Primary Care Transformation in Academic Medical Centers

*IHI Improving Patient Care in the Office Practice and Community*

March 10, 2014

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Objectives of Session

- Describe an approach to launching a collaborative across academic primary care practices
- Describe early findings from the work at Harvard Medical School, including findings on leadership engagement, team structures, patient and provider satisfaction, and clinical process and outcome measures.
- Identify key lessons learned that others can apply in transforming primary care teaching practices in academic medical centers
Introductions
Overall Goal/Aims of AIC

• Create a learning community across Harvard clinical affiliates focused on continuously improving systems for primary care delivery and education
• Create a platform for combined educational and delivery innovation
  – Trainees are integrated within high-functioning primary care teams that provide:
    ➢ proactive, population-oriented care focused on wellness, prevention and highly effective chronic disease management
• Achieve sustainable improvements in the experience of care for patients in our affiliated clinics
• Increase quality and start to reduce costs for patients at our affiliated clinics

Double Helix of Academic Primary Care Delivery Reform

Practice Change  Educational Change

Building Blocks for Change
- Teams
- Leadership
- QI strategy
- Empanelment
The Academic Innovations Collaborative

- 19 AMC-affiliated primary care practices
  - 6 hospital-based
  - 13 community-based
    - Community health center and private practices
- 11 Residency Programs
  - 7 Internal Medicine, 1 Family Medicine, 1 Med-Peds, 2 Pediatrics
What We Aim to Accomplish Together

1. Establish team-based care
2. Manage populations prospectively
3. Find/manage “high-risk” populations
4. Improve physician/workforce satisfaction
5. Improve patient and trainee experience

The Power of Teams

Effects of QI Strategies for Type 2 Diabetes on Glycemic Control

<table>
<thead>
<tr>
<th>Quality Improvement Strategy</th>
<th>No. of Trials</th>
<th>Favors Intervention</th>
<th>Favors Control</th>
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<td>Patient Reminders</td>
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<td>Patient Education</td>
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<td>Electronic Patient Registry</td>
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<tr>
<td>Clinician Education</td>
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<td>Facilitated Relay of Clinical Information</td>
<td>15</td>
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<td>Self-Management</td>
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<td>Audit and Feedback</td>
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<td>Clinician Reminders</td>
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<td>Continuous Quality Improvement</td>
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<tr>
<td>All Interventions</td>
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Key Components of the AIC

• Funding sources:
  — HMS Center for Primary Care - $8 million
  — Academic Health Centers - $6 million

• How we spend our funds:
  — Full-time program manager at each large AHC
  — Protected time for practice transformation
  — Learning sessions, academies, coaching
  — Design, operation, evaluation

• Time frame: 2 years, launched July 2012

Engaging Leadership
The Structure of the AIC

• At each clinic site:
  ─ Transformation team – 6-12 staff members including residents
  ─ Aims statement
  ─ Develop and test changes during Action Periods
• Learning sessions – 3x per year, in person
• Monthly conference calls

The Structure of the AIC

• Practice coaching - from CPC/IHI/Qualis Health
• Leadership academy
• Educator and trainee academy –
  ─ Resident curriculum
  ─ Learner-led quality improvement and care coordination activities
• Patient engagement – patient/family advisory councils, regular patient surveys, patients on transformation teams
<table>
<thead>
<tr>
<th>AIC</th>
<th>P^3</th>
<th>Colorado</th>
<th>Pennsylvania</th>
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<tbody>
<tr>
<td>Participants</td>
<td>19 HMS-affiliated teaching practices &amp; community clinics</td>
<td>25 FM/IM/Peds teaching practices in NC, SC, VA</td>
<td>10 FM programs</td>
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<tr>
<td>Change Model</td>
<td>Qualis Change Concepts &amp; IHI Breakthrough</td>
<td>IHI Breakthrough</td>
<td>Plan-Do-Study-Act</td>
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<td>Components</td>
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<td>Multidisciplinary Teams</td>
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<td>Learning Sessions</td>
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<td>x</td>
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<td>Webinars/Conference Calls</td>
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<td>Shared Website</td>
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<td>PCMH E-learning Modules</td>
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<td>x</td>
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<tr>
<td>Consultants/ Practice Coaching</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Leadership Sessions</td>
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<tr>
<td>Resident Participation on Teams</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Residency Curriculum Development</td>
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<td>x</td>
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<td>NCQA PCMH Application</td>
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<td>PCMH Monitor Assessment</td>
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<td>Monthly Update Reports</td>
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<td>x</td>
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<td>Online-Registry</td>
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**AIC Set-Up For Quality Improvement**

- Using data to drive improvement
- At practice level
- Building capacity through a quality improvement strategy
  - writing aims, connecting measures and testing/implementation
- The SNMHI Change Concepts provide a road map for guided transformation
How Do Practices Know if they are Making Progress?

Measurement for Improvement

- Regular Measurement – monthly transformation updates, run charts
- Tiered, flexible measurement strategy
- PCMH-A tool
- External evaluation
- Stories of Improvement
The Work of the AIC

Aim Statement #1:
• Assign Panels
• Team-based Care Teams
• Outreach to Patients
by July 2013

Aim Statement #2:
• Balance Panels
• Team Huddles
• Self-Management Goals
by January 2014

Aim Statement #3:
• Balance Panels
• Pre- and Post-visit
• Planned Care Visits
by July 2014

Data: Site-Specific Measures
Looking Under the Hood

- The Change Concepts for Practice Transformation: What’s different?
- Transformation in academic medical centers compared to other settings: What’s different?
- Measuring progress using the PCMH-A: What’s different?

Examples of Medical Home “Frameworks”
The SNMHI Framework: The Change Concepts for Practice Transformation


PCMH Implementation Resources

- Patient-Centered Medical Home Assessment (PCMH-A)
- Introductory materials (http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf) describe how and where to begin PCMH transformation
- Executive Summaries provide a concise description of each Change Concept, its role in PCMH transformation, and key implementation activities and actions
- 13 Implementation Guides (http://www.safetynetmedicalhome.org/change-concepts) provide a full introduction, implementation strategies and tools, and case studies
- 38 webinars
- 3 policy briefs on medical home payment and health reform
- 23 tools that can be used to test or apply the key changes
- A downloadable registry of tools and resources (http://www.safetynetmedicalhome.org/sites/default/files/All-Resources.xls)
Goal:
To have effective, involved leaders help staff see a better future, and give them the tools, resources and time to achieve it.

Goal:
To have in place a sustainable, broadly inclusive approach to continuous quality improvement that includes trusted performance measurement and a strategy for changing practice.

Laying the Foundation: Why is it Important?

- Leadership and QI strategy provide the foundation for redesign.
- Practices that succeed in quality improvement initiatives have adaptive reserve – the ability to learn and change.
- Key feature is leadership that can: envision a future, facilitate staff involvement, and devote time and resources to make changes.
- Practices that don’t routinely measure and review performance are unlikely to improve.
**Goal:**
To assign all patients to a provider/care team to facilitate continuous care and population management.

**Goal:**
To develop skilled and well organized care teams, and ensure that patients are able to see their care team consistently over time.

Teams should be designed to meet the needs of patient panels (typically include provider, MA, RN, front desk staff)

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**Building Relationships: Why is it Important?**

- Empanelment is the platform for population health:
  - Links patients to care teams
  - Profoundly changes culture and sense of accountability
- Team involvement in the care of chronically ill is the single most powerful intervention.
- Patients who have a continuity relationship with a personal provider have better health process measures and outcomes:
  - Continuity of care increases the likelihood that the provider is aware of psychosocial problems impacting health.
Goal:
To encourage patients to expand their role in decision-making, health-related behaviour change and self-management and to communicate with them in a language and at a level they understand.

Goal:
To use planned interactions and follow-up with patients according to patient need, and to identify high-risk patients and ensure they are receiving appropriate care management services.

Changing Care Delivery: Why is it Important?

- Patient activation is tied to health improvement.
- Patient involvement in QI activities and health center boards helps maintain the focus on patient and family needs.
  - It also makes change process more efficient by incorporating end-user feedback in real time, and potentially avoiding useless or even harmful tests of changes
- Well-organized care is patient-centered care.
- Well-organized care is good care:
  - Practices that do pre-visit planning (huddle) have better measures of chronic disease control and preventive care.
Care Coordination

Goal:
To track and support patients when they obtain services outside the practice, and ensure safe and timely referrals or transitions.

Enhanced Access

Goal:
To ensure that established patients have 24/7 continuous access to their care teams via phone, email, or in-person visits.

Reducing Barriers to Care: Why is it Important?

- Evidence of cost savings comes, primarily, from improvements in care coordination and access.
- Even a few hours of off-hours appointment access is associated with reduced ED use.
Lots of PCMH Assessment Tools Already Exist, Such As…

- NCQA PCMH Recognition™ Readiness Tool
- Medical Home Index
- MHIQ®
- Safety Net Medical Home Scale

However, none of these align directly with the Change Concepts for Practice Transformation

Background

- Developed for the SNMHI by the MacColl Center for Health Care Innovation (Group Health Research Institute) and Qualis Health
- Based on the ACIC (Assessing Chronic Illness Care) survey tool developed by the MacColl Center
- Developed to measure a site’s progress towards achieving the 8 Change Concepts
- Self-administered assessment first tested by 65 SNMHI sites every six months and now being used in a number of improvement initiatives, including the AIC

The PCMH-A Has Dual Roles

- It serves as a tool to assist practices in having internal conversations that allow many voices to contribute to observations about strengths and opportunities for improvement.
- It serves as a tool to assist practices in tracking incremental progress over reasonable time periods as they strive to transform into patient-centered medical homes.

Example: PCMH-A PCI Component

<table>
<thead>
<tr>
<th>Components</th>
<th>Level D</th>
<th>Level C</th>
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<tbody>
<tr>
<td>Assessing patient and family values and preferences</td>
<td>…is not done.</td>
<td>…is done, but not used in planning and organizing care.</td>
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<tr>
<td>Score</td>
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<td>4 5 6</td>
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</table>

Opportunities

- Significant Implementation

<table>
<thead>
<tr>
<th>Level B</th>
<th>Level A</th>
</tr>
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<tbody>
<tr>
<td>…is done and providers incorporate it in planning and organizing care on an ad hoc basis.</td>
<td>…is systematically done and incorporated in planning and organizing care.</td>
</tr>
<tr>
<td>7 8 9</td>
<td>10 11 12</td>
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</table>
PART 1: EMPANELMENT

1a. Determine and understand which patients should be empanelled in the medical home, and which require temporary, supplemental, or additional services.

1b. Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

1c. Understand patient supply and demand and balance patient load accordingly.

1d. Enable feedback to team and for external reporting on processes of care and population outcomes.

<table>
<thead>
<tr>
<th>Components</th>
<th>Level D</th>
<th>Level C</th>
<th>Level B</th>
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<tr>
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<tr>
<td>Score</td>
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<td>4 5 6</td>
<td>8 9</td>
<td>10 11 12</td>
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<tr>
<td>2. Registry of panel-level data</td>
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<tr>
<td>Score</td>
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<td>4 5 6</td>
<td>7 9</td>
<td>10 11 12</td>
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<tr>
<td>Score</td>
<td>1 2 3</td>
<td>4 6</td>
<td>7 9</td>
<td>10 11 12</td>
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<tr>
<td>4. Reports on care processes or outcomes of care</td>
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<td>Score</td>
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<td>4 6</td>
<td>7 9</td>
<td>10 11 12</td>
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</tbody>
</table>

Total Health Care Organization Score: 28
Average Score (Health Care Org. Score/4): 7.00

Data: PCMH-A Score

![Data: PCMH-A Score](image)
Academic Innovations Collaborative

Traditional Academic Primary Care Practices (EXISTING STRUCTURES & PROCESSES)

Enhanced Academic Primary Care Practices (NEW STRUCTURES & PROCESSES)

OUTCOMES OF INTEREST

Aim 1
Strategies/Tools for AMC Practices

Aim 2
Provider Work Satisfaction
Trainee Skills and Experience

Aim 3
Care Quality and Health Plan Costs

Confounding Factors
Predisposing Characteristics
Age, Sex

Enabling Factors
SES

Perceived Needs
Medical Complexity

Providers
Size, Location
Case Mix,
Payment Change

Confounding Factors
Patients

Providers

Size, Location
Case Mix,
Payment Change

Courtesy of Alyna T. Chien, MD, MS

ACADEMIC INNOVATIONS COLLABORATIVE NEWSLETTER

FAMILY CARE ASSOCIATES
THE 19TH AIC CLINIC

By Maya Venkataramani, MD and Kitty O’Hare, MD

Earlier this year, the Brigham & Women’s Hospital/Boston Children’s Hospital Medicine-Pediatrics Residency Program was presented with a great challenge, but even greater opportunity. The Brigham Department of Medicine invited us to open a new practice—Brigham and Women’s Family Care Associates at Faulkner Hospital. We were truly excited by this opportunity to create a new primary care home for our adult and pediatric patients.

One of our first actions was to create a mission, vision, and values statement that would help to guide our efforts in building our clinic. We are proud that our residents were heavily involved in shaping this statement:

Our mission is to improve the health of the families we serve with a commitment to excellence in everything we do. We partner with...

To be sure that all new team members would be committed to our mission, behavioral interviewing techniques were used during staff recruitment. Prior to opening, our team—administrative assistants, practice managers, nurses, and physicians—participated in a two-day staff orientation that included training in the change concepts, the model for improvement, and patient-centered communication.

Our team also created a staff compact, established a patient agreement form, developed a five-year vision plan and defined our first-year goals. By the time our doors opened on July 1, our staff already had a solid foundation for working together. Through twice-daily huddles prior to clinical sessions and weekly practice team meetings, we ensure that all team members are actively involved in providing and improving care.

...
Key Lessons Learned

• Change in complex AMC affiliated clinics is possible
• Success is built on a foundation of engaged leadership
• Having a QI method is key
• The Qualis Change Concepts provide a useful roadmap that can be contextually adapted
• Regular and varied forms of measurement are KEY
• Building teams is both a process AND an outcome
• Engaging patients and trainees is critical
• We have just begun…