

Evolving Care Models and Population Management

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- ▶ **TransformMED** is an *independent*, wholly owned subsidiary of the American Academy of Family Physicians.
- ▶ **TransformMED** is *not-for-profit* serving all of primary care.

TransformMEDSM

The TransformMED Patient-Centered Model A Medical Home for All



**A continuous relationship with a personal physician
coordinating care for both wellness and illness**

- Mindful clinician-patient communication:
trust, respect, shared decision-making
 - Patient engagement
 - Provider/patient partnership
 - Culturally sensitive care
 - Continuous relationship
 - Whole person care

Access to Care & Information

- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

Practice Management

- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Practice-Based Services

- Comprehensive care for both acute and chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic & support services
- Ancillary diagnostic services

Health Information Technology

- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

Care Management

- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies

Quality and Safety

- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Care Coordination

- Community-based services
- Collaborative relationships
 - Emergency room
 - Hospital care
 - Behavioral health care
 - Maternity care
 - Specialist care
 - Pharmacy
 - Physical Therapy
 - Case Management
- Care transition

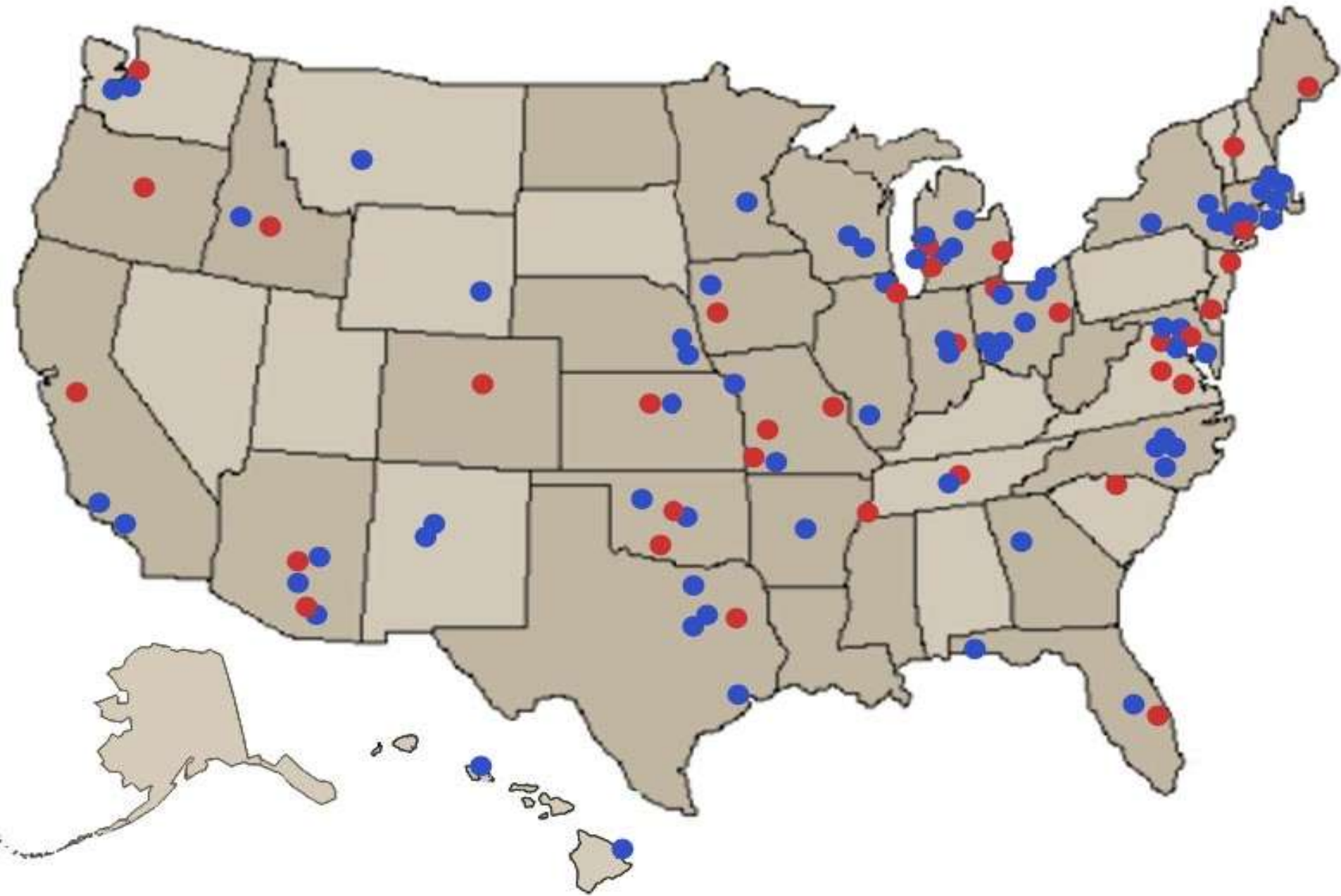
Practice-Based Care Team

- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Why Patient Centered Medical Home

- ▶ The Patient Centered Medical Home creates a **framework** for change.
- ▶ The Patient Centered Medical Home creates a common **language** for change.
- ▶ The Patient Centered Medical Home creates an **opportunity** for change.
- ▶ The framework, language and opportunity for meaningful Care Coordination and Population Management

Project Locations



Viewing Primary Care in a New Light

- ▶ Primary Care as Referral Feeder, Mission Extension
- ▶ Primary Care as Financially Sustainable Portfolio Entity, Future Payment Risk Buffer
- ▶ Primary Care as Vehicle for Care Continuum Integration(Care Coordination), Population Health Improvement

Evolution of Expectations of Primary Care Practices for Effective Care Coordination and Population Management

- ▶ Team-based care
- ▶ Focus on the top of license/training & interest
- ▶ Improved communication
- ▶ Improved data flow & access
- ▶ Right patient at the right time
- ▶ Patient-centered aligned incentives – outcomes, quality, cost
- ▶ Accountability – outcomes, quality, cost

TransforMED Experience

- ▶ Four Critical Success Factors: Teamwork, Leadership, Change Management, Communication
- ▶ Some level of facilitation either in-person or virtual generally required
- ▶ Collaborative learning and peer to peer learning both in person and virtual very powerful
- ▶ Practices require clear roadmaps and vision with structured guidance
- ▶ On-line learning communities clearly have a role
- ▶ Regular feedback on progress “to and from” all stakeholders critical
- ▶ Time and financial efficiencies need to be created

Challenges to Transformation

- ▶ A la carte PCMH—All aspects of the medical home model are interdependent.
- ▶ High value to “touch”—An on-going challenge for small practices.
- ▶ Practices want to be “spoon fed” —“Tell me what to do.” Showing the way and providing resources is often not enough.
- ▶ Concurrent PCMH and EMR makes sense but complexity and variables to manage increase exponentially.
- ▶ “Boots on the ground” staff must be credible and comfortable in practices.
- ▶ Care Management/Care Coordination education

Physician Group Perspective

- ▶ Wary of new payment methodologies
- ▶ Shared savings is viewed as a good thing, but enthusiasm declines proportionate to risk
- ▶ Emerging tensions or at least guardedness related to payers and health systems
- ▶ A desire to “affiliate” rather than sell
- ▶ Biggest concern about technology is loss of productivity
- ▶ “My practice is already a medical home.”

PCMH Value for the Physician



- ▶ Demonstrate the “value” of primary care
- ▶ Improve the quality of care
- ▶ Lower the cost of care to the healthcare system
- ▶ Reduce unnecessary and duplicated care
- ▶ Focus on populations of patients
- ▶ Improve physician compensation
- ▶ Improve work/life balance
- ▶ Allow physicians to do “doctor things”

Challenges to Success

- ▶ Practice Culture
- ▶ Difficulty collecting data—value of self-populating registries
- ▶ Sustainability
- ▶ Patient Satisfaction
- ▶ Importance of aligned incentives
- ▶ Critical need to create time and economic efficiencies (all new money can't come externally)
- ▶ Understanding the concept of “fixed costs”

What is needed going forward?

- ▶ Practice transformation support with payers and health systems serving as “conveners”
- ▶ Aligned payment methodologies
- ▶ New, effective virtual learning environments particularly for small practices
- ▶ Technology that more easily interfaces with the practice environment while supporting care collaboration and population management (secure messaging, self-populating registries)

Observations

- ▶ The healthcare world is changing in ways that we have not seen in our lifetime with the possible exception of Medicare
- ▶ The blurring of chronic disease projects and PCMH projects remains a major challenge
- ▶ The lack of understanding of PCMH by practicing physicians remains a problem
- ▶ The lack of patient engagement remains the “Achilles heel” of PCMH
- ▶ Current PCMH recognition standards measure what can be measured and do not give a complete picture

The Value of Primary Care



One year data from payer pilots has demonstrated that individual practices can provide the same higher quality at lower cost as published data from large integrated systems.

.....because everyone deserves a Medical Home.

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