HealthTeamWorks

Building Systems. Empowering Excellence.

A Year in Review

The Colorado Multi-Stakeholder Patient-Centered Medical Home Pilot

PCPCC CMD Meeting

June, 1, 2010

Multi-Payer Pilot Stakeholders

Health Plans
- Aetna
- Anthem-Wellpoint
- CIGNA
- Colorado Medicaid (HCPF)
- CoverColorado
- Humana
- United Healthcare

Employers
- Colorado Business Group on Health
- Centura
- IBM
- McKesson
- State of Colorado
- Patient Centered Primary Care Collaborative (PCPCC)

Physician Societies
- AAFP/CAFP
- American College of Physicians
- Colorado Medical Society

Others
- Colorado Health Department (CDPHE)
- University of Colorado-Denver
- Consumers

Hospitals
- HealthONE
- Centura
- Exempla
- Memorial Hospital
- Colorado Hospital Association
- Others

Associated IPAs
- Integrated Physician Network
- Northern Colorado IPA
- Physician Health Partners
  - Primary Physician Partners
  - South Metro Physicians
- MedSouth

Pilot Partner Region
- Health Improvement Collaborative of Greater Cincinnati

Pilot Evaluator
- Harvard School of Public Health

Funders
- The Colorado Trust
- The Commonwealth Fund

The Front Line Innovators!

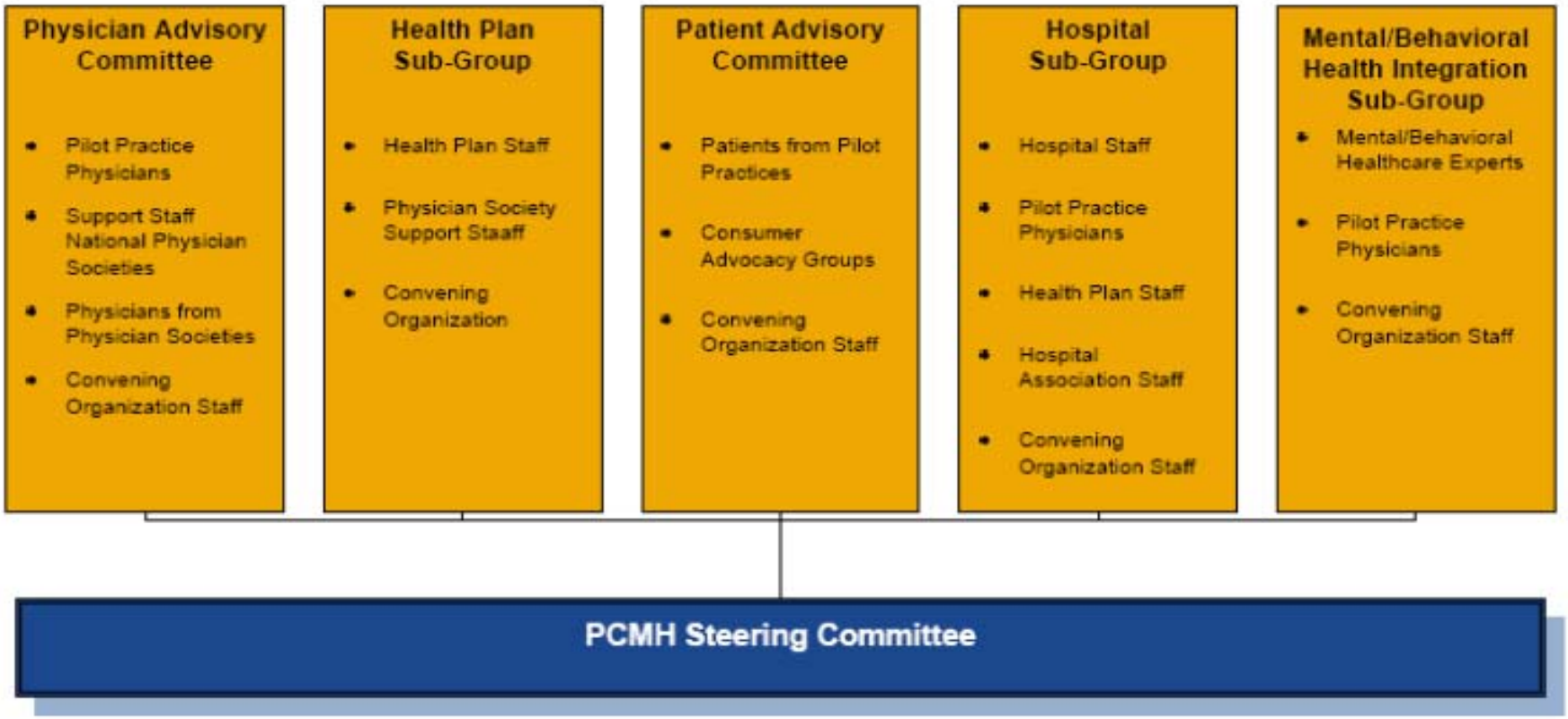
- Belmar Family Medicine
- Broomfield Family Practice
- Clinix Health Services of CO
- DeYoung Family Medicine
- Family Care Southwest
- Family Practice Associates
- Ideal Family Healthcare
- Internal Medicine Clinic of Ft. Collins
- Lakewood Family Medicine
- Lone Tree Family Practice
- Michael Mignoli MD
- Miramont Family Medicine
- Mountaintop Family Health
- Provident Adult & Senior Medicine
- Southpark Internal Medicine
- Westminster Medical Clinic

Pilot Parameters

- Two-to-three-year pilot
  - Convened January 2008; TA December 2008; Started May 2009
- PCMH Joint Principles
- NCQA PCMH Recognition
  - 14 at Level III; 2 at Level II
- 17 Family & Internal Medicine Practice sites
  - Various sizes across the Front Range
- 20,000 patients covered (100,000 affected)
- Three-tiered payment structure
  - Fee for service (FFS); Care management fee (PMPM); P4P

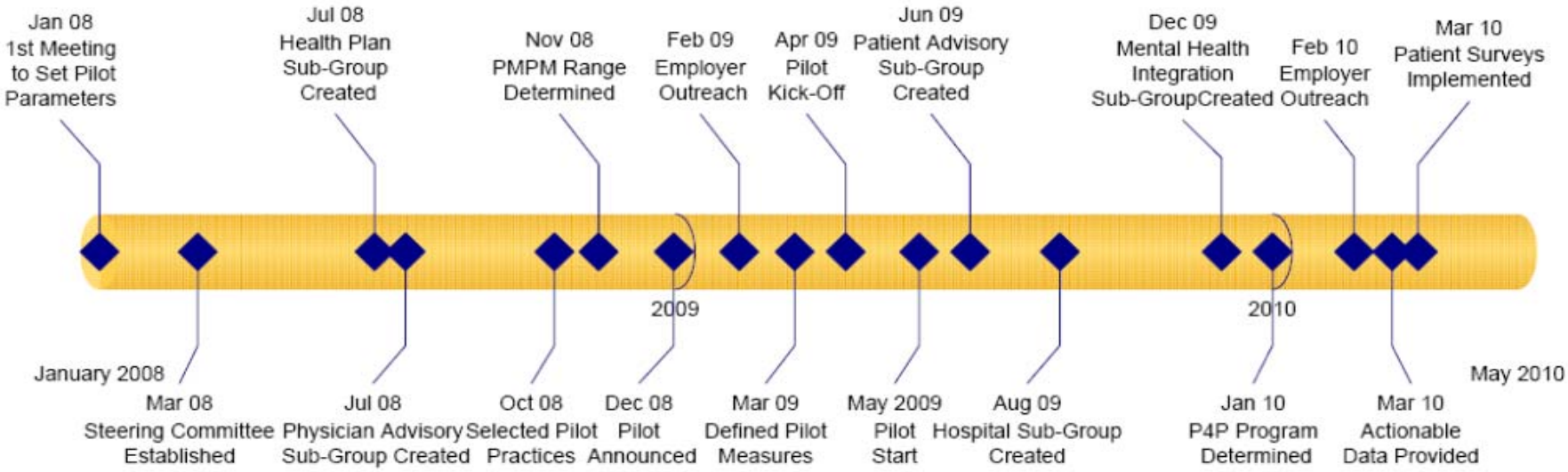
The Colorado Multi-Payer Committee Organization Chart

Phase II – Operationalization & Implementation
12/5/2008-Current



COLORADO CLINICAL GUIDELINES COLLABORATIVE

Colorado Multi-Stakeholder, Multi-State Patient Centered Medical Home Pilot Convening Organization Timeline



- First meeting, held in person, to determine pilot parameters, stakeholder involvement, budget requirements, practice selection criteria, reimbursement model etc…
- Steering Committee Established, includes representation from health plans, physicians, physician societies, and others. Meetings held bi-monthly with 2 additional in person meetings
- Physician and Health Plan sub-groups formed to work on the operationalization issues
- Selected pilot practices based on location, quality improvement history, culture, technology and participating insurer penetration
- PMPM range determined by physician advisory committee and health plan sub-group through research and estimated cost to practices to add the additional scope of work transform into a PCMH
- Announced the pilot to the healthcare community in the Denver metro and across the state of Colorado
- ASO participation deemed vital to the success of the pilot to improve payment penetration in each practice

- Pilot measures determined based on national measures
- Reception held for practices and health plans to celebrate the launch of the pilot
- Official launch of the pilot
- Patient sub-group created to ensure the patient voice is considered and involved in the process, including creating patient education materials
- Hospital sub-group created to work on improving bi-directional communication between PCPs and hospitals
- Mental health integration sub-group created to focus on the integration of mental and behavior health into the pilot practices
- P4P Specifications finalized through the work of the health plans and physician advisory group
- Actionable data provided to pilot practices from health plans
- Uniform patient satisfaction surveys implemented

Patient-Centered Planned Care

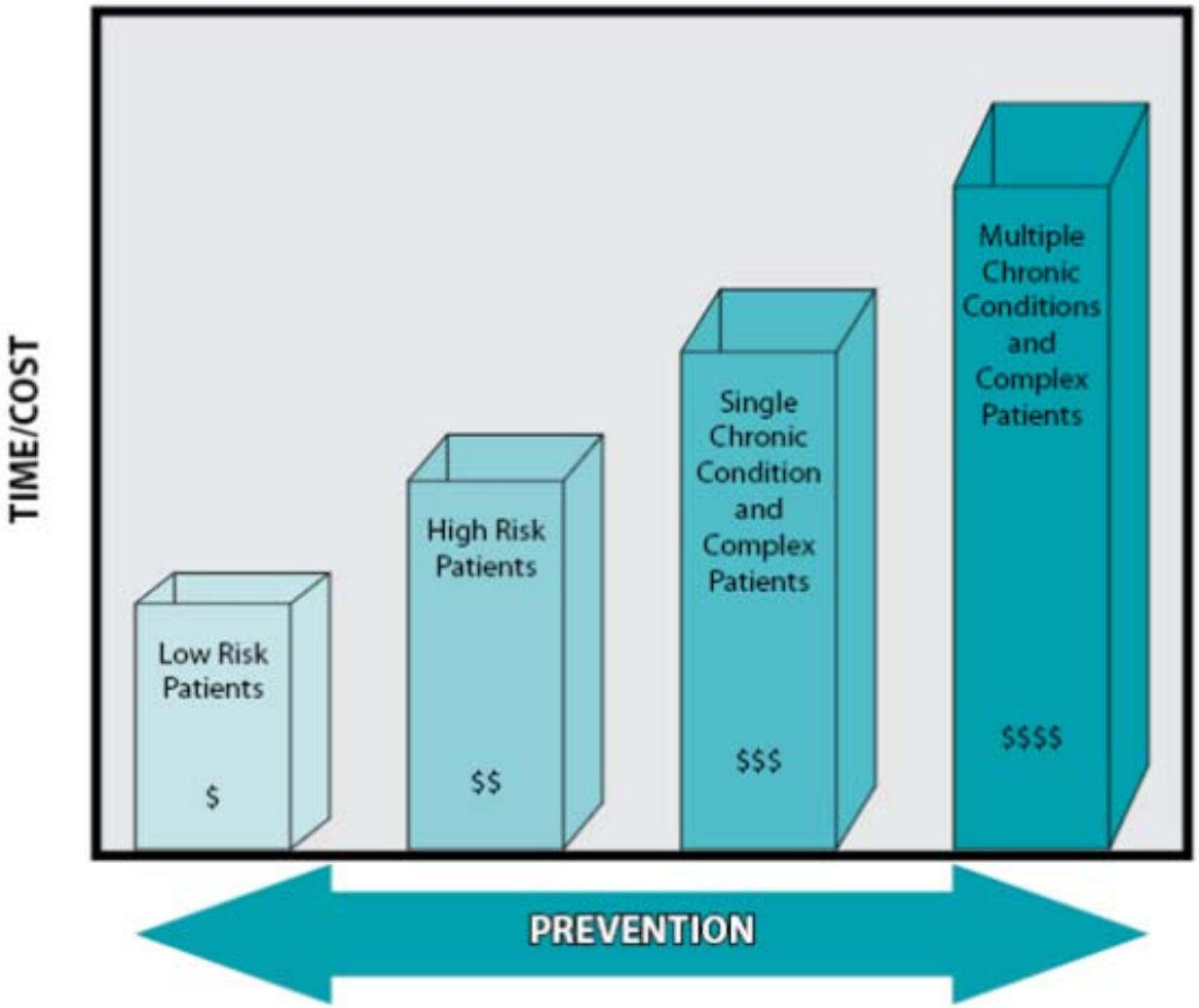
COLORADO CLINICAL GUIDELINES COLLABORATIVE

Improved Outcomes

- Increased Healthy Behaviors
- Improved Quality, Safety, and Clinical Outcomes
- Increased Collaboration between Patient, Care Team, and Medical Neighborhood
- Improved Physician and Staff Satisfaction and Retention
- Reduced Cost Trends

Adapted from:
www.NewHealthPartnerships.org

Prioritizing Care Plan Management and Care Coordination



Goals/Measures

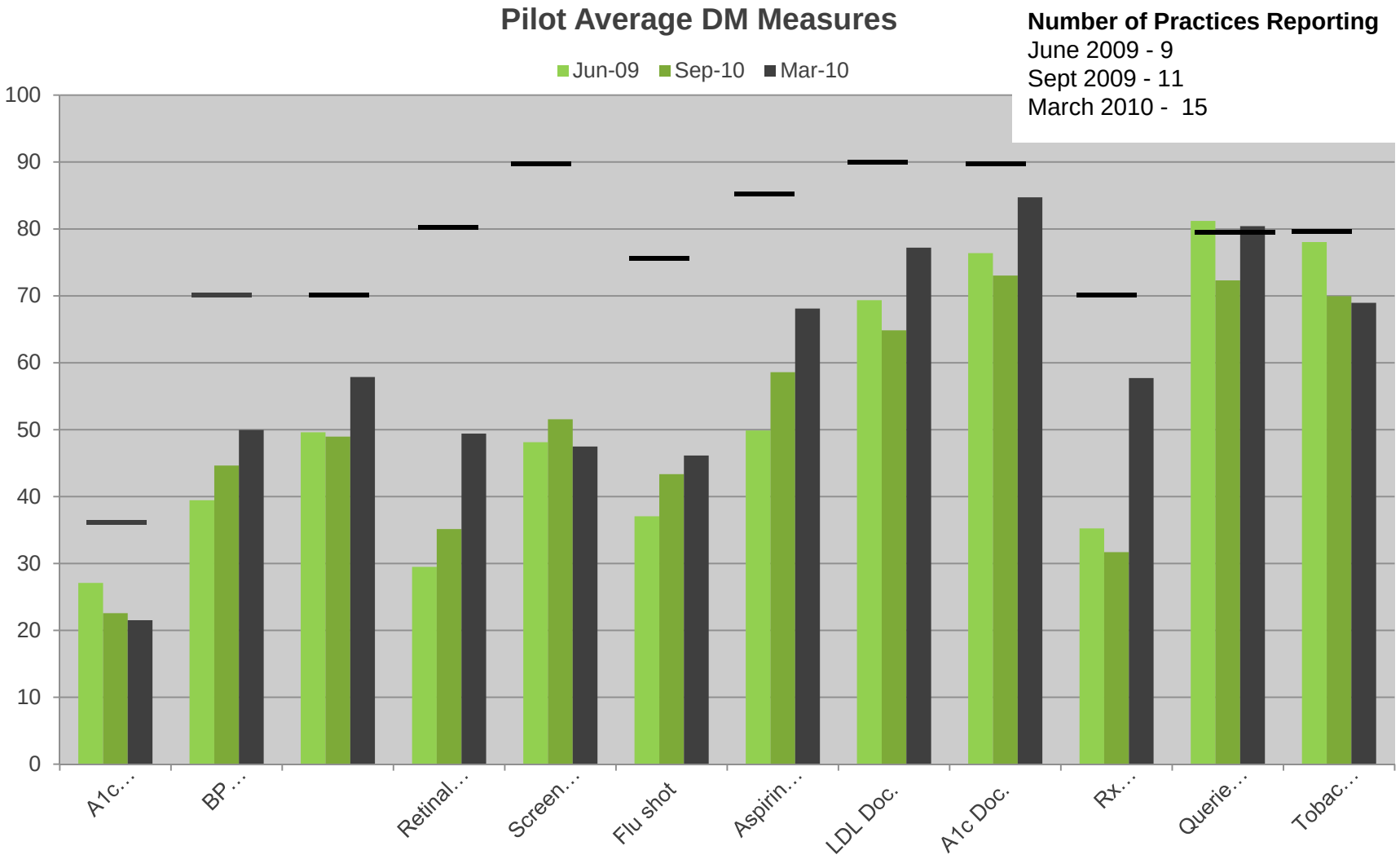
- Improve quality
  - Diabetes
  - Cardiovascular disease
  - Tobacco
  - Depression
  - Prevention
- Reduce cost trends
  - Emergency room (ER) visits
  - Hospital admissions
  - Generic pharmacy
- Improve satisfaction
  - Patients/families
  - Health care team

- **Internal**
- **External**
  - **Matched comparison design**
  - **Meredith Rosenthal**
    - **Harvard**

P4P Measures

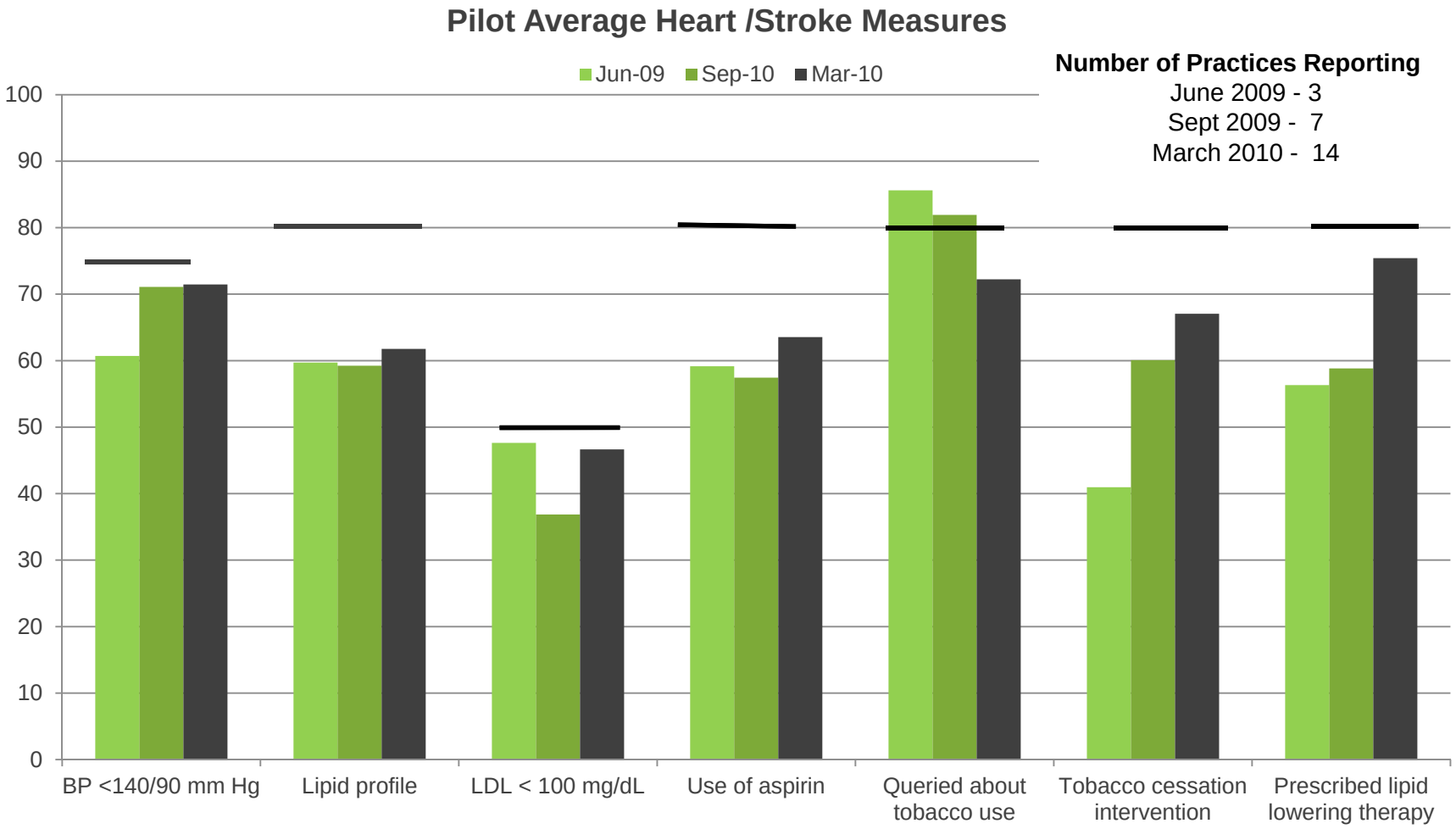
P4P Clinical Measures	P4P Targets
1. HgA1c>9 (DM)	15%
2. BP <130/80 (DM)	25%
3. LDL <100 (DM)	36%
4. Tobacco Counseling (DM)	80%
5. Depression Screening (DM)	40%
6. LDL <100 (CV)	50%
7. BP <140/90 (CV)	75%
8. Tobacco Counseling (CV)	80%
9. Depression Screening (CV)	40%
Cost Trend Measures	
Reduce ER Visits	5%
Reduce IP Hospitalizations	5%
Increase Generic Pharmacy	10%

Data Slides



Number of Practices Reporting
June 2009 - 9
Sept 2009 - 11
March 2010 - 15

Data Slides

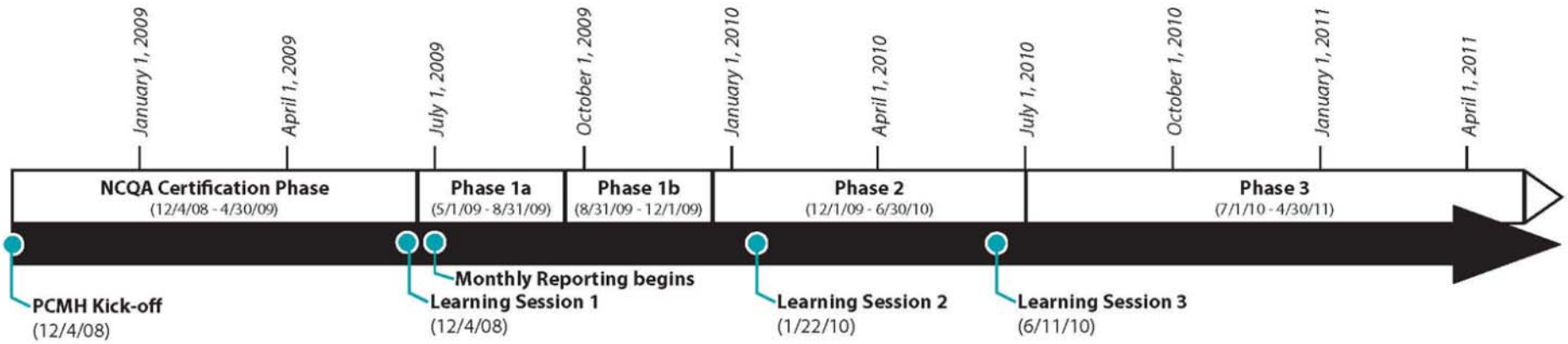

Pilot Average Heart /Stroke Measures
Jun-09
Sep-10
Mar-10
100
90
80
70
60
50
40
30
20
10
0
BP <140/90 mm Hg
Lipid profile
LDL < 100 mg/dL
Use of aspirin
Queried about tobacco use
Tobacco cessation intervention
Prescribed lipid lowering therapy
Number of Practices Reporting
June 2009 - 3
Sept 2009 - 7
March 2010 - 14

STRONGER Patient & Provider Relationships

Mountaintop Family Health

Pat Schmidlapp

Colorado Multi-State Multi-Stakeholder Technical Assistance Timeline



Phase 1a (May 2009 – Aug 2009)

Review and Use Quality Improvement Tools and Models

Use of Technology
- Registry

Patient Centered Care/Communication/Engagement
- Patient Self Efficacy and Individualized Assessment
- Patient Self-Management Support

Decision Support/Team Based Care/Patient Tracking
- Evidence Based Guidelines
  - » Diabetes, Heart/Stroke, Depression Screening
- Team based Care

Access and Scheduling
- Implement various ways to increase access

Organization of Practice
- Leadership Team-building

Phase 1b (Aug 2009 – Nov 2009)

Patient Centered Care/Communication/Engagement
- Patient Satisfaction/Experience

Decision Support/Team Based Care/Patient Tracking
- Evidence Based Guidelines
  - » Diabetes, Heart/Stroke, Depression Screening

Care Management
- Establish Medical Neighborhood

Access and Scheduling
- Implement various ways to increase access

Phase 2 (December 2009 – June 2010)

Use of Technology
- E-Prescribing

Decision Support/ Team Based Care/ Patient Tracking
- Evidence Based Guidelines
  - » Back Pain, Prevention, Depression - Acute and the rest of Heart/Stroke measures
- Shared Decision Making
- Test and Referral Tracking

Care Management
- Coordination of Care/Transition of Care with Medical Neighborhood
- Community Resources

Access and Scheduling
- Implement various ways to increase access

Organization of Practice
- Human Resources
- Finance

Phase 3 (July 2010 -)
- Maintain Phase 1 and Phase 2
- Evidence Based Guidelines
  - » Prevention, Depression - Continuation, other optional measures

Ongoing Pilot Events and Reports
- Regular team meetings (at least 2 per month)
- Learning Sessions 1, 2, and 3
- Monthly practice calls on the 1st and 3rd
- Fridays of each month
- Monthly reporting of clinical measures
- Monthly reporting of summary report

Technical Assistance

1. Office Redesign

Based on IPIP - Planned Care Model - IHI

Focused Approach Related to NCQA Tool

In Office QI Coaches
Learning Collaboratives & Calls
Monthly Practice Reporting

2. Technology

Care Plan - Registry

Common Communication Platform
HIPAA Compliant E-Mail

Patient Portal- Engagement

3. Integrating Care

Expand Services; Coordinate/ Integrate care with "Medical Neighborhood" using Compacts

Co-Located/Shared/Referred Services

Care Plan Manager/Coordinator

4. Patient Centered

Enhance Access

Form Partnership with Patients – Shared Decision Making

Patient Activation & Satisfaction (Experience)

Quality Improvement

- **Practice Structure**
- Care Coordinators - 94%
- Registry for Diabetes and Heart/Stroke – 100%
- Compacts – 18%

Expanding Team Roles

Cost

- Reducing ER – 4 practices doing mini pilots
- Admissions,
- Generic Pharm - E-prescribing 100%

Patient Satisfaction

- **Access - Expanded hours and email communication**
  - Extended Hours – 75%
  - E-Mail – 87%
  - Website 100%
  - Patient Education and Engagement – 100%

Provider and Staff Satisfaction

IMPROVED Communication: Hospitals & PCPs

Sky Ridge Medical Center PCMH Sub-Committees

Emergency Department ~Educate ED staff regarding PCMH ~Identify patients who belong to PCMH ~Collaborate with PCPs and exchange information freely		**HIM** ~Develop timely notification to PCPs when patients are in the ED ~Ensure all results are faxed to PCPs ~Review information being sent to PCPs for quality
Future Programs and Marketing ~Market services provided by SRMC ~Advertise PCMH pilot participation ~Serve as Medical Neighborhood for our community		**Physician Relations** ~Identify and work with PCPs who have joined the PCMH model ~Educate PCPs in the community about our services and support for pilot ~Evaluate progress

Better Care Coordination – Medical Neighborhood

Jan Vergo, RN

Westminster Medical Clinic

INCREASED Patient Activation

Creation of Patient Advisory Committee

- Developed *(with input from the Physician Advisory Committee)* patient education materials
- Provided feedback on the development of the patient survey and other patient communications
- Working with their practices to boost the role of the patient in the practice

UnitedHealthcare
Healing health care. Together.

How the Medical Home Drives Value: What We Are Operationally Doing Different

Expanded Patient-Centric Clinical Services and Capabilities

Enhanced Access
- Timely appointment scheduling
- Evening, weekend and holiday hours
- After-hours support

Care Coordination and Chronic Condition Management
- Weekly identification of patients in transition or at risk
- Specialty referral coordination and tracking
- Disease and case management enrollment

Team Care
- Physician-directed team both in and outside of the practice setting
- Management of care transitions across the health care continuum

Performance Measurement, Assessment and Improvement
- Practice in accordance with clinical evidence
- Performance evaluation based on medical best practices
- Measurement of clinical processes and outcomes

Clinical Information Systems
- Care management
- Decision support
- Electronic prescription filling

Enabling Technology and Practice Support

Technology and Tools
- Personal Health Record
- Point of care information
- Electronic prescriptions
- In-depth reporting

Care Coordination Management and Support
- Health plan care and disease management
- Educational materials
- Patient activation tools

Transformation Support
- Assigned facilitator
- Online tools
- "Boots on the ground" resources

PRACTICE QUALIFICATIONS (Based on NCQA PCC-PCMH Standards)

Benefits

- More time for patients
- Better care continuity
- Improved care transitions
- Improved quality of reporting
- More efficient care delivery
- Enhanced patient focus
- Improved patient safety
- Improved practice profitability and satisfaction
- Simplified and coordinated health care experience

PHYSICIANS PRACTICE CONNECTIONS NCQA RECOGNIZED PRACTICE

Questions?

Thank You!

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