Aligning Forces for Quality
Planned Care Collaboratives

Local Innovation in Primary Care
October 2011
• Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation’s (RWJF) signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities and provide models for national reform.

$3 Million to York/Adams counties
AF4Q SCPA

• Local Innovation in Primary Care
  – Public Reporting- Community Checkup
  – Ambulatory Quality Improvement
  – Transitions of Care
Patients with diabetes whose LDL cholesterol levels are in good control

HIGHER IS BETTER

% that met the desired result ↓

National Average 45.5% ↓

Community Average 50.2% ↑

<table>
<thead>
<tr>
<th>Office</th>
<th>Result</th>
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<tbody>
<tr>
<td>Biglert Family Medicine</td>
<td>90%</td>
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<tr>
<td>Qaryland Medical Center</td>
<td>85%</td>
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<tr>
<td>Michael T. Stenman, DC, LLC</td>
<td>80%</td>
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<td>Shrewsbury Family Practice</td>
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<td>Brockie Internal Medicine Consultants</td>
<td>73%</td>
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<td>York Hospital Community Health Center</td>
<td>71%</td>
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Pyramid of Primary Care Practice Excellence

Payment Reform

Planned Care Collaborative

Physician Clinician Learning Network & RWJF AQN

Quality Forum Newsletter & periodic QI improvement webinars

www.aligning4healthpa.org website
(PCMH practice change materials and resources available)

Consumer Engagement
Planned Care Collaboratives 1 and 2
2010 and 2011

- Yorktowne Family Medicine
- York Hospital Community Health Center
- East Berlin Family Medicine
- Brockie Internal Medicine
- Gettysburg Adult Medicine
- WellSpan Endocrinology - York
- Pinchot Family Medicine
- WellSpan Lung, Sleep, Critical Care
- Partners in Family Medicine
- Apple Hill Internal Medicine
- Thomas Hart Family Practice
- Fairfield Family Medicine
- Herrs Ridge Family Medicine
- WellSpan Endocrinology - Adams county
- Biglerville Family Medicine and Adams Cumberland Family Medicine

7,000 People with Diabetes
11,200 with DM
72,000 Total People
122,000 Total
Planned Care Collaborative

• Patient Centered Medical Home

• Process Improvement methodology - coaches

• Measure and improve quality

• Patient Partners
An approach to primary care that emphasizes partnership with the patient and, as appropriate, the patient’s family.

The foundation is the patient’s ongoing relationship with a personal physician and care team who takes the lead in coordinating the patient’s health care.

Expected to reduce preventable hospitalizations, hospital readmissions, and emergency room visits while improving health outcomes and reducing the cost of health care services.
Planned Care Collaborative

• How do we do this, when we feel like this?
Process Improvement Coaches

- AF4Q Planned Care Coordinator
  - Rush Gross
- SKF in Hanover
  - Matthew Metz
- McClarin Plastics, Inc. in Hanover
  - Scott Crandall
- WellSpan Health
  - Patrick Ball
  - Ron Benenson, MD
  - Deb Englar
  - Diana Karas
  - Sandy Tompkins
  - Sandy Abnett (assistant)
- Cindy Mattern
- Bill Gordon
Create a Structure that Supports Change

Practice Leadership Team (physician, clinical leader and office manager) meets regularly to plan and evaluate small tests of change.

Communication between the practice leadership team and all staff and providers in the practice regarding improvement opportunities is an ongoing process.
Planned Care Collaborative Process Improvement Coaches

• “Make some room on the plate”
• Waste Reduction Prioritization Tool
  – *What prevents you from providing quality care to your patients?*
• Capture Current State
  – Process flow map from the patient perspective
• High level observations to capture variation
Current State Process Flow

Patient Process Flow – Pt arrival to Exam Room

Pt arrives and checks in at registration desk

LPN preps room for the visit

LPN sees that a pt has arrived via computer entry

Registration notifies the unit that pt has arrived

Is the room ready?

NO YES

Is the paperwork available?

NO YES

Waste is occurring. Nurse has a 50% chance of finding the right registration desk

LPN gathers paperwork and calls for pt by name

LPN verifies pt with two identifiers

Pt is escorted to the appropriate unit

Pt's weight and height is taken

Pt is taken to the exam room

Registration
notifies the unit that pt has arrived

Pt is preps room for the visit

LPN walks to the registration desk for paperwork

LPN walks across hallway to other registration desk

14 Steps ➔ 9 steps

Is there a standard procedure for when a room is cleaned and prep for next patient?
KanBan in Supply Closet
Applying KanBan to Vaccine Center
Measure and Improve Quality
Diabetes - BP< 140/90

Planned Care Collaborative 1

Axis Title

- BROCKIE IM
- EAST BERLIN FM
- GETTYSBURG ADULT MEDICINE
- YORK HOSP COMM HLTH CTR
- YORKTOWNE FM
- TARGET
- PCC2 Average

Measure and Improve Quality
Diabetes - yearly urine test
How Much Illness and Death could be Avoided in York and Adams Counties?

- **15,000** Number of patients with diabetes
- **25%** Percent of patients whose A1c > 9%

<table>
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<tr>
<th>Target A1c Range</th>
<th>Complications</th>
<th>Deaths</th>
<th>Myocardial Infarctions</th>
<th>Amputations or Deaths</th>
<th>Microvascular Disease</th>
<th>Heart Failure</th>
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<td>8 - 9%</td>
<td>179</td>
<td>16</td>
<td>28</td>
<td>39</td>
<td>0.018</td>
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<td>7 - 8%</td>
<td>226</td>
<td>29</td>
<td>20</td>
<td>46</td>
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<td>6 - 7%</td>
<td>332</td>
<td>72</td>
<td>62</td>
<td>48</td>
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Patient Partners

- 2 patients per practice
- Training/empowerment
- Monthly Patient Partners’ meetings
- Dinner Learning Sessions with Practices
- Join their practice leadership team for monthly meeting
Patients

Practice Leadership Team (physician, clinical leader and office manager) meets regularly to plan and evaluate small tests of change.

Communication between the practice leadership team and all staff and providers in the practice regarding improvement opportunities is an ongoing process.

PI Coach

Patients
Planned Care Collaborative

Potentially avoidable ED visits and hospitalizations
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<th>MRN</th>
<th>Discharge Date</th>
<th>Principal Diagnosis</th>
<th>Primary Care Physician Group</th>
<th>Sex</th>
<th>Patient Zipcode</th>
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Planned Care Collaborative 2: 35 patients with 43 admissions
Planned Care Collaborative 2
2010 Admissions to York Hospital and Gettysburg Hospital for Lower Extremity Amputations (patients with diabetes)

<table>
<thead>
<tr>
<th>MRN</th>
<th>Discharge Date</th>
<th>Principal Diagnosis</th>
<th>Primary Care Practice</th>
<th>ICD9 Procedure</th>
<th>Patient Age</th>
<th>Inpatient Charges</th>
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<td>Septicemia, MSSA Staph Aureus (03811)</td>
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Performance Matters

- Two Examples of Payment Reform Pilots in York and Adams Counties

1. PA Chronic Care Initiative pilot with Medicare PCMH pilot joining in January 2012
   - Brockie Internal Medicine
   - Gettysburg Adult Medicine
   - White Rose Family Practice
   - Apple Hill Internal Medicine**
   - Family First Health**

2. Highmark PCMH Pilot- started June 2011
   - East Berlin Family Medicine
   - Biglerville Family Medicine/ Adams Cumberland Family

** Non-compensated practices
Practice 1:
1165 Medicare Beneficiaries

Trends of Potentially Avoidable Hospitalizations and ER Visits
(Rate per 100 beneficiaries): 7/1/2007 to 6/30/2010
Practice 1:
Average Annual Medicare Payment/FFS Beneficiary

Trends in the Average Annual Medicare Payments per FFS Medicare Beneficiary: 7/1/2007 to 6/30/2010
Practice 1:
Average Annual Medicare Payment/Beneficiary

Average Annual Medicare Payment per Beneficiary: 7/1/2009 to 6/30/2010

Matched non-NCQA PCMH Practices
(age, sex, disabled, severity of illness, Medicaid, etc.)
Practice 2:
756 Medicare Beneficiaries

Trends of Potentially Avoidable Hospitalizations and ER Visits (Rate per 100 beneficiaries): 7/1/2007 to 6/30/2010
Practice 2: Average Annual Medicare Payment/FFS Beneficiary

Trends in the Average Annual Medicare Payments per FFS Medicare Beneficiary: 7/1/2007 to 6/30/2010
Practice 2:
Average Annual Medicare Payment/Beneficiary

Average Annual Medicare Payment per Beneficiary: 7/1/2009 to 6/30/2010

Matched non-NCQA PCMH Practices (age, sex, disabled, severity of illness, Medicaid, etc.)
AF4Q SCPA

• Getting to Value (increased quality/ decreased ED visit and hospitalizations → decreased costs)

• Pay for quality and value, not volume