Primary Care Transformation: Lessons from the Field

Medical Home Summit
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Health Care Delivery System Reform
The Commonwealth Fund

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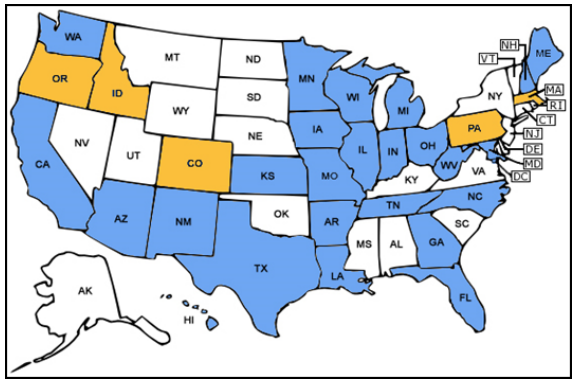
Affordable, quality health care. For everyone.

Questions explored today

- What's needed for practice transformation?
- What are key features of technical assistance to support primary care sites transition to PCMH?

Safety Net Medical Home Initiative



- 5-year PCMH demonstration to support 65 safety net primary care sites implement PCMH
- Goal: to develop and demonstrate a replicable and sustainable implementation model to transform safety net primary care practices into patient-centered medical homes (PCMH)
- Administered by Qualis Health in partnership with the MacColl Center for Health Care Innovation

Funding Partners for the Initiative

Beth Israel Deaconess Medical Center

PARTNERS HEALTHCARE

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The Colorado Health Foundation™

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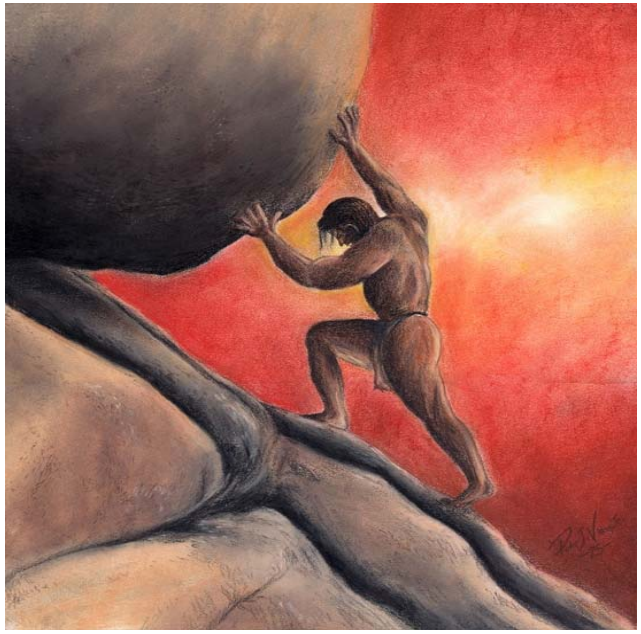
How does a practice become a PCMH?

"Change is hard enough; transformation to a PCMH requires epic whole-practice re-imagination and redesign."*

***Nutting et al. Ann Fam Med. 2009; 7:254-260**

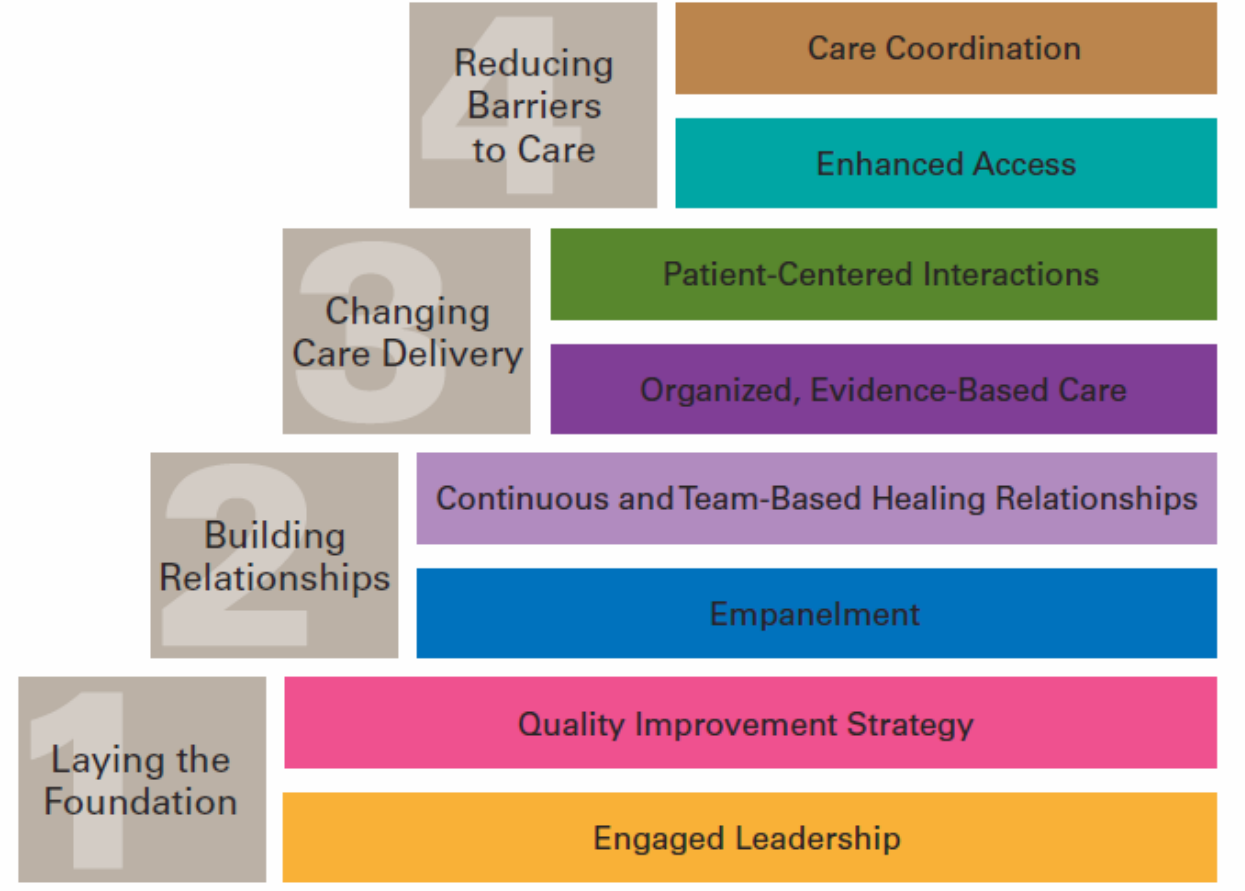


PCMH transformation is not business as usual

What helps practice transformation?

What helps practice transformation?

Eight Change Concepts
Framework for Practice Transformation:



Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The Changes Involved in Patient-Centered Medical Home Transformation. *Primary Care: Clinics in Office Practice.* 2012; 39:241-259.

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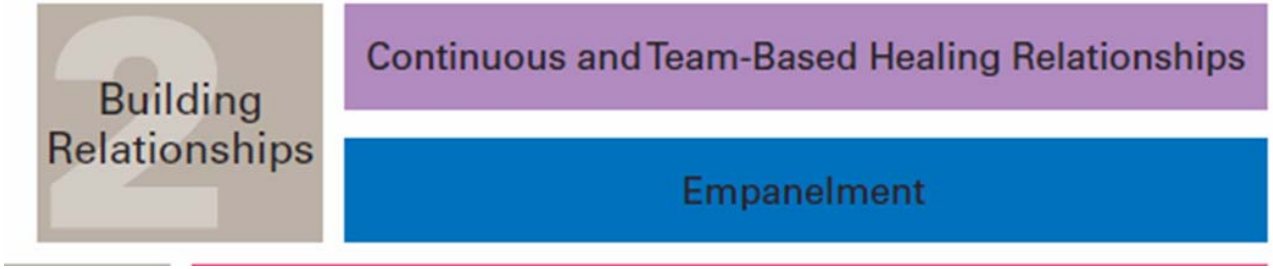
What Have We Learned?

- Successful practices have "*adaptive reserve*"– the ability to learn and change
- Effective leaders:
  - envision a future
  - facilitate staff involvement
  - Dedicate time and resources to make changes. Review and act on the data
- Practices that don't routinely measure and review performance are unlikely to improve
- The responsibility for PCMH transformation must be shared by all staff, and made explicit through protected time to meet and specific QI resources
- PCMH is built into job descriptions and hiring practices
- Turnover is one of the most disruptive events to successful transformation
- QI is difficult unless information technology is stable.



What Have We Learned?

Empanelment is critical:

- changes practice culture and accountability,
- fosters a population focus and the development of teams, and
- facilitates meaningful measurement (at the provider level) and population management.

Empanelment is harder than it looks:

- Assumes stability of providers and patients
- Requires continuous attention

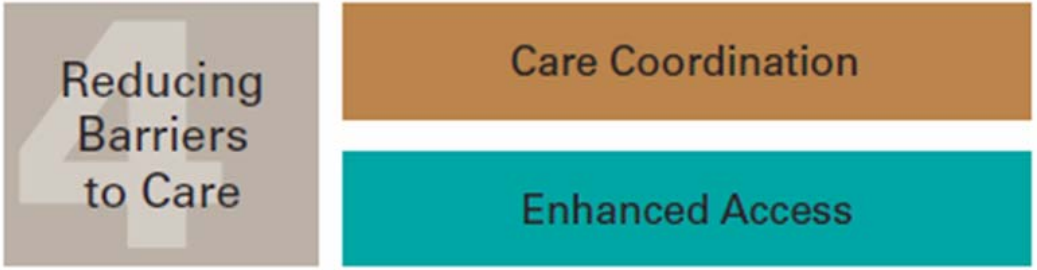
Without high-functioning teams, practices find it nearly impossible to implement patient-centered interactions, organized evidence-based care, and care coordination

Teamwork in the care of chronically ill is the single most powerful intervention

Creative practices are expanding the roles of MAs or Community Health Workers

What Have We Learned?

- Successful sites:
  - assess patient/family needs and preferences
  - systematically involve patients is decision-making, not ad hoc
  - involve patients/families in QI
  - Adopt the mantra: *“Nothing about me without me.”*
- Effective practices train *all* staff on patient communication and engagement techniques: “teach-back”

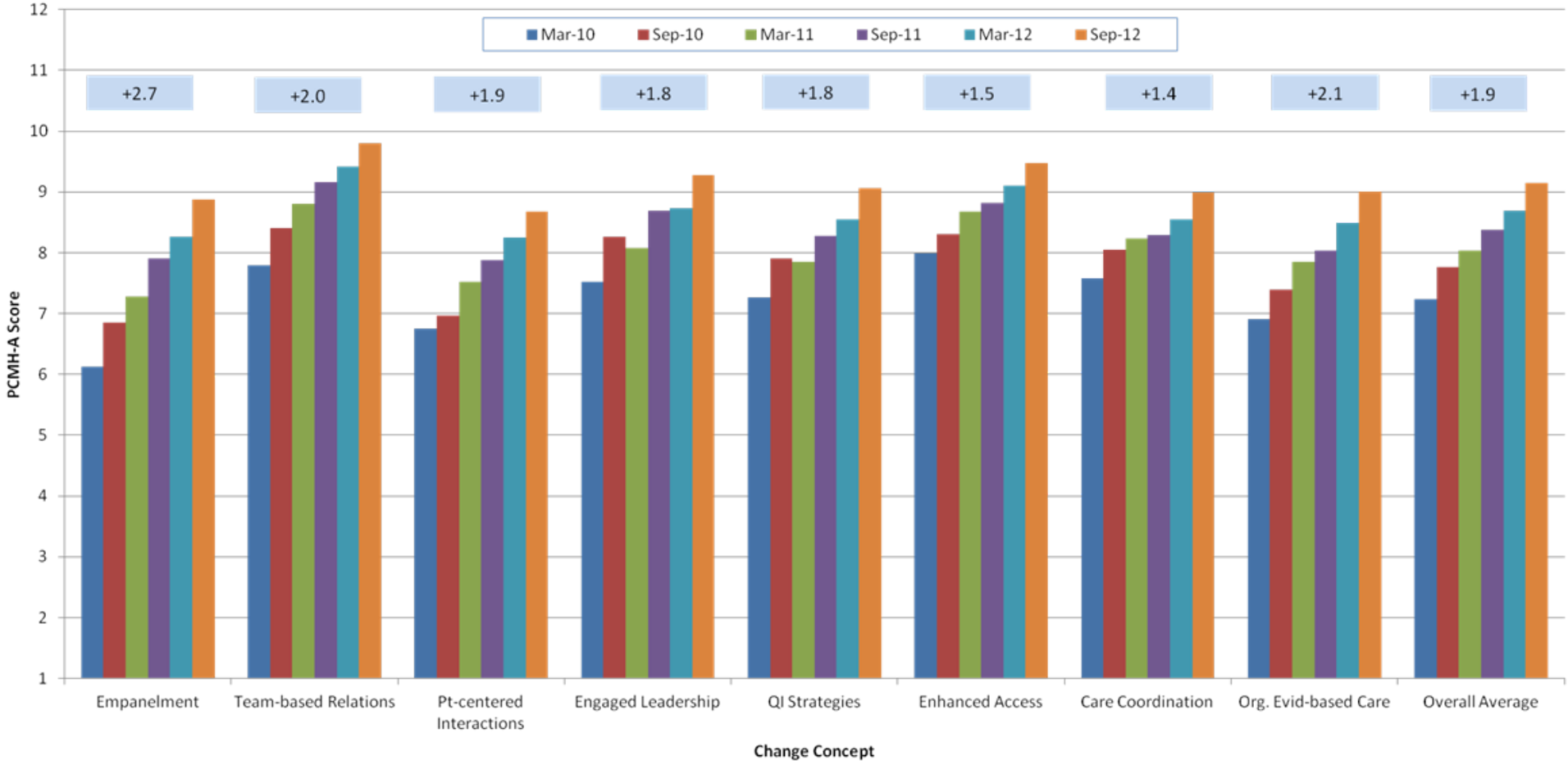


What Have We Learned?

- Evidence of cost savings comes primarily from improvements in care coordination and access.
- Even a *few* hours of off-hours appointment access is associated with reduced ED use
- Care coordination isn't left to chance. Effective practices assign key activities and embed them in daily work

Average Change Concept Scores Across All Partner Sites
Mar 2010 - Sep 2012

(Numbers in boxes contain the increase in Change Concept score from Mar 2010 to Sep 2012)



What helps practice transformation?

Practice Facilitation: Individual Site Level Coaching

Practice coaches:

- Articulate the “roadmap” and help connect the dots
- Assist sites with assessment of needs and priorities
- Help train teams on change management and project management skills
- Identify tools to support the work

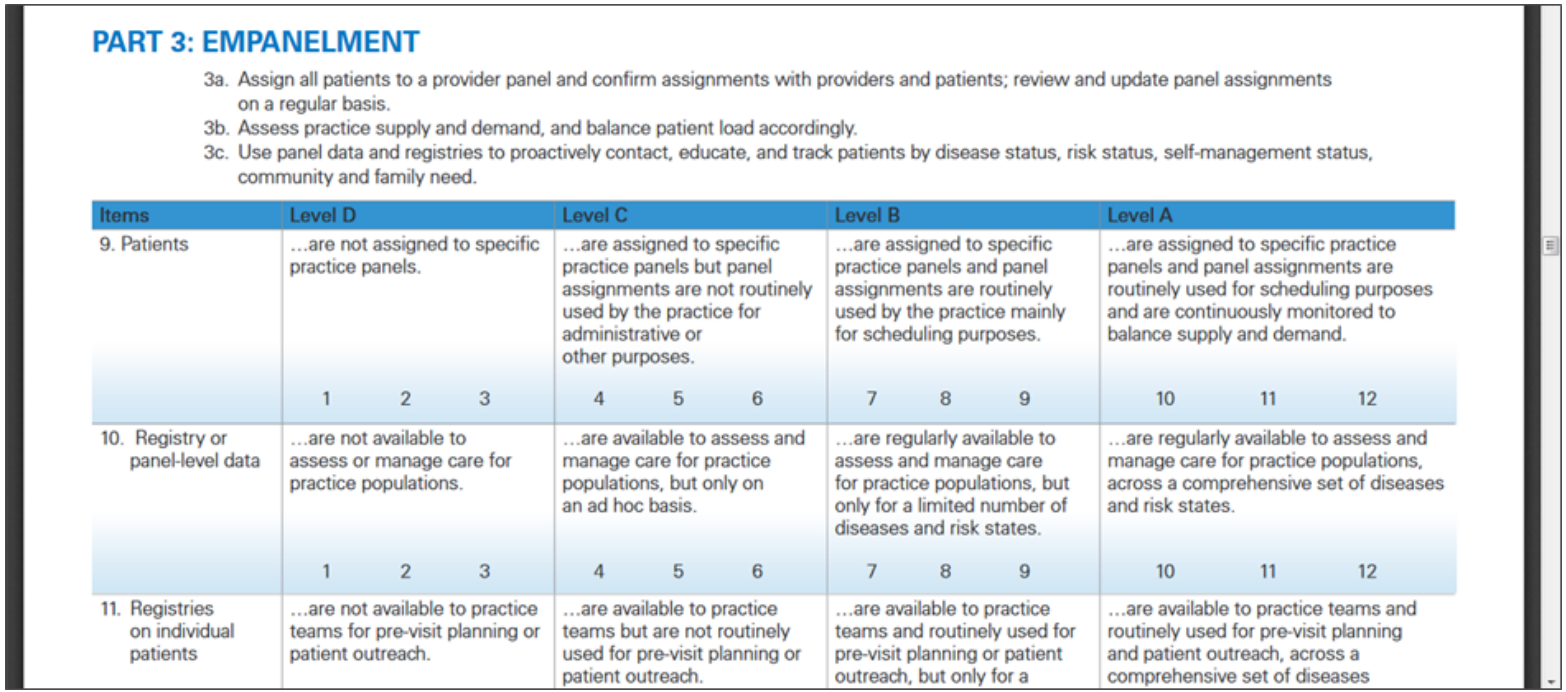
Someone dedicated to the practice/site

Coaching often occurs on-site monthly (or quarterly)

Ratio: 1 coach per 5-7 practice sites

Ideally, create network of coaches too, to help share ideas

Assessment Critical to Facilitation: the PCMH-A



PART 3: EMPANELMENT

3a. Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.
3b. Assess practice supply and demand, and balance patient load accordingly.
3c. Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

Items	Level D	Level C	Level B	Level A
9. Patients	...are not assigned to specific practice panels. 1 2 3	...are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes. 4 5 6	...are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes. 7 8 9	...are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand. 10 11 12
10. Registry or panel-level data	...are not available to assess or manage care for practice populations. 1 2 3	...are available to assess and manage care for practice populations, but only on an ad hoc basis. 4 5 6	...are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states. 7 8 9	...are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states. 10 11 12
11. Registries on individual patients	...are not available to practice teams for pre-visit planning or patient outreach.	...are available to practice teams but are not routinely used for pre-visit planning or patient outreach.	...are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a	...are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases

Learning Communities

- Sites learn best from one another
- Peer networks help spark and maintain momentum
  - Interactions can be a mix of in-person and remote opportunities
- Some aspects of PCMH (leadership, teams) are difficult to *teach.* Effective to show (e.g., field trips).
- Networks can provide ongoing support
- Can facilitate spread and sustainability

Learning Communities: Value of Field Trips

- Most valued form of technical assistance
- Both host and visiting teams value this approach
- Trips range from 1-3 days with 2-3 people each
- Three purposes:
  - To help sites having difficulty getting started
  - Mid-implementation (visit sites a little “ahead”)
  - “Energy boost”

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Data Monitoring and Feedback

- Select clinically meaningful metrics
- Facilitators coached on how to use data to improve care
- Co-development of measurement strategy important
- Sites selected own measures within following domains:
  - Clinical quality
  - Transformation
  - Patient experience
  - Provider/staff satisfaction
  - Utilization
- PCMH-A completed every six months
- Most difficult area due to constrained capacity

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Data Feedback, But for Whom? Why?

Purpose	Desire to Maximize	Primary Stakeholders
Patient Care	Individual accuracy, timeliness, relevance	Clinicians
Quality Improvement	Applicable to local environment; believability; actionability	Clinical and administrative leadership
Program Monitoring	Ability to detect changes over short periods of time, comparability	Implementers; funders/payers; QI field
Evaluation	Generalizability, validity, comparability	Funders, policymakers, academics

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Data Monitoring and Feedback

"My initial sense of measuring was . . . this isn't worth it. I'm a good doctor, I work very hard, I keep up with the literature. I didn't think measurement would make a difference. It was a striking and difficult experience when I realized I wasn't doing as good a job as I thought, as measured . . . If you assume you are doing a good job, you are leave the door wide open for not doing a good job. If you measure and improve at whatever level you start – if you can show improvement, that's the part that's far more inspiring."

Source: S. Alidina et. al. *American Journal of Managed Care*, 2014.

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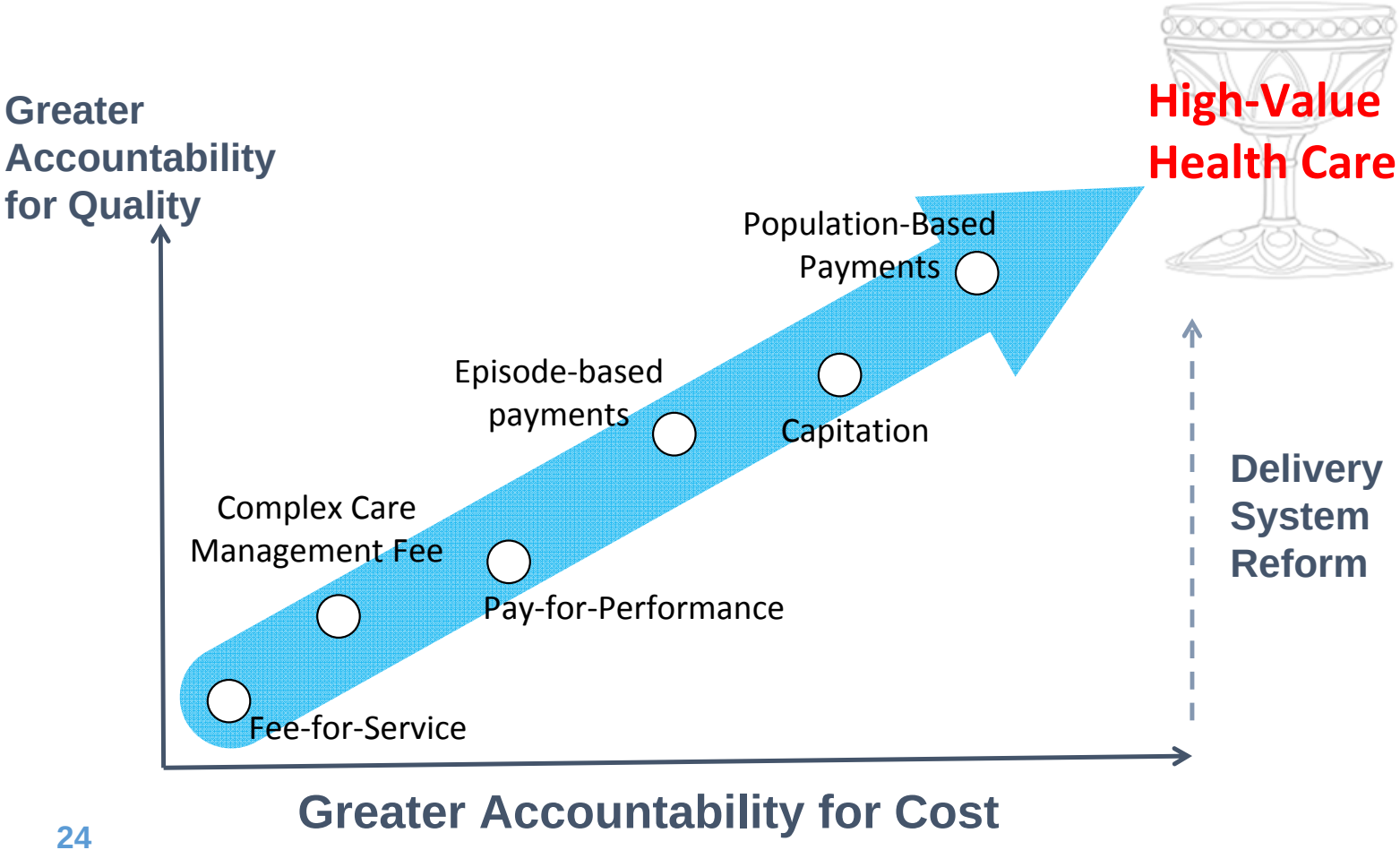
Data Monitoring: Practical Tips

- Seek usefulness, not perfection
- Keep it simple
- Balanced set of measures
- Use quantitative and qualitative
- Measure small samples to start
- Form measurement teams
- Display key measures with trends over time
- Build it into daily work
- Review with teams on monthly basis; leadership involvement

What helps practice transformation?

Payment Reform Now Moving in the Direction Toward Value Change



Challenges in the Use of Incentives to Drive Improvement Within an Organization

1. Organizations are built on trust. Modifying incentives will call that trust into question, at least initially.
2. Current incentive program designs are based on traditional rational economic theory
3. Financial rewards can be useful, but can also crowd out intrinsic motivation and degrade performance
4. Evidence from non-health care settings suggests several ways to harness financial and non-financial incentives to produce culture change

Humans are PREDICTABLY IRRATIONAL

- **Behavioral Economic Theory**
  - Humans deviate from "purely rational" behaviors in systematic ways
- **Size of incentives matters, but how they are delivered may be even more important**
  - Framing (loss or gain)
  - Immediate or lagged
  - Level of uncertainty, complexity of the reward

Sources: Ariely, D. (2008). Predictably irrational. New York: HarperCollins.
Mehrotra A, Sorbero ME, Damberg CL, Using the lessons of behavioral economics to design more effective pay-for-performance programs. *American Journal of Managed Care*, Vol. 16, No. 7, 2010, pp. 497-503.

Avoiding Crowd-Out of Intrinsic Motivation

- **Organizational Culture**
  - Hospitals with lowest 30-day mortality rates for heart attack patients…
    - Involve physicians in the incentive design process (self-determination)
    - Had a clear mission and highly involved senior management teams
    - Had non-punitive/learning environment, willing to admit & improve errors/gaps in care (appeals process)
- **Appeal to intrinsic motivation (do not rely on solely on financial/extrinsic awards)**
  - Commitment contracts, allowing physicians to volunteer goals
  - Peer comparison reports to measure performance associated with financial rewards
- **In-kind or symbolic rewards less likely to "crowd out" intrinsic motivation**

Sources: Curry, L. A., Spatz, E., et al. (2011). What distinguishes top-performing hospitals in acute myocardial infarction mortality rates?: a qualitative study. Annals of Internal Medicine, 154(6), 384-390.

Behavioral Economics Principles

Principle	Description
Limits of information provision	People rarely respond to information alone
Inertia or status quo bias	People prefer familiar routines
Choice overload	Having too many choices impedes decisionmaking
Immediacy	A reward today provokes stronger response than a reward in the future
Loss aversion	The same incentive is more powerful framed as a loss than as a gain
Relative social ranking	People care about how they compare with others they know or those nearby
Goal gradients	People try harder when close to achieving a goal
Limits of willpower	Willpower is a limited resource across daily activities
Mental accounting and salience	People are more likely to notice a bonus given as a separate check

Emanuel EJ et al. Ann Intern Med 2016

What helps practice transformation?

Implementation Guides and Tools

- Patient-Centered Medical Home Assessment (PCMH-A)
- 13 Implementation Guides provide implementation strategies, tools and case studies
- 23 tools that can be used to test or apply the key changes, including an NCQA PMCH Recognition Crosswalk
    - Downloadable registry of tools and resources
- 38 webinars
- 3 policy briefs on medical home payment and health reform
- 15+ peer-review papers (and more coming)

http://www.safetynetmedicalhome.org/

“Improvement moves at the speed of trust.”

Peter Pronovost, MD
The Johns Hopkins University

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