Texas RHP9 Speaker Series

May 28, 2014

The Need for Wrap-Around Care: Integrating Behavioral Health and Primary Care

John W. Burruss, MD
Chief Executive Officer, Metrocare Services

The Need for Wrap-Around Care: Integrating Behavioral Health and Primary Care

John W. Burruss, M.D.
CEO
Metrocare Services

Objectives

- Establish the benefits of integrated care
- Define the stages of integrated care
- Outline the steps toward integrating care
- Explore barriers and pitfalls to integrating care
- Provide some detail of the costs of integrating care

Bona Fides

- PCP at Kelsey-Seybold in Houston
- Completed Psychiatry Residency
- Chief of Psychiatry for Harris County Hospital District
  - One Psychiatry Clinic until 2005
  - 15 by 2006
  - 14 with integrated care

Why Integrated Care?

- 50% of adults with a behavioral condition do not receive treatment *at all*
- 70% of children do not get help *at all*
  - Takes 9 years on average between symptom onset and treatment
- 25 – 50% of patients in any clinical setting struggle with a BH condition

Why Integrated Care?

Research has shown improvements in:

- Access
- Patient Satisfaction
- Provider Satisfaction
- Patient Adherence
- Clinical Outcomes
- Sustainability of Clinical Outcomes

Why Integrated Care?

Untreated or poorly treated BH conditions lead to unnecessary expenditures through noncompliance and acute care services.

The US could save *$26 – 48 BILLION* each year through effective integration of medical and BH services.

($3.2B for Texas ; $300M for Dallas)

Why Integrated Care?

- Psychiatrists and other BH team members offer essential clinical skills
- BH has employed intensive services for decades [ACT, Case Mgmt, Navigation]
- Research has shown better outcomes and improved resource utilization
- More patients covered by one Psychiatrist Helps address workforce issues

What is Integrated Care?

An evolving relationship:

Consultative Model (aka Coordinated Care)

- Psychiatrists sees patients in consultation in his/her office – away from primary care

Co-located Model

- Psychiatrist sees patients in primary care or vice versa

Collaborative Model

- Shared Site with Regular (Scheduled!) Interaction
- Shared Caseload with Joint Responsibility for Outcomes
- Shared Health Record

Co-located vs. Integrated Care

Co-Located

- Ancillary Provider
- Referral
- Written communication
- Fixed Schedule
- Full Schedule
- Narrow Focus
- “Psych Problem”

Integrated

- Embedded Team Member
- Hand Off
- Verbal Communication
- Flexible Schedule
- Intentional Gaps
- General Focus
- Behavioral Medicine Issue

Primary Care vs. BH Setting

- Bi-Directional Flow is a must
- Passing relationships not patients
- “Four-Quadrant Model”

LOW ⇦ Behavioral Health risk/status ⇨ HIGH

Quadrant II

⇧BH ⇩PH

- BH Case Manager coordinates with PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other Community Supports

Quadrant IV

⇧BH ⇧PH

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager coordinates with PCP and Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ER
- BH and medical/surgical IP
- Other community supports

Quadrant I

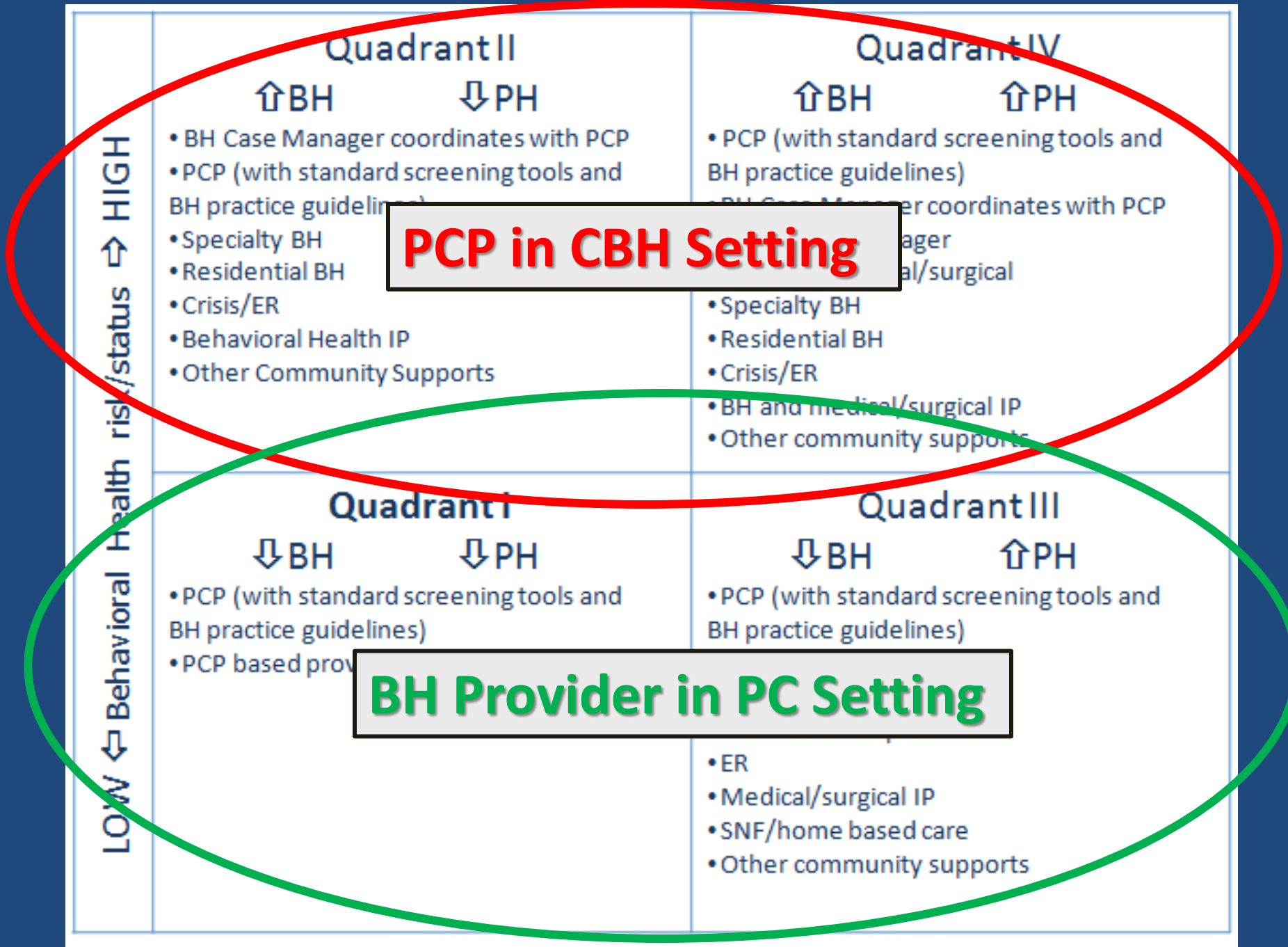
⇩BH ⇩PH

- PCP (with standard screening tools and BH practice guidelines)
- PCP based provider

Quadrant III

⇩BH ⇧PH

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH provider
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports


Quadrant II
⇧BH ⇩PH
• BH Case Manager coordinates with PCP
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• Specialty BH
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• Other Community Supports
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• PCP (with standard screening tools and
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BH practice guidelines)
Quadrant III
⇩BH ⇧PH
• PCP (with standard screening tools and
BH practice guidelines)
• ER
• Medical/surgical IP
• SNF/home based care
• Other community supports
PCP in CBH Setting
BH Provider in PC Setting
LOW ⇦ Behavioral Health risk/status ⇨ HIGH

Before you start (Style Differences)

- Multi-tasking vs. One-at-a-time
- Emphasis on task vs. time
- First contact vs. specialist care
- Life-long vs. Intermittent
- Comprehensive vs. Focused
- “Ship Captain vs. Harbor Pilot”

Before you start (Biases)

- BH Clinicians are uncommunicative
- When they do communicate,

  BH Clinicians say too much
- Confidentiality = Protecting Turf
- What happens in “therapy” anyway?
- Will they analyze me??

Research actually shows…

- Highly positive feedback
- Greater sense of competency
- Enjoyment treating complex patients
- Better job satisfaction
- Better provider retention
- Both groups felt less isolated

So you're ready to begin

- Leadership Support
  - This will require money!
- Universal Screening – i.e. PHQ-9
- Space for Co-location
- EMR Adaptation (If needed)
- Scheduling

So you're ready to begin

- Navigators
- Peer Support
- Patient & Family Education
- Behavioral Health Specialists
- Psychiatry

The Goal: System-Level Integration

- One Health Record (With Patient Consent)
- One Treatment Plan
- Shared Outcomes
- Intentional Daily Contact
- Shared Financial Responsibility
- Structured Team Sessions

Team Process

- Day-to-Day Operational Communication
- Process Communication
- Clinical Case Reviews
  - “Tough” or ambiguous patients
  - Treatment Advances
  - Joint Patient Interviews

Training

SAMHSA Center for Integrated Health Solutions

- The Integrated Healthcare Curriculum for Schools of Social Work
- Self-paced Course for Addiction Treatment Professionals
- Online Training Curriculum for Psychiatrists Working in Primary Care
- Primary Care Physician Training Curriculum

www.integration.samhsa.gov

Training

SAMHSA Center for Integrated Health Solutions

- Peer Whole Health Action Management
- Case to Care Management Training
- Certificate Program in Integrated Care Management for BH Specialists
- Mental Health First Aid or everyone

www.integration.samhsa.gov

Measuring Outcomes

- Most payers will require this at some point
- Quarterly is optimal; Bi-annual acceptable
- The 9-Item Patient Health Questionnaire (PHQ-9) can be used for this also

What Does It Cost?

- Space & adequate support staff
- Health Record compatibility
- Contracting changes
- Coding and Billing expertise
- Training time
- Reserved Time for Conferences & Regular Communication

What Does It Cost?

• Peer Specialist	$18 – 24K
• Navigator	$28 – 32K
• BH Specialist	$45 – 65K
• Nurse Practitioner	$100 – 115K
• Psychiatrist	$175 – 225K

Nurturing

- Both groups will change
- Expect at least 12-18 months for maturation
- Requires Continued Commitment
- Good results can be expected for everyone!

Questions?

Bringing Care to the Patient: The Mobile Healthcare Program

Norman Seals

Assistant Chief, Emergency Medical Rescue Bureau, Dallas Fire-Rescue Department

Bringing Care to the Patient: The Mobile Community Healthcare Program

Norman Seals, Assistant Chief
Emergency Medical Service Bureau
Dallas Fire-Rescue Department

Dallas Fire-Rescue EMS

- One of six Bureaus in Dallas Fire-Rescue
- Sole provider of 9-1-1 services to the City of Dallas
- 1.2 million residents, 386 square miles
- 2,000 total employees, 920 paramedics
- 40 front line Rescues, 3 Peak Demand
- ALS engine companies

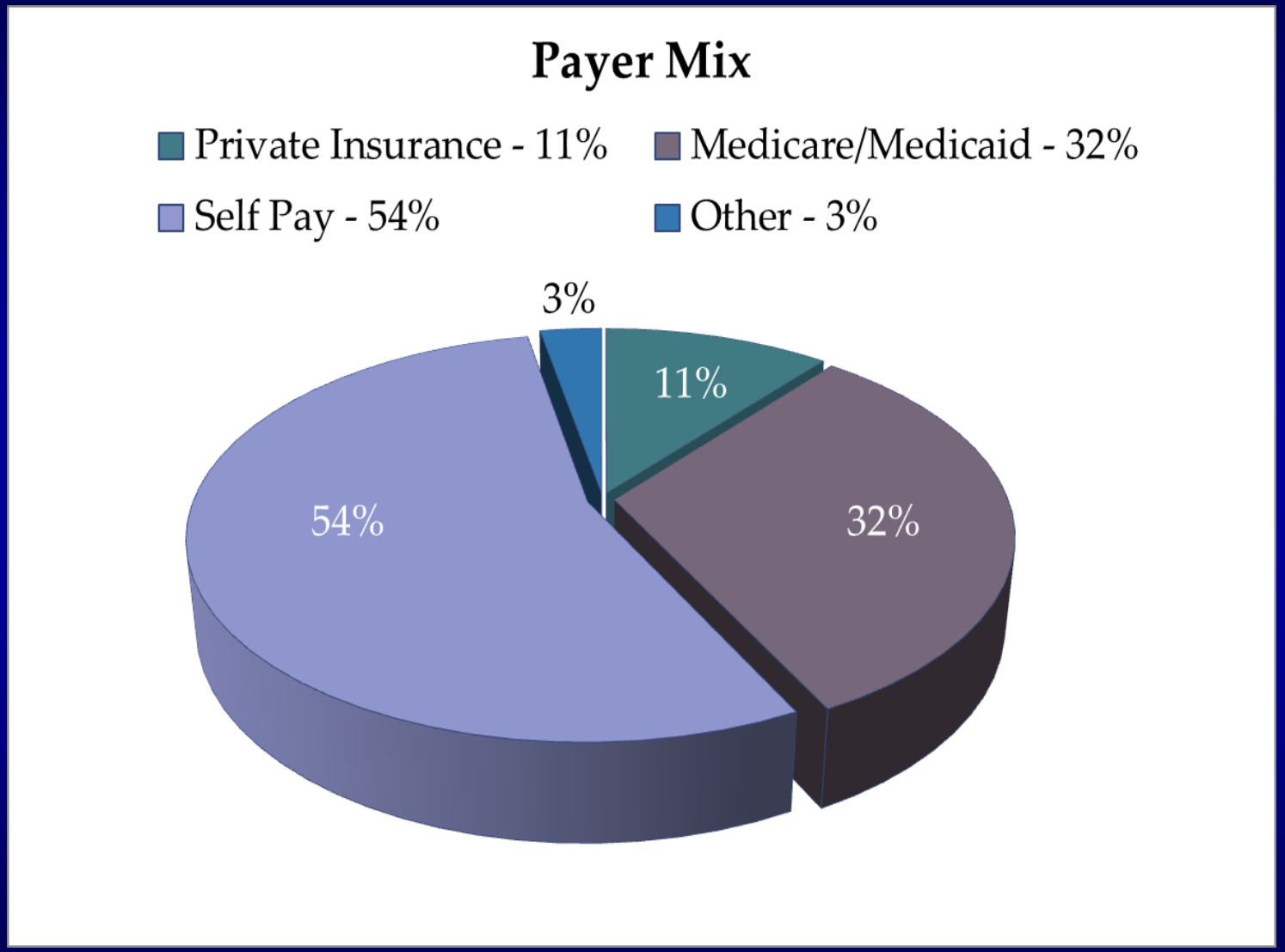
Dallas Fire-Rescue EMS

- FY13 – 193,820 calls (6.5% increase)
- 82% of total call volume
- Average utilization rate: 52.64%
- Average calls per Rescue: 4,625
- Average response time: 6:01
- 70,000 transports

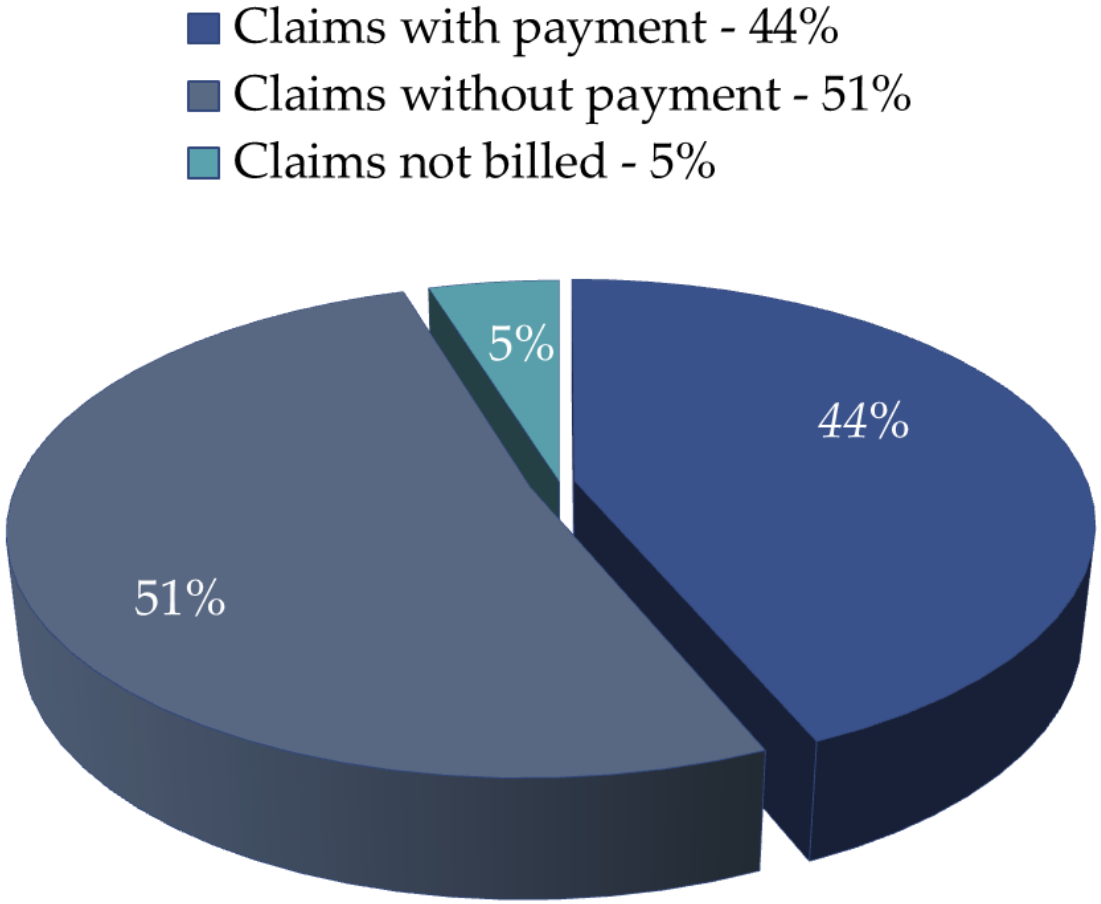
Dallas Fire-Rescue EMS

- Additional EMS focal areas
  - Strong Special Events program
    - Over 800 events per year
    - Over 1.5 million participants at these events
  - Quality Management process
  - Strong inquiry management process
  - Working toward stronger data sharing capability
- Revamp of service delivery model

DFR EMS 1972-2013


Payer Mix
Private Insurance - 11%
Medicare/Medicaid - 32%
Self Pay - 54%
Other - 3%
3%
11%
54%
32%

EMS Claims FY13




Why yes, I'm a bit stressed.
Why do you ask?


BREAKING NEWS ... BREAKING
News
Health reform


HEALTHCARE REFORM
NEW WAY


HEALTHCARE
REFORM


Health Care
Reform

“Despite a level of health expenditures that would have seemed unthinkable a generation ago, the health of the U.S. population has improved only gradually and has fallen behind the pace of progress in many other wealthy nations," said Harvey V. Fineberg, president of the Institute of Medicine

“In every measure examined, including life expectancy and quality of life”, Dr. Fineberg said, “the U.S. ranking fell among the 34 members of the Organization for Economic Co-operation and Development, a think tank for developed countries”

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

THE WALL STREET JOURNAL.

July 10, 2013

Institute for Healthcare Improvement

- Improving the patient experience (quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

ACA impacts on EMS

- Not directly addressed in ACA
- Look at what's happening in the hospital world…
  - Accountable Care Organizations (ACO's)
  - Outcome-based payment models
  - Bundled payments
  - Medicare Spending per Beneficiary calculations
  - **Emphasis on care coordination, including outpatient and post acute care**

ACA impacts on EMS

- Satisfaction-based reimbursement
- Cost vs. outcome information published
- Rating systems
- CMS Bonuses/Penalties
- Increased audits
- Increased fines

- Threats & Opportunities

Mobile Integrated Healthcare/ Community Paramedicine

What is Mobile Integrated Healthcare?

- History
- Scheduled versus unscheduled care
- Patient advocacy and healthcare navigation
- 360º assessment and problem solving
- An innovative solution to healthcare delivery

Frequent Utilizer Program

"Frequent ED users have a substantial burden of disease, and they have high rates of primary and specialty care use. They also have linkages to outpatient care that are comparable to those of other ED patients" "The majority of frequent users… have private or Medicare coverage."

John Billings and Maria C. Raven: Dispelling an Urban Legend; Frequent Emergency Department Users Have Substantial Burden of Disease; Health Affairs, 32, no. 12 (2013): 2099-2108

Contracts

- ACO's
- Readmission Penalties
  - AMI
  - Pneumonia
  - Heart Failure
  - COPD
  - Elective Hip and Knee Replacement Surgery

Contracts

- Can serve to strengthen EMS position in the healthcare continuum
- Can’t meet all of the needs of the hospitals but can certainly assist with certain patient populations
  - High risk of readmission
  - Mobility or transportation issues
  - Uninsured

DFR Mobile Community Healthcare Program

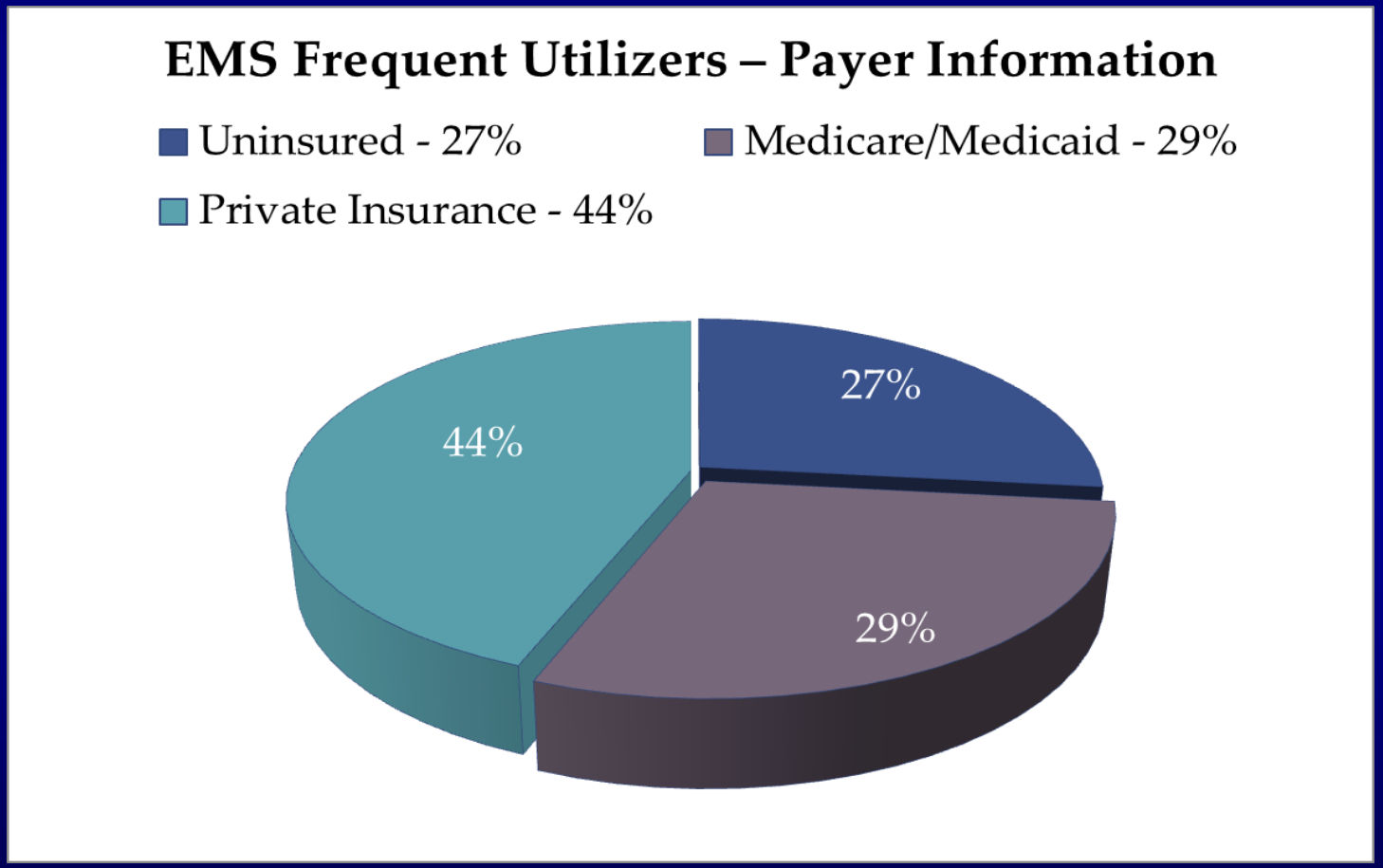
DFR MCHP

- Beginning with four medics and one supervisor
- Training
- First patient contact: March 19, 2014
- Will add additional staff/capability in September 2014
- Will be two-phased:
  - Frequent utilizers
  - Contracts with local healthcare providers

Frequent Utilizer Program

- The Dallas experience in FY 13:
  - 254 patients received service 12+ times
  - Over 4,500 calls
  - Net billed: $2,608,292
  - Net collected: $997,359
  - Balance uncollected: $1,610,933
- Case Study

Frequent Utilizer Program

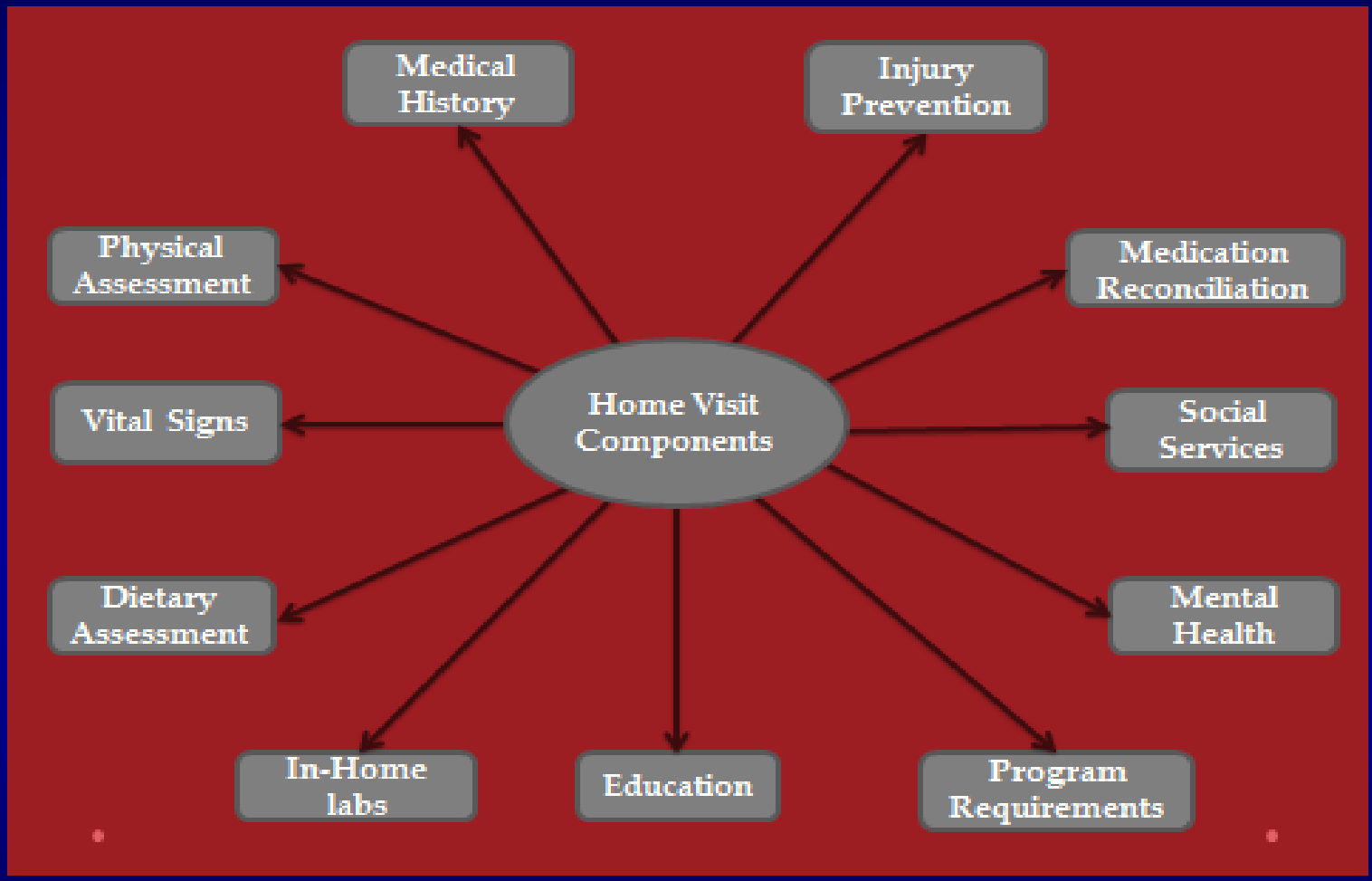


Hospital partnerships

- Currently in negotiation with two area hospital systems
- Post-discharge readmission avoidance
- Medical Directors from DFR and hospital will agree on treatment guidelines
- Collaborative effort to ensure patient compliance with discharge instructions

DFR MCHP

- Pre-visit collection of information
- In-home evaluation
  - History
    - Includes medication inventory/reconciliation
  - Physical exam
  - Diagnostics as needed
  - Psycho-social evaluation and referral prn
  - Individualized care plan development


Medical History
Injury Prevention
Physical Assessment
Medication Reconciliation
Vital Signs
Home Visit Components
Social Services
Dietary Assessment
Mental Health
In-Home labs
Education
Program Requirements

DFR MCHP

- Assessment and clinical decision making:
  - Stable
    - Document and schedule follow-up
  - Stable with minor concerns:
    - Contact program case manager
  - Urgent consultation required
    - Contact designation provider
    - Transport as needed

- First metropolitan fire-based EMS agency to introduce this type of program
- Early success story: 22.5% reduction in EMS and ED access by enrolled patients in the first 30 days
- Lives are being changed!
- Provides high quality care for the patient, in the right environment and at the right cost!

Questions?

LUNCH

- Located in the Folsom Room
  - Food pickup outside of room
  - Beverage Stations inside room
  - Tables with chairs available in room
- You may eat in the Folsom Room or in the Auditorium.
- PLEASE DO NOT EAT IN THE FOYER AREA

Next Speaker Begins @ 12:30

The Electronic Movement: Improving Healthcare through Data Exchange

Christine Killgore-Lannan
Director of Privacy, Parkland Health & Hospital System

THE ELECTRONIC MOVEMENT: Improving Healthcare through Data Exchange

Chris Killgore-Lannan, JD, CIPP, EC

Chief Privacy Officer

Parkland Health & Hospital

HEALTH INFORMATION EXCHANGE

- An HIE provides the capability to electronically share clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of an HIE is to facilitate access to and retrieval of clinical data to provide safer and more timely, efficient, effective, and equitable patient-centered care.
- HIE systems facilitate the efforts of physicians and clinicians to meet high standards of patient care through electronic participation in a patient's continuity of care with multiple providers.

BENEFITS OF AN HIE

- Immediate access to treatment information
- Reduction in the need for duplicate tests/treatment
- Potential for more accurate information
- Prevention and detection of fraud and abuse
- Improved continuity of care
- May help with “Meaningful Use” requirements

PERMISSIBLE PURPOSES UNDER HIPAA FOR EXCHANGE OF PHI

- HIPAA permits disclosures between physicians for treatment purposes.
- It also permits disclosure of PHI for certain health care operations (provided that both the disclosing provider and the recipient provider have or have had a treatment relationship with the patient):
  - Performance Improvement
  - Continuity of Care
  - Recommending treatment alternatives
  - Fraud prevention and detection
  - Credentialing
  - Care Coordination

PERMISSIBLE PURPOSES UNDER HIPAA FOR EXCHANGE OF PHI

- Research – but problematic.
- Required by law disclosures – but problematic.
- Payment purposes – but problematic.

MORE HIPAA INFO…

- The minimum necessary requirement applies if the disclosure is for a purpose other than treatment.
- The HIPAA Omnibus Rule requires patient consent, but does not require opt out.
- Under HITECH, the patient has a right to request and receive an accounting of disclosures – including for treatment, payment, and health care operations if the disclosure is made through an exchange. The accounting of disclosure must occur within 30 days of the date of the request. Who is responsible for maintaining the accounting?


RON MORGAN
"If the treatment is unsuccessful, do you give back the information I released?"

BUT, HIPAA IS NOT THE END OF THE STORY

- Other laws may be more stringent and may preempt HIPAA
  - State laws are likely to address minors, deceased persons, and sensitive conditions such as communicable disease, mental health, pregnancy and others.
  - Texas law also requires notice. There is a debate regarding the right to opt in vs the right to opt out.
  - The Federal Substance Abuse Rules limit disclosures of chemical dependency information when a provider treats or refers patients to chemical dependency treatment or is involved in substance abuse prevention AND receives federal funds. Disclosure of information identifying a patient as receiving treatment for substance abuse requires express authorization from the patient and specific language prohibiting further disclosure. Can you purge chemical dependency information if you need to do so? Or, should you be collecting a FSAR-compliant authorization? Can you handle it if a patient revokes the authorization?

MINORS

- If a minor can consent to care (personally) and actually does – then, under HIPAA, the privacy right runs to the minor. If you treat minors for sensitive conditions like pregnancy or STDs or mental health, a parent's consent (or implied consent) to participate in the HIE may not be sufficient.
  - NOTE: This might be one reason to put your option language in the consent to treat.

DECEASED PERSONS

- Do you have a process to purge the records of deceased persons from an electronic transfer of information?
  - Are you requiring opt in?
  - Are you relying on implied consent?

OPT IN VS OPT OUT

- Under Texas HB 300 (2011), you must give notice of participation in an electronic health exchange. You can place the notice in your Notice of Privacy Practices or provide separate notice.
  - What is your appetite for demonstrating respect for patient privacy?
  - You must have a process for managing opt in or opt out. Your process must be sound or you could inadvertently cause unauthorized disclosures.

WHO WILL HAVE ACCESS?

- What kind of HIE are you considering?
  - Regional, State-wide, National?
- Does the HIE allow participants that are not providers, such as car insurance companies, government agencies, or insurance plans? Note: authorization is not required for payment purposes under HIPAA.
- How do these participants support or militate against the purpose of the exchange?

BUSINESS ASSOCIATES

- HITECH indicates that the various participants in an HIE and the HIE are business associates of one another. Now, subcontractors and their subcontractors are also business associates. Contract very carefully.

COMMON ISSUES

- LIABILITY!!
  - You cannot rely on the data. Though the purpose is treatment, you must exercise independent medical judgment. If you make a medical error based on information you pulled from the exchange, YOU are liable and not the HIE or the data submitter.

COMMON ISSUES (CONT'D)

- LIABILITY!!
- Privacy and security breach. Does the HIE carry insurance? Does its vendor if the PHI is housed by the vendor? Who is liable – the covered entity that provided the data? The HIE? The vendor? What if the data breach occurs at another participant's place of business but involves your data? Are there adequate notice requirements? If patients must be notified, who pays? Are some participants shielded by statutory damage caps or immunity?
  - If you have cyber security coverage, does it cover another covered entity's PHI in your possession? Or, your PHI in another covered entity's or business associates' possession?

COMMON ISSUES (CONT'D)

- Sensitive conditions and records requiring express authorization are often not exchanged. Hence, the records received through the HIE may be incomplete.
- If sensitive conditions are exchanged, the contract should specify who is responsible for getting the required authorization – the submitter? The recipient?

COMMON ISSUES (CONT'D)

- Security.
  - How is the data maintained and by whom?
    - Backed up? How often? Physically secure? Technically secure?
  - Do you have the right to audit before submission of PHI?
  - Is the data stored in an encrypted format?
  - Is it encrypted during transmission?
  - Is a full set of data provided to the HIE or does the system use edge servers?

COMMON ISSUES (CONT'D)

- Disposal and/or record retention
  - Who is responsible?
  - What schedule is used?
  - How is the PHI destroyed?
  - What if you want to end your participation in the HIE? Can you get your data back?
  - What if you send data in error, can you get that data back?

COMMON ISSUES (CONT'D)

- Contracts are often template agreements called "Data Usage and Reciprocal Support Agreements" or "DURSA."
  - There may be little you can negotiate. The larger the exchange, the less you can negotiate.
  - The language is very important. Make sure you are absolutely comfortable with every section of the agreement.

COMMON ISSUES (CONT'D)

- Financial concerns
  - How much does the HIE cost and how is the fee schedule set up?
  - Is the HIE financially sound and using a financially sound vendor?
  - Are there sufficient participants to suggest long-term viability? Who are the participants? Major players or smaller data submitters?
  - Can the HIE withstand the costs associated with a breach of privacy or security?

RESOURCES

- http://healthit.gov/HIE
- https://www.hhsc.state.tx.us/hhsc_projects/oehc/StatewideExchange.shtml
- http://www.hietexas.org/

QUESTIONS??
COMMENTS?
THOUGHTS?
WINNING LOTTERY NUMBERS?

Navigating the Patient-Centered Medical Home Model

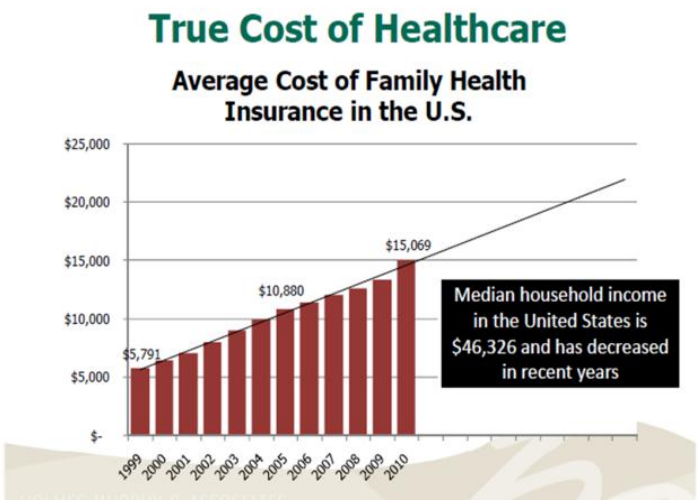
Cliff T. Fullerton, MD, MS
Chief Officer – Population Health and Equity, Baylor Scott and White Health

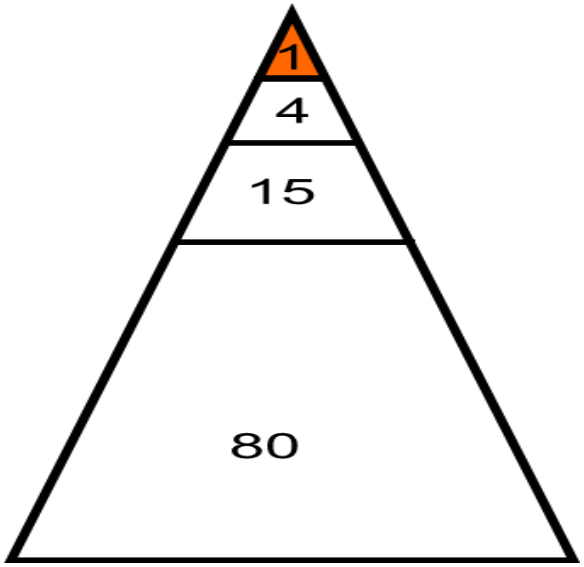
Patient Centered Medical Home

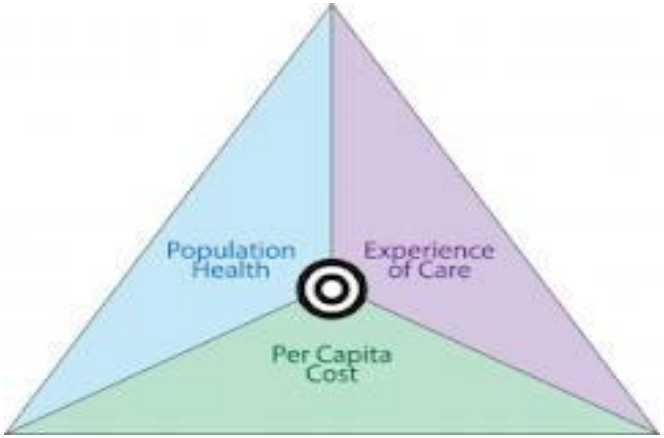
Cliff Fullerton, MD, MS

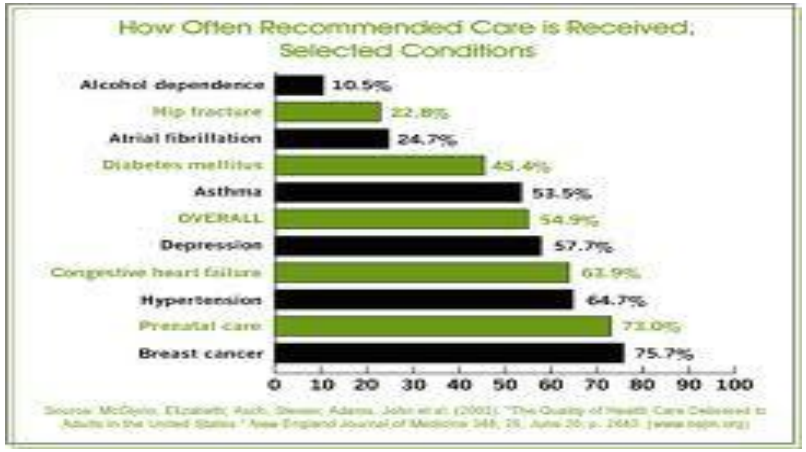
What We Know

What is Driving the Call to Change?









What is the Top Priority?

“With all the money we owe China, I think you might correctly say, Hu's your daddy.”
Rep Michelle Bachmann, R-Minn

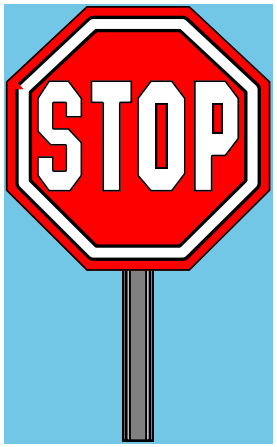
The Watchword

System Change Concepts
Why a Chronic Care Model?

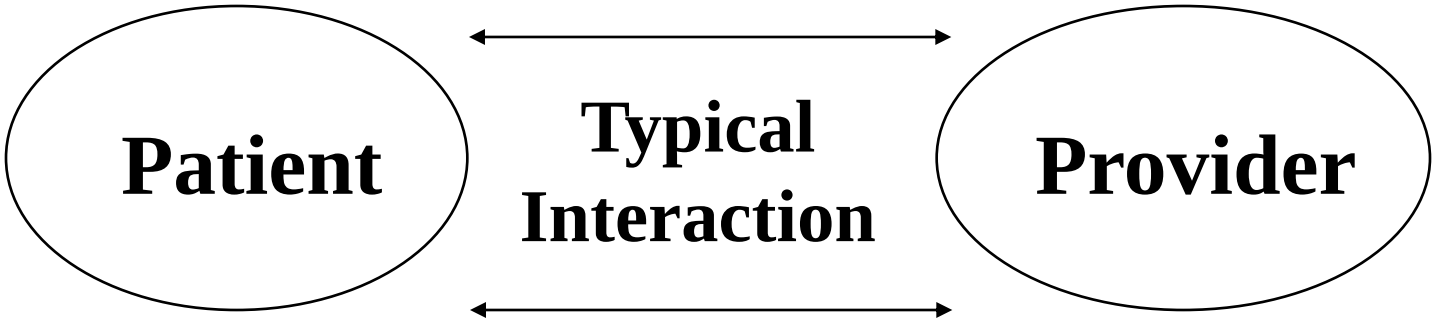
- Emphasis on physician, not system, behavior
- Commonalities across chronic conditions unappreciated.

To Change Outcomes Requires Fundamental Practice Change

- Interventions focused on guidelines, feedback, teams and role changes can improve processes
- Interventions that address more than one area have more impact
- Interventions that are patient-centered change outcomes.

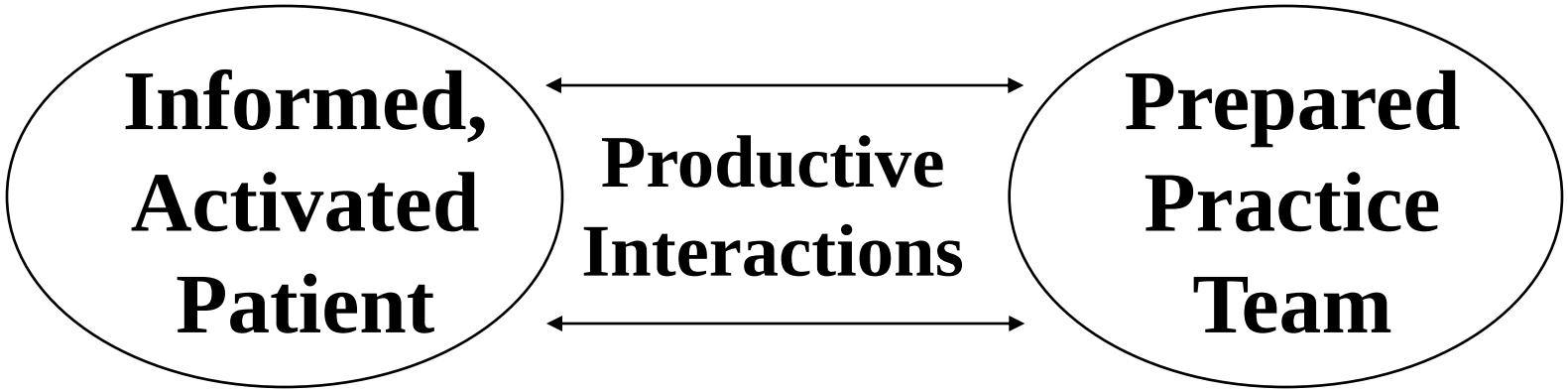


Essential Element of Good Chronic Illness Care



What would make this interaction productive?

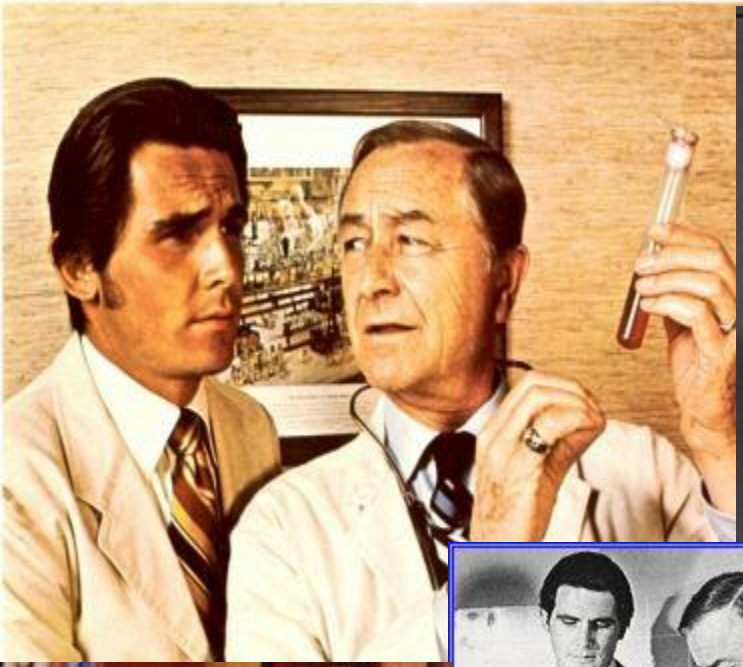
Essential Element of Good Chronic Illness Care

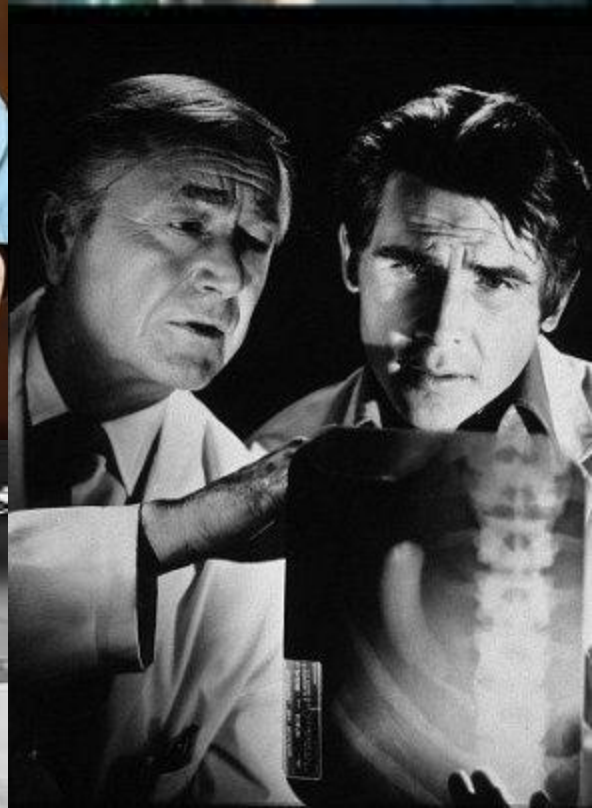


What characterizes a "prepared" practice team?

At the time of the visit, they have the patient information, decision support, people, equipment, and time required to deliver evidence-based clinical management and self-management support

What is Wrong with this Vision of the Medical Home?





Current Ambulatory Medical Team Who are the typical members?

New Team System

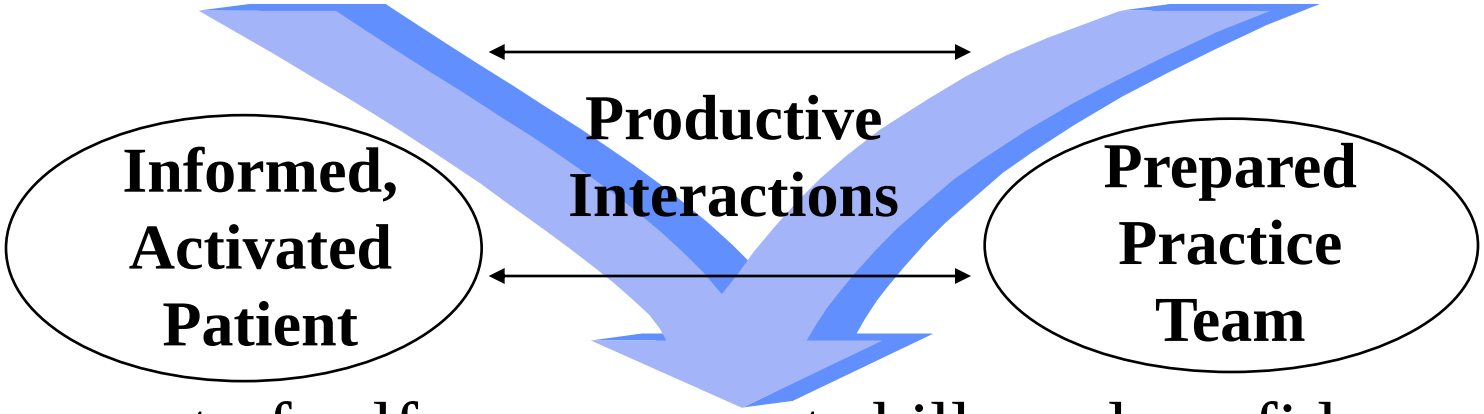
Who should be on the team?

What characterizes a "informed, activated" patient?

Informed, Activated Patient

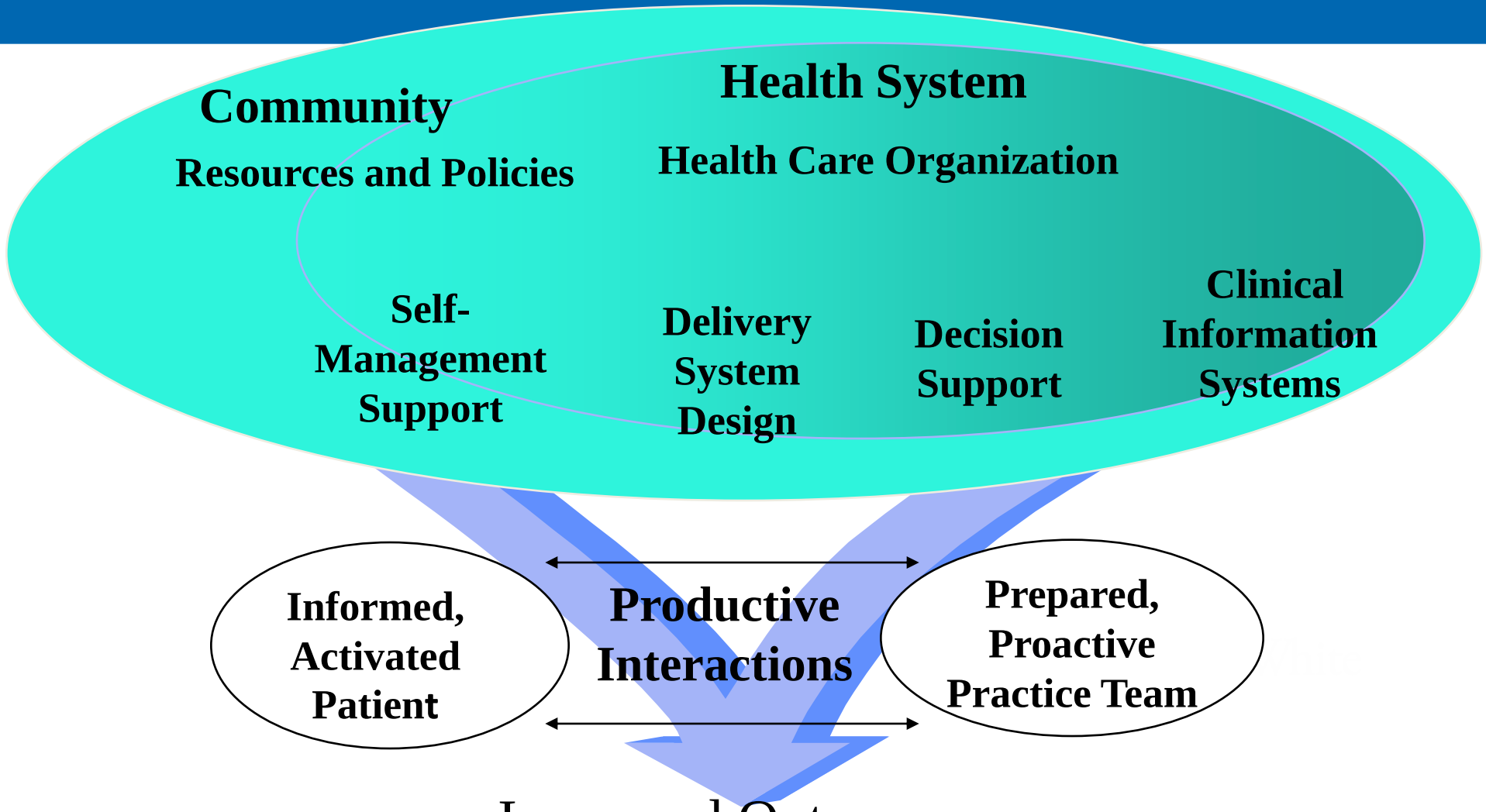
Patient understands the disease process, and realizes his/her role as the daily self manager. Family and caregivers are engaged in the patient's self-management. The physician/team is viewed as a guide on the side, not the sage on the stage!

How would I recognize a productive interaction?



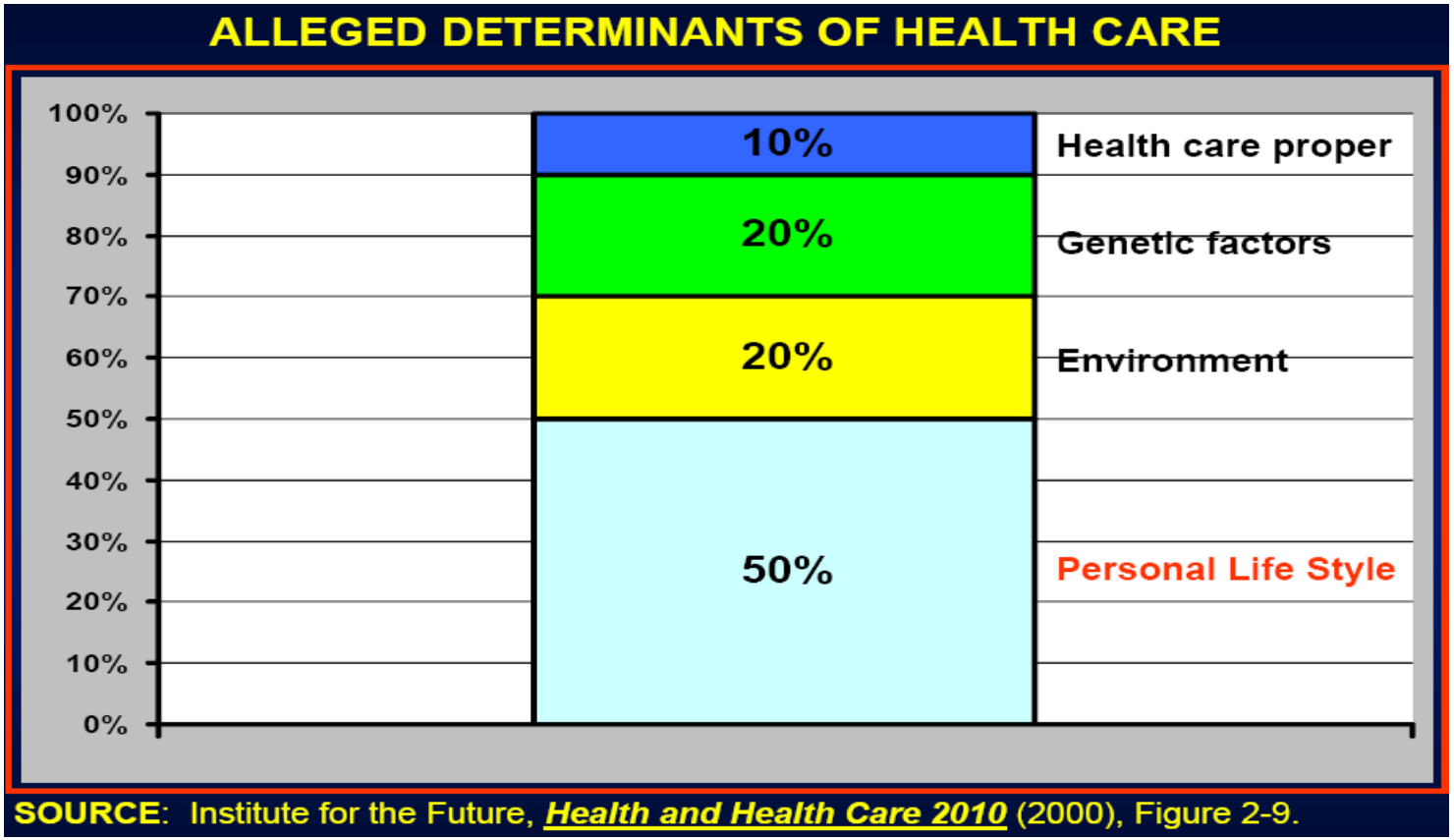
- Assessment of self-management skills and confidence as well as clinical status
- Tailoring of clinical management by stepped protocol
- Collaborative goal-setting and problem-solving resulting in a shared care plan
- Active, sustained follow-up

Chronic Care Model



Personal Lifestyle: Chronic Disease Care Differs from Acute Care

Patient behavior is the most important determinant of outcome



Self-management Support

- Emphasize the patient's central role.
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up.
- Organize resources to provide support

The Activated Patient

Activated patients *believe* they have important roles in managing their care, collaborating with providers and maintaining their health.

Beliefs

"The part of you that decides"

The Activated Patient

They have the skills and behaviors to manage their condition, collaborate with health care team members, maintain their health and access appropriate and high quality care.

Skills and behaviors

They have developed a habit.

The Activated Patient: outcomes

- Studies identify patient activation as the differentiator in improved outcomes in:
  - Diabetes: (improved Hgb A1C)
  - CHF: (reduction in hospitalization rates, increase in symptom free days)
  - Arthritis: (reduction in medication complications, increase in symptom free days)

The Activated Patient: the business case

Many studies identify patient activation as the key to reductions in health care costs borne by the patient, the payor and the health care system.

The Activated Patient: the personal case

- We are problem solvers.
- We are not responsible FOR our patient's behaviors, but we are responsible TO them.
- Thoughtful, creative and innovative work to meet these obligations is the right thing to do.
- …and it's fun!

What topics should self-management education cover?

- Problem-solving
- Decision making
- Finding and using resources
- Forming partnerships with the HC team
- Taking action
- Emphasizing goal of patient responsibility

Lorig & Holman 2003

Patient-Centered Medical Home

- 2007 - The AAFP, AAP, ACP, and AOA publish the Joint Principles of the Patient-Centered Medical Home with 7 Core Features
- Components are:
  - Multidisciplinary team
  - Clinical decision support tools to guide decision making at point of care
  - Ongoing plan of care
  - Enhanced access to care (email, etc)
  - Quality outcomes
  - Health information technology
  - Self-management support

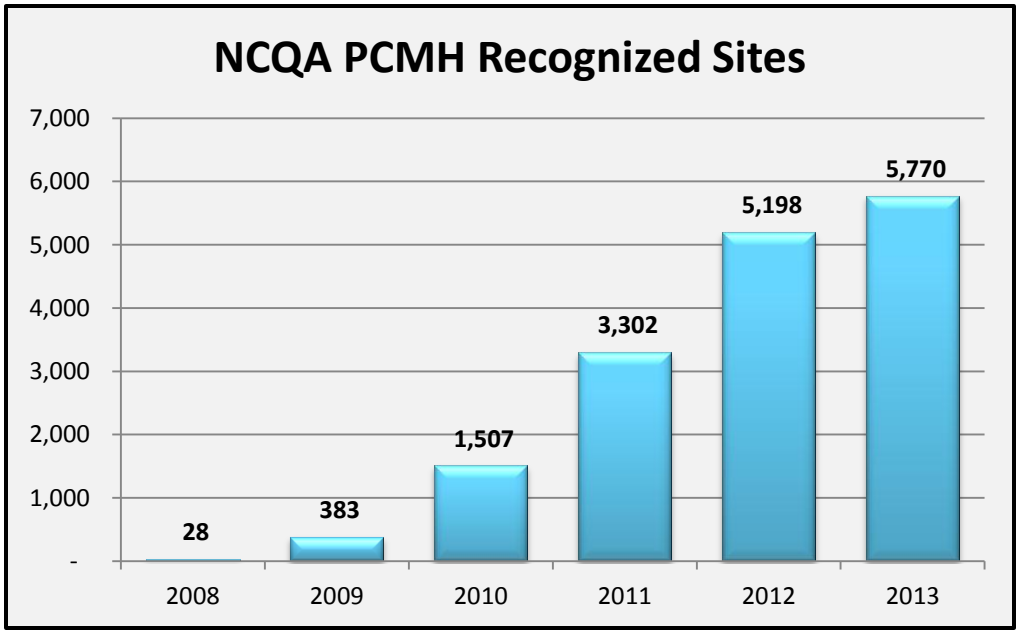
This is ***NOT*** a Gate-keeper Model of Care
it ***IS*** a Coordination of Care

Patient Centered Medical Home
Why All the Fuss?

- Access
- Quality
- Cost-value
- Coordination/fragmented
- Prevention

Patient Centered Medical Home Recognition

- Approximately 7,000 practices have achieved PCMH recognition (also known as certification or accreditation).
- Several national programs offer medical home recognition, including the Accreditation Association for Ambulatory Health Care (AAAHC), the Joint Commission, the National Committee for Quality Assurance (NCQA), and URAC (formerly the Utilization Review Accreditation Commission).



Source: The Patient-Centered Primary Care Collaborative; "The Patient Centered-Medical Home's Impact on Cost & Quality: An Annual Review of the Evidence, 2012-2013

Patient Centered Medical Home

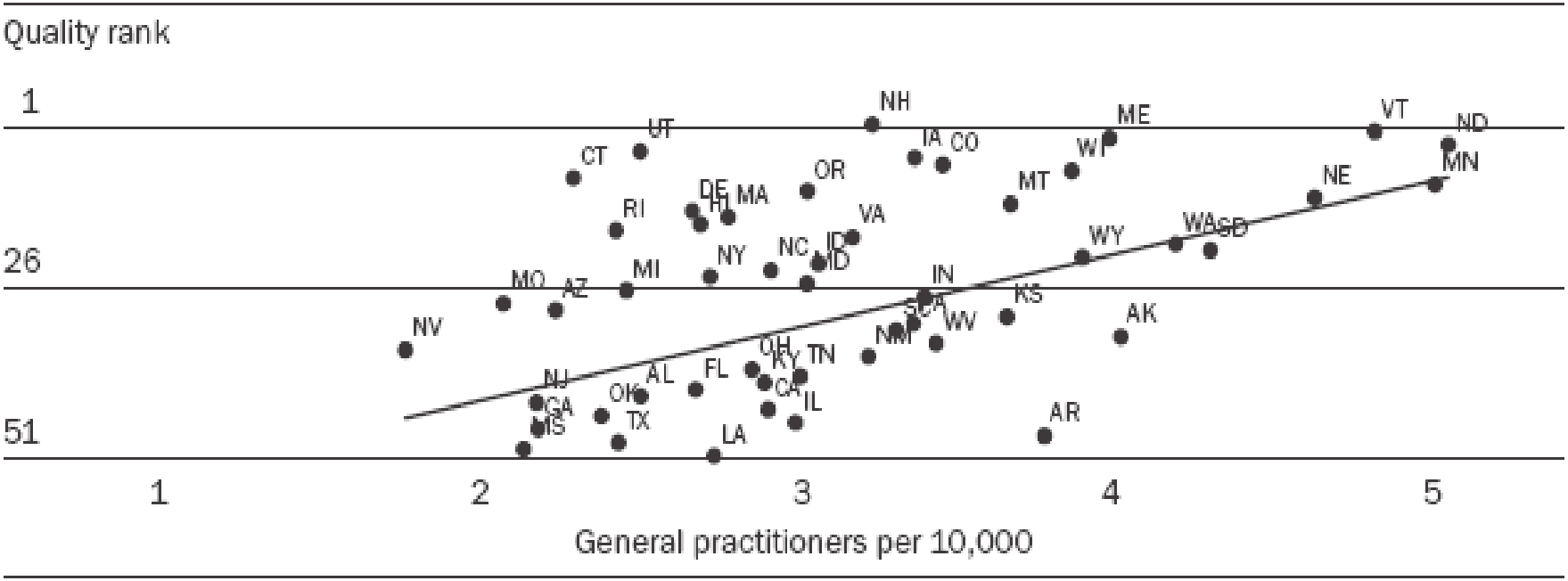
Intent

Patient centered, safe, high quality, coordinate care, timely, efficient, equitable.
Which is more likely to deliver? Which is more work and has more cost?
Which do you want?

Why are Primary Care Physicians Vital to Chronic Disease Management?

EXHIBIT 8

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



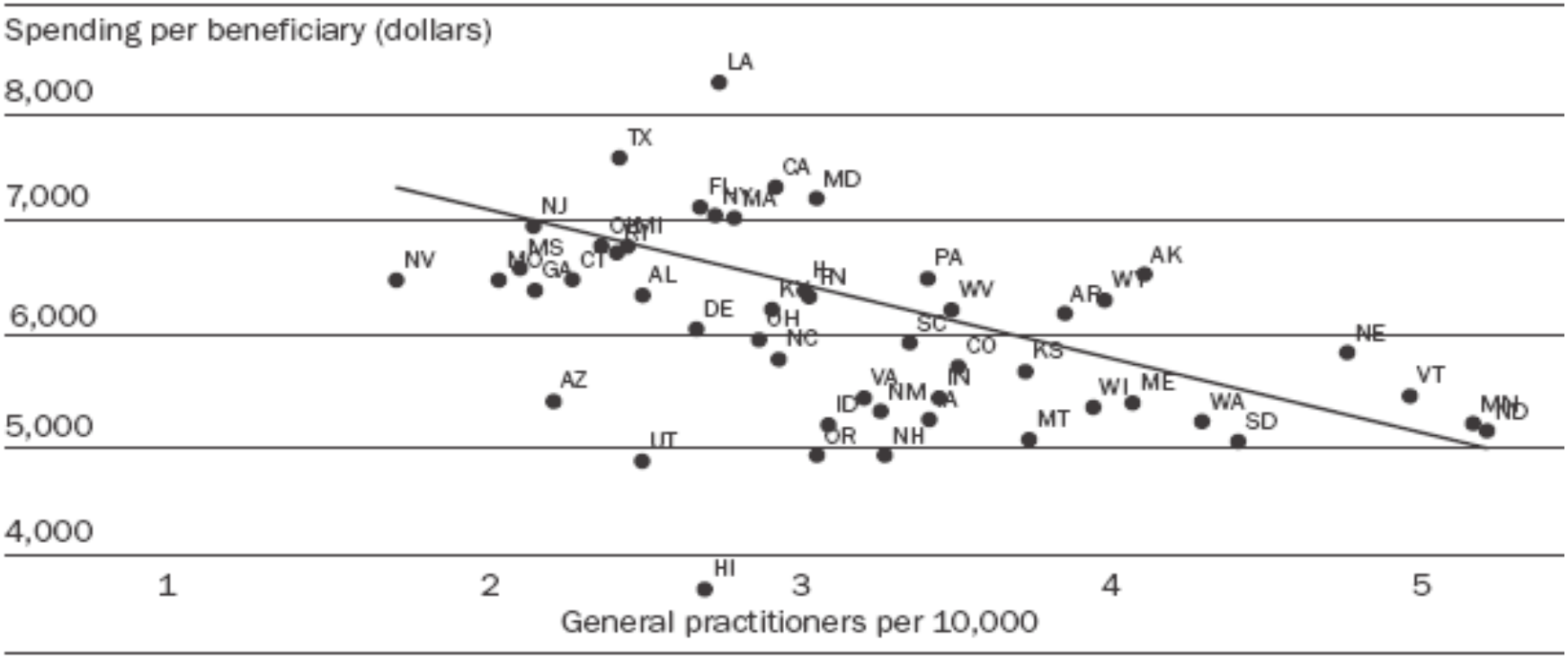
SOURCES: Medicare claims data; and Area Resource File, 2003.

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

Why are Primary Care Physicians Vital to Chronic Disease Management?

EXHIBIT 9

Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

Momentum

- Endorsed by
  - All major health plans
  - Most of the Fortune 500
  - Consumer organizations
  - Labor unions
  - AMA
  - 17 specialty societies

- Many demonstration pilot programs through governmental agencies and commercial insurers
- State legislation supporting PCMH

Patient Centered Medical Home

2011 PCMH Content and Scoring

Standard 1: Enhance Access and Continuity		Pts
A.	**Access During Office Hours****	**4**
B.	After-Hours Access	4
C.	Electronic Access	2
D.	Continuity	2
E.	Medical Home Responsibilities	2
F.	Culturally and Linguistically Appropriate Services	2
G.	Practice Team	4
		20

Standard 2: Identify and Manage Patient Populations		Pts
A.	Patient Information	3
B.	Clinical Data	4
C.	Comprehensive Health Assessment	4
D.	**Use Data for Population Management****	**5**
		16

Standard 3: Plan and Manage Care		Pts
A.	Implement Evidence-Based Guidelines	4
B.	Identify High-Risk Patients	3
C.	**Care Management****	**4**
D.	Medication Management	3
E.	Use Electronic Prescribing	3
		17

Standard 4: Provide Self-Care Support and Community Resources		Pts
A.	**Support Self-Care Process****	**6**
B.	Provide Referrals to Community Resources	3
		9

Standard 5: Track and Coordinate Care		Pts
A.	Test Tracking and Follow-Up	6
B.	**Referral Tracking and Follow-Up****	**6**
C.	Coordinate with Facilities/Care Transitions	6
		18

Standard 6: Measure and Improve Performance		Pts
A.	Measure Performance	4
B.	Measure Patient/Family Experience	4
C.	**Implement Continuously Quality Improvement****	**4**
D.	Demonstrate Continuous Quality Improvement	3
E.	Report Performance	3
F.	Report Data Externally	2
G.	Use of Certified EHR Technology	0
		20

****Must Pass Elements**

Patient Centered Medical Home

PCMH 2011 and Meaningful Use

PCMH closely aligned with MU	Associated PCMH 2011 Standard
1. Electronic prescribing	1. 3E: Use Electronic Prescribing
2. Drug formulary, drug-drug, drug allergy checks	2. 3E: Use Electronic Prescribing
3. Maintaining an up-to date problem list of current and active diagnoses and medications	3. 2B: Clinical Data
4. Recording demographics on preferred language gender, race, ethnicity and date of birth	4. 2A: Patient Information
5. Recording and charting changes in vital signs	5. 2B: Clinical Data
6. Recording smoking status	6. 2B: Clinical Data
7. Reporting ambulatory quality measures	7. 6F: Report Data Electronically
8. Implementing clinical decision support rules…	8. 3A: Implement Evidence-Based Guidelines

NCQA 2014 Content and Scoring

Points	Standard/Element	Must-Pass = 50% Score
10	**PMCH 1: Patient-Centered Access**	
4.5	Element A Patient-Centered Appointment Access	✓
3.5	Element B 24/7 Access to Clinical Advice	
2	Element C Electronic Access	
12	**PMCH 2: Team-Based Care**	
3	Element A Continuity	
2.5	Element B Medical Home Responsibilities	
2.5	Element C Culturally and Linguistically Appropriate Services (CLAS)	
4	Element D The Practice Team	✓
20	**PCMH 3: Population Health Management**	
3	Element A Patient Information	
4	Element B Clinical Data	
4	Element C Comprehensive Health Assessment	
5	Element D Use Data for Population Management	✓
4	Element E Implement Evidence-Based Decision Support	
20	**PCMH 4: Care Management and Support**	
4	Element A Identify Patients for Care Management	
4	Element B Care Planning and Self-Care Support	✓
4	Element C Medication Management	
3	Element D Use Electronic Prescribing	
5	Element E Support Self-Care and Shared Decision Making	
18	**PCMH 5: Care Coordination and Care Transitions**	
6	Element A Test Tracking and Follow-Up	
6	Element B Referral Tracking and Follow-Up	✓
6	Element C Coordinate Care Transitions	

NCQA 2014 Continued

Points	Standard/Element	Must-Pass = 50% Score
20	PMCH 6: Performance Measurement and Quality Improvement	
3	Element A Measure Clinical Quality Performance	
3	Element B Measure Resource Use and Care Coordination	
4	Element C Measure Patient/Family Experience	
4	Element D Implement Continuous Quality Improvement	✓
3	Element E Demonstrate Continuous Quality Improvement	
3	Element F Report Performance	
Not Scored	Element G Use Certified EHR Technology	

HTPN Road Map for Discussion

I **Transformation Snapshot**

II **Building the System-Level Platform**

III **Results and Lessons Learned**

Profile of Participating HealthTexas Clinics

Based on Medical Home Project Benchmarks for 9 Sites

2,000-3500 patients per physician panel

1.5-3.7 clinical support staff per physician (MA, LVN, RN, NP, PA) Some practices include team members in social work, community health, radiation technologists, CDE

Physicians can determine staff model design; none has hired more staff for PCMH activity to date

System has added centralized care coordination dept to support all practices

No Such Thing as a Typical Site

"With so many sites we have every model out there. That's the beauty of PCMH and the NCQA guidelines– it's not prescriptive as to how to accomplish the criteria, just that you are doing it."

Pat Link
Director of Patient Centered Medical Home
HealthTexas

Taking NCQA's Option to Apply Jointly Based on Shared Parameters

Example HealthTexas Site Characteristics
Shared Across Sites

Common Site Elements	
✓	Electronic health record
✓	Patient communication guidelines
✓	Referral tracking, test tracking, E-RX
	Standards for treating three common chronic conditions (Adult vs. Pedi)
	Tracking reports for meeting/not meeting guidelines
	Care coordination
	Site-specific quantitative measures (e.g., extent of capture of patient information such as e-mail address, race, preferred communication mode)

Summarized for multiple sites in one common application

Addressed in site-specific applications

Main PCMH-Related Changes Across Clinic Sites

Main PCMH Workflow Changes at HealthTexas Sites

Expanding Patient Access

- Re-evaluate existing levels of access ("eye-opening" results on third-day available appointments)
- Confront conceptual change: Patients determine urgency of being seen
- Re-engineer visit workflow, boost efficiency to free up appointment times
- Expand office hours
- Guidelines

Revising Staff Model

- Adding non-physician providers (some sites)
- Adding RNs, LVNs to support patient education
  - Visit separately with patient after physician time
  - Reconfirm instructions, solicit questions, identify barriers, go over care plan
- Introducing care coordinators

Pre-Planning Patient Visits

- Physicians and MAs review charts pre-visit
- Identify outstanding services: Tests, documentation (e.g., discharge report), refills
- Identify patient-specific factors and steps
  - "This patient tends to bring in blood sugar testing, let's remind"
  - "This patient struggles to understand care plan, let's ask for a family member to accompany"

Major transition to installing, customizing, incorporating EHR into workflow*

* See discussion in "System Platform" section of presentation

Road Map for Discussion

I Transformation Snapshot

II Building the System-Level Platform

III Results and Lessons Learned

Invest Broadly in Transformation, Ongoing Operational Help

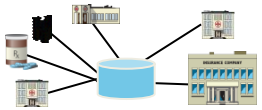
Key System-Level Assistance Categories for PCMH Transformation

Clinical, Administrative Leadership

Budgeted time for staff and physicians dedicated partly or wholly to designing, implementing PCMH effort

Strategic Vision and Project Planning

- Leaders and committees hammer out general vision, goals, common support plan for PCMH sites
- (Sites customize many elements of own operational model)



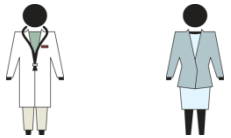
Common IT Platform

- Longstanding, pre-PCMH initiatives around EHR and clinical standardization
- EHR, portal solutions extensively customized for Baylor/HealthTexas

Hands-on Assistance

- Administrative team writing NCQA applications on clinics' behalf
- Library of educational and support materials created for clinic use

Dyad Model Provides "Influential and Implementation Arm"



Physician Leader **Administrative Leader**

Key Physician Leadership Duties/Skills

- Brings physician perspective to PCMH design and project planning
- Helps paint the vision of PCMH transformation for committees, physicians at sites
- Addresses high-level questions and concerns about the model
- Directs physician leadership team working in the field
- Participates in payer and employer discussions

Key Administrator Leadership Duties/Skills

- Oversees project planning and implementation
- Manages, provides input for committee work
- Leads administrative team working on support infrastructure and transformation help for sites
- Leads application process
- Engages diverse administrative stakeholders across system and departments
- Share best practices across sites
- Identify new work needed as uncovered by pilots

Strategic Vision and Project Planning

Strategic objectives	Key Focus Indicators	Goals
Develop infrastructure to support the Patient Centered Medical Home initiative	• Design of the PCMH initiative • Achievement of physician support • Achievement of employee support • Recognition of the NCQA PCMH Standards at the HTPN and/or practice levels • Design of technology tools needed to support PCMH	• Select right staff • Design the PCMH Strategic Plan • Design, implement physician communication venues • Design, implement employee communication venues • Develop tools to meet all NCQA Standards • Achieve NCQA Recognition of all primary practices: • Provide connection with BHCS technology
Improve patient quality of care	Quality metrics (from HTPN Best Care Committee)	• Improve care team's awareness and compliance with preventive measures • Improve care team's awareness and compliance with chronic disease management • Improve patients' engagement and self- management of prevention measures and treatment of diseases
Improve patient perception of service and access	• Service metrics • Access metrics	• Provide for the patients' ease in communicating with and accessing the care team • Provide for the patients' positive interaction with the care team • Provide care that is culturally and educationally sensitive

Strategic objectives	Key Focus Indicators	Goals
Improve care coordination between care sites	Care coordination metrics	• Implement a Care Coordination Model to support the PCMH initiative
Improve employee satisfaction and engagement through implementation of PCMH	• First year retention of HTPN employees • Retention of HTPN employees employed between 1-3 years	• Improve employee satisfaction through an increase in skill appropriate work • Improve employee satisfaction through an increase in practice efficiencies
Improve physician satisfaction and engagement through implementation of PCMH	• Physician satisfaction survey results • Physician retention	• Improve physician satisfaction and engagement with HTPN • Increase physician revenue through efficiencies, productivity and reimbursement rates • Lessen administrative burden to allow more quality time with patients

HealthTexas and Baylor HealthCare Staff with PCMH Goals

System-wide Incentives and Objectives

- **Baylor Healthcare system executives** Progress toward ACO development
- **HealthTexas Provider Network executives** (E.g., applications completed within a fiscal year; care coordination rolled out to clinics)
- **PCMH administrative/operations team** (E.g., applications completed within a fiscal year; care coordination rolled out to clinics)
- **Site-level staff** (e.g., clinic efficiency, service excellence e.g., ease of patient appointments)

Road Map for Discussion

I Transformation Snapshot

II Building the System-Level Platform

III Results and Lessons Learned

PCMH: Evaluations and Results

PCMH studies continue to demonstrate impressive improvements across a broad range of categories. PCMH has been shown to be effective at reducing cost of care, emergency department visits, inpatient admissions, readmissions, and at improving access, patient satisfaction, and preventative services.

	Total Studies	Cost Reductions	Fewer ED Visits	Fewer Inpatient Admissions	Fewer Readmissions	Improvement in Population Health	Improved Access	Increase in Preventive Services	Improvement in Satisfaction
PEER-REVIEW/ACADEMIA									
Reported outcomes	(n=13)	61% (n=8)	61% (n=8)	31% (n=4)	13% (n=1)	31% (n=4)	31% (n=4)	31% (n=4)	23% (n=3)
INDUSTRY REPORTS									
Reported outcomes	(n=7)	57% (n=4)	57% (n=4)	57% (n=4)	29% (n=2)	29% (n=2)	14% (n=1)	29% (n=2)	14% (n=1)

Recent research finds that the longer a PCMH model of care has been in place, the greater the cost savings and improvement in quality and outcomes

The Patient-Centered Primary Care Collaborative's recently published PCMH's Impact on Cost & Quality can be found here: PCMH Impact on Cost & Quality

Some of the Realities of a Major Multi-Site PCMH Rollout

- Cannot approach change in a “one-off” manner when so many practices are involved: Formal project planning needed
- Up-front processes and initial launch planning require twice as much time as expected—later iterations can move more quickly
- Major changes require significant “influence time”—cannot simply dictate across system. Transformation must become part of the culture (especially when project scale is large)
- IT portion of transformation its own (time-consuming) project
- Leaders, as educators, must be humble. Trainings are not inherently great—unless they are effective

Some of the Results of a Major Multi-Site PCMH Rollout

- New broad conversations-e.g. pre-visit planning, access, patient activation, expanded teams
- All practices with extended hours or partnership with practice that does
- All practices with a basic level functionality and policy manuals
- New contracts
- Diabetes Outcomes: 20% relative improvement
- Achieved meaningful use
- Preventive Care: 15% relative improvement
- Patient satisfaction in the top 90%
- Road map for future grow/matuation