Sustaining a Patient Centered Medical Home Program

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Learning Objectives

After this presentation, you will be able to:

1. Create an organizational structure for a sustainable medical home

2. Identify barriers and success strategies
Our Agenda Today

• Who is Partners Healthcare?
• Our Programs
• Challenges
• Breakout Session #1 – Challenges

• How We Sustain Our Programs
• Secrets to Success
• Breakout Session #2 – Success Strategies
• Debrief & Wrap up
Who is Partners Healthcare

To Put Our Experience Into Perspective
By the numbers...

2016

1.5M patients served annually

6,500 physicians

9,100 nurses

68,000 employees

$12.5B revenue
Partners currently manages ~600,000 lives in various accountable care relationships

**1. Commercial**
- Alternative Quality Contract (AQC)
  - Younger population, specialists critical to management
  - Covered lives: ~350k

**2. Medicaid**
- Neighborhood Health Plan, Medicaid ACO Pilot
  - Population with significant disability, mental health, and substance abuse challenges
  - Covered lives: ~80k

**3. Self Insured**
- Partners Plus
  - Commercial population, but savings accrue directly to Partners, and improves our own lives
  - Covered lives: ~100k

**4. Medicare**
- Next Generation ACO (2012-2016 Pioneer ACO)
  - Elderly population, care management central to trend management
  - Covered lives: ~100k

Medicaid ACO (2018) could add 65K lives
Partners - Center for Population Health
Jointly decided, locally led, centrally supported

Center for Population Health
founded in 2012

Why is it important today: With health care becoming increasingly expensive and complex, we aim to lower costs and move toward a more integrated, patient-centered care model.

- Improve quality of care
- Slow down the overall growth of health care costs
- Enhance care coordination
- Engage patients in their own care
- Use technology & analytics to support patient care
How We Develop and Implement Our Programs
**Primed Status: Foundational Work**

- **High Risk Chronic Cond**
- **Care Management**
- **Population Mgmt Tool**
- **Test and Referral Tracking**
- **Practice Redesign w/Lean**
- **Team-Based Care**
- **EMR**
- **Patient Portal**

- **Quality**
- **Improvement**

- **Better Patient Care**
- **Tools**
- **Structure**
- **Capacity**

- ✔ **Within your practice many pieces already there**
Progress to date

Phase 1: Primed Status
Phase 2: NCQA
Phase 3: Sustain, Maintain and Improve

As of today, PCMH progress:*  
• 63% practices  
• 81% providers*  
• 81% risk lives

* Q3 2017 Performance

Modify consultant model to support ongoing QI efforts and more frequent touch points with practices
Early Results: Phase 1

Stories from the Field

• Skeptic tells others “My practice is being transformed”
• “Seeing 3 or 4 more patients a day”
• “Opened my panel for the first time a year”
• “MA absenteeism has dropped dramatically”
• “No more stops in the driveway”

Testimonials: [www.partners.org/pcmh](http://www.partners.org/pcmh)

Correlation with Quality and Culture

• Practices that implemented foundational PCMH elements earlier performed better on Quality and safety metrics
Phase 2: NCQA

- Initial NCQA PCMH Recognition
  - Time-intensive application process supported by PCMH Consultant
  - Building and expanding on current workflows/systems
  - Develop an awareness for practice culture and active advancement of “team”

Central Support structure:

- Roadmap
- Education
- Consultant support
- QI Collaborative
- EHR System supports:
  - Lab tracking
  - Referral tracking
  - Registries
  - Pre-validation of Epic System
Patient Centered Medical Home Implementation

**Practices**
- Lean
- MA Academy
- Top of License
- Consultants
- Flow Management
- Incentives

**Consultants**
- NCQA Trained
- Lean Trained
- Soft skills
- Practice Relationship

**Physician Organizations**
- Central-Local Partnership
- Leadership
- Incentives

**Internal Performance Metrics**
PCMH Primed Status and NCQA Recognition as of Q2 2017

NCQA  Primed Status

Target 100% Partners in Care Phase 1 (Primed Status)

Target 100% Partners in Care Phase 2 (NCQA+)

PCPs

Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

2012 2013 2014 2015 2016 2017 2018

55% 80%
Results: Phase 2

- **Increase in Patient Satisfaction following NCQA Implementation:**
  - **Spring 2016:** Primary Care of Wellesley achieved Level 3 NCQA Medical Home Recognition.
  - **Patient Satisfaction:** Press Ganey patient experience mean scores (which reflect patient satisfaction) jumped from 82.5 to 94.2.
  - **Transformation:** As part of the NCQA process, the practice implemented workflows to improve patient access, care coordination, team-based care, and placed a major focus on quality improvement efforts.

**Before PCMH (2014-2015)**

**After recognition (2016-2017)**

Broader measure and evaluation underway

Phase 3 - Sustain & Improve

Maintain PCMH Core Competencies → Enhanced PCMH Competencies → Advanced Primary Care Services
Our Challenges

Local Control

Leadership

NCQA

Technology
Breakout Session -- Challenges
Secrets to Success/Lessons Learned
Population Health Programs as “the” Solution

- Goal: Use Quality data to identify practices not meeting hypertension quality metrics, offer centrally-supported toolbox to better engage patients in hypertension treatment.

Hypertensive patients

- Remote monitoring
- Virtual outreach (coaching/texting)
- Patient education
- Telehealth/E-visits
Secrets to Success

1. Culture
   1. Collaboration
   2. Commitment
   3. Innovation

2. People
   1. Leadership Support
   2. Local Physician Champion
   3. Staffing
   4. Investing in Staff

3. The Right Pace

4. The Right Tools
   1. EMR
   2. Data

5. Carrots and Sticks
   1. Incentives
   2. Mandates
Breakout Session – Strategies for Success
Debrief and Wrap Up
My Personal Takeaway

After this presentation, you will be able to:

1. What Model will I use back at home to support my Patient Centered Medical Home Implementation?

2. Barriers to Success and Strategies that I identified
Thank You!

For Questions please feel free to contact:

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