Strengthening Primary Care for Patients:

Presbyterian Health Plan | Albuquerque, N.M.

Background

Presbyterian Health Plan, Inc., (PHP) is owned by Presbyterian Healthcare Services, a nonprofit, integrated health care system consisting of a health plan, the Presbyterian Medical Group (PMG) and hospital system. PHP serves more than 420,000 members throughout New Mexico.

PHP has supported the development and deployment of patient-centered medical home (PCMH) practices across the state of New Mexico, including at the PMG and seven other network primary care groups spanning both urban and rural areas of the state. These combined PCMH programs touch approximately 120,000 PHP members and involve approximately 250 primary care physicians in 30 different practice locations. As of February 2013, approximately five more primary care practices were in various stages of entering into the program.

For PHP, the impetus to implement primary care transformation was multifaceted. The journey to pursue PCMH started with the PMG, the largest primary care group in PHP's network. The need for new care delivery models was evident in the Presbyterian delivery system due to rising primary care caseloads and disjointed work flows, growing physician frustration with the large amount of non-medical work with which they were faced and the desire to align quality improvement with care delivery models.[1] At the same time, legislators in New Mexico were pushing health plans to take on an increased role in motivating primary care practices to embrace the medical home model.

Health plan and PMG leadership partnered with the Patient-Centered Primary Care Collaborative through the Alliance of Community Health Plans, which helped PHP and PMG pull together their efforts. Goals of PCMH implementation included an increased focus on quality, chronic care and prevention processes and better coordination of care.[2]

Initiative Title: Patient-Centered Medical Home
Start Date: 2009
Practices: 8
Physicians: 30
Covered Lives: 120,000

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care.

The community-based and regional health plans and provider organizations from across the country that make up ACHP's membership provide coverage and care for approximately 16 million Americans. These 22 organizations focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and the quality of care, including patient care coordination, patient-centered medical homes, accountable health care delivery and use of information technology.

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Implementation

Even prior to PCMH implementation, PHP had experience applying internally derived patient-centered care processes throughout its system; these implementations would later dovetail with PCMH criteria. For many years, the health plan had offered on-site and nurse coordinators — both in urban and rural communities and at its larger hospitals, skilled nursing facilities and rehabilitation centers — and its care management program was designed to help reduce communication silos often experienced among health care providers. Then in 2008, the PHS delivery system began its Hospital at Home program, which allows primary care physicians and specialists to coordinate the delivery of hospital-level care to patients in their homes rather than in a hospital.[1]

Features of the PCMH

> Presbyterian Medical Group focused on creating more accessible venues of care as an alternative to face-to-face visits, including group visits and phone coaching.

PMG implemented a variety of changes in its PCMH model at primary care clinics. For one, PMG focused on creating more accessible venues of care as an alternative to face-to-face visits. Individuals with similar illnesses can attend group visits, increasing the efficiency of care delivered, as one provider can simultaneously coach multiple patients. For high-risk members who meet "readiness to change" assessments, PHP nurse care coordinators are trained to implement personalized health improvement plans over the phone through PHP's Healthy Solutions disease management coaching program.

The PMG PCMH practices provide care through care teams, which consist of a physician, pharmacy clinician, behavioral health specialist, care manager and promotora (locally trained health coach with strong cultural ties to the community).[2] Care managers are an integral part of the care team, tasked with increasing post-visit outreach, coordination of care among care team members and follow-up for patients with chronic conditions. Care team work flows are based on Lean principles.

Customization of the PCMH Models

Each of the seven active PCMH practices outside PMG has its own focus and priorities. Although a core set of principles comprise the PCMH programs, PHP's goal is to assist each group in the development of a program that fits the culture and make-up of the provider group and the nature of the patient population, including prevalent conditions, quality care management gaps and utilization patterns. Features of a PCMH program may differ by the type, size and location of primary care sites.

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For example, a group of eight pediatricians in a rural area with a high prevalence of asthma trained and hired an asthma educator. The group also trained its staff to provide targeted outreach to patients who had been in the emergency department (ED), designed an incentive plan to incorporate outreach into daily work flows and focused many of their efforts on same-day clinic access.

Another group of more than 40 family medicine primary care physicians with clinics around the state combined a central care management function with training at each individual site to deploy care management activities. The physicians flag high-risk patients, particularly with diabetes, in their electronic medical record and develop and coordinate care plans that can be shared across sites to prevent avoidable admissions.

Plan-Provider Collaboration and Data Sharing

PHP offers a variety of services to assist primary care practices in PCMH transformation. A monthly report is generated of their patients who have been to the ED for a condition that could have been treated in ambulatory care and those who frequently visit the ED. This allows the physicians to educate their patients on access issues or better coordinate their care to avoid ED visits. Another service, Pres Online, streamlines administrative tasks, giving providers and staff an easily accessible way to identify members' eligibility and claims status and freeing them to perform other tasks like pre-visit planning.

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In the third quarter of 2013, PHP will deploy a new care management software program that will give providers a portal into a highly integrated care assessment and care planning tool with streamlined prior authorization processes. Refreshed daily, this system will provide the full scope of clinical data and information that will directly impact the practice's ability to more effectively manage their patients, as a "one-stop shop" for all clinical needs for PHP members.

PCMH groups are encouraged to work closely with the health plan to align their patient panel assignments, enabling practices to effectively measure their performance and trends on quality and utilization measures. Groups are also encouraged to send relevant data to PHP, such as lab results, and PHP captures these in a database that feeds the data warehouse.

Centrally located care managers supplement care management performed at the point of care, helping match high-risk members, identified through predictive modeling, to an appropriate level of intervention that may be beyond the scope of the provider group to manage. PHP has developed a tool for PCMH pilot care managers that details how to follow up with members who have over-utilized the emergency room.

In general, PHP is very visible within the PCMH pilot practices. As PHP Director of Value-Based Reimbursement Susan Dezavelle stated, "We have regular meetings with these groups. We have a lot of measurements and we're sharing a lot of data with them, we're very hands-on."[3] The plan holds individual monthly meetings with each PCMH practice to review data, trends and drilldown information to identify root causes for gaps in care or utilization patterns. These meetings also involve discussion about process changes, progress towards National Center for Quality Assurance (NCQA) recognition or how to leverage electronic medical records to enhance care coordination. In addition, PHP shares anecdotal best practices from other groups. In the future, the health plan aims to host a conference with representatives from the various groups.

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Sustainability

PHP rolled out its first medical home pilot at the PMG Isleta Clinic in July 2009 and spread the model to two other primary care groups in 2010. As of February 2013, the model has been implemented in eight primary care groups comprising 30 practice sites.

Practices involved in the PCMH initiative have generally gone through two phases. The first is a pilot phase in which PHP gives each practice a grant to support primary care transformation, and during which providers and staff can build expertise. Prior to entering this program, providers complete an eight-question PHP-developed survey to help the group evaluate its readiness to participate.

Questions encompass the group's status of EMR implementation, plans for NCQA recognition, establishment of a PCMH team and a review of baseline data and ask providers to select measures and targets and identify general proposed processes to support the improvement activities.

Once an agreement is signed, PHP provides grant money to, for example, hire staff to do care management, design or build new processes, oversee NCQA accreditation or educate providers. Initial grants are proportionate to the PHP membership of the group. Additional payouts are made when there is documented evidence of quality improvements, reduced inpatient admissions and/or reductions in ED utilization for PHP member populations.

Practices involved in the PCMH initiative have gone through two phases; the first involves grants for practice transformation, and the second includes incentives for quality and utilization.

Based on a practice's commitment and outcomes during the pilot phase, the group may move to the care management phase. Before transitioning, practices define a list of specific targets they aim to improve, including key measures they consider meaningful and what the practice will do differently to have an impact on those measures. Once in this phase, the practice is paid a monthly payment per member for care management, with higher expectations for outcomes to be achieved, shared savings, expanded measures and meaningful targets that drive quality and financial outcomes. In this model, PCMH practices receive a periodic tiered incentive based on a combination of both quality and utilization measures.

PHP is committed to providing practices with grant money and is structuring its PCMH program to move into a more sustainable model. At the same time, it does not want to overly burden practices with too many utilization measures that must be met before moving to the care management phase, so the plan currently requires three financial quarters of data as well as details on two financial measures before practices can be included under the care management payment arrangement.

NCQA PCMH Recognition

PMG's 10 PCMH sites in the Albuquerque area have achieved NCQA PCMH Level III recognition as of September 2012, and four of the seven other groups have received NCQA recognition at one or more sites within their practices.

While NCQA standards are a good tool for measurement and provide a foundation for medical home development work, says PHP leadership, they are not the final step in PCMH implementation. If a group that implements NCQA PCMH requirements fundamentally shifts the way it delivers care for patients, then the practice increases its ability to be truly patient-centered. However, PHP believes there are many other processes that must be built, such as those around population management registry information and follow-up, in order to actually have an impact on care measures.

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One lesson learned from the program development and evolution is the importance of balancing fidelity to the standard program structure and honoring the uniqueness of each PCMH program. PHP also more fully appreciates the importance of considering administrative burdens on primary care groups when designing program requirements and expectations. It is critical to stay focused on specific outcome measures and interventions, says PHP leadership, as well as regular data analysis and reporting, care coordination and the incorporation and engagement of providers in the development and refinement of the PCMH model.

Outcomes

PHP decided to limit outcome measures to utilization frequencies as opposed to measuring changes in total costs of care, as there were too many uncontrollable factors that could impact costs. Measuring ED utilization and inpatient medical admission is a requirement of participating in the PCMH program, although admissions may be difficult to measure with a group such as pediatrics where the rate is already low. Other outcome measurements were decided collaboratively among PHP and the practices. When possible, outcomes are measured using the practices' own electronic medical record systems.

For non-PMG-owned practices, pilot sites typically identified two utilization measures and two quality measures to improve on. For the care management phase, the health plan added an additional quality measure which is then calculated into a balance five-tiered measure for shared savings. The PMG decided to create a scorecard to measure even more outcomes than required, which include clinical, financial, access and patient and provider satisfaction measures, tracked on a monthly basis through the CG-CAHPS® survey for PCMHs. Due to the resource intensity of completing these measurements, PHP does not require other groups to perform such intensive analyses.

Measureable outcomes have been reported and show an encouraging start to the program. They have also clearly illustrated the areas that are more difficult to affect. For example, PMG sites have shown significant progress with quality outcomes, in management of their patients with diabetes and management of anticoagulation test results. Areas that PHP leadership wants to focus on improving for 2013 include blood pressure management and asthma.

Utilization improvements were significant for the PMG in some segments of its population, including reduced ED visits for the Medicaid population through its partnership with the Presbyterian hospitals to navigate non-emergency patients from the ED to primary care. Other PCMH groups all showed improvements in some or all of their quality measures and in ER visits; one group achieved more than an 11 percent reduction in ED visits for its Medicaid members. Inpatient admissions are the most challenging to affect, say PHP leadership, especially among the more transient populations, and will be the focus for the health plan and health system going forward.

> Presbyterian Health Plan has seen reduced emergency department visits for its Medicaid population and improvements in quality measures.

Scale

In 2011 and 2012, PHP expanded to a total of eight PCMH groups; as of February 2013, five of the groups were in the pilot phase and two were in the care management phase. Five more groups were in the process of developing a program. PHP hopes to add seven to 10 additional primary care groups to the program in 2013.

In 2012, PHP joined Project ECHO (Extension for Community Healthcare Outcomes) in collaboration with the University of New Mexico, with funding from an Innovation Award from the Center for Medicare & Medicaid Innovation. The three-year pilot focuses on intensive outpatient management for very high-risk patients and involves coaching primary care teams to care for patients with multiple chronic diseases. PHP will be contributing grant type funding directly to the provider groups to hire staff for Project ECHO.

Should PCMH outcomes continue to decrease hospital utilization, PHP leadership has noted that the shared savings and payment models will likely have to be adjusted to include groups other than primary care, including hospitals and specialists.

In January 1, 2013, Presbyterian Healthcare Services (PHS) and Intel launched the Connected Care program, an innovative partnership that demonstrates how employers, providers and payers can be effective partners in advancing health care transformation.[4] As part of the Connected Care program, Intel and PHS established a custom integrated delivery system model that aims to give Intel employees more personalized, evidence-based, coordinated and efficient care. Presbyterian is involved in benefit design, plan design and delivery optimization at Intel's Rio Ranch, N.M., facility. In turn, PHS has an opportunity to accelerate its transformative efforts and is applying Connected Care types of innovations across its system.

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[1] Vijayaraghavan, Vineeta and Klitzner, Ariana. "Presbyterian Healthcare Services: A Care Study Series on Disruptive Innovation within Integrated Health Systems." *Robert Wood Johnson Foundation*. 2010.
[2] Dezavelle, Susan. "*Overview of Patient Centered Medical Home."* 2011. <http://www.docstoc.com/docs/117670542/Overview-of-Patient-Centered-Medical-Home>
[3] Participant interview with Rebecca Malouin, Ph.D., 2011
[4] DeVore, Brian; Wilson, Ben and Parsons, JJ. "Employer-Led Innovation for Healthcare Delivery and Payment Reform: Intel Corporation and Presbyterian Healthcare Services." Intel. Available <http://www.intel.com/content/dam/www/public/us/en/documents/white-papers/healthcare-presbyterian-healthcare-services-whitepaper.pdf>

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.

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