FAMILY MEDICINE AND COMMUNITY HEALTH SPRING RETREAT

April 11, 2014

MAKING OUR PRACTICES WORK BETTER IN A RAPIDLY EVOLVING WORLD

SETTING THE STAGE

April 11, 2014

FHCH Spring Retreat

- Welcome!
- Thanks!
- Introductions
- Quick review of the agenda
- Housekeeping

Agenda/Objectives

- **Change is here, and it's different this time**
  - To provide a snapshot illustrating the current state of health care reform in the US and in Massachusetts
- **There are some things you should know**
  - To provide a lexicon describing current health reform programs that are underway in central Massachusetts
- **We have a lot of work to do within our practices**
  - To create a common understanding of the direction our Department is taking within this environment
- **Lean will be a valuable way to get the work done**
  - To describe the use of "Lean" as a valuable tool for success within our rapidly changing environment

Disclosures

- None

- I believe:
  - Primary care is the foundation for the future
  - Family Medicine is the foundation for primary care
  - We are on our way toward transforming primary care
  - A Community Health framework is critical to success

It's different this time

Evidence of movement from fee-for-service to value-based care

Cost of care on the front pages

April 4, 2013

Elisabeth Rosenthal: New York Times Series *"Paying Till It Hurts"*

She joins *Fresh Air*'s Terry Gross to talk about why American medical bills are so high, and what needs to change.

Rosenthal has worked at *The New York Times* as an international environmental correspondent, a reporter in the Beijing bureau, and a metro reporter covering health and hospitals.

Courtesy of The New York Times

Interview Highlights

On the goal of her health care series

"[The purpose is] to make Americans aware of the costs we pay for our health care. Because so many of us have insurance and we don't see the bills, we tend to think of health care as free. 'Why not get that colonoscopy? It doesn't cost anything. What's the difference if my hip replacement costs $100,000? I'm not paying.' But, in fact, we're all paying. And as we know, health care is a huge cause of individual bankruptcies now. Copays and deductibles are going up, and the nation — because it pays for a lot of medical care and subsidizes a lot of medical care — just can't afford the way we're doing this anymore."

On the man who went to Belgium to get a hip replacement

"In Belgium, he paid $13,660 for everything. That included his new hip implant, the surgeon's fees, the hospital fees, a week in rehab and a round-trip plane ticket from the U.S., soup to nuts.

"Now, if he had done that surgery in the U.S, it would've been billed at somewhere between $100,000 and $130,000 at a private hospital. ... So there's a huge difference. In fact, this gentleman, Mr. Shopenn, was a great consumer, and he tried to have it done in the U.S., and he

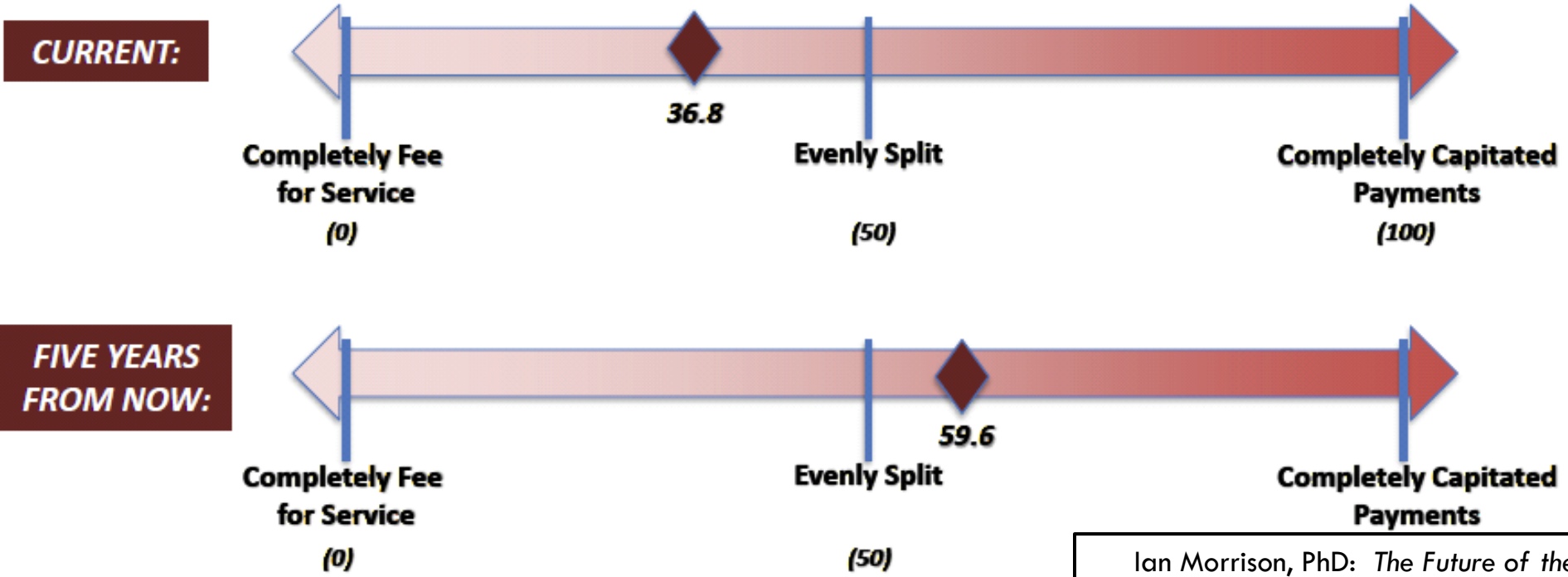
At the 2013 AAMC meeting

Ian Morrison, PhD: *The Future of the Healthcare Marketplace: Playing the New Game.* AAMC Plenary Presentation, Philadelphia, 11/3/13

- Audience filled with Deans and CEOs from Academic Health Science Centers

Most hospitals anticipate significant movement towards capitation over the next 5 years

*Payment Model for Hospital – Current and Five Years from Now**



Ian Morrison, PhD: *The Future of the Healthcare Marketplace: Playing the New Game.* AAMC Plenary Presentation, Philadelphia, 11/3/13

SOURCE: Harris Interactive Strategic Health Perspectives Hospital Exec Survey 2012-2013 (2013 n=210)

Q705/Q706/Q707: Many hospitals are starting to be paid differently for their services, moving from a fee for service [illegible] capitation or value based payments. Where is your hospital/hospital system on the spectrum today, and where will you be five years from now?

Something is bending the cost curve*

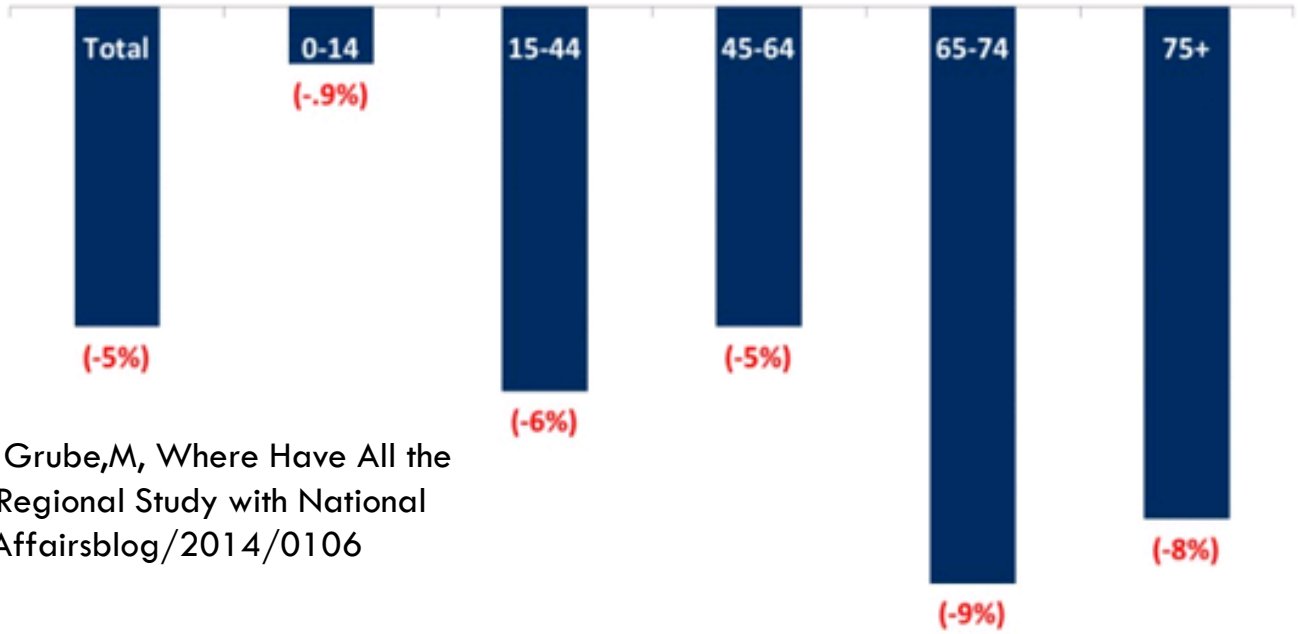
- Since 2009, health care costs in the US have grown between 3.6-3.8%
  - During all four years, these rates were the slowest rates ever recorded in the fifty-three-year history of the National Health Expenditure Accounts

*Health Affairs, January, 2014

Health care utilization is dropping

- A study of health care utilization from 2010-12 by 8.5 million residents in a 7 county area around Chicago (66% of the population of Illinois) showed across the board decreases in hospital utilization rates:

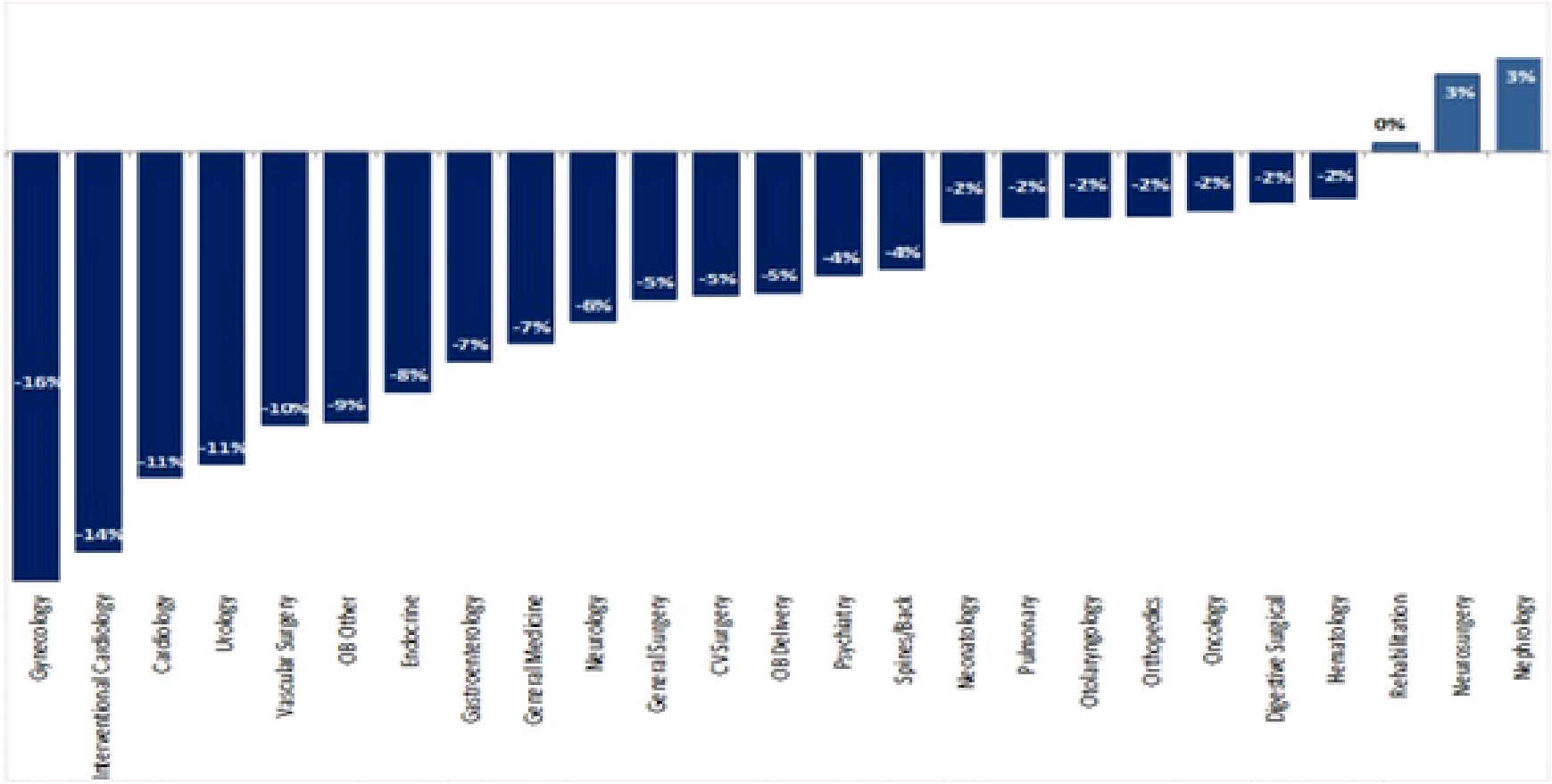
Figure 3. Inpatient Utilization Rates per 1,000: Percentage Change by Age Group



York, R, Kaufman, K, Grube,M, Where Have All the Inpatients Gone? A Regional Study with National Implications. HealthAffairsblog/2014/0106

Specialty utilization is dropping

Figure 4. Change by Service Line in Utilization Rate per 1,000 Population: 2010-2012



The greatest decreases are for Ambulatory Care Sensitive Conditions

Table 3. Change in ACSA Utilization Drops Versus All Other Cases by Service Line: 2010-2012

Service Line	% ACSAs	% All Other Cases in the Service Line
Cardiology, Interventional	**(23.5%)**	**(12.7%)**
General Medicine	**(13.6%)**	**(5.7%)**
Gastroenterology	**(12.8%)**	**(6.2%)**
Endocrine	**(12.0%)**	**(1.4%)**
Thoracic Surgery	**(11.1%)**	**(9.0%)**
Neurology	**(7.8%)**	**(5.6%)**
General Surgery	**(6.8%)**	**(3.2%)**
Pulmonary	**(2.4%)**	**0.3%**
Cardiology	(10.2%)	(11.5%)
Vascular Surgery	(5.8%)	(9.3%)
Urology	(3.8%)	(12.1%)

Conclusions

- The Chicago regional study indicates that there is indeed early evidence that the transformation agenda *is* taking hold
- Changes in health care utilization aren't solely based on the recession
- Doctors and hospitals are changing the way they care for patients with chronic conditions
  - Likely using intensive medical management to keep patients out of the hospital
- Accountable and risk-based care is having a statistical impact above and beyond intensive medical management

York, R, Kaufman, K, Grube,M, Where Have All the Inpatients Gone? A Regional Study with National Implications. HealthAffairsblog/2014/0106

Structural Reforms

Vermont Health Care Innovation Project

- Delivery system reform AND payment reform
  - State developing infrastructure to support delivery system reform
    - IT that works
    - Shifting to payment models that support value
    - Care management
  - 2017: Green Mountain Care
    - The nation's first single payer plan

Robin Lunge: Dartmouth Symposium on Health Care Delivery Science, Hanover, NH, 4/5/14

Accountable Care Organizations

- December, 2011: 32 ACOs
- July, 2012: nearly 90
- April, 2012: 27
- January, 2013: >100

- There are now 600 ACOs in the United States
  - All are hitting targets for quality
  - 50% are achieving cost savings
  - 25% are receiving bonus payments
- There have been some surprising players
  - Networks of Federally Qualified Health Centers
  - Walgreens has formed three

Elliott Fisher: Dartmouth Symposium on Health Care Delivery Science, Hanover, NH, 4/5/14

In Massachusetts

- 2010: Tufts, Harvard Pilgrim intend to expand coverage through global payments
- 2012: Five Medicare Pioneer ACOs
  - Atrius
  - Beth Israel Deaconess
  - Partners
  - Mt. Auburn
  - Steward Health Care
- 2014: 613,000 BC/BS members covered by an Alternative Quality Contract

In central Massachusetts

"Duals over 65"

- Patients over 65 who are eligible for Medicare (they are >65) and Medicaid (they meet income requirements)
  - **SCO (Senior Care Oganization) –** Five Medicare/Medicaid programs in Massachusetts designed to provide full service, innovative care to patients in community and institutional settings
  - **Fallon Navicare:** a SCO, sponsored by Fallon Community Health Plan
    - the preferred product for patients in the UMass Memorial system
    - New initiatives underway at HFHC, Benedict Family Medicine, Benedict Internal Medicine
      - To be linked to Fallon projects for duals under 65
  - **Evercare and Senior Whole Health:** Two SCOs with which UMass Memorial has maintained contracts for tertiary care only

"Duals *under* 65"

- Patients under 65 who are eligible for Medicare (they are disabled) and Medicaid (they meet income requirements)
  - Several pilot projects – referred to as "**One Care**" – underway across the state, working with selected insurance companies in each region
  - **Fallon Total Care:** the preferred product for patients in the UMass Memorial system
    - Pilot sites include Benedict Internal Medicine, Benedict Family Medicine, Hahnemann Family Health Center, Barre Family Health Center and Plumley Village Health Services
  - Community Health Link working on a product managed by **Commonwealth Care Alliance** in addition to Fallon Total Care

Primary Care Payment Reform (PCPR)

- **Under Chapter 224 (2012), the state has mandated that 80% of its Medicaid enrollees will be in an alternative payment program within three years**
  - PCPR is a pilot program in the MassHealth program devoted to rolling out payment reform and behavioral health integration for patients
  - For now, only within the PCC program
  - Started March 1, 2014
    - 30 entities, 50 practices across the state
    - Massachusetts safety net hospitals – Boston Medical Center, Cambridge HealthAlliance, UMass Memorial – are the largest entities – early entry provides input into the program

Primary Care Payment Reform (PCPR)

- Practices in Worcester involved in the pilot include:
  - Medical Group practices – Barre, Benedict Family Medicine, Benedict Pediatrics, Hahnemann Family Health Center, Nashaway Pediatrics (CMG), Plumley Village, Tri River
  - Community Health Link
  - Family Health Center of Worcester
- First pass – this is a small number of patients for any individual practice
- Much of the support and technical assistance for the program is coming from UMass Commonwealth Medicine

What's different about PCPR?

- Capitated primary care rate, otherwise FFS for behavioral health and specialty care
  - Based on prior utilization (statewide)
  - Correction factor for severity – coding is important!
  - Still need to submit bills as if FFS – coding is important!
- Management fee $12.50 PMPM
- 5% upside option for quality
- Opportunity for shared savings
  - Based on total medical expense
  - Payment dependent on rates of screening for cervical cancer, mammography and well child visits 3-6 years of age

PCPR Deliverables (some over 18 months)

- Meaningful use
- Use of registries for 3 chronic diseases, with at least one behavioral health measure
- Licensed care manager
  - Provide care plans for highest risk/cost patients
- Multidisciplinary care teams
- 24/7 access
- Initially operate as a level 1 PCMH
- Planned visits and follow up
- Care coordination across settings
- Behavioral health integration
- Self management support
- Quality
  - Pay for reporting in the first year; P4P in years 2+
  - HEDIS

PCPR data sources

- Claims
- Patient satisfaction surveys
- The electronic record

Other innovations impacting UMass Memorial

- 2013: BCBS Alternative Quality Contract
- 2014: Harvard Pilgrim support for a pilot project in the diabetes center (effective 4/1/14)
- Under discussion: Employer-based urgent care and/or primary care
- 2015: Medicare ACO
  - All non-managed Medicare patients attached to a PCP in the UMass Memorial Medical Group (estimate 20,000 patients)
  - Will expand to additional PCPs within the Managed Care Network
  - A fee for service Medical Shared Savings Plan (MSSP)

Conclusions

- Change is real, and fundamental
- It's not going away
- Massachusetts is the epicenter
- Primary care is the epicenter

The impact

Dissonance

- Caught between fee for service and global payment
  - Conflicting incentives, all in play at the same time
- Claims of the success of the _____ (insert ACA, PCMH, ACO, AQC, etc)
- Claims of the failure of the _____ (insert ACA, PCMH, ACO, AQC, etc.)
- Claims that health care costs are rising, or falling
- Pressure to keep people out of the hospital, or in the hospital

Strife

- Slow shift from profit centers to cost centers
  - Hospitals: Winners and losers as hospitals find their way
    - Making major cuts to cope with dropping revenues
  - Physicians and organizations:
    - New opportunities for collaboration clouded by short term financial considerations
    - Major work to be done regarding funds flow
- Pressure to demonstrate value, with imperfect measures

We've had some successes

- PCMH Level 3 Designation
  - Hahnemann Family Health Center
  - Plumley Village Health Service
  - Barre Family Health Center
  - Benedict Pediatrics
  - Nashaway Pediatrics
  - Hahnemann Internal Medicine
- AQC: Movement in quality scores

We have a lot of work to do

- It's a journey
- You need to transform yourself
- NCQA is a checklist. You need:
  - Time
  - Experience
  - A series of supports: Teams, training, communication, staffing, etc
- You need to live in a medical neighborhood
- You need payment reform
- You need to keep steady while the system changes around you

Lean

" . . . an organization's cultural commitment to applying the scientific method to designing, performing, and continuously improving the work delivered by teams of people, leading to measurably better value for patients and other stakeholders"

Toussaint, J, Berry, LL. The Promise of Lean in Health Care.

*Mayo Clinic Proc.*2013 Jan;88(1):74-82.

Lean: Six Basic Principles

1. *Lean is an attitude of continuous improvement*

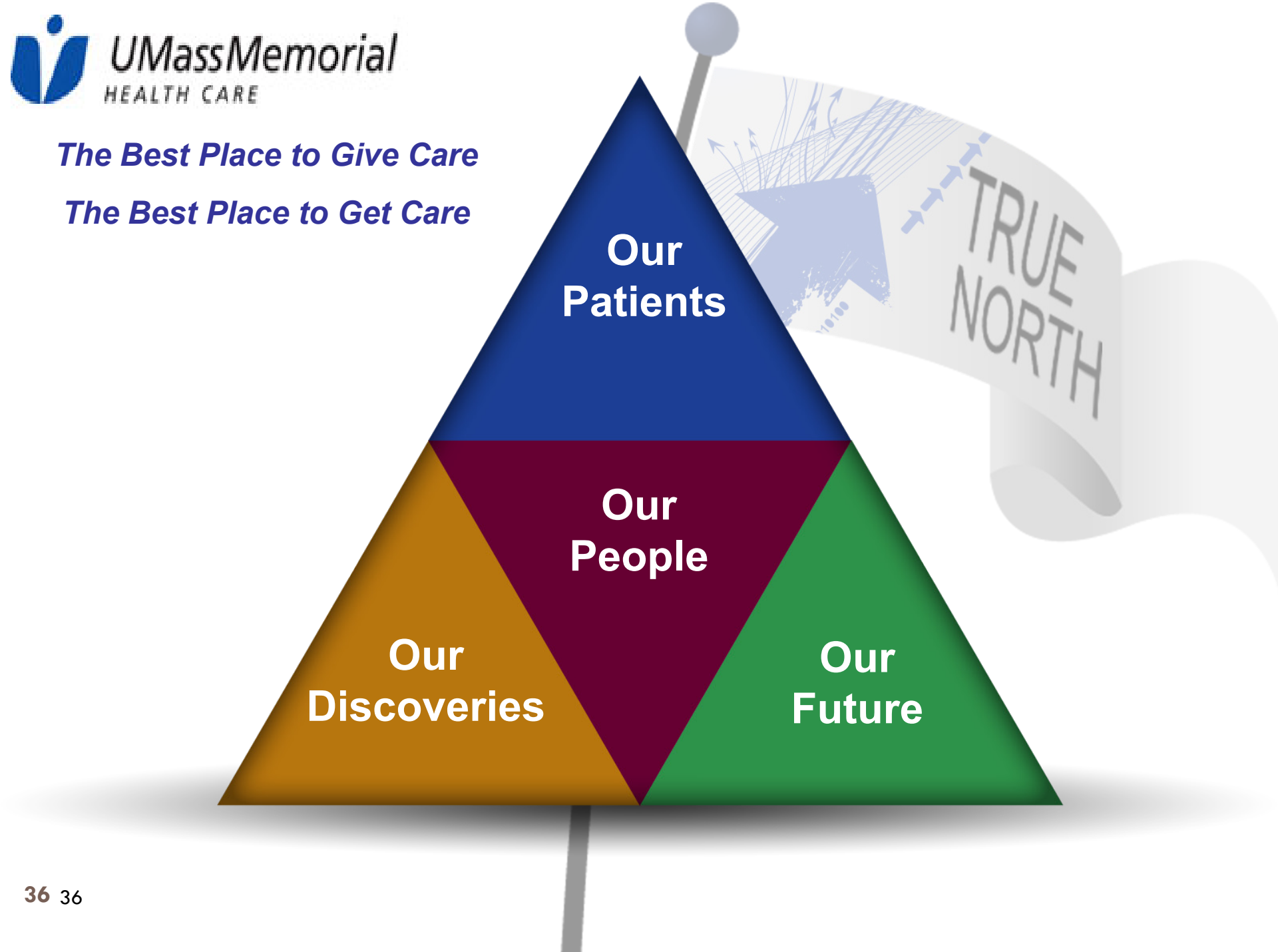
2. *Lean is value creating*

3. *Lean is unity of purpose*

UMassMemorial HEALTH CARE

The Best Place to Give Care

The Best Place to Get Care



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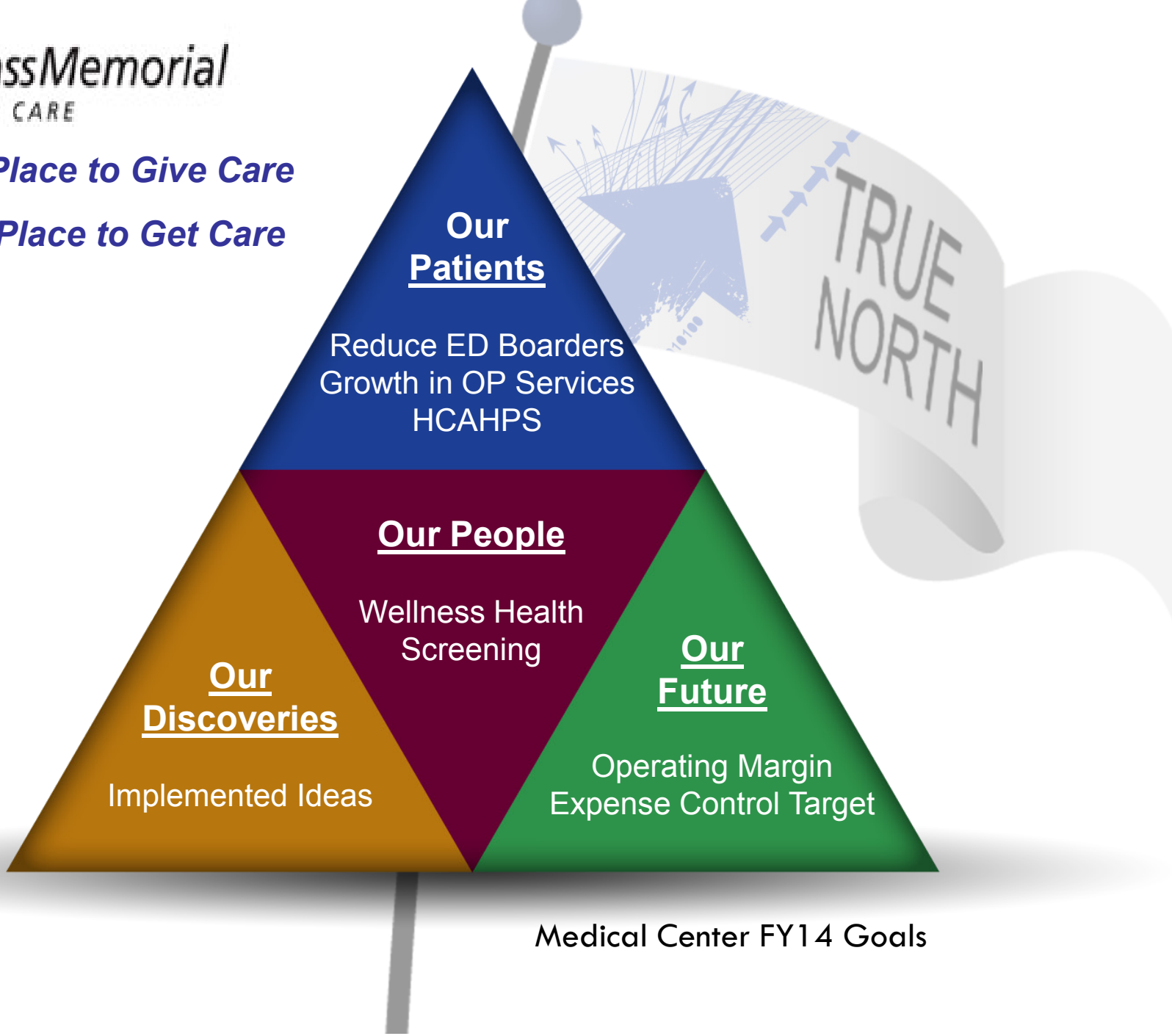

Medical Center FY14 Goals

Family Medicine and Community Health

Must Do/Can't Fail

- Revitalize the Fitchburg Family Medicine residency and its practice
- Shift the culture from "*I am a victim*" to "*I can make things better*"
- Make our practices work better
- Implement first payment reforms in ways to create a solid platform for the future

Lean: Six Basic Principles

4. *Lean is respect for the people who do the work*

5. *Lean is visual*

6. *Lean is flexible regimentation*

Measuring Patient Satisfaction

Projects underway

- A3: Working Effectively in Family Medicine – Dan Lasser
- A3: Implementation of scribes at the Barre Family Health Center – Steve Earls and Sue Begley
- A3: Improving Measures of Quality of Care – Dennis Dimitri
- A3: Attaining Phone Service Level Excellence in Family Medicine – Dave Gilchrist
- A3: Diabetes Quality Initiative – Joseph DiFranza
- A3: Improving Patient Waiting Times at Plumley Village – A Proxy for Improving Clinic Flow - Katharine Barnard
- A3: Feedback for Change – Alan Chuman
- A3: Patient in Room, Ready, on Time – Melanie Gnazzo
- A3: Resident Scheduling for Continuity of Care – Stacy Potts

Projects underway

- A3: Floating the Center's Boat – Sandy Blount
- A3: Inpatient to outpatient transitions – Warren Ferguson and Beth Koester
- A3: Establishing a Colposcopy Referral Service at a Family Medicine Residency Training Site - Ronald Adler
- A3: Idea System Utilization and Sustainability in Family Medicine – Melissa McLaughlin
- A3: Defining Faculty Roles – Bob Baldor
- A3: Increasing Scholarship/Dissemination of Practice Innovations – Linda Weinreb
- Project A3: Transformation of the Fitchburg Residency and Practice – Nicholas Apostoleris

Roadmap

- Don't be afraid to ask questions
- Be accountable for the basics
  - Access
  - Quality
  - Cost
- Look to develop new collaborations
  - Don't let old turf issues get in the way
  - Try not to create new turf issues
- Keep your head down – we are moving forward

Roadmap

- Don't try to boil the ocean
- Follow the money – We care for some of the most complicated patients
- Focus on vulnerable populations
  - Dually eligible
  - Patients with complex co-morbitities
  - Elderly
  - End of Life
  - Children with complex medical needs
  - Patients with significant behavioral/mental health issues
  - HIV, Hepatitis C, substance abuse

Roadmap

- Learn from each other in areas of strength, develop or expand expertise in selected areas
  - PCMH
  - Motivational interviewing
  - Integrated primary care psychology
  - Colposcopy
  - Maternity care
  - Sports/musculoskeletal disorders
  - HIV, Hep C
  - Palliative care
  - Other selected specialty areas
- Recognize that we will be the foundation for a new system for care

Bibliography

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- York,RW,Kaufman,K,Gruve,M. Where Have all the Inpatients Gone? A Regional Study With National Implications. *Healthaffairs.org*/blog/ 2014/01/06.

TRUE NORTH, LEAN, AND OUR STRATEGIC PLAN

WHAT ABOUT RESEARCH, EDUCATION AND SCHOLARSHIP?

April 11, 2014

FM/CH Must Do/Can't Fail Projects

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UMass Medical School/UMass Memorial Heath Care – Department of Family Medicine and Community Health
Strategic Plan

Clinical Services	Education		Research	Community Health
The Department will promote and provide innovative, high quality, evidence-based clinical care delivered to diverse communities	**The Department will be a leading resource for addressing the primary care and public health workforce needs of the Commonwealth of Massachusetts** • ***We will train clinically competent, patient-centered and community-responsive clinicians and public health professionals to provide quality health care services to diverse populations*** • ***Our training programs will be based in clinical and community settings that reflect the health care needs of the Commonwealth, with emphasis on training for shortage area practice***		**The Department will increase its national recognition for its research focused on health promotion and disease prevention and on innovative approaches to delivering evidence-based practice in primary care, with a particular focus on eliminating socioeconomic and racial health disparities.**	**The Department will distinguish itself and be recognized nationally for integrating CH into FM practice, training and scholarship**
We will recruit and retain a Family Medicine workforce of a size and breadth to meet the needs of the diverse community of central Massachusetts We will support innovative systems and programs that support all Department practices in the care of patients across the entire spectrum of clinical settings We will implement practice improvements that increase the satisfaction of physicians and patients and improve quality and effectiveness We will apply methods for the creation, measurement, and maintenance of a clinically superior healthcare workforce We will cultivate and encourage integration of clinical teaching in all of our practices as part of the culture of the department	**Our predoctoral training programs** will ensure that all medical students graduate with a firm grounding in the principles of Family Medicine and of Community Health, and will include innovative curricula related to serving underserved populations **Our Family Medicine Clerkship** will place students in dynamic teaching practices that are models for the provision of Family Medicine. **Our Family Medicine Residencies** will be highly competitive, and will attract and sustain a diverse group of learners within supportive and innovative learning environments. **Our Sports Medicine Fellowship** will be a regional and national leader in the field of Primary Care Sports Medicine through education, research, clinical services, and community outreach.	**Our Preventive Medicine Residency** will prepare primary care physicians to assume leadership positions in public health and preventive medicine. **The Worcester-based MPH Program** will prepare health care professionals and medical students for careers and leadership positions in public health and community health. **Our Behavioral Science Program** will be a national model for training medical and psychological providers to offer integrated behavioral health services in primary care. **Departmental CME offerings** will support our faculty via innovative lifelong learning practices. **Faculty development activities** will be coupled with the recruitment of community-based preceptors and will focus on training and supporting expert teachers and excellent role models.	Our core research faculty will formally organize as a Research Group on Primary Care Quality, Access and Outcomes that will expand the productivity, visibility, and relevance of its research Working with community practices and partners, Medical School departments and Commonwealth Medicine, we will enhance our approaches to research collaboration that are bidirectional and responsive to community priorities We will enhance the scholarly environment across the Department through strengthened efforts in the residencies, fellowships, and at each of our health centers	We will serve as an academic partner with community agencies and public health entities in the development of community-responsive services to improve health equity and reduce health care disparities We will integrate training in population health concepts and the application of community health strategies within clinical training sites We will serve as an academic partner for Commonwealth Medicine and other departments to establish and evaluate innovative and sustainable models of health care for diverse and vulnerable populations

ORGANIZATION AND CULTURE: We will be a highly functioning academic and clinical Department:	The Department's leadership and management infrastructure will be mission-driven, aligning planning and implementation, clarifying expectations, and supporting a culture of innovation and professional growth
OUR VISION Our Department will be nationally recognized for its innovation and impact in Family Medicine and Community Health **OUR MISSION** Our Department sets the highest standards of patient care, education, and research in Family Medicine and in Community Health, and is committed to improving the health of populations, with special emphasis on those most vulnerable.	**OUR VALUES** • Advocacy • Collaboration • Commitment • Innovation • Professional growth

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OUR VALUES

- Advocacy
- Collaboration
- Commitment
- Innovation
- Professional growth

Vision and Mission

Vision:

Our Department will be nationally recognized for its innovation and impact in Family Medicine and Community Health

Mission:

Our Department sets the highest standard of patient care, education, and research in Family Medicine and in Community Health, and is committed to improving the health of populations, with special emphasis on those most vulnerable

Goals

- **Education:** *The Department will be a leading resource for meeting the primary care and public health workforce needs of the Commonwealth of Massachusetts*
  - *We will train clinically competent, patient-centered and community-responsive clinicians and public health professionals to provide quality health care services to diverse population*
  - *Our training programs will be based in clinical and community settings that reflect the health care needs of the Commonwealth, with emphasis on training for shortage area practice*

Goals

- **Clinical Service:** *The Department will promote and provide innovative, high quality, evidence-based clinical care delivered to diverse communities*
- **Community Health:** *The Department will distinguish itself and be recognized nationally for integrating community health into family medicine practice, training, and scholarship*
- **Research:** *The Department will increase its national recognition for its research focused on health promotion and disease prevention and on innovative approaches to delivering evidence-based practice in primary care, with a particular focus on eliminating socioeconomic and racial health disparities*

Academic medicine?

Roadmap

- Wise use of resources
- Build on innovation
- Create synergy and leverage talent

- The importance of resilience

Discussion