

PATIENT CENTERED MEDICAL HOME:

Community Medical Providers' Success

A
project of the
Community Medical
Providers medical group,
California Academy of Family
Physicians and Fresno Unified
School District/Joint
Health Management
Board



CALIFORNIA ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR CALIFORNIA

CONTENTS

- 01** OVERVIEW • 3

- 02** PATH TO SUCCESS • 5

- 03** CRITICAL SUCCESS FACTORS • 8

OVERVIEW

01

Looking for ways to improve the health of beneficiaries and address the escalating costs of care, the self-insured Fresno Unified School District/Joint Health Management Board (JHMB) decided in late 2010 to join the California Academy of Family Physicians (CAFP) in supporting a local Patient Centered Medical Home (PCMH) initiative. In July 2012, after 18 months of preparation and training, a primary care medical group – Community Medical Providers (CMP) – launched the initiative. One year later, at the end of June 2013, CMP had saved the district nearly \$1 million in total claims.

The project, a collaboration of CMP, CAFP and the School District, covered approximately 2,500 patients comprising 10 percent of the District's 25,000 beneficiaries.

Goals included improving the quality of care in specific disease areas such as diabetes, cardiovascular disease and behavioral health; improving prevention and medication adherence; and reducing costs associated with emergency room visits, hospital admissions and prescription drugs. The primary care practices in this project succeeded in all of these areas.

Over 12 months, the number of patients with diabetes whose blood sugar had been confirmed as under control increased by 50 percent. Among patients with diabetes and patients with coronary artery disease, blood pressure control and low-density lipoprotein (LDL) control increased significantly. Breast cancer screening and body mass index counseling increased across the entire patient population and patient satisfaction improved. Medication adherence among high-risk members increased by seven percent.

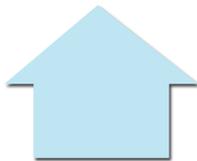
High-risk member costs decreased by 16 percent; inpatient admissions decreased by nearly 22 percent; and emergency department visits decreased more than three percent. The cost of total claims decreased by nine percent for a gross savings of more than \$972,000.

Project Results

Community Medical Partners achieved several measurable improvements over 12 months, including:

Clinical Measures

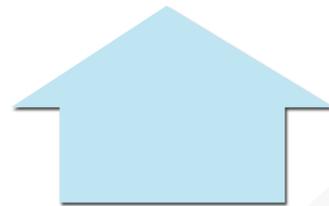
The number of patients with diabetes for whom blood sugar was confirmed as under control **increased by 50%**



Medication adherence among high-risk patients **increased.**



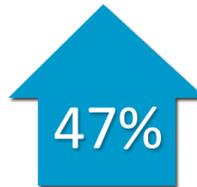
Among patients with **diabetes** and patients with **coronary artery disease**, blood pressure control and LDL control **increased significantly.**



Breast cancer screening and body mass index counseling **increased across the entire patient population.**

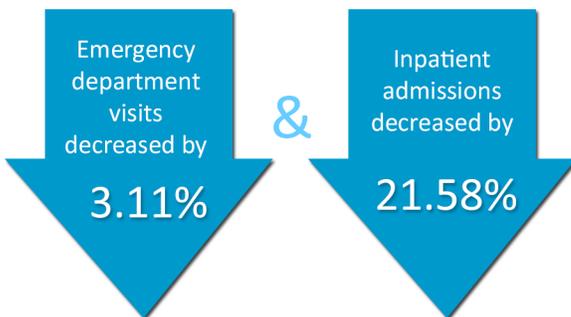


Patient satisfaction **increased.**



The percentage of school district beneficiaries working with the Employee Assistance Program (a new referral target) **increased by 47%.**

Hospitalizations and emergency department admissions **decreased:**



Health care dollars were saved:

\$972,519

Medical claims spend **decreased** by 9% for a savings of \$972,519.



PATH TO SUCCESS

02

“Health care as we know it is changing and the Patient Centered Medical Home is going to be a significant part of that. It’s about delivering a service when it’s needed and not worrying about the cost. It’s delivering appropriate care, measuring the outcomes and doing the right thing for the patient.”

Grant J. Nakamura, MD, FAAFP,
Medical Director, Community
Medical Providers

CMP – a multi-practice medical group of 45 physicians, nurse practitioners and physician assistants across multiple sites at the start of this project, and now grown to 68 physicians and other professionals – accomplished improvements during the initiative by making several practice changes necessary to function as medical homes.

Eight CMP practices received initial PCMH coaching from HealthTeamWorks. By December 2012, the CMP quality improvement (QI) coach had expanded the PCMH project to all 16 CMP practice sites. Physicians, other providers and staff learned about the PCMH model and change management; transitioning to team-based care; using registries to better track patient conditions and the care received; using more-sophisticated data collection from electronic health records (EHR) to evaluate care and outcomes; hiring a QI coach to coordinate ongoing change work, measurement and feedback; and hiring a complex case manager to proactively reach out to high-risk patients.

Getting Started

“Six critical stages shape a transformation like this,” said CAFP Executive Vice President Susan Hogeland, CAE. *“Each one is important and they often overlap. These include:*

- *research, planning and design;*
- *initial physician, provider and staff education and implementation;*
- *engagement and prior data collection;*
- *the initiative;*
- *analysis and review; and*
- *evaluation of opportunities for broader implementation.”*

After initial months of pre-project discussions, official PCMH work began in November 2011

with research, planning and design. The Physician Advisory Group meetings, PCMH coaching and education began in January 2012. Practices began redesign and other QI work in summer 2012. CAFP hired consulting firm HealthTeamWorks to assist with Stages 1 and 2. CMP then hired a QI coach on staff in fall 2012. CAFP provided additional assistance throughout the initiative.

Claremont Partners, a consulting firm working with JHMB throughout the initiative, handled data warehousing, measurement, analysis and assistance in identifying opportunities for improvement.

“Transforming a practice into a medical home is work. It’s time-consuming and expensive, and you need good support behind you, but it’s an investment in doing the right thing. I’m convinced this model can transform medical care in America.”

Kevin Wingert, MD, CMP Family Physician

Preparation for the initiative and transformation to medical homes occurred chronologically as follows:

2011

- Identifying leaders/decision makers/champions
- Determining which CMP practices would participate
- Forming Physician Advisory Group to lead initiative
- Forming the PCMH Operations Group and site-specific QI teams
- Confirming budget, funding sources and payment structure for the initiative
- Measuring readiness among CMP practices to begin transformation work
- Gathering data and developing a dashboard for baseline and improvement data
- Identifying opportunities for improvement
- Defining the “high-risk” patient category
- Beginning grant-funded practice redesign

2012 (January – June)

- Initiating recurring team meetings, team building and extensive QI/PCMH education
- Establishing expectations for teams (e.g., sufficient time to meet, learning session participation and data-submission requirements)
- Ongoing Physician Advisory Group, Operations Committee, and site-specific QI Team meetings and training
- Selecting registry, population management software (CDEMS)
- Finalizing which metrics to use (e.g., quality measures, utilization measures such as hospital and emergency department admissions and pharmacy spend, Employee Assistance Program (EAP) referrals and patient and staff satisfaction data)
- Designing processes to improve in areas being measured (e.g., new processes for EAP referrals, prescribing practices, office flow, registry use, patient education and visit follow-up)
- Deciding on responsibilities and model for new care manager & QI coach position
- Finalizing CMP compensation plans with JHMB

July 2012 – June 2013

- 12-month measurement period

July 2012 – December 2013

- Full PCMH Initiative

CRITICAL SUCCESS FACTORS

03

CMP leaders attribute their many substantial improvements to a multi-faceted, sweeping-but-focused dedication to change based on the critical success factors they identified. Using these, they met the six characteristics identified by Rachel Willard, MPH and Thomas Bodenheimer, MD in their article, *“The Building Blocks of High-Performing Primary Care: Lessons from the Field,”* published by the California Health Care Foundation in 2012. This research shows that the essential characteristics are: data-driven improvement, empanelment and panel size management, team-based care, population management, continuity of care and prompt access to care.

Investing in Information Technology

The CMP practices had paper medical records at the start of this project and needed to select disease/population management software to be better able to create patient registries and plan and monitor care. The Physician Advisory Group evaluated available products and selected the Chronic Disease Electronic Management System (CDEMS). CMP now is moving to EPIC as part of an initiative by Santé IPA, which will eventually allow patients to view their medical records, including lab results.

“You’ve got to have a good registry,” said CMP family physician Kevin Wingert, MD.

“They’re a highly motivated group that accepts nothing less than perfection. They want to do the best for patients, so they respond to data that inspire and support meaningful change.”

Laurie Frye, MPH, CMP QI Coach

“If you don’t, this can’t work. The computer is going to be able to tell you how you’re doing.”

Becoming more data based has been time-consuming and expensive, physicians reported, and the cost of upgrading information technology can be one of the most expensive investments needed for PCMHs. The resulting data, however, are nearly priceless.

CMP designed a process, for example, for using the registry to run a list of patients who were due or overdue for mammography exams. Office staff members sent each woman a letter with an enclosed referral slip. Several months after this first campaign, a patient arrived for her annual check-up and told staff members she would always come to their office for care because they had “saved my life.” When she received the reminder letter and referral, she had gone for an exam and a lump was found in one breast. As a result of the timely reminder letter for her mammography exam, the lump in her breast was caught early and removed. She

shared with the CMP Office staff that she was now “cancer-free.”

Gathering Data

The fee-for-service payment model has encouraged a U.S. health care system in which care is episodic and heavily weighted toward specific procedures. Changing the focus to population management, identifying opportunities for improvement and measuring change are major activities in medical homes. Improving blood pressure, blood sugar and LDL levels across an entire patient population, for example, requires data.

Laurie Frye, MPH, CMP’s QI coach, offered this example: *“One of our physicians said, ‘I can tell you that the A1C levels for all of my patients with diabetes are at 7 or under.’ When I ran a subset of diabetes patients report from the registry, the report showed that he was correct. Among all the patients whom the physician had seen and knew had diabetes, their A1C results were 7 or below.*

Among patients with diabetes and patients with coronary artery disease, blood pressure control and LDL control increased significantly



“What the physician didn’t realize, however, was how many of his patients with diabetes hadn’t been seen at the office recently, and hadn’t had a current A1C test. As it turned out, several patients who hadn’t been to the office had old A1C test results over 7 and some over 9. That’s the challenge of manual charts and no registry. That physician was practicing excellent medicine, but he needed more information to be able to deliver care where it was needed.”

A 15-minute patient visit can be more robust with a physician engaged in decision-making, rather than looking through a chart, whether paper or electronic, to determine when the last mammogram or lab tests took place, PCMH proponents point out. Using registries and established office processes in a PCMH, for instance, a medical assistant can provide referral forms and lab slips when needed, based on a patient’s diagnosis and previous care as

indicated in an EHR and the physician can then simply decide whether to use them.

Creating a Robust QI Infrastructure

The sequence of hiring QI consultant HealthTeamWorks; creating the Physician Advisory Group, PCMH Operations Group and individual site QI teams; and then hiring an on-staff QI coach set CMP up for success and gave the group a structure to support ongoing QI work in the future. Initial intensive training for teams and ongoing education ensure each group has the tools necessary to continually improve care.

“Our consultants train and coach health care teams to achieve continuous quality improvement using a systems approach,” said HealthTeamWorks CEO Marjie Harbrecht, MD, a family physician.

“ Knowledge is crucial, but it’s only as valuable as the systems used to reliably apply it.”

Marjie Harbrecht, MD, CEO, HealthTeamWorks

“The goal is to make measurable impacts on cost, quality and the experience of healthcare for patients and the healthcare team.”

The Physician Advisory Group leads CMP's PCMH work. Physician members monitor improvements as well as opportunities for additional improvements in patient care, leading the charge to move to ever-greater levels of quality and patient-centeredness. They also monitor where CMP stands on the steps necessary for NCQA PCMH recognition, identify challenges and barriers to reaching the next steps and prioritize which issues to tackle to move forward.

The five-member Physician Advisory Group includes the chief medical officer, two family medicine physicians, a pediatrician and a family

nurse practitioner. Members were selected based on several criteria, including:

- (1) a passion for and willingness to be a leader for the PCMH transformation; and
- (2) practicing at a site with a large number of Fresno Unified School District patients.

The PCMH Operations Group, comprised of one physician and one team leader from each practice, leads and oversees the implementation work.

A QI Team at each site leads individual practice transformation among all the physicians, providers and staff. Process improvements are a major part of their work.

“ Less-than-optimal care rarely arises from lack of medical knowledge, but rather comes from the absence of reliable, efficient processes and systems that make it easy to apply consistent guidelines and protocols.”

Marjie Harbrecht, MD

Mastering Change Management and QI Skills

Quality improvement is a science. With evidence-based QI approaches, CMP made considerable patient care improvements and saved nearly a million dollars in just one year. Such gains are not easy to realize, however, and require entirely new ways of thinking and working together.

When moving from “the way we’ve always done things” to new goals, skills, systems and processes, really understanding and then using QI principles can make the difference between success and failure.

Learning best practices is also vital and saves teams from recreating an already excellent wheel. This speeds up the improvement cycle and prevents teams from implementing

intended solutions that have a lower chance of success. The role of a QI coach in helping bring about these changes is key.

“The role of the QI coach is that of motivator, facilitator, communicator and educator,” said Ms. Frye. *“As a coach, I support busy primary care practices and QI teams as they develop skills such as change management (Plan, Do, Study, Act or the PDSA cycle), setting and prioritizing goals, developing action plans, problem solving and workflow mapping. A key role is supporting the monthly QI team meetings to keep a disciplined rhythm and pace toward improving outcomes for patients, families and staff.”*

**New Goals, Skills,
Systems and
Processes**



“ We’re helping patients understand what health and wellness really mean and not just taking care of the sick moment.”

Adriana Padilla, MD, CMP Family Physician

Engaging in Practice Redesign

Moving to team-based care and improving medical practice and office operations are at the heart of a successful quality improvement effort.

Early in the process, CMP began considering ways to manage high-risk patients more effectively. Creating high-functioning teams responsible for patients' care and outcomes has been shown repeatedly in other PCMH projects to be a lynchpin of success, and so was a main focus here. Dr. Wingert and CMP family physician Patrick J. Stuart, DO, FAAFP led the move to teams at CMP because the model made sense to them.

"We already worked somewhat in this model," Dr. Wingert said, *"but formalizing roles so*

everyone works at the top of their license and capacity, and adding a QI coach and complex care manager to the mix took us to a new level."

The transition to teams and to new roles for physicians, nurse practitioners, medical assistants and office staff started with the physicians, who decided which aspects of their work could be delegated. Training, standing orders and protocols ensured that quality remained high.

"Over time, as processes became more refined, trust became stronger," Ms. Frye said. *"The teams are becoming more and more sophisticated within this model over time."*

“It's always really nice to see the light start to shine in patients' eyes when they begin to understand the concept of prevention and not just seeing the doctor for not feeling well.”

Adriana Padilla, MD

Investing in Care Coordination

Better coordinating patients' care between visits, among referral targets and post-hospitalization is another effective PCMH practice that has an enormous impact on patient care, patient satisfaction and cost reduction.

Consistently scheduling a patient with the same primary care physician on consecutive visits is a start. Hiring a care coordinator – one of the main investments CMP made – is another strong step. Designing processes so the practice knows whether a patient filled a prescription, went for lab tests, followed through on a referral or was recently hospitalized are others.

"I have the privilege of reaching out to some of our patients by phone before and after office visits to provide additional health education, assist with challenges and support these patients toward reaching the health goals they have created with their physicians," said CMP PCMH Care Coordinator Raquel Hernandez-

Chavez, RN. *"This type of outreach supports the continuity of care that's a significant component of a PCMH."*

With a well-timed phone call to a 76-year-old patient recently discharged after a hospitalization for sepsis, for example, Ms. Hernandez-Chavez learned that the patient interpreted "q 12 hours" to mean he should take his prescribed antibiotic at the same time every morning. She explained that he needed to take the medication at both 10 am and 10 pm and he agreed.

Care coordination is part of the reason that medication adherence rates among high-risk patients in the PCMH initiative increased seven percent compared with the Fresno Unified School District group as a whole.

"This is quite an accomplishment and the first time any program has increased medication adherence rates since we began collecting data on the plan in 2007," said Devon Devine, JD, a Claremont Partners consultant.

Developing New Kinds of Relationships with Patients

Communication between physicians, other providers and patients in a medical home is collaborative, with the goals of providing patient education and empowering patients to take responsibility for their health as well as their illness. From motivational interviewing to identifying and solving barriers to care, physicians and other providers can forge a patient relationship that lasts long past the appointment.

"It's always really nice to see the light start to shine in patients' eyes when they begin to understand the concept of prevention and not just seeing the doctor for not feeling well," said CMP family physician Adriana Padilla, MD. *"That's a missing part of the equation for trying to keep the patient population healthy – we're helping patients understand what health and wellness really mean and not just taking care of the sick moment."*

"That's the change – not coming in just for the prescription, but for the education as well," said CMP Family Nurse Practitioner Terri Dickey, FNP.

"The way we work now, patients can actually see their progress with their weight, their blood pressure," said CMP Team Leader Carrie Garant. *"We've always been a friendly office, but it has helped to be able to look at things together and bring the patients into that conversation. It gives them the feeling that they have better control over their health care."*

Offering expanded access with longer office hours, same-day appointments for urgent needs, reasonable wait times, after-hours options (such as CMP's Urgent Care office), essential and timely referrals and electronic communication options (such as email and access to EHRs) all contribute to patients' sense that this is, indeed, their medical home.

“That’s the change – coming in not just for the prescription, but for the education as well.”

Terri Dickey, FNP, CMP Family Nurse Practitioner

Establishing Compensation for Care Management and Coordination

Stepping out of the constraints built into a health care system based on a fee-for-service model – and a system in which prevention and primary care have long been undervalued – takes time, energy, determination, optimism, commitment ... and funding.

Preventive health care, expert management of chronic conditions and patient education and empowerment are not adequately funded in a health care system that has focused instead on treating conditions after they become emergencies or at least acute.

Payment reform is an essential part of moving to a PCMH model because the investments in information technology, new staff positions and new ways to utilize physicians' time must be appropriately funded.

CAFP and JHMB together supported CMP in making these essential investments and changes, and the results speak for themselves.

This practice transformation was made possible by a three-tiered blended payment model that included fee-for-service payments for visits and services; a monthly payment (tied to the number of beneficiaries included in the initiative) that supported additional care coordination and health information technology upgrades; and bonus payments for achieving quality improvements and cost reductions.

“What seemed a Quixotic quest is now taking shape,” said Dr. Stuart. “With the desired goal of cost-effective improvements in medical outcomes and patient experience, we’re moving forward with confidence.”

Preventive health care, expert management of chronic conditions and patient education and empowerment are not adequately funded in our health care system.

“ This is quite an accomplishment – the first time any program has increased medication adherence rates since we began collecting data on the plan in 2007.”

Devon Devine, JD, Claremont Partners, Consultant to Fresno Unified School District/Joint Health Management Board

Contact Us

For more information about transforming a medical practice into a Patient Centered Medical Home, please contact:

- **Leah Newkirk**, JD, Vice President, Health Policy, California Academy of Family Physicians, lnewkirk@familydocs.org
- **Devon Devine**, JD, Claremont Partners, ddevine@claremontpartners.net
- **Laurie Frye**, MPH, Quality Improvement Coach, Community Medical Providers, lfrye@santehealth.net



CALIFORNIA ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR CALIFORNIA