PRACTICE TRANSFORMATION TOOLKIT

Practice Transformation Road Map:

A Quick Start Guide to Principles, Processes and Planning for Practice Transformation

Help for Managing Complex Change in your Practice

A Joint Publication of the

Tri-State Regional Extension Center

KENTUCKYREC

the Health Collaborative
where collaboration creates transformation

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Introduction

Whether you are somebody who gives health care, gets health care or pays for health care, you know that our health care system should work better than it does. A number of serious health challenges threaten our nation and our communities:

- Care costs too much.
- It's poorly coordinated.
- Too many people are not healthy.
- Quality of care can be spotty.
- Doctors, nurses and other caregivers aren't able to spend the time needed to help patients achieve optimum health.
- Doctors, nurses and other caregivers too often lack information needed for better patient care.

Tremendous changes are underway in health care across the nation. Community and regional partners have organized resources and committed to help practices. These resources can guide practice leadership and staff in how best to navigate the changes ahead, improve care for their patients and thrive in this new business climate.

This "Practice Transformation Road Map" is a practice-friendly overview of the changes happening in health care. ***Our goal is to help practices see that the seemingly overwhelming task of practice transformation can be accomplished through a series of small, manageable steps.*** The Road Map is intended to be a guidebook for understanding the journey ahead and some strategies to help your practice reach its intended destination as efficiently and effectively as possible. There is basic information and background on quality improvement, meaningful use, medical home, and payment innovation. The Road Map also contains case studies of practices that are successfully tackling change and thriving. Exercises, checklists and other resources are intended to help practices do some of the prep work needed for practice transformation.

What successful practices can expect the future to look like:

- *Information flowing electronically, so it's there when needed for patient care.*
- *Incentives for providing the right care at the right time.*
- *Practices reimbursed for the value -- rather the volume -- of services provided.*
- *Tools for care teams to coordinate a patient's care better across many different settings and providers.*
- *Better information about performance so that practice leadership can set goals on how to improve and serve patients better.*

Who Prepared this Road Map?

A team from the Tri-State Regional Extension Center, the Kentucky Regional Extension Center and the Health Collaborative of Greater Cincinnati worked together to prepare this Practice Transformation

Road Map. The Regional Extension Centers are Meaningful Use Experts. They have successfully helped thousands of health care providers implement electronic health records (EHRs) and qualify for meaningful use. The RECs also provide privacy and security services and Patient Centered Medical Home (PCMH) support. The Health Collaborative of Greater Cincinnati is a nationally recognized leader in practice transformation, PCMH, payment innovation and quality improvement. ***Support for this resource is provided under cooperative agreement 90RC0025/01 from the Office of the National Coordinator for Health IT, U.S. Dept. of Health and Human Services.***

1. The Drivers of Change

Undergirding the changes in health care today is a framework called **the Triple Aim**. The Triple Aim was developed by leaders at the Institute for Healthcare Improvement. Whatever your role in healthcare, most people can agree that we need to improve health care to facilitate achievement of the Triple Aim.

The Triple Aim is:

- ✓ ***Better care for individuals.***
- ✓ ***Better health for populations.***
- ✓ ***Lower per-capita costs.***

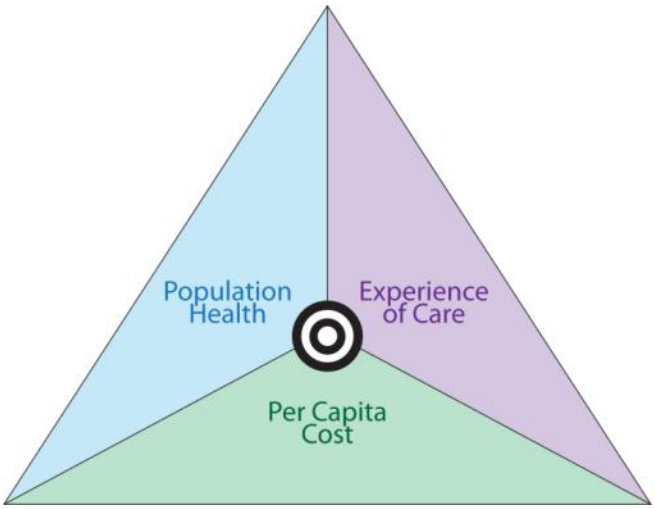


Figure 1. The Triple Aim Diagram from the Institute for Healthcare Improvement

Changes under ARRA/HITECH and the ACA

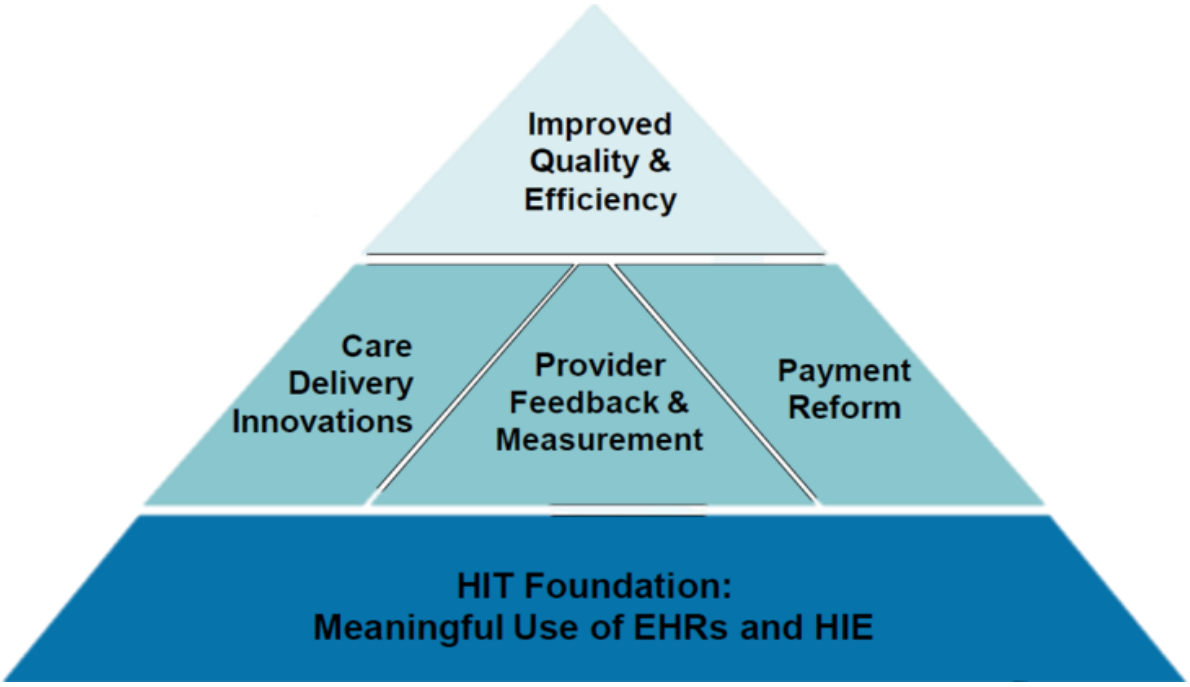
Two new laws were passed that are spurring many changes in health care. The 2009 American Recovery and Reinvestment Act, a portion of which is known also as the HITECH Act. authorizes incentive funding for health care providers who demonstrate **"meaningful use of health information technology."**

The Centers for Medicare and Medicaid (CMS) are responsible for creating rules for the EHR Incentive Program, while the Office of the National Coordinator for Health Information Technology oversees EHR standards and certification requirements needed to support meaningful use and the EHR Incentive program. The two agencies work together to prepare and issue the federal regulations that govern meaningful use requirements.

HITECH authorizes CMS and state governments to pay eligible professionals (EPs) and eligible hospitals (EHs) that meet meaningful use. EPs who attest to meaningful use early can receive

up to $44K under the Medicare EHR Incentive Program[1] or up to $63,750 under Medicaid. Hospitals can be eligible for millions in incentives depending on their Medicare and Medicaid patient mix. Incentive payments come in 3 Stages – with increasing requirements at each stage. Use of an EHR and electronic connectivity across health care providers comprise the essential foundation for improving health care (Figure 1).

Figure 2. Policy Framework for Health IT as a Foundation for Transformation



The Patient Protection and **Affordable Care Act (ACA)** became law in 2010. This sweeping health care reform law established the CMS Center for Medicaid and Medicare Innovation (CMMI), a new department within CMS to oversee broad changes in how the government pays for health care services. The ACA enables transition from fee-for-service to value-based purchasing.

Many new payment models from CMMI are being tested in markets across the country including:

- Accountable Care Organizations,
- Bundled Payment Models,
- Comprehensive and Advanced Primary Care Models that build on PCMH models, and
- Many other initiatives aimed at improving care for specific populations.

[1] For more information about the graduated payment schedule, please visit http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html.

More information on payment innovation models is found on page 27.

While Washington debates further changes to health care laws, practice leaders and staff need to understand what all of these changes mean for them. Health care is undergoing many fundamental changes at a pace not experienced in decades. And, now they are happening all at once. There are so many new demands, and practices are already feeling overwhelmed. It begs the question: How can a practice manage all these changes and thrive?

Health care is undergoing fundamental changes. There are so many new demands, and practices are already feeling overwhelmed.

How can a practice manage all these changes and thrive?

Accountability and alignment are essential to surviving and thriving through this level of transformational change. One of the most important elements to success is ***not undertaking the work alone***. Having a team to support the work both inside and outside the practice is critical.

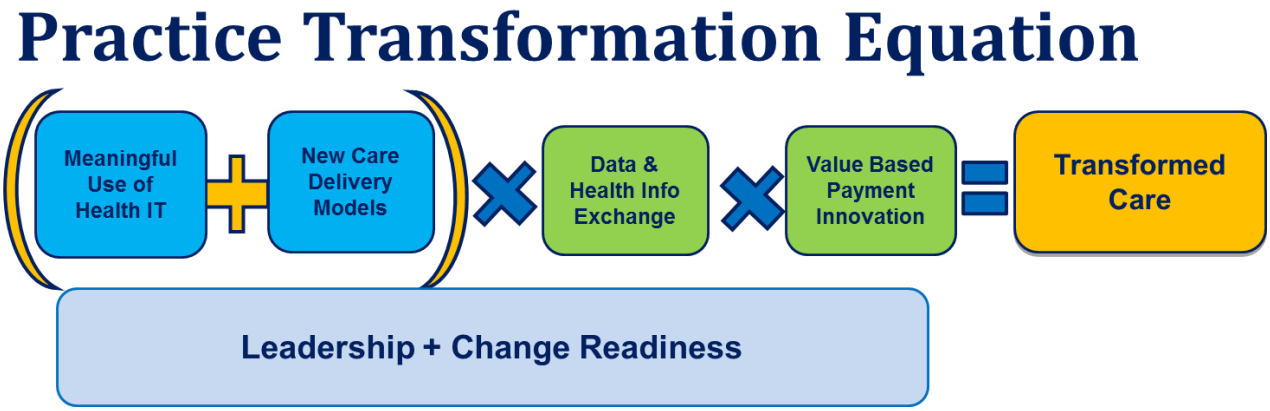
There are also important ways ***to align the work across complex programs.*** Practice staff needs to know that there is overlap between meaningful use, medical home and payment innovation requirements. Remember the adage: killing two birds with one stone? Experienced staff from the REC can help practices with helpful hints and tips to ensure that meaningful use becomes a building block for the medical home and payment innovation. The REC can support practices not only through Stage 2 Meaningful Use, but also help align meaningful use with medical home and payment innovation.

2. What is Practice Transformation?

Practice transformation is a broad term. It encompasses both the community-level resources and practice-level changes necessary to become a high performing practice that can support the Triple Aim of better care, better health and lower costs across an entire population of patients. Practice transformation includes all the elements needed to achieve the Triple Aim: an EHR and meaningful use, patient-centered care, connectivity across a medical neighborhood, evidence-based decision making, data-driven improvement and new forms of payment for care.

Whichever model or process for transformation that a practice might pursue, there are some common elements for success. The Practice Transformation Equation below lays out some of the essential elements to achieving transformation.

Figure 3. The Elements of Practice Transformation



More information about various components of practice transformation is outlined on the following pages including:

- Quality Improvement Principles on pages 10-12.
- Meaningful Use on pages 13-16.
- Patient Centered Medical Home on pages 17-26
- Payment Innovation Models on pages 27-36.

Why Pursue Practice Transformation? What are the Benefits?[2]

Pursuing new ways of caring for patients is hard work. There is no doubt about it. But practices that are going through the transformation process say the benefits far outweigh the costs, and they would never go back to the old ways of doing things. Why?

1. **Patients like it.** Changes such as same day scheduling, team-based care, electronic tools and empanelment mean that patients experience care differently. Practices have found patients are more satisfied with their care as a result of the changes they made.

2. **Patients are healthier.** Using technology tools, data-driven decision making and pre-visit planning, practice teams are supported in their effort to deliver all recommended care for patients, particularly for patients with chronic conditions. More frequent reminders of needed preventive care and patient educational materials also means there are fewer gaps in care.

3. **Get paid for doing the right things.** Leveraging practice transformation work into payment innovation opportunities allows practices to be paid for being proactive,

[2] See http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf , http://www.annfammed.org/content/8/Suppl_1/S45.full and http://www.ebri.org/pdf/programs/policyforums/Grundy-outcomes1210.pdf

orienting patient interactions toward prevention and wellness and connecting the dots with other providers. These are all things practices want to do consistently, but currently face barriers related to the lack of rewards in the fee-for-service system.

4. **More joy and professional satisfaction in the long run.** Many clinicians and staff report that going through the practice transformation process gave them enhanced professional satisfaction and made their patient interactions more enjoyable and less hectic. The whole care team can experience renewed enthusiasm for pursuing exceptional care for patients, and the practice has the data to demonstrate it is consistently getting better.

In addition, practice transformation activities that combine meaningful use with PCMH hold the potential for enhanced revenue as payment systems evolve. Of note, insurers across the country – including WellPoint, Aetna, Blue Cross/Blue Shield, Humana, UnitedHealth and others – are embracing the PCMH as a model that will achieve improved care and quality and reduce costs. WellPoint, for example, estimates that its new PCMH program could reduce its projected medical costs by up to 20 percent in 2015 based on analysis of its current medical home pilot projects. UnitedHealth predicts that its PCMH efforts will save twice as much as they cost.[3]

For practices interested in undertaking practice transformation, the rest of this road map lays out various guideposts and touch points on journey to achieving the Triple Aim, including using Quality Improvement principles, pursuing meaningful use, becoming a PCMH, and participating in payment innovation.

[3] See http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

Greater Cincinnati: A Community Model for Health Care Innovation

The Greater Cincinnati - Northern Kentucky region has demonstrated a 20-year commitment to transforming health care in the tri-state region. Community leaders, health care providers and other stakeholders have invested generously in multi-stakeholder collaboration, working together to address shared health care challenges and developing innovative solutions to address those challenges.

Greater Cincinnati's efforts over the past decade have focused on the following 5 Pillars.

Five Pillars of Health Care Innovation in Greater Cincinnati:

1. Strong Primary Care
2. Information Technology
3. Quality Improvement
4. Consumer Engagement
5. Payment Innovation

As a result of collaboration around these 5 Pillars, the region has succeeded in improving population level outcomes:

- Demonstrated **5 percent all-payer population level reduction in readmission rates** for congestive heart failure across 18 hospitals.
- One of the **highest per capita rates of PCMH transformation in the US** with 118 PCMHs recognized to date.
- A **7% increase in the composite diabetes (D5) scores** among the Beacon PCMH Cohort practices.
- Improvements in population-level outcomes for children with asthma - **lengthening the times between ED visits or admissions** from an average of 173 days (baseline) to 314 days on average.
- A community-led, multi-payer, multi-provider PCMH pilot achieved as much as a **4 percent cost reduction and 2 to 1 return on investment** for payer participants.
- According to a GE study of Greater Cincinnati's efforts, GE employees and families enrolled in medical homes had **3.5 percent fewer visits to the emergency room and 14 percent fewer hospital admissions** over the four years from 2008 through 2012.
- Innovative consumer engagement and transparency resources available through the Health Collaborative's **YourHealthMatters.org website**, one of the highest consumer visit rates for provider quality of care information.

3. The Basics of Quality Improvement

In order to achieve the Triple Aim, practice teams must understand the fundamentals of quality improvement (QI) and change management. This involves practices learning how to take incremental steps based on time-tested models and tools. Numerous models, principles and processes underlie QI initiatives in health care settings today. Your REC can help.

In fact, the REC has assisted hundreds of providers in incorporating QI processes with great effect, whether the practices are pursuing PCMH certification, trying to improve care for a specific population of patients or achieving meaningful use objectives. The examples below of QI tools such as Key Driver diagrams, Plan-Do-Study-Act cycles demonstrate how the REC is well-positioned to assist practices in improving care in a manageable way.

Applying Time-tested QI Processes[4]

For any change in the practice, good planning is essential. Developed by the Associates in Process Improvement, the Model for Improvement is utilized in many collaborative health care settings as a straightforward place to start. The Model for Improvement is based on three questions:

1) **AIM:** ***What are we trying to accomplish?*** The first question is meant to establish an aim for improvement that focuses on the practice's efforts. Using practice data and what patients and other customers, such as payers, believe are important helps define an *aim*. Aims should be as concise as possible. And, sometimes it takes a few trials of testing an aim before it becomes focused and specific.

2) **MEASURE:** ***How will we know that a change is an improvement?*** Using health care data allows you to measure where you are now, where you need to go and then monitors if you are getting there. This is where a robust EHR and health IT infrastructure come into play. Your EHR allows superior performance and best practices to be more quickly identified (and shared or replicated). This is also facilitated due to clarity on how the improvement will be defined and measured which is determined early in the process.

3) **IDEAS:** ***What changes can we make that will result in an improvement?*** Until an idea is tested, the outcome is unknown. A Plan, Do, Study, Act (PDSA) cycle is a critical tool in this stage of the QI process. A PDSA cycle is a trial and learning (learn by testing) method to discover what is an effective and efficient way to change a process. PDSA cycles in health care allow practices to make short, quick changes and provide practices with specific feedback on whether an idea is worth implementing.

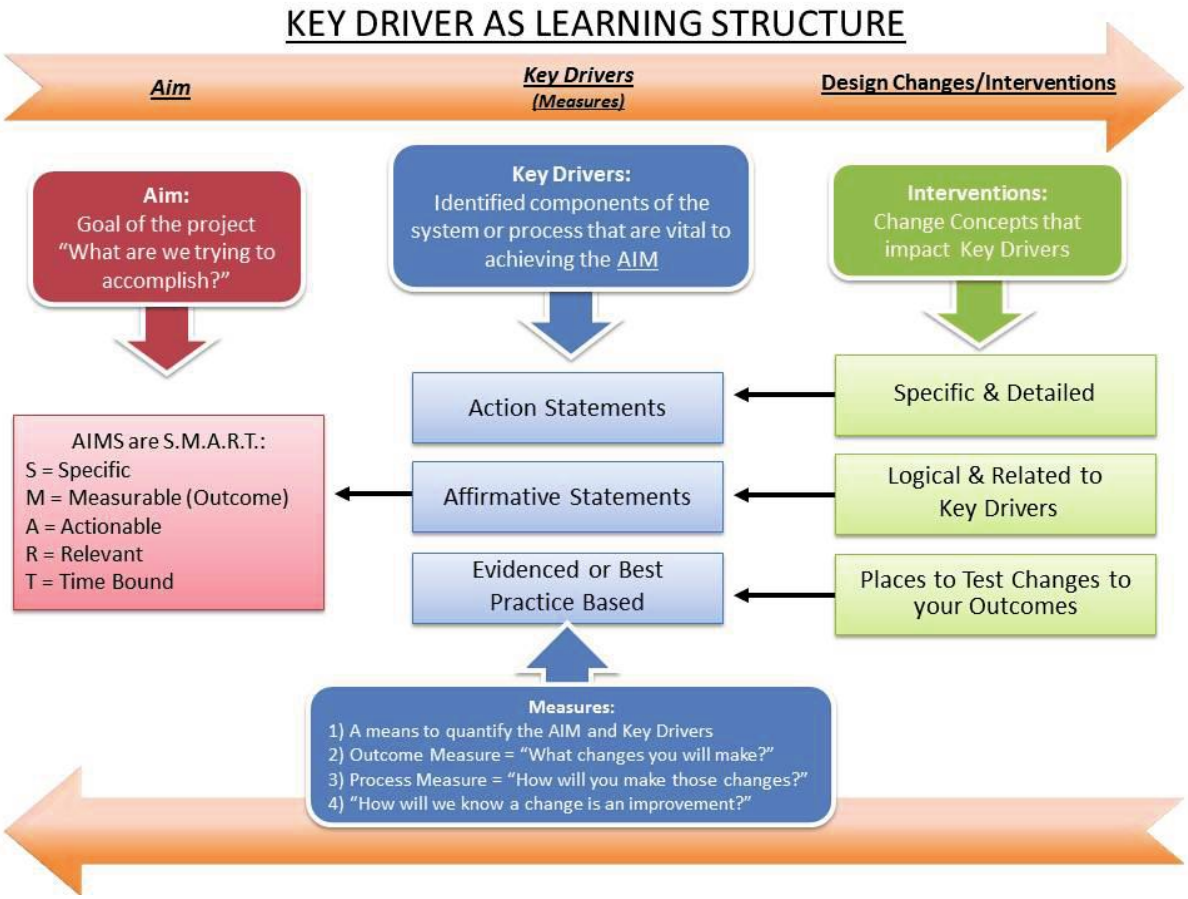
Putting the Plan in a Structure: The Key Driver Diagram

Key Drivers are essential activities that influence a specific aim or set of goals. A Key Driver Diagram organizes the process visually and provides structure and specificity to guide the practice's QI activities. Simply put, a Key Driver Diagram provides the practice with a QI

[4] We would like to thank the Colorado Beacon Consortium and the Institute for Healthcare Improvement, for portions of the content on QI and processes.

roadmap to achieve their aim. Key drivers and interventions are derived from evidence-based standards and best practices. A practice's QI team can update the drivers and interventions throughout their pursuit of the aim or goal. Figure 4 below illustrates the Key Driver Diagram.

Figure 4. Key Driver Diagram



PDSA Cycles: Testing and Refining the Plan

PDSA cycles have been used for decades to improve processes in business but, in fact, everyone uses PDSA cycles in their daily lives. We plan our day, we conduct our activities, we study the results and we make adjustments or changes as necessary. REC staff teaches practices how to utilize PDSAs and practices are encouraged to use PDSA cycles extensively throughout the QI process. The specific steps involved in the PDSA model are described briefly below.

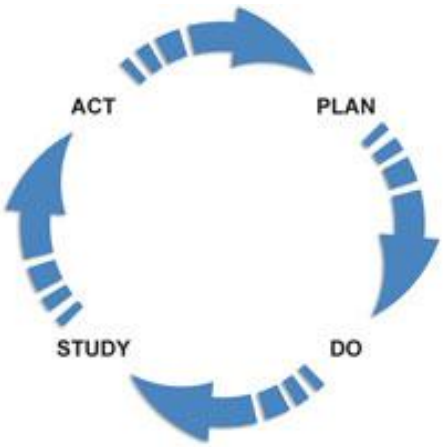


Figure 5: Plan, Do, Study, Act Cycle

- **PLAN:** Plan a change, test or activity aimed at improvement. State the objectives of the cycle. Make predictions! Develop a plan to carry out the cycle.
- **DO:** Do the plan. Carry out the test. Document problems and unexpected observations. Begin analysis of the data. These should be small tests of rapid cycle changes.
- **STUDY:** Study the results. Complete the analysis of the data and compare to predictions. What was learned?
- **ACT:** Act on the results. Practices either adopt the change, modify it and try it again or abandon it. Practices also ask themselves, what the next PDSA cycle will be or whether it is time to sustain the gains made.

For examples of how this applies to health care, specific PDSA exercises are provided below.

Building a High Performing Practice

The REC can also teach practices how to develop and apply additional QI strategies that will continue to advance their QI efforts. These strategies include, but are not limited to:

- **Run charts** to collect and review data that helps a practice analyze whether the intended improvement is occurring and "tell the story" about their successes.
- **Failure Modes and Effects Analysis (FMEA)** that assists a practice conducting retroactive and/or prospective analyses of their processes. FMEA includes an analysis of probable outcomes as well as consequences/benefits.
- **Risk Stratification** for populations of patients to guide the practice's "next steps" with patients based on their current status.
- **Using technology tools** such as alerts and clinical decision support to improve care processes.

4. The Role of Meaningful Use in Practice Transformation

EHRs can provide many benefits for providers and their patients, but the benefits depend on how they're used. Meaningful use is the set of standards defined by the Centers for Medicare & Medicaid Services (CMS) Incentive Programs that governs the use of EHRs and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria.

The requirements for meaningful use in Stages 1 and 2 are specifically designed to help physician practices implement the kind of technology needed to improve care. While achieving meaningful use is challenging, it is the necessary first step one the practice transformation journey.

Why is Technology so Critical to Practice Transformation?

The benefits of the meaningful use of EHRs include:

- ***Complete and accurate information.*** Using the EHR, providers document clinical information they need to provide the best possible care. But unlike paper records, capturing clinical information in a structured way electronically makes managing a whole population of patients easier and more effective. Electronic tools can help busy practices capture opportunities for preventive care and provide evidence-based care.
- ***More connected information.*** EHRs facilitate greater access to the information providers need to diagnose health problems earlier and improve the health outcomes of their patients. EHRs also allow information to be shared more easily among doctors' offices, hospitals, and across health systems, leading to better coordination of care. Providers will know more about their patients and their health history before they walk into the examination room.
- ***Patient empowerment.*** EHRs will help empower patients to take a more active role in their health and in the health of their families. Patients can receive electronic copies of their medical records and share their health information securely over the Internet with their families.

A Look at Stage 2 Meaningful Use

On September 4 2012, CMS published a final rule that specifies the Stage 2 criteria that eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) must meet in order to continue to participate in the Medicare and Medicaid Electronic Health Record Incentive Programs. All providers must achieve meaningful use under the Stage 1 criteria before moving to Stage 2.

Aligning Meaningful Use and Medical Home

Did you know achieving Stage 1 Meaningful Use gives you approximately 23 points to start for your PCMH recognition?

Stage 2 uses a “core” and a “menu” structure for objectives that providers must to achieve in order to demonstrate meaningful use. Core objectives are objectives that *all* providers must meet. There are also a predetermined number of menu objectives that providers must select from and meet in order to demonstrate

meaningful use. To demonstrate meaningful use under Stage 2 criteria, EPs must meet 17 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 20 core objectives.

Stage 2 Core Measures

CPOE	**eRx**	**Collect Demographics**	**Chart Vital Signs**	**Smoking Status**
Clinical Decision Support	**Electronic Access (Portal)**	**Clinical Summaries**	**Protect Health Info. (Privacy & Security)**	**Incorporate Lab Results**
Generate Patient Lists	**Send Patient Reminders**	**Educational Resources**	**Medication Reconciliation**	**Summary Care Record**
			Submit Immunization Data	**Use Secure Messaging**

Stage 2 Menu Measures

Submit Syndromic Surveillance Data	**Record Electronic Notes in Patient Records**	**Imaging Results**
Record Family Health History	**ID & Report Cancer Cases**	**ID & Report Specialized Cases**

Meaningful Use and Clinical Quality Measures

All providers are also required to report on Clinical Quality Measures (CQMs) in order to demonstrate meaningful use. Beginning in 2014, all providers regardless of their stage of meaningful use will report on CQMs in the same way. Specifically,

- EPs must report on 9 out of 64 total CQMs.
- EHs and CAHs must report on 16 out of 29 total CQMs.

In addition, all providers must select CQMs from at least 3 of the 6 key health care policy domains recommended by the Department of Health and Human Services' National Quality Strategy. These domains include:

- Patient and Family Engagement

- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

For more information on meaningful use, visit the CMS EHR Incentive Program site.

Meaningful Use & PCMH Case Study: *Dr. Robyn Chatman*

Robyn Chatman, MD is a dynamic health care leader with broad professional interests in eliminating health disparities, mitigating disasters through rapid medical response and the use of health information technology to improve care and practice efficiency. These interests are reflected in her eclectic and synchronistic career activities. She is a Board Certified Family Physician and was formerly managing partner at Trinity Family Medicine (Trinity), a NCQA Level 3 Patient Centered Medical Home, in Cincinnati, Ohio. Dr. Chatman also served as Medical Officer on the Disaster Medical Assistance Team OH-5 and Medical Director for the Greater Cincinnati Beacon Collaboration.

Dr. Chatman understands the tremendous value that an electronic health record (EHR) brings to a practice: "*We were able to set electronic reminders for patients for things such as flu shots. And, the ability to track patient's prescriptions is huge. We verified that a prescription was sent, where it was sent and with how many refills. We also checked the patient's formulary before sending the prescription which reduced call backs and saved time*."

An EHR has tremendous benefits for the patients, as well. One Trinity patient reached his employer sponsored coverage limit after suffering a stroke and had to pay for everything out of pocket. To reduce costs, the patient purchased POC INR meter (an instrument that, in simple terms, tests the clotting tendency of blood) so that INR's can be taken at home. The patient was able to use the EHR's patient portal to communicate blood glucose and blood pressure information with the physician. As a result, Dr. Chatman only saw the patient when a more comprehensive evaluation was needed.

The biggest benefit of an EHR to Dr. Chatman was the consistent and thorough documentation of every aspect of the patient's care. Everything from telephone messages through findings from the physical exam are in the patient's EHR. This creates a platform for high quality and consistent care. Because this information is electronic, Dr. Chatman has had the ability to access the patient's chart when she is away from the office but on call. With a busy practice and many other leadership responsibilities, this kind of accessibility has been incredibly valuable to Dr. Chatman.

Transformation Exercise: *Capturing Patient Demographics for MU + PCMH*

Step 1: Plan - Select a sample of 5 patients and pull those patient records for an audit. Look at the data compared to the Stage 2 Meaningful Use and PCMH requirements below. Predict: 2 of the 5 charts will not have the required information appropriately documented.

S2MU Core Objective 3	*Record the following demographics:* 1) Preferred language 2) Sex 3) Race 4) Ethnicity 5) Date of birth	**PCMH 2011 Component 2**: Identify and Manage Patient Populations	*2A1-2A12 Patient Information:* 1) Date of birth 2) Gender 3) Race 4) Ethnicity 5) Preferred language 6) Telephone Numbers 7) Email Address 8) Dates of Previous Clinical Visits 9) Legal Guardian/ Health Care Proxy 10) Primary Caregiver 11) Advance Directives 12) Health Insurance

Step 2: Do - Determine the care team members responsible for entering demographic information. Work with one of those individuals to designate specific fields where information should be entered for the next 5 patients.

Step 3: Study - Identify what reports you are currently able to pull from your EHR or patient management system. Designate someone to pull the report and compare data entry against the reports that are available. Is the report complete or were there gaps? Do you need to consult your EHR vendor or IT support staff to make sure information is complete? Were there gaps in your reports? How can you better standardize the data capture process?

Step 4: Act - Develop processes with staff input on how to better standardize the data capture process for demographic information to meet meaningful use and PCMH requirements.

5. An Overview of the Patient Centered Medical Home

What is a Patient Centered Medical Home and Why is It Important?

The next important destination on the practice transformation journey is becoming a patient centered medical home. The concept of medical homes is gaining momentum in the United States as a proven alternative to a fragmented and costly primary health delivery system. Research has demonstrated that medical homes can not only lead to higher quality and lower costs but also improve patient and provider experiences of care.[5] *In short, practices that become a high performing medical home demonstrate excellence in the provision of patient care and this fact is being recognized by providers, patients and payers.*

There are several organizations that recognize and/or certify medical homes. The PCMH certification awarded by the National Committee of Quality Assurance (NCQA) is the most common among primary care providers. PCMH is an integrative care model which strengthens the provider-patient relationship through enhanced coordination of care and communication. Specific features of a PCMH include an engaged leadership; embedded quality improvement strategies; each patient is linked with a provider team; continuous, team-based healing relationships; patient-centered interactions; organized, evidence-based care; care coordination, and enhanced access to care.[6]

NCQA PCMH Standards

The NCQA PCMH program emphasizes six standards that a practice must achieve. These standards align with the core components of the Triple Aim to improve health, quality and reduce costs (NCQA, 2011). The six standards include:

1. **Enhance Access and Continuity.** Team-based care as well as access and advice during and after office hours.
2. **Identify and Manage Patient Populations.** Data is collected and analyzed for improved population

[5] See http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home
[6] See http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx

management, facilitated by the use of EHRs.

3. **Plan and Manage Care.** Evidenced-based guidelines are followed for the management of acute and chronic conditions as well as prevention.
4. **Provide Self-Care and Community Support.** Patients and their families are connected with better information, tools and connections with community partners for improved self-care management.
5. **Track and Coordinate Care.** Referrals, care transitions and clinical results are closely monitored and managed through EHRs and health information exchange tools.
6. **Measure and Improve Performance.** Data is continuously used to measure and improve the quality of care and patient experience.

Why Become a PCMH?

The benefits of becoming a PCMH are similar to the more general benefits of practice transformation as a whole. From a clinical perspective, a PCMH strengthens the clinician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. In a PCMH, each patient has a relationship with a primary care clinician who leads a team that takes collective responsibility for the patient's care. Case studies of providers from across the country have noted the following benefits of being a PCMH, with published research showing the same impacts:[7]

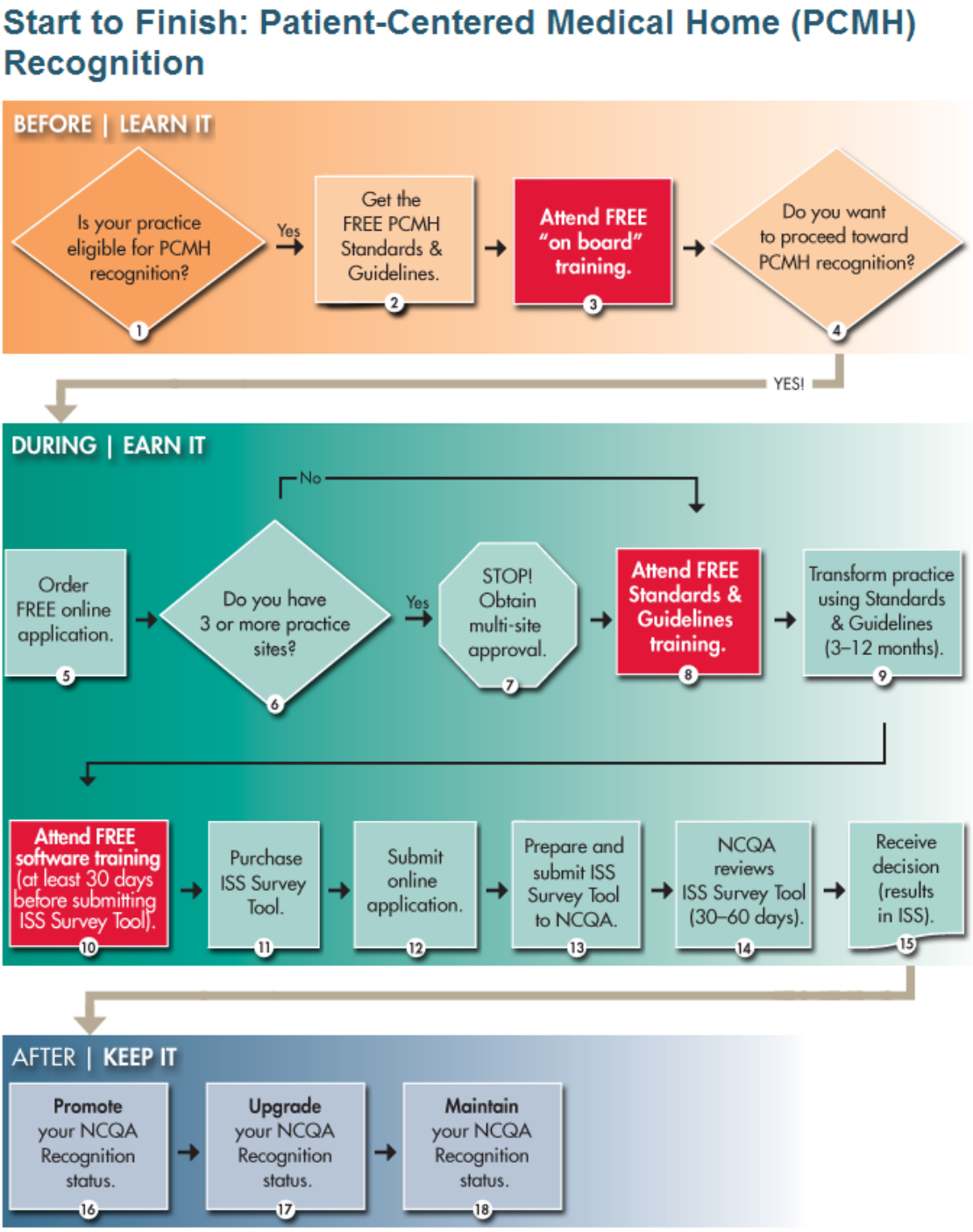
- Enhanced, patient-focused and evidenced-based care with improved health outcomes.
- Strengthened routes of communication between various parts of the healthcare system resulting in improved transitions of care.
- Streamlined access to care.
- Recognition of staff for the work they do in coordinating patient care.
- Enhanced job satisfaction among staff.
- Internal and external recognition that the practice provides state-of-the-art primary health care, including the potential for enhanced revenue.
- Increased expertise in the use and application of EHRs and other health information technology to improve care.
- Ability to objectively assess the care delivered and identify areas for improvement.

A Note on PCMH Timelines:

Achieving PCMH recognition can take from 12-18 months up to 2 years. Working with a trained PCMH coach can accelerate this process for your practice.

[7] See http://www.ncqa.org/Portals/0/Public%20Policy/HIMSS_NCQA_PCMH_Factsheet.pdf

Figure 6. PCMH Flow Chart

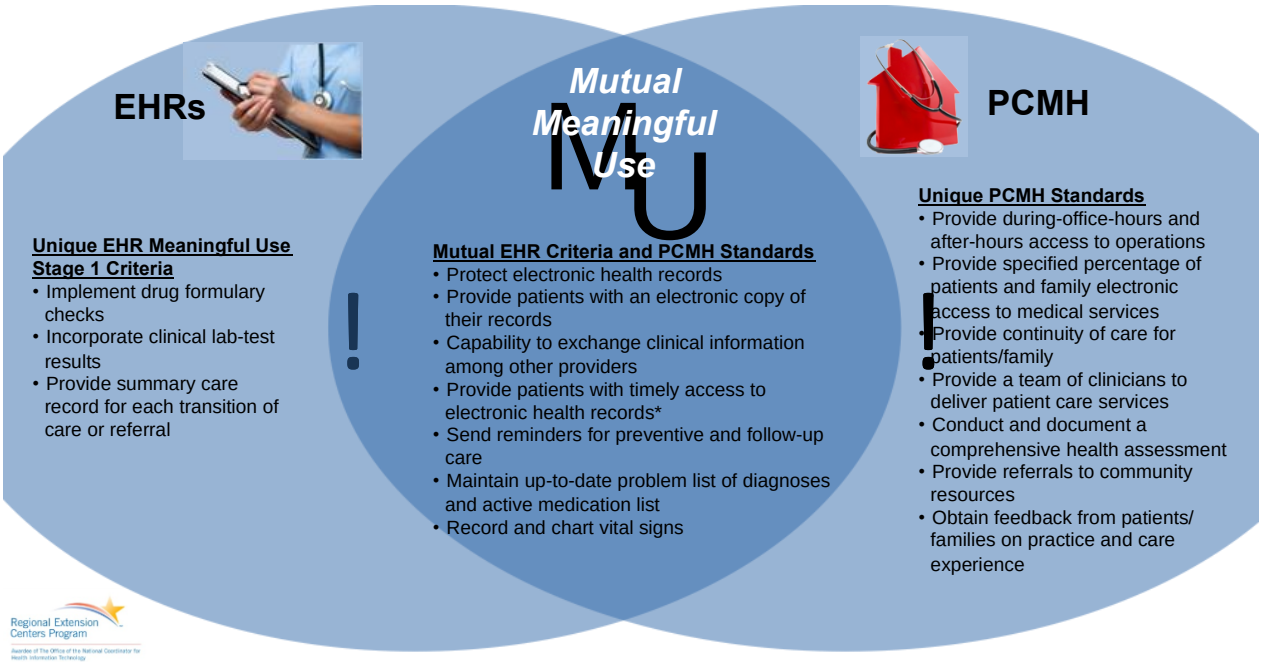


Learn more online at
http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx

What is the Intersection between PCMHs, Meaningful Use and EHRs?

The goals of a PCMH are in alignment with many of the objectives of Stage 1 and Stage 2 Meaningful Use. A robust EHR supports both PCMH and Stage 1 and Stage 2 Meaningful Use goals and objectives. It behooves practices to not only maximize the use of their EHRs but ensure that their systems are sophisticated enough to make the monitoring, collection and reporting of patient data streamlined and easy. Figure 5 below illustrates the alignment between EHRs, PCMHs and meaningful use.

Figure 7. EHR, Meaningful Use and PCMH Alignment



How is the PCMH Application Assessed, Scored and Certified?

The REC can assist practices from the beginning to the end stages of the PCMH certification process. The NCQA's three recognition levels allow practices with a range of capabilities to meet the standards' requirements successfully. Each level reflects the degree to which a practice meets the requirements of the elements and factors that comprise the standards with an increasing level of capabilities. Each element requires specific activities and documentation by the practice. The point allocation for the three levels is as follows:

- Level 1: 35–59 points and all 6 must-pass elements,
- Level 2: 60–84 points and all 6 must-pass elements, and
- Level 3: 85–100 points and all 6 must-pass elements (NCQA, 2011).

Must Pass Elements

Six "Must Pass" elements are considered essential to the PCMH, and are required for practices at all recognition levels. Practices must achieve a score of 50% or higher on Must Pass elements:

- **PCMH 1: Element A: Access During Office Hours**
- **PCMH 2: Element D: Use Data for Population Management**
- **PCMH 3: Element C: Care Management**
- **PCMH 4: Element A: Support Self-Care Process**
- **PCMH 5: Element B: Track Referrals and Follow-Up**
- **PCMH 6: Element C: Implement Continuous Quality Improvement**

Critical Factors

In addition to the Must Pass elements, there are also parts of elements that are "Critical Factors." These factors are required for practices to receive more than the minimal number of points. Without these factors, it is difficult to achieve a high score.

- **PCMH 1A: Access During Office Hours**: *#1. Provide same-day appointments.*
- **PCMH 1B: After-Hours Access:** *#3. Provide timely advice by phone when office is closed.*
- **PCMH 1G: The Practice Team:** *#2. Holding regular team meetings.*
- **PCMH 3D:** Medication Management: *Reviews and reconciles medications for more than 50% of care transitions.*
- **PCMH 3E: Use Electronic Prescribing:** *#2. Generates at least 75% of eligible prescriptions.*
- **PCMH 4A: Support Self-Care Process:** *#3. Collaborates with at least 50% of patients to develop and document self-management plans and goals.*
- **PCMH 5A: Test Tracking and Follow-Up:** *#1. Tracks lab tests and flags and follows-up on overdue results **AND** #2. Tracks imaging tests and flags and follows-up on overdue results.*
- **PCMH 5A, F1-6: Test Tracking/Follow-Up**: *#1. Tracks lab tests, flags/follows-up on overdue results, **AND** #2. Tracks imaging tests, flags/ follows-up on overdue results.*

The combined list of Must Pass and Critical Factors gives practices a sense of the immediate action items they need to think about when considering PCMH recognition. The REC can help identify some quick start activities that build upon meaningful use and that address the Must Pass and Critical Factors needed for PCMH.

For more information, visit the NCQA PCMH website.

Transformation Idea: *Getting Paid for Care Coordination during Care Transitions*

One of the challenges for practices is finding ways to get paid for delivering better quality of care. One new reimbursement mechanism is getting paid for coordinating with other providers during transitions of care. Several payers allow PCPs to code for "Transitional Care Management" or TCM. According to the American Academy of Family Physicians, TCM includes services "provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living)". Below are some of the important features of TCM for practices to be aware of if they are interested in more information. The REC can also guide practices through the steps of achieving TCM within their own practice as well.

How are Discharge, Patient Contact and High Complexity Defined under TCM?

- **Discharge**: discharge from an inpatient setting such as acute care hospital, rehabilitation hospital, long term acute hospital, or skilled nursing facility. It also refers to discharge from observation status in a hospital or a partial hospital program (mental health facility) ED and assisted living facilities are excluded.
- **Contacting the patient:** If the provider or staff attempts to contact the patient or caregiver at least twice and is unable to make contact within 2 business days, the provider may still bill the TCM code if all other criteria are met during the 30 days after discharge. The 2 failed attempts must be documented in the patient's chart.
- **High complexity:** If a patient has a potentially life or limb threatening problem with a significant risk of readmission within the next 30 days or if the provider has to review a large amount of testing and consultation information.

Code Requirements: Provided below are example of coding requirements for Transitions of Care Management.

1. **Code 99495 – Requirements:**
    a. Communication (direct contact, telephone, electronic) with the patient or caregiver within 2 business days of discharge
    b. Medical decision making of at least moderate complexity during the service period
    c. A face to face visit within 14 days of discharge
    d. Pays approximately around- $162.
2. **Code 99496 – Requirements:**
    a. Communication (direct contact, telephone, electronic) with the patient or caregiver within 2 business days of discharge
    b. Medical decision making of high complexity during the service period
    c. A face to face visit within 7 days of discharge
    d. Pays approximately around $229

Components of TCM- a Non-Face-To-Face Encounter

1. Make the initial contact with patient or caregiver
2. Communicate with home health agencies and other community resources the patient uses.
3. Educate the patient or caregiver regarding self- management, independent living and ADLS.
4. Assess the patient's adherence with the treatment regimen
5. Identify community and health resources
6. Medication reconciliation

Components of TCM-a Face-To-Face Encounter

1. Obtain and review discharge information
2. Review the need for follow up on pending diagnostic tests and treatment
3. Interact with other qualified health care professionals who will assume or reassume care of the patient's system specific problems (specialist)
4. Education
5. Establish or reestablish referrals and community resources
6. Examination
7. Medication reconciliation

Payment under TCM: Payers that are currently participating/paying in TCM include Medicare, Cigna, Aetna, and United Health Care.

When to submit the TCM claim:

- The claim should be billed no sooner than the 30th day after the patient was discharged, not at the face-to-face visit. The date of service should be the 30th day after discharge.
- If a patient presents to a practice with the same problem after the initial TCM code and prior to the 30 days are up, the practice can still bill for the visit with an E/M service code 99213, 99214
- **Note:** Only one provider may bill a TCM code for each patient discharge, so the practice may not be eligible or be paid if the patient follows up with more than one physician.

Meaningful Use + Medical Home Case Study: *UC Med Peds Clinic*

The University of Cincinnati (UC) Internal Medicine and Pediatrics (UC Med/Peds) practice is a hospital-based clinic, located on the main campus of UC Hospital in Cincinnati. UC Med/Peds is a part of the safety net system for patients with no insurance and Medicaid makes up the majority of their payer mix (43 percent). UC Med/Peds has a patient base of approximately 5,000 with 12,500 patient visits each year. On the surface, the payer mix and number of patients and providers cycling through this busy practice might seem to make it a less than ideal candidate for pursuing patient centered medical home. But the commitment of the physicians and staff made all the difference in helping them work as a team.

Dr. Jonathan Tolentino of UC Med/Peds Clinic shares his insights on practice transformation.

"Our practice is a teaching clinic. We have six attending physicians, nearly 30 residents and several RNs and Medical Assistants," states Dr. Jonathan Tolentino of UC Med/Peds. "We work hard as a team to provide comprehensive, collaborative care. As a result, our working environment and the care we provide to patients is among the best in primary care."

UC Med/Peds implemented an electronic health record (EHR) along with other health IT tools, and has emphasized using these tools to support patient-centered care and continuous quality improvement. The practice was selected to be part of the Greater Cincinnati Beacon program's Adult Diabetes cohort in the spring of 2011. The practice received Level III Patient Centered Medical Home certification by the National Committee of Quality Assurance in July 2012. Related to meaningful use, all six attending physicians at UC Med Peds received the Adopt/Implement/Upgrade payments through Ohio Medicaid, and 1 physician has attested to Stage 1 Meaningful Use so far. The others are not far behind.

The practice has seen amazing results as health information technology is coupled with a PCMH mindset and quality improvement strategies. UC Med Peds also is one of the pioneers in using the region's Emergency Department/Admission Alert System, a new health information exchange platform implemented under the Beacon program. The Alert System electronically notifies the practice in real time when one of their patients has had an ED visit or hospital admission. This information fills in an important gap; in the past, the communication channels between hospitals and primary care providers were slow in relaying this information, if at all.

To prepare for the use of the Alert System, UC Med/Peds spent time planning and testing how the alerts could be integrated into the practice workflow through PDSA cycles. For example, front desk schedulers were initially assigned the responsibility of addressing the alerts. After doing a workflow PDSA cycle, it was determined that the Medical Assistant was a better fit for addressing the alerts because of the time and clinical decision making required.

The clinic has been utilizing the Alert System since March 2012 and receives an average of 2.64 alerts each day. The practice also designed and tested other quality improvement strategies including an algorithm to respond to the alerts and a risk stratification tool to sort the patients into high- and low-risk categories.

In anticipation of meeting Stage 2 Meaningful Use, the practice is using its team-based approach to plan. "As a team, we are driven by continuous quality improvement," observes Dr. Tolentino. "We constantly ask ourselves, 'What are we missing here? How can we improve the system and the care we provide to patients?' Our EHR and the Alert System have been great tools to use in our efforts to prevent ED visits among our patients with chronic diseases."

Transformation Exercise: *PCMH Eligibility Questionnaire*[8]

This eligibility questionnaire is your first step in determining whether your practice is eligible to apply for PCMH certification. Contact your REC for guidance on interpreting your answers and next steps in the PCMH application process.

Do you have an active unrestricted license as a doctor of medicine, osteopathy, nurse practitioner or physician assistant?	☐ Yes	☐ No
Is your practice acting as the primary care provider for your patients?	☐ Yes	☐ No
Are you an OB/GYN practice? (If yes, note, you are eligible for a separate Specialist Program)	☐ Yes	☐ No
Do your nurse practitioners and/or physician assistant have their own panel of patients?	☐ Yes	☐ No
Does your state require that nurse practitioners be led by a physician(s)?	☐ Yes	☐ No
Is your practice is made up of different type of clinicians, for example surgeons, OB/GYN specialists, dental services?	☐ Yes	☐ No
Are there a group of primary care providers within this group?	☐ Yes	☐ No
Is your primary care practice in a hospital based setting?	☐ Yes	☐ No
Is your primary care practice a residence clinic?	☐ Yes	☐ No
Do your residences have their own panel of patients?	☐ Yes	☐ No
Can your patients' choose any one of the providers as a personal physician?	☐ Yes	☐ No
Are your medical records for all of patients in your practice available to be shared by all clinicians as appropriate?	☐ Yes	☐ No
Do all of your practitioners use the same clinical and administrative system i.e. scheduling, prescribing, maintenance of medical records, follow up etc.?	☐ Yes	☐ No
Are all of your practitioners following the same procedures and protocols?	☐ Yes All ☐ Yes Some ☐ Not much	

[8] Learn more about PCMH eligibility at http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx

Transformation Exercise: *PCMH Next Step Check List*

If eligible for PCMH, it is time to do some prep work. The checklist below lays out some next steps for as your practice works on becoming a Patient Centered Medical Home.

- ☑ **Establish a PCMH Team.** Include both clinical and administrative staff such as doctors, NPs, PAs, MAs, front desk staff, call person, billing/finance, EHR Super Users, IT support, EHR Vendor representative.
- ☑ **Review the NCQA website and the PCMH Getting Started workbook**.
- ☑ **Contact your EHR vendor**. Ask them if they have:
  - a PCMH dashboard or other PCMH specific reports/functions
  - PCMH documentation for specific to their software application
  - PCMH on line and or phone support.
- ☑ **Develop a crosswalk of meaningful use elements with PCMH requirements**.
  - Review your meaningful use Menu items that are part of PCMH.
  - Contact REC staff to get help with developing this crosswalk.
- ☑ **Review Eligible Staffing – No Clinician Left Behind.**
- ☑ **Gather up and organize your community resources/referrals.**
- ☑ **Assess your patient portal:**
  - Does your practice need to implement a patient portal?
  - How many of your patients use the portal at this time?
  - Is it time for a patient portal marketing campaign?
  - Are you sending to and receiving messages from your patients via the portal?
  - Do you use your portal to send educational materials, reminders for follow-up appointments, etc.?

PCMH Eligibility Tips:

- Recognition is on a per location basis.
  - If you have 1 or 2 locations you will seek certification for each of those locations.
  - If you have 3 or more locations you may be eligible to seek certification on a multi-site basis; this determination will be made by NCQA.
- Eligibility is for a three (3) year period and is renewable.
- All eligible providers at the location, i.e. outpatient primary care clinicians who have their own panel of patients, must participate in the certification program.
- The practice must provide primary care to all of the patients within the practice

6. Overview of New Payment Innovation and Care Delivery Models

The final destination on the transformation journey is getting paid differently for delivering high quality care. Provided below is an overview of new care delivery and payment models that CMS and private payers are using to incentivize practices to change how they deliver care.

New Care Delivery Models

Accountable Care Organizations or ACOs are one example of a payment innovation model. ACOs are **networks of providers** that coordinate care for patient populations. The goal of an ACO is to control costs, increase quality, and improve population health. Often ACOs are offered bonuses for hitting quality and cost targets (some ACOs may also receive penalties for not hitting them). There are now more than 400 ACOs in the U.S. that include the following:

- Medicare Pioneer ACO Program
- Medicare Shared Savings Program (three CMMI options)
- Private insurer ACO contracts
- Medicaid ACO initiatives

Another payment innovation model is **Comprehensive Primary Care or Advanced Primary Care.** Under this kind of model, primary care practices (PCPs) receive monthly care management fees to provide "whole person" enhanced care for patients, primarily those with chronic illnesses. This model builds off of the PCMH model. There are multiple programs supporting this model of payment innovation, including:

- Comprehensive Primary Care Initiative
- Multi-payer Advanced Primary Care Practice Demo
- FQHC Advanced Primary Care Practice Demo
- HRSA Patient-Centered Medical/Health Home Initiative
- Medicaid Health Home State Plan Option

What is the difference between ACOs and Comprehensive/Advance Primary Care Models?

ACO	Comprehensive Primary Care
• Emphasizes primary care	• Emphasizes primary care
• May or may not include hospitals, specialists	• Does not include hospitals or specialists
• Risk sharing	• No risk
• Attribution – patients assigned on plurality of care	• Attribution – often based on recent visit(s), typically a two-year look back

How Do Practices Get Paid under New Payment Models?

Traditionally, health care providers are paid on a **Fee-For-Service** (FFS) basis. That is, a service is billed based on the number of units provided and the complexity of the service delivered. The problem with FFS arrangements is they are inherently biased toward encouraging the provision of a greater volume of services. Thus, the US health care system is known for having one of the highest cost and poorest quality health care systems in the industrialized world.

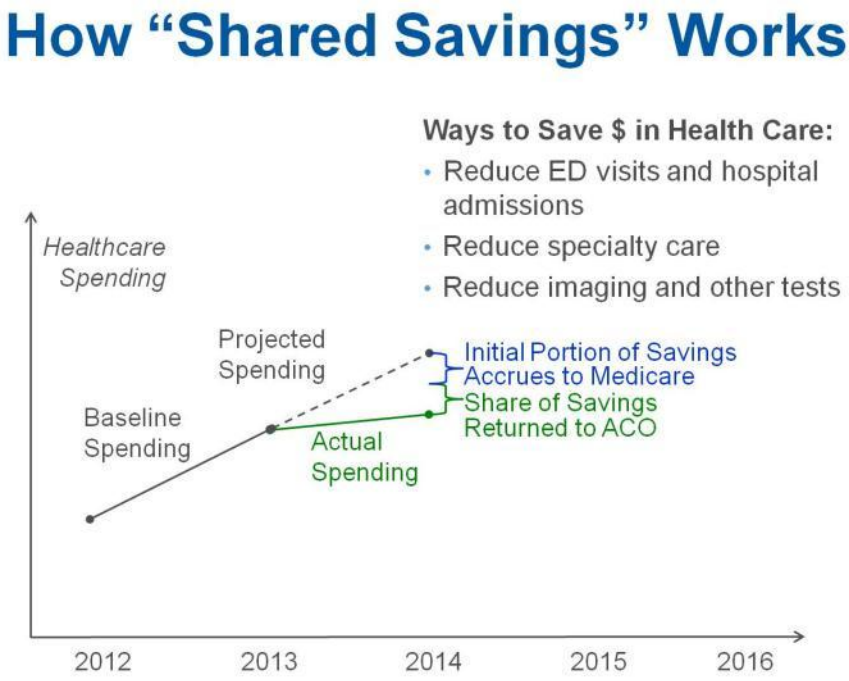
But new forms of payment are being tested under the delivery models described above. They include:

- **Incentive Payments** – bonuses or fees paid to providers that meet certain qualifications, such as becoming a medical home or meeting certain performance or quality targets, usually as a per member per month fee above and beyond FFS payments.
- **Shared Savings or Risk-Sharing** – payments or penalties for providers that are based on reductions or increases in health care costs for an assigned population of patients. Under shared savings a payer can reward a provider by sharing a portion of the cost-savings that come from the new delivery model (see Figure 8 below).
- **Bundled Payments** – also known as an episode-based payment, episode-of-care payment, or case rate payment. This model involves giving all providers involved in care and treatment a fixed payment for a specified episode of care. By bundling payments across a group of providers – such as hospitals, post-acute care providers, physicians, and other practitioners – for a specified episode of care (such as knee replacement surgery) there are greater incentives for all the providers to manage care well and reduce risk for high cost, preventable complications. CMMI has more information on various Bundled Payment options.
- **Capitation** – providers are paid a set amount for a group of patients over a period of time, regardless of the amount of services used. There are two main types:
    - **Global Capitation** (full-risk) involves a provider being responsible for a full set of services for a panel of patients.
    - **Partial Capitation** (partial-risk) involves a provider being responsible for a specified set of services for a panel of patients.

Common Elements of Payment Innovation Initiatives

Because payment innovation initiatives involve providers bearing some level of risk for lowering the cost of care for patients, there are some common strategies used by providers and payers to track and manage lowering the cost of care and improving outcomes for patients. Practices interested in payment innovation can work together with the REC to share best practices and promising approaches for tackling the tough challenges involved with implementing these elements.

Figure 8: Shared Savings



- ***Patient Attribution & Empanelment***

One of the biggest areas of concern early in any payment innovation initiative is determining which patients are the responsibilities of which providers. If you are a PCP on the hook for lowering the total cost of care for your panel of patients, then a key question is: "*Which patients are really mine and which belong to another practice or provider?"*

Patient attribution is the term used for a process of assigning patients to a certain provider or practice for the purposes of accountability and payment. There are different ways to handle attribution: prospective or retrospective, by individual provider, practice site or organization-wide and patient-specific versus episode of care assignment. Frequently, health plans or administrators will look back at which PCPs gave care to a patient in the previous year or two years, but this can be confounded by patients who visit multiple providers in a given time frame. Other factors such as number of visits, billing or other factors can also be considered.

Empanelment, in contrast, is a practice-based approach used frequently by medical homes under new payment models. Empanelment is the process whereby a PCP and the practice team assume responsibility for a group of patients. This ensures that the practice team "owns" the health and well-being of this population of patients. Having responsibility for a specific panel of patients means care teams can track and monitor progress against goals on that population of patients. Empanelment also allows for more longitudinal patient-provider relationships, which in turn result in improved health outcomes.

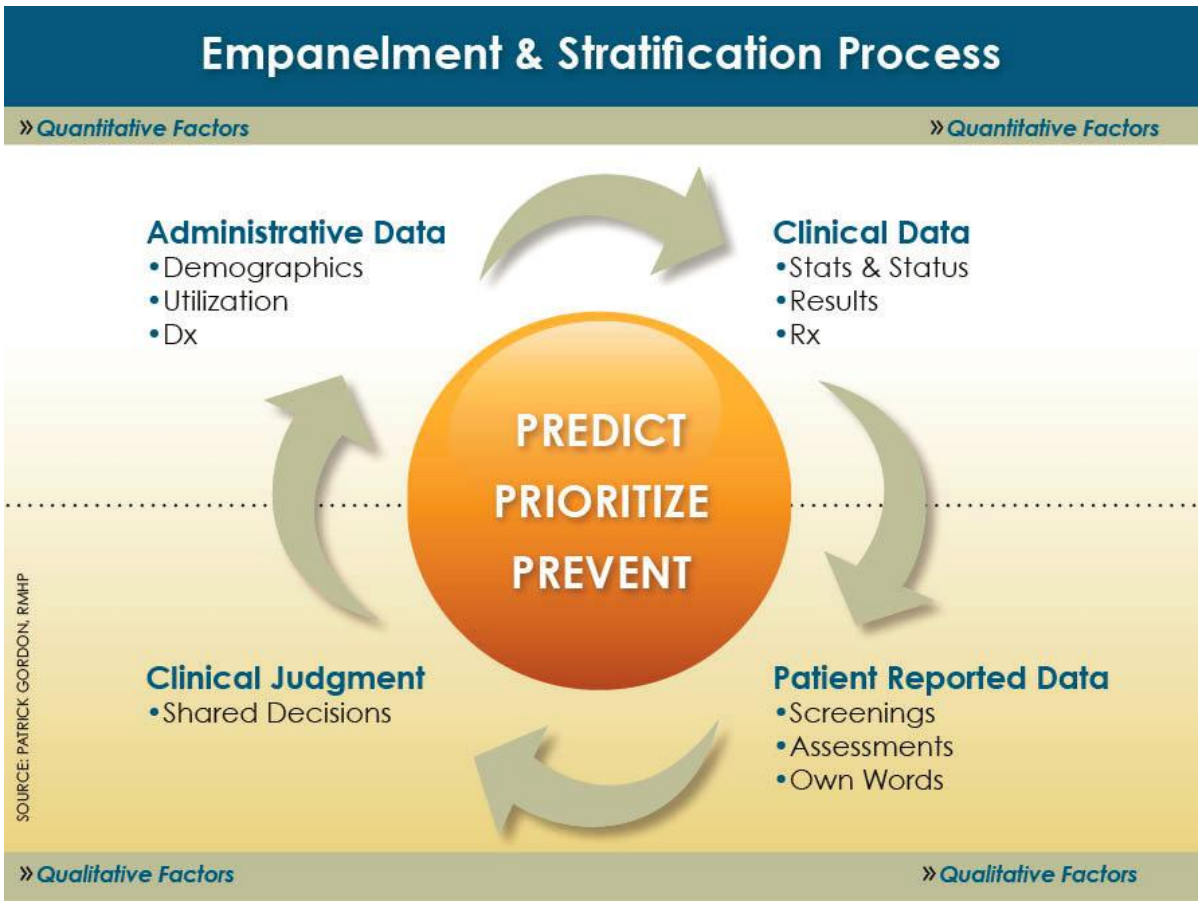


Figure 9: Empanelment and Stratification

- ***Care Management & High Risk Patients***

Once a panel of patients is assigned to a care team, that care team can then undertake a variety of **care management** activities aimed at improving the health outcomes and cost profile for that population of patients. Frequently, care teams will use **risk stratification** to prioritize their population health improvement efforts and focus on patients with the greatest potential for preventable, high cost complications. Risk stratification uses various factors, such as number of past utilizations, chronic disease state and poor health status, to group patients into categories of need. Two simple risk stratification models are provided on page 36. Practices then use a variety of interventions to help proactively manage their high-risk patients, such as tracking patients in a registry to identify gaps in care, patient outreach by a care manager, pre-visit planning and patient education and self-management, to ensure patients are receiving the right care at the right time.

- ***Care Coordination & the Medical Neighborhood***

Because patients frequently see multiple providers, it is not enough just to have an efficiently run medical home. Under new payment models, PCPs can be responsible for the ***total*** cost of care for their patients. That means they are responsible for care that occurs elsewhere in the

health care system. Medical home transformation emphasizes care coordination with other providers, but payment innovation demands it, especially for high-risk patients. Coordinating care with other health care and social services providers across the “medical neighborhood”, including other referral hospitals, specialists, home health, transportation services and meal programs can be critical to keeping patients well and preventing high-cost complications.

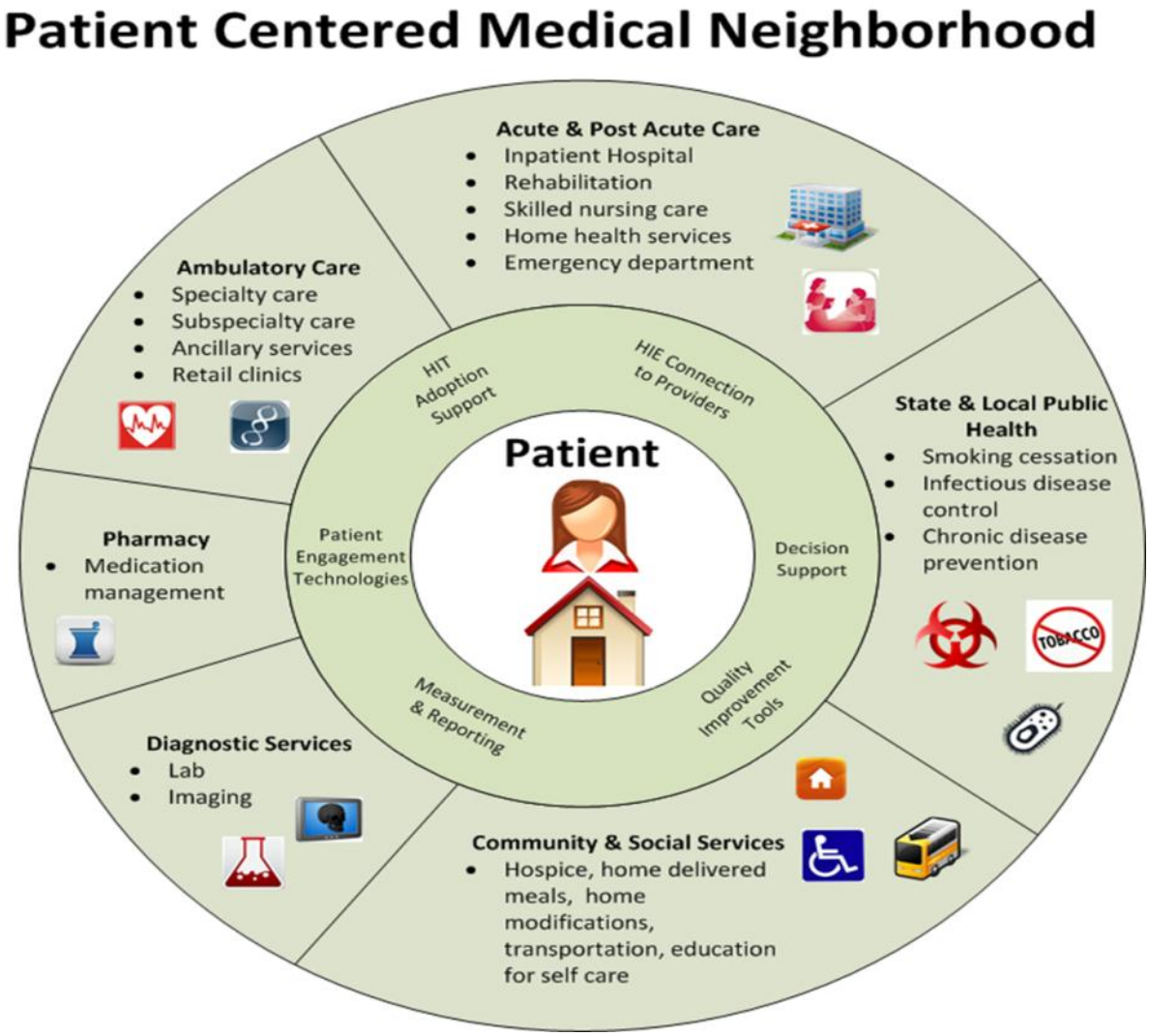


Figure 10. The Medical Home in the Center of the Connected Medical Neighborhood

- ***Patient Engagement & Experience of Care***

Potentially the biggest untapped resource for lowering the cost of care and improving outcomes is the patient and their family. Patients with chronic conditions are typically among the heaviest users of health care services, and much of day-to-day chronic disease management occurs outside the practice such as taking medications properly, eating right, getting exercise and

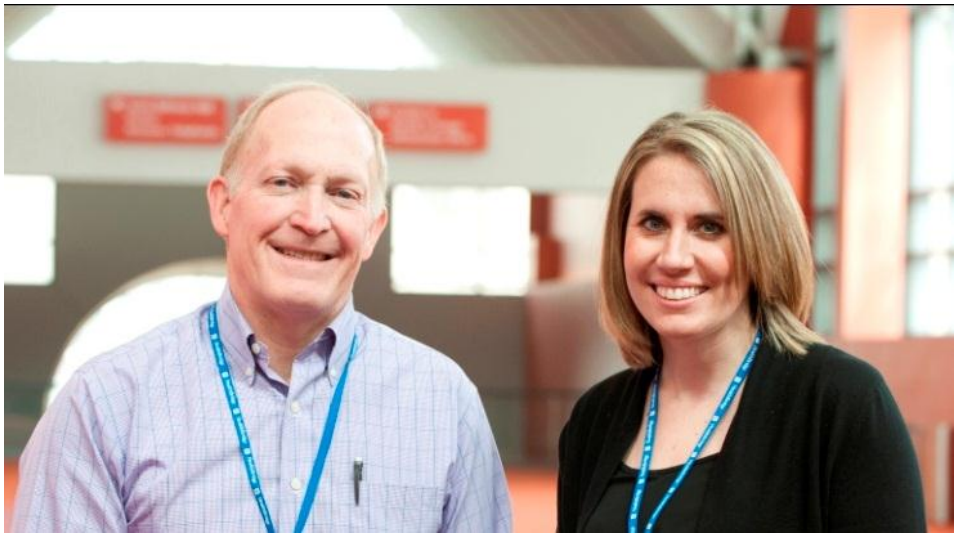
monitoring blood pressure, blood sugar or other factors. Therefore, meaningful use, medical home and new payment models are emphasizing patient engagement, patient education and self-management like never before. Under new payment models, practices are often required to perform specific monitoring of patient satisfaction and engagement, such as collecting Patient Activation Measures (PAM) or monitoring patient experience of care (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey).

Payment Innovation Case Study: *Summit Family Physicians*

Building a high quality, small, family-based practice requires a lot of dedication, forward thinking and hard work. Summit Family Physicians in Middletown, Ohio is an example of what that kind of dedication can do. Amazingly, Summit demonstrated that the transformation process from being on paper to being an electronically connected, high performing PCMH can be done *in just over a year*.

Summit is a very busy practice with 3 physicians and 1 family nurse practitioner who care for an average of 85 patients each day. With assistance from the Tri-State Regional Extension Center, in just a few months, Summit went from paper to being live with an electronic health record system (EHR) in September 2011. The practice achieved meaningful use in December 2011, right on time.

At the same time, the practice became involved with the Health Collaborative's practice transformation cohort to improve care for patients with diabetes and become a recognized PCMH. An EHR and all the capabilities that it provides revolutionized the practice through improvements to workflow and patient care.



Dr. Mark Fraser and Leah Brunie, ANP share their experiences with attendees at the 2012 Meaningful Use Conference

"The Tri-State REC staff helped us to pick the EHR system best suited for our practice," said Dr. Mark Frazer, a physician at Summit Family Physicians. "The REC staff helped

me and my staff to understand all the changes taking place in health IT and how we can improve the workflow for better patient care."

Summit's involvement with a group of other PCMH practices in a learning cohort under the Beacon Community Program made a complex certification process both manageable and exciting. "It has been an asset to be involved with the Beacon PCMH cohort. Learning from other practices through collaborative training sessions and having access to hands-on coaching from Beacon staff has made an overwhelming process seem totally doable," states Leah Brunie, family nurse practitioner at Summit. "Being a PCMH is a total practice change and with it, Summit has become the best of the best in terms of quality patient care."

Summit was recognized as a Level 3 NCQA PCMH practice in November 2012.

In the midst of all the other changes it was undertaking – meaningful use, medical home and being part of the Beacon Community program – a new opportunity to apply for a payment innovation demonstration became available. The Greater Cincinnati – Dayton – Northern Kentucky market was selected for a CMMI Comprehensive Primary Care initiative in April 2012.

Summit Family Physicians was one of 75 leading practices chosen in August 2012. Under the CPC initiative, CMS and 8 commercial insurers are working together in a coordinated fashion with providers to implement comprehensive primary care that improve care, outcomes and lowers costs. Practices are given per member per month incentive payments for the first two years and then will participate in shared savings. Medicare provides a risk-adjusted PMPM of $8-40 per beneficiary, with commercial insurers paying less than that amount. For most practices, they are being paid a PMPM for more than 2/3rds of their patients. While being in CPC is hard work, practices are developing new ways to deliver and get paid for high quality patient care.

More information on the Comprehensive Primary Care initiative is available through the CMS CPC website or through the Health Collaborative's CPC resource page.

Transformation Exercise: *Assessing Payment Innovation Readiness*

Gather a small team from your practice to discuss participation in various new care delivery and payment models. Have the group discuss the effects of various changes on the practices using the table below. In the table, enter the appropriate symbol in the table based on the following categories:

- If your team expects the impact on an input ***to increase***, place a plus sign **"+"** in the appropriate space in the table;
- If your team expects the impact on the input ***to decrease***, place a minus sign **"–"** in the appropriate space in the table;
- If your team expects the impact to have ***no clear effect***, place an **"x"** symbol in the appropriate space in the table.

Effect Estimator of New Care Delivery or Payment Models on Practice Outcomes

New Model Feature	Training Costs	Service Volume	Per Service Inputs			Office Expense	Admin Staff	Malpractice Premiums
			RVU*	MD Time	Clinical Staff Time			
Open Access Scheduling								
Online Appointments								
Electronic Medical Records								
Group Visits								
E-Consults								
Care Management								
Web-Based Information								

Team Approach								
Medical Protocol Software								
Outcome Analysis								

*Adapted from: Financial Model for Sustaining Family Medicine and Primary Care Practices, The Lewin Group, July 2004. *RVU = Relative Value Unit*

Next, discuss and answer the following questions about various payment models your practice is considering. List the top three to four areas of concern that were uncovered in the team's discussion.

1. Which items from the list of major variables that was distributed standout for you as being critical to the Payment Innovation model discussed in your team?
2. What do you see at the 2-3 greatest challenges to implementing a Payment Innovation model?
3. What are the 2-3 key capabilities required to implement Payment Innovation in your practice?
4. What are key strengths of the PCMH model that will help to achieve positive outcomes in payment innovation?
5. What are the model's shortcomings, if any, with respect to patient-centered medical home (PCMH) transformation?
6. Thinking about the payment model that you are considering, is becoming a PCMH a complimentary process?
7. How might the model incent cooperation, coordination, and cost-effectiveness among all providers within a practice area?
8. What might be some of the pitfalls for not preparing for Payment Innovation in your practice?
9. How would your team define success?

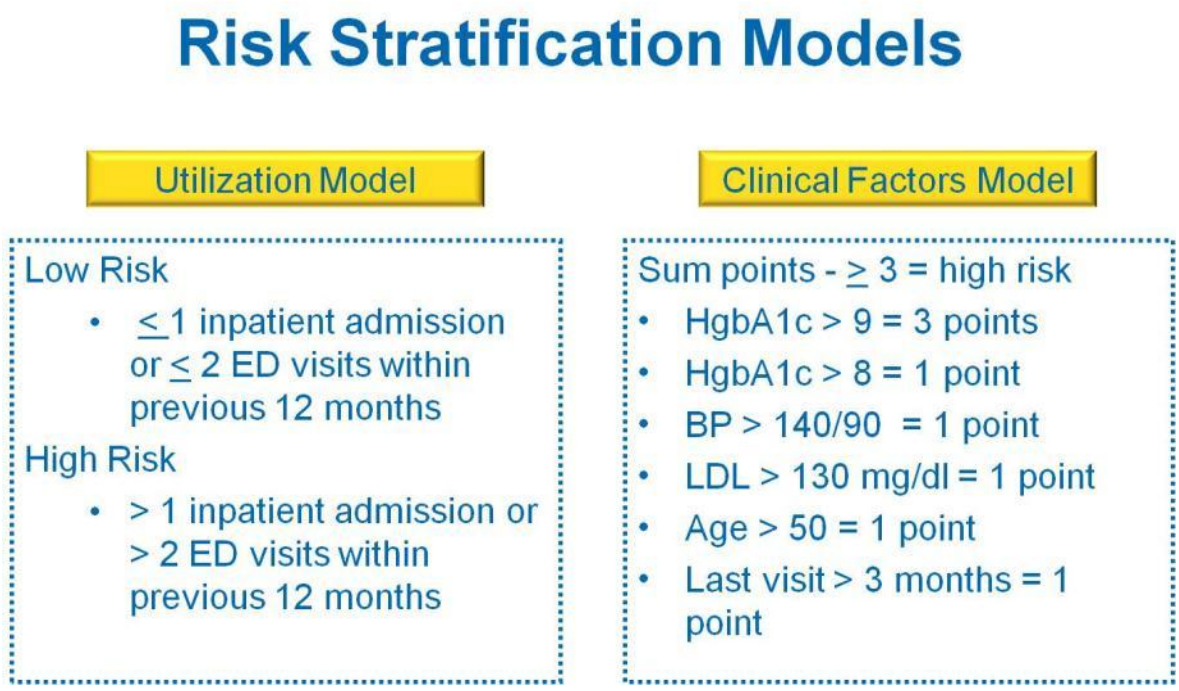
Transformation Exercise: *Identifying High Risk Patients*

Step 1: Plan - It can be overwhelming to think about stratifying your entire patient population, so start small. Choose an area of focus based on your specific practice demographics (i.e. Diabetes, Asthma, Hypertension). Determine if you can pull population level data from your EHR using fields such as diagnosis/chronic condition, age, insurance status, last visit, ED or inpatient hospitalization or clinical factors (e.g., blood pressure, LDL, smoking status, etc.)

Step 2: Do - Run a report from your EHR on patients with heart disease or diabetes that includes fields from one of the Risk Stratification Models below. For example, a practice could run a report of all patients 65 and older with diabetes with Emergency or Hospital admissions over the last 12 months.

Step 3: Study - Spot check a few patients to see if the data in your EHR matches what is in the report you ran. Determine how many patients from the list would fall into the high risk category with the information you have in the report.

Step 4: Act - From the high risk list, determine if there is an appropriate preventive service or other follow up needed for this group of patients. Send a letter to those patients (e.g., blood pressure is high or hemoglobin A1c is missing) with consistent messaging across all of the letters and include a phone number for feedback and making an appointment. Have front office staff track responses.



Getting Started Checklist[1]

The process for spearheading and managing practice transformation is similar to the framework of treating a patient; you have to make an assessment, formulate goals & a treatment plan, implement the plan and follow-up to ensure it's working. Below is a checklist of some of the initial areas you'll want to explore to get started on the road to practice transformation.

Assessment

- ✓ **Readiness** - What is your practice's level of readiness for change?
- ✓ **Leadership** - Does your practice have at least one "physician champion" who believes in the value of QI work and the application of EHRs and health IT to that work?
- ✓ **Team** - Can you identify potential members of a leadership team who are willing and able to do the nuts and bolts of the QI work, including a physician champion, a practice administrator and both clinical and administrative leads?
- ✓ **Technology** - Does your EHR have the functionality to easily capture and report data relevant to Meaningful Use, PCMH or other quality measures?
- ✓ **Resources** - Have you contacted your Regional Extension Center to learn what further support is available?

Formulation

- ✓ Has the practice team been formed and educated about expectations, the practice transformation process and available tools?
- ✓ Has the team completed a preliminary analysis of the practice as a whole, such as a Strengths-Weakness-Opportunities-Threats (SWOT), a Value-Stream Mapping exercise, or Institute for Healthcare Improvement's (IHI) Improvement Map?
- ✓ Has the practice used data to identify potential areas for change as well as problem areas?
- ✓ Has leadership and the practice team developed a vision for the practice's transformation? What are the practice's initial goals for change?
- ✓ How will the goals be measured? Remember: *"What gets measured, gets managed!"*
- ✓ Has the team completed the Key Driver Diagram?
- ✓ Has an action plan been developed, complete with tasks, deadlines, ownership of tasks and identification of additional resources that are needed?

Implementation

- ✓ Has the Team communicated a compelling, inspiring vision across the practice as a whole?
- ✓ Is the team empowering and encouraging all levels of staff to engage in the change process?
- ✓ Is the team constantly and actively monitoring implementation, building on what is working well, changing and modifying what is not working well?
- ✓ Is the team utilizing PDSAs for this monitoring?

Follow-Up

- ✓ Is the team regularly meeting to review the practice transformation process as well as actively soliciting feedback to learn how things are progressing across the board?
- ✓ Is the team publicly celebrating when milestones and small wins are achieved and appreciating everyone for a job well done?

[1] Checklist content adapted from the Colorado Beacon Consortium's Quality Improvement Toolkit as well as *Putting Theory into Practice: A Practical Guide to PCMH Transformation Resources* by the Patient Centered Primary Care Collaborative which can be downloaded at http://www.pcpcc.org/guide/putting-theory-practice.

Conclusion

The goal of the Practice Transformation Road Map is to help practice leaders and staff to understand the tremendous changes underway in health care and to navigate these changes well. The Road Map is simply a guide to managing change in the practice using time-honored and tested principles and processes.

Much of the devil is in the details, however. Meaningful use, medical home, care delivery and payment innovation are big, complex subjects that the Road Map can only cover at a high level. If readers are interested in learning more and beginning the journey to better care and better outcomes for patients, we encourage you to contact the REC. Our dedicated REC staff are ready to provide support and assistance, including:

- Help with planning, project management and developing an effective team
- Tips and helpful hints to align Stage 2 MU and NCQA PCMH work
- Support for preparing for and participating in payment innovation
- Individualized coaching as well as group learning opportunities.

For more information, please contact:

Tri-State REC
2649 Erie Avenue, 2nd Floor
Cincinnati, Ohio 45208
(513) 531-0267
www.tristaterec.org

Kentucky REC
2355 Huguenard Drive, Suite 100
Lexington, KY 40503
859-323-3090
http://kentuckyrec.com/

Glossary of Terms & Acronyms

There are many terms used throughout the practice transformation process. Below is a list of some acronyms and terms that are frequently used by practice transformation experts.

- **ACA** – Affordable Care Act
- **ACO** – Accountable Care Organization
- **ARRA** – America Recovery and Reinvestment Act
- **CPC** – Comprehensive Primary Care initiative
- **ED** – Emergency Department
- **EHR** – Electronic Health Record
- **HIE** – Health Information Exchange
- **HIT** – Health Information Technology
- **HITECH** – Health Information Technology for Economic and Clinical Health Act
- **IT** or **IS** – Information Technology, Information Systems
- **PCMH** – Patient Centered Medical Home
- **PCP** – Primary Care Practitioner
- **REC** – Regional Extension Center
- **S1MU** – Stage 1 Meaningful Use
- **S2MU** – Stage 2 Meaningful Use

Accountable Care Organization – A network of providers that coordinate care for patient populations with the goal to control costs, increase quality, and improve population health.

Bundled Payment – A model that gives all providers involved in care and treatment a combined and fixed payment for a specified episode of care; also known as an episode-based payment, episode-of-care payment, or case rate payment.

Care Coordination – Health care services and communication for the patient across all elements of the broader healthcare system.

Care Management – Health care services performed by health care providers to assist “at-risk” and chronically ill patients achieve better health and manage their conditions over the long-term.

Care Model - A model that represents the ideal system of healthcare for people with chronic disease and an approach to re-designing healthcare to mirror that ideal system. Developed by Improving Chronic Illness Care, the model has six components: community resources and policies, healthcare organization, self management support, decision support, delivery system design, and clinical information systems.

Quality Improvement Team Members - The members are those individuals who attend the Learning Collaboratives and meet on a regular basis for performance improvement work.

Cycle - See “PDSA cycle”.

Electronic Health Record (EHR) - An electronic health record (EHR) is an official health record for an individual that is shared among multiple facilities and agencies. Digitized health information systems are expected to improve efficiency and quality of care and, ultimately, reduce costs.

Empanelment – The act of assigning individual patients to specific primary care providers and care teams to form the basis for better population health management and continuity of care.

Health Information Exchange (HIE) - The mobilization of healthcare information electronically across organizations within a region, community or hospital system which provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged.

Health Information Technology (HIT) - The umbrella framework to describe the comprehensive management of health information and its secure exchange between consumers, providers, government and quality entities, and insurers. Health information technology (HIT) is, in general, increasingly viewed as the most promising tool for improving the overall quality, safety and efficiency of the health delivery system.

Learning Collaborative - A one day meeting during which participating organization teams meet with faculty and collaborate to learn key changes in the topic area, including how to implement them, an approach for accelerating improvement, and a method for overcoming obstacles to change. Teams leave these meetings with new knowledge, skills and materials that prepare them to make immediate changes.

Measure - A focused, reportable unit that will help a team monitor its progress toward achieving its aim. The Collaborative has a list of required key measures for each condition, as well as a list of additional key measures that have been found to be helpful to the team in achieving excellent results.

Model for Improvement - An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes. The model includes use of “rapid-cycle improvement,” successive cycles of planning, doing, studying, and acting (PDSA cycles).

Patient Attribution - The process of assigning a patient or patients to a provider or providers to establish provider accountability for care efficiency, quality and cost.

Patient Centered Medical Home – PCMH is a model developed by the National Commission on Quality Assurance to assist providers in transforming the organization and delivery of primary care. It emphasizes six core standards for practices to achieve different levels of PCMH certification.

PDSA Cycle - Another name for a cycle (structured trial) of a change, which includes four phases: Plan, Do, Study, and Act. The PDSA cycle will naturally lead to the “plan” component of a subsequent cycle.

Population of Focus (POF) - A designated set of patients who will be tracked to determine whether changes have resulted in improvements. The ideal size to track for most chronic disease populations is between 100-200 patients (this is a dynamic number and will fluctuate slightly from month to month). It is this subpopulation that will then be the initial focus of the change in practice.

Pre-Work - The time before the first Learning Collaborative when teams prepare for their work in the Collaborative. Pre-Work activities include attending webinars, forming a team, registering for the first Learning Collaborative, scheduling initial meetings, preparing an aim statement, defining a Population of Focus, selecting measures, and beginning to populate a registry.

Registry - A list or database set of records that contain individual patient information. The registry should provide the following: clinically useful and timely information, reminders and feedback for providers and patients, identify relevant patient subgroups and support proactive care, and facilitate individual patient care planning. “Registry size” refers to the count of patients represented in the list.

Run Chart - A line chart showing results of improvement efforts plotted over time. The changes made are also noted on the line chart at the time they occur. This allows the viewer to connect changes made with specific results.

Team - The group of individuals, usually from multiple disciplines who drive and participate in the improvement process. A core team of three individuals attend the Learning Collaboratives, but a larger team of six to eight people participate in the improvement process in the organization.

Test - A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement, and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

Resources

- EHR Incentive Program information from CMS - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/
- Meaningful Use information from HealthIT.gov - http://www.healthit.gov/policy-researchers-implementers/meaningful-use
- Health Collaborative PCMH Info - http://the-collaborative.org/home/what-we-do/patient-centered-medical-homes/
- The HealthBridge YouTube Channel for health care transformation videos - http://www.youtube.com/user/HealthBridgeHIE
- PCMH program information from NCQA - http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx
- Kentucky REC website - http://kentuckyrec.com/
- Stage 2 Meaningful Use information from the Tri-State REC: http://www.tristaterec.org/s2mu
- Tri-State Regional Extension Center – S2MU Central - http://www.tristaterec.org/Resources/S2MUCentral.aspx