Strengthening Primary Care for Patients:

Independent Health | Buffalo, N.Y.

Background

Independent Health was created in 1980 as a result of a University of Buffalo graduate school research project, and today covers over 365,000 members in western New York. Independent Health has a long history of partnering with primary care practices, such as through its Quality Management Incentive Award, which the plan began offering in 1992, and its participation in the Institute for Healthcare Improvement's Idealized Design of Clinical Office Practices (IDCOP) program in 1999. [1]

Many of the themes born from IDCOP, such as increased access, quality measurement and instituting multi-disciplinary care teams, were repeated and improved upon throughout the health plan's patient-centered medical home (PCMH) pilot; having an established relationship with primary care practices as a result of IDCOP paved the way for PCMH implementation in the practices.

The Independent Health PCMH pilot began in 2009, aiming to "breathe life back in the primary care community."[2] By offering both increased reimbursement and support personnel, the objective was not only to empower and reduce the workload of overburdened primary care practitioners, but also to draw talented young physicians to the field by making primary care more attractive. Second, knowing that 30 percent of care delivered is either duplicative or unnecessary, Independent Health aimed to decrease waste and ensure that the plan's physicians provide high-quality care.

Initiative Title: The Primary Connection
Start Date: 2009
Practices: 22
Physicians: 140
Covered Lives: 50,000

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Implementation

Evolution of the PCMH Model

In 2008, Independent Health began discussing PCMHs at the plan level and — in the latter part of that year — brought together both primary care physicians and members to discuss PCMH best

practices. The group used the National Committee for Quality Assurance (NCQA) PCMH standards as a basis to discuss what was working and what was not working at the plan around nine domains of primary care (such as access and communication) to determine areas of improvement.

Independent Health began its three-year PCMH pilot program in January 2009 with 18 diverse practices across western New York. In the first year, the plan focused on getting practices to buy into the concept of a PCMH and to familiarize them with the concept of a medical home, such as what practices would have to change and what a reimbursement model might look like. The plan provided grant money for practice improvement and practices began thinking about how to change care delivery. Besides the grant incentives, the payment model employed by Independent Health was a hybrid of fee-for-service, prospective/risk adjusted per member per month (PMPM) fees and retrospective performance payments based on quality outcome measures.

Independent Health recognized that NCQA accreditation was not sufficient to achieve the significant practice transformation that was necessary to embrace fully the new model of care.

In the second phase of the PCMH initiative, Independent Health focused on helping practices achieve NCQA PCMH recognition. All 18 practices received Level III recognition, but by 2010 Independent Health recognized that accreditation was not sufficient to achieve the significant practice transformation that was necessary to embrace fully the new model of care.

Therefore, in 2010 Independent Health began its practice transformation effort "in earnest," attaining buy-in from practices, getting care teams on board with understanding process improvement and teaching practices the changes that had to take place in terms of care teams, care coordination and other aspects of patient-centered care.

At the same time, the plan realized that the PCMH "could not function as an island unto itself,"[2] according to Kim Fecher, director of practice management and physician services.[1] There were certain factors that Independent Health could influence within its own practices and with its members, but in other aspects the plan was at the mercy of specialists and other providers. There was an increasing awareness that providers were dependent on each other to be successful and manage the population-at-large. In response, the plan extended its three-year pilot by another six months as it planned next steps. Independent Health had already provided an alternative reimbursement model for three years and knew that it would have to change to be sustainable; what emerged was The Primary Connection.

The Primary Connection

The Primary Connection was based on the idea of what the PCMH could achieve so that physicians could impact the total continuum of care, by improving care coordination, facilitating patient/physician engagement and influencing care beyond the walls of the practice. The goal was to put the primary care physician (PCP) at the center of a patient's care, facilitate specialty engagement and communicate effectively with patients and providers.

Independent Health realized that, to achieve these goals, the project would have to be led by PCPs; the plan therefore empowered PCPs to take a leadership role and take ownership of the process, as well as to engage other providers. Independent Health developed a leadership council comprising PCPs, a consumer representative and an employer, who became the leaders and drivers of the PCMH intervention. As Dr. Robinson, a family practice physician and chairman of The Primary Connection's Leadership Council said, "Independent Health brought the primary care physicians together to design what we thought would be the ideal health care system. We are now implementing those plans."[3]

The reimbursement model was modified to include a shared savings component, based on meeting a quality threshold and as of February 2012, 22 practices and 140 primary care physicians had signed onto this concept of the shared savings model, becoming part of The Primary Connection.

Specialty Engagement

Although Independent Health realizes that it has little leverage for guiding change within specialty groups, it can work closely with the PCMH pilot sites — which do have influence over specialty behavior — to further affect cost trends and improve care quality.

Independent Health and providers have met with specialists to talk through how to improve the coordination of care model and how to use data to partner with each other. The plan aims to understand and share data on top-performing specialists, opportunities to improve and engagement with evidence-based best practices to raise the bar for all specialists and providers. It has brought specialists and PCPs together to ensure data are meaningful, useful and accurate, realizing that sending data without context can alienate providers. Independent Health has also hired a consultant who supports specialty physicians in understanding data.

> "At Buffalo Medical Group and Independent Health, we believe transforming health care is a collective responsibility. As such, we are committed to identifying and implementing sustainable solutions to improve the quality and effectiveness of health care through a long-standing relationship built on trust and transparency."[4]
>
> - Irene S. Snow, M.D., medical director of Buffalo Medical Group and Michael W. Cropp, M.D., president and CEO of Independent Health

The Primary Connection providers decided to address cardiology as the first specialty, so Independent Health facilitated meetings between representatives from The Primary Connection and key cardiologists from the community. The conversation focused on ways to work better together and challenges facing each group. The primary care physicians expressed the desire for specialists to refer patients back to primary care after seeing them, and for better communication to more effectively coordinate patients' care. Specialists, in turn, said that they wanted PCPs to make more selective referrals — that is, refer only the patients who truly required a specialist's care — as well as provide meaningful information on why each patient is referred.

The Primary Connection has also met with radiologists and gastroenterologists. Out of an initial conversation with radiologists, Independent Health convened a sub-team that mapped out process improvement and pre-consultation call work flows so that physicians could access radiologists by phone and consult about which tests would be appropriate to order for their patients. The PCPs were given information about what radiologists believe constitute quality referrals, as well as a contact list of all radiologists within the community, included those who were available for pre-consultations.

Opportunities for Learning and Collaboration

Independent Health offers multiple opportunities for individual and shared learning, with a focus on cultivating shared goals among its entire PCMH group. During the early planning phases of the model, intense physician and patient collaboration was fostered by inviting both physicians and health plan members to PCMH advisory boards. Their fresh opinions helped Independent Health develop key features of the pilot. Health plan personnel noted that collaboration with stakeholders from outside the health plan was a reality check, as it ensured that the plan was keeping the needs of patients front and center.

Since the inception of the PCMH program in 2009, the plan has led monthly learning collaboratives among its providers. In 2012-2013, the plan has continued to facilitate large-group learning sessions, hosted every other month. Focused work groups, such as one for pediatrics, support the large sessions and meet each month that the large group does not; at these work groups, providers develop strategies around specific opportunities for improvement. Additional ad-hoc work groups look at condition-specific best practices, such as for heart failure management from both a primary and specialty care perspective. A bi-weekly email provides additional information and tools for learning.

The collaboratives are led by Primary Connection physicians; while Independent Health facilitates them, the focus of each meeting is dialogue between providers and physicians themselves decide what to implement together. Once key initiatives or programs are decided on as priority areas, health plan care coordinators and consultants are responsible for helping practices develop systems of care that would make use of those programs.

Practice Transformation Teams

One of Independent Health's strategies for implementation of medical home elements during its PCMH pilot and throughout The Primary Connection initiative has been support of change management and practice improvement literacy. The health plan facilitates the improvement of primary care practices' management models by providing practice management consultants (PMC) to the individual practices. These PMC provide the offices with strategies to support office redesign and process improvement that will result in improvements in key measures of the Triple Aim. Examples of their work include facilitating electronic medical record (EMR) utilization, developing quality improvement teams, creating standardized policy and job description templates and maintaining general oversight of the implementation of NCQA requirements.

Health plan-employed consultants and care coordinators support practices logistically and clinically.

In addition to the PMC, the health plan also assigned patient care coordinators (PCC) to practices to interact with the practice clinical team. These PCC ensure coordination of care for high-risk patients and provide pharmacy support for medication therapy management.

Practices formed care teams to better coordinate patient care and foster improved relationships between clinical and administrative staff. Similarly, work flows and staff roles were defined, improving the communication and collaboration within practices. Practices maximized their EMR use, focusing on preventative and chronic care management, and used websites and patient portals to communicate with patients. As a result of these initiatives, Independent Health saw improved communication between providers and patients, with increased access and reduced appointment wait times.

Hospital Diversion Initiative

One of the physician-driven initiatives was a hospital diversion project, which aimed to ensure that care was delivered in the appropriate settings. The hospital diversion pilot started out in five practices with a framework and dialogue around what kind of patients required an additional level of intervention. Providers identified some diagnoses that were often being referred to hospitals, such as cellulitis, and determined whether non-hospital care would be more appropriate for those conditions.

To facilitate more effective referrals, Independent Health established relationships with health care organizations in the community. The plan identified long-term care facilities that would agree to receive short-term, three-day admissions for certain members, as well as home care agencies that would give priority to patients who required treatment to avoid hospitalization. Independent Health then gave physicians lists of these facilities as alternatives to hospitalization. Health plan care

Patient Story: Plan-Provider Collaboration

Collaboration among health professionals improves care quality.

Sandra C., an Independent Health member for more than 20 years, visited her primary care physician, David Pawlowski, M.D., after suffering a cat bite. When an injection of antibiotics did not clear up the swelling and redness, it was determined that Sandra needed inpatient treatment for the infection.

Independent Health Practice Care Coordinator Susan Schuler, R.N., who was employed by the plan and embedded in Independent Health-affiliated PCMH practices, arranged for Sandra to be admitted to Northgate Healthcare Facility rather than a hospital. Located in a suburb of Buffalo, N.Y., Northgate is a comprehensive inpatient and outpatient facility offering rehabilitation programs and therapy to patients after injury or illness. As Sandra recalls, "within an hour, I had the medicine and I was on my way to getting better."

At Northgate, Sandra received IV antibiotics under close supervision of an infectious disease specialist, along with rehabilitation in a less acute setting, which helped her avoid a more costly hospital stay. In addition to prompt and efficient care, Sandra was pleased that the care coordinator found a care option that was close to her home. She commends the team effort among her doctor's office, Independent Health and Northgate, and says she feels confident in the coordination of care and the attention she received.

"There is always a high level of care given from Dr. Pawlowski and his office, but I think this brings another level to your care," says Sandra. "You know that there's Independent Health and the doctor working together, and it really relaxes me to know I have that there. It made a big difference."

When they collaborate with each other and other professionals, doctors are able to provide the best care for their patients. Independent Health is able to foster better coordination by providing doctors' offices with practice care coordinators like Susan. With all health care professionals working in unison, patients receive quality, cost-effective and appropriate care.

coordinators helped providers set up processes in each office so that this work would become part of the practices' standard daily work flows; together, they identified barriers to change and strategies to overcome these barriers. The plan has received positive feedback from members concerning the initiative.

Independent Health has also facilitated improvements in care transitions processes by providing information to physicians on discharges in the service area and supplying pharmacy review. The plan wants to ensure that patients see their PCPs within seven days of discharge from the hospital, receive medication reconciliation, have services and resources in place and are able to self-manage their condition.

Sustainability

Data and information have been key to providing enhanced care; Independent Health and its team of analysts work closely with physician practices to share information about performance and areas of opportunity. The plan also invested in new tools to give more accurate and useful information on both primary care practices and specialty practices, such as predictive modeling software, chronic condition registries and population segmentation information. Transparency is critical to this effort; although sharing data is currently optional, Independent Health plans to institute mandatory information sharing in the future.

Providers are the main drivers of innovation in The Primary Connection and determine what changes would facilitate higher-quality care and could become an extension of their office. Top-down programs are not sustainable when a provider is working with multiple payers, all of whom have different PCMH models, says Independent Health leadership.[2] The high level of physician input and ownership in the project helped overcome initial provider skepticism about the feasibility of improving certain initiatives and improve the likelihood of their success.

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In the early days of the PCMH initiative, between 2009 and 2010, care coordinators who were embedded in the practices were managing the high-risk, high-cost patients. As of 2012, The Primary Connection practices were doing much of this work themselves, and had moved from focusing on individual patients to thinking more broadly about population health management.

Outcomes

Independent Health provides quarterly dashboards to practices and includes measures for acute and chronic conditions, preventive care, cost measures, emergency room utilization and generic pharmacy use. In addition, the health plan measures patient and staff satisfaction annually.

Independent Health PCMH pilot practices costs associated with emergency room utilization were 15 percent less than their non-PCMH counterparts. In addition, they demonstrated a 19 percent increase in generic statin prescribing. Overall, the 18 pilot practices saw a 10 percent decrease in total cost, corresponding to $2.9 million in savings. The practices also saw an 8 to 10 percent improvement in their measures of quality related to preventive services and acute and chronic conditions. Patient satisfaction and team vitality also improved.

Scale

According to a three-year evaluation of the program completed in 2011, early pilot sites showed a positive return on investment. As Independent Health Chief Medical Officer Thomas Foels, M.D., indicated, "There are early indications that the medical cost for these populations is trending downward, creating its own budget to reinvest back in the primaries."[1] Going forward, Independent Health hopes to further reform its payment model to more heavily reflect performance outcomes and conversely reduce dependence on fee-for-service.

Provider groups who meet the minimum requirements for participation are being engaged in the same way the original 18 practices were, through practice transformation grants and a focus on NCQA certification. These practices will be included in The Primary Connection 2013 as they become more prepared to become part of the initiative.

[1] Radel, Stephen; Norman, Allyn; Notaro, John and Horrigan, Dennis. "Redesigning Clinical Office Practices to Improve Performance Levels in an Individual Practice Association Model HMO." *Journal of Healthcare Quality*. 23.2 (2001): 11-15.
[2] Participant interview with Rebecca Malouin, Ph.D., 2011
[3] "Community Physicians and Independent Health Announce Groundbreaking Collaboration." *Independent Health*. September 6, 2012.
[4] Snow, Irene and Cropp, Michael. "Another Voice: Partnership of Payers, Providers Improves Outcomes." *Buffalo News*. December 4, 2012.

A copy of the full ACHP report on strengthening primary care for patients, supplementary profiles on member plan initiatives, a one-page fact sheet and other resources are available online at www.achp.org or by emailing innovations@achp.org.