Transforming Care with Data and Relationships

Why is something that makes so much sense so hard to do?
Today’s agenda

• Understanding the task
• How the task is rooted in your brain
• Learning to play a new game
• Why data and leadership matter
• Case study
Health care cost is consuming the American economy.
The rational response to fires

- National coordinated effort to rationalize and optimize efficiency and efficacy
The all too human response

- We’ve known how to spray each other for years, and we’re good at it
- We don’t know how to fight fires
- Spraying each other is familiar and comfortable, albeit unpleasant
- Fighting fires is the unknown
It’s not a math problem. It’s a sociology problem.

- We don’t make decisions about important stuff the way we think we do
- We don’t like each other much, from decades of spraying each other
- We don’t understand that those wet people over there are now essential to us winning the game
How we thought we make decisions, circa 1980

- Thought enters our consciousness
- Make rational assessment
- Make decision
- Have feelings about decision
How we actually make decisions

- Brain perceives input in limbic system (responsible for fight or flight)
- Brain decides on necessary action
- Feet already moving
- Input reaches cortex, where we make up reason why our feet are already moving
- *And so we prefer the painful familiar to the unknown*
If only we could start with a blank slate. But instead...

- Decades of fighting over money
- Siloed bottom lines purposed to perpetuating siloed bottom lines
Your job, Mr. Phelps…
Theory Of The Game

- Hedgehog concept: change provider behavior
- Clean data + committed peers = physician change
- Two critical functions:
  - Turning data into actionable information and guidance
  - Building and maintaining relationships so immunologically identified as self, not other
How Do We Learn To Play Games?

• Learn the rules
• Find the scoreboard
• Listen to the coach
• Improve by practicing and playing
What equipment do we need to play?
What’s On The Equipment List?

• “Clean Data + Committed Peers = Physician Change”
• Clean Data is composed of reliable data streams and analytics; the translation of information into knowledge
• Committed Peers means physician leaders who are willing to speak the hard truths and model group behavior
• And…
Trust.
“Trying to change any bizperson is difficult. Trying to change someone who doesn’t trust you is almost impossible.”—Tim Sanders, *Love is the Killer App*
Clean Data

• Claims set for 2-3 years to understand utilization of population to be managed
• Valuation of each service, expressed as a pmpm
• Adjust historical run rate based on changes to unit pricing, introduction of new units, e.g., new drugs
• Appropriate risk corridors
Committed Peers

- Clinical leaders who understand the financial task
- Letting the data speak the truth and point the way
- Integrity
- Level 5 leadership: fierce resolve, humility, dedicated to a future it might not inhabit
Case Study

- 40 PCPs organized into 15 practices (largest practice= 6 physicians)
- Admitting to two competing hospital systems
- Entering risk arrangement
- ~6000 beneficiaries
- No common EHR
Baseline

• “We’re all good docs, so we should be good at this naturally.”
• Utilization 1700 bed days/1000
• Diffuse referral patterns
First Year Experience: Large Deficits

• Kubler-Ross stages of grief
  – Denial
  – Anger
  – Bargaining
  – Acceptance/ownership of performance
• The beginnings of mutual accountability—”you’re a great friend, but I’m not sure I want to be in business with you”
Later Results

• Year 2 referral patterns narrowed based on cost, communication, and service to PCPs=
value
• Referral rate to nonpreferred specialists drops by two-thirds
• Bed days 1700 to 1300
• Erased deficit by end of year 2, and began paying bonuses
The greatest consistent damage to businesses and their owners is the result, not of bad management, but the failure, sometimes willful, to confront reality.—Larry Bossidy and Ram Charan, Execution
Thank you!

Jay Want, MD
Want Healthcare LLC
jay@wanthealthcarellc.com
303.388.0919
So who knows about this?

- Dan and Chip Heath, *Switch*
- John Medina, *Brain Rules*
- Dan Gilbert, *Stumbling on Happiness*
- Daniel Kahneman, *Thinking Fast and Slow*
Resources on leading change

• Getting to Yes by Roger Fisher, William Ury, and Bruce Patton
• “Level 5 Leadership: The Triumph of Humility and Fierce Resolve” by Jim Collins, HBR On Point, Product no. 5831
Change is hard. Make it easier for people.

- Establishing a sense of urgency
- Forming a powerful guiding coalition
- Creating a vision
- Communicating the vision
- Empowering others to act on the vision

Source: *Leading Change* by John Kotter
Change is hard. Make it easier for people.

- Planning for and creating short-term wins
- Consolidating improvements and producing still more change
- Institutionalizing new approaches

Source: *Leading Change* by John Kotter
Changing The Way We Change: Four vital signs of a collaboration

• Conflict: is it dealt with openly and constructively?
• Learning: Does the collaboration learn and generalize learning?
• Identity: Do the participants identify with the collaboration, or just their work group?
• Power: Do people feel they have the power to affect their own work conditions?
About your speaker

- General internist by training
- Ran provider-owned MSO that is now a Pioneer ACO
- CMMI Innovation Advisor
- CMO for Center for Improving Value in Health Care (Colorado)
- TA provider for AF4Q (RWJF)
Take Homes

• Providers can organize and begin to perform clinically and financially with proper infrastructure: data, analysis, leadership, and personnel to facilitate change
• Tipping point is cultural/attitudinal: who is responsible for my poor performance?
• Risk should be proportional to ability to create physician change to improve performance, and actuarially sound
How Data is Used to Drive System Transformation in ME, NH and VT
Using Data to Drive Transformation
Dartmouth-Hitchcock Experience

Kevin Stone
CHI Healthcare Transformation Learning Symposium
May 21, 2013
Drivers to Accomplish D-HH Pioneer ACO Aim

Aim and Outcome

Achieve Healthiest Population Possible

Primary Drivers

Provide Right Care at Right Place and Right Time

Effective Primary Care Engagement

Secondary Drivers

Effective Care Coordination
- Assess Patient Risk/Health Needs
- Manage Transitions in Care
- Focus on high risk patients

Use Technology and Data to its Maximal Functionality for Patients and Providers

Effective Distribution of Care Pathways throughout System

Patient Engagement with Primary Care
- Provide Performance data to clinicians
- Incorporate Behavioral Health
- Fully Deploy Shared Decision Making

Effect Specialist-Primary Care clinician relationships

Dartmouth-Hitchcock
Information Suite
creating a Single Source of Truth

Integrating clinical information, claims data, and patient reported information
- Population health analytics
- Predictive modeling
- Quality performance benchmarking

Enhancing EHR data
- Patient-centric data model
- Single source for all users
- Actionable information
Online Views

enabling patient & population management

- Supports & enables management of patients and populations using a single source of truth
- Facilitates decision support based on evidence-based medicine and best practices
- Encourages cost-effective personalized care

### Administrator View
- population level financial risk
- individual system trends
- actual and projected performance and cost comparisons
- risk based contract concerns & issues

### Physician View
- population health, patient experience & predicted cost information
- benchmark performance against peers
- focus efforts on patients at highest clinical or financial risk

### Care Coordinator View
- patient census
- clinician orders
- application recommendations
- follow up scheduling tool
- risk level & priority
- encourages patient and medical team interaction
What % of my patients with a diagnosis of HTN have both systolic & diastolic BP values less than 140/90?

Hypertension Control by Medical Home

Patients seen in last 3 years.
Each month reflects most recent blood pressure taken in the 12 months.
Using Data to Drive Improvement
Maine PCMH Pilot

Lisa M. Letourneau MD, MPH
Health Care Symposium
May 2013
PCMH Evaluation & Data for Improvement

• Practice changes: culture surveys, self-reports
• Patient experience of care (CG-CAHPS surveys)
• Clinical quality measures
• Cost & resource use (Practice Performance Reports)
  – e.g. Total costs, hospitalizations, readmissions, ED use, imaging
“A strong adaptive reserve includes such capabilities as a strong relationship system within the practice, shared leadership, protected group reflection time, and attention to the local environment. In the beginning of NDP, practices varied considerably in their adaptive reserve, and that capability was major determinant of a practice's initial progress” (NDP)
% of patients age 65 years and older with at least one pneumococcal immunization in their lifetime

Family Medicine -

- Pilot Goal
- This Practice
- ME Median
- NH Median

Time Period:
- 2008
- 2009
- 2010
- 2011
- 2012
- 2013

Graph represents the percentage of patients by quarters from 2008 to 2013.
Practice Performance Summary

Includes:

• Practice panel demographics
• Practice performance compared to peers
• Evaluation of overall effectiveness & efficiency
• Practice score on key utilization measures
• Opportunities for improvement
Contact Info / Questions

Lisa Letourneau MD, MPH
  • LLetourneau@mainequalitycounts.org
  • 207.415.4043

Maine Quality Counts
  • www.mainequalitycounts.org

Maine PCMH Pilot
  • www.mainequalitycounts.org
    (See “Programs” → PCMH)
How Data is Used to Drive System Transformation

Lisa Dulsky Watkins, MD
Associate Director, Vermont Blueprint for Health
Department of Vermont Health Access
lisa.watkins@state.vt.us

Healthcare Transformation Learning Symposium
May 21, 2013
A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services

Multi-insurer payment reform that supports this foundation of medical homes and community health teams

A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry

An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact
INTEROPERABILITY

Patient: John Doe
Age: 38
Notes: Presented with acute abdominal pain

Patient: John Doe
Age: 38
Notes: Presented with acute abdominal pain

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Central Registry provides:
- visit planners
- outreach tool
- care coordination
- reporting
Health Information Transmission (Sprints)

- “All hands on deck” in a systematic process
- Focus on a complete end to end process for moving useful data
- From source (e.g. EHR) through VT HIE to Central Registry
- Focus on data quality including quantitative assessments
- Measure of success - clinician attestation (data is trustworthy, reliable)
- Strategies that impact data quality statewide (e.g. translations)
- Reliable centralized clinical registry for multiple purposes
Regional Tools and Learning: Data Driven Initiatives for System and Payment Reform
The Future of Health Care in Vermont

• “Because of escalating costs, the future effectiveness of health care in Vermont will depend on whether timely and significant changes can occur”
• “A more organized and integrated system of health care in Vermont is both essential and feasible”
• “Collaboration among our two regional medical centers, and strong regional relationships with community hospitals will result in more efficient use of capital, eliminate overlapping services and competition, result in cost advantages for both consumers and providers”

• Second Grafton Conference June 24-26, 1984, --- Sponsored by the Windham Foundation, Grafton, Vermont
Health Care Reform in Vermont

Reliable Data is Critical for Success

- Vermont All Payer Claims Data Base (VHCURES)
  - Data base now includes Commercial, Medicaid, and Medicare claims
  - Validation of data for specific purposes remains a challenge

- Vermont Health Information Exchange (VITL)
  - Need to expand connectivity and improve data quality (normalization of data)
Office-based Physicians Using EHRs in New England, December 2012

Source: CDC/NCHS, National Ambulatory Medical Care Survey, December 2012
<table>
<thead>
<tr>
<th>Vermont Hospitals</th>
<th>Patient Demographics</th>
<th>Lab Test Results</th>
<th>Radiology Reports</th>
<th>Discharge Summaries</th>
<th>Medication History</th>
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Other Hospitals

Dartmouth Hitchcock Medical Center

Complete — The interface is in production, and contributing data to the health information network.

Pre — The interface is in production in a pre-Medicity format, but data is not being stored.

In Progress — The interface is being developed. It may be at any stage from the pre-work required of the organization, through the analysis, build, and testing prior to being moved to production.

Hold — The organization is not actively working on the interface.
Regional Showcase Presentations
Developing Standards for Payment and Delivery System Reform Models in Vermont

Ena Backus, MPP
Healthcare Transformation Learning Symposium
May 21, 2013
Overview

- Vermont Health Reform and the Role of the Green Mountain Care Board
- Payment and Delivery System Reform
- State Innovation Model Grant
- Workgroups for Supporting Payment and Delivery System Reform
Vermont Health Reform and Role of Green Mountain Care Board

- **Department of VT Health Access:**
  - Exchange
  - Expansion of Advanced Primary Care Practice Model

- **Green Mountain Care Board:**
  - Cost Containment
  - Payment reform

- **Governor’s Office:** Single payer financing and operations
Roles of the Green Mountain Care Board

**Regulation**
- Health insurer rates and rules (including the new Exchange)
- Hospital budgets
- Major capital expenditures (certificate of need)

**Innovation**
- Payment reform
- Health care delivery reform
- Data and analytics
- Payer policy
Vermont Innovation: Payment and Delivery System Reform

- Move away from Fee-For-Service
- Incorporate Performance Measures: Cost, Quality, Experience
- Include All Payers
- Build on Blueprint for Health
- HIT Connectivity

Reformed Payment and Delivery System
State Innovation Model (SIM): Supports Testing of 3 Models

- **Shared Savings Accountable Care Payments**
  - Single network of providers takes responsibility for managing the costs and quality of care/services for a group of Vermonters

- **Bundled Payments**
  - Provide a single payment to a group of providers for an acute or chronic care episode

- **Pay-for-Performance**
  - Incorporate the total costs and quality of care/services into provider compensation
Payment and Delivery System Reform Models

- Pay-for-Performance
- Population Based Payments
- Bundled Payments
- Global Budgets

Reformed Delivery System
Work Groups for Supporting Payment and Delivery System Reform

- Facilitated work groups made up of representatives from across state agencies, payers, and providers
- Work groups report to SIM Steering Committee made up of broader external stakeholders, including consumers
- SIM Steering Committee reports to SIM Core Team made up of leadership from Green Mountain Care Board, Department of Vermont Health Access, Agency of Human Services, and Agency of Administration
Work Groups for Supporting Payment and Delivery System Reform

- Model Testing Standards Work Group
- Quality and Performance Measures Work Group
- Data and Health Information Infrastructure Work Group
- Population Health Work Group
Model Testing Standards Work Group

- Currently developing standards for expanding ACOs to Commercial payers and Medicaid
  - Includes expanding shared savings to individuals and small businesses in the Exchange

- Two Medicare Shared Savings Programs
  - Accountable Care of the Green Mountains
  - OneCare Vermont
    - All hospitals in the state by July 1, 2013
    - Includes Brattleboro Retreat Psychiatric Hospital
    - Includes more than half of physicians in Vermont
Model Testing Standards Work Group

- Developing standards for expanding ACOs to include Medicaid and Commercial payers
  - Attribution standards
  - Trend standards
  - Standard calculation and distribution of savings
  - Lock-in standards
  - Payment alignment standards
  - Standard risk adjustment (sub-group)
Quality and Performance Measures Work Group

- Focusing on Commercial payers and Medicaid
  - Recognizing differences in populations but aiming for relative consistency across payers

- Quality and performance measures
  - To improve quality and performance
  - To qualify shared savings payments
  - To assess utilization
Quality and Performance Measures Work Group

- Building from applicable Medicare Shared Savings Program Measures
- Considering additional currently reported measures
- Considering additional measures not currently reported
- Considering areas for greatest improvement
- Streamlining survey based measures (sub-group)
Workgroups for Supporting Payment and Delivery System Reform: Moving Forward

- Expand focus of standards and measures groups to include Bundled Payment and Pay-for-Performance models
- Implement agenda-driven facilitation with Data and Health Information Infrastructure and Population Health work groups
Three trajectories of transformation: health care payment, care delivery and regulation

Payment per person, or per population

More organized care delivery (a “system”)

Payment per unit of service

Regulation of systems based on outcomes

Less organized care delivery (an individual practice or hospital)

Regulation of discrete institutional inputs
CITY OF PORTLAND POS
EMPLOYEE HEALTH PLAN

Collaborative work to impact change for high quality and efficiency
Presented by Janice Kimball, Benefits Manager
City of Portland Labor/Management Health Advisory Committee (LMHAC) composed of a representative from each of the 8 collective bargaining units and equal representation from management. Committee monitors claims experience and reviews data that provides information about costs and utilization associated with inpatient, outpatient, professional and prescriptions.

10/11-9/12 compared to 10/10-9/11 (unadjusted paid pmpm)
IP = $71.23 to $86.29
OP = $115.69 to $96.24
Professional = $137.61 to $133.91
Total Medical = $324.54 to $316.44
Rx = $49.08 to $52.56
Facts About the City’s Health Plan

- 1365 subscribers, 2700 covered lives
- Current FY13 self-funded medical budget = $14.8 million
- Current weekly premium cost for employees = $0 Ee, $42.70 Ee & Child(ren), $60.98 Ee & Adult, $103.67 Ee, Adult & Child(ren)
- $10, $15, $20, $50 therapy, PCP, specialist & ER copays
- $0 deductible
- 10% coinsurance outpatient & inpatient hospital services
- 20%/25%/30% Rx coinsurance
- PCP designation required for enrollment
- PCP referrals required
Fall 2011 – Decision point for leveraging membership of Maine Health Management Coalition. Seek Coalition’s assistance to begin conversation with LMHAC regarding current plan design and what can be done to address group’s concern about rising premium costs and potential impact for ACA Cadillac tax in 2018.

LMHAC attends MHMC annual symposium November 2011. All members read T.R. Reid’s “The Healing of America” and have the opportunity to hear him speak.

City issues RFP for health plan administration services December 2011. Seeking 3 year service agreement with partner that can address quality and efficiency of health care delivery. Aetna new partner effective July 2012.
Value based purchasing comprehensively addresses the way health benefits are structured and utilized by employees. Implementing value based programs increases the likelihood that consumers will make positive behavioral changes, which will lead to better health and curbed health care costs for plan sponsors and employees alike.

**Module 1:** Examining What You Have, Determining What You Want  
**Module 2:** Bright Spotting: Best Practice Locally, Regionally and Nationally  
**Module 3:** Securing High Quality Healthcare Services  
**Module 4:** Preventing Poor Health  
**Module 5:** Monitoring Your Benefits Package to Respond to Your Group’s Needs and Assure the Best Value for Benefit Dollars  
**Module 6:** Designing Your Benefit Package  
**Module 7:** Communications Campaign – Explaining to Plan Members
• LMHAC brainstorms after education modules
• Members need to be engaged in their health care
• Wellness critical for improvement of population health
• Desire to achieve high quality and cost efficiency
• Outcomes important
• Management of chronic illnesses critical for avoidance of emergency room utilization and hospital admissions/readmissions
• Lower rate of premium increase
CITY OF PORTLAND, MAINE

Assessing Our Population

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<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
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<tr>
<td>Asthma</td>
<td>1.4%</td>
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<tr>
<td>Allergy</td>
<td>1.0%</td>
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<tr>
<td>Depression</td>
<td>6.1%</td>
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<tr>
<td>Diabetes</td>
<td>3.8%</td>
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<tr>
<td>Gastritis</td>
<td>3.3%</td>
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<tr>
<td>High Blood Pressure</td>
<td>7.3%</td>
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<tr>
<td>High Cholesterol</td>
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<tr>
<td>Low Back Pain</td>
<td>6.4%</td>
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<tr>
<td>Migraines</td>
<td>1.8%</td>
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CITY OF PORTLAND, MAINE

Data Goals

• Identify and provide better care to high utilizers through data coordination with Maine providers.
• Find and promote high value care in our area for lower costs and better health outcomes.
• Create specific, targeted interventions based on the City’s unique population characteristics.
• Monitor how wellness programs and benefit design strategies affect our City’s health and bottom line.
Emergency Room Utilization

- Recent MHMC Reporting shows change of 7.0%
- $693,000 paid; $21.52 paid PMPM
- 632 services for 492 claimants
- 80% with 1 ER visit, 20% with multiple ER visits
- 41% of paid expenses attributed to claimants with multiple visits
- 21 ER visits for chronic conditions (asthma, migraine, diabetes, hypertension)
- 35 ER visits for potential non-emergent care (acute pharyngitis, bronchitis, sinusitis)
CITY OF PORTLAND, MAINE

Wellness Program

- Wellness allowance provided by partner, Aetna
- City looking for expertise in design of wellness programming
- MHMC sponsors “CEO Champions”
- City of Portland is one of the participants
- Access to Phil DiRusso, Worksite Health Specialist, Maine CDC
- City completes HERO Best Practice Scorecard
- Wellness Committee formed February 2013
- Wellness Program Interest Survey
- Wellness Fair June 21, 2013
Green Light – 100% Coverage

- Preventive Services – U.S. Preventive Services Task Force guidelines
- Chronic & non-chronic Care Office Visits with PCMH
- E-Visits to participating providers
- Tobacco Cessation, Nutritional Counseling
- Diagnostic Lab and Xray
- Chronic Care Generic Rx – Asthma, Diabetes, High Cholesterol, High Blood Pressure, Heart Failure
- Hospice Care & Outpatient Mental Health

Yellow Light – Shared Decision Making

- Colorectal and Prostate Cancer Procedures
- Hip Replacements
- Herniated Disc Surgeries

Red Light – Copay, Deductible and/or Coinsurance

- MRIs / CTs / PETs, Sleep Studies, Upper GI Endoscopies, Bariatric Surgery
- Knee and Hip Replacements / Resurfacing, Knee and Shoulder Arthroscopy
- Spinal procedures (such as injections) for pain
- Sinus Surgery, Chiropractic, Acupuncture, Massage Therapy, Infertility
Where do we stand right now?

- Current PCP designation shows 45% members already aligned with PCMH
- Challenge and education to move remaining 55% of members to PCMH
- All labor reps like “carrots” (services at 100% coverage)
- Some labor reps concerned about “sticks” (introduction of deductible and increased out-of-pocket maximum)
- Some labor reps concerned with attachment of wellness plan to insurance plan through premiums for singles
- Premium for singles (15%) able to be worked down to $0 by completing HRA, biometric testing, meeting with a health coach, documenting fitness related activity and being tobacco free or enrolled in a smoking cessation program
The Nature of the Patient-Centered Medical Home

Experience from the NH Citizens Health Initiative Multi-Stakeholder Medical Home Pilot

Signe Peterson Flieger
Brandeis University

May 21, 2013
Healthcare Transformation Learning Symposium
Durham, New Hampshire
The Pilot

• 9 practices across New Hampshire.
  – Mix of FQHC, hospital-owned, independent.
  – Geographically diverse.
• July 2009 through December 2011.
• Payments by four commercial insurers, average $4 PMPM.
• All sites achieved Level 3 recognition as a patient-centered medical home by NCQA (2008 standards).
Evaluation

• Site visits and interviews at each site.
• Medical Home Index.
• Surveys of Relational Coordination.
• PCMH Clinical Quality Data.
• Claims-based analysis using NH CHIS (multi-payer claims database).
WHAT THE SITES HAD TO SAY...
The medical home is a spectrum

I'm one of those believers in that you're not are or you aren't - you're somewhere in the spectrum and we're not all the way there yet. I don't think any practice ever is. We've moved along that spectrum. – Family Physician

• NCQA recognition process:
  – Useful tool to move forward along this spectrum.
  – Provided a gap analysis to identify areas for targeted improvement.
  – “having that recognition doesn't make you a medical home.” - Administrator
There is no one medical home model

- Team-based care
- Care coordination
- Standardization of care
- Disease registries
- Quality improvement processes
- Performance data and transparency
- Open access
- Behavioral health
- Patient-centeredness
Team-based Care

• Members of the team varied:
  – Provider/Nurse/Medical Assistant
  – Behavioral Health Professional
  – Care Coordinator
• Role maximization.
• “Getting the right people in the right jobs.” – Family Physician
• Provide continuity of care for patients beyond primary care provider.
• Required change in culture.
Care Coordination

• Different roles provided this service:
  – Social workers
  – Nurses
  – Shared duties across multiple positions

• Different services coordinated:
  – Social services
  – Spectrum of health care services
    • Focus on transitions

• Sometimes combined with delivery of behavioral health services.

• Seen as critical despite providing services that are not reimbursable.

• Sometimes funded by pilot PMPM payments.
Care Coordination

We like to think of ourselves as really the heartbeat of the medical home, which sounds grand, but I think it’s true. The patient is clearly the center, but if the patient is the hub of the wheel, we keep the spokes plugged in and moving forward I think. I do a lot of different things as a care coordinator. I think the overarching principle is just contact with patients, and it happens in a lot of different ways, but those touches are what make it work.

-Care Coordinator
Medical Home Index (Adult)

• Tool developed by the Center for Medical Home Improvement.

• Self-assessment across six domains:
  – Organizational capacity
  – Chronic condition management
  – Care coordination
  – Community outreach
  – Data management
  – Quality improvement/change
## Medical Home Index Scores

<table>
<thead>
<tr>
<th>Site</th>
<th>Medical Home Index</th>
<th>MHI Mean</th>
<th>MHI Org Factor Mean</th>
<th>MHI Data Factor Mean</th>
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<tr>
<td>B</td>
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<td>6.31</td>
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<td>6.36</td>
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<td>7.16</td>
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<tr>
<td><strong>Average</strong></td>
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<td><strong>5.81</strong></td>
<td><strong>5.72</strong></td>
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<td><strong>Median</strong></td>
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<td><strong>5.85</strong></td>
<td><strong>6.55</strong></td>
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</table>
Relational Coordination

• 7 communication and relationship dimensions:
  – Frequent, timely, accurate, and problem-solving communication.
  – Relationships of shared goals, shared knowledge, and mutual respect.

• Assessed through a survey based on communication and relationships between roles.

• Higher levels of relational coordination are associated with improved outcomes (e.g., better quality, higher efficiency).
Relational Coordination Scores

- Diversity of role type and function across 9 sites.
- Three site-level aggregations for relational coordination scores.
- **Clinical Core**
  - Family physician, other physician (pediatrician, OB/GYN), nurse practitioner, physician assistant, registered nurse/licensed practical nurse, and medical assistant.
- **Staff Core**
  - Clinical Core plus receptionists/front desk staff/office manager.
- **Clinical Plus Core**
  - Staff Core plus any combination of care coordinators, social workers, and/or behavioral health professionals inside the organization.
# Site Level RC and MHI Scores

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<th>RC – Staff Core</th>
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Predictors of Relational Coordination and Medical Homeness

• Having a care coordinator is associated with lower relational coordination.
• Being a hospital-owned practice is associated with lower relational coordination.
• Being an FQHC is associated with higher relational coordination.
• Few clear predictors of medical homeness.
Thoughts to leave you with...

• If you’ve seen one medical home, you’ve seen one medical home.
• Team-based care and care coordination are key elements, yet differ in implementation.
• Within NCQA Level 3 recognized practices there is significant variation in other measures related to medical home.
More thoughts to leave you with...

• As the included roles get broader in scope, relational coordination decreases (within practices).

• Data-related aspects of the Medical Home Index are higher than organizational capacity aspects.

• Having a care coordination and being hospital-owned is associated with lower relational coordination, while being an FQHC is associated with higher relational coordination.
THANK YOU!

Questions or Comments:
Signe Peterson Flieger, signepf@brandeis.edu

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