

Primary Care Renewal

- Building Successful Practices In The Era Of Accountability
- Creating Contagious Change



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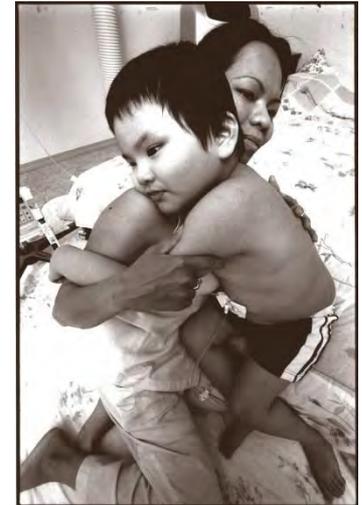
May 27, 2011



CareOregon

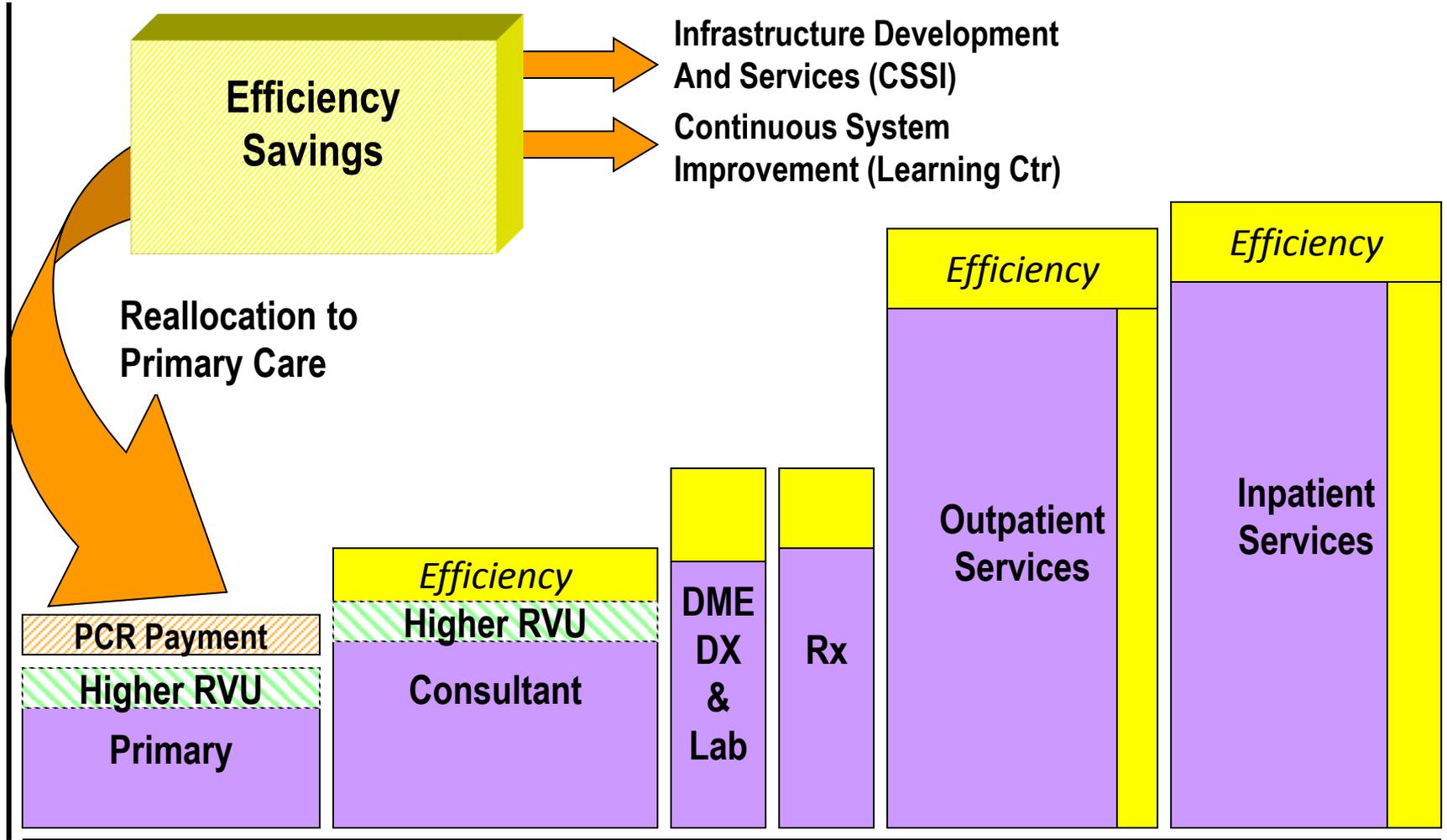
Our Vision: Health Oregonians regardless of their income or social circumstances.

- **State Funded Health Plan for “vulnerable” citizens**
 - Medicaid: Women and Children, Disabled/ Chronically Ill
 - Medicaid/ Medicare “Special Needs” Plan
- **Responsible For All Physical Health Care Costs**
 - Mental Health Paid Separately
- **150,000 Members**
- **Not for Profit**
- **Current Contracted network**
 - 50% Safety Net CHCs
 - Diverse Private Primary Care Practices
 - Major metro and rural hospitals
- **Focus on Quality As A Business Strategy since last recession...**



Bruce Davidson

Primary Care Efficiency / “Medical Home” For High Functioning Sustainability



New Primary Care System Paradigm: **What Should We Really Be Doing?**

- **What we have**
 - **Accountability: Services/** “encounters”
 - Historical “tribal” based roles
 - Usually built around needs of practice and providers
 - Rigid clinician visit centric payment model/ limited flexibility
 - Medically resourced
- **What is now demanded**
 - **Accountability: Population outcomes/** “continuous relationships”
 - Team “at top of license and capability” for outcomes
 - Built around/ responsive to needs of patient/ community
 - Empowered for continuous learning with resources, skills, aligned incentives
 - Resourced to population needs / integrative

Transformational Paradigm Shift

- **From historical (craft) practice:** “We do it that way because this is what we do and how practice has evolved.

- “What we do” =
“What we’ve always done”

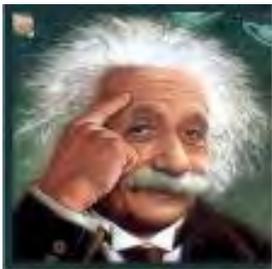


Well, just by looking around I can tell that you haven't taken full advantage of many staff training opportunities...

- “Ritualism”: When you have forgotten why you are doing what you are doing...

Transformational Paradigm Shift

- **To intentional, self reflective, collective practice:** “We do it that way because this is the best way so far we have figured out to accomplish our (new) strategic goals.”
 - Is “what we do” = “what we really should be doing?”



“Insanity: doing the same thing over and over again and expecting different results.”

Everything I Know Is On This Slide

What *Should*
We Be
Doing?

What Is Primary Care's New Accountability?

- Demonstrate that our patients get all needed services...
- ..and are not going to the ED or Hospital unnecessarily
- Do it efficiently and cost effectively

ENDS

ENDS?

What We Need to Deliver That:

- Know who our patients are and what they each need
- Be there when they need us
- Provide optimal medical management
- Provide holistic person centered support
- Ensure workflows / roles are (re) designed for optimal outcomes

MEANS

MEANS?

How We Make It Happen Every day:

- Vision: what are we ALL really about?
- Effective Leadership: "Bottom up top enabled"
- Skills: Improvement and engineering technology
- Competencies: Data management and use
- Aligned Incentives: financial and cultural
- Collective Learning: all of us are smarter than any of us

MAGIC

MAGIC?

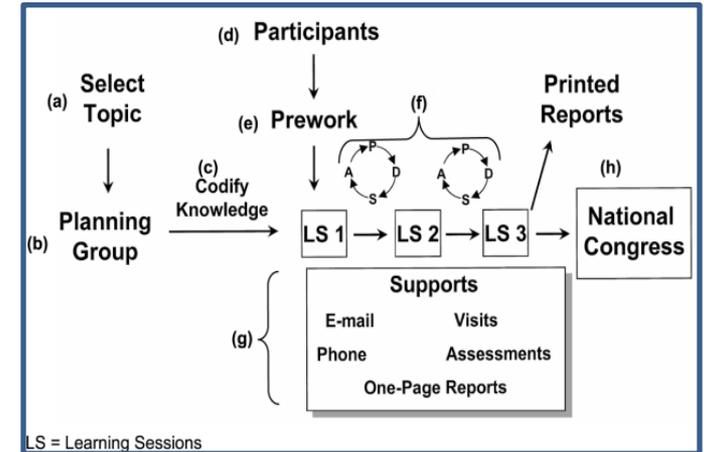
“Primary Care Renewal”

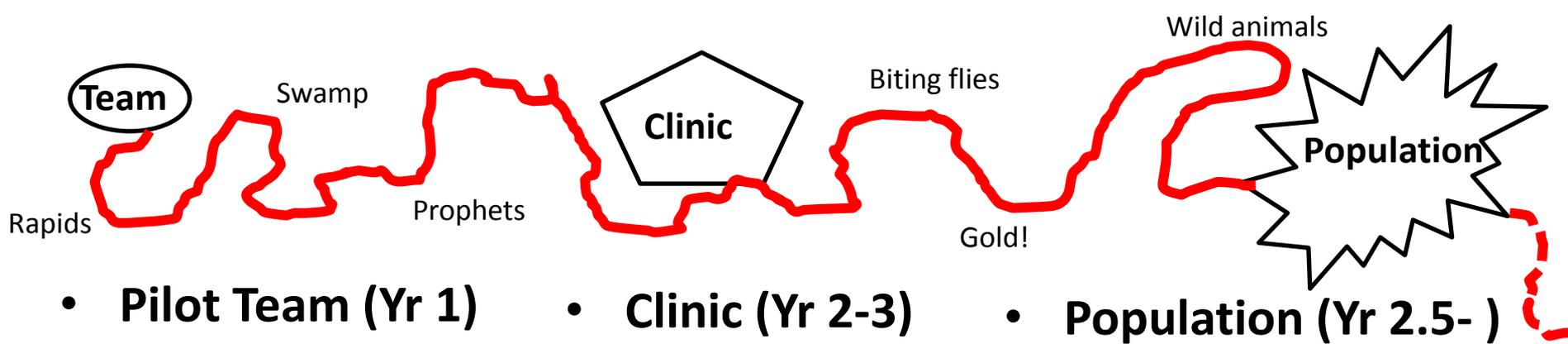
- Agreed Basic “Design Principles:”
 - Customer Driven Care
 - Team Based Care
 - Proactive Panel Health Improvement
 - Integrated Behavioral Health
 - Barrier Free Access
- Commitment to continuous learning and “intentionality”
 - Process Improvement Training for all participants, “Coaches”
- CareOregon funding for clinic “pilot teams”



Building A Learning Collaborative

- **Charter Meeting: Agree on Vision and Core Principles**
 - Freedom to explore how principles implemented based on context.
- **“Step into the work” collectively:**
 - Breakthrough Series Collaborative with “Pilot” care teams
 - Create “emergent” new knowledge through practice
- **Establish a learning system**
 - Lead with principles, follow with tools and measures
 - Emphasis on high yield change methods
 - Model for Improvement/ PDSA cycles
 - **Transformation as “culture change”**





- **Pilot Team (Yr 1)**

- Team?
- New Roles
 - Coaches, BHC, Care Mgrs
 - Learning Groups
- Panels!!!
 - Panel data
- Division of Labor
 - Top of License”
- Team Practices and Workflows
 - Huddling, Meeting, Scrubbing
- BTS Collaborative



- **Clinic (Yr 2-3)**

- Spread?
 - In clinic, X clinic
- Leadership
 - PCR: Steering Ctte
 - Clinic: Structure?
- Team Coaching
 - Clinic data
- New Payment model
- Learning System?
- Standardization?



- **Population (Yr 2.5-)**

- Primary Care Accountability?
 - What health, experience, cost outcomes?
- New Skills & Competencies
 - Care Management Collaborative
- Sub population Needs?
- New Partnerships
 - Integration with other services



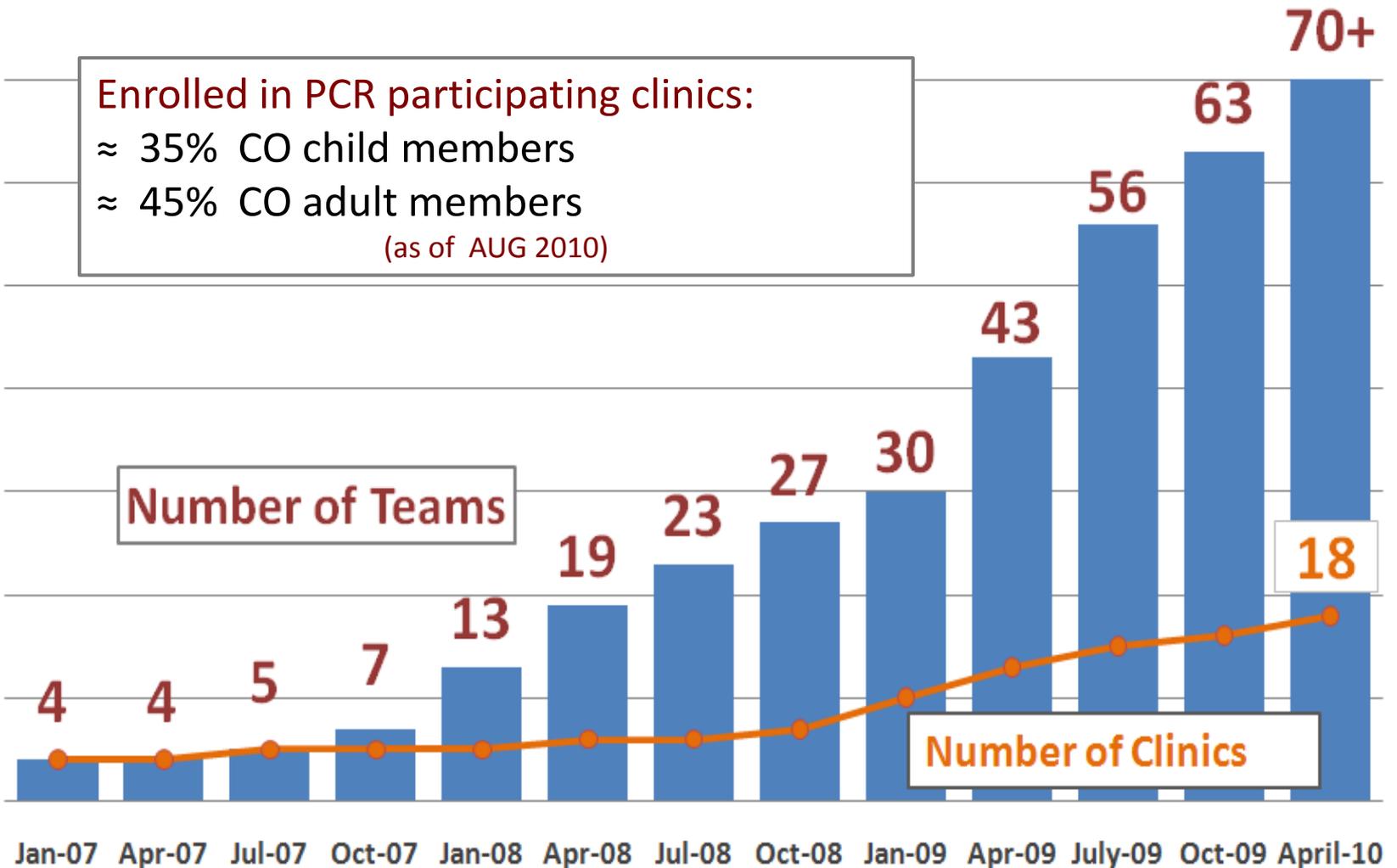
SPREAD -- Primary Care Renewal

Enrolled in PCR participating clinics:

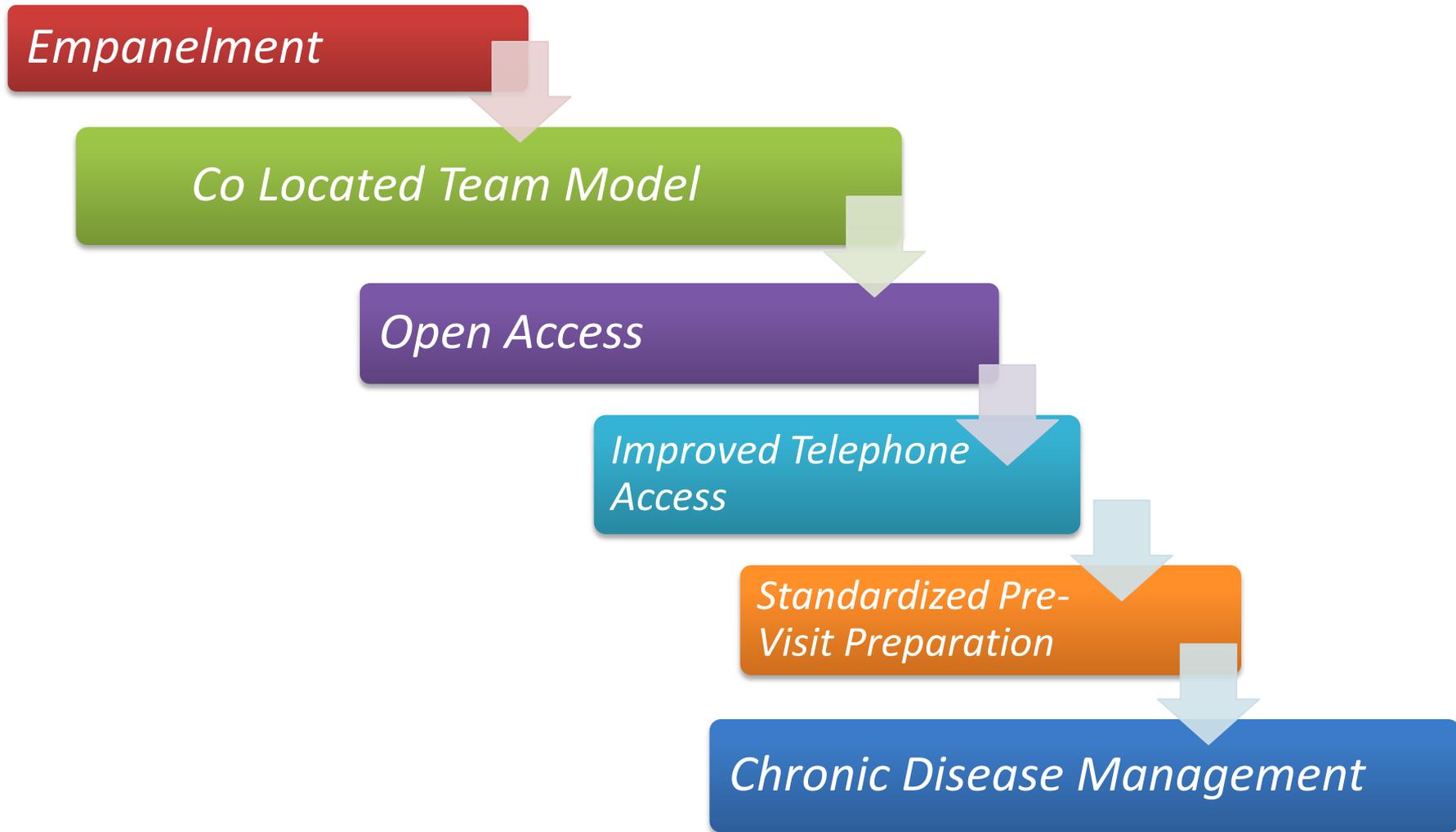
≈ 35% CO child members

≈ 45% CO adult members

(as of AUG 2010)

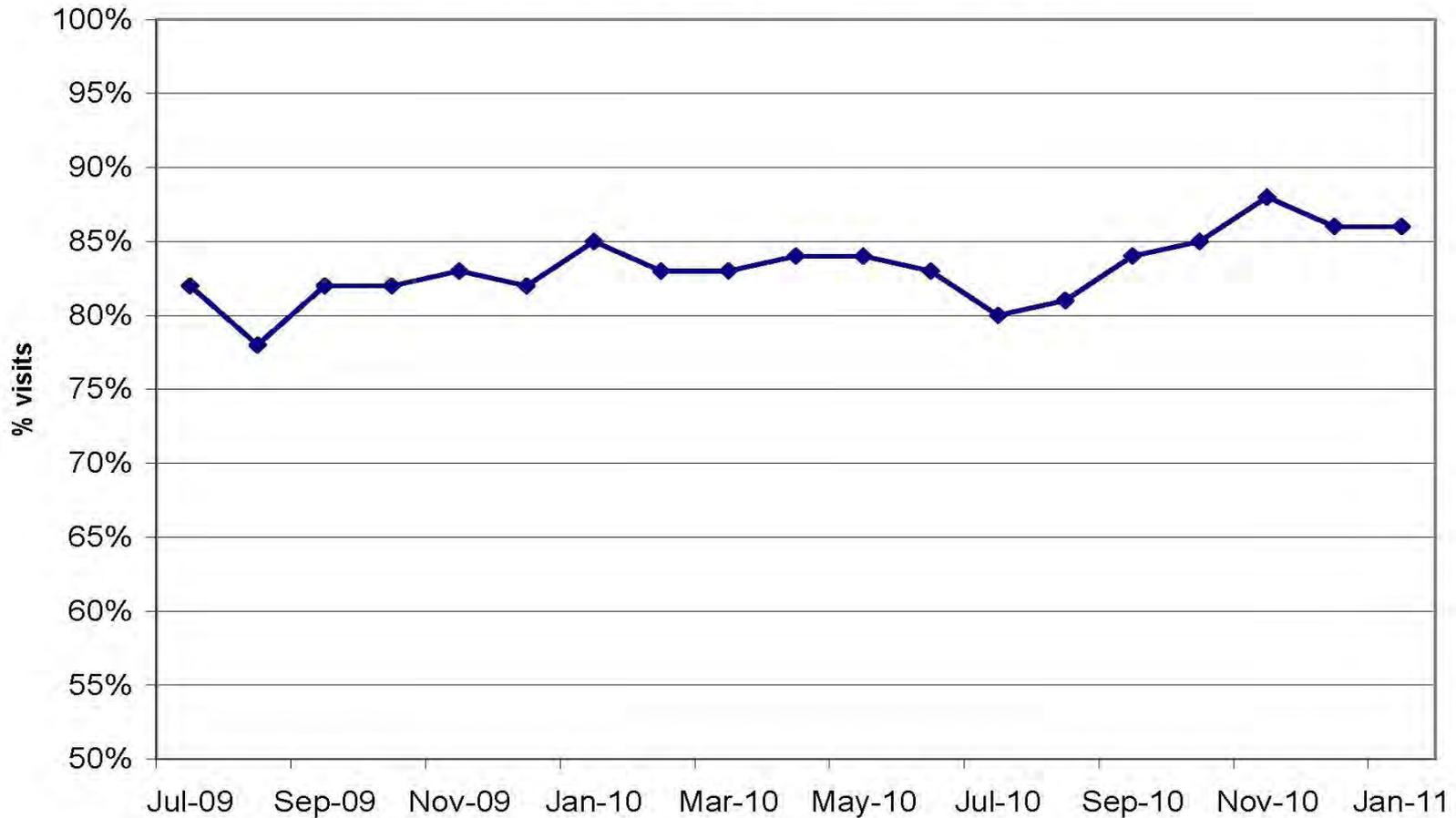


Medical Home Implementation



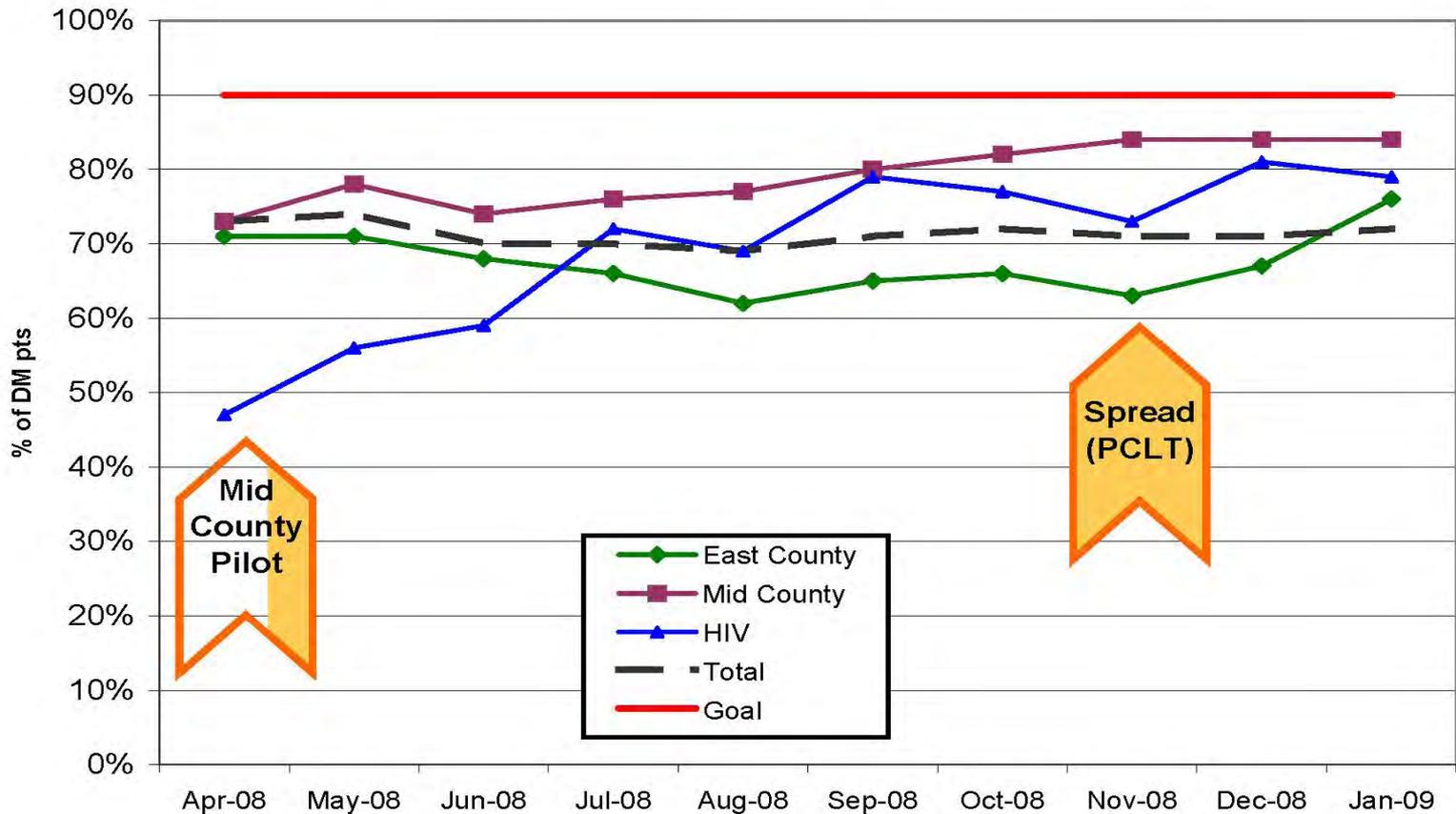
Primary Care Continuity

% of time patient sees their own PCP
represents the proportion of visits where a patient sees their own PCP



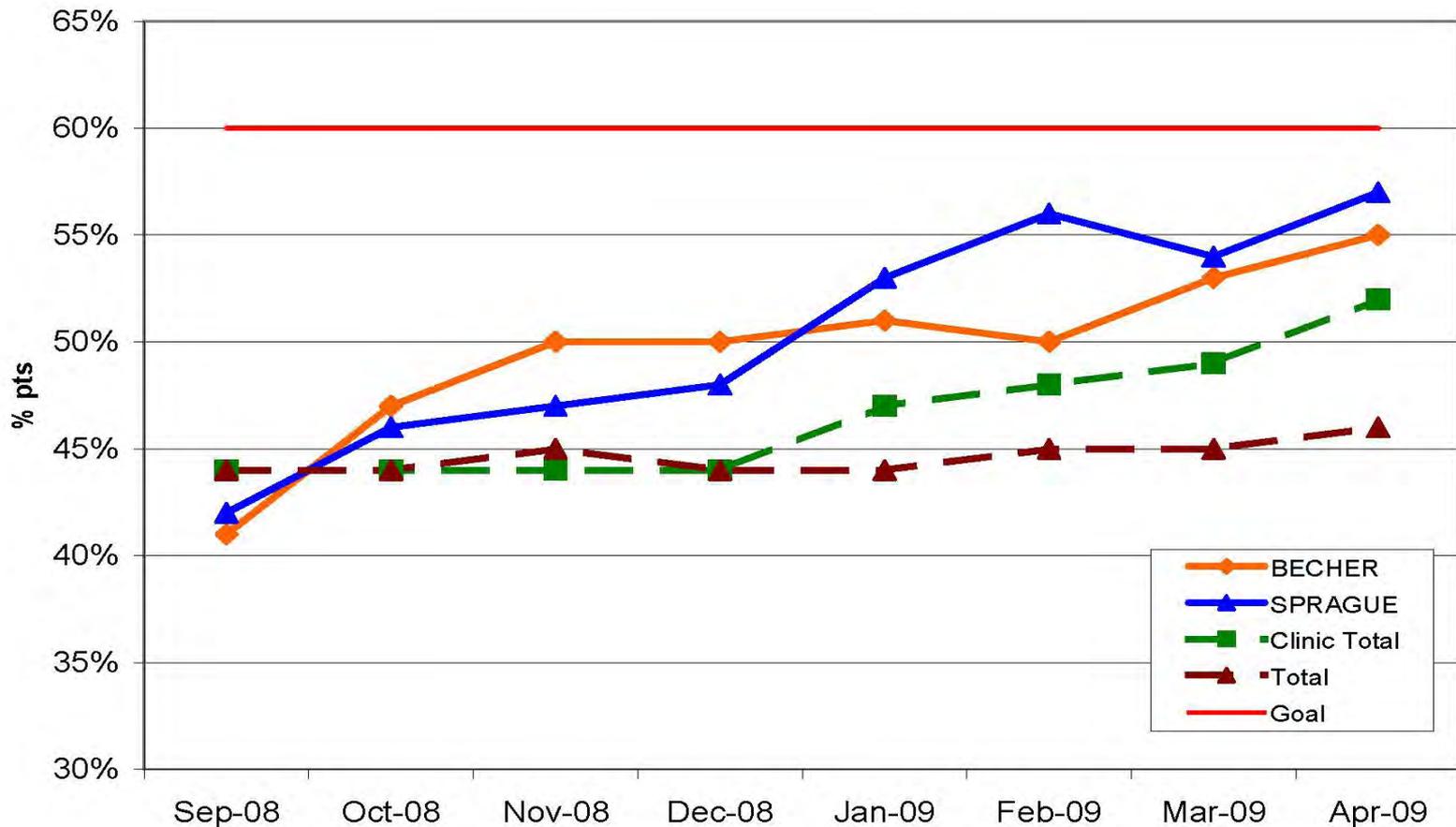
Primary Care Proactive Outreach

% of DM pts with HbA1c in the last 6 months



Primary Care Proactive Outreach

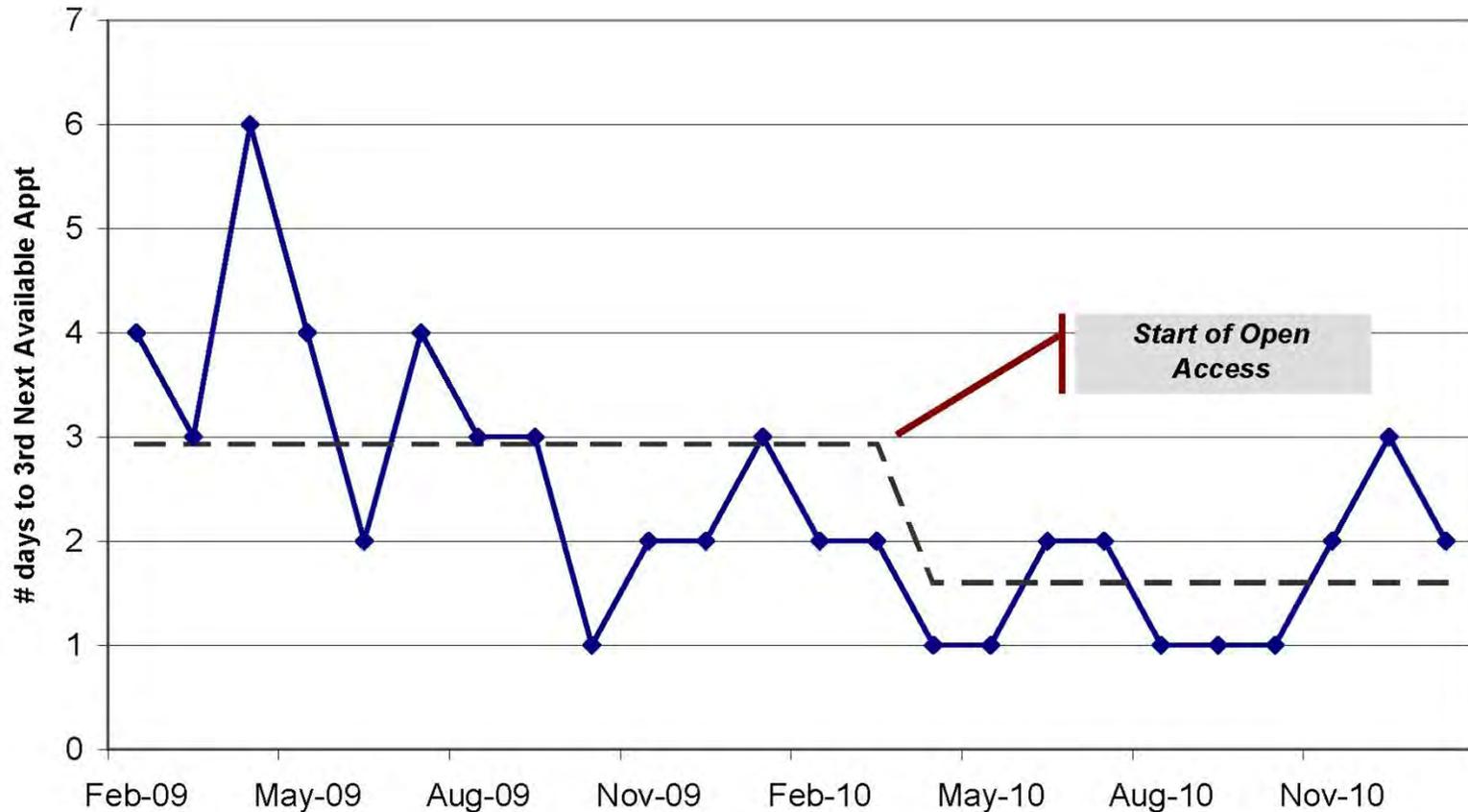
% of HTN pts with BP under control



Primary Care Open Access

Days until 3rd Next Available Appointment - All Primary Care

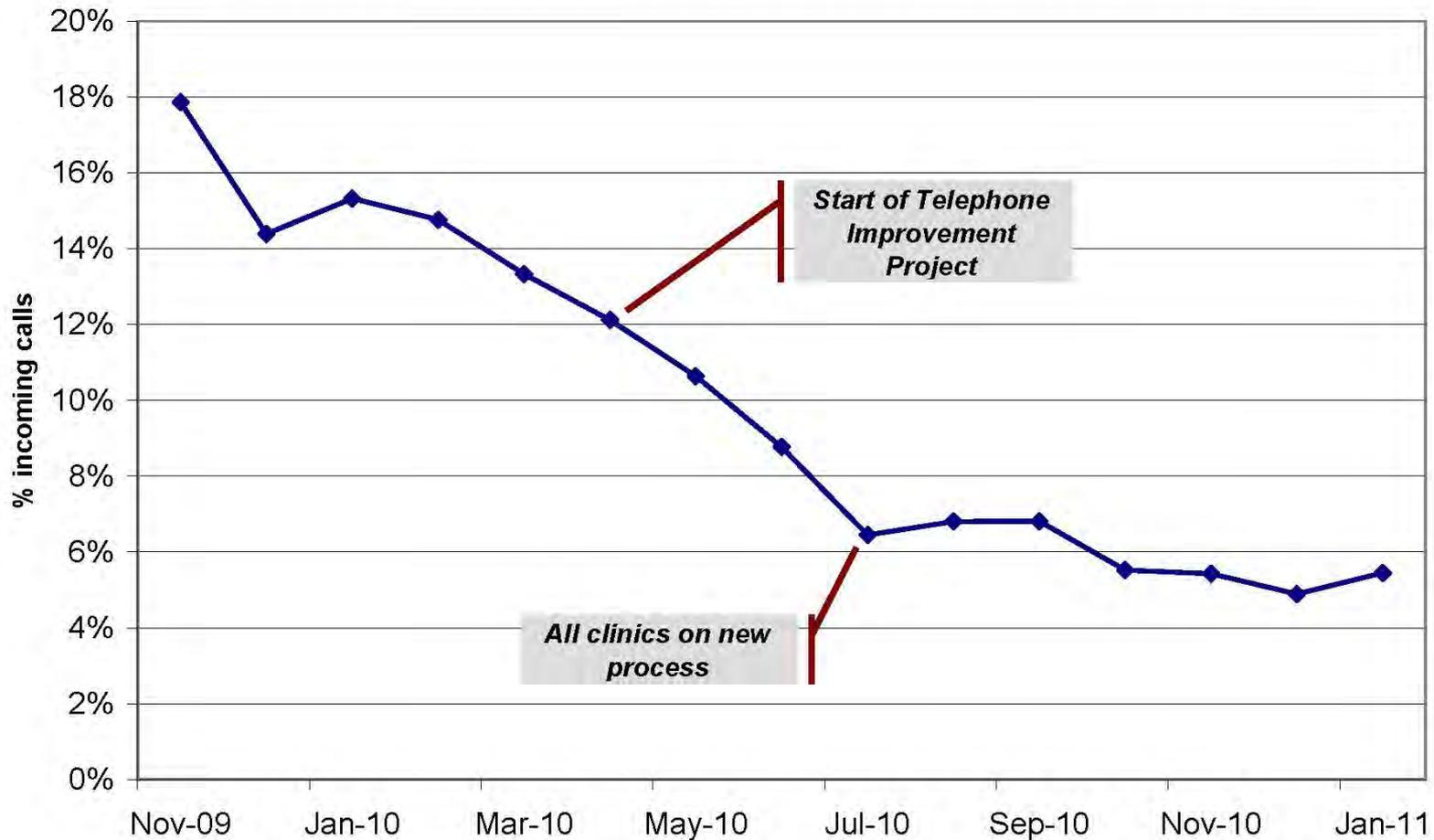
*represents the average # of days until 3 open appointments across all Providers (Med and BH)
on Monday morning*



Primary Care Telephone Responsiveness

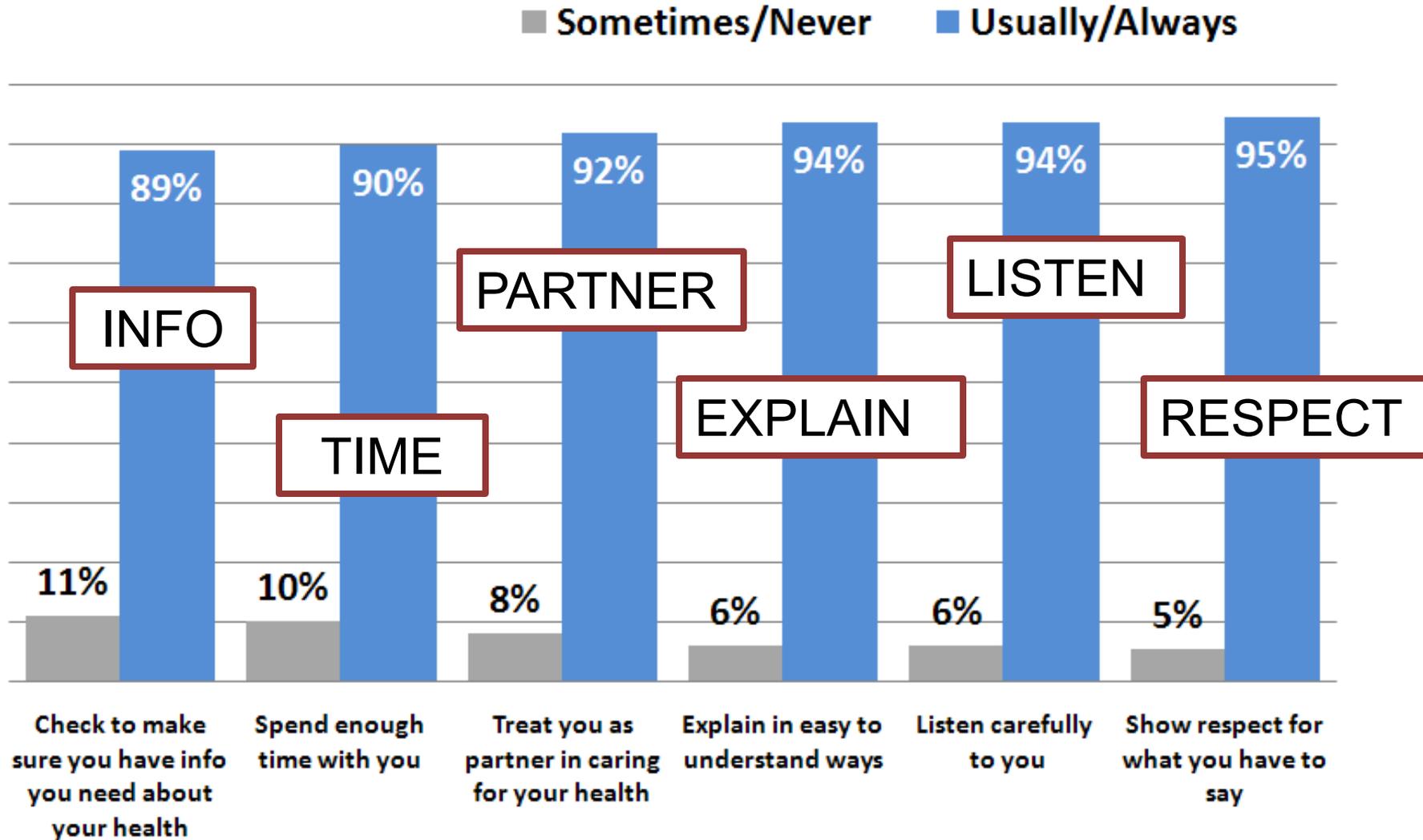
% of Abandoned Calls - All Primary Care

represents the proportion of calls into the clinic where patients hung up before the call was answered

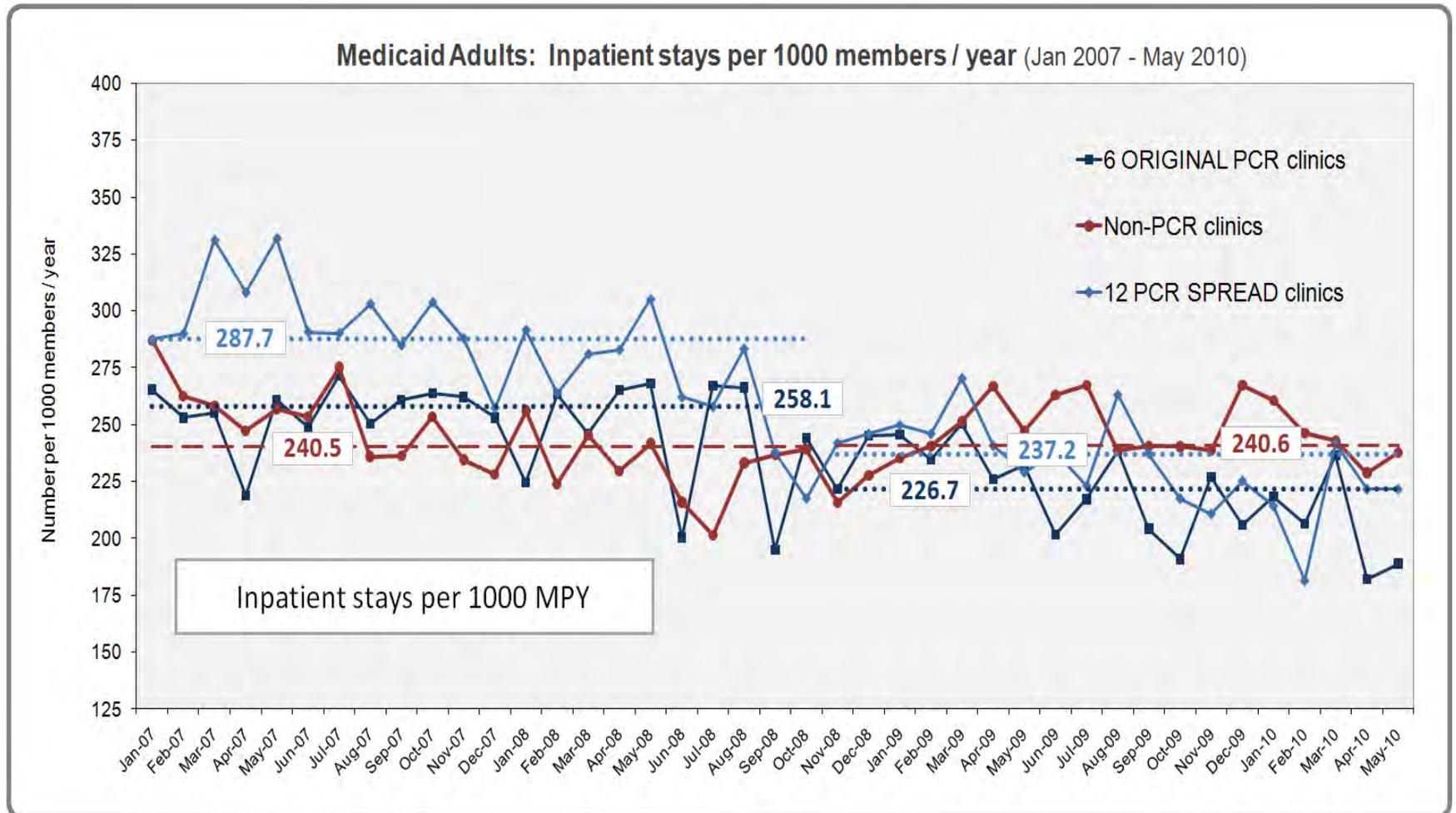


6 Components of Patient Centered Care

In the last 6 months, how often did your health care team:



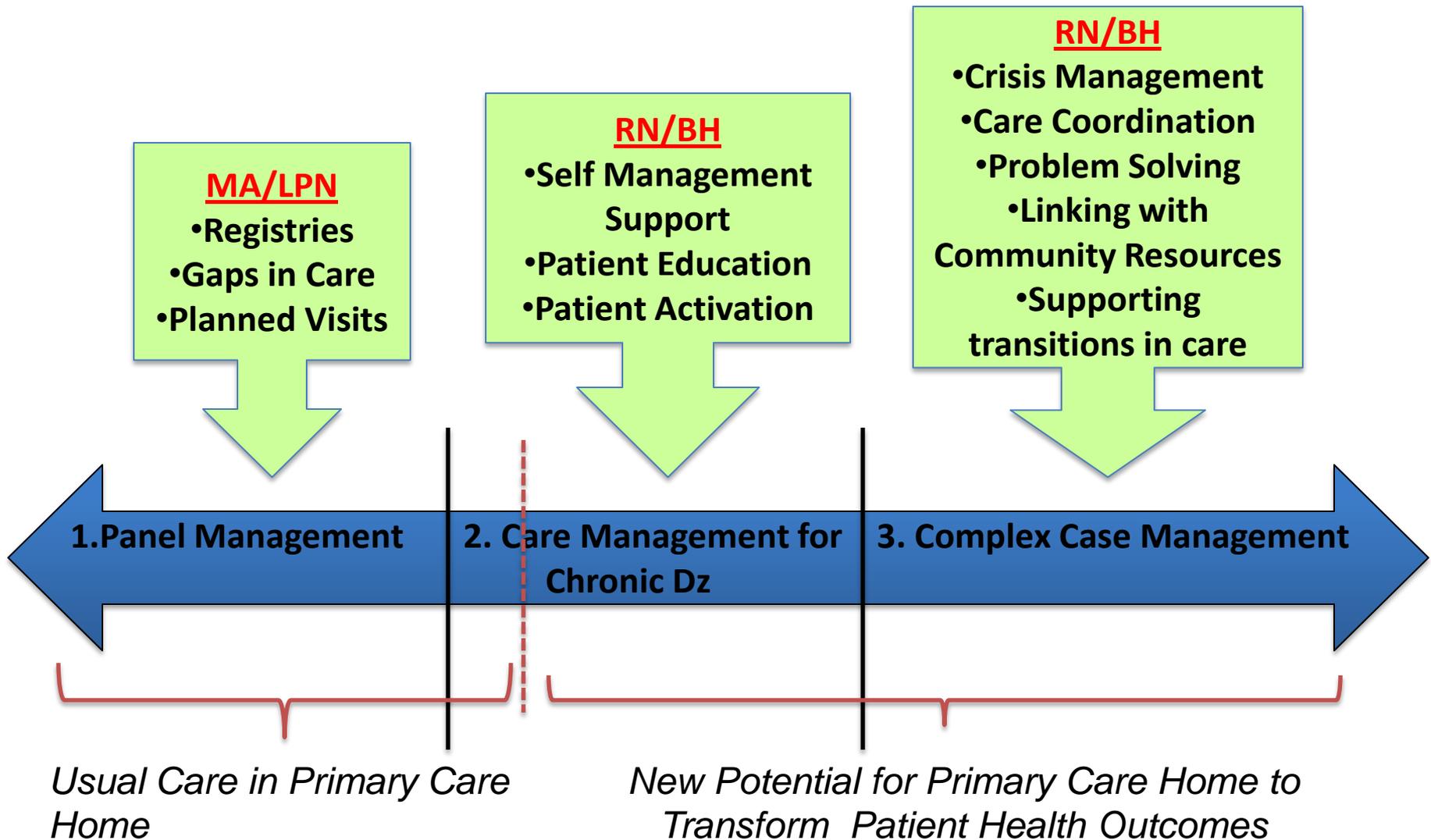
Overall Inpatient Utilization Rate (all-cause)



Co Designed Payment Model

- **2009: Quarterly payments to PCR medical home clinics based on member assigned, risk adjustment**
- **Variable payment based on cumulative scoring:**
 - Tier 1: Pay for participation, reporting
 - Tier 2: Pay for improvement / at target
 - Tier 3: Pay for outcomes (ED, Hospital)
- **2010: Redesign with more accountability**
 - Entry Criteria: Teams, Panels, Reporting Systems established, Workplan (per qrt/ yr)
 - More quarterly metrics (required / optional): continuity, access, clinical, care management metrics with cumulative scoring vs Tiers.
 - Annual Improvement payments: patient satisfaction, utilization (decreased ED, Hosp)
- **Goal: Aligning Payment System with Learning and Improvement**

Primary Care Population Health Strategies



If Transformed Primary Care Can Do It Better...

Putting More “Primary Care” Back Into Primary Care Practice

- How do we shift functions done at the health plan back into Primary Care where they can potentially be done more effectively?
 - “CareSupport” – health plan complex care case management program
 - Shouldn’t this be embedded in Primary Care?
 - Disease Management – telephonic vendor programs vs clinic based self management supports
 - 2010 PCR Care Management Collaborative on depression (IMPACT model) and diabetes

The PCR Approach to Care Management

- Identified key drivers and used them to build the will and capacity
- Led with evidence-based interventions

Depression Care

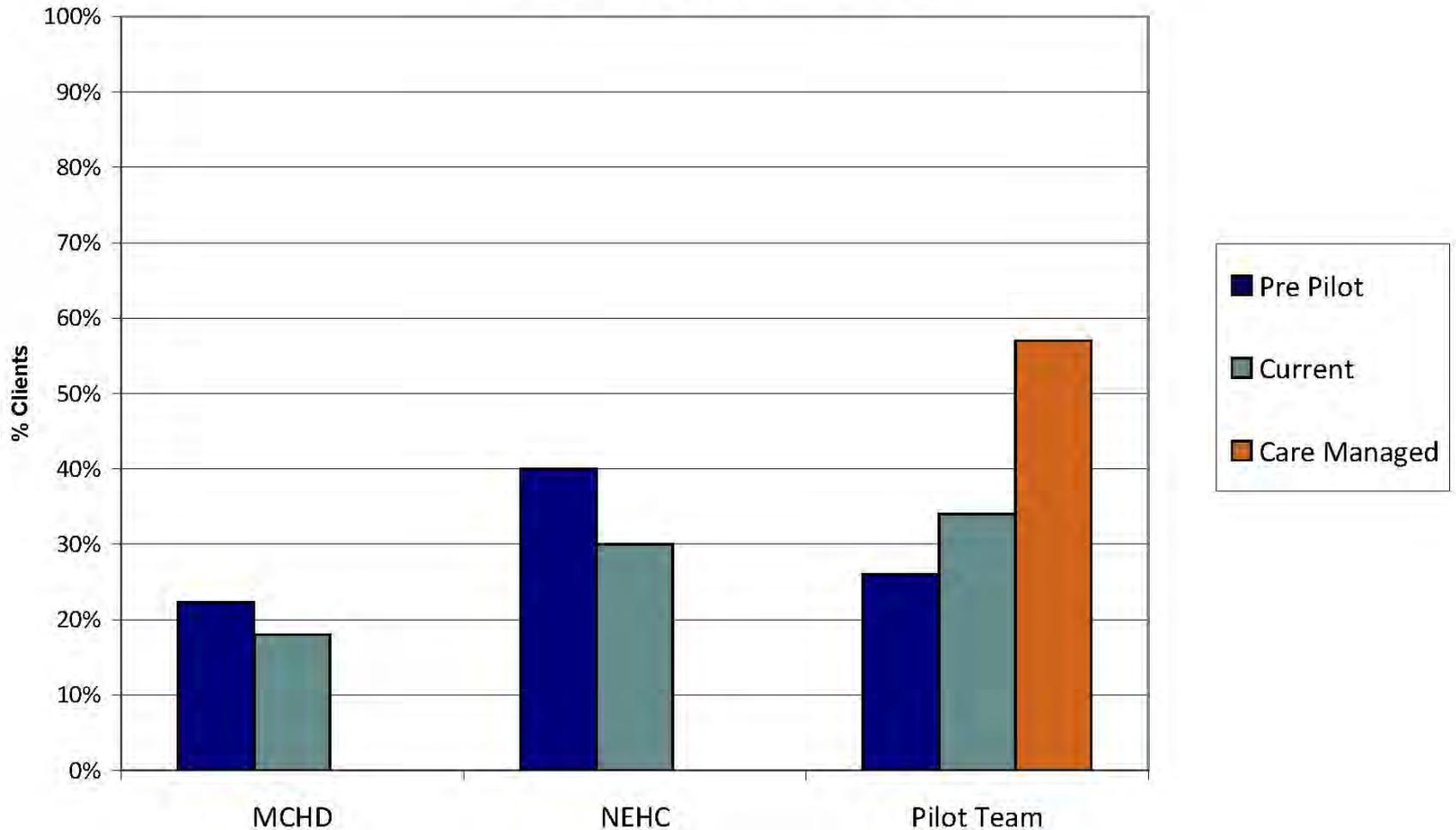


Diabetes Care

- Started with pilots; encouraged site specific clinical leadership
- Behavioral competencies prioritized
- Team learning collaboratives
- Commitment to evolve EMR to support care management practice
- Quarterly reporting of both process and outcome metrics

Early Results: Depression

50% Reduction in PHQ-9
Pre - Post Depression Pilot



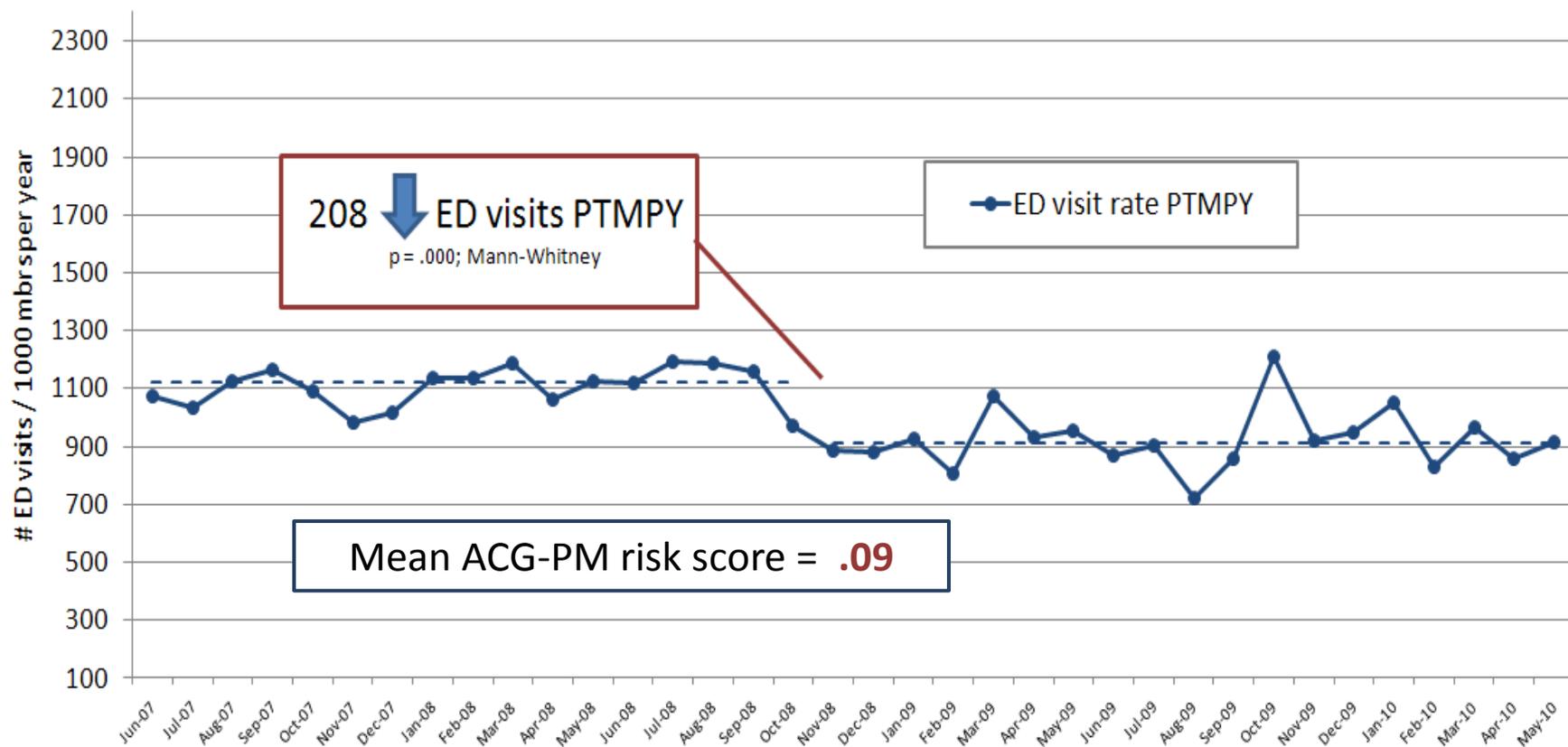
Another Type of Care Management: ED Outreach



Clinic-Specific ED Utilization Rates for CareOregon Members

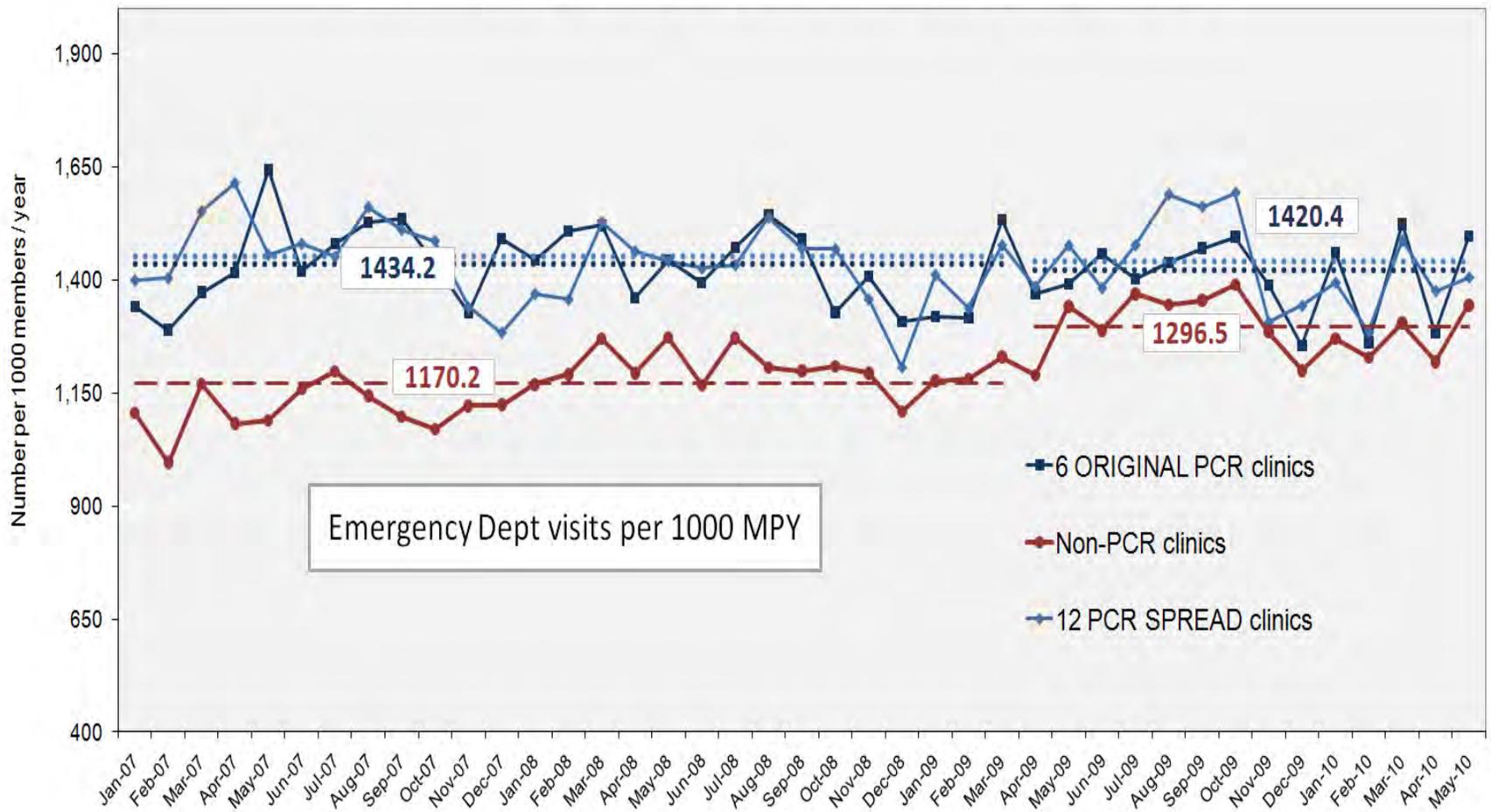
CareOregon Adult Medicaid -- ED visits per 1000 mbrs/per year (June2007 - May2010)

Primary Care Renewal CLINIC #2



Overall CareOregon ED Utilization Rates

Medicaid Adults: ED visits per 1000 members / year (Jan 2007 - May 2010)





The Time is Now

