

Putting the Medical Home into Practice for Children

July 12, 2018



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Patient-Centered
Primary Care
COLLABORATIVE

Welcome & Announcements

- Welcome – [Ann Greiner](#), PCPCC President & CEO
- Upcoming PCPCC Webinar – www.pcpcc.org calendar of events to register
 - ✓ **July 17:** [Integrating Physical and Behavioral Health: The View from Primary Care Providers and Payers \(speakers from Harvard Medical School and UPMC\)](#)
- **PCPCC Annual Conference – Key Policies to Elevate Primary Care**
 - Washington, DC, November 8, 2018
 - Registration: www.pcpccevents.com
- **Members Only Workshop:** Investing in Primary Care – Advancing a National Strategy
 - Immediately following the PCPCC annual conference, Executive Members are invited to an **exclusive workshop** on November 9, 2018
 - **Registration:** www.pcpccevents.com
- Stay tuned for the release of **PCPCC’s annual Evidence Report** on 8/8/2018
- Interested in PCPCC Executive Membership?
 - Email Allison Gross (agross@pcpcc.org) or visit: www.pcpcc.org/executive-membership

Panelists



Ann Greiner

CEO & President
PCPCC



Chip Hart

Director of Pediatric Solutions
PCC Pediatric EHR Solutions



Susan Kressly, MD

Fellow
American Academy of Pediatrics



Susanne Madden, MBA, CCE

CEO
Verden Group

Putting the Medical Home into Practice for Children

Susan J Kressly, MD, FAAP
Chairperson
AAP Payer Advocacy Advisory Committee

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AGENDA

- Family-centered Care: What's Different and New in Pediatrics
- Opportunities and Challenges in Pediatrics
- Helpful Resources



Family-Centered Care: What's Different and New in Pediatrics



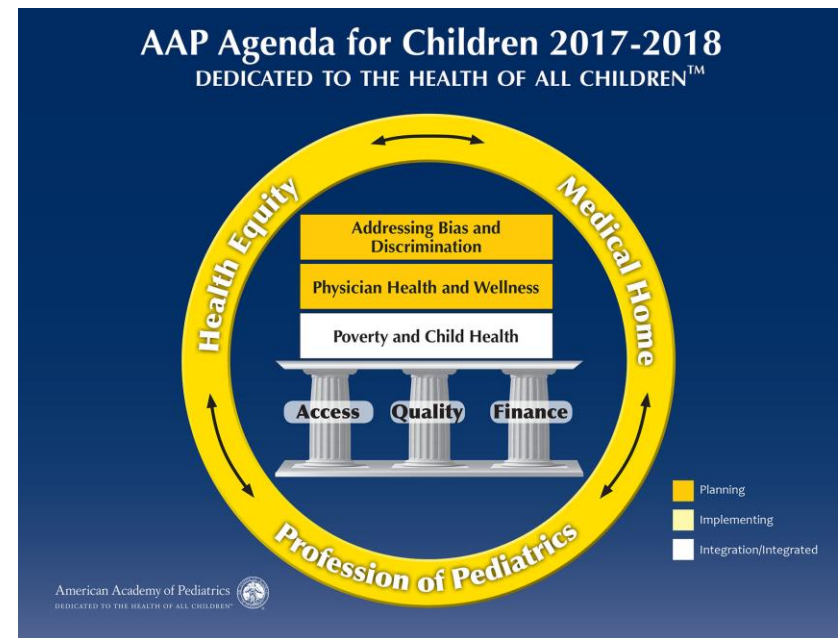
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HISTORY

- Long history in pediatrics/at the American Academy of Pediatrics (AAP)
- AAP Universal Principles
 - All children have, and all pediatricians provide, a medical home
 - All children/all systems of care maintain health equity
 - The profession of pediatrics is sustained, maintained, and improved

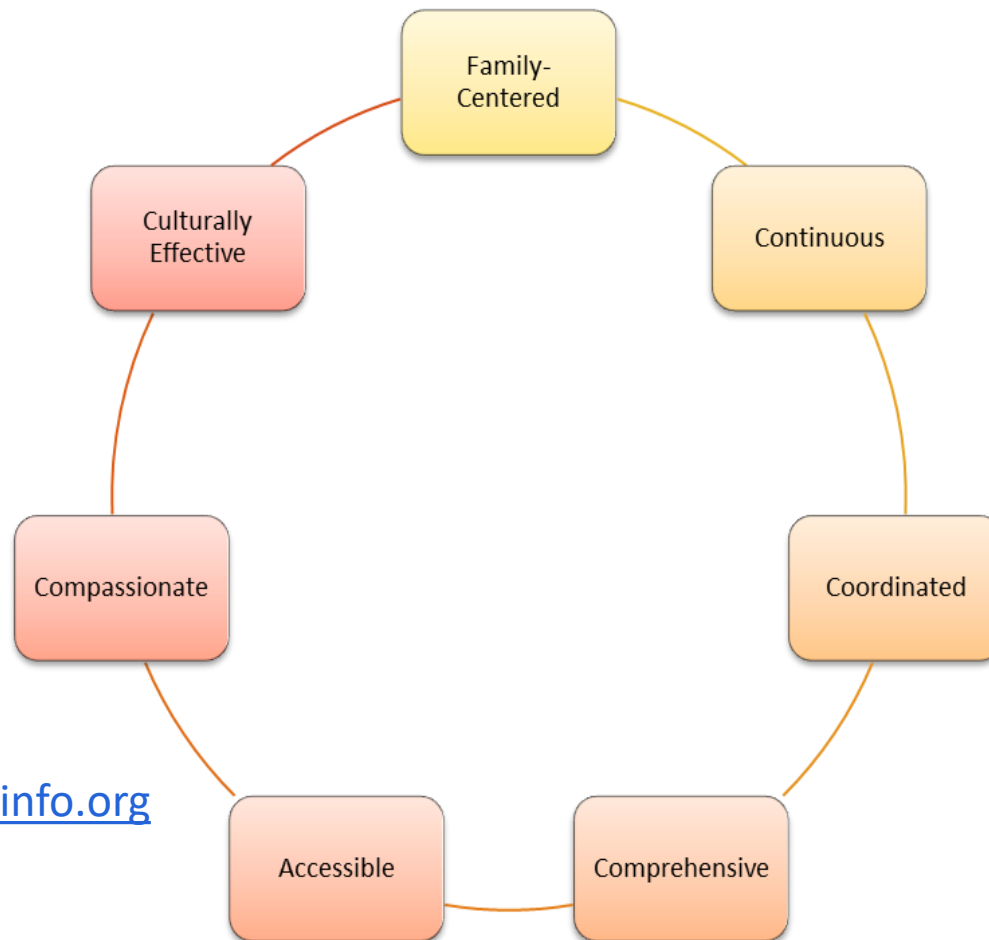


WHAT IS A MEDICAL HOME?

- An approach to providing comprehensive and high quality primary care (it's not a place or a building!)
- A focus on building and developing partnerships with families, clinicians, and community organizations/resources
- 7 core tenets of FCMH



CORE TENETS



www.medicalhomeinfo.org

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QUADRUPLE AIM

Impact on Healthcare Costs	<ul style="list-style-type: none">• Access to source of care¹• Reduced emergency room visits^{1, 2, 3, 4, 5}• Lower Per Member Per Month costs⁶• Reduced out-of-pocket spending⁷
Impact on Healthcare Quality	<ul style="list-style-type: none">• Anticipatory guidance provided⁸• Seen by a primary care clinician within last year³• Immunizations^{9, 10}• Well-child visits⁹
Impact on Family Experience /Satisfaction	<ul style="list-style-type: none">• Positive parental experiences¹¹• Meeting day-to-day demands¹²• Decreased missed workdays¹³• Decreased time burden¹⁴• Access to care⁴
Impact on Clinician Experience /Satisfaction	<ul style="list-style-type: none">• Decreased burnout¹⁶• Greater job satisfaction¹⁷



Opportunities and Challenges in Pediatrics



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OPPORTUNITIES (OR CHALLENGES)

- Changing demographics in pediatric patient population
- Retail health clinics/focus on “consumerism”
- Misalignment between clinician and family ideals/perspectives in healthcare; need for family engagement
- Focus on systems of care and integrated care
- Focus on population health, social determinants of health and mental/behavioral health
- Clinician satisfaction/work-life-balance
- Alternative payment models



AAP GUIDING PRINCIPLES FOR FCMH PAYMENT

- Payment should be sufficient to fund 3 types of services provided based on the medical home model
 - Traditional episodic care encounters
 - Case management/care coordination, integration of mental health, family education
 - Maintenance of health information technology and its application to quality improvement activities/population health initiatives



AAP RECOMMENDATIONS RELATED TO PROVIDER PAYMENT FOR FCMH

- Alternative Payment Models (APMs) specifically designed for pediatricians and pediatric subspecialists
- No financial penalty from negative results of patient satisfaction surveys
- Establish expert pediatric advisory groups
- Federally-funded, pediatric-specific entity to support innovations



AAP RECOMMENDATIONS RELATED TO PROVIDER PAYMENT FOR FCMH

- Cover telehealth/telemedicine provided via primary care practices to support the medical home model for delivery of care
- Additional payments for vaccines, medications, and other medical products
- Additional payment for transition from pediatric-to-adult health care
- Shared savings incentives
- No 'withhold' payments



EXAMPLES OF ALTERNATIVE PAYMENT MODELS

- Percentage of premium (upside only)
- Capitation (limited downside)
- Full risk (% of premium or based upon previous years cost)
- Bundled payment



Helpful Resources



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RESOURCES

- [National Center for Medical Home Implementation](#) – a cooperative agreement between the Maternal and Child Health Bureau and the American Academy of Pediatrics
- [Building Your Medical Home Resource Guide](#)



RESOURCES CONT'D

- AAP Practice Transformation Resources
 - [AAP Practice Transformation Page](#)
 - [AAP Practice Transformation Implementation Guide](#)
 - [AAP Medical Home Page](#)
- AAP Policy and Clinical Reports
 - [AAP Team-Based Care Policy Statement](#)
 - [AAP Care Coordination Policy Statement](#)
 - [AAP Shared Decision-Making Clinical Report](#)
 - [AAP Family-Centered Care Policy Statement](#)
 - [AAP Health Care Transition Clinical Report](#)



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Utilizing PCMH for Operational Efficiency & Profitability

The Benefits of Adopting the Medical Home Model

- Clinical staff work at the top of their license, saving time and money, allowing practices make the best use of staff and resources
- Better coordinates care across specialists and incorporates use of community resources
- Increases technology use, improving ROI
- Allows for more comprehensive services, improves service 'mix' resulting in more optimal charges
- Positions practices for P4P / Value Based Contracting
- Improves revenues per visit, seasonal cash flow dips
- Increases patient satisfaction

Best Use of Staff & Resources

Having staff work up to the best of their capability is more efficient and more satisfying for the staff

- Nurses utilize triage and follow up skills
- Physicians / providers are focused on care delivery, not on remembering to track down results
- Workflows become much more proactive, gets away from reactive fire-drills every day
- Staff better understand their role in the delivery of care, take more responsibility in that delivery
- Team members get away from silos and work more collaboratively together

Best Use of Staff: RESULTS

- ✓ Decreased 'busy work' results in overall lower cost of care, greater staff satisfaction, less staff turnover, less burnout
- ✓ Proactive workflows allow for patient recall, smoothing out 'dips' in delivery of services in the 'off season' and more consistent delivery of age-specific services resulting in better cash flows and great revenue-per-visit (needed services don't fall through the cracks, e.g. a missing immunization)

Best Use of Staff: CASE

- ◆ 4-provider client in FL reduced staff turnover by 30% in two years after medical home implementation
 - Staff survey revealed greater satisfaction with work due to ‘involvement’, more appropriate ‘use of skill set’ and ‘feeling part of a team’ rather than silo-ed
 - Rather than having to increase number of staff to support PCMH, improved workflows, better patient outreach and more resources for patients including education resulted in LESS staff needed to manage day-to-day operations

Better Coordination with Specialists / Community

- Formal agreements with specialists in coordinating care help to drive better outcomes
- Improves turnaround time for receiving reports from specialists / other providers, allowing for more timely interventions, streamlines follow up
- Applied systems of follow up and follow through means no patients fall through process gaps
- Focus on understanding and tapping into community resources are available can reduce practice costs too

Improved Technology Use

- Utilization of features such as reports that allows for recalling on overdue patients, certain populations
- Utilization of technology for patient engagement can reduce phone calls, no shows, and allow for pre-visit activity, which reduces costs
- Improved documentation, including comprehensive health assessments that can be data-mined for follow up care and disparities in care, driving better outcomes
- Built in evidence-based decision support tools help to deliver better care, creates consistency of care

Improved Tech: RESULTS

- ✓ Ability to run reports to track patients for overdue visits allows for practice to proactively 'recall' patients for services:
 - Less seasonality in cash flow
 - Appropriate services delivered more consistently increases revenue
 - Ability to deliver missed services (overdue vaccines, absent depression screening etc.) improves revenue per visit
 - Addition of needed services such as ensuring asthmatics received flu shots early in season improves care and allows for earlier delivery of services

Improved Tech: CASES

- ◆ Utilization of recall reports by a client in NC resulted in
 - Improved well visit rates between 7% and 10% (Chip Hart will present specific findings)
- ◆ 2-provider client in NY utilized EMR data to implement recall for patients to schedule for missed services (screenings, immunizations, med rechecks) and improved cash flow by in off season by \$75,000
- ◆ Client in CA utilized EMR to identify asthmatics which resulted in an increased early flu immunization rate of 32%

Positioning for Value-Based Contracting

- Easier to manage metrics associated with HEDIS measures, vaccine rates, P4P, through better use of technology and focus on specific measures
- Greater visibility into cost drivers and opportunity to limit or control those costs
- Better documentation, supporting better coding and optimizing revenues
- Consistent protocols, visit templates and components capture specific aspects for quality improvement for measurement and improvement
- Negotiation tool

Contracting: RESULTS

- ✓ Some Payers have financial PCMH incentives for practices that achieve recognition (NCQA, TJC, AAAHC and homegrown initiatives) under the model.
 - Example, Aetna paid \$3 PMPM in many markets to those practices that achieved NCQA Level 3
- ✓ Recognition proves to Payers that there are savings and contracting opportunities with PCMH practices
- ✓ Can be used to open negotiations and as leverage if there are no defined initiatives already in place
- ✓ Allows for practices to work effectively with P4P measures

Contracting: CASE

- ◆ Client in PA effectively utilized their PCMH recognition with two Payers:
 1. Payer had no PCMH incentives but recognized that the practice was contributing extra value and savings to its network. Fees were increased by 8%.
 2. Payer had P4P program that practice had failed to achieved prior to transitioning to PMCH. Focus on improving select HEDIS measures allowed practice to exceed the baseline metrics and receive quarterly bonus payments under the contract

Creates a Culture of On-Going Improvement

- PCMH provides a framework for continually improving quality
 - This provides a 'roadmap' for practices to build training programs and performance targets around
- Inspires staff to constantly improve workflows
 - Everyone is pulling oars in the same direction
- Allows for focus on key areas of care
- Helps drive practice 'culture', mission and vision
 - Decreases burnout and staff turnover

On-Going Improvement: CASES

- ◆ ‘Supergroup’ in NJ, recognized 3 times by NCQA (2011,2014, 2017):
 - Requires all new practice members to go through the NCQA PCMH program in order to build quality, efficiency and savings from the ground up
 - Continues to achieve high scores across a variety of metrics despite onboarding new practices that are not yet PCMH-recognized
 - Chip Hart will present specific data points

Improves Patient Satisfaction

- A reputation for excellent care:
 - Increases word-of-mouth referrals and enhances marketing efforts (reducing expenditures)
 - Positions you in the community as the 'go to' practice
 - Improved patient retention increases revenues

- Involves patient in their own care (parents)
 - Care plans help to involve patient / parent directly in care outcomes e.g. tracking asthma, med compliance
 - Better patient education reduces patient call backs and after hours inquiries

Q & A

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July 2018

Selection Bias

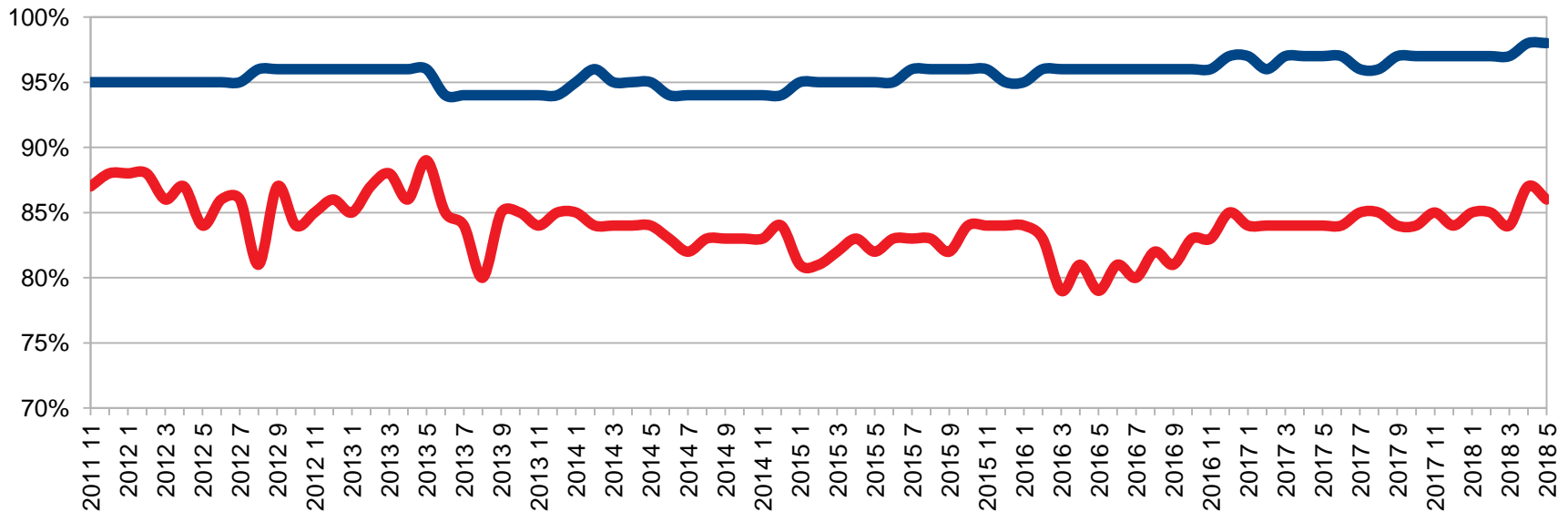
- **Who is most likely to participate in PCMH programs?**
- **What is the potential for high-performing practices?**

Example Performance – NJ

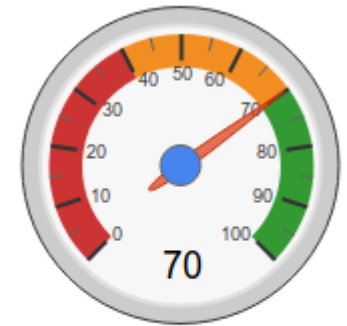
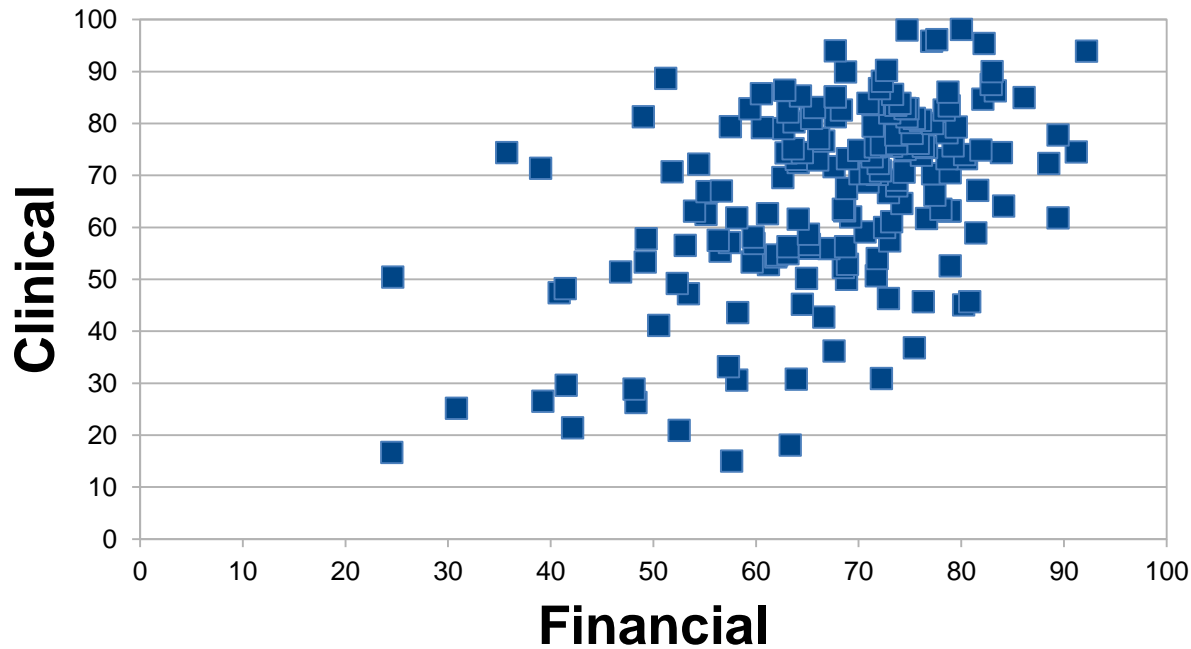
Well Visit Coverage

— <15m Well

— 3-6y Well



Relationship of Disciplines



70

Performance Results

- **Not limited to smaller practices**
- **PCMH sets new plateau**
- **Interesting secondary results: Diags/Visit, RVUs/Visit**
- **Relationship between well visits and imms**

Example Performance – NC

Clinical Performance

Impact

Well Visit Rates

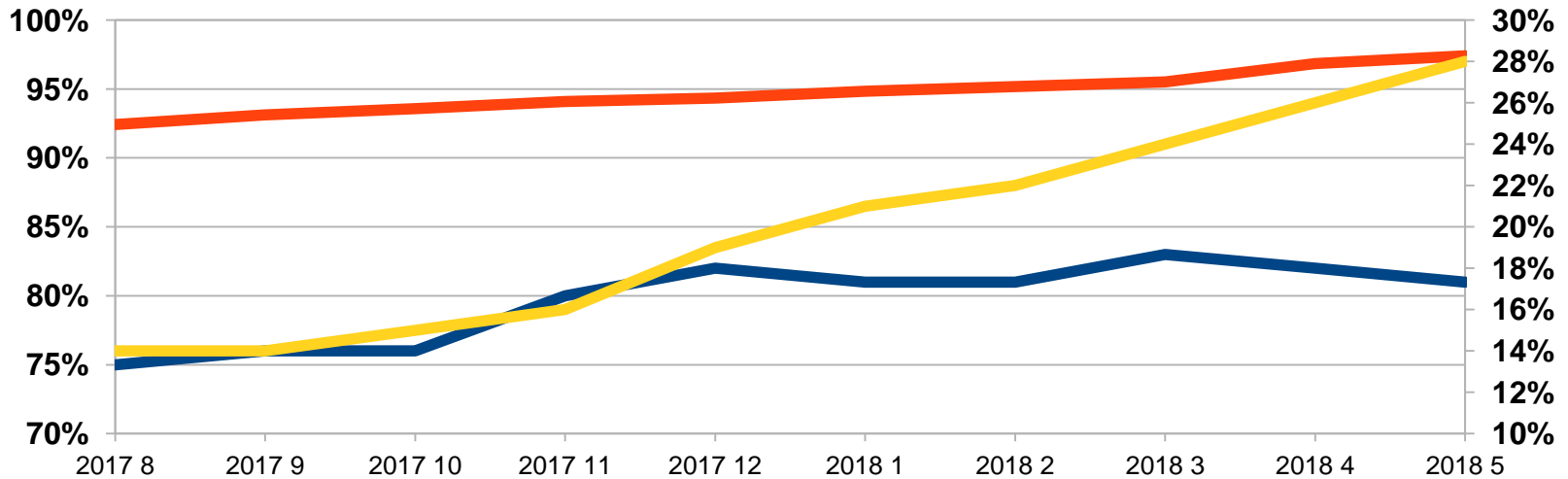
Rev/Vis	+5%
3-6yo	+7%
RVU/Vis	+3%
7-11yo	+9%
12-17yo	+10%

Financial

Example Performance - MD

Clinical Improvements

7-11y Well Adol Screening Flouride



Questions?



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