PCMH Staff Model

Trends and Options

HEALTH CARE ADVISORY BOARD

About the Medical Home Project

The Medical Home Project in Brief

The Health Care Advisory Board's ongoing research collaborative on the medical home (PCMH)

- 450+ provider organizations
- Continuous research into PCMH problems and solutions
- Special initiatives, events, benchmarks, tools, and expert support
- HCAB members may participate at no additional cost

Getting started: Contact your relationship manager, visit www.advisory.com/hcab/medicalhome, sign up for The Blueprint blog, or e-mail Amanda Berra at BerraA@advisory.com

Top 5 MHP Resources to Date

1. "Transforming Primary Care" (Best practice study)
2. Innovator Spotlight Webconferences
   - "Launching 45+ Medical Homes" (Baylor)
   - "Elevating Staff to Top of License" (Kaiser NW)
   - "Training Health Coaches" (Mercy Clinics Inc.)
3. Medical Home Contracting (Resource guide)
4. Health Coach Financial Impact Calculator (Tool)
5. Primary Care/Medical Home Benchmarking Initiative (Custom reports and white paper)

2012 Year Ahead: Upcoming Work in the MHP

Medical Homes in the System Setting

The ROI of the Medical Home

Optimizing Medical Home IT

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Road Map for Discussion

I	PCMH Workflow: A Departure from the Status Quo
II	Snapshot of PCMH Task Owners
III	Reinventing the Clinic Team: Three Cases

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Establishing a Working Definition of "Medical Home"

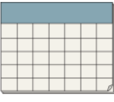
Breaking It Down to Fundamentals

The Medical Home Model

Primary Care Practice

Comprehensive Care

Patient Engagement

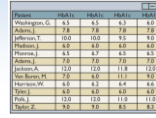


Enhanced Access

Coordinated Care

Team of Providers

Non-physician providers support medical home's ability to provide additional services



Disease Registry

Provides patient metric data to track and monitor patients for improved management

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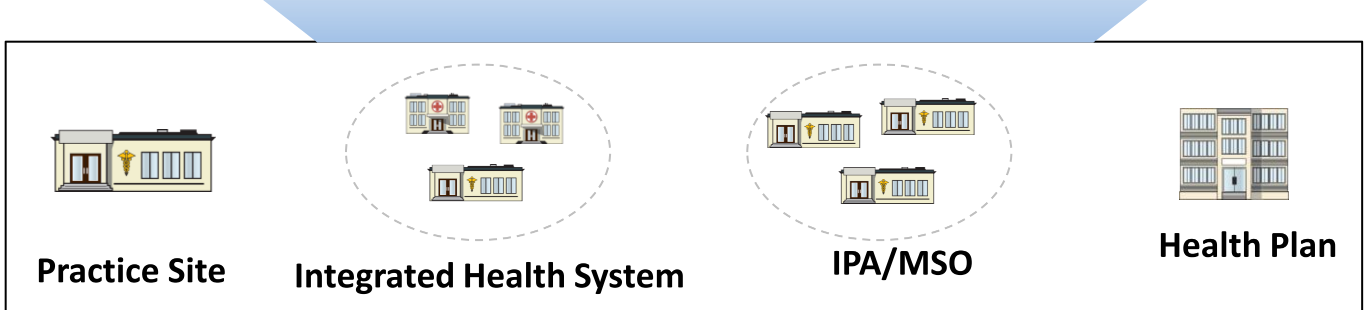
Source: Health Care Advisory Board interviews and analysis.

"Where Does the Function Live?" A Separate Question

PCMH Functional Configuration Differs Across Organizations

Potential Functional Owners in Any Given PCMH Site

PCMH Function	Care Team Leadership	IT Platform	Care Plan Monitoring	Care Coord.	Health Coaching	PCMH assessment metric selection	Consumer/ Employer Branding
Owner		?	?	?	?	?	?



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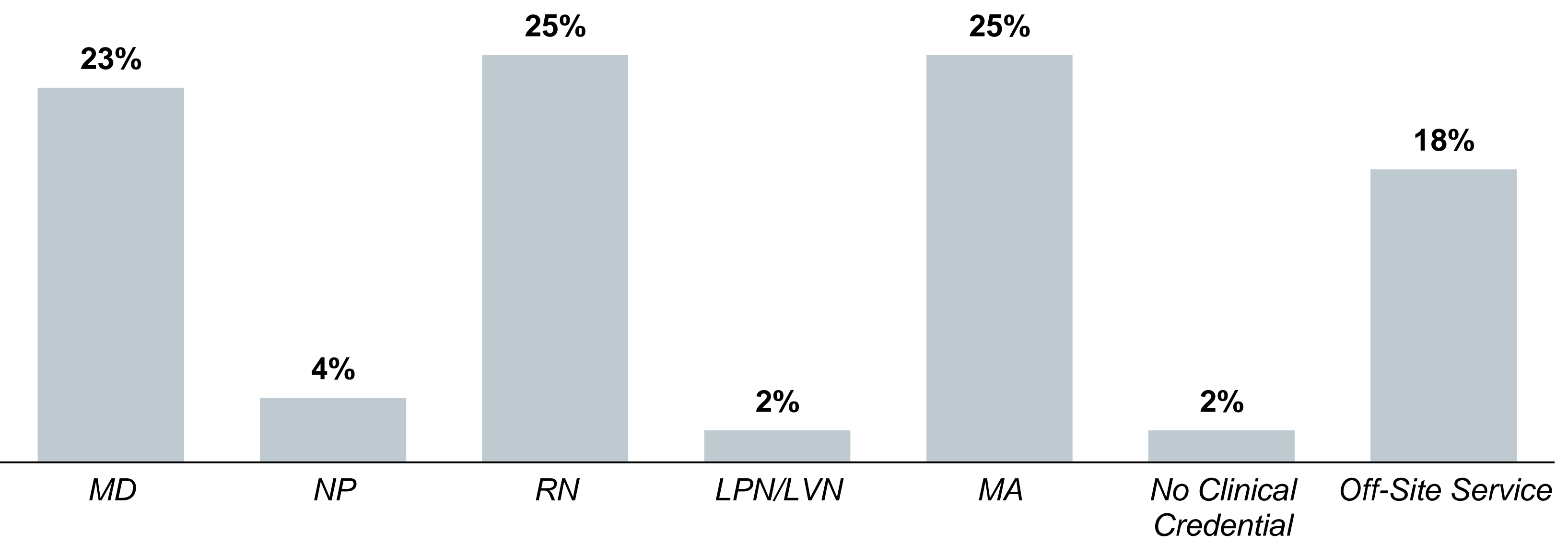
Diverse Model for Patient Self-Management Support

Primary Owner of Patient Self Management Support, by Clinical Credential

N=55 medical home sites



Source: Advisory Board Medical Home Project "2011 Primary Care/Medical Home Benchmarking Initiative"

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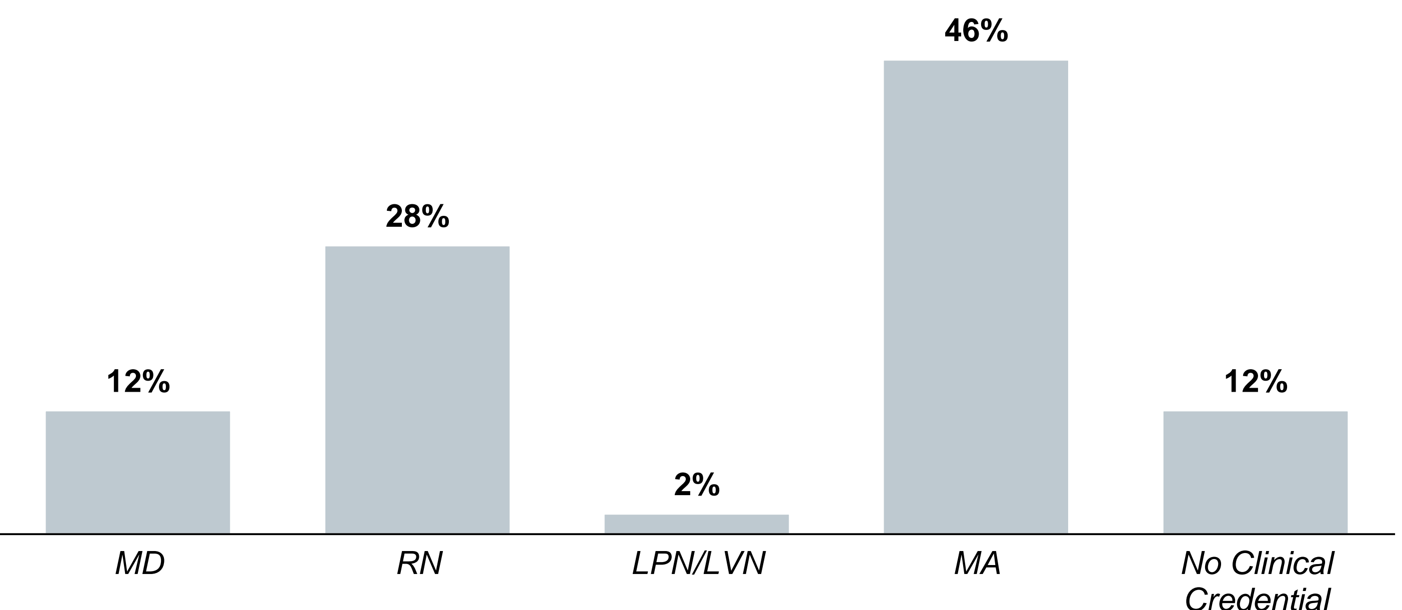
No Outsourcing Pre-Visit Chart Review



Source: Advisory Board Medical Home Project "2011 Primary Care/Medical Home Benchmarking Initiative"

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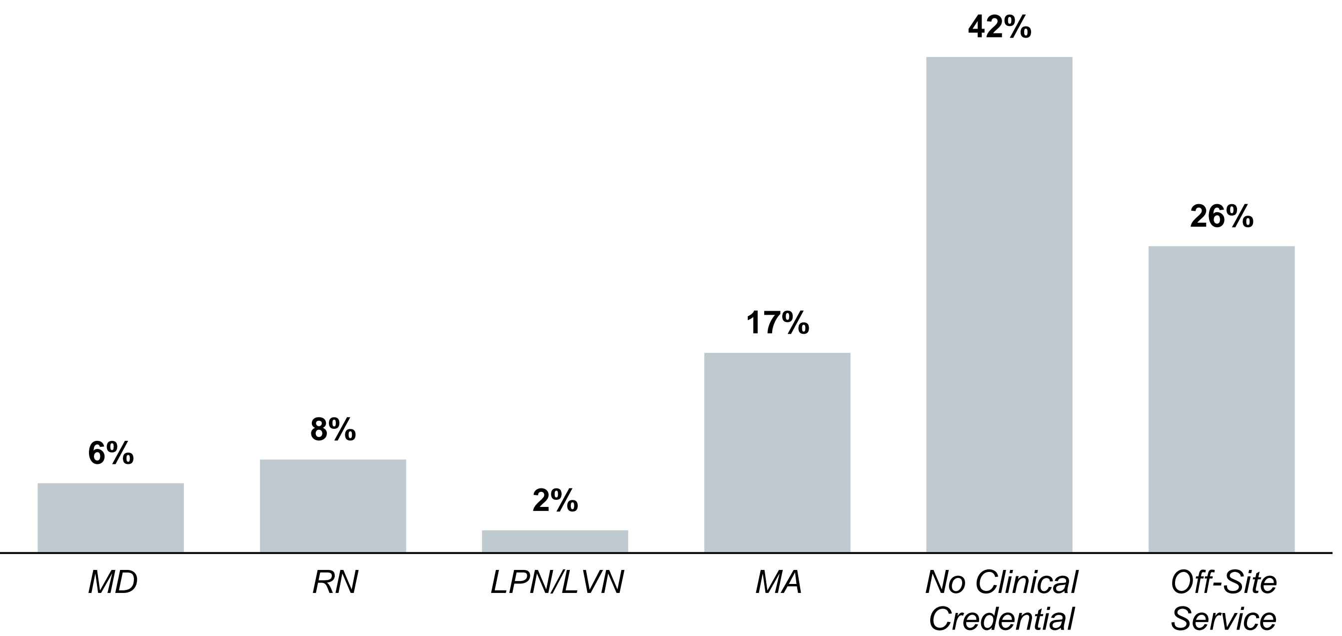
Offloading and Outsourcing Data Entry



Source: Advisory Board Medical Home Project "2011 Primary Care/Medical Home Benchmarking Initiative"

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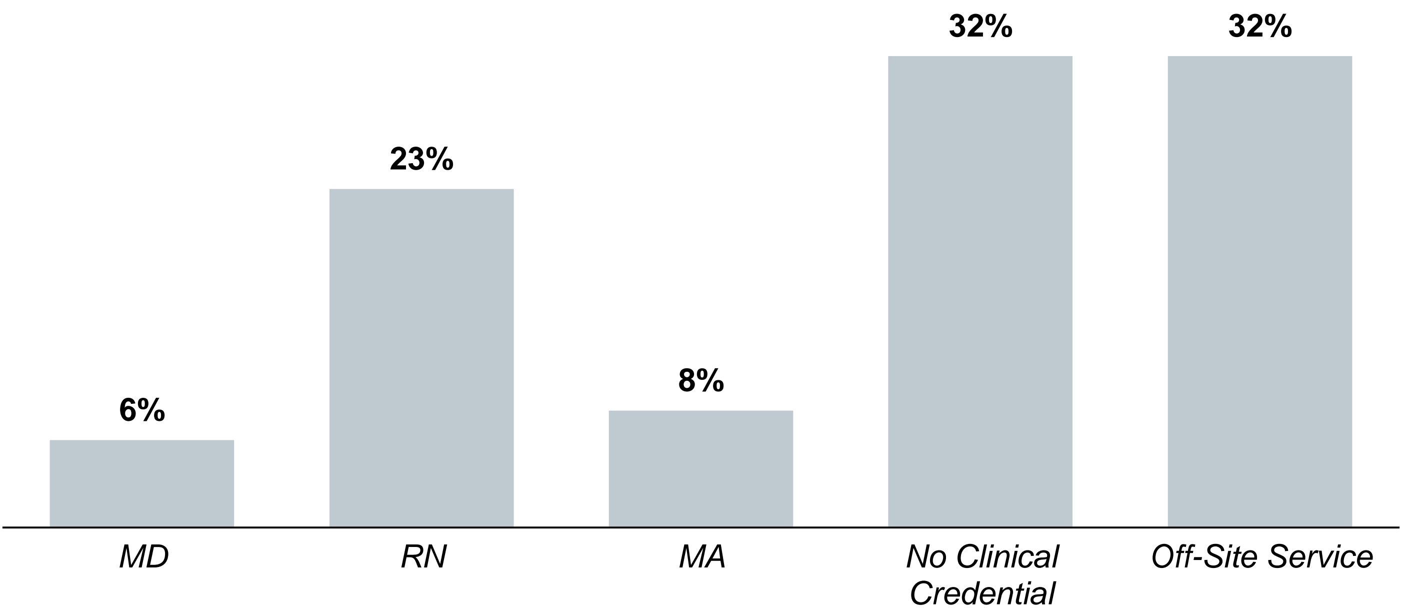
Bringing in Specialized Expertise in Analysis

Primary Owner of Population Management Data Analysis, by Clinical Credential

N= 55 medical home sites



Source: Advisory Board Medical Home Project "2011 Primary Care/Medical Home Benchmarking Initiative"

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Road Map for Discussion

I PCMH Workflow: A Departure from Status Quo

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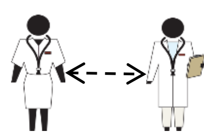
Three Basic Options for PCMH Staff Model

Options Not Mutually Exclusive

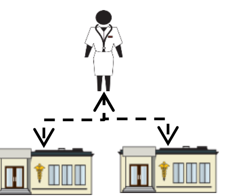
Diffused Across Existing Staff

- All existing in-office staff change current work duties to support medical home process changes, services
- Need for more efficient care processes and workflow so medical home efforts do not mean additional work on top of "regular" job duties



Dedicated Staff Member

- Centralize majority of medical home services in single office staff member, usually an RN
- Transitioning current staff member to this role often speeds process of practice transformation, but prior position will need to be backfilled



Outsourced Resource

- Referring, accessing care team support functions from a system or network level entity instead of providing services within practice walls
- Examples from health system include chronic disease centers of excellence, centralized care management

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Source: Health Care Advisory Board Interviews and analysis

Exemplifying the RN Health Coach Model

Case in Brief: Mercy Clinics, Inc.

- 150-physician group, 70% primary care physicians, employed by Mercy Medical Center in Des Moines, Iowa
- Launched health coach program in 2002
- Target patient population started with better management of diabetic patients, has expanded to include other chronic conditions (such as asthma) as well as better management of preventive needs across the entire patient panel
- Each clinic started with one health coach, role expanded at each site to best meet clinic needs. Building up to a 1:1 coach-to-physician ratio
- PCPs, paid on a revenue less expenses compensation model, able to support the medical home model in the current fee-for-service environment, realizing nearly a 4:1 return on health coach FTE investment.

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Source: Health Care Advisory Board interviews and analysis

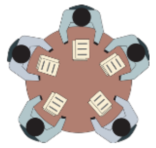
Mercy Health Coaches Spearhead PCMH Transformation

Health Coach Complement Overview

Mercy Clinics, Inc.

28 full time health coaches; every clinic has at least one

Specialized health coaches
- Pediatric health coach (1)
- Stroke health coach (1)
- Hospital transition health coach (1)



All coaches complete formal 28-hour training
- Ongoing support offered through two-hour group meetings monthly to share challenges and tactics

Health Coach Responsibilities
- Manage disease registry
- Conduct pre-visit chart review
- Provide patient self-management support
- Coordinate care across continuum
- Support quality improvement activities

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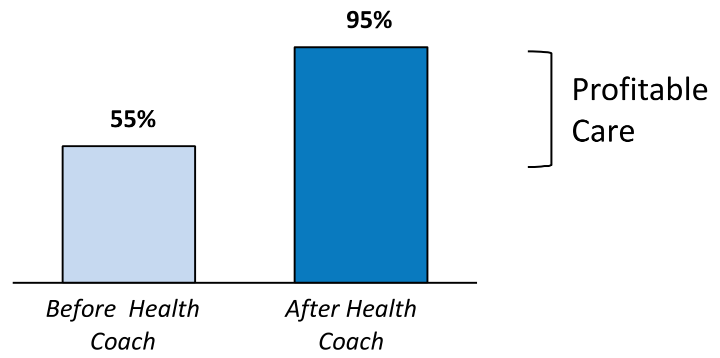
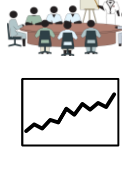
Sustainable Care Transformation Under Fee-for-Service

Finding the Business Case for Health Coach FTEs at Mercy Clinics



Components of Health Coach Business Case



- Increased Office Visit Revenue
- Increased Lab Revenue
- Increased Clinician Productivity
- Shared Medical Appointments
- Pay-for-Performance Capture

Case in Brief: Mercy Clinics, Inc.

- 150-physician group, 70% primary care physicians, employed by Mercy Medical Center in Des Moines, Iowa
- Health coach activities improve compliance and documentation for chronic patients, especially diabetics, enabling higher level E&M billing, increased clinician productivity, and more PCPs achieving existing pay-for-performance bonuses
- Each practice, responsible for own profit and less, saw 4:1 return on hiring health coaches

1 Chronic and preventive care.

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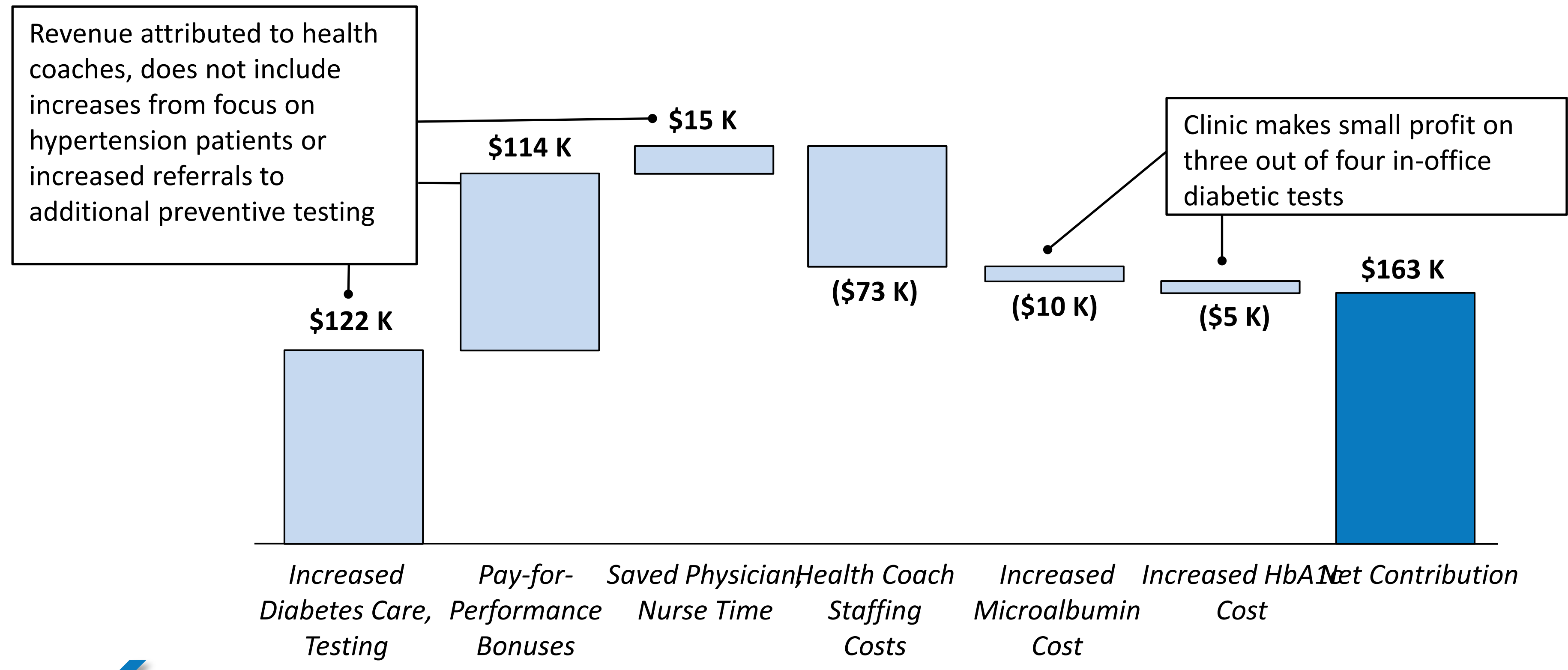
Source: Swieskowski D, "Improving Chronic Care: Health Coaches & the Business Case," available at http://www.idph.state.ia.us/hcr_committees/common/pdf/prevention_chronic_care_mgmt/improvigchronic_care_presentation.pdf, accessed August 31, 2009; Health Care Advisory Board interviews and analysis.

Nearly a 4:1 Return on Care Team Investment

Health Coaches Supporting Medical Home Model in Fee-for-Service Environment



To help assess the financial ROI from adding a health coach to your PCP practice(s), please see the Medical Home Health Coach Practice Impact Calculator available at www.advisory.com/hcab/medicalhome

Source: "Mercy Clinics: The Medical Home," *Group Practice Journal*, April 2008; Health Care Advisory Board interviews and analysis.

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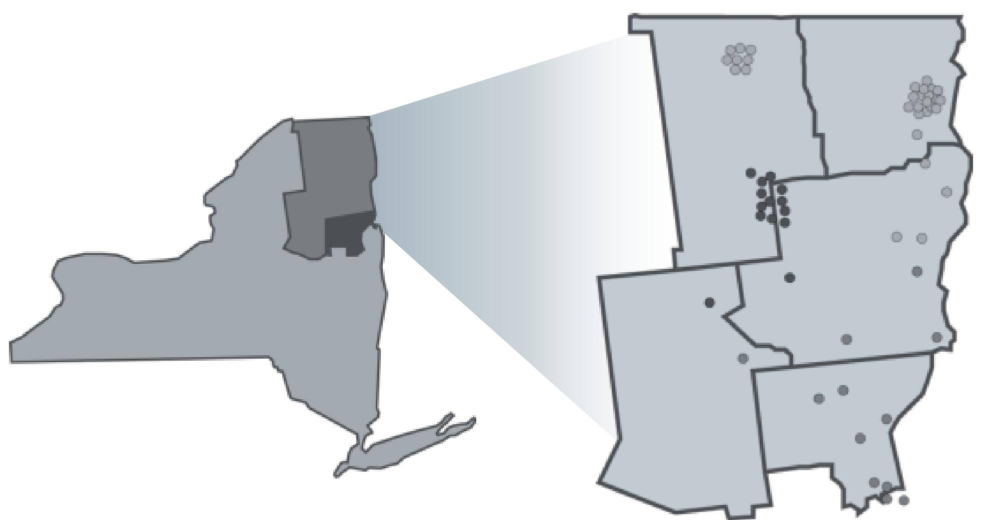
Centralized Care Management for PCMH Sites

The Adirondack Medical Home Pilot

Adirondack Region of Northern New York



Case in Brief: Adirondack Medical Home Pilot

- Five-year pilot to generate health care value in Adirondack region of Northern New York
- Key objective is to transform physician practices into NCQA recognized medical homes
- Launched in January, 2010; previously codified by New York state legislature in 2009
- Supervised by both New York Department of Health, Department of Insurance

Source: "Adirondack Region Medical Home Pilot," http://adkmedicalhome.org, accessed May 3, 2011; Health Care Advisory Board interviews and analysis.

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Committing to Substantial Practice Redesign

PCPs Agree to Major Changes in Practice Operations, Investments

Key Requirements to Join Pilot

Achieve medical home recognition (level 2 or level 3)

Accept assignment as patients' personal provider

Implement same day access

Adopt EMR with e-prescribing system

Implement evidence-based care

Create disease management supports

Coordinate care across continuum

Join regional health information exchange

Participate in quality measurement and improvement activities

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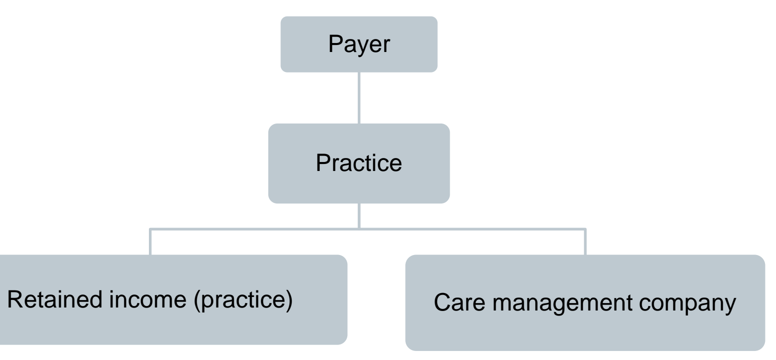
Rewarding Primary Care Transformation

Twin Funding Strategies Subsidize Practice Investments, Stabilize Income

Care Management Fees From Payers

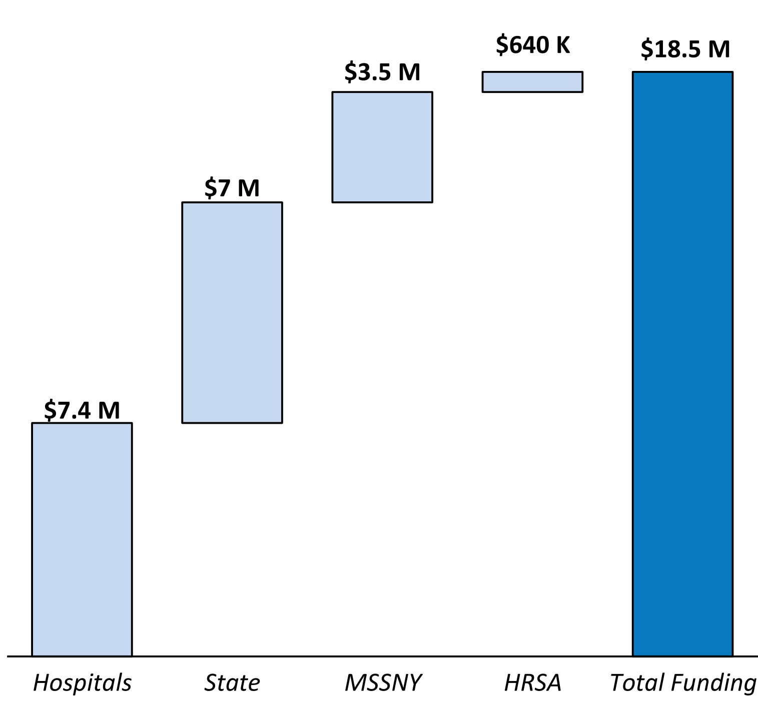
Bolstering Practice Economics



Year	Total Medical Home Payments	Average Payment Per Physician (Before Fees to Care Management Co)
2010	$8.74 M	$85,650
2011	$10.50 M	$103,000

Grant Funding

Supporting Health IT, Infrastructure Investments



Source: Burke, G and Cavanaugh, S. "The Adirondack Medical Home Demonstration: A Case Study," United Hospital Fund, 2011; Health Care Advisory Board interviews and analysis.

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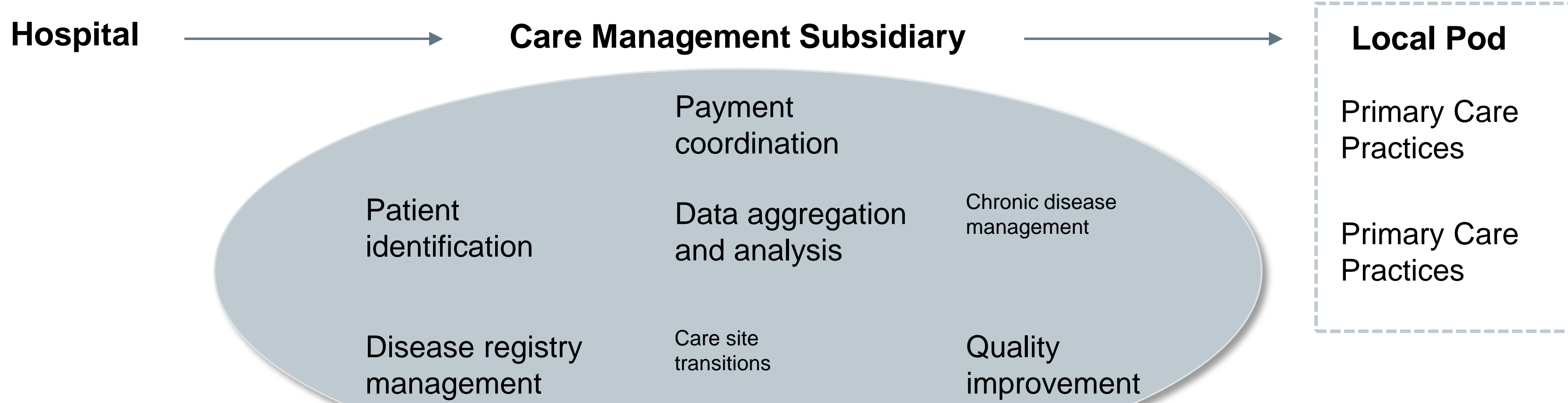
Building a Scalable Care Management Infrastructure

"Pods" Distribute Care Management Costs Across Practices



Program in Brief: Care Coordination "Pods"

- PCP practices organize into three local pods for provision of care management services
- Hospitals form subsidiary care management companies, lease services to pods
- Pods pay either portion of PMPM or fee-for-service rate to care management company
- Structure allows hospitals to create scalable, sustainable care management model

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Particular Focus on Transitional Care

Targeted Support Services, Care Navigation for 30-60 Days Post Discharge

Adirondack Pilot Transitional Care Program

Care management nurses pick highest-risk admitted patients

Meet patients in hospital for discharge planning

Medication reconciliation with pharmacist

48-72-hour phone call or home visit follow-up

Primary care appointment within two weeks

Appointment rate currently about 60%

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Many Strategic Decisions to Make

PCMH Flexibility Gives Great Leeway in Model Design

	Areas of Diversity Among PCMH Sites
✔	IT solutions, degree/extent of care standardization, and use of both in day-to-day practice workflow
✔	Approaches to improving patient access (e.g., hours, non-face-to-face channels, dedicated team members
✔	Patient segmentation/population focus (e.g., which conditions/populations/patient profiles to focus on; and/or what degree of total risk segmentation to do)
✔	Approaches to health coaching and care management (e.g., decentralized across practices, or centralized support from system, network, or health plan)
✔	Staff model: Number/type of clinical support staff members, job descriptions/scope of practice, and role in day-to-day workflow

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