Strategies for Achieving PCMH

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Primary Care Delivery Transformation Through Patient Centered Medical Homes

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All 40 of Morton Plant Mease Primary Care’s practice locations, including the USF-MPM Family Medicine residency practice site, received Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) Level 3 Recognition from the National Committee for Quality Assurance (NCQA).

USF-MPM FM Program was the first residency practice site in Florida (any specialty) to receive PPC-PCMH Recognition from NCQA.
My Background

Clinically Integrated Network
Master of Science in Healthcare Quality & Safety Management

The Master of Science in Healthcare Quality and Safety Management (MS-HQSM) is a specialized degree program offered by the Jefferson School of Population Health (JSUP) in cooperation with the American College of Physician Executives (ACPE). The MS-HQSM degree program is designed specifically for physician
Setting the Context

How did PCMH evolve and why pursue it?  
How to transform your practice into a PCMH?
Health care in the United States is not as safe as it should be—and can be. At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.
U.S. health care delivery system does not provide consistent, high-quality medical care to all people. Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge—yet there is strong evidence that this frequently is not the case. Health care harms patients too frequently and routinely fails to deliver its potential benefits. Indeed, between the health care that we now have and the health care that we could have lies not just a gap, but a chasm.
Rising Costs Not Sustainable

Health Care Spending as Percentage of GDP

OECD Average in 2011 = 9.3% of GDP

Source: OECD Health Data 2013. Produced by Veronique de Rugy, Mercatus Center at George Mason University.
**Lowest Rank at Highest Cost**

**EXHIBIT ES-1. OVERALL RANKING**

<table>
<thead>
<tr>
<th>COUNTRY RANKINGS</th>
<th>Top 2*</th>
<th>Middle</th>
<th>Bottom 2*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OVERALL RANKING (2013)</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Quality Care</td>
<td>2</td>
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<td>Effective Care</td>
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<tr>
<td>Access</td>
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<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Cost-Related Problem</td>
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<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>11</td>
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</tr>
<tr>
<td>Efficiency</td>
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<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Equity</td>
<td>5</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Healthy Lives</td>
<td>4</td>
<td>8</td>
<td>1</td>
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<tr>
<td>Health Expenditures/Capita, 2011**</td>
<td>$3,800</td>
<td>$4,522</td>
<td>$4,118</td>
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</tbody>
</table>

Notes: * Includes ties. ** Expenditures shown in SUS PPP (purchasing power parity); Australian $ data are from 2010. Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).
Mandates Going Forward

• Improve safety

• Improve quality
  – Patient care
    • Processes
    • Outcomes
  – Patient experience

• Lower per capita costs
“Strategic planning does not deal with future decisions. It deals with the futurity of present decisions. Decisions exist only in the present. The question that faces the strategic decision-maker is not what his (or her) organization should do tomorrow. It is: What do we have to do today to be ready for an uncertain tomorrow?”

Peter Drucker, 1909 – 2005
“Father of Modern Management”
Strategic Planning:
Defined for a Family & Sports Medicine Doc

“Don’t skate to where the puck is, but where the puck will be.”

Wayne Gretzky
NHL Player then Team Owner
The Future of Family Medicine (FFM) Project

- Strategic plan for FM
- Embraced IOM reports
- Published in 2004
- Market research
- Six task forces
- Summary report published in *Annals of Family Medicine*
- Full text PDF version available at [http://www.annfammed.org/cgi/reprint/2/suppl_1/s3](http://www.annfammed.org/cgi/reprint/2/suppl_1/s3)
- Proposed a new practice model
FFM Components of the “New Model Practice”

- Personal *medical home* (borrowed from Pediatrics)
- Patient-centered care
- Team approach
- Elimination of barriers to access
- Advanced information systems
- Redesigned offices
- Integrated whole-person orientation
- Care provided in a community context
- Emphasis on quality and safety
- Enhanced practice finance
- Commitment to provide Family Medicine’s consistent set of services
Joint Principles of the Patient-Centered Medical Home (PCMH)

- Developed through collaboration among the US primary care medicine organizations
  - American Academy of Family Physicians (AAFP)
  - American Academy of Pediatrics (AAP)
  - American College of Physicians (ACP)
  - American Osteopathic Association (AOA)
- Published in February 2007
Joint Principles of the PCMH

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Payment changes
Lessons Learned from AAFP PCMH Demonstration Project

• Change is NOT easy!
  – Humans resist change
  – Change has a cycle
  – Kotter’s change model

• Four critical factors for success
  – Leadership
  – Teamwork
  – Communication
  – Resilience
Humans Resist Change

Are you too busy to improve?

No thanks!

We are too busy
The Change Cycle

- Uninformed Optimism (Honeymoon period)
- Informed Optimism
- Informed Pessimism
- Completion
Kotter’s Change Model

1. Create a sense of urgency
2. Pull together a guiding coalition
3. Develop change vision and strategy
4. Communicate for understanding and buy-in
5. Empower all others to act
6. Produce short-term wins
7. Don't let up!
8. Create a new culture
Human Resilience

• Adversity Quotient (AQ)
  – One’s hard-wired pattern of responding when “bad” things happen
Communication

\[ \frac{n(n-1)}{2} \]

- 2 people = 1 communication channel
- 4 people = 6 communication channels
- 12 people = 66 communication channels
- 15 people = 105 communication channels
- 50 people = 1,225 communication channels
- 12,000 people = 71,994,000 communication channels
NCQA Recognition
2008 PCMH Standards

Does your medical home practice have the infrastructure in place to begin to do population health management?
NCQA Recognition
2011 PCMH Standards

Do you have the infrastructure in place, AND are you actively managing the health of the population that makes up your medical home practice?
NCQA Recognition
2014 PCMH Standards

Do you have the infrastructure in place, are you actively managing the health of the population that makes up your medical home practice, AND are you collaborating with behavioral health, AND is your quality (process measures, outcomes, patient satisfaction scores) improving?
The Cold, Hard Truth About PCMH Recognition
The Cold, Hard Truth About PCMH Recognition
Evidence Supporting PCMH


CMS Comprehensive Primary Care Initiative (CPCI)

- 500 primary care medical home practices across 8 states are participating
- This represents 2,144 providers serving an estimated 313,000 Medicare beneficiaries
Impact of CMS CPCI

• Providing additional evidence that the PCMH model improves quality of care, enhances patient safety, increases patient satisfaction, and reduces per capita healthcare costs

• As a result, using an existing provision in the Affordable Care Act, CMS is likely to change the way it reimburses primary care practices across the US to a more value-based model, followed by most third party payers (insurance companies and large employers)

• After this occurs, *primary care practices that are not PCMH practices could suffer financially and some may become non-viable*
HHS has set a goal of tying 30% of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50% of payments to these models by the end of 2018.

HHS also set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.

This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

CMS’ Modus Operandi
Two Reasons This Is NOT the Preferred Strategic Response
And HHS Is Targeting the Entire System, NOT Just CMS

- To make these goals scalable beyond Medicare, Secretary Burwell also announced the creation of a Health Care Payment Learning and Action Network.
- Through the Learning and Action Network, HHS will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs.
- HHS will intensify its work with states and private payers to support adoption of alternative payments models through their own aligned work, sometimes even exceeding the goals set for Medicare.
- The Network will hold its first meeting in March 2015, and more details will be announced in the near future.

Goals for PCMH at GHS

• Achieve the IHI Triple Aim
  – Improve population health and clinical outcomes, improve patient experience, decrease per capita costs

• Management of chronic conditions
  – Emphasis in patient education, patient self-management, and risk stratified care management

• Focus on managing high-risk, complex patients

• Focus on improving care coordination
  – Managing transitions from hospital to home, or hospital to post-acute care, and follow up appointments with primary care providers
Goals for PCMH at GHS

- Greater emphasis in preventative care
  - Patient reminders for immunizations, screenings, labs, etc.
- Reduce hospitalizations, readmissions, and ED visits
- Reduce medication errors
- Increase patient understanding of medications
- Population health management and use of EHR, registries, and HIE (through CCI) to improve overall care
- Improve constantly (part of GHS’ mission)
- Transform healthcare for the good of the patients and communities we serve (GHS’ vision)
CMS Meaningful Use Criteria Moved Us Toward NCQA 2011 PCMH Standards

CMS Meaningful Use

Goal A: Improve quality, safety, efficiency, & reduce health disparities

Goal B: Engage Patients and Families

Goal C: Improve Care Coordination

Goal D: Improve Population and Public Health

Goal E: Ensure Adequate Privacy & Security Protection for PHI

NCQA PCMH 2011

PPC1: Access and Communication

PPC2: Patient Tracking & Registry

PPC3: Care Management

PPC4: Pt Self Management Support

PPC5: Electronic Prescribing

PPC6: Test Tracking

PPC7: Referral Tracking

PPC8: Performance Improvement

PPC9: Advanced Electronic Comm
PCMH Progress at GHS

• PCMH concept introduced to Primary Care Focus Group in 2013 and consensus was to pursue
• Camden Group engaged late 2013/early 2014
• PCMH Physician Champions identified
• PCMH Steering Committee & Task Force were formed and continue to meet regularly
## PCMH Steering Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Martha Paap</td>
<td>PCMH Specialist</td>
<td>CCI</td>
</tr>
<tr>
<td>Scott Hultstrand</td>
<td>PCMH Consultant</td>
<td>SCMA</td>
</tr>
<tr>
<td>Angelo Sinopoli, M.D.</td>
<td>VP &amp; CMO/President</td>
<td>GHS/CCI/MyHFN</td>
</tr>
<tr>
<td>Sean Bryan, M.D.</td>
<td>Physician, Chair</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>Jennifer Snow</td>
<td>Strategic Project Director</td>
<td>Clinical Integration</td>
</tr>
<tr>
<td>William Curran, M.D.</td>
<td>Physician, Vice Chair</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>Joanne Skaggs, M.D.</td>
<td>Physician</td>
<td>Internal Medicine</td>
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<tr>
<td>William Childers, M.D.</td>
<td>Physician, Vice Chair</td>
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</tr>
<tr>
<td>Graham Lawrence, M.D.</td>
<td>Physician</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>George Haddad, M.D.</td>
<td>Physician, Vice Chair</td>
<td>Pediatrics</td>
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<tr>
<td>Nancy Markle</td>
<td>VP of Clinical Operations</td>
<td>CCI</td>
</tr>
<tr>
<td>Jennifer Smith</td>
<td>Director, Administration</td>
<td>Internal Medicine</td>
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<tr>
<td>Susan Mullinax</td>
<td>Director, Administration</td>
<td>Family Medicine</td>
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<tr>
<td>Marc McCauley</td>
<td>Director, Administration</td>
<td>Pediatrics</td>
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<tr>
<td>Stacey Beers</td>
<td>Manager, Practice Operations</td>
<td>Internal Medicine</td>
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<tr>
<td>Pam Smith</td>
<td>Manager, Practice Operations</td>
<td>Family Medicine</td>
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<tr>
<td>Christina Wheeler</td>
<td>Manager, Practice Operations</td>
<td>Pediatrics</td>
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<tr>
<td>Candice Springs</td>
<td>Project Coordinator</td>
<td>Clinical Integration</td>
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<tr>
<td>Peter Maurides, M.D.</td>
<td>Physician</td>
<td>Internal Medicine</td>
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<tr>
<td>Mary Ann Shepard, M.D.</td>
<td>Physician</td>
<td>Pediatrics</td>
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## PCMH Task Force

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<tr>
<td>Pam Smith</td>
<td>Manager, Practice Operations</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>Patricia Savoie</td>
<td>Referral Specialist</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>Debbie Babb</td>
<td>Clinical Coordinator</td>
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<tr>
<td>Donna Gosnell</td>
<td>Practice Manager</td>
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<tr>
<td>Duke Spinelli</td>
<td>Practice Manager</td>
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<tr>
<td>Jennifer Alexander</td>
<td>Office Coordinator</td>
<td>Family Medicine</td>
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<tr>
<td>William Childers, M.D.</td>
<td>Physician, Vice Chair</td>
<td>Family Medicine</td>
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<tr>
<td>Julie Kay</td>
<td>Coding Specialist</td>
<td>Pediatrics</td>
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<tr>
<td>Christina Wheeler</td>
<td>Manager, Practice Operations</td>
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<tr>
<td>Michelle Albrecht</td>
<td>Practice Manager</td>
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<tr>
<td>Sherry Mathis</td>
<td>Practice Manager</td>
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<tr>
<td>Billie Joe Paige</td>
<td>Practice Manager</td>
<td>Internal Medicine</td>
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<tr>
<td>Laura Sweatt</td>
<td>Practice Operations Specialist</td>
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<tr>
<td>Meg Carter, M.D.</td>
<td>Physician</td>
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<td>Stacey Beers</td>
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<tr>
<td>Carmel West</td>
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<tr>
<td>Leslie Owens</td>
<td>Clinical Services Manager</td>
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<tr>
<td>Temetria Adams</td>
<td>Information Technology</td>
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<tr>
<td>Barbara Kraft</td>
<td>EHR Informatics</td>
<td>Information Services</td>
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<tr>
<td>Rebecca Cannon</td>
<td>EHR Informatics</td>
<td>Information Services</td>
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PCMH Progress at GHS

- Corporate level application to NCQA
  - 3 GHS/UMG practices selected to represent the 31 GHS/UMG practices that qualified
    - Cross Creek Internal Medicine
    - Pediatric Associates – Greer
    - Riverside Family Medicine – East
  - Submitted to NCQA in April 2014
    - 11 standards and 1 must pass element
  - Response from NCQA received June 2014
    - Received 30.75 out of possible 34 points
PCMH Progress at GHS

• Individual level applications to NCQA
  – 1 GHS/UMG practice has to submit outside of the corporate level application
    • Different version of eCW

• Total of 32 GHS/UMG primary care practices applying to NCQA for PCMH Recognition
  – All site specific applications will be submitted before the end of March 2015
Next Steps at GHS

- Await practice by practice responses from NCQA
- Celebrate NCQA PCMH Recognitions
- Look for opportunities to learn from mistakes and grow stronger as a team
- Begin to implement NCQA 2014 PCMH Standards
- Continue evolving into advanced medical homes within evolving advanced medical neighborhoods within an integrated care delivery system within a clinically integrated network
Thank You! Questions?

G H S C l i n i c a l U n i v e r s i t y P a r t n e r s