PITTSBURGH REGIONAL HEALTH INITIATIVE
Spreading Quality, Containing Costs.

EXECUTIVE SUMMARY

February 2010

PRIMARY CARE IN THE SPOTLIGHT

Although debate over pending federal healthcare legislation continues, the crucial importance of better primary care has clearly been accepted by policymakers across the political spectrum. Whatever the final legislative outcome in Washington, D.C., strengthening primary care – through physician reimbursement, medical education, health information technology, and coordination of care — will be a central feature. This issue of *Executive Summary* summarizes PRHI's and southwestern Pennsylvania's singular series of initiatives to bolster primary care, and describes how they complement each other and support projects aimed at spreading and sustaining breakthrough improvement.

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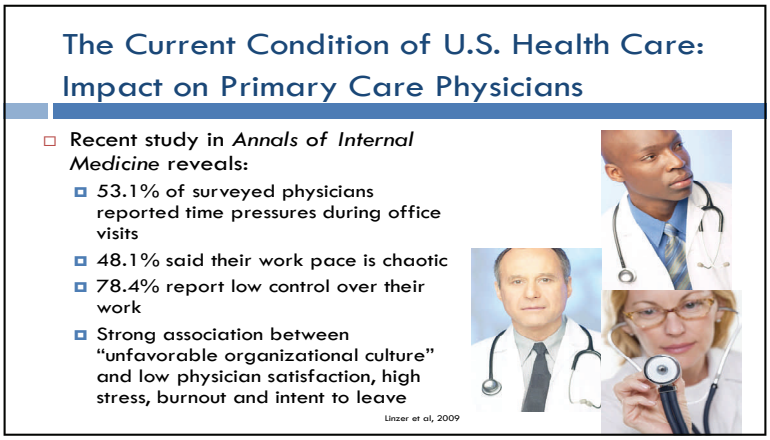

PRHI is creating in our region a national center for primary care practice transformation. As discussed further below, PRHI and its partners are also making southwestern Pennsylvania into a locus for exploring promising new reform concepts through innovative regional pilots and demonstrations.

A CENTER OF PRIMARY CARE INNOVATION

The starting point was PRHI's 2008 application on behalf of southwestern Pennsylvania that led to the region's selection as one of just four sites for the Centers for Medicare and Medicaid Services (CMS) EHR Demonstration. Competition for this designation was very intense, but PRHI's submission was selected from among scores of applicants.

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IN THIS ISSUE:

PRHI's Center for Perfecting Patient Care℠ has been approved by the Pennsylvania State Nurses Association as a provider of continuing education.

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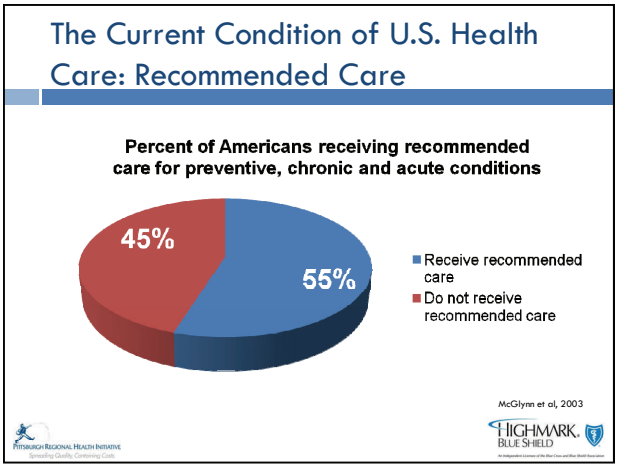

Through a series of groundbreaking projects conceived and undertaken during the past two years, the Pittsburgh Regional Health Initiative (PRHI) has put southwestern Pennsylvania into the national forefront of transforming primary care, particularly among smaller private practices and federally qualified health centers (FQHCs). PRHI and its strategic partners are currently engaging more than 1,200 primary care providers through 300+ small private practices and one dozen FQHCs and look-alike community health centers. These projects have the potential to leverage more than $100 million in additional public and private payments to help affected providers implement health information technology and adopt redesigned work processes for better performance and patient outcomes.

Attendees at the CMS EHR Demonstration Project Kickoff in Pittsburgh in May 2009.

As Dr. David Blumenthal, the National Coordinator for Health Information Technology (ONC) and a distinguished internist, asserts at every opportunity, EHR "meaningful use" will require physicians to modify everything they do, from how they make medical decisions to how they document patient encounters to how they interact with colleagues and patients. Large, vertically integrated health systems have internal structures and resources to support adoption and meaningful use of sophisticated health information technology.

However, notwithstanding the substantial financial incentives, small private practices, FQHCs and look-alike community health centers – which deliver the majority of outpatient care – are generally unready to implement electronic health records and new work processes rapidly.

In southwestern Pennsylvania, PRHI has committed itself to be the principal resource and conduit for the help that these provider organizations will need. PRHI and its strategic partners have developed a singular group of practice improvement professionals to provide hands-on assistance to primary care organizations. Their work begins with helping practices to prepare for change, purchase and adapt to EHRs, and continues through a one- to two-year process of practice staff training and support that will transform the quality, safety and efficiency of patient services by affected providers.

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CMS EHR Demonstration:

After CMS designated PRHI as its Community Partner for the demonstration, PRHI recruited 975 providers in 278 targeted, small primary care practices (most among the four demonstration sites, in spite of southwestern Pennsylvania being the smallest in size). CMS does not provide practice improvement resources as part of the Demonstration. In response, PRHI and Highmark Blue Cross Blue Shield entered into a strategic partnership, and the Practice Champions program was created to support providers and practices.

PRACTICE CHAMPIONS CURRICULUM

Module 1: Purchasing and Implementing Electronic Health Records

Module 2: Introduction to Perfecting Patient Care

Module 3: Building a Transformation Team

Module 4: Optimizing the use of Electronic Health Records

Module 5: Chronic Disease Management and Electronic Patient Registries

Module 6: Transforming your Practice to a Patient-Centered Medical Home

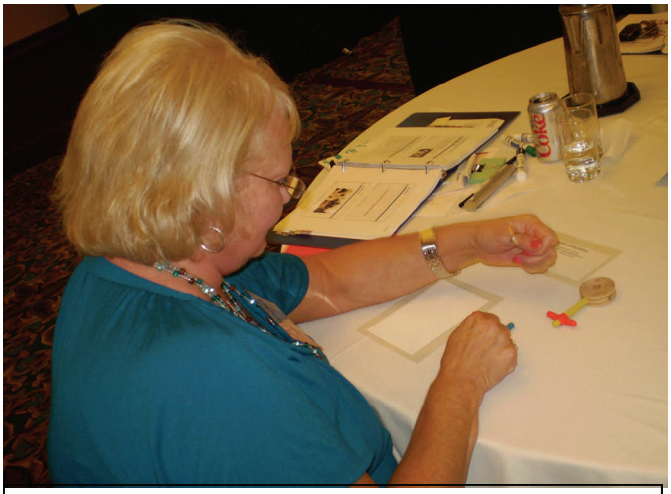
Module 7: Integrating Behavioral and Physical Health in Primary Care

Module 8: Primary Care Business Administration

Led by PRHI's Chief Medical Officer, the PRHI Practice Improvement Team is comprised of 20 experienced professionals who work directly with participating practices and healthcare professionals. After initial practice assessments, the Team is introducing EHR adoption, PPC principles and practice improvement concepts to practices through an eight-module curriculum, to be followed by customized, on-site assistance for individual practices. From the outset, practices' appetite for this training and support has exceeded expectations.

Safety Net Medical Home Initiative:

During 2009, the Commonwealth Fund selected PRHI as one of five Regional Coordinating Centers for its Safety Net Medical Home Initiative (SNMHI). SNMHI seeks to show the feasibility of upgrading primary care services provided by safety net providers, including attainment of NCQA Level 2 Patient-Centered Medical Home standards – which parallels requirements for successful participation in the CMS EHR Demonstration. PRHI recruited 10 local FQHC's for the project, encompassing 40 primary care providers. PRHI's Practice Improvement Team has conducted detailed needs and capabilities assessments, and adapted its PPC-based EHR implementation and practice improvement curriculum to meet individual FQHC needs: advanced coaching toward PCMH standards and EHR meaningful use; use of patient registries to bolster chronic disease management; and support for initial EHR adoption using recently received federal funds under the HITECH Act.



Through a simple Tinker Toy exercise, this Site Director at one of the FQHCs is able to work with her team to identify and overcome common work-design barriers.

Governor's Office of Health Care Reform (GOHCR) — Chronic Care Pilot in Southwestern Pennsylvania:

The GOHCR, through its southwestern Pennsylvania regional chronic disease pilot, has provided specific funding for PRHI's work in lowering hospital readmission rates and improving safe transitions in care. Building on our Chronic Disease Readmission Reduction Project (see next page), PRHI is using GOHCR resources to build a novel electronic disease registry linking physician practices of three partner community hospitals, and retain a team of committed nurse managers who will coordinate patient-centered care to a cohort of chronic obstructive pulmonary disease (COPD) clients. The customized clinical pathways proposed emphasize evidence-based care and smoking cessation. Readmission rate tracking aligns with pay-for-performance of the dominant local insurers, and creates the long-term sustainability needed for this type of specialized care.

Integrating Treatment in Primary Care (ITPC):

This PRHI demonstration project, undertaken in 2009, is focused on better care in primary care settings for patients with one or more chronic conditions, coupled with co-occurring behavioral health problems (depression and unhealthy substance use). PRHI research has shown a strong connection between undiagnosed and untreated behavioral health problems and ineffective chronic disease management. Through PPC-based training, PRHI is supporting healthcare professionals at five practices and community health centers, including standardizing best-practices to screen for and provide initial treatment of behavioral health problems: IMPACT (Improving Mood: Promoting Access to Collaborative Treatment) for depression and SBIRT (Screening, Brief Intervention, and Referral to Treatment) for unhealthy substance use. Project metrics include IMPACT and SBIRT adherence, patient outcomes, staff satisfaction, orientation toward patient-centered care, and healthcare costs.

Kickoff session for the Safety Net Medical Home Initiative held in July 2009 in Pittsburgh.

During the 3-day ITPC Kickoff Training held in March 2009, the practices involved in the project acquired skills to facilitate of primary health and behavioral health. (Right, top): A Perfecting Patient Care℠ Coach leads an exercise that helps a practice define their "ideal" in delivering integrated care. (Right, bottom): Another practice is learning how to use "process mapping" to define their day-to-day workflow.

ENVISIONING THE FUTURE

Even as this unprecedented concentration of resources helps hundreds of Pittsburgh-area primary care practices and thousands of providers bootstrap themselves to use modern electronic information tools, redesigned work processes, and best practices in chronic disease management, the larger goal – a high-performing healthcare delivery *system* – has generated even more ambitious ideas for PRHI and its partners.

Twelve years of PRHI initiatives have encompassed dozens of projects, scores of hospitals, thousands of providers, and variety of clinical areas: infections, medication reconciliation, patient falls, pathology, obstetrics, skilled nursing facilities, cardiac surgery, orthopedics, diabetes, behavioral health, chronic disease management, primary care, emergency room and care coordination. Time after time, in limited clinical settings, application of PPC principles by frontline healthcare professionals has shown the potential for breakthrough improvements in quality, safety and efficiency. But spreading and sustaining these advances has proven elusive.

New PRHI projects rely on the same PPC methodology and are building on the primary care transformation work described above. They are moving our region to the next step – how to progress from pro-active EHR-enabled primary care to consistent delivery in every healthcare setting of the highest quality at the lowest necessary cost.

COPD Readmission Reduction Project (CDRR):

Regional COPD 30-day readmission rates approach 25 percent, which puts COPD in second place regionally in terms of frequency and total number of 30-day readmissions for chronic conditions. CDRR is operational at two inpatient/ outpatient sites: UPMC St. Margaret's Hospital/ Renaissance Family Practice and Forbes Regional Hospital/Premier Medical Associates. The project is demonstrating that use of PPC methods to coordinate care effectively between inpatient and outpatient settings has dramatic effects on the quality and efficiency of care for at-risk patients.

Among the identified problems and solutions: wide variability in patient inhaler use is addressed by standardized in-hospital patient education by respiratory therapists; lapses in required post-discharge follow-up, including required physician appointments, are resolved by timely, comprehensive transitions of care, including making appointments before discharge; poor communications between hospitals and primary care providers that undermine care coordination are remedied by timely, routine information-sharing about patient admissions, discharges, medications, etc.; a variety of post-discharge problems are averted by a full-time care manager who assures coordination of care and follows a patient from hospital to home visits.

After winning the 2009 Silver Fine Award for Teamwork Excellence in Health Care, the Reducing 30-day COPD Readmissions Team from UPMC St. Margaret accepts their $15,000 award from The Fine Foundation, the Jewish Healthcare Foundation and Pittsburgh Regional Health Initiative.

(In anticipation of accelerating EHR implementation in the region through the CMS EHR Demonstration and other initiatives, PRHI has re-mapped CDRR process improvements for use in a fully-enabled HIT infrastructure. There may be significant news about this soon.)

At the one-year mark, COPD readmissions among affected patients have been reduced by more than 50percent. These results speak loudly about the potential for reducing and eliminating preventable hospital readmissions for a variety of chronic conditions. Engagement and systematic problem-solving by teams of providers, working across healthcare settings, can achieve huge gains in patient outcomes and substantially lower net healthcare costs. There is, however, a practical impediment to implementing CDRR more broadly – the current payment system does not support many of the incremental provider interventions that are needed to avert costly re-hospitalizations.

The Current Condition of U.S. Health Care: Financial Burden

- **Chronic disease costs account for more than 75% of the nation's healthcare costs**
- **Direct and indirect costs of diabetes: $174 billion per year**
- **Direct and indirect costs of arthritis: $128 billion per year**
- **In 2008, cost of heart disease was estimated to be $448 billion**

Centers for Disease Control, 2008

James Costlow, MD, Premier Medical Associates, addresses the attendees at PRHI's Accountable Care Network meeting in September 2009.

Accountable Care Networks (ACNs):

A crucial part of the current public policy debate about healthcare is how to re-shape healthcare payments and finances to support attainment of quality, safety and efficiency goals. The fee-for-service payment method generates financial rewards on the basis of volume and intensity of services provided; it is antithetical to value. A simpler, results-based approach could encourage innovation, reward best practices and emphasize efficiency and value. Health policy experts at the Brookings Institutions and elsewhere conceived of such an approach – Accountable Care Organizations – and Accountable Care Organization experiments are incorporated into both House and Senate health reform bills. Accountable care organizations are theorized as groups of providers that integrate care across settings and are paid according to the effectiveness and efficiency with which they deliver care to a specified patient population. Payments could be in the form of partial or global capitation, bundled payments for acute episodes of care, or as shared savings between providers and payers if mutually agreed targets are met.

Large, vertically integrated health systems have the internal structures and resources to become accountable care organizations. However, community hospitals and small private practices that delivery more than half of outpatient care generally have neither, and will not be able to move readily to a new payment and delivery model. The CDRR project results described above suggested a need and an opportunity for PRHI to

test a transitional model for these hospitals and practices – the Accountable Care Network (ACN).

Beginning with a September 2009 conference at which experts from Brookings and Dartmouth presented to and interacted with 75 local hospital, primary care, and health plan leaders, PRHI has enabled a regional consideration of the accountable care concept, and has sought to assess interest and identify potential ACN participants. The most likely ACN approach is one that would be organized as a cluster of primary care practices (each participating in the CMS EHR demonstration) with a community hospital to which they admit the bulk of their patients. Each hospital-practice cluster would select one or two chronic conditions, and follow the same PPC-enabled path to improvement as the CDRR project participants above. Thus far, there are preliminary commitments from two such hospital-practice clusters. Discussions with key payors are moving forward, too. The goal is to initiate at least two ACN pilots later this year.

For more information about accountable care organizations and ACN's, go to http://www.prhi.org/documents/PresentationsfromSept92009ACNMeeting.pdf

PRIMARY CARE'S FUTURE

The projects described in this issue are only parts of our aspirations to bolster primary care. PRHI is a primary partner in an application filed recently for a federal Regional HIT Extension Center program in western Pennsylvania, through which direct EHR adoption and meaningful use assistance is to be provided to thousands of additional western Pennsylvania providers.

Ongoing PRHI internal research on re-hospitalizations will figure in new, regional readmission reduction initiatives, building on the success of the COPD Readmission Reduction project. For these endeavors, PRHI is exploring avenues for public and/or private payor participation in reimbursement approaches (e.g., with Accountable Care Networks).

We are also mindful of longer term problems. The American Association of Medical Colleges estimates that there will be a shortfall of as many as 46,000 primary care doctors by 2025 – not including increased demand if national universal coverage is enacted.

Tomorrow's Healthcare™ is a dynamic, web-based portal that is designed to guide institutions through whole organization transformation by teaching, supporting, and sustaining Quality Improvement (QI) and work redesign in healthcare settings. Tomorrow's Healthcare™ combines for the first time in a single site QI tools and methods, education, data tracking, professional networking capabilities, and human resource management mechanisms to streamline, standardize, and simplify the way organizations and practices engage in QI. Primed to become the premier way to cost-effectively apply QI, learn, and gain skills in healthcare work environments, THC is at the forefront of a movement for patient-centered healthcare that is grounded in collaboration, transparency, process redesign and accountability.

During a recent visit to Pittsburgh, Ed Wagner, MD, director of the MacColl Institute-Center for Health Studies, discusses team-based care delivery with participants of the Safety Net Medical Home Initiative.

In other industries, disruption of work processes is a natural and necessary step in making products and services more accessible and affordable. In labor-intensive industries, technology-enabled disruption of business models has been a crucial tool for reducing costs and improving quality.

In September, the nonpartisan Brookings Institution's Engelberg Center for Health Care Reform issued a report that advocated permitting "greater use of nurse practitioners, pharmacists, physician assistants, and community health workers." This change is already occurring in many states, through expanded licensing scopes for nurses, nurse practitioners and physician's assistants. Also, retail clinics are proving to be popular among consumers and payors – due to convenience, quality (within prescribed limits of services) and lower cost.

Expanding demand for primary care services and limited numbers of primary care physicians assure that these changes will spread. Care must be taken to assure patient safety and the centrality of physician-patient relationships. But one of the potential benefits is enabling family physicians to concentrate on higher-end services and more complex issues for which they are uniquely qualified.

Similar innovation is needed in chronic care. Patients with one or more chronic conditions account for three-fourths of all healthcare spending. A growing number of these have complex healthcare needs stemming from multiple chronic illnesses, economic or social circumstances, mental or physical disability, or other barriers to access. They often require expanded services which are beyond the capacity of their personal physicians – particularly for physicians in solo or very small practices: coordination of care among multiple providers; access to and coordination of ancillary therapies and medical equipment; advocacy on the patient's behalf for needed considerations in the workplace, housing, or transportation; and related social services food and nutrition, insurance, personal finances, and in-home care-giving.

Hiring additional staff dedicated to these tasks is economically unfeasible due to the lack of reimbursement. Even if these services were fully reimbursed, however, the small practice setting does not seem to be the most effective and efficient avenue for effective chronic disease management.

Patient-Centered Medical Home

Meeting the needs of those with complex healthcare needs underpins "patient-centered medical homes" (PCMH). PCMH emphasizes communication and transfer of information among providers (facilitated by EHR implementation). Wellness and disease prevention remain in the physician's province. With the aid of point-of-care access to imaging and analytic tools, online decision support via EHRs, telemedicine and other new technology, the role of primary care physicians in diagnosis and early treatment of maladies can be anticipated.

Although PCMH encourages "empanelment" of patients with a designated PCP, something which the smaller practices have always done well, requirements for complex patients are increasingly beyond their capacities (e.g., maintaining linkages with community organizations that foster full-service care management for various disease states).

Crucial to the PCMH model is the care manager, who enables both the patient and the physician to be kept up to date on all aspects of care in a timely fashion, and prevents duplication of services. Care management also adds pro-active preventive care, seeking out patients to remind them of recommended health maintenance, especially for those who have additional needs such as foot exams for diabetics or yearly cholesterol checks for patients with hypertension. This is the feature of the medical home most readily adapted by larger private practices; insurers have begun to cover certain services under this

umbrella such as diabetes education, nutritional counseling, and the like. Many primary physicians already do this type of care management themselves, and may even enjoy the process, but it is time-consuming and, if reimbursed at all, not reimbursed at a level consistent with what a physician's time costs.

FQHCs as Centers for Chronic Disease Care

Medical care management can reinforce the role of the physician as a team leader, who assesses and diagnoses problems and plans the management strategy, while relying on other team members or networks of professionals who specialize in specific areas of chronic disease care. Large practices are already moving in this direction. Small practices, however, cannot independently afford to employ care managers for their patients with chronic diseases.

Many Federally Qualified Health Centers (FQHCs), and their "look-alikes" that make up the medical "safety net" in this country, are already serving as medical homes for their complex patients, coordinating medical and social care. Care management services are not provided by physicians, but by local networks of internal and external professionals, including community-based providers with which FQHCs have relationships.

It seems logical not just to consider what safety net providers would be able to do for their patients, if provided with more funding, but also to evaluate care redesign and payment strategies that would allow private providers to access FQHC care management services for their patients. Such a model, a "Primary Care Comprehensive Extension Center," would greatly reduce the need for creating new services in private physician offices and concentrate the work in places where there is already experience with coordinating care, providing clinical pharmacy consults, working with integrated mental health providers, and supporting patients with impediments to receiving available care due to language, cognitive ability, transportation, etc.

PRHI will be delving into questions related to this idea in the weeks and months to come, with the possibility of undertaking a few pilot projects, provided funding can be obtained. If you have questions or comments about this, or any of the other concepts discussed in this issue, please forward them to PRHI's Chief Medical Officer, Dr. Keith Kanel, at kanel@jhf.org.

Gain the Perfecting Patient Care℠ Advantage

2010 Open University Schedule

March 8-11
June 21-24
September 13-16
November 15-18

Physician CME credits and Nursing CNE credits are available.

PRHI has developed a nationally recognized systems improvement methodology for health care — **Perfecting Patient Care℠ (PPC)**.

PPC principles have guided scores of quality improvement projects including the **reduction of central line-associated blood infections**, **medication errors and accurate patient identification**, the **reduction of MRSA** and the **reduction of pathology errors**.

Its **Open University** has educated thousands of healthcare workers across the United States.

To enroll in an Open University or to learn about customized trainings for your organization contact Barbara Jennion, Director of Perfecting Patient Care℠, at bjennion@prhi.org or 412-586-6711.