ACO/PCMH and the Role of Clinical Integration in Transitions of Care: Learn How to Successfully Use the Patient Journey Model and Tools for Improving Ratings

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Primary Care

Practice Management

Health IT

Patient Service

Quality Built In

Great Outcomes
Primary Care

Great Outcomes

Quality Built In

Patient Service

Practice Management

Health IT

Culture of Improvement
Performance Measurement
Reliable Systems

Financial Personnel
Clinical Systems

Convenient Access
Personalized Care
Care Coordination

Process Automation (EHR)
Communication
Connectivity
EBM Support
Clinical Information Systems

Continuous Healing Relationship
Whole Person Orientation
Family and Community Context
Comprehensive Care

Patients
Office Staff
Physicians
Community
Principles of The Patient Centered Medical Home/Accountable Care/Clinical Integration

- Personal Physician trained to provide continuous, comprehensive care
- Physician-Directed Medical Practice
- Whole Person Orientation
- Coordinated Care
- Quality and Safety
- Enhanced Access to Care
- Payment appropriately recognizes added value provided to the overall system

“Better patient care for the best price”
On the Path Toward Accountability

Uncertainty of Timing, Not Direction, Our Principal Strategic Challenge

Provider Cost Accountability

Prospective Payment System
Pay-for-Performance
Hospital-Physician Bundling
Episodic Bundling
Shared-Savings Model/ACO
Capitation

Source: The Advisory Board, 2010
## Evolution of Payment Reform

### Past and Emerging Models of Accountability in Provider Payments

<table>
<thead>
<tr>
<th>Supporting Better Performance</th>
<th>Paying for Better Performance</th>
<th>Paying for Higher Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pay for reporting.</strong> Payment for reporting on specific measures of care. Data primarily claims-based.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Payment for coordination.</strong> Case management fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).</td>
<td><strong>Pay for performance.</strong> Provider fees tied to one or more objective measures of performance (e.g., guideline-based payment, nonpayment for preventable complications).</td>
<td><strong>Episode-based payments.</strong> Case payment for a particular procedure or condition(s) based on quality and cost.</td>
</tr>
<tr>
<td><strong>Shared savings with quality improvement.</strong> Providers share in savings due to better care coordination and disease management.</td>
<td><strong>Partial or full capitation with quality improvement.</strong> Systems of care assume responsibility for patients across providers and settings over time.</td>
<td></td>
</tr>
</tbody>
</table>
Making It Real for You: Workflow Redesign

- Prevention and Wellness
- Chronic Diseases
- Population Management
- Care Teams
- Your Patients

The Patient Pathway
Patient Care Pathway Creates a Map of the Patient Experience through the Healthcare System

My Practice — New Considerations:

- Diagnosis
- 6-Month Follow-Up Visit
- 1-Year Follow-Up Visit

Coordinated care team
Patient empowerment
Health literacy
Patient population management
Electronic medical records

Patient Dashboard
- Treatment plan
- Other considerations:
  - Patient history
  - Culture
  - Etc.

Physician discusses long-term disease management plan

Patient: Diagnoses

RN Coordinator

Office calls/emails with self-management & education to patient & family unit

Patient: Follow-up 6 months after diagnosis

Patient Dashboard
- Treatment plan
- Other considerations:
  - Patient history
  - Culture
  - Etc.

Physician discusses long-term disease management plan

6-Month Follow-Up Visit

RN Coordinator

Office calls/emails with appointment reminder

Patient: Follow-up 1 year after diagnosis

Patient Dashboard
- Treatment plan
- Other considerations:
  - Patient history
  - Culture
  - Etc.

Physician discusses long-term disease management plan

1-Year Follow-Up Visit

Patient Group Education

RN Coordinator

Other opportunity for patient to enroll questions to RN

Patient: Follow-up 1 year after diagnosis

Patient Dashboard
- Treatment plan
- Other considerations:
  - Patient history
  - Culture
  - Etc.

Physician discusses long-term disease management plan

Electronic medical records

EMR

- Determine patient Health Literacy
- Patient self-management
  - Review diet and exercise plan
  - Assess medication adherence
- Non-smoking Medication Review: Patient brings Rx, medications in form (supplements/vitamins) and TELLs YOU how they take them

Other considerations:
- Patient history
- Culture
- Etc.
Chronic Care Model (CCM)

Community

Resources & Policies

Health System

Health Care Organization

Clinical Information Systems

Decision Support

Delivery System Design

Self-Management Support

Improved Outcomes

Productive Interactions

Informed, Activated Patient

Prepared, Proactive Practice Team

Slide from E. Wagner
The Patient Dashboard: A Means to Assess, Monitor, and Modify

### Initial Visit

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<th>Test</th>
<th>Data</th>
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<tbody>
<tr>
<td>Height</td>
<td>5´6&quot;</td>
</tr>
<tr>
<td>Weight</td>
<td>160 lbs</td>
</tr>
<tr>
<td>BMI</td>
<td>25.8 kg/m² (overweight)</td>
</tr>
<tr>
<td>Average of 3 office BP measures</td>
<td>140/89 mm Hg</td>
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</table>
| Treatment                     | • HTN management: ACE inhibitor (ramipril 10 mg qd); (second medication of choice)  
                                • Diabetes management: metformin 850 mg bid |

### 6-Week Visit

<table>
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<th>Test</th>
<th>Data</th>
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<tbody>
<tr>
<td>Height</td>
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</tr>
<tr>
<td>Weight</td>
<td>155 lbs</td>
</tr>
<tr>
<td>BMI</td>
<td>25.0 kg/m² (slightly overweight)</td>
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<tr>
<td>Fasting blood glucose</td>
<td>110 mg/dL</td>
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<tr>
<td>Average of 3 office BP measures</td>
<td>127/78 mm Hg</td>
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</tbody>
</table>
| Treatment                     | • No change to meds  
                                • Continue nonpharmacologic interventions  
                                • Focus on lifestyle changes to control blood glucose |

*The information presented in this case is a hypothetical example and not based on an actual patient*
# The Patient Pathway Highlights Team-Based Care Models: Every Member Plays A Part

## Shared Responsibilities to Reach a Common Goal

<table>
<thead>
<tr>
<th></th>
<th>Patient Registry</th>
<th>Motivational interview</th>
<th>Checked medication adherence</th>
<th>Updated EMR</th>
<th>Distributed educational tools</th>
<th>Lifestyle SMBG (diet/exercise)</th>
<th>Outreach to patient after appointment</th>
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<td><strong>Nurse/NP/P A</strong></td>
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<tr>
<td><strong>Office Staff</strong></td>
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<tr>
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Evolution of Expectations for Physicians—Clinical Integration

- Team-based care
- Focus on the top of license/training & interest
- Improved communication
- Improved data flow & access
- Right patient at the right time
- Patient-centered aligned incentives – outcomes, quality, cost
- External accountability – outcomes, quality, cost
The Virtual Medical Home

- ACO
- Payors
- Buyers
- Providers
The Bottom Line: Volume to Value

• Quality / Cost
  • Maximize the numerator
  • Decrease the denominator
LEADERSHIP

The leader always sets the trail for others to follow.