TRANSFORMATION

TEAM-BASED CARE

POPULATION HEALTH

HEALTH IT

MACRA

HEALTH CARE POLICY

An Official Conference by NCQA

PCMH Congress™

September 14–16, 2018

San Diego Convention Center

San Diego, CA

pcmhcongress.com

Commit. Transform. Succeed.

Return on Investment:
Show Me the Dollars in Value of PCMH
Illinois

Megan Reyna, MSN, RN
Advocate Physician Partners

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Faculty Disclosure

- **Megan Reyna, MSN, RN** has no financial relationships to disclose relating to the subject matter of this presentation.

Learning Objectives

- Learn how a large ACO and clinically-integrated healthcare delivery system found ROI though NCQA PCMH transformation of aligned primary care practices in a value-based environment.
- Understand how to successfully scale NCQA PCMH clinical transformation throughout a large ACO's primary care network.
- Evaluate the impact of NCQA PCMH transformation through an analysis of quality performance from a robust clinical integration program.

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Organization Overview

Advocate Physician Partners

- Founded in 1995
- Nationally Recognized Clinical Integration (CI) Program launched in 2004
- One of the largest ACOs in the U.S. and the first commercial ACO in Illinois
- Leader in Population Health Management
- Central Verification Office Certified by NCQA
- By the Numbers
  - 5,000 physician members (1,500 employed and 3,500 independent)
  - 350 associates
  - 11 PHOs
  - 973,000 covered lives under value-based agreements
  - Serving over 1 million patients through CI Program

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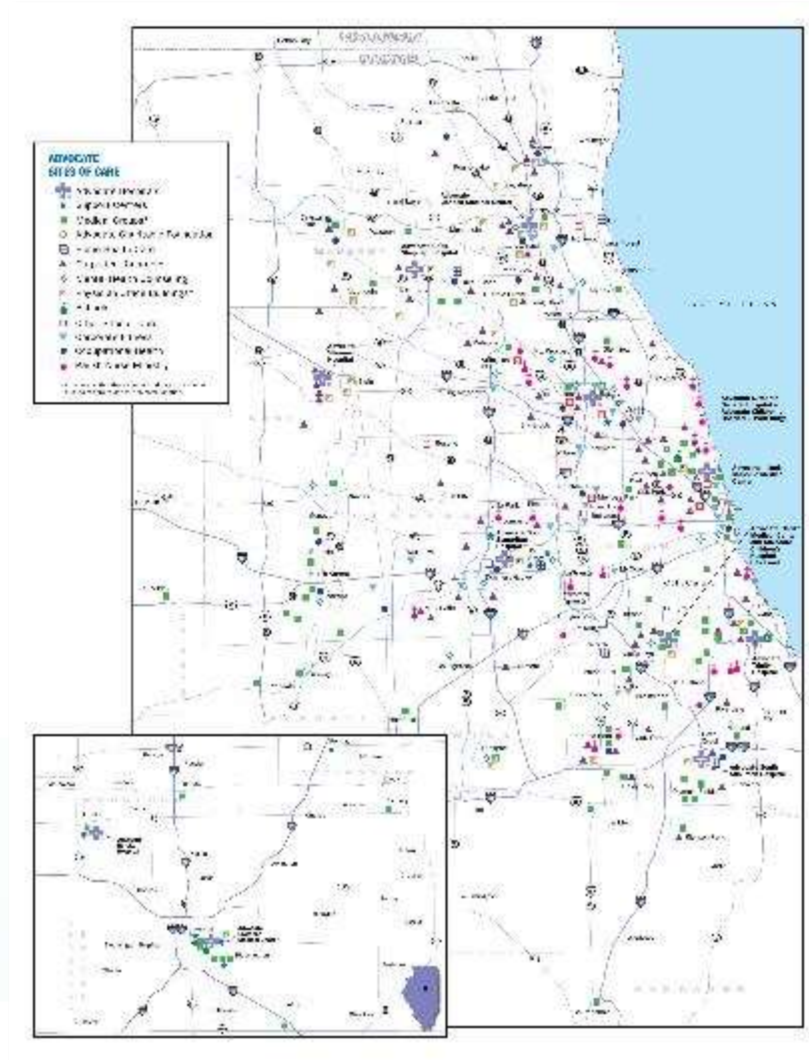
Advocate Health Care

- 12 Hospitals
  - 10 acute care hospitals
  - 1 children's hospital – 2 campuses
  - 1 critical care hospital
  - 5 level 1 trauma centers
  - 4 major teaching hospitals
- Over 450 sites of care
- 35,000 associates
- 11,000 daily census in home health/post-acute network
- $5.5 billion total revenue
- 17.9% market share



REIMAGINING HEALTH. TRANSFORMING CARE.

27
HOSPITALS

500
OUTPATIENT LOCATIONS

Nearly 3M
UNIQUE PATIENTS

8,100+
PHYSICIANS

70,000
TEAM MEMBERS

Nearly $2B
COMMUNITY BENEFITS IN 2016

AdvocateAuroraHealth

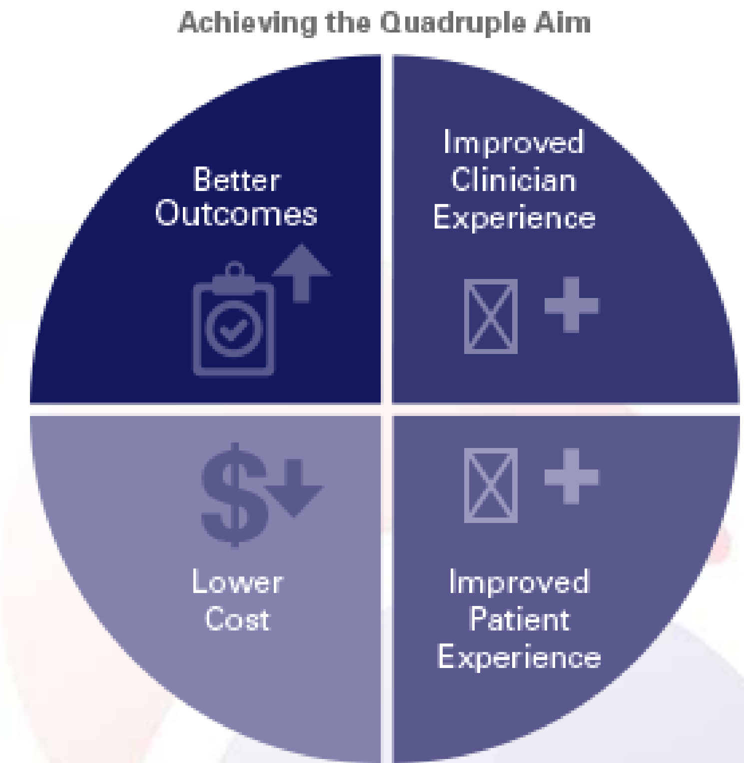
Advocate Health Care

Aurora Health Care®

APP PCMH Program Overview

Why is APP Encouraging PCMH Adoption?

- To secure optimal risk based contracts demonstrating:
  - Improved patient satisfaction
  - Competitive access to care
  - Transparency in quality reporting
- Support with Achieving the **Quadruple** Aim
  - **Better Outcomes**
  - **Lower Cost**
  - **Improved Patient Experience**
  - **Improved Clinician Experience**
- Success with Clinical Integration = Improved financial performance
  - **Quality**: Outreach to close gaps in care
  - **Efficiency**: Utilization Data & In-Network Care
- Core tenets of PCMH model of care = method PCP practices can use to work Clinical Integration into practice routine



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Membership Requirement

Eligible* Primary Care Physicians must meet and maintain NCQA PCMH recognition standards

OR

Have achieved a comparable recognition

- AAAHC
- URAC
- Joint Commission

*Advocate Physician Partners Contracted Physicians meeting minimum requirements as outlined in the Membership Agreement

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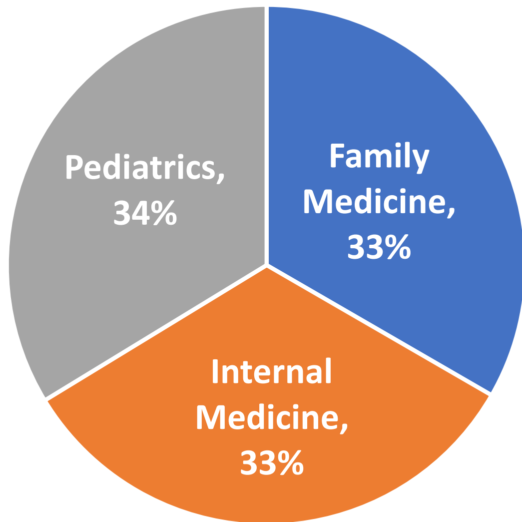
Reasons an aligned practice may be **deferred** from the Advocate Physician Partners PCMH Program:

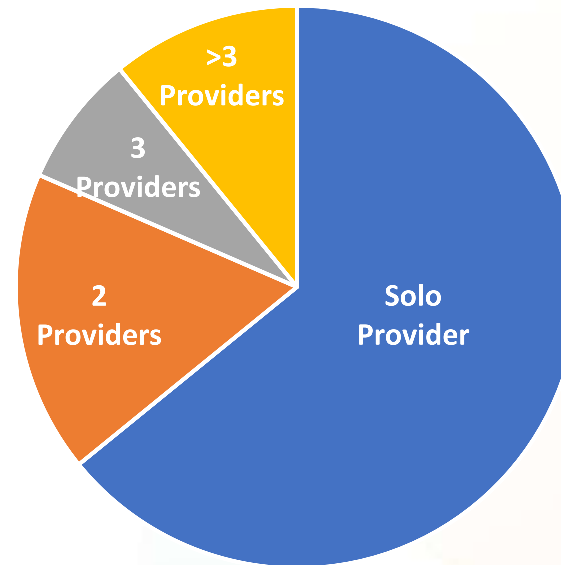
- Practices employed by Advocate Medical Group or another health system.
- Physician(s) terming or retiring by the end of the program year.
- APP practice(s) with less than 350 attributed patients. A sufficient sample size is needed to submit to NCQA.
- Physician(s) who have failed to meet the minimum Clinical Integration (CI) score threshold as outlined in the participating physician agreement and/or not in good standing with all APP membership requirements

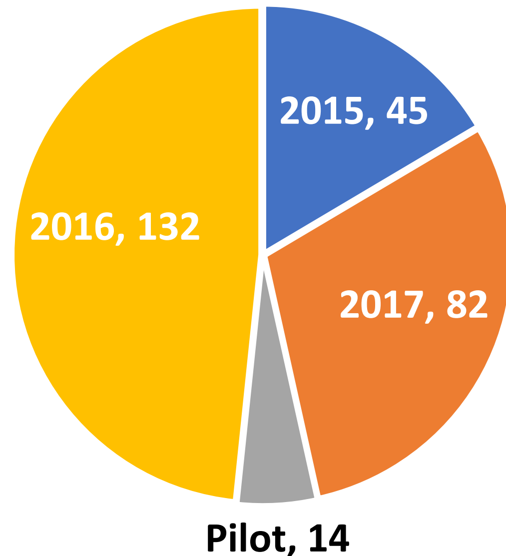
Participating Practice Overview

273 APP Aligned PCP Practices Participated

518 Physicians







PHO	Number of Practices Participated
BroMenn	6
Christ	55
Condell	24
Good Samaritan	21
Good Shepherd	16
Illinois Masonic	27
Lutheran General	54
Sherman	22
Silver Cross	24
South Suburban	14
Trinity	10
Total	**273**

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Focus of APP PCMH Approach

1. Profile each practice population by contract and clinical risk
2. Improve on Clinical Quality Measures, Patient Experience, Access to Care, and Resource Stewardship
3. Conduct outreach to patient populations
4. Implement practice huddles to foster safety, reliability, and communication
5. Enhance Patient access to care
6. Integrate Care Management & Pharmacy for high risk and rising risk population
7. Coordinate Care within Network

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APP PCMH Practice Transformation Curriculum

1. 12 month, APP Advisor supported, curriculum.
2. PCMH concepts and requirements taught in group setting
3. Biweekly, 2 hour, in-office/remote working sessions
4. Educating practices on 100 criteria
5. 40 Core and 25 Credits
6. 3 virtual check-ins with NCQA required
7. Workflow assessment and gap analysis
8. Implementing revised workflows
9. Best practice education

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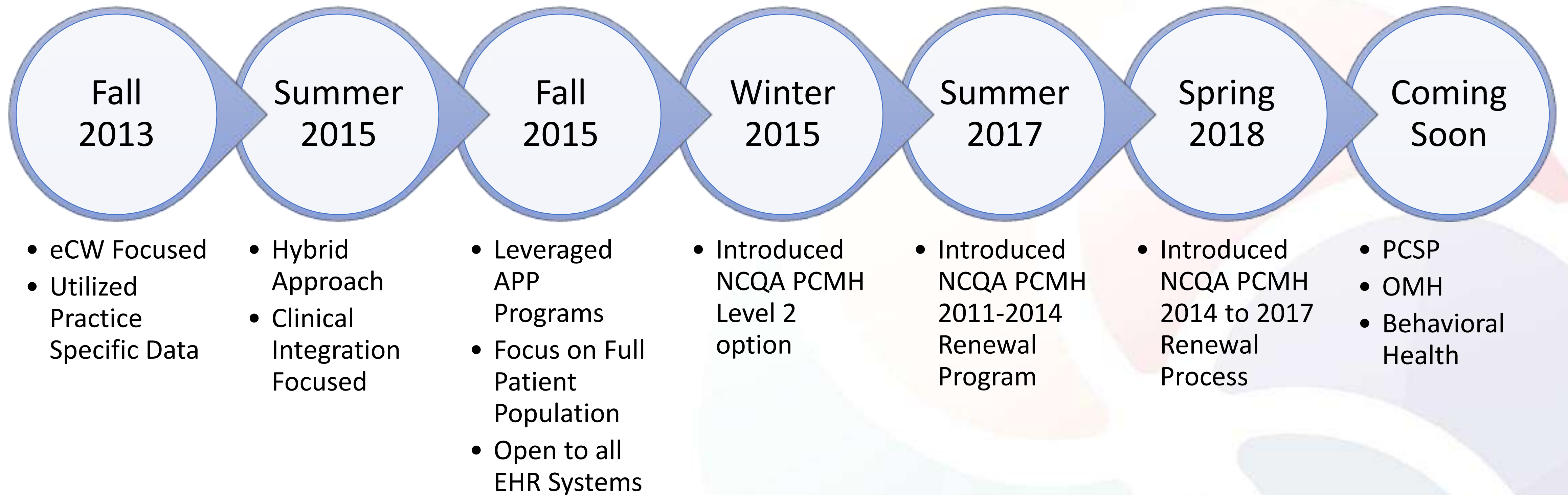
PCMH Advisor’s Role

- The PCMH Advisor works closely with practice on transformation and assists with overcoming any barriers the practice faces.
- Advisors assigned to each PHO region and regional PCP practices
- Collaborate with the PCMH Transformation Team and assigned NCQA evaluator
- Educate about NCQA standards and guidelines to practice staff for recognition
- Guide the practice with best practice workflows and solutions
  - Referral and Test Tracking and Follow Up
  - Daily Safety Huddles
  - Quality Improvement on CI Scorecards

Practice’s Role

- Identify a clinician lead and transformation manager
- Read and become familiar with PCMH standards
- Commitment to work closely with the PCMH Advisor
- Participate in PCMH onsite working sessions
- Complete action items assigned by the PCMH Advisor before next working session
- Complete PDSA’s
- Complete documentation, such as policies, screenshots, and reports
- Engages with NCQA during virtual reviews to demonstrate practice workflows
- Communication with PCMH Advisor

Evolution of the APP PCMH Program



- eCW Focused
- Utilized Practice Specific Data

- Hybrid Approach
- Clinical Integration Focused

- Leveraged APP Programs
- Focus on Full Patient Population
- Open to all EHR Systems

- Introduced NCQA PCMH Level 2 option

- Introduced NCQA PCMH 2011-2014 Renewal Program

- Introduced NCQA PCMH 2014 to 2017 Renewal Process

- PCSP
- OMH
- Behavioral Health

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Team Structure

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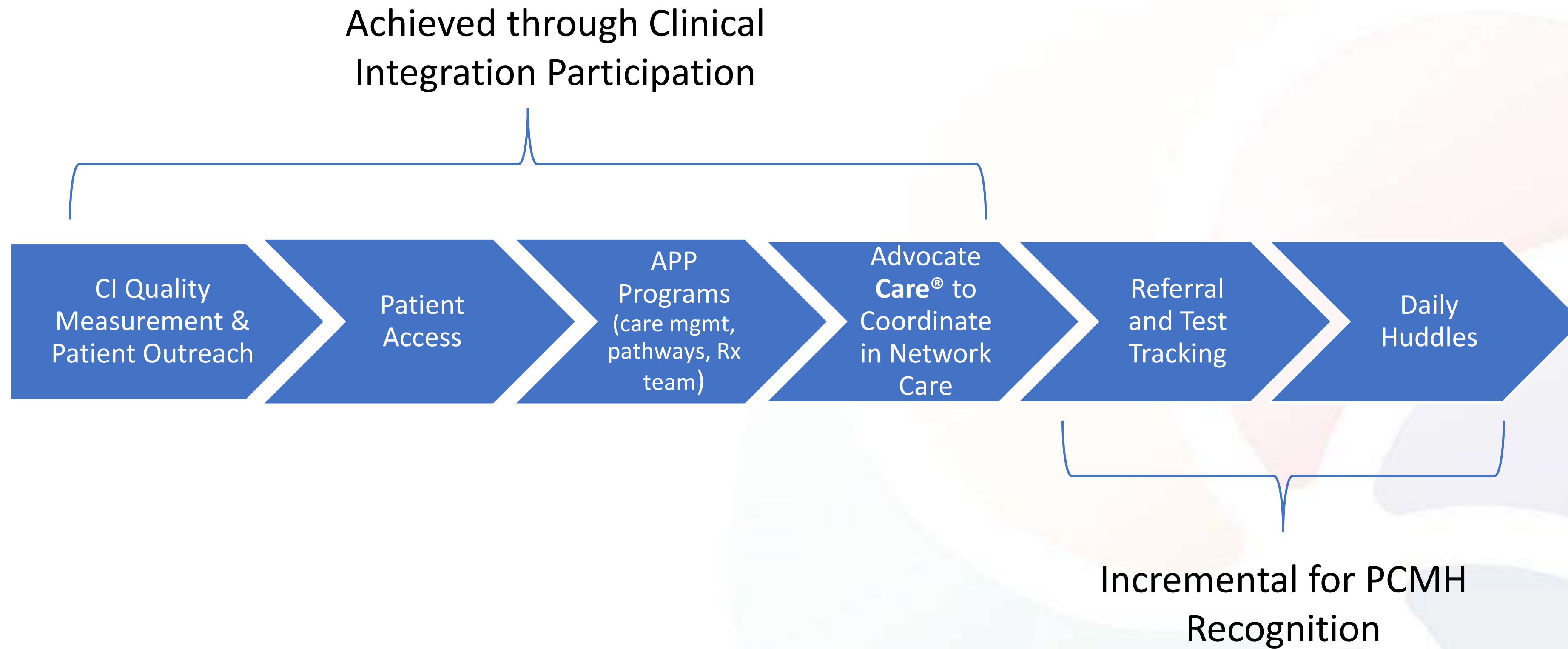
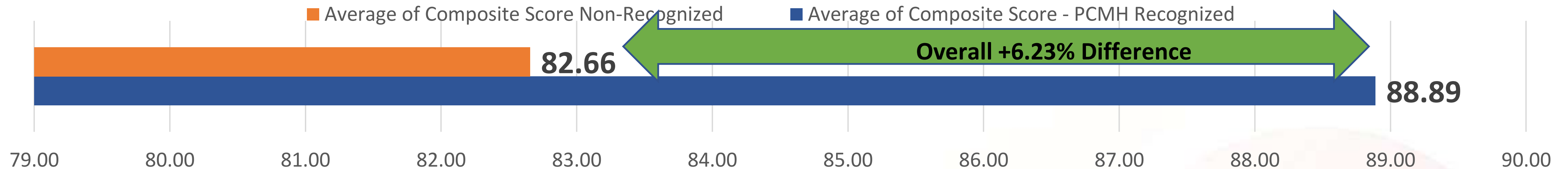
Leveraging Clinical Integration for PCMH Recognition

- APP PCMH team will guide practices through the process



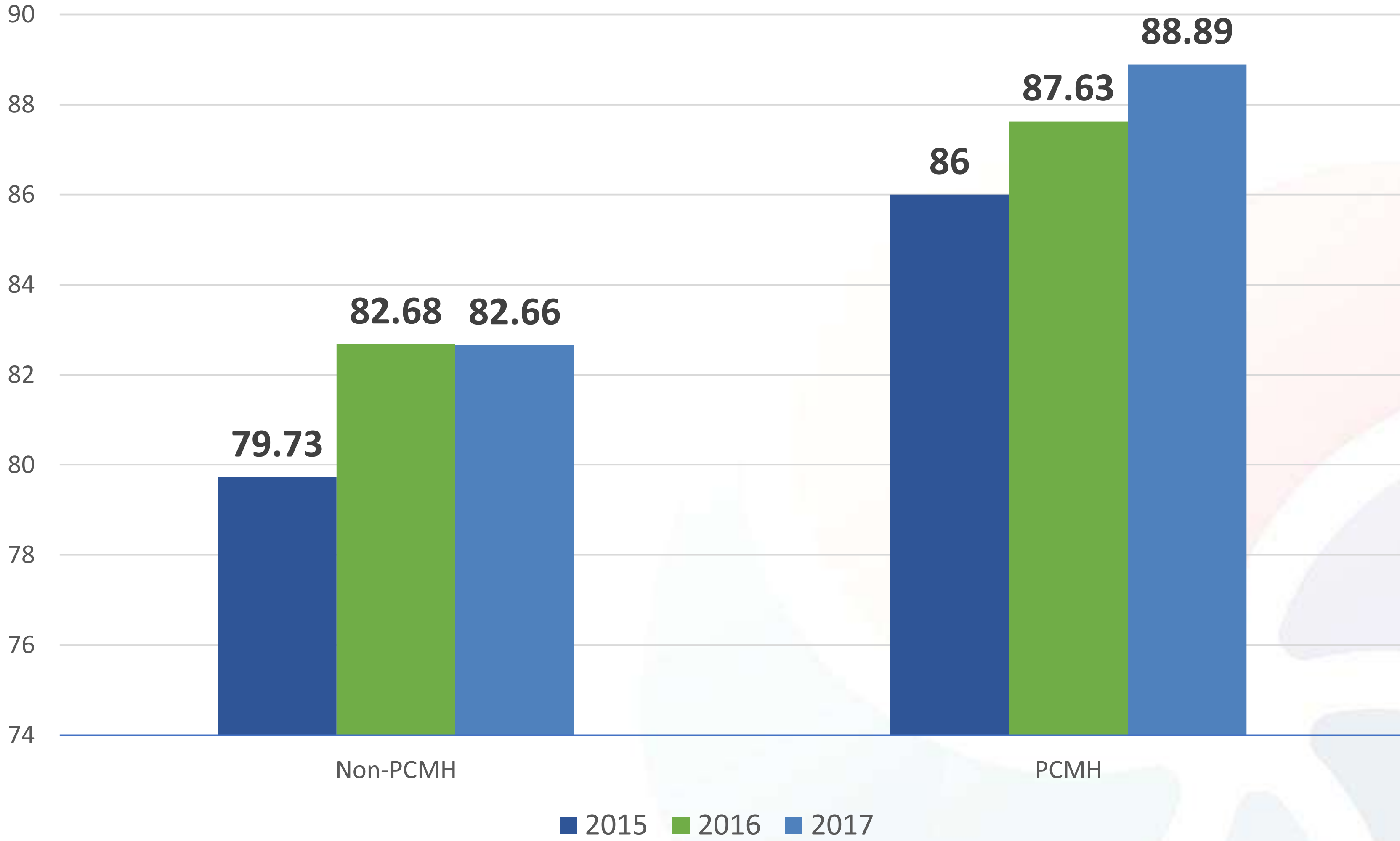
APP PCMH Recognized Practices Results

2017 APP Clinical Integration Results: PCMH Recognized vs. Non-Recognized



APP PCMH Recognized		Not Recognized	
	Average of Composite Score		Average of Composite Score
BroMenn PHO	92.47	Termed Practices	26.10
Christ PHO	87.30	Christ PHO	82.84
Condell PHO	91.70	Condell PHO	84.89
Good Samaritan PHO	85.81	Good Samaritan PHO	87.53
Good Shepherd PHO	88.74	Good Shepherd PHO	91.35
Illinois Masonic PHO	92.23	Illinois Masonic PHO	82.01
Lutheran General PHO	89.46	Lutheran General PHO	86.06
Sherman PHO	88.99	Sherman PHO	84.79
Silver Cross Health Connection	88.65	Silver Cross Health Connection	70.89
South Suburban PHO	82.62	South Suburban PHO	81.13
Trinity PHO	88.57	Trinity PHO	79.82
Grand Total	88.89	Grand Total	82.66
*All of BroMenn Recognized		*Includes recognized not by APP	

Overall Clinical Integration Score Comparison 2015-2017



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Standard PDSAs

Wellness/Preventive Care Services
Colorectal Cancer Screening

Clinical Quality Measures
Asthma Action Plan 5-64 years
Asthma Control Test 5-64 years
Diabetes HbA1c <8% ≥19 to <65 years
Diabetes Annual Eye Exam ≥19 to <65 years & ≥ 65 years

Resource Use and Care Coordination
Generic Medications
Primary Care in the ED Utilization

Immunizations
Combination Rate 3 Series of Immunizations by Age 2, Non-Medicaid
Rotavirus Vaccination, Non-Medicaid
Influenza 2 Vaccinations by Age 2, Non-Medicaid
**Influenza Vaccine ≥2 to <65 years*

Patient/Family Experience
Access to Care
Physician Communication Quality
Patients Rating of Doctor
Courteous & Helpful Office Staff

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Wellness/Preventive Care Services

Colorectal Cancer Screening

	2015	2016	2017
Colorectal Cancer Screening ≥51 to <65 years	64%	67%	72%

Clinical Quality Measures

Asthma Action Plan, Asthma Control Test, Diabetes HbA1C <8%, Diabetes Eye Exam

Measure	2015	2016	2017
Asthma Action Plan 5-64 years	85%	93%	95%
Asthma Control Test 5-64 years	84%	92%	94%
Diabetes HbA1c <8% ≥19 to <65 years	67%	69%	71%
Diabetes Annual Eye Exam ≥19 to <65 years	58%	62%	64%
Diabetes Annual Eye Exam ≥ 65 years	71%	74%	75%

Immunizations

Non-Medicaid Combo Rate 3, Rotavirus, Influenza 2 vaccines by age 2

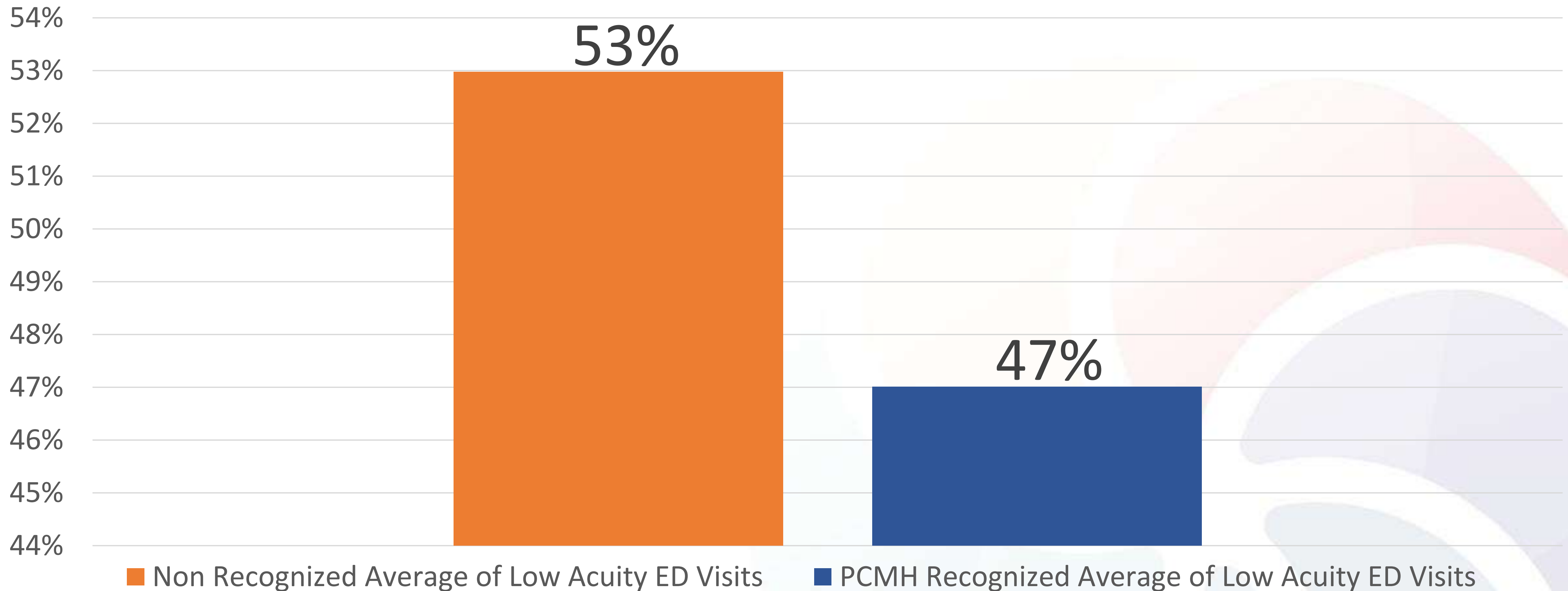
	2015	2016	2017
Non-Medicaid Combo Rate 3 by Age 2	82%	83%	85%
Non-Medicaid Rotavirus Vaccination	86%	89%	91%
Non-Medicaid Influenza -2 vaccines by Age 2	61%	61%	58%

Resource Use/Care Coordination

PCMH & Pharmacy MTM Partnership: Generic Medication Usage

Generic Medication Usage	2015	2016	2017
Generic Medication Usage	87%	91%	93%

Low Acuity ED Visits 2016-2017



Summary

- Advocate Physician Partners Membership Requirement with Patient-Centered Medical Homes
- PCMH Recognized practices contributed to the over $10 million in savings
    - $10,089,064 dollars saved with colorectal cancer screening, asthma control, diabetes control, avoided rotavirus hospital costs, and reduced drug expenses.
- PCMH Recognized practices score 6% higher in our Clinical Integration Program than our non-Recognized practices
- PCMH Recognized practices average 6% fewer low acuity ED Visits than non-Recongized by expanding Patient-Centered Access in

PCMH 2.0 – Next Steps

- Movement from clinical transformation to value transformation
- Innovations
  - Telehealth
  - Social Determinants of Health
  - Virtual Behavioral Health
- Medical Neighborhood
- Partnership with Process Improvement Team

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It happened here…

Situation: Patient newly diagnosed with Diabetes was prescribed insulin at an APP aligned PCP practice. At their 3 month check up the physician noticed the patients fasting glucose and HgA1c was consistently high.

Background: The physician is part of the APP PCMH Program and implemented care plans within the practice for rising risk population. The physician was trained by the PCMH Advisor on the teach back method and how to demonstrate this while completing care plans with patients. The physician decided after diagnosing a patient with diabetes at their 3 month check in to complete a care plan due to high fasting glucose and HgA1c.

Assessment: The physician used the teach back method with the patient during a care plan visit to see how they are injecting their insulin. The patient demonstrated with their insulin pen where they are injecting themselves, it was then when the physician noted that the patient was not properly removing the pen cap to release the insulin. The physician educated the patient on the use of the insulin pen.

Recommendation: PCMH to continue to teach and stress importance of Be Safe behaviors, including teach back method. SBAR to be used as an example. Importance of new diabetic insulin education reviewed at the practice by the physician.

Questions