and support for self-management

- Requires two enablers:
  - IT infrastructure (registry, predictive modeling, EHR)
  - Aligned contracts that cover people and IT infrastructure costs
Harvard Pilgrim HealthCare-Funded PCMH Pilot - Year One – Plymouth, MA

Patients
- Patient population: diabetics in Plymouth with HPHC commercial insurance; TMP; THP GIC
- Stratification of A1c data and MD choice

Patient interventions:
- Toolkit
- Care Manager for highest-risk patients
- Better access to specialty services (CDE, endocrinology, pulmonary, etc.) and expanded hours coverage
- Group educational sessions
- Newsletters

Physicians
- Quality Improvement
  - Medication adherence skill building and data
  - Patient report cards on DM-related parameters
  - Data gathering and analysis
  - Clinical guideline development and implementation
  - Care coordinator to support care plan implementation
HPHC-Funded PCMH Plymouth Pilot - Year Two

Patients

- Patient population:
  - COPD and HTN patients added to diabetics in Plymouth with HPHC commercial insurance, TMP and THP GIC
  - Stratification of A1c data and MD choice for DM; MD referrals for COPD/CHF

- Patient interventions:
  - Home visits and telephone follow-up
  - Toolkit
  - Care Manager for highest-risk patients
  - Better access to specialty services (CDE, endocrinologist, pulmonary, cardiology, etc.)
  - Expanded hours coverage
  - Group educational sessions
  - Newsletters

Physicians

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NCQA Practice Recognition

- Practice Advisor to coach practices and assist with application
- Use of EHR as platform for PCMH practice workflow improvement and implementation

New England Quality Care Alliance
Affiliated with Tufts Medical Center

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Key Lessons From Pilot

- Need critical mass of patients – otherwise staff and physician engagement limited

- Start with practices who are interested

- Practices must have had EHR for minimum 6 months, preferably longer

- Face to face encounters with care manager important for complex patients
New focus...

- 16 active PCMH practices by end of FY 2011 (9/30/11)

- Expansion into all practices within the network over the next 3 years
NEQCA PCMH Team

- Integrated Care Manager (ICM): RN sees 5% most complex, 100 patients/practice, scheduled to meet ICM in 90 days

- Clinical Pharmacist: available to provide counseling to PCPs and patients

- Behavioral Health support: psychiatrist support for care managers on regular basis as well as case review sessions and training

- Quality Specialist: addresses work flow and assists with NCQA accreditation process
Practice Commitment

- ‘PCMH clinical champion’ supporting all aspects of the project as defined by NCQA which include:
  - plans for improvement based on:
    - best practice criteria
    - evidence-based medicine

- ‘PCMH operations champion’ who will collaborate with the NEQCA staff to:
  - support the operational components of the office’s redesign
  - act as a point of contact
  - provide selected patient panel scheduling for ICM
  - serve as process owner in the practice for application and data collection and submission for NCQA PCMH recognition
# Barriers and Challenges

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<thead>
<tr>
<th>Barrier</th>
<th>Potential Solutions (examples)</th>
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<tbody>
<tr>
<td>Difficulty with practice engagement</td>
<td>Agreement with LCO leadership at start of project with clear expectations and focus on engagement of practice; support for process improvement Emphasis on this as part of on-boarding process; involvement of NEQCA leadership if necessary</td>
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<tr>
<td>Lack of patient engagement</td>
<td>Create clear and consistent messaging; starts with PCP's &amp; all members of team engage patient</td>
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<td>EHR-related issues</td>
<td>Support staff training on eCW; QS as troubleshooter and liaison to EHR team</td>
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<td>Lack of community behavioral health (BH) providers and resources</td>
<td>Use of RNs trained in BH; back up from Tufts MC; Build BH network</td>
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Additional Challenges of Small Practices

- Space: lack of office space, phone lines
- Invasion of privacy: not used to having someone else in their office
  - Concern about being watched
  - Perception of loss of control over their practice
- Variability in practice management and skill level of staff
A New Wrinkle - NEQCA’s Integrated Support Model

The NEQCA Integrated Support Model:

- EHR Optimal Use
- Work Flow Redesign
- Practice QI training
- PCMH Certification
- Integrated Care Management

Overlap between Meaningful Use and PCMH Creates new opportunities and challenges
Return on Investment: Too Soon to Tell

- Savings will come from reduced acute admissions and ED visits

- Breakeven at 2.5% reduction in admits and ED visits

- ROI at milestones will guide program
Lessons Learned

- Small practices vary widely in ability and desire to change – start with those who are willing

- Must build teams around PCPs: centralization allows for standardization of care management teams, processes, training

- It is possible to succeed in small practices but be prepared for challenges