The Primary Solution

for America's Health Care

PCPCC Medical Home Summit

March 18, 2014

Philadelphia

Philip Briggs, MD, MBA,
FAAFP
CEO, Founder, Atrinea Health

Purpose

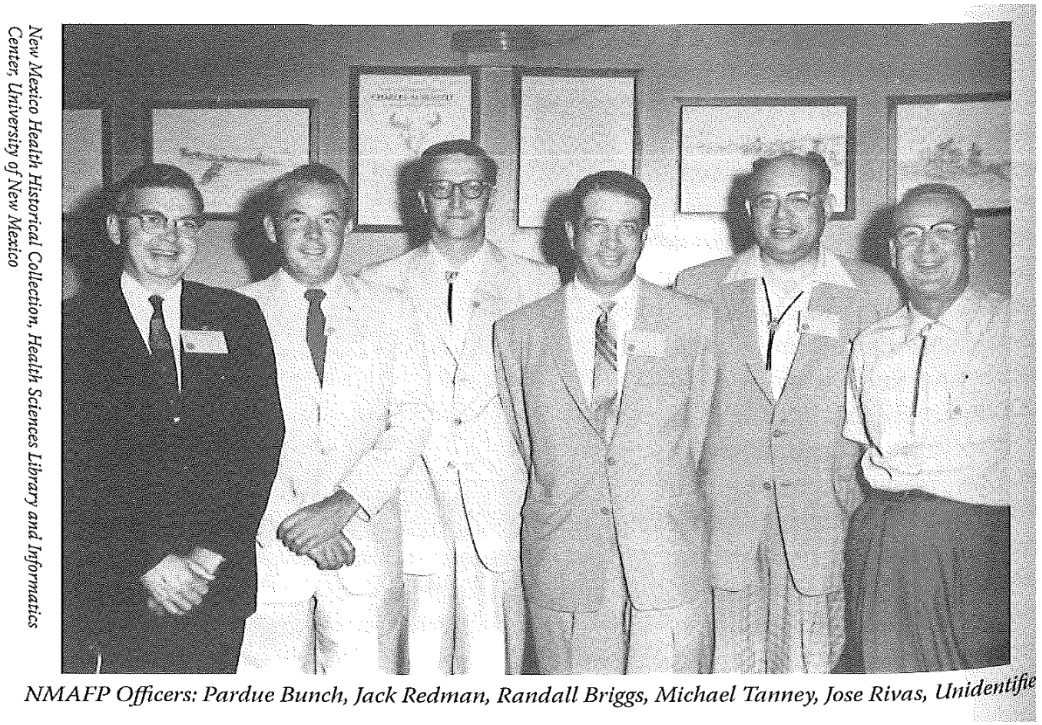
The purpose of this presentation is to illustrate the opportunity that our specialty has at hand to transform the American health care system by greatly increasing the quality of care we deliver in our clinics.

Goals for Family Medicine

- Lifestyle specialty with a heart
- Double current income
- Go home on time
- No call
- Days should be brisk but enjoyable
- Focus on interface with patients
- Biological focus

My Background

- Education
- Primary Care
- Urgent Care
- Health Policy
- Business Management



New Mexico Health Historical Collection, Health Sciences Library and Informatics Center, University of New Mexico

NMAFP Officers: Pardue Bunch, Jack Redman, Randall Briggs, Michael Tanney, Jose Rivas, Unidentifie

Family Practice Management®

May-June 2012 Table of Contents

OPINION

Back to the Future: The Way Forward in Health Care Reform

It's 1995 all over again. Let's get it right this time.

Philip D. Briggs, MD, MBA

Fam Pract Manag. 2012 May-June;19(3):5-6.

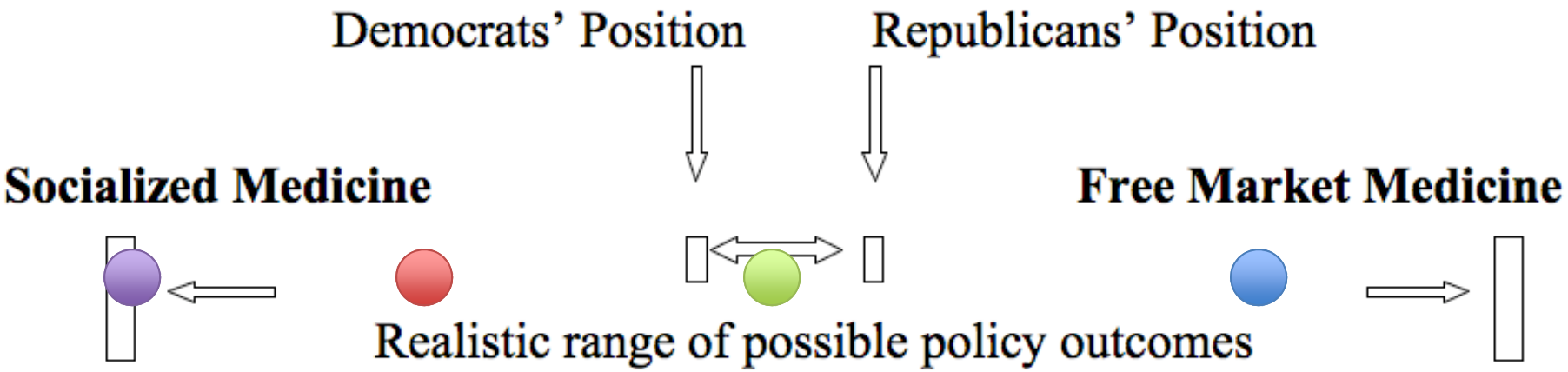
So much of what is happening in health care today is eerily similar to what was happening in the mid-1990s. If that period were a movie, we would have called it *Capitation*, and this current feature would be called *Return of Capitation*. At the end of the first, the dead monster's eyes would begin to glow again faintly, letting the audience know that a sequel would be a real possibility. Now he's back, and he's angry.

Recently, I re-read a 1995 article about how family physicians should respond to changes in health care written by William J. (Terry) Kane, MD, and published in *Family Practice Management*.[1] Kane, a family physician, had held high-level executive positions with Sharp HealthCare in San Diego and with various health plans. I was on the American Academy of Family Physicians (AAFP) Board of Directors at the time, and I remember Kane delivering a fascinating talk on managed care and macroeconomic trends in the industry and in our specialty. He later presented it as the keynote address at the AAFP Scientific Assembly; his article was based on that talk.

Opportunities

1. Extend patients' lives and improve their quality of life
2. Solve the nation's primary care physician shortage
3. Double the quality increase that NCQA PCMH recognition yields
4. Cut global health care costs by half
5. Double the income of family physicians while enhancing their life style

Political Landscape & Direction of Health Care



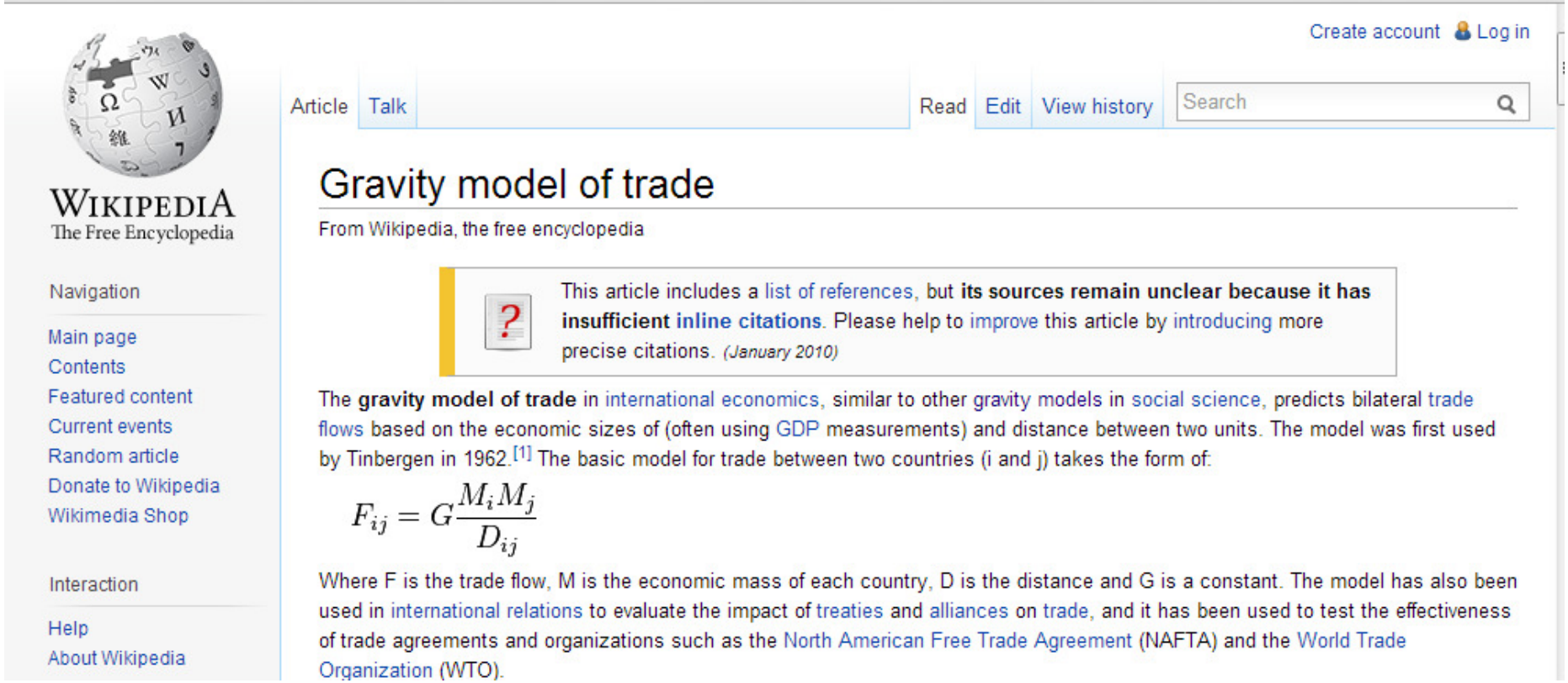
Socialized "Universal" Healthcare
Government burden to supply care
High levels of government aid
Government control of health economy

Free-market solution
Personal Obligation of Health
Private payers and non-governmental aid
Consumer based health economy

- Current US Health System
- Mexican Seguro Social
- US Healthcare Before Medicare (1965)
- England's National Health Service

For 50 years policy has shaped the economics of healthcare delivery, it is now out of control

Gravity Model of Trade



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Gravity model of trade

From Wikipedia, the free encyclopedia

This article includes a list of references, but **its sources remain unclear because it has insufficient inline citations**. Please help to improve this article by introducing more precise citations. *(January 2010)*

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The **gravity model of trade** in international economics, similar to other gravity models in social science, predicts bilateral trade flows based on the economic sizes of (often using GDP measurements) and distance between two units. The model was first used by Tinbergen in 1962.[1] The basic model for trade between two countries (i and j) takes the form of:

$$F_{ij} = G\frac{M_i M_j}{D_{ij}}$$

Where F is the trade flow, M is the economic mass of each country, D is the distance and G is a constant. The model has also been used in international relations to evaluate the impact of treaties and alliances on trade, and it has been used to test the effectiveness of trade agreements and organizations such as the North American Free Trade Agreement (NAFTA) and the World Trade Organization (WTO).

The Value of Health Care

$$\text{VALUE} = \frac{\text{PATIENT SATISFACTION} + \text{OUTCOMES}}{\text{COST}}$$

Value equation for any service or product applies to health care with multiple quality aspects

Current Family Medicine Landscape

Average MD Graduate's Debt:
$156,456.00

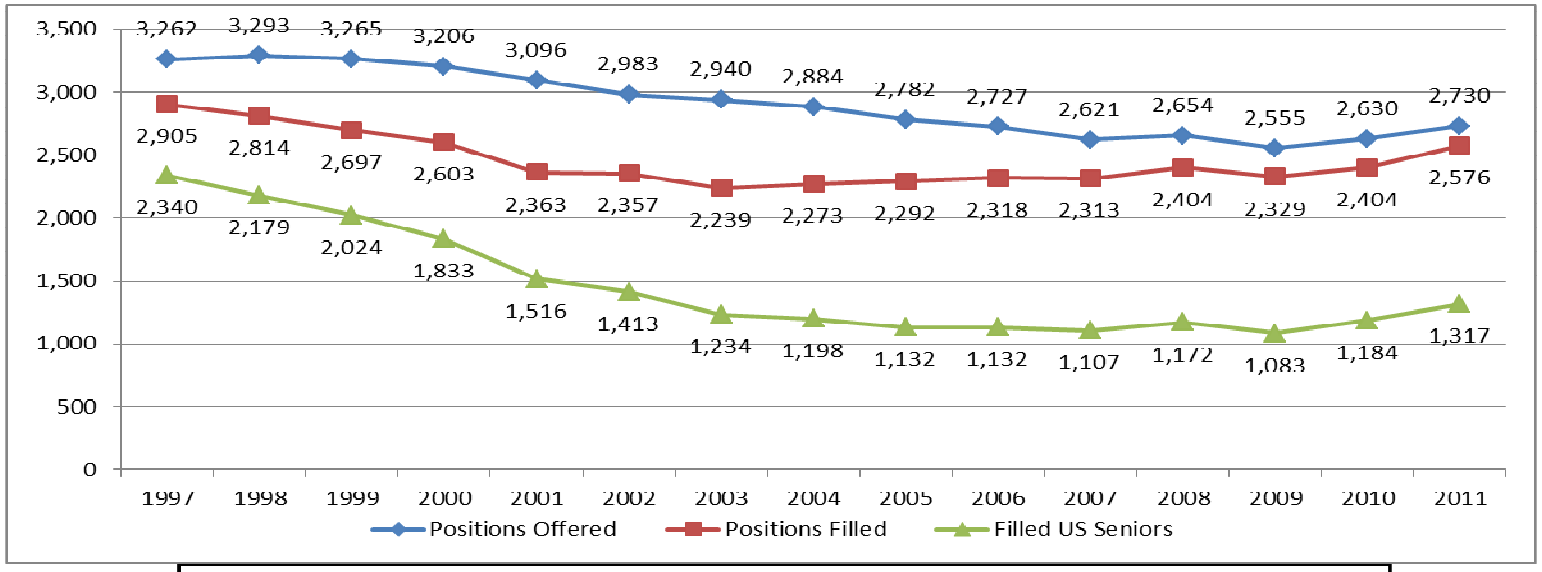
87 percent of graduating medical students carry outstanding loans.

Decrease in primary care physicians

Decreased diversity of physician workforce

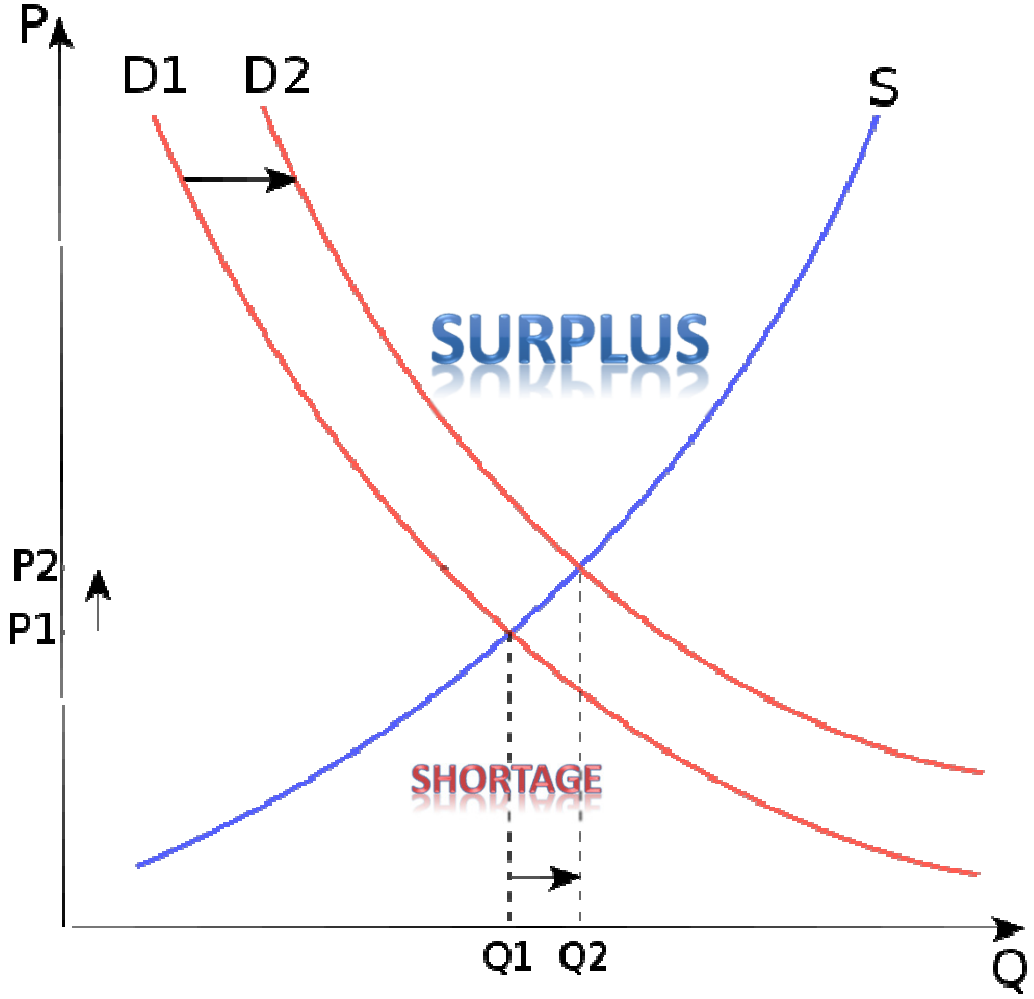
Promoting unsafe physician behaviors

AAFP Residency Matching Program Data



Physician shortages. Reimbursement problems. New models of care. Healthcare IT. Quality initiatives. All of these issues contribute to the current crisis in primary care… more medical students are choosing medical specialties over primary care

Supply and Demand Shortages



High demand with low supply should yield higher prices but with price controls we have shortages

Projected Shortage

Association of American Medical Colleges (AAMC) projects a shortage of 45,000 primary care physicians by 2020

Projected Shortage ?

Work Force Latest News | Videos

Doc Shortage May Be Smaller Than Projected

By David Pittman, Washington Correspondent, MedPage Today
Published: January 11, 2013

The projected shortage in the nation's primary care physician work force may be overstated, and any that does develop can be eliminated with wider adoption of EHRs and practice restructuring, a study suggests.

By working in practices of two or three doctors while shifting as little as 20% of patients to a nonphysician provider and using an EHR, "most if not all of the projected primary care physician shortage could be eliminated," according to an analysis of several scenarios published in the January issue of *Health Affairs*.

Key Strategies for Growth

- Urgent Care…evenings and weekends
- Consolidated Business Office
- Call Center
- IPA
- Franchised Business Model

The Patient-Centered Medical Home

History of PCMH

The Future of Family Medicine: A Collaborative Project of the Family Medicine Community

Future of Family Medicine Project Leadership Committee

James C. Martin, MD, Project Leadership Committee Chair, Family Practice Residency Program at CHRISTUS Santa Rosa Health Care, San Antonio, Tex.

Robert F. Avant, MD, American Board of Family Practice, Lexington, Ky; Marjorie A. Bowman, MD, MPA, Department of Family Practice and Community Medicine,

ABSTRACT

BACKGROUND Recognizing fundamental flaws in the fragmented US health care systems and the potential of an integrative, generalist approach, the leadership of 7 national family medicine organizations initiated the Future of Family

Future of Family Medicine

- Medical home-from pediatrics 1960s
- Basket of services-??Goldilocks??
- Biopsychosocial model of primary care

Biopsycho_{social}

Joint Principles

Joint Principles of the Patient-Centered Medical Home
Published on Patient Centered Primary Care Collaborative
(http://www.pcpcc.net)

Joint Principles of the Patient-Centered Medical Home

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

February 2007

Introduction

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH.

Joint Principles

PCPCC Published in 2007

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and integrated
- Quality and safety
- Enhances Access
- Payment
- Supported by AAFP, AAP, ACP, AOA

Practice Transformation Advocacy

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TransforMED helps Physicians' Practices and Independent Physician Associations (IPAs) improve quality, safety, satisfaction and the bottomline. **More »**

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TransforMED helps payers deliver high quality care and reduce costs while improving patient health and increasing staff satisfaction and patient engagement. **More »**

HOSPITALS & HEALTH SYSTEMS

TransforMED helps hospitals and health systems engage physicians and improve care through implementation of the Patient-Centered Medical Home. **More »**

EDUCATION EVENT CO-SPONSORED BY THE AAFP AND TRANSFORMED

Free Webinar on Comprehensive Primary Care Initiative (CPCI)

February 1, 2012 1:00 p.m. CST

What is the CPCI? What does it mean for primary care?
How can it benefit you and your practice?

Led by the Centers for Medicare and Medicaid Innovation, the Comprehensive Primary Care Initiative (CPCI) offers a ***blended payment model*** from public and private purchasers to primary care practices that provide "comprehensive primary care." In this free webinar, participants will progress from an overview of the CPCI to a detailed presentation of the practice and community infrastructure requirements for participating in the program.

Click here to register »

CPCI

TransforMED is transforming the practice of Primary Care

AAFP

TransforMED is how primary care practices become high-performing Patient-Centered Medical Homes (PCMH). Using a transformative process of practice redesign focused on patient care and practice team satisfaction, organized around the **TransforMED Patient-Centered Model**, TransforMED facilitators leverage best-practices from their experience guiding **transformation projects** across the country to provide clinical integration services, collaborative environments and learning opportunities to medical practices and stakeholders such as payers, hospital systems, IPAs, as well as state and federal government bodies. Since 2005, TransforMED has provided effective solutions to hundreds of practices and thousands of doctors, thereby touching the lives of more than 20 million patients. TransforMED is a non-profit subsidiary of the American Academy of Family Physicians (AAFP). **Are you ready to transform?**

p4

TransforMED also coordinates a residency demonstration initiative known as P4 – which stands for Preparing the Personal Physician for Practice. P4 is leading the transformation of family medicine residency education training to prepare tomorrow's physicians for new models of care and demonstrate the value of science-based, high quality, patient centered primary care. **Find out more about P4**

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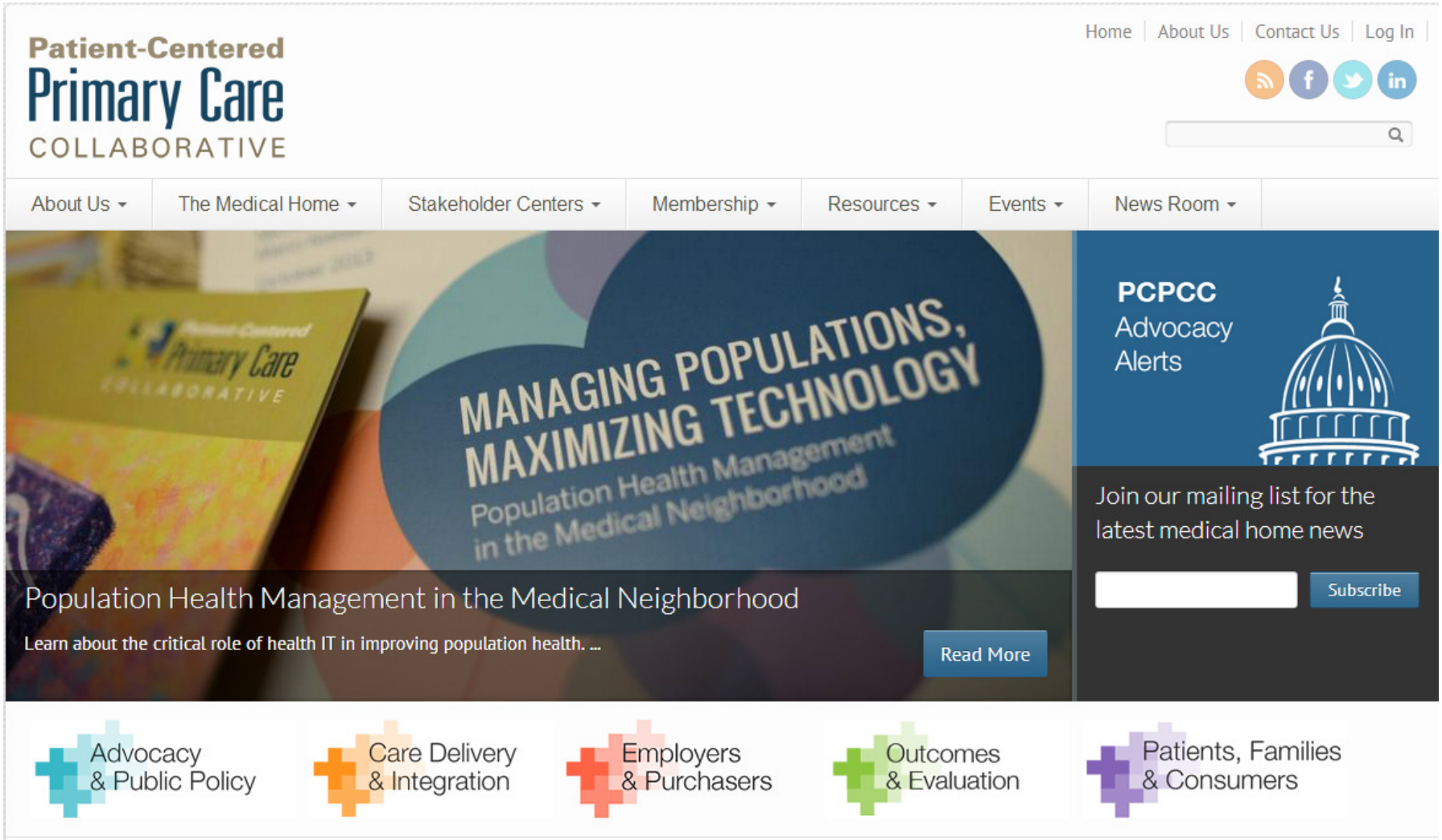
Patient-Centered Primary Care Collaborative (PCPCC)



Definition

"The **medical home**, also known as the **patient-centered medical home** (PCMH), is defined as 'an approach to providing comprehensive primary care... that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient's family'. The provision of medical homes may allow better access to health care, increase satisfaction with care, and improve health."

PCMH Video - Emmi Solutions

Standardization and Credentialing - NCQA

National Committee for Quality Assurance (NCQA) and the PCMH

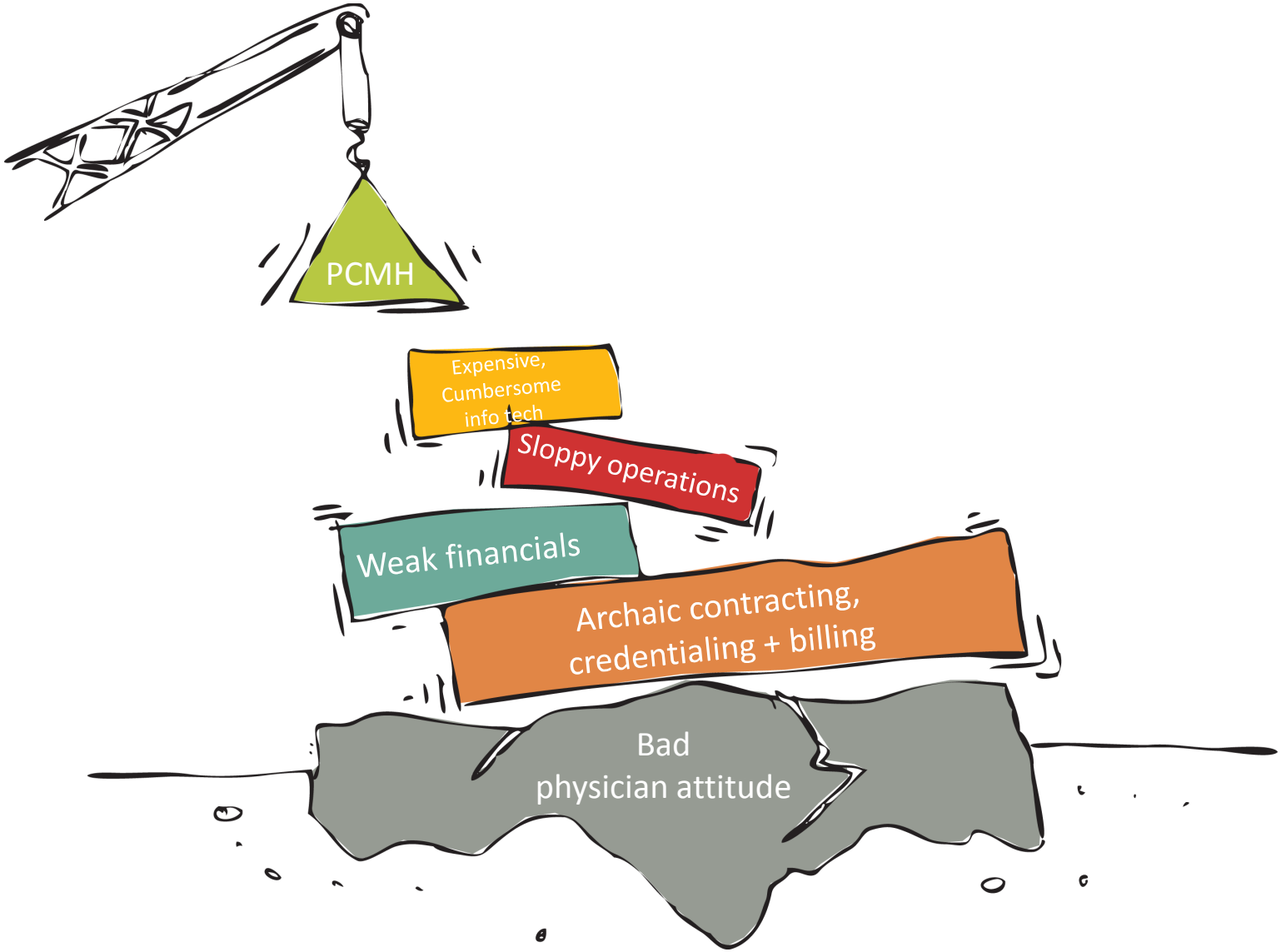
- NCQA developed a set of standards and a 3-tiered recognition process to assess the extent to which health care organizations are functioning as medical home
- Obtaining recognition via the PPC-PCMH programs requires completing an application and providing adequate documentation to show evidence that specific processes and policies are in place

NCQA Standards and Elements

Standard	Elements
Enhance access and Continuity	Office hour access, after-hour access, electronic access, continuity, medical home responsibilities, culturally and linguistically appropriate services, practice team
Identify and Manage Patient Populations	Patient information, clinical data, comprehensive health assessment, use data for population management
Plan and Manage Care	Implement evidence-based guidelines, identify high-risk patients, care management, manage medications, use ePrescribing
Provide Self-Care Support and Community Resources	Support self-care processes, provide referrals to community resources
Track and Coordinate Care	Test tracking and follow-up, referral tracking and follow-up, coordinate with facilities/care transitions
Measure and Improve Performance	Measure performance, measure patient/family experience, implement continuous quality improvement, demonstrate continuous quality improvement, report performance, report data externally

Orange signifies must pass elements

How Not to Use PCMH



How to Use PCMH

Christensen's Disruptive Innovation

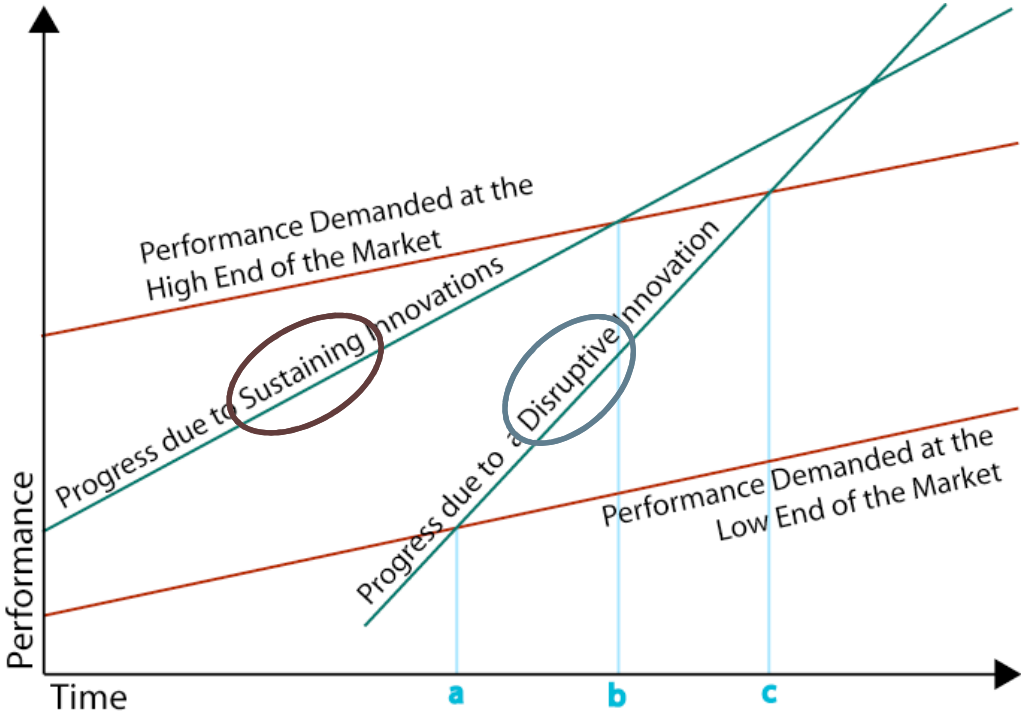
Sustaining Innovation: Innovation that improves a product in an existing market in ways that customers are expecting.

Disruptive Innovation: Innovation that creates a new (and unexpected) market by applying a different set of values, often by lowering cost or including a different set of consumers

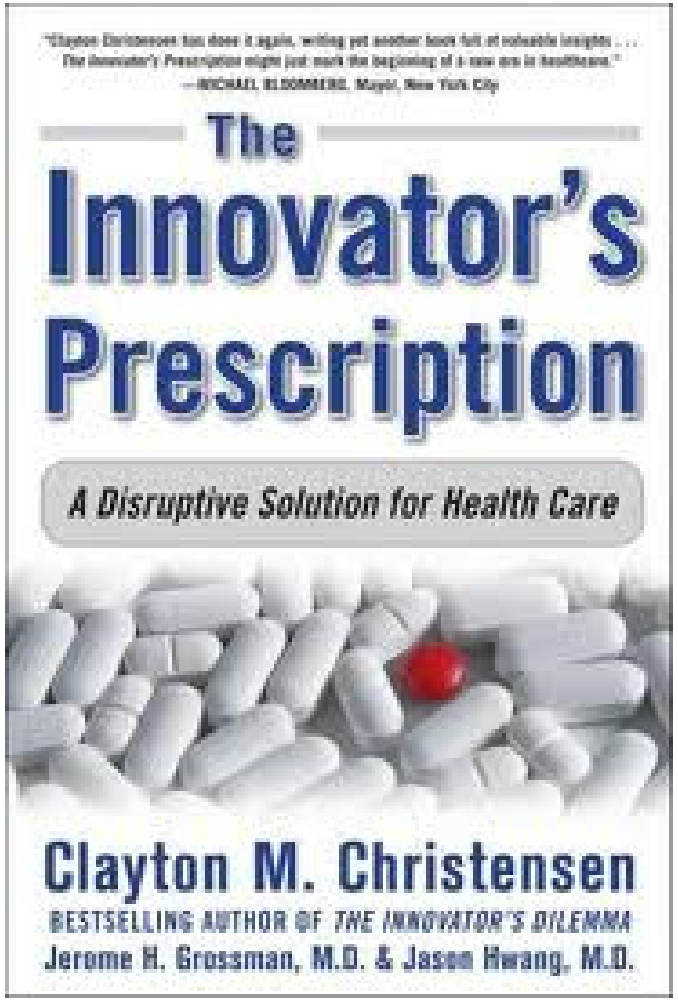
a: Point at which Disruptive innovation begins to form a market

b: Point when Sustaining Innovation outperforms the possible demands of the product

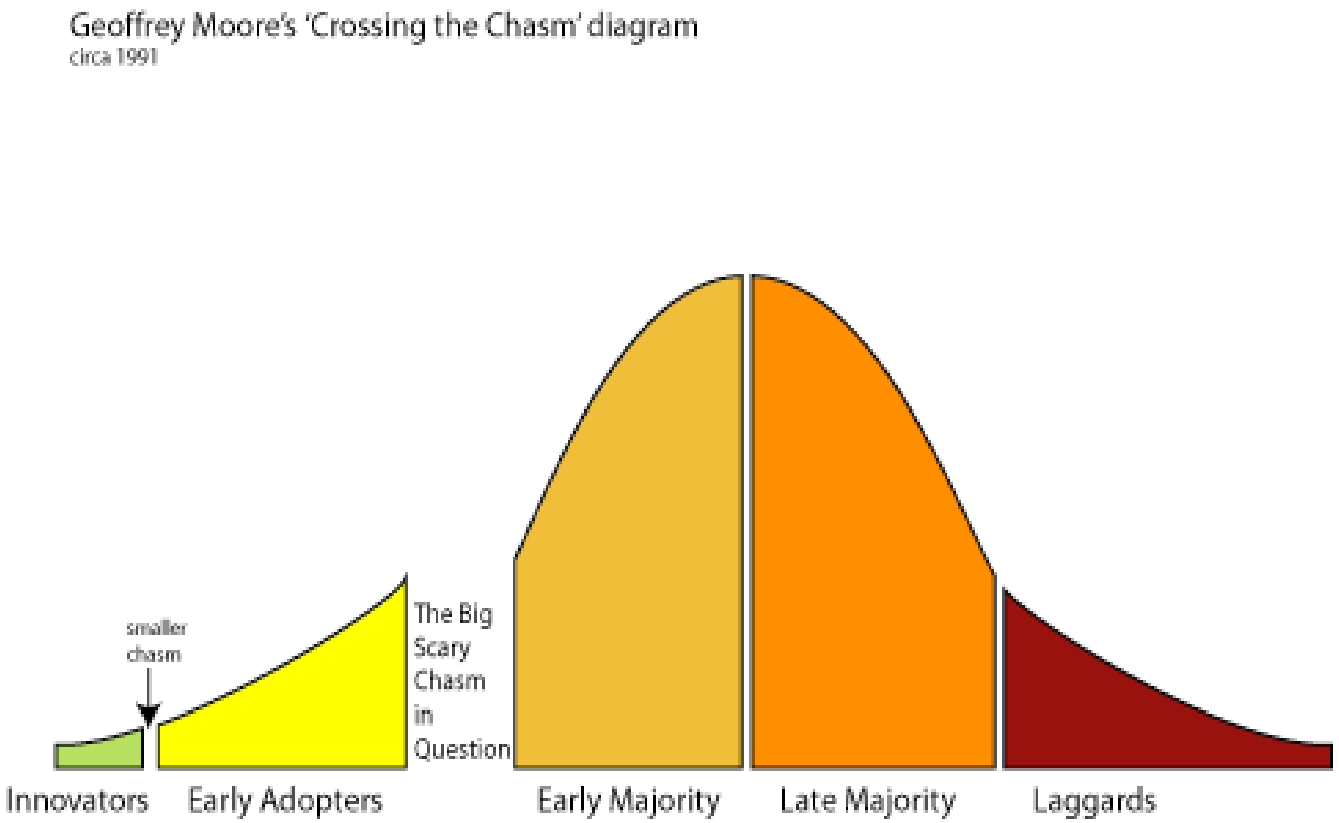
c: Point when disruptive innovation outperforms the market, eliminating the Sustained market and opening the market for new disruption



Christensen's The Innovator's Prescription

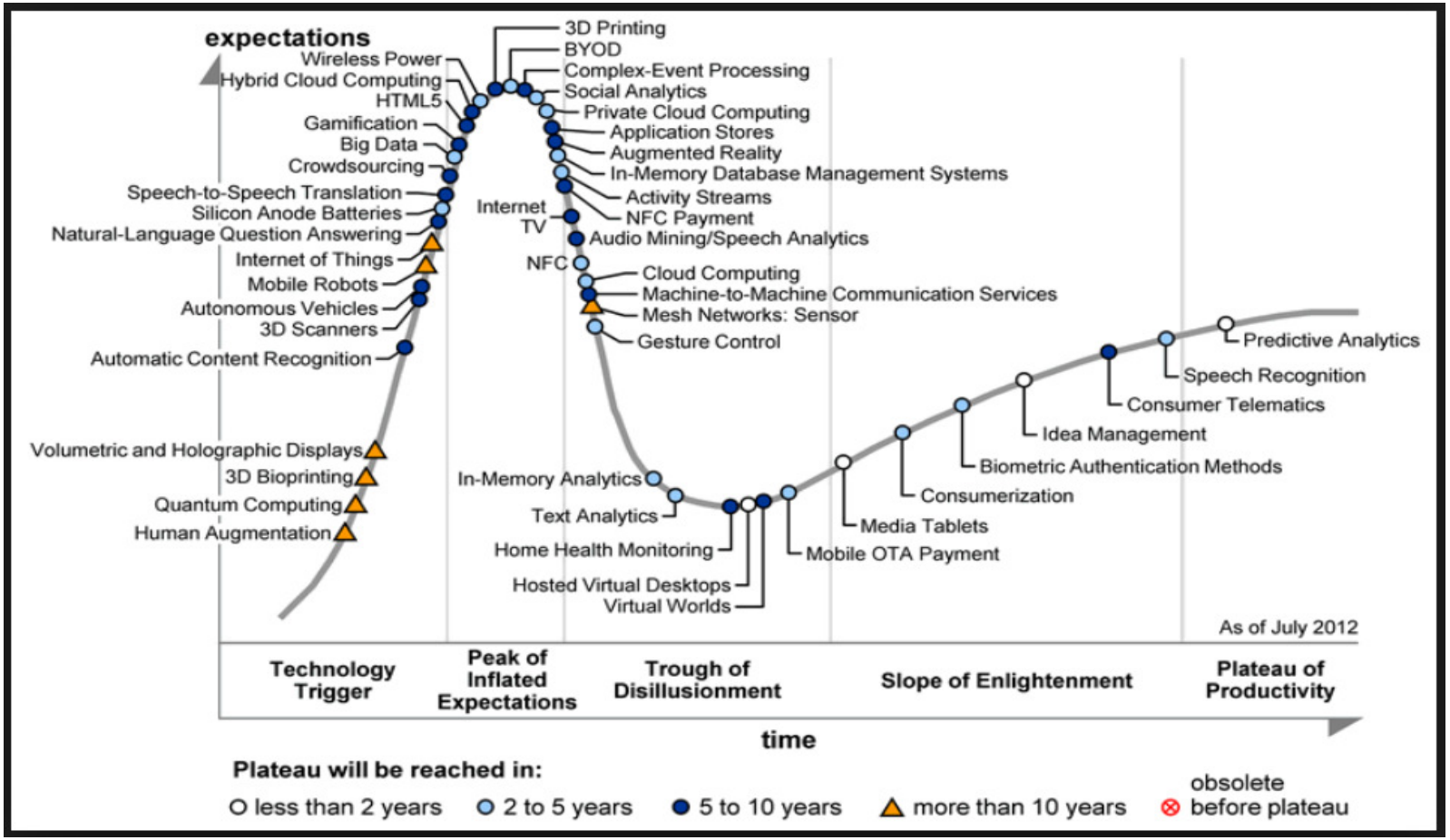


Moore’s Crossing the Chasm



Where is PCMH now?

The Gartner Hype Cycle of New Technology Adoption



Tools of measuring provider and clinic performance

Quality in Family Practice

NCQA level of facility -
Measures the quality of the entire team

Individual physicians in practice will be assessed the same by the payers

Distinct quality of physicians and other providers will become an internal measure

Using Six Sigma Tools to Enhance the Patient Center Medical Home

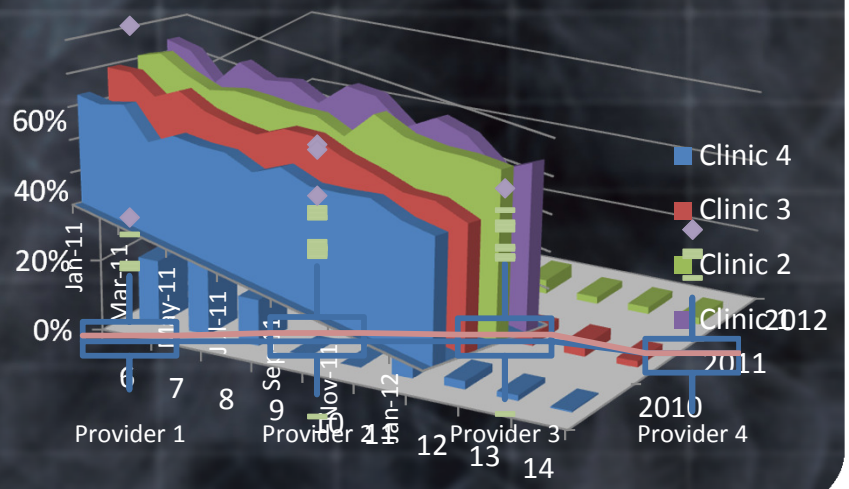
Clinical Effectiveness Index = Outcomes × Patient Satisfaction × Productivity

Provider Productivity

Patient Satisfaction

Patient Registries

- Surveys
- Diabetes
- Lifetime
- 10% of patient
- Asthma
- Patients per
- population
- Hypertension
- Provider Specific
- Dyslipidemia
- In clinic and via mail



Patient Satisfaction

Forno	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	YTD
Satisfaction Scores and % Highly Satisfied								
Survey Volume	157	52	34	42	22	45	40	392
Percent Highly Satisfied	71.0%	93.3%	85.3%	86.9%	70.5%	83.3%	93.8%	80.6%
Question #1 *The amount of time you waited to get an appointment*	4.31 54.5%	4.85 86.5%	4.47 61.8%	4.68 68.3%	4.50 54.5%	4.49 62.8%	4.79 82.1%	4.52 64.6%
Question #2 *Convenience of our location*	4.52 60.5%	4.83 86.5%	4.79 85.3%	4.66 70.7%	4.59 59.1%	4.71 75.6%	4.87 87.2%	4.66 71.5%
Question #3 *Getting through to the office by phone*	4.50 63.6%	4.72 78.0%	4.73 75.8%	4.72 77.8%	4.53 57.9%	4.70 75.0%	4.87 86.8%	4.64 71.6%
Question #4 *Length of time waiting at the office for your visit*	4.13 45.9%	4.71 80.8%	4.53 67.6%	4.43 52.4%	4.48 57.1%	4.49 58.1%	4.75 85.0%	4.40 59.1%
Provider Specific: **Question #5** *Time spent with the care provider*	4.58 65.4%	4.88 88.5%	4.68 79.4%	4.80 80.5%	4.55 63.6%	4.67 66.7%	4.88 87.5%	4.69 73.6%
Provider Specific: **Question #6** *Explanation of what was done for you*	4.69 72.4%	4.90 90.2%	4.76 79.4%	4.81 81.0%	4.59 63.6%	4.82 82.2%	4.90 92.5%	4.77 79.0%
Provider Specific: **Question #7** *The technical skills (thoroughness, carefulness, competence) of the care provider you saw*	4.73 75.8%	4.94 94.2%	4.85 85.3%	4.86 85.7%	4.68 68.2%	4.84 84.4%	4.93 92.5%	4.81 82.4%
Provider Specific: **Question #8** *The personal skills (courtesy, respect, sensitivity, friendliness) of the care provider you saw*	4.76 78.3%	4.96 96.2%	4.85 85.3%	4.85 85.4%	4.73 77.3%	4.84 84.4%	4.95 95.0%	4.83 84.4%
Provider Specific: **Question #9** *Sensitivity to your special needs or concerns from the care provider you saw*	4.71 73.7%	4.96 96.2%	4.85 85.3%	4.90 90.5%	4.68 68.2%	4.82 82.2%	4.93 92.5%	4.81 82.1%
Provider Specific: **Question #10** *Your satisfaction with getting the help that you needed*	4.68 72.6%	4.96 96.2%	4.85 88.2%	4.88 88.1%	4.64 63.6%	4.82 82.2%	4.95 95.0%	4.80 81.6%
Question #11 *Your feeling about the overall quality of the visit*	4.66 69.4%	4.90 90.4%	4.79 82.4%	4.86 85.7%	4.73 77.3%	4.84 84.4%	4.93 92.5%	4.78 79.6%
Question #12 *Your impression of the facility (cleanliness, comfort, noise, organization)*	4.63 66.9%	4.92 92.3%	4.82 82.4%	4.81 81.0%	4.77 77.3%	4.87 86.7%	4.88 90.0%	4.77 78.3%
5 Highly Satisfied • 4 Satisfied • 3 Neither • 2 Dissatisfied • 1 Highly Dissatisfied								81.9%

Measured

Outcomes

Clinical Activities Outcome Data

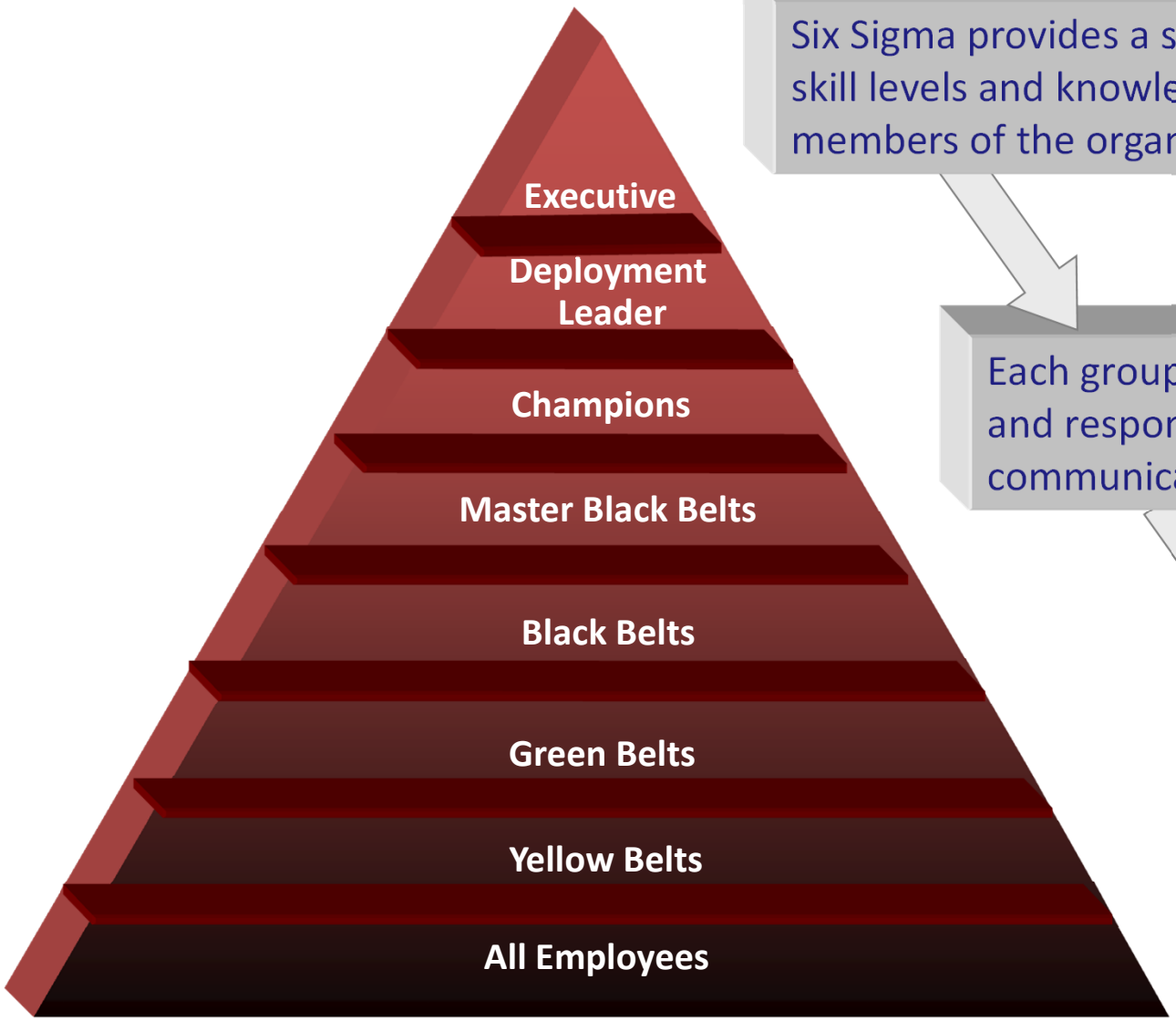
Areas for Analysis	Data Source of Measure	Current Performance
Cholesterol	LDL-C threshold 1: ≥100 mg/dL	2010 = 69% n=54 2011 YTD = 53% n=730
	LDL-C threshold 2: ≥130 mg/dL	2010 = 31% n=54 2011 YTD = 23% n=730
HYPERTENSION	Stage 1 or higher SBP 140+ or DBP 90+	2010 = 54% n=197 2011 YTD = 41% n=793
DIABETES	HbA1c Management: Testing	2010 = 89% n=190 2011 YTD = 80% n=576
	HbA1c Management: Poor Control (>9%)	2010 = 10% n=190 2011 YTD = 5% n=576
	Blood Pressure Management: % monitored	2010 = 98% n=190 2011 YTD = 99% n=576
	Lipid Profile % completed	2010 = 82% n=190 2011 YTD = 86% n=576
	Lipid Management: Control (LDL ≥100 mg/dL)	2010 = 39% n=190 2011 YTD = 37% n=576

Our Goals

- NCQA Level I = minimum
- NCQA Level III = 50th percentile
- Above 50th percentile will be proprietary measures, largely based on Six Sigma tools

Operations management using Lean Six Sigma in PCMH facilities

Six Sigma Roles



Six Sigma provides a structure of skill levels and knowledge for all members of the organization.

Each group has well defined roles and responsibilities and linkages of communication.

Effect: Individuals are focused on and capable of meeting the the needs of the business & customer.

Lean Six Sigma

Lean

Strength: Efficiency

Six Sigma

Strength: Effectiveness

- Method/Way
- Tools and Tactics
- Muda
- Business Strategy
- Philosophy of Operational Excellence
- Process Measurement and Management
- DMAIC

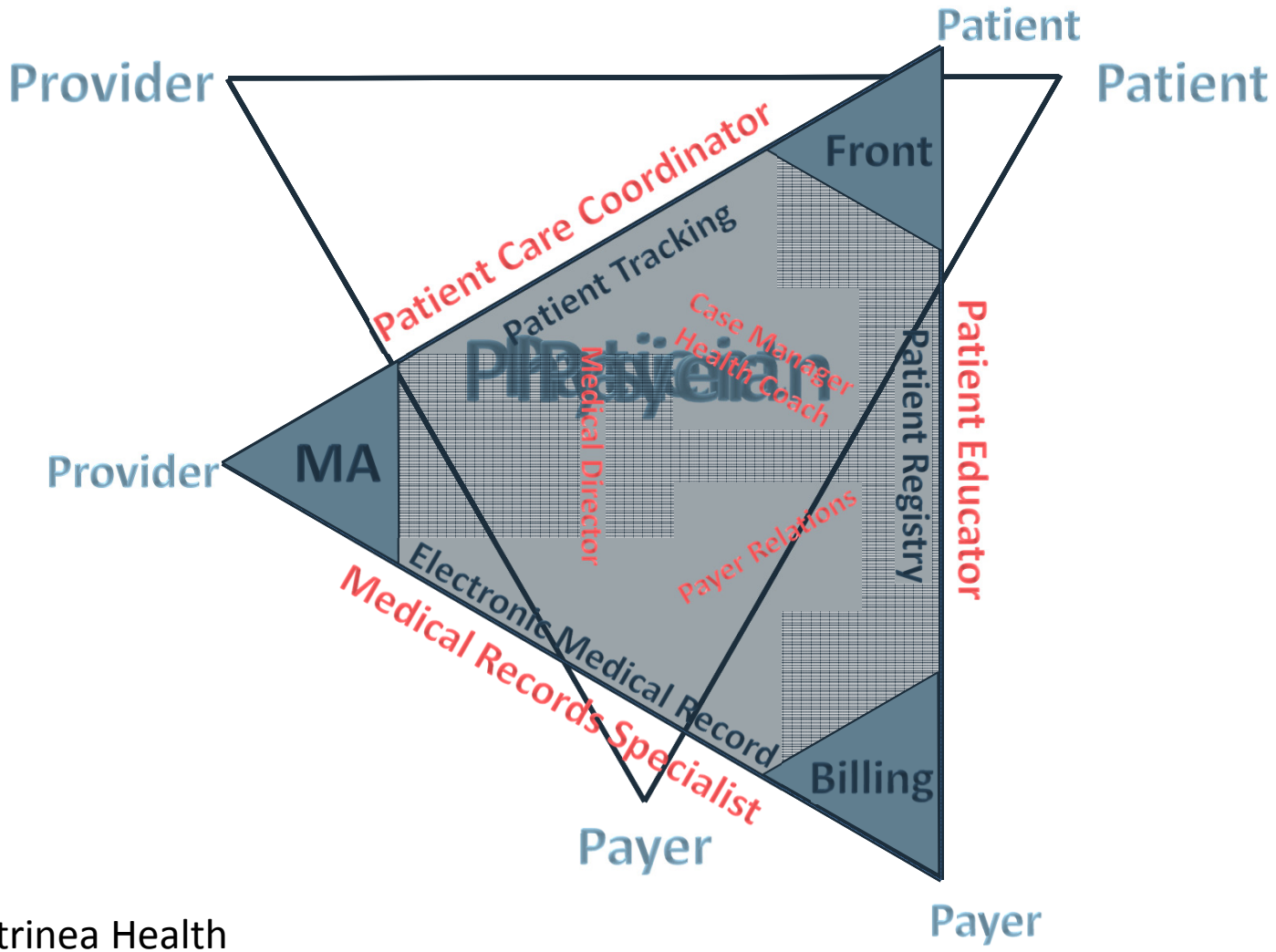
Waste

- Overproduction
- Correction
- Inventory
- Motion
- Over processing
- Conveyance
- Waiting

5S

- Seiri – Put things in order
- Seiton – Proper arrangement
- Seisco – Clean
- Seiketsu – Purity
- Shitsuke - Commitment

PCMH Team and Relationships



“Rocks in the Backpack”

Smoking	Counselling, schedule prescription visit with provider, care plan, milestones, etc.
Obesity	Health coaching
Alcohol abuse	Screening, initial counselling
Immunizations	Identify deficiencies and update after provider confirmation
Depression	Screening, counselling, psychotherapy (referral as needed)
Domestic violence	Screening
Automobile safety	Child safety seat use
Pets	No role
Work safety	Site specific per customers
Helmet use	Screening and counselling
Development	Screening, counselling, DDI
Growth	Screening
Preventive	MG, Pap, FIT / colonoscopy, lab, PSA, AAA US, BD as indicated per guidelines
Complicated patients	Case management

Provider's role after team handoff

Smoking	Firm admonition to stop smoking; prescription if needed
Obesity	Firm admonition for diet and exercise
Alcohol abuse	Firm admonition, referral
Immunizations	Affirm standing order for immunizations if not contra-indicated
Depression	Referral, prescription per guidelines if indicated
Domestic violence	Referral
Automobile safety	No role
Pets	No role unless specific indication, i.e. recurrent strep
Work safety	Site specific per customers
Helmet use	No role
Development	Referral
Growth	Referral
Preventive	Affirm standing order
Complicated patients	Refer to case manager

Briggs Method

- Listen to MA summarize history and ROS to provider in front of patient
- Expand on history
- Review studies with patient (studies done before office visit or at office per MA protocol)
- Perform physical exam: quietly, thoughtfully, thoroughly but quickly. Abnormals may be articulated between organ systems.
- Order any in-office studies needed
- Communicate assessment(s) and plan(s) to patient
- Sign prescriptions and office visit document (ideally biometric)

Briggs Method, explained

- Ideally all documention flows out of the above with no effort on the providers part.
- A dictated portion is always an option for complex differential diagnoses, etc.
- Staff translates the physicians communication in lay language to medicalese
- Prescriptions must be affirmed individually and the office visit including assesment and plan is affirmed with one action

Briggs Method, explained II

- Provider must be absolutely confident that patient will receive standard patient information sheets on all diagnoses and prescriptions per pre-established protocols
- Discussion with patient is focused on medical issues: bonding and small talk minimized but not eliminated

Provider Training-Mock Exam Room

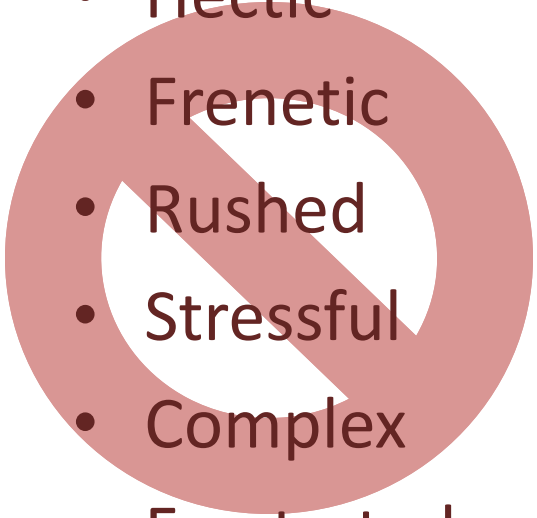
View from the Gallery

Training Conference Center

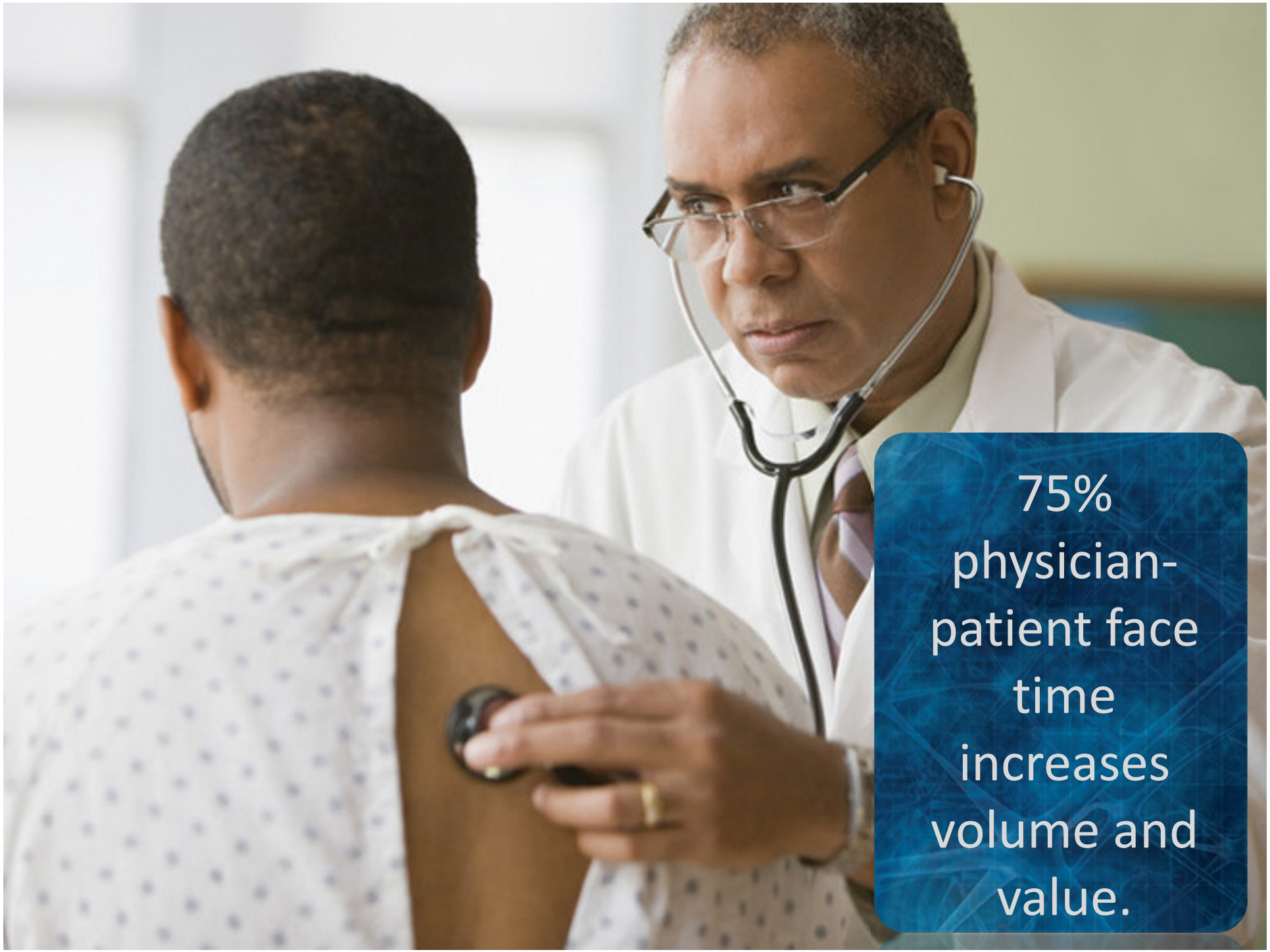
Volume vs. Value

Provider Experience

- Busy
- Full
- Brisk
- Light
- Simple
- Supported

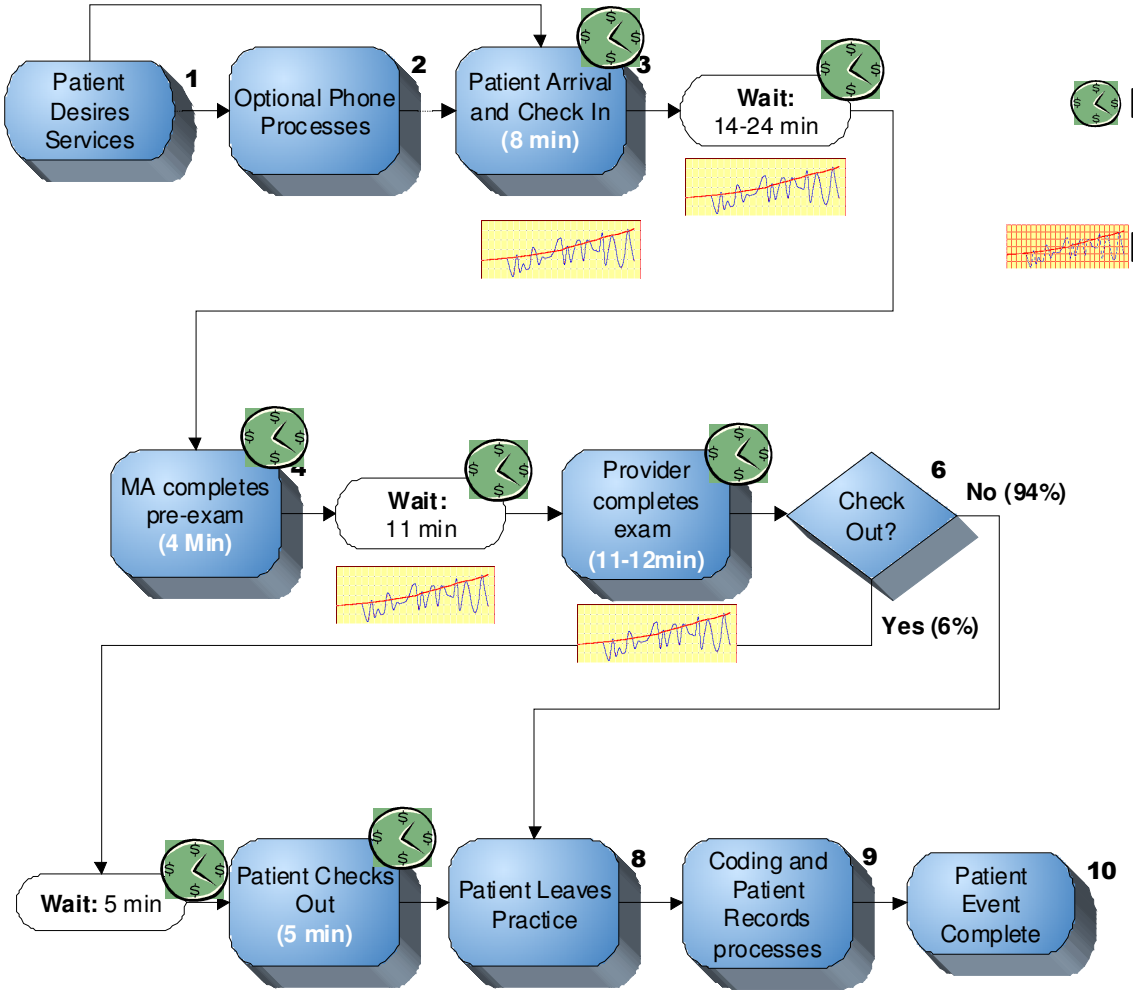


- Hectic
- Frenetic
- Rushed
- Stressful
- Complex
- Frustrated


75%
physician-
patient face
time
increases
volume and
value.


Patient Experience:
High Touch with High Tech support in background

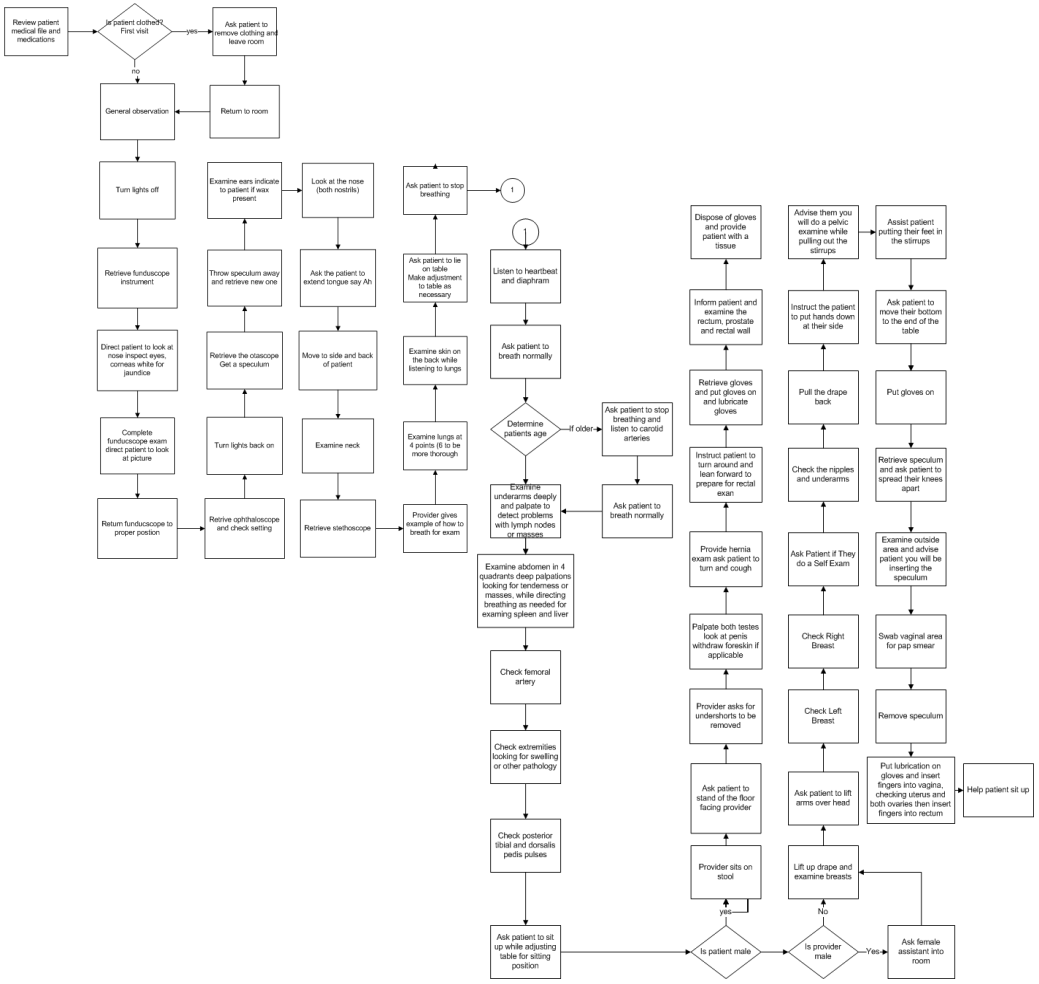
Current High Level Workflow



Excessive Wait

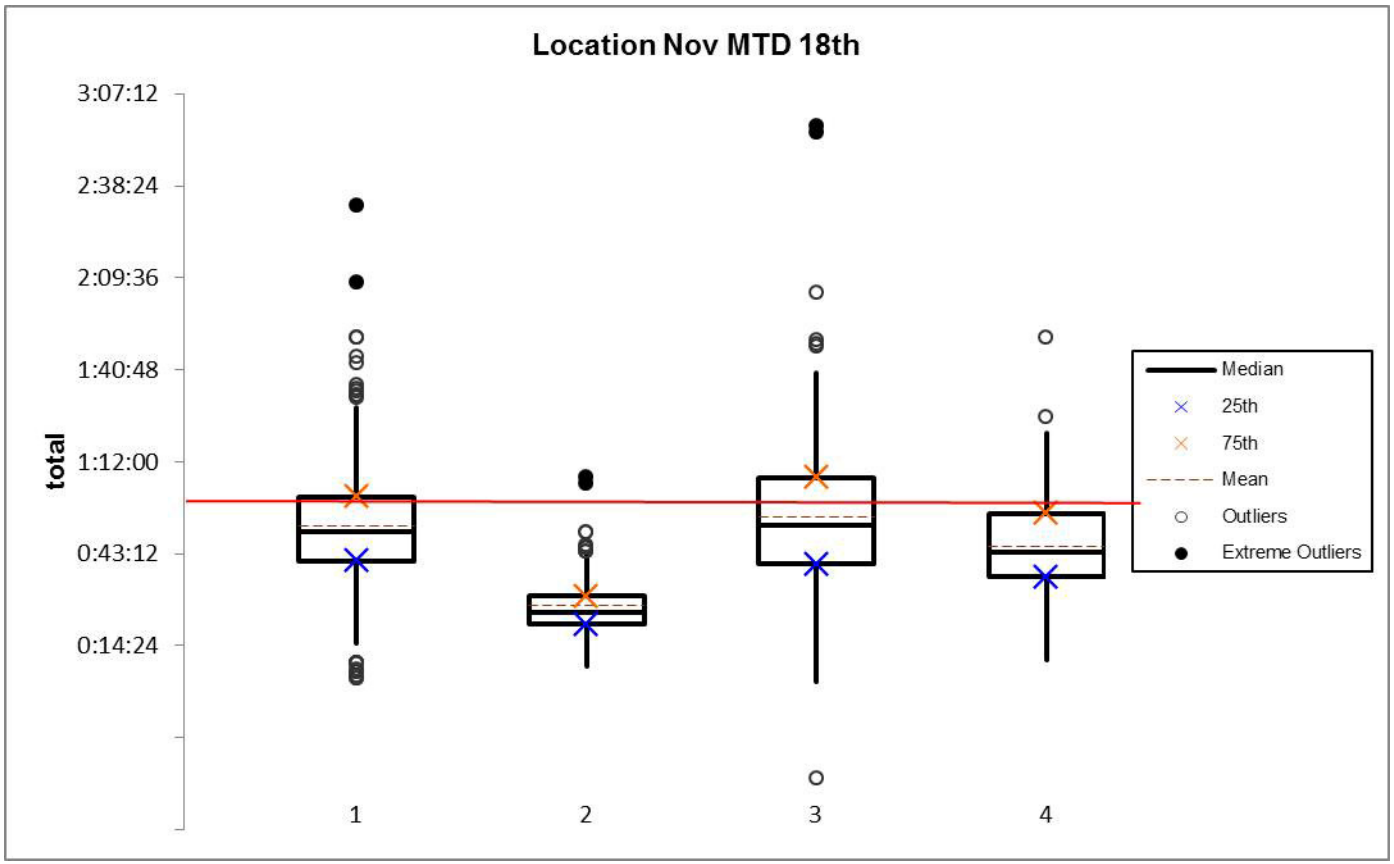
Excessive Variation

Exam Step Expectations



- Exam steps defined and timed for common exam types
- Providers expected to follow standardized steps to meet time requirements
- Additional (unrelated) requests from patient outside of steps referred for follow up appointments
- Providers having significant variation or exceeding required times can be audited against exam steps

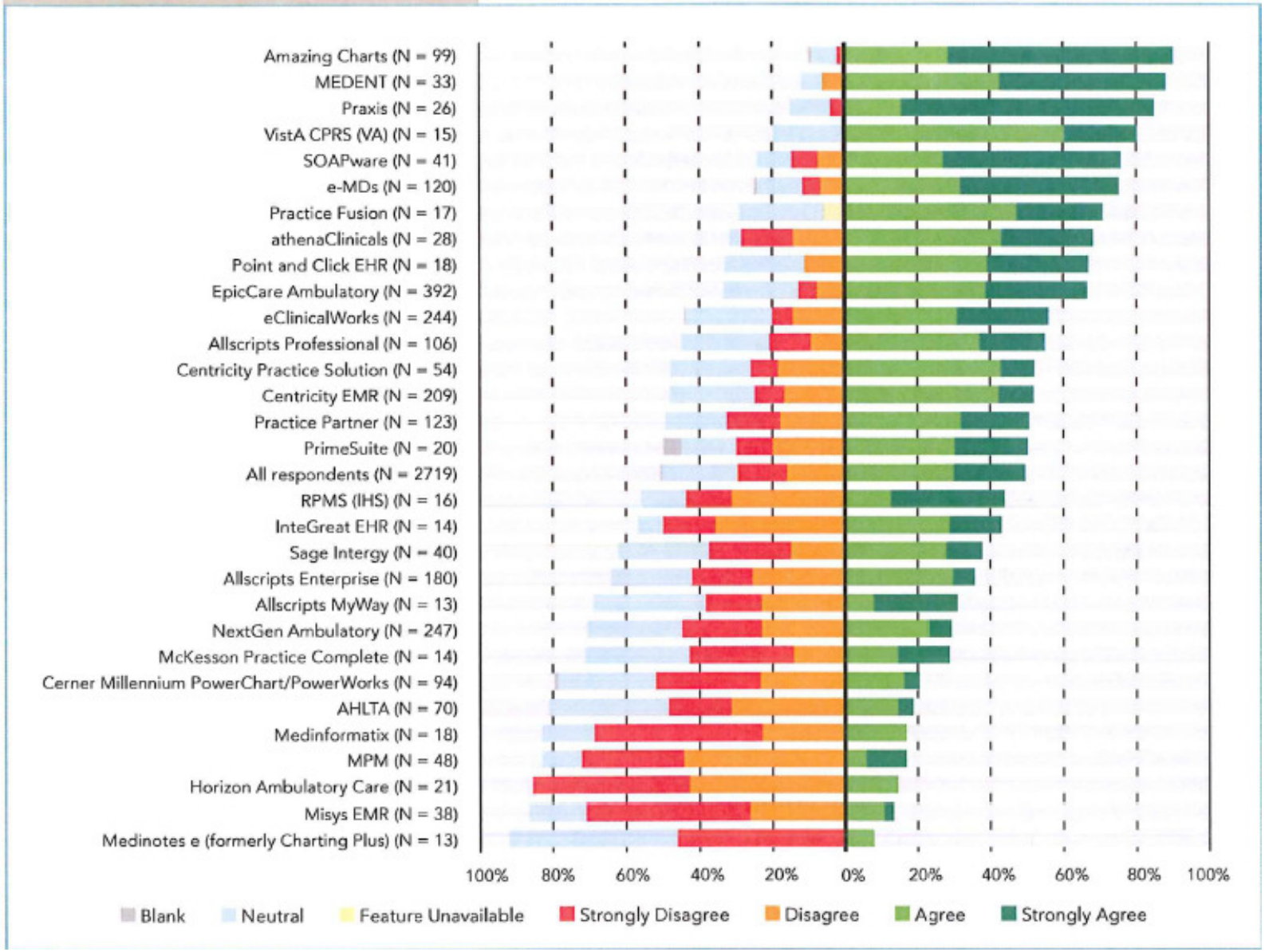
Clinic Location Cycle Times



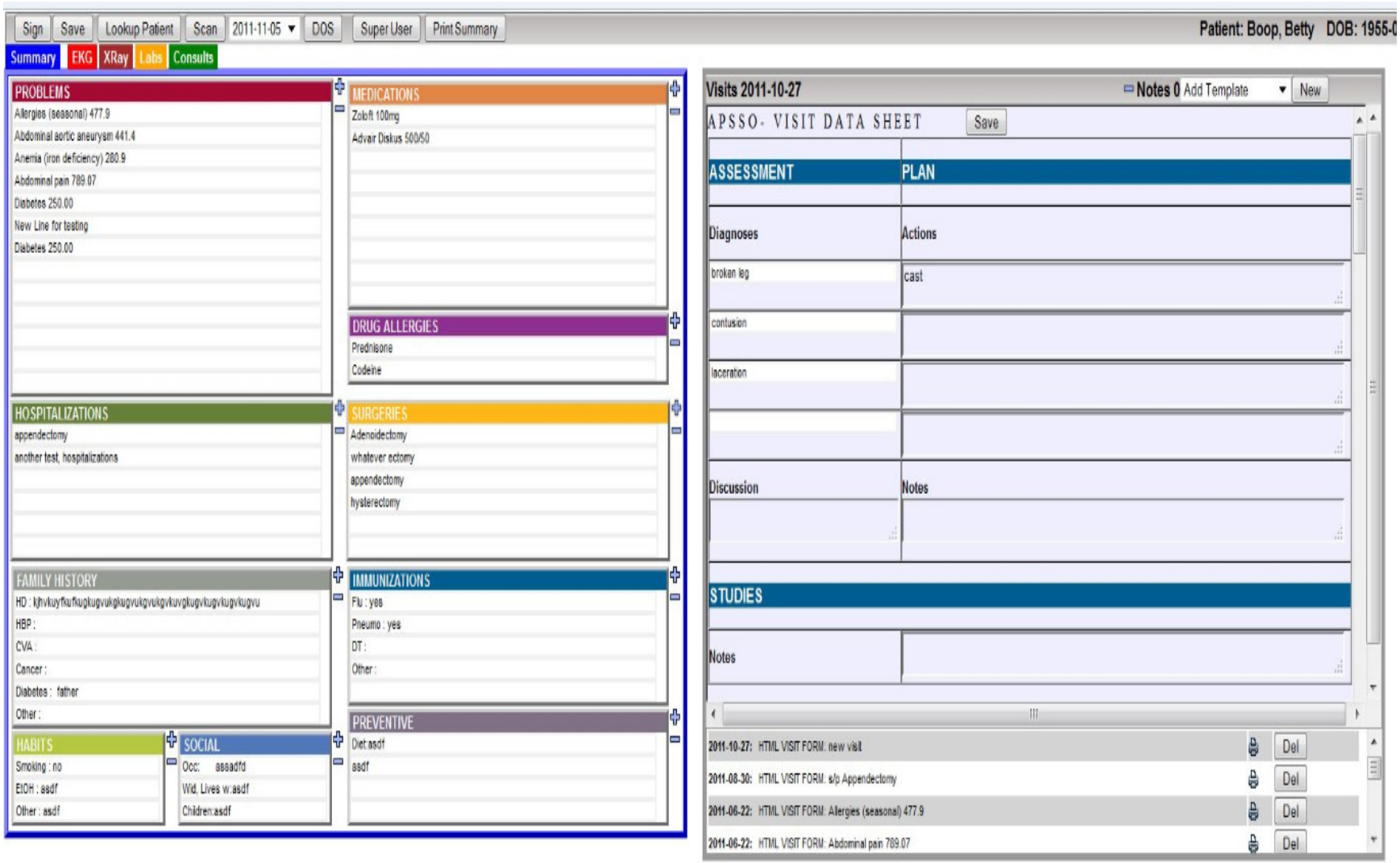
Health Information Technology

RESPONSE SPECTRUM:

'I am highly satisfied with this EHR.'



EMR to support clinical work flow



Government Regulations

Keeping the incentives in context

	EPs	Year 1	Year 2	Year 3	Year 4	Year 5	**Total**
Incentive Payments	9	$ 191,250	$ 76,500	$ 76,500	$ 76,500	$ 76,500	**$ 497,250**
One More Patient per Day	9	$ 249,480	$ 249,480	$ 249,480	$ 249,480	$ 249,480	**$ 1,247,400**

- Assuming all our providers qualify, the incentives will generate $500,000 over the five year period
- If each of these providers saw just **one more patient a day** we would generate $1.2 million over the five year period.

Government Regulations

Keeping the incentives in context

Meeting meaningful use just for the ARRA money is like having a baby just for the tax refund.

Profitability in volume-based reimbursement while preparing for and transition to value-based funding

Volume vs. Value

- Before Capitation
- During Capitation
- After Capitation

Successful when busy

Busy practices are always going to be more successful and more profitable.

75% physician-patient face time increases volume and value.

Volume vs. Value

Practicing at the
Top of License vs. Top of Board Certification

"With value-based funding I treat only the most difficult and interesting cases."

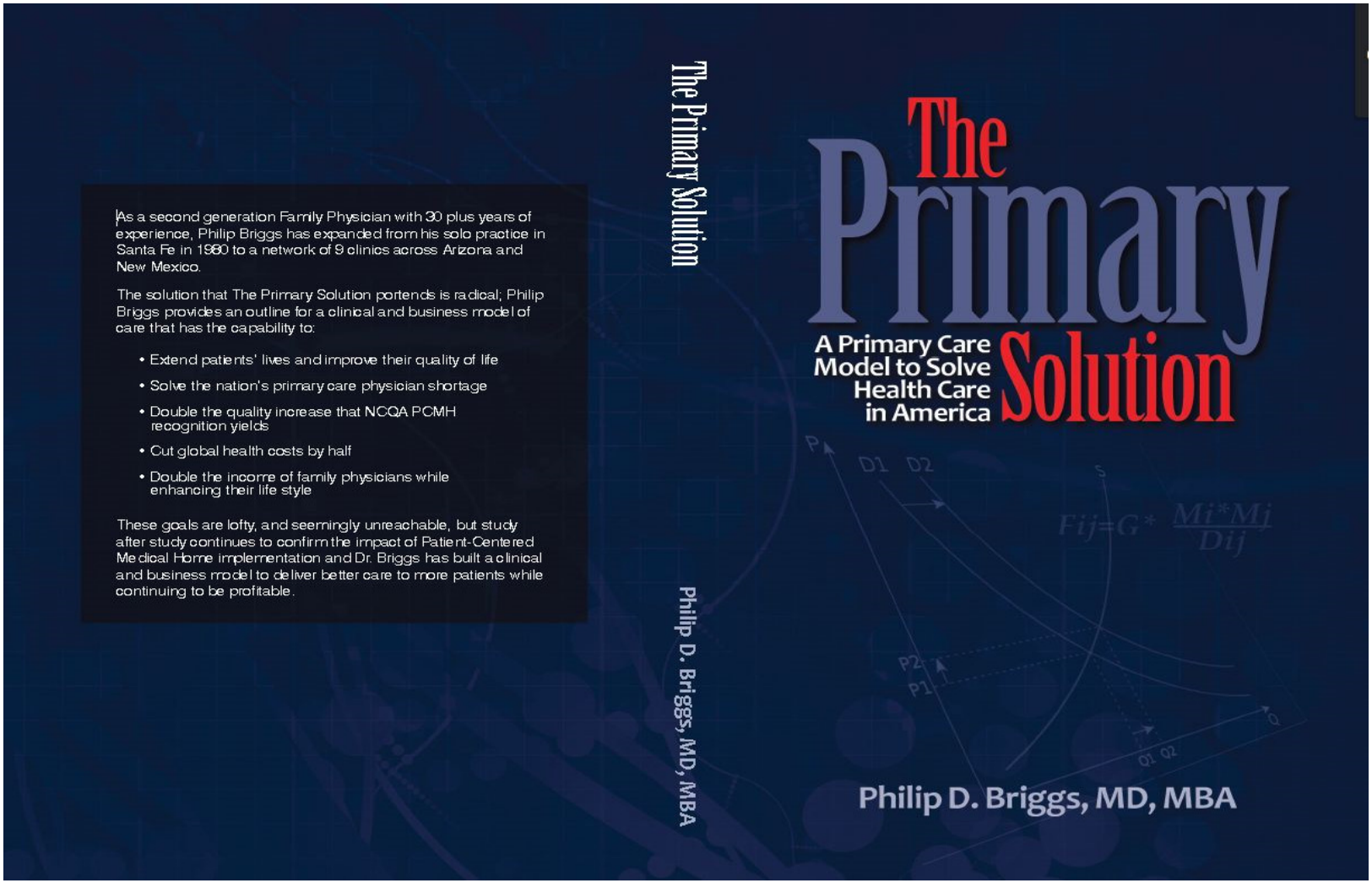
WRONG

In value-based funding physicians still treat what some might consider trivial illnesses. They have a team supporting them however; and their time is just better allocated.

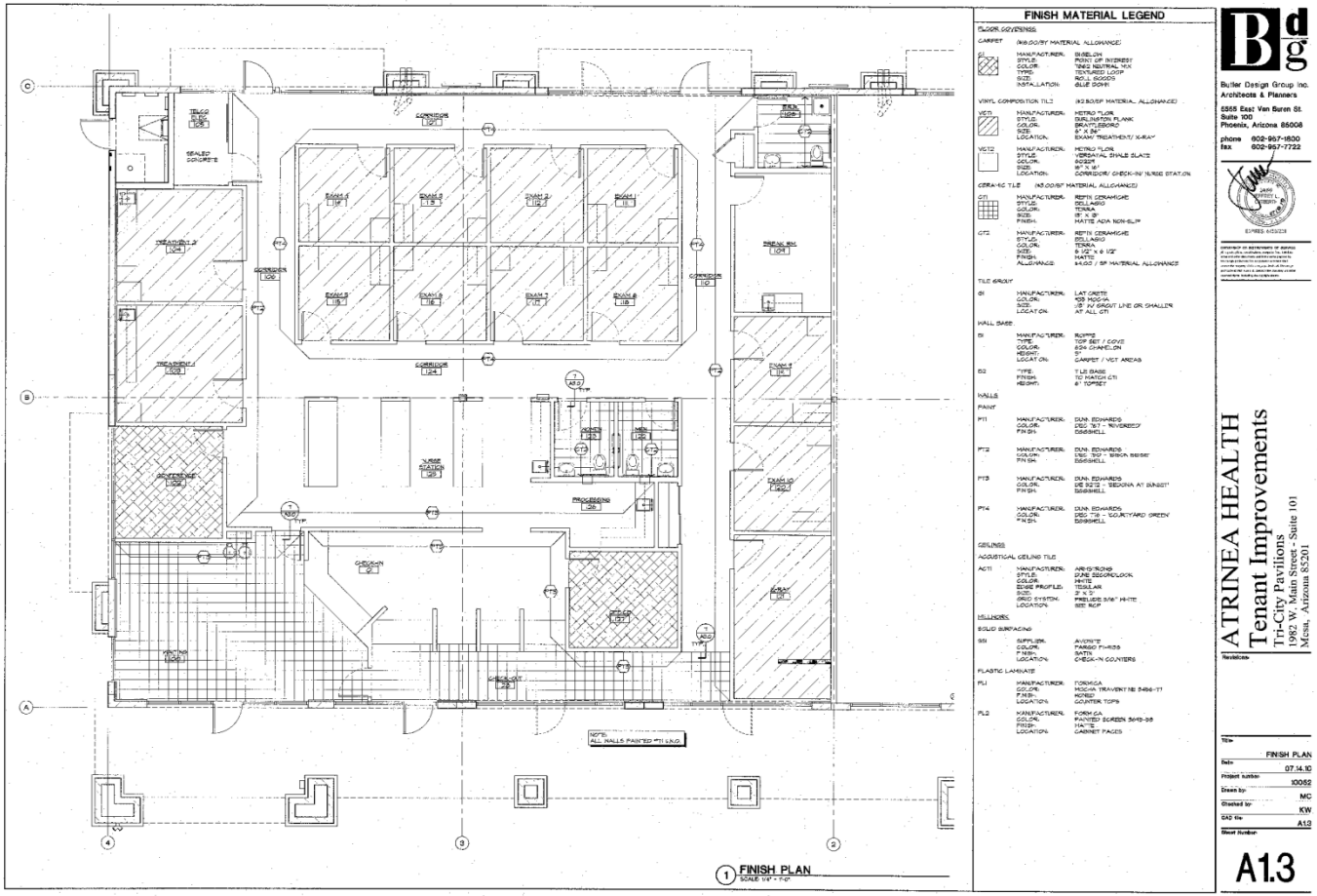
Franchising as a strategy for expansion and horizontal integration


ACCESS
PREVENTION
INNOVATION

In-Depth Description



Architects plan-Mesa



Architects model-Mesa

Atrinea Health Mesa –
Opened Nov. 2010


AtrinealHealth
10 Exam Rooms
2 Treatment Rooms
5,000 Square Feet


System Transformation
Through Spectrum of Care

ACO

Accountable Care Coalition of New Mexico
Established by Sangre de Cristo Medical Group, LLC

ACO Implementation Project Dashboard

Implementation Manager: Mishka Glaser / Melissa Guajardo
Executive Director: Jason Garszczynski
ACO Date: 1/1/13

Support Manager: Trisha Dixon
Care Coordination: Maryelle Van Assende
Revision Date: 2/05/13

Complete	On Target	Some/Low Risk	Not Started	High Risk

ACO Executive Summary

Milestones	Owner	Finish	Status	Summary
tracts between ACO & CHS plete.	CHS – ACCNM - TBD	1/1/13	Complete	1/1/13 ACO

Medical Neighborhood

A few notes about the Medical Neighborhood, and the relationship between primary care practices and specialists:

- Specialists will face the same pressures for efficiency that PCPs do
- Neither of us will be communicating by phone, except perhaps rarely
- The relationship will be team-team rather than physician-physician
- We will have a common interest in the “triple aim”: better care, better outcomes, and lower costs
- Common practice guidelines will be forged jointly and used by all providers
- Administrative leaders in the practices will play a much more prominent role
- Accountability will be a key common goal
- Health Info Tech will play a key role
- Leveraging payer contracts to pay for outcomes is a critical aspect

Technology

And the New World of

Healthcare


Los Alamos
NATIONAL LABORATORY
EST.1943


NEW MEXICO
Angels
INVESTING IN INNOVATION


TECHNOLOGY
VENTURES
CORPORATION


Sandia
National
Laboratories
Exceptional service in
the national interest


STC.UNM
THE INNOVATION DOOR TO
THE UNIVERSITY OF NEW MEXICO

Primary care of the Future

- Personalized Medicine

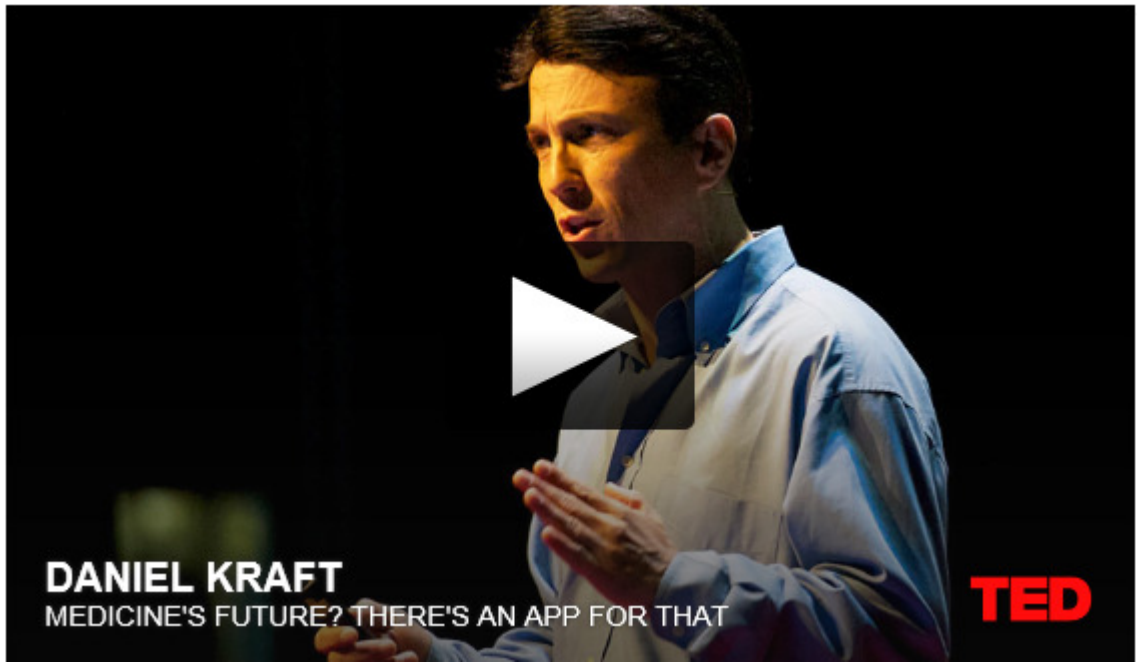
  Fully sequenced patient genome, interfaced with practice guidelines and specific therapeutic decisions

- Precision Medicine

  Black box lab, nanotech device, 100 tests from a few drops, real time

  Cross sectional imaging: visualizing the coronary arteries with an annual PE

Daniel Kraft – There's an App for That



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Questions

Urgent Care + Family Practice

AtrineaHealth™

Your trusted Family Doctor and Urgent Care Specialist under the same roof

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