Residency Program & Community Health Center Collaboratives

Lessons from the Field: Building a Medical Home Residency Training Program for Medicine Department & Health Centers

William Warning, MD, FAAFP

Co-Director, Education & Training Task Force, PCPCC

Program Director, Crozer-Keystone Family Medicine Residency

Springfield, PA william.warning@crozer.org

Introduction

- Presentation Outline
  - *What?*
  - *Who?*
  - *How?*

- Objectives - by the end of this presentation, attendees will be able to:
  - *List key components of one collaborative model*
  - *Replicate (at least parts) in their respective communities/settings to transform "mass" practices utilizing the PCMH/CCM*

What? Improving Performance in Practice (IPIP)

- Sponsored by the PA Primary Care Coalition (developed to address workforce needs in PA)
  - PA Academy of Family Physicians (PAFP)
  - PA Chapter, American Academy of Pediatrics
  - PA Chapter, American College of Physicians
- Strong partnership with PA Association of Community Health Centers
- Operated by the PAFP Foundation

What? Background

- PA Chronic Care Initiative (CCI) launched in May of 2008
- Goals:
  - *Transform primary care practices into Patient-Centered Medical Homes (PCMH)*
  - *Improve quality care and reduce costs for chronic diseases using the Chronic Care Model (CCM)*
- Government was "convener" and insurers "persuaded" to fund practices in a pilot program
- Over 200 primary care practices across PA
- Now part of the national CMS Multi-Payer Advanced Primary Care Practice (MAPCP)
- No delineation: academic vs. private practices

Out Of This . . .Focus on Education

- Staff from PAFP recognized the potential of this model for Family Medicine Residency Programs
- Four faculty from "successful" practices in CCI brought on to lead the Residency Program Collaborative (RPC)
- Funding
  - Initial unrestricted grant from pharma
  - Branched into "clean" source (PA DOH, CDC, etc.)
- Physician Faculty Led
  - Not "practice coach" led
  - Faculty from academics
    - Know *unique challenges and opportunities* of academic clinical practice

Who? PAFP Residency Program & Community Health Center Collaboratives

- Largest single state collaborative of its kind in the country
- Funded by PA DOH and Pharma
- Heavy focus on the Chronic Care Model and systems change with PCMH
- Full range of services: data, education, support from staff/physician faculty
- Focused on safety net providers
- More than 19,000 patients

Who? PAFP Residency Program & Community Health Center Collaboratives

- PCMH Collaborative of the FM and IM residency programs and Community Health Centers in PA
- Learning and Supportive Collaborative
- Two Groups:
  - RPC 1 started June 2010 with:
    - 19 FM Residency programs
    - 1 IM Residency program
  - RPC 2 started June 2011 with:
    - 4 FM Residency programs
    - 1 IM Residency program
    - 14 Community Health Centers

Who? RPC & CHCC Groups

- **RPC1 and RPC2 GET A FACELIFT!**
  - Collaborative Structure Change - Effective June 2012
  - Split into two distinct groups: One for the Residency Programs (RPC) and the other for Community Health Centers (CHCC)
  - Allows faculty and teams to focus on individual needs of each group!
  - Overall aim of creating a culture of continuous quality improvement and patient-centeredness remains strong!

Who? RPC & CHCC Groups

- How we look today….
  - Broad Statewide representation
  - 1 group of Family Medicine residency programs (RPC)
    - 27 participating teams
  - 1 group of Community Health Centers (CHCC)
    - 21 participating teams
  - Operated solely by PA IPIP in partnership with the PA Association of Community Health Centers

Format – What Participants "See"

- Three, one day learning sessions
  - Different parts of the state
  - Usually in conjunction with other PAFP meeting
- Monthly conference calls/webinars
- Schedule calls and/or email dialogues with physician faculty and/or staff
- Must submit monthly data reports
- Must apply for NCQA PCMH recognition

Format – Behind the Scenes
(What Faculty/Staff Do)

- Outline curriculum/overall goals/timelines
- Plan/Lead 3, 1-day learning sessions
- Oversee teams
  - Review data reports with custom feedback
  - Reach-out/cajole . . .
- Plan/Lead monthly conference calls/webinars
- Answer calls and/or email dialogues with practices
- Update Collaborative website (add resources, best practices, links, etc.)

Format – Behind the Scenes
(What Faculty/Staff Do)

(continued)

- Strategic Planning
- Financial Management
- Fundraising
- Occasional list-serve didactics/tips
- Bi-weekly planning conference calls
- Endless faculty/staff emails
  - Asynchronous planning/discussions
- Disseminate/share *about* the collaborative
  - Institute for Healthcare Improvement (IHI), PCPCC, STFM, FMEC, PAFP members, PACHC members, funders and other stakeholders

Funding - Where Does It Go?

- Physician faculty
  - Monthly stipend and travel expenses for learning sessions
  - Minimizes conflict with current jobs/roles of faculty
  - Allows real-world faculty!
    - *"To overcome that problem, in my practice we tried..."*
- Salaried staff: paid by PAFP as part of their "core" job
- No "practice coaches"
  - Due to the salaried cost and geographical logistics of covering all sites
  - Emphasize that the teams need to do the work internally…with support

What's in it for the Practices?

- NO monetary compensation except Learning Session travel reimbursement per team *(pending grant funding)*
  - But, we need buy-in from residencies AND their hospital administrators
- Educate residents for the future…*Preparing the future workforce*
- Improve quality and care in their practices
- Prepare for P4P and PCMH based incentives
- Recruitment! (students **want** to train at PCMH's)

What's in it for the Practices?

(continued)

- Credibility with home institutions
- CME
- ABFM Maintenance of Certification Part IV Credit for IPIP Collaborative
- If they don't have a registry, one provided for free (RMD)
- High quality training and education they can't get anywhere else for free
- Structured, supported community of peers

Team Participants

- Minimum 3 members (5 members ideal):
  - Physician (usually the practice Medical Director)
  - PGY2 Resident
  - Clinical Supervisor-Nurse/MA/Others
  - Practice Manager
  - IT Support

Team Requirements

- Attend live learning sessions (3x/year)
- Participate in monthly team calls
- Report monthly data
- Work with a physician mentor (faculty)
- Apply for NCQA PCMH Recognition

Faculty

- Chair, Co-Chair plus 6 Faculty
  - All primary care physicians, all faculty at residency programs
- Develop and deliver the education
- Work directly with learners
  - Each are assigned to a group of teams
- Review and interpret data

Data Collection

- Robust data systems
  - Expert staff
  - Stable, scalable platforms
- Education stresses data integrity
- Extranet where teams submit data and download reports is user friendly
- Evaluate data significance against Benchmarks
- TRANSPARENT data reporting/review

Measurement

If you don't Measure it, you can't Move it!

PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS

pennsylvania DEPARTMENT OF HEALTH

Logout: Sherrie Whisler

File Data Reports Tools Help

Metrics Data Entry

Practice: AAO
Reporting Period: July 2011

Asthma | Diabetes | Hypertension | IVD | Prevention

Metric Name	Previous Value	Current Value	Current Message(s)		
*Asth Pts 5-40 Cnt	2,000	2,200	Denominator		
* Asth Flu Vaccine Cnt	1,800	2,000	90.91%		
*Asth Persistent Cnt	1,600	1,800	Denominator		
* Asth Pharma Therapy Cnt	1,400	1,600	88.89%		

Save Submit Close

Upcoming Events

July 1, 2012
Kickoff New Website!
Virtual
more information...

July 2, 2012
Pilot Program Launch
more information...

2704 Commerce Drive, Harrisburg, PA 17110
Toll Free: (800) 648-5623 Phone: (717) 564-5365 Fax: (717) 564-4235

Project Data Diamond - Windows Internet Explorer

http://pafpweb03.pafpqi.com/D2Reporting/rdPage.aspx?rdReport=PracticeRunChart&MeasureList=0&exportButtonVisible=1&rdRequestForwarding=Form

Organization:

AAO

Measure:

- Asthma - Asth Flu Vaccine
- Asthma - Asth Pharma Therapy
- Asthma - Asth Smoke Cess
- Diabetes - DM A1C < 7
- Diabetes - DM A1C > 9

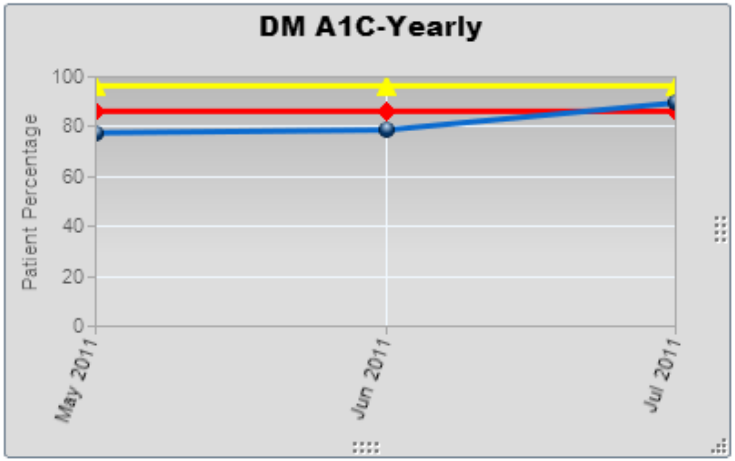
Report Starting Period: May 2011

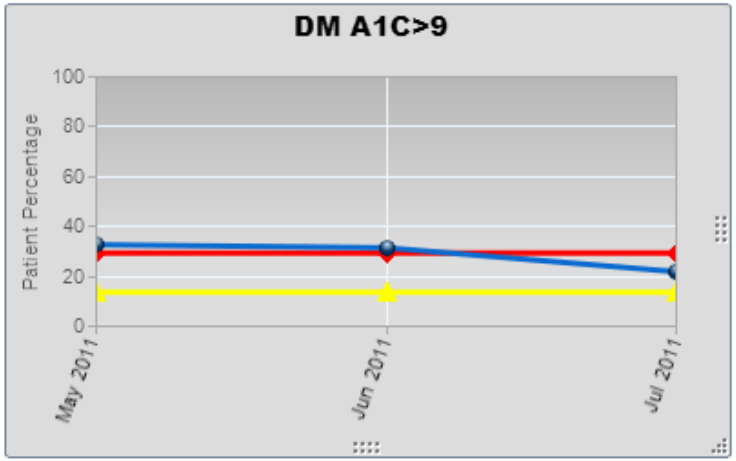
Practice
50th Percentile
90th Percentile

View Selected Measure(s) Run Charts

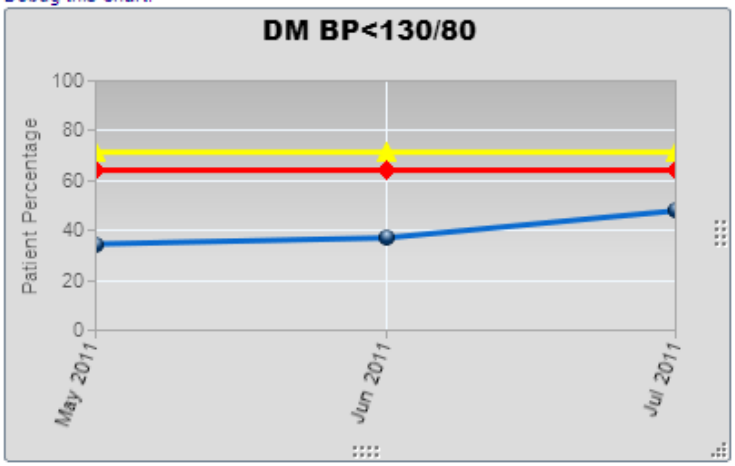
Export to PDF

eMail These Run Charts

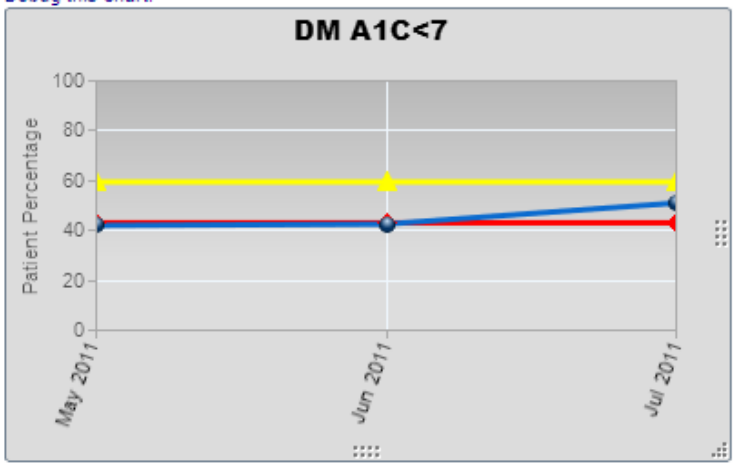




Debug this chart.



Debug this chart.



DM Measures

- Good HbA1C Control (<8)
- Poor HbA1C Control (>9)
- HbA1C Documented
- Intermediate LDL Control (<130)
- Good LDL Control (<100)
- Good BP Control (<140/80)
- Intermediate BP Control (<140/90)
- LDL Documented
- Eye Referral
- Retinopathy Screened
- Foot Examination
- Aspirin Prescribed
- Statin Prescribed
- Nephropathy Attention
- ACE/ARB Prescribed
- Self-Management Goals
- Tobacco Use Documented
- Smoking Cessation Counseling
- Diabetics who use Tobacco
- Pneumococcal Vaccination
- Influenza Vaccination

IVD Measures

- Count IVD
- Blood Pressure (<140/90)
- Lipid Testing
  - includes total cholesterol, TG, HDL-C, LDL-C
- LDL Result (< 100 mg/dL)
- Lipid Therapy
- Aspirin or Antithrombotic
- Smoking Status / Smoking Counseling

Depression Measure

Measure	Numerator	Denominator	Status	Additional Information
Screened for Depression	# Patients 18-75 screened annually for depression with a standardized tool	Total DM patients 18-75	Required	Example of tool: PHQ-2 or PHQ-9

BP Outcomes Challenge
PDSA Focus

Challenge:

Each program attempted to get **20** or more diabetic patients identified with **BP's greater than 130/80** to goal of **less than 130/80** in a four month period.

Winners:

The top teams having the greatest number of patients to achieve BP control from their baseline data (per division) **WINS!**

BP Outcomes Challenge Design

Time Frame:

June 2012 – October 31, 2012

Divisions:

Programs were assigned to one of three divisions based on panel denomination size:

Large, Medium, or Small

BP Outcomes Challenge Design

Data :

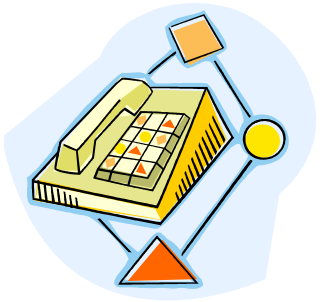
Each month teams reviewed the RPC BP performance rankings (transparent) and received a personal team run chart.

PDSAs:

Monthly PDSA cycles of change focused on Blood Pressure improvement.

BP Outcomes Challenge Design

Monthly Calls:



Teams with early successes were asked to share their PDSA's during calls so that the RPC groups could learn from their experiences.

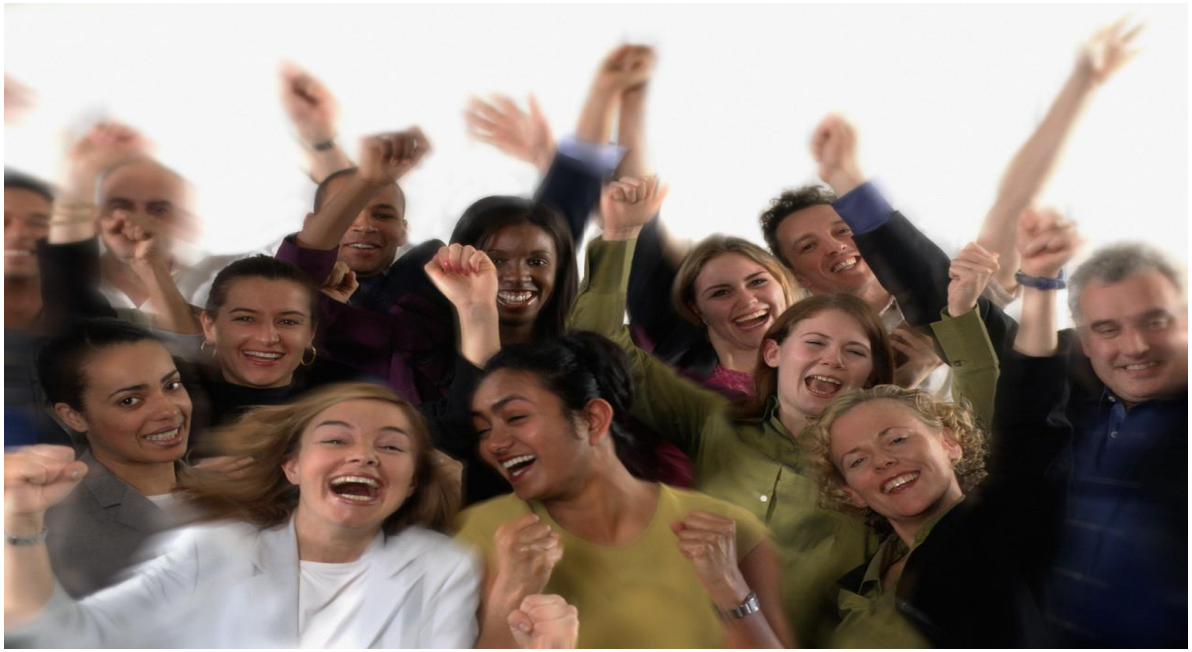
All teams were encouraged to share **challenges and barriers** that they encountered so that other programs could offer support and potential solutions.

Our Results

318 Patients Impacted

6% Increase in patients BP < 130/80

(39% to 45% control)



BP Outcomes Challenge

6% of our patients will benefit from:

- Diabetes Risk reduction: **32%** decreased risk
  - $10,683 cost savings per person
  - **$3.4 million** savings from this BP Challenge efforts
- Stroke Risk reduction: **44%** decreased risk
  - $103,576 cost savings per person
  - **$32.9 million** savings from this BP Challenge efforts

NCQA Recognition

Recognition stats for the 21 teams in the RPC as of June 2012:

NCQA Recognition (100%)

- ☆ **Level 3: 18 teams (85%)**
- ☆ Level 2: 1 team (5%)
- ☆ Level 1: 2 teams (10%)

Collaborative Learning Model

- Initially
  - Staff/faculty organized
  - Faculty-led (presentations)
  - NCQA application heavy
- Now
  - Staff/faculty organized
  - Team-led
    - "Best practice" sharing
    - Team "Sound Offs"

…A true *collaborative*

Timelines for Teams

Learning Sessions	Conference Calls Wednesdays 4:00 to 5:00 PM	Data Reporting Schedule
March 7, 2013 – Valley Forge, PA **May 31, 2013 –** Harrisburg, PA **November 8, 2013 –** Erie, PA	February 27, 2013 March 27, 2013 April 24, 2013 May 22, 2013 June 26, 2013	February 5, 2013 March 5, 2013 April 5, 2013 May 6, 2013 June 5, 2013

Sample Learning Session Agenda

	Registration – Pennsylvania Academy of Family Physicians Staff
8:00 AM – 8:15 AM - Steamtown Room	"Let's Get This Party Started!" (RPC1 and RPC2) – Dr. William Warning, RPC Faculty Chairperson and Dr. Jorge Scheirer, CHCC Faculty Chairperson
8:15 AM – 9:15 AM - Steamtown Room	"Recipe For Success – What are the Ingredients for Primary Care Practice Transformation?" – Dr. Perry Dickinson, Department of Family Medicine, University of Colorado School of Medicine
9:15 AM – 9:30 AM - Steamtown Room	"CDC Survey Update" – Sarah O'Dell, ICF International
9:30 AM – 9:45 AM	***** BREAK *****
9:45 AM – 10:30 AM - Steamtown Room	"RPC: Performance/Team Data Review" – Dr. William Warning, RPC Faculty Chairperson
10:30 AM – 11:30 AM - Steamtown Room	"Team Sharing – Outcome Results" – Dr. George Valko, RPC Faculty
11:30 AM – 12:30 PM	***** TEAM NETWORKING LUNCH - - - - - SHARE YOUR EXPERIENCES *****
12:30 PM – 1:30 PM - Steamtown Room	***** BREAKOUT SESSION for CLINICAL STAFF ***** "Implementation of PCMH into the Family Medicine Residency Curriculum" – Dr. Perry Dickinson, Department of Family Medicine, University of Colorado School of Medicine
12:30 PM – 1:30 PM - Casey Ballroom "C"	***** BREAKOUT SESSION for CLINICAL SUPPORT STAFF ***** "An Engagement Party for the Clinical Support Staff and their Patients" – Colleen M. Schwartz, RN and Judy Jones, Pennsylvania Academy of Family Physicians Staff
1:30 PM – 2:30 PM - Steamtown Room	"Depression and Diabetes" – Dr. Lee Radosh, RPC Faculty
2:30 PM – 2:45 PM - Steamtown Room	"Integration: Behavioral Health" – Pam Wilshere, LCSW, MBA, Pennsylvania Academy of Family Physicians Staff
2:45 PM – 3:00 PM	***** BREAK *****
3:00 PM – 3:30 PM - Steamtown Room	"Focus on Blood Pressure" – Dr. William Warning, RPC Faculty Chairperson
3:30 PM – 3:45 PM - Steamtown Room	"Root Cause Analysis – HTN" – Dr. William Warning, RPC Faculty Chairperson
3:45 PM – 4:15 PM - Steamtown Room	"Lowering Blood Pressure" PDSA Development and Faculty Rounds – Dr. William Warning, RPC Faculty Chairperson
4:15 PM – 5:00 PM -Steamtown Room	Team Reporting on PDSAs
5:00 PM - Steamtown Room	Wrap Up – Dr. William Warning, RPC Faculty Chairperson

Sample Team Call Agenda

Residency Program Collaborative
Wednesday, June 27, 2012
4:00 PM - 5:00 PM – Team Call
5:00 PM to 6:00 PM – Faculty Question & Answer Period

Welcome and General Announcements • Practice Monitor Survey (sent last week)---Please complete by July 3, 2012 • Penn State Evaluation of the Residency Program Collaborative – Residents encouraged to complete brief survey • June LS Travel Receipts – to Kris by July 2nd	Kris	5 minutes
*** RPC Blood Pressure Outcomes Challenge *** Let the Games Begin!!!  THE CHALLENGE:	Dr. Warning	
1. Review Blood Pressure Outcome Challenge Initiative Timeline	Dr. Warning	10 minutes
2. Review data and cohort rankings		
3. Practice specific root cause analysis: Teams should review 10 patients charts for where the most recent visit documentation confirmed BP's >140/ 90.	Dr. Warning	5 minutes
4. Sound Off- PDSA's	Dr. Radosh	5 minutes
5. Next Month (be prepared to share): a. Involve practice staff- design interventions b. Identify 10 HTN specific visits c. Invite 10 patients for visits from exception report.	Dr. Valko/Dr. Neill Dr. Warning	30 minutes 5 minutes

Next Call: 7/25/2012 ~ Webinar Information will be sent via email. Please feel free to contact Kris Samara, Dir of QI Collaboratives at ksamara@pafp.com for assistance or guidance.

Outcomes of Collaborative?

- Many outcomes we could track
- Examples:
  - Educational
  - Clinical
  - Administrative/financial
- Details available

Evaluations

- Penn State University
  - Contracted by the PAFP Foundation for an independent study to analyze the effectiveness of our intervention both in the practices and among residents
- CDC Evaluation
  - CDC's Division for Heart Disease and Stroke Prevention made decision to conduct evaluability assessments to identify policy and system-level strategies that prevent or reduce high blood pressure

Evaluations

(CDC continued)

- RPC/CHCC Collaborative awarded through a competitive evaluation program based on findings from the assessment (nominated by the PA DOH)
- 1 of 2 awardees nationwide
- 30-month intense evaluation (September 2011 start date)
- Document and confirm what the CDC already believes – that our intervention is effective
- **Expected Outcome** – Develop informed recommendations for replicating this program in other settings, disseminate and share lessons learned to practitioners, program managers and policy-makers AND Sustainability

Selected Collaborative Highlights

- *Physician* Led and supported
  - Experienced faculty who each oversaw NCQA Level 3 teams
- We began with developing the *infrastructure* and goals
  - NCQA guidelines ("litmus test" – got program/practice buy-in)
  - Then evolved into CCM implementation
- Our collaborative - similar to a "Community of Practices"
- Sustainable - lean faculty structure
  - STRONG, talented, experienced administrative support
- Large organization (PAFP) at the core
  - Can leverage resources (ex: tack on our LS's to PAFP CME to reduce overhead/costs)
  - Attract donors/funders, bridge to other organizations
  - Instant "credibility"
- IPIP recognized
- Streamlined reporting and communicating by the web (PAFP Quality Improvement site)
- Performance Improvement Tracking Tool
  - Allows teams to be self reflective
  - Organizes specific faculty suggestions

Selected Collaborative Challenges

- Participant AND faculty distractions
  - Clinical (other responsibilities, flu season, etc.)
  - Residency (resident orientation, recruitment season, holiday season, etc.)
- Lack of administrator buy-in
  - Must be able to show clear benefits to hospital system
- Lack of financial incentive for practices
  - Sustainability (beyond practices' interests in PCMH recognition)?
- Evolving / expanding goals by dynamic faculty and staff (exciting opportunities, but too many directions?)
- Inconsistent data reporting by some practices
  - Takes 6 months to get good, consistent reporting
  - Data integrity an issue early on
- Curriculum is fluid . . driven by participants' needs
  - A positive . . but a challenge!
- Constantly Changing healthcare world
  - CCM/PCMH should be king . . or we all bought into a failed experiment

Summary

- A large collaborative like this can be developed and sustained
- Identify the goals (PCMH recognition, CCM transformation, etc.) and infrastructure, *then* the format/details
- Utilize experienced peers (such as physicians) with similar challenges/understanding as participants
- Leverage technology (webinars, data management tools, etc.) and asynchronous communication
- Hire outstanding support staff to oversee/develop the day to day operations and logistics
  - Faculty provide leadership/vision and practice assistance
- Be flexible in curriculum and format

Questions/Comments