Healthcare Financial Management Association Texas

The Hows and Whys of a Patient-Centered Approach to Population-Based Healthcare

February 18, 2014
Mr. Joshua D. Halverson, Principal

- With more than 15 years of experience in healthcare strategic and business planning and financial management, Mr. Halverson possesses extensive knowledge of strategic, operational, and financial best practices among physician groups and in the context of their integration within health systems.
- Mr. Halverson specializes in economic alignment between physicians and hospitals involving acquisition, group development, compensation planning, and operations improvement.
- He leads the ECG Dallas, Texas, office.

Ms. Emma M. Mandell, Manager

- Ms. Mandell has extensive experience in healthcare management; strategic planning; care redesign; and quality, process, and performance improvement.
- Her concentration is in care and payment redesign, working with several health systems on patient-centered medical home (PCMH) and accountable care organization (ACO)/value-based delivery design, development, deployment, and strategy.
- Ms. Mandell works in ECG’s Contracting and Reimbursement practice.
Agenda

I. Welcome and Objectives
II. Strategic Vision
III. The Three-Phased Approach
IV. Key Considerations
V. Case Study
VI. Key Takeaways
I. Welcome and Objectives
I. Welcome and Objectives

Today’s Objectives

Realize the strategic importance of a PCMH transformation.

Understand the three-phased approach to building a PCMH.

Discuss key components and changes required to operate within a PCMH model.

Identify opportunities, challenges, and risks.

Learn from a case study about PCMH.
II. Strategic Vision
II. Strategic Vision

The PCMH model supports a strategic vision aimed at improving quality and community health while reducing overall healthcare spending.

Shared Vision

Creating a Healthier Community

Improving Quality

Lowering Costs

Guiding Principles

Is patient- and family-centered.

Offers demonstrable outcomes.

Will be mutually beneficial and sustainable as reimbursement methodologies evolve.

Aligns interests between providers, payors, and patients.

Supports the Triple Aim.

Encompasses the entire continuum of care.

With more than 90 commercial payors, 25 government programs, and numerous other accrediting entities leading PCMH initiatives, the momentum for PCMH continues to build.
The PCMH model has emerged as a crucial component of the future of the care delivery system.

Care delivery is reactive, inconsistent, and based on patient’s expressed needs.
Care delivery is proactive, standardized, and managed by a care team.

II. Strategic Vision
The Evolution of the PCMH

To ensure success and sustainability, the PCMH model requires a thorough and thoughtful approach with regards to design, implementation, and improvement over time.

PCMH Key Components

- Patient-Centered Care
- Team-Based Care
- Access to Care and Information
- Care Coordination
- Care Management and Population Health
- Health Information Technology (IT)
- Measurement for Improvement
- Quality and Safety

PCMH Proponents

- Primary Care Physicians
- Specialists
- Midlevel Providers
- Medical Students and Residents
- Payors
- Federal and State Government
- Patients
Recent reports suggest that PCMHs continue to demonstrate significant improvements in cost, utilization, population health, prevention, access to care, and patient satisfaction.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Location</th>
<th>Cost and Utilization</th>
<th>Population Health and Prevention</th>
</tr>
</thead>
</table>
| BlueCross BlueShield of Alabama Medical Home Program | Alabama | • Fewer ED visits and hospital days.  
• Cost savings of $1.9 million. | Compared to network average:  
• 13.6% higher rate of colorectal cancer screenings.  
• 11.8% higher rate of breast cancer screenings. |
| Highmark, Inc., PCMH Pilot | Pennsylvania | • 9% fewer inpatient admits.  
• 13% fewer 30-day inpatient readmissions.  
• 5% decrease in total PMPM costs for CAD.  
• 3.5% decrease in total PMPM costs for diabetics.  
• 2% decrease in overall healthcare costs. | No data at this time. |
| CareFirst BlueCross BlueShield | Maryland | • $98 million in total cost savings.  
• Average of 4.7% savings achieved through panels earning incentives. | 3.7% higher quality scores for PCMH panels that received incentives.  
• Rise of 9.3% in quality scores for PCMH panels from 2011 to 2012. |
| Blue Cross Blue Shield of Michigan PCMH Program | Michigan | • 8.8% fewer adult ED visits.  
• 17.7% fewer pediatric ED visits.  
• 11.2% lower rate of adult primary care sensitive ED visits. | No data at this time. |

III. The Three-Phased Approach
III. The Three-Phased Approach

ECG leverages an all-encompassing approach to PCMH transitions, ensuring the model is successful and sustainable in a market that is moving toward population health and clinical integration.

The three-phased approach provides a structured means of transforming care delivery.

**Implementation (Learning)**
- A readiness assessment is conducted.
- A shift is made to a PCMH model that aligns with the organization’s strategic goals.
- Resources are available.
- Leadership is engaged.
- The required fundamentals, structure, and design are established.

**Evolution (Adopting)**
- Processes, IT infrastructure, resource allocation, and culture evolve to fit the model and ensure value-based care delivery.
- Emphasis is placed on continuous improvement, incorporating Lean tools or other performance improvement tools to further improve the model.

**Integration (Owning)**
- Integrated with internal and external providers to optimize patient care, including specialists and hospitals.
- Clinical and financial alignment of the model.
- Leveraged for other initiatives, such as ACOs, population health, and clinical integration.
- Continued emphasis is placed on improving the model.
III. The Three-Phased Approach

*Implementation*

Implementing a PCMH can be daunting, as many organizations are not ready for the substantial transition required.

**Strategic questions to consider:**
- How does the model support the organization’s strategic goals and vision?
- How does the organization ensure clinical and financial alignment with the model?
- What is the appropriate structure and design needed?

**Fundamental elements to consider:**
- Commitment and support of clinical and administrative leadership.
- Ongoing clinical engagement.
- Staff and leadership with change management skills.
- Required capital and resources, as well as ongoing reimbursement.

*While the specifics will vary by organization, a successful implementation will consider both the strategic and tactical implications of a transition to a PCMH.*
A detailed readiness assessment is useful when exploring an organization’s ability to implement, as well as evolve and integrate the PCMH model.

Key Components

- **Care Delivery Model** – Reviews the extent that the organization provides patient-centered, team-based care; engages patients and families in their health; follows standard clinical protocols; ensures care coordination; and manages population health.

- **Care Network** – Considers the breadth of services provided within the delivery network, alignment among providers, integration of the PCMH with specialists and hospitals, and extent that performance standards are utilized.

- **IT** – Assesses the use, optimization, and deployment of IT resources to manage patient care.

- **Financial Management** – Analyzes SHIP/Stamford’s current payor contracts and determines whether restructuring of contracts is necessary to ensure reimbursement is appropriately aligned with care delivery under the PCMH model.
III. The Three-Phased Approach

Evolution

The evolution phase emphasizes practices and physicians adopting the PCMH model and making it part of their culture and processes.

Key Components

- **Cultural Change** – Physician/staff behavior and practice culture.
- **Continuous Improvement** – Continuous development and improvement of the model.
- **Ongoing Support** – Committed clinical and administrative leadership that supports and promotes operating within the model.
- **Time** – Additional time needed to transition to the model and the impact on schedules and volume.
- **Resources** – Additional resources requisite to support the model as it evolves (e.g., training programs, patient engagement services, staffing needs, healthcare IT).

When taken together, these elements help ensure that the introduction and ongoing management of the PCMH model will be as seamless as possible.
III. The Three-Phased Approach
Evolution – Staffing Considerations

To operate a successful PCMH, job descriptions will need to be updated and staff trained to work at the “top of their license.”

Example Retraining Program at Kaiser¹

<table>
<thead>
<tr>
<th>PCP</th>
<th>Midlevel Providers</th>
<th>LPNs/MAs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEFORE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treats and educates both simple and complex patients.</td>
<td>Spends most of time triaging incoming patients.</td>
<td>Sees patient to room.</td>
</tr>
<tr>
<td>Manages midlevel providers and LPNs/MAs.</td>
<td></td>
<td>Performs basic administrative tasks.</td>
</tr>
<tr>
<td><strong>AFTER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creates care plan for simple and complex patients, which support staff can carry out.</td>
<td>Treats simple and complex patients according to PCP’s care plan.</td>
<td>Treats simple patients per care plan.</td>
</tr>
<tr>
<td>Focuses time on treating complex patients.</td>
<td>Manages LPNs/MAs.</td>
<td>Educates and coaches patients.</td>
</tr>
</tbody>
</table>

¹ Source: The Advisory Board Company and Health Care Advisory Board interviews and analysis.

Physicians offload certain functions and free up time to treat patients who need it most.
III. The Three-Phased Approach
Evolution – Staffing Considerations (continued)

Reallocating tasks away from the physician is critical to success. Compared to non-PCMH clinics, PCMH physicians more often delegate responsibility for hospital/referral coordination, data analysis/entry, and triage.

Sites Reporting Physicians as Task Owners, by Task

<table>
<thead>
<tr>
<th>Task</th>
<th>Non-PCMH</th>
<th>PCMH</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Analysis</td>
<td>15%</td>
<td>3%</td>
<td>↓80%</td>
</tr>
<tr>
<td>Data Entry</td>
<td>9%</td>
<td>3%</td>
<td>↓67%</td>
</tr>
<tr>
<td>Handle Triage Questions</td>
<td>8%</td>
<td>3%</td>
<td>↓63%</td>
</tr>
<tr>
<td>Referral Coordination</td>
<td>12%</td>
<td>5%</td>
<td>↓58%</td>
</tr>
<tr>
<td>Hospital Coordination</td>
<td>50%</td>
<td>24%</td>
<td>↓52%</td>
</tr>
<tr>
<td>Plan Visits</td>
<td>8%</td>
<td>5%</td>
<td>↓38%</td>
</tr>
<tr>
<td>Support Patient Self-Management</td>
<td>27%</td>
<td>18%</td>
<td>↓33%</td>
</tr>
<tr>
<td>Sore Throats</td>
<td>73%</td>
<td>68%</td>
<td>↓7%</td>
</tr>
</tbody>
</table>

NOTE: Non-PCMH n = 23 to 26; PCMH n = 36 to 41.

1 Data from The Advisory Board Company.
The roles and responsibilities as well as FTE requirements within PCMH practices vary from traditional practices.

### Industry Standard Roles

<table>
<thead>
<tr>
<th>Clinical Roles</th>
<th>Administrative Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>Quality Improvement and/or</td>
</tr>
<tr>
<td>Midlevel (e.g., NP, PA)</td>
<td>Clinical Analysis Support</td>
</tr>
<tr>
<td>Nurse</td>
<td>Reporting/Decision Support</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>IT/Technical Support</td>
</tr>
<tr>
<td>Case Manager</td>
<td>Billing Support</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Program Manager</td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
</tr>
<tr>
<td>Nutritionist</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
</tr>
</tbody>
</table>

### FTEs Added to Support PCMH

- **48%** Did Not Add FTEs
- **52%** Added FTEs

N = 33

1 Source: The Advisory Board Company.

_There is no single answer to the staffing model, but there are multiple variables to consider – panel size, visit volume, visit length, support staff, and IT capabilities._
### III. The Three-Phased Approach

**Evolution – Panel Size Considerations**

In addition to staffing, consideration must be given to panel size. The PCMH introduces new time-consuming tasks, making panel-sizing decisions even more important.

<table>
<thead>
<tr>
<th>Decrease</th>
<th>PANEL SIZE</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Driver</strong></td>
<td>Larger practice.</td>
<td>Smaller practice.</td>
</tr>
<tr>
<td></td>
<td>High severity of illness, more time required for acute and chronic care.</td>
<td>Low severity of illness, more time spent on preventive care.</td>
</tr>
<tr>
<td></td>
<td>Basic EHR system or none at all.</td>
<td>Fully equipped and integrated EHR, patient portal, and telemedicine.</td>
</tr>
<tr>
<td></td>
<td>Patients interact with many physicians, increasing return rate.</td>
<td>Patients typically interact with PCP only, lowering the visit return rate.</td>
</tr>
<tr>
<td></td>
<td>Minimal clinical support, physician still performs most coordination and other support duties.</td>
<td>Robust care team operating at top of license, allowing physician to care for complex patients.</td>
</tr>
</tbody>
</table>

**Components**

- Physician Count
- Patient Severity
- IT Infrastructure
- Provider-Patient Continuity
- Care Team Size and Utilization

*PCMH panel sizes are often smaller at first but have the potential increase as the PCMH becomes business as usual.*
This mismatch between workload and capacity has been a key driver of the shift to interdisciplinary, team-based patient care.

With the number of insured increasing and the patient population aging, physicians do not have enough time to provide comprehensive care.

### Time Required To Meet Clinical Guidelines For 2,500 Patient Panel

<table>
<thead>
<tr>
<th></th>
<th>Hours/Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Needs</td>
<td>3.7</td>
</tr>
<tr>
<td>Chronic Needs</td>
<td>10.6</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>7.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21.7</strong></td>
</tr>
</tbody>
</table>

While there is high variability in PCMH panel size, academic research has shown reasonable sizes range from 1,400 to 1,950 patients.¹

A 2012 study modeled how panel sizes would change if portions of preventive and chronic care services were delegated to nonphysician team members.

Reasonable Panel Size Based on Percentage of Care Delegated

Panel Size

Preventive Care Delegated Chronic Care Delegated

1,400 50% 25% 20%
1,525 60% 30% 40%
1,950 77% 47% 60%

The final phase, integration, goes beyond the PCMH itself to include hospitals, specialists, and payors, as well as other initiatives.

The Results of Integration Are Threefold:

- Patient care is improved as physicians work together to develop best practices and standardized ways of practicing medicine.
- Population health management is improved as organizations operate more efficiently and keep costs down, improving long-term viability.
- Organizations are well-positioned in the competitive healthcare market as a high-quality, high-value provider.

Integration Opportunities

<table>
<thead>
<tr>
<th>Medical Neighborhood</th>
<th>Payors and State Initiatives</th>
<th>Other Initiatives</th>
</tr>
</thead>
</table>
| Extend the PCMH to encompass the full care continuum and include specialists and hospitals (e.g., NCQA specialty recognition and TJC hospital recognition). | Align reimbursement and payment arrangements with the PCMH model. | Leverage the PCMH to achieve larger initiatives, such as developing an ACO, clinical integration, and population health.

The PCMH model is expanded to integrate the previously fragmented and inefficient healthcare system, focusing on the patient’s total health picture.
III. The Three-Phased Approach
Integration – Funding and Reimbursement Considerations

Costs to implement and maintain a PCMH model vary based on practice size, existing capabilities, time, and patient population characteristics. Innovative payment models that support the PCMH continue to be a priority as payors and providers realize the need for clinical and financial alignment of care and payment delivery models.

Potential Payment Models to Support Medical Home Models

- Share in savings from reduced hospitalizations.
- Bonus payments for achieving measurable and continuous quality improvements.
- Pay for care coordination within a practice and between providers.
- Recognize the value of care management that falls outside the normal visit.
- Recognize case mix differences in patient populations.
- Support e-mail and telephone consultation.
- Support adoption and use of health IT for quality improvement.
- Recognize the value of remote monitoring of clinical data using technology.

Maintain payment levels for face-to-face visits.

Source: Authors’ summary of “Joint Principles of the PCMH” released by the AAFP, AAP, ACP and AOA in 2007.
Recognizing this issue, payors and state initiatives offer some type up-front funding, as well as innovative payment models that focus on paying for value.

**Horizon BCBS**
Piloting care coordination fees and shared savings in New Jersey.

**BCBS Michigan**
3,800 PCMH-designated physicians earn an enhanced fee for office visits.

**Aetna**
Paying PCMH providers an extra $2 to $3 PMPM for coordinating care.

**United Healthcare**
Provides PCMHs with care management fees and incentive payments.

**CareFirst BCBS**
Providers receive a 12% increase in fee schedule, and new fees for care plans.

**WellPoint**
Increased FFS fees, PMPM fees for clinical coordination and shared savings.
IV. Key Considerations
IV. Key Considerations

Opportunities

- Prepare the organization to better manage population health.
- Improve the quality and value of healthcare while reducing or controlling costs.
- Improve efficiency of patient flow, access, and scheduling.
- Position the organization to be successful in value-based purchasing arrangements.
- Create a system-wide, standardized practice of medicine, ensuring seamless care across the continuum of care.
- Expand the PCMH model into specialty practices and hospitals.
- Leverage the PCMH as the outpatient arm of an ACO.
- Align care delivery with payment delivery, moving from volume- to value-based reimbursement.

There are several opportunities when implementing the PCMH model of care, both clinical and financial.
IV. Key Considerations

Challenges

In order to build a successful PCMH model, there are typically several challenges that need be overcome.

Challenges

• Maintaining continuous system-wide buy-in and support for the model.

• Meeting operational requirements.
  – Appropriate level of staffing needed.
  – Additional or revised work flows, policies, and procedures required.
  – Utilization and optimization of EMR.

• Prioritizing and sustaining the PCMH transformation to meet the increasing market pressures and remain an industry leader.

• Determining the required start-up capital/financing as well as performance incentives and reimbursement available.

The PCMH model requires ongoing management and improvement to ensure success and sustainability.
IV. Key Considerations

Risks of Inaction

- Payors are seeking to partner with providers in population health management initiatives, using PCMHs as a proxy to identify partners.
- Future incentives and cost-saving opportunities may not be available to organizations that are not PCMHs. Examples include:
  - Investment in further development of PCMH capabilities and infrastructure.
  - Payment for practice performance in managing population health.
- Some payors are designing benefit packages wherein patients have waived co-pays if they seek care at a PCMH; volumes may be affected by patients choosing to seek care elsewhere.
- Inadequate monitoring and coordination of care can result in lost opportunities (e.g., referral leakage).

*Postponing care delivery transformation may result in missed opportunities, increased waste, and excess costs over time.*

Given the growing prevalence of the PCMH model, patients and providers are beginning to expect this type of care delivery across the country.
V. Case Study
ACME Medical is one of the leading multispecialty practices on the East Coast.\(^1\)

**Situation**

- Large physician organization with more than 150 providers.
- Numerous multispecialty facilities, encompassing more than 20 specialties.
- Located in a saturated, forward-thinking market.

**Challenges**

- Pressures of the industry and market to provide value-based care.
- Provision of high-quality care to patients in an efficient, cost-effective manner.
- Shift from a culture of volume to value-based care and payment delivery.
- Meeting the market demands of becoming a PCMH.

\(^1\) Medical practice name has been changed for confidentiality purposes.

*Although a leader in the market, ACME Medical sought additional opportunities for continuous improvement to ensure the highest quality of care at a lowest cost.*
V. Case Study

Approach

In 2011, ACME Medical announced its intent to apply for National Committee for Quality Assurance (NCQA) PCMH recognition, to be completed by 2012. This allowed just over a year for the planning and implementation phase.

Activities
- Comprehensively review NCQA PCMH requirements and costs.
- Confirm approach and priorities.
- Collect and review data.
- Review preliminary findings.

Activities
- Conduct gap analysis.
- Conduct readiness assessment.
- Identify challenges or barriers to success.
- Determine the structure, design, and resource needs.

Activities
- Develop PCMH oversight committee.
- Develop PCMH topic-specific work groups to address gaps.
- Develop communication plan.
- Restructure physician compensation and compact to align with PCMH.
- Develop or revise policies, procedures, and guidelines.

Activities
- Engage clinical and administrative leadership.
- Implement new policies, procedures, and guidelines.
- Provide training and education to providers and patients.
- Submit documentation to NCQA for recognition.
In 2012, ACME Medical became the first practice in the state to receive Level 3 NCQA PCMH recognition using the 2011 tool. ACME has truly adopted the model and has already experienced significant improvements in numerous areas.

<table>
<thead>
<tr>
<th>Measure</th>
<th>2012 Results¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Measures</strong></td>
<td></td>
</tr>
<tr>
<td>Medication Management – Annual Follow-Up for Medications</td>
<td>95%</td>
</tr>
<tr>
<td>Cardiovascular LDL-C Test</td>
<td>94%</td>
</tr>
<tr>
<td>Diabetes Management – Composite Score</td>
<td>87%</td>
</tr>
<tr>
<td>Annual Wellness Visit Performed</td>
<td>95%</td>
</tr>
<tr>
<td>Patients Identified as High-Risk, Assigned to Case Manager</td>
<td>100%</td>
</tr>
<tr>
<td>After-Visit Summary Provided to Patient at Checkout</td>
<td>85%</td>
</tr>
<tr>
<td>Daily Discharge Reports Provided</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Patient Satisfaction Measures</strong></td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td>90%</td>
</tr>
<tr>
<td>Communication With Patients</td>
<td>95%</td>
</tr>
<tr>
<td>Timely Appointments, Care, and Information</td>
<td>95%</td>
</tr>
</tbody>
</table>

¹ 2012 results were compiled from multiple reports measuring outcomes of PCMH.
V. Case Study
Implementation, Evolution, and Integration

ACME Medical has successfully achieved Phase 1 – implementation – and is currently working on Phases 2 and 3 – evolution and integration.

**Implementation**

- Collaboration with payors to align PCMH efforts and initiatives.
- Integration of PCMH with specialists and hospitals.
- Leverage PCMH for ACO development and population health.

**Evolution**

- Evolve current state model, incorporating Lean tools and techniques.
- Form PCMH Cost-Savings Committee.

**Integration**

- Team-Based Care
  - Physician, Nurse, Medical Assistant, Case Manager, Social Worker, Nutritionist, Pharmacist

- Ensure Access to Patient Care and Information
- Plan and Manage Care
- Coordinate and Integrate Care
- Performance Measurement and Quality Improvement
- Health IT
- Care Management and Population Health

*Physician, Nurse, Medical Assistant, Case Manager, Social Worker, Nutritionist, Pharmacist*
VI. Key Takeaways
VI. Key Takeaways

*Healthcare organizations have the opportunity to benefit physicians, hospitals, and the communities they serve by being innovative leaders through a PCMH strategy.*

- Simply implementing a PCMH is not enough to ensure its success. A sustainable transition to a PCMH involves a three-phased process: implementation, evolution, and integration.

- When considering the transition to a PCMH, align the model with the organization’s strategic objectives before beginning implementation.

- Subsequently, in the evolution phase, healthcare organizations must adapt their processes and culture to fit the model.

- During integration, healthcare organizations align with payors and other medical providers to develop innovative payment methods while delivering the best possible patient care.

- Failing to adopt a PCMH model puts healthcare organizations at risk of missing opportunities for growth and potential revenue.

*With an effective PCMH in place, healthcare providers can at last focus on what really matters: delivering value-based care that is truly patient-centered.*