FOR THE HEALTH OF TEXAS:

HEALTH HOMES FOR CHILDREN AND FOR ADULTS WITH CHRONIC ILLNESS

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TRANSFORMING TO A PATIENT-CENTERED MEDICAL HOME: LESSONS FROM THE NDP

Carlos Roberto Jaén, MD, PhD, FAAFP
Professor and Chair of Family and Community Medicine
University of Texas Health Science Center at San Antonio

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FAMILY AND COMMUNITY MEDICINE

Overview

- Process
  - Timeline
  - Evaluation Design
  - NDP Model
- Outcome
  - Definitions
  - Key Findings
- Lessons and Recommendations

Timeline

2000

- **Keystone III Conference (Oct.)**
- Early recognition that the health care system is in serious trouble, commissioned study in 2002.

2004

- **Future of Family Medicine Report (Nov.)**
- Need for New Model of practice: “proof of concept” demonstration project in typical family practices

2006

- **AAFP creates TransforMED and begins NDP**
- 36 family medicine practices randomized to two arms to implement NDP Model with independent evaluation

Timeline

2007

- **Joint Principles of a Patient Centered Medical Home (Feb.)**
- AAFP, ACP, AAP and AOA release consensus statement

2007

- **NCQA announces Physician Practice Connections (Nov.)**
- A program with criteria that medical practices should meet to be recognized as medical homes

2008

- **Primary Care Patient-Centered Collaborative (Jun.)**
- Announces16 significant state-level or multipayer medical home demonstration projects are underway.

Timeline

2008

- **NDP intervention ends (Jul.)**
- 17/18 facilitated practices and 15/18 self-directed practices complete trial

2009

- ***Annals of Family Medicine (May)***
- Publishes “Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home”

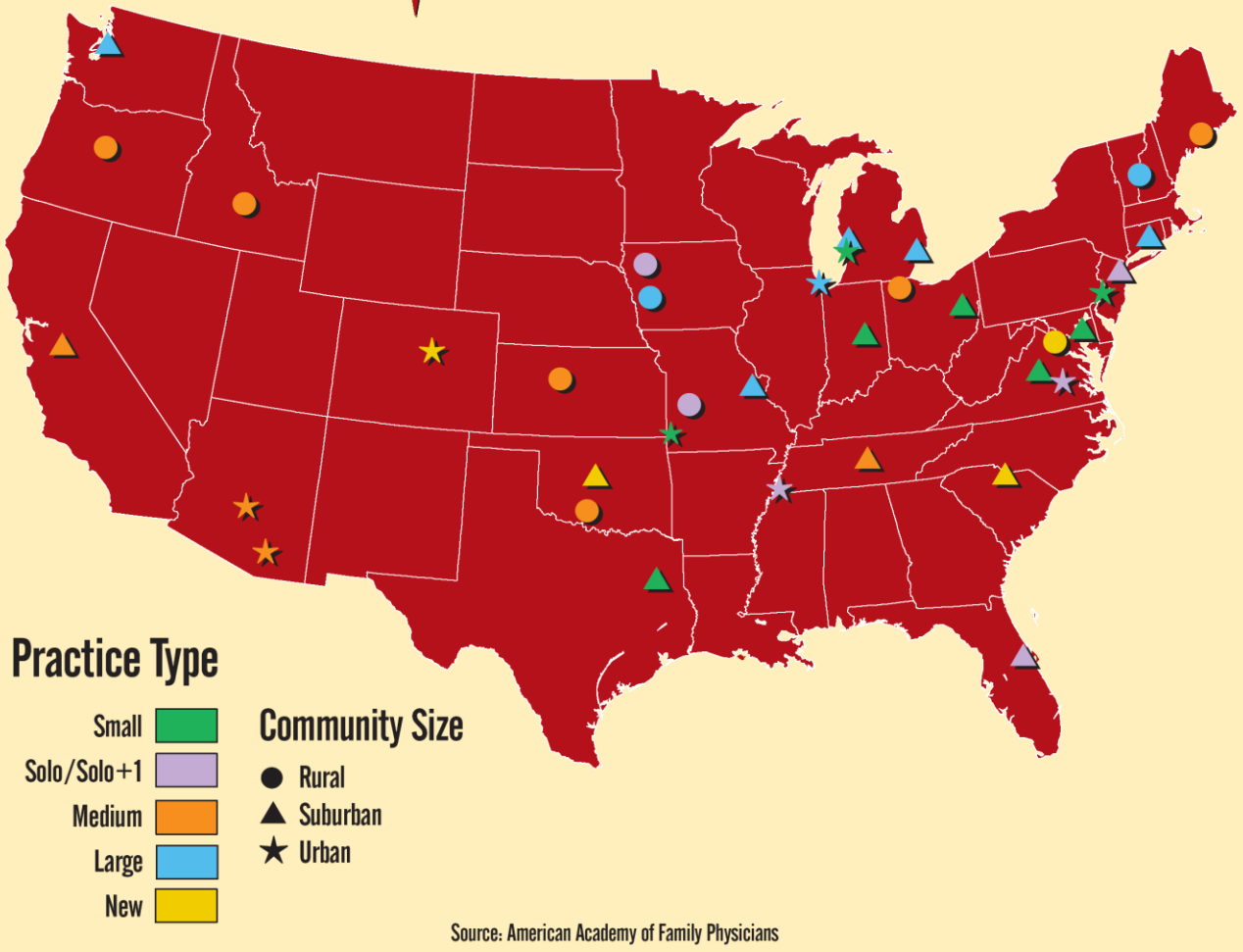
2010

- **Special Issue of *AFM* to be published**
- 8 peer-reviewed articles describing methods, findings and implications with support of CWF and FM organizations

Sample Selection

- **Maximize diversity of geography, size, age, and ownership arrangements**
  - **Stratified by practice size, region of the county, age of the practice**
  - **Special AAFP advisory committee selected practices**
- **36 practices randomly assigned to either facilitated or self-directed groups**

TransforMED Demonstration Practice Locations



Source: American Academy of Family Physicians

Intervention: Resources Available

Facilitated

- Facilitator
- Expert Consultation
  - Practice Finances
  - Health Information Technology
  - Quality Improvement
- Software and Support
- Four Learning Sessions & Regular Group Conference Calls

Self-directed

- Web-based Tools without On-site Assistance
- Self-organized Own Learning Session at Midpoint

Mixed Methods Emergent Design

- Comprehensive quantitative data collection at beginning, middle & end
- "Real time" analyses of qualitative interviews, observation, phone & email communications, observations during learning sessions
  - Analyzed weekly
  - Analysis retreats every four months
  - Suggest changes in design
- Integrate combined data at end

NDP Intervention:

Remodeling This Old House

- **NDP Model & Facilitation Emphasized Implementing Technical Components**
- **Maintained Emphasis on Physician & Office-based Encounter**
- **Did Not Alter Reimbursement System**
- **Limited Connection to PCMH "Neighborhood"**

Operational Definition: *Patient-Centered Medical Home*

- **Number of NDP Model Components (39 items) Implemented**
  - **Access to care & information**
  - **Care management**
  - **Practice services**
  - **Continuity of care**
  - **Practice management**
  - **Quality and safety**
  - **Health Information Technology**
  - **Practice-based care**

Can the NDP Model Be Built?

- **ALMOST over 2 years**
  - **In highly motivated practices**
  - **>70% components in place in both groups**
  - **Mostly what supported "business as usual"**
- **Struggled with "what didn't easily fit"**
  - **E-visits & Group visits**
  - **Proactive population management**
  - **Team-based care**
- **Patient perception of care got worse**

What Does It Take to Build It?

- "Facilitation" & More than the NDP
- Six Themes:
  1. Internal capability, esp. adaptive reserve is critical for managing change
  2. Developmental pathways vary by practice
  3. Motivation of key practice members is critical
  4. Larger system helps & hinders
  5. Transformation is more than a series of changes - requires shifts in roles and mental models
  6. Practices benefit from multiple facilitator roles: consultant, coach, negotiator, connector, librarian, & facilitator
- A Different Environment

Practice Internal Capability

PRACTICE CORE

- **Resources**
  - Material
  - Human
- **Organizational Structure**
  - Leadership
  - Compensation, reward, & accountability systems
  - Management model
- **Functional Processes**
  - Clinical care
  - Operations
  - Finance

ADAPTIVE RESERVE

- Action/Reflection Cycles
- Facilitative Leadership
- Learning Culture
- Sensemaking
- Improvisational Ability
- Stories of Change
- Relationships & Communication

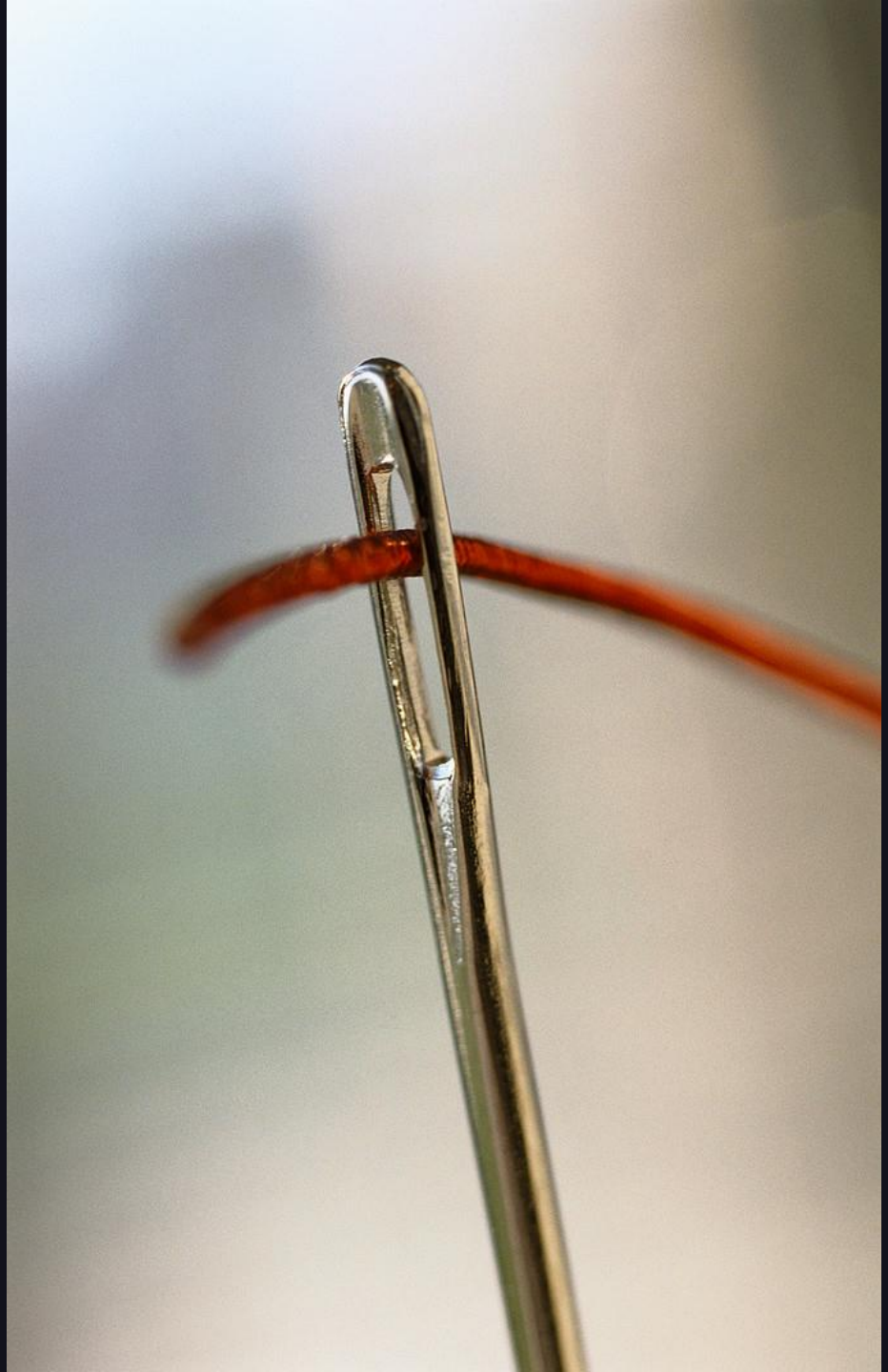
ATTENTION TO LOCAL ENVIRONMENT

Does the NDP Model Make a Difference in Quality of Care?

- **Small improvement in <u>Condition-Related</u> indicators of quality**
  - ACQA Composite by 8.3% in facilitated and 9.1% in self-directed practices ($p < .0001$)
  - Chronic disease composite 5.2% facilitated and 5.0% in self-directed practices $p = .002$).
- **No change in <u>Patient Experience-Related</u> indicators of quality**

Can the NDP Model Be Widely Disseminated?

- **With Enormous Resources & Much Time**
  - **HIT $ & Support**
  - **Extension Agent Model**
  - **3-5 Years or More**
- **SHOULD IT?**



PCMH Models must continue to evolve

- Emphasize 4 core attributes of primary care
- Move beyond physician-led to more collaborative care models
- Incremental changes not enough - encourage disruptive innovations
- Promote local variations in PCMH model development and implementation
- Discourage limited pilots with small management fees and disease focus lasting less than 2 years

Delivery system reform & resources should be in place for implementing PCMH development

- **Must change how pay primary care**
  - **Separate documentation of care from billing & eliminate wRVUs (work-related value units)**
  - **Encourage capitation, bundling, direct care or some mix**
- **Promote business models that encourage integration across health care system**
- **Promote pilots that test PCMH and ACO linkage and last > 2 years**
- **Develop nationally shared on-line platform for communication and care coordination**
- **Develop EHRs prioritizing clinical care as opposed to billing documentation**
- **Implement extension agent model for training in leadership, change management, practice operations & for leveraging HIT resources**

In the meantime …

At the practice level:

- **Help primary care practices strengthen their core, develop adaptive reserve, and enhance attentiveness to local environment**
- **Promote continued evolution of NCQA- PCMH recognition process**
  - **Emphasize core attributes of primary care and patient-centeredness**
  - **Lengthen time span**
  - **Add categories that help practices prioritize internal capability development**

In the meantime …

<u>With medical education</u>:

- **Prepare clinicians for less episodic care & more population- based care**
- **Prepare clinicians for partnering with collaborators in their practice**
- **Increase experimentation & flexibility in primary care residency training**
- **Support changes in med. school admissions & pre-med. requirements to encourage more generalists**

In the meantime …

<u>In health care research</u>:

- **Promote research to better understand practice development process**
- Encourage all PCMH pilots to include mixed method evaluation with strong qualitative component & assure adequate funding of evaluation.
- **Accelerate work to develop better measures**
  - **4 core attributes of primary care**
  - **Whole person health within community context**
  - **Healing relationships**

Leaving This Old House …

PCMH = Team of people embedded in community seeking to improve health & healing in that community & consisting of:

- **Fundamental Tenets of Primary Care**
- **New Ways of Organizing Practice**
- **Development of Internal Capabilities**
- **Health Care Delivery System & Payment Changes**

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www.AnnFamMed.org

Context for Understanding the NDP and the PCMH

Methods for Evaluating National Demonstration Project

The Conduct & Evolution of the NDP Intervention

Patient Outcomes at 26 months in the PCMH

Experiences of practices in the NDP

Effect of facilitation on practice outcomes in the NDP

Primary Care Practice Development: A Relationship-Centered Approach

Summary of the NDP & Recommendations for the PCMH

Supplemental Slides

NDP Model: Access to Care and Information

- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

NDP Model: Practice-based services

- Comprehensive care for both acute & chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

NDP Model: Care Management

- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies

NDP Model: Care Coordination

- Community-based resources
- Collaborative relationships
  - Emergency Room; hospital care; behavioral health care; maternity care; specialist care; pharmacy; physical therapy; case management
- Care Transition

NDP Model: Practice-Based Care Team

- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner/Physician Assistant
- Patient participation
- Family involvement options

NDP Model: Quality and Safety

- Evidence-based best practice
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

NDP Model: Health Information Technology

- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

NDP Model: Practice Management

- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

NDP Model: Patient-centered

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication: *trust, respect, shared decision-making*
  - *Patient engagement*
  - *Provider/patient partnership*
  - *Culturally sensitive care*
  - *Continuous relationship*
  - *Whole person care*

TransforMED℠
Patient Centered Medical Home

Access to Care and Information
- Health care for all
- Same-day appointments
- After-hours access coverage
- Lab results highly accessible
- Online patient services
- e-Visits
- Group visits

Practice Management
- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Practice Services
- Comprehensive care for both acute & chronic conditions
- Prevention screening and services
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Quality and Safety
- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Continuity of Care Services
- Community-based services
- Collaborative relationships
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management

Practice-Based Care Team
- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Find out more at www.TransforMED.com