INSTITUTE FOR HEALTHCARE IMPROVEMENT

INSTITUTE FOR HEALTHCARE IMPROVEMENT
SUMMARY REPORT: 90-DAY PROJECT

Primary Care 3.0

10/30/10

Executive Summary:

The Primary Care 3.0 90-Day project centered around four main areas of work: describing the characteristics of existing great primary care; exploring how primary care can be better integrated in community, non-practice settings; enhancing the capacity of primary care to coordinate specialty and hospital services; and supporting primary care practices that perform the financial management/commissioning function for patients.

Existing great primary care (2.0) is characterized by its work in the following nine areas: care-team development, population-based planned care, working on quality access, efficiency and reliable design in the office, information technology support, leadership engagement, strong learning systems, and patient engagement. Primary Care 3.0 moves beyond these concepts to include horizontal integration, vertical integration, and financial management of the patient journey. Its goal should be, explicitly, the Triple Aim. New models of payment are needed to support PC 3.0 practices. In this paper we explore some of the payment models that have been proposed in the state of Michigan; we recommend that the final payment scheme blend several of these models to maximize the benefits and minimize the drawbacks of each.

Primary Care 3.0 is particularly timely because of the policy environments in the US, where Accountable Care Organizations are in development, and England, where GPs will be asked to commission care for their patients through GP consortia. IHI's work on the Triple Aim and the concept of Primary Care 3.0 positions it well to offer guidance to the early-adopters in both countries. We propose a course for British GPs to be offered in 2011 that would center around the primary drivers for a successful shadow GP consortium: IT support, improving the health of the consortium population, improving health care integration, and financial management.

I. Research and Development Team:

- Leader: John Whittington
- Colleague: Ian Rutter
- Colleague: Zoe Kawaller

II. Intent:

The intent of this project is to apply the concepts of primary care 3.0 to support English GPs with their new commissioning responsibilities and to equip US primary care for its role in new structures such as the accountable care organization (ACO).

III. Background:

IHI has been working on primary care for many years; that work was reviewed in the research and development paper Primary Health Services for the 21st Century 4/30/10.

Neal Halfon and Helen DuPlessis at UCLA give a very insightful vision to both the changes and direction for primary care and health systems in general. "The first version of primary care (Primary Care 1.0) focused on acute health conditions, and some chronic disease treatment. The current version of primary care (Primary Care 2.0), epitomized by the Wagner Care Model,[1] builds upon the acute care based 1.0 model to include a more integrated approach to providing clinical prevention and management of chronic disease. The next step in this evolutionary pathway, (Primary Health Care 3.0) will usher in a primary health system that provides a more prospective and anticipatory approach to care delivery, that harnesses the collective intelligence of physicians and patients to collaborate freely to solve problems, and that connects with and integrates evolving community health teams and their prevention and health promotion efforts, and is firmly positioned within an organizational structure that supports health development as well as disease management." [2] Building on their work we are outlining below some of the main areas that IHI should be working on to help GPs in England and primary care in the US.

There are four main areas of work that have been outlined for Primary Care 3.0 research: maximize the quality of existing great primary care, expand and integrate primary care into the community to help maximize health over a lifetime, expand and integrate primary care with specialist and hospital services and, lastly, further develop the management/commissioning function of primary care as i.e. managing the whole patient journey including financial responsibility. In this model, the goal of primary care is the Triple Aim for the population that it cares for.

IV. Description of Work to Date:

Three sites were visited to inform this work: Southcentral Foundation in Anchorage, University of New Mexico, and Hidalgo Medical Services in New Mexico. Brief descriptions of those visit can be found in Appendix A, B and C. An additional visit occurred to England to discuss policy changes that are under way in England and how we can support the GPs during these changes. Also conversations were held with individuals who have been working to improve primary care. Documents that outlined the changes that are occurring in England were also reviewed for this work. Many organizations were approached about conducting tests but so far not testing has occurred.

---

[1] Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice* 1998;1(1):2-4

[2] DuPlessis HM and Halfon N. Proposal for the 3.0 primary health system innovation workshop series. UCLA Center for Healthier Children, Families and Communities. 2010

- Detailed explanation of the four main areas of work described above
- Development of a plan to help support GPs in the UK throughout policy changes. This will include a 1-2 day seminar for English GPs in 2011, focused on the needs of GPs as they work in consortia.
- Testing PC 3. concepts

V. Results of the 90-Day Scan:

The fist deliverable that was outlined was to provide a more detailed description to the four main areas of primary care 3.0.

First we need to maximize the quality of existing primary care. The items listed below represent what we see great organizations working on today.

1. Care-team development
2. Population-based planned care
3. Working on quality access
4. Efficiency and reliable design in the office
5. Information technology support
6. Leadership engagement
7. Strong learning system
8. Patient Engagement
9. Accountable outcomes

In appendix D we provide a more detailed explanation of these 9 items.

Second we need to expand and integrate the role of primary care into optimizing health. If Primary Care 1.0 was trying to prevent death, and Primary Care 2.0 was focused on managing chronic disease, then 3.0 is focused on optimizing life. In order to do that, primary care needs to integrate into the community to help maximize health over a lifetime. This really builds upon ideas that are part of primary care 2.0, such as population-based planned care but then pushes this idea further by integrating primary care with other community organizations. The English model probably comes very close to this already, with a primary care team that is connected with many community resources.

There are promising examples in the US, however. Hidalgo Medical Services are federally qualified health centers in New Mexico. They have a portfolio of work focused on improving the health of communities they serve. Their projects include work such as identifying diabetes, working with school-age children, teen moms and young men. They have decreased teen pregnancy rates and improved the number of teen moms who graduate and even go on to college.

Part of their novel approach includes a board that is made up 100% of members using their services. They have community health workers who are trained to deal with a wide range of services: assisting people with application for service, helping diabetics deal with health care issues, and managing the programs for youth and teens mentioned above. Their novel approach is being supported by the CDC, and they are spreading to other parts of the U.S.

Third, we need to expand and integrate the role of primary care with specialist and hospital services along with coordinating care between these services An extensive range of specialist services can safely and efficiently be shifted into primary care settings to better vertically integrate care. We have seen examples in the VA where cardiologists and primary care providers worked together in a heart failure clinic to manage complex patients and improve the care. The University of New Mexico developed an extensive program to improve the skills of primary care in that state. Specialists will also be more involved with coaching, helping other providers manage cases and less direct management themselves. For areas that cannot be shifted into the primary care setting, the primary care team must proactively coordinate care with specialist and hospital services. This would include clearly defining agreements of care between specialist and primary care, along with a system that would "pull" patients out of hospital care back into their primary care setting. In New Zealand, for example, intake coordinators who work in the primary care office pull patients out of the hospital back into the practice, as opposed to most US systems today that weight for patients to be pushed out of the hospital and back into their primary care office.

Lastly we need to further develop the management/commissioning function of primary care.

Becoming responsible for the health, all care services and the finances allocated for their population across the whole continuum of health and care 24/7. This requires the allocation of the "totality" of the budget to Primary Care and the responsibility for managing it, The Triple Aim Challenge and measurement across all functions being the norm. In England the new government is planning on shifting the financial responsibility for the population to the GPs through there GP consortia.[3] It is unlikely that in the US such a dramatic shift will occur but you could imagine a system that used a community health plan and primary care to have financial responsibility for a population. The ACO concept in the US potentially could push collaboration between primary care and health plans in this direction.

To take on this responsibility primary care will need a detailed understanding of the patient population, their health needs and other important demographics. This could then be used to plan for the health needs of a population. In the US we use an actuarial model based on past health care use we try to predict future use without much intervention in the design of services. The English system attempts to understand past use and then proactively design services that will meet the needs of their community.

---

[3] Secretary of State for Health. Equity and Excellence: Liberating the NHS. Crown Copyright 2010. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

Segmentation of the population will be important. It turns out that about 5% of the population spends 50% of the money. There is a need to identify and manage this population closely.

Ongoing monitoring the health care spend in a community is needed, which will require real-time patient-level hospital data (which is crucial for managing discharges and reducing readmissions.

In England there will be a need for GP consortium leadership structure – governance and decision-making; if the budget is getting spend too quickly, how will the GP consortium respond – who will respond?

Managing GP clinical variation will be needed. There is significant variation on referral usage, hospitalization rates, emergency room usage, medications etc among primary care doctors.

Building upon the 4 components of the PC 3.0 model we developed a plan to support the GP consortia that are developing in the UK. Please See Appendix E.

Comment on payment models

Primary care in the US, as with the rest of health care in the US, is financed primarily through fee–for-service payment models. This payment system has focused health care on producing individual health services. Much of primary care 2.0 and 3.0 is focused on managing and coordinating individual health services into a cohesive whole. New models of payment are needed to support this change, and no one model can achieve this by itself. Figure 1 is an illustration of payments models that were considered this year by the state of Michigan for an application for the CMS Multi-payer Advanced Primary Care Practice Demonstration

Explorations of a Common Payment Methodology for PCMH

Payment Methodology	Pros and Cons
Enhanced FFS	Fit for some payers and not for others Rewards volume Risk of increased fee for self-pay patients
Incentive or Reward Payments	Most payers doing this Inconsistent measures Limits in reward pool (cost shifting away from other providers or initiatives)
PMPM	Attractive to providers Fit for some payers, prohibitive for others Possible use as "currency" (i.e. pmpm equivalents)
Expanded service codes	Direct support for expansion of services such as care management and telephone follow up Rewards volume Limited to certain service providers Limited by employment relationships Out of pocket expenses
Delegation agreements	Supports infrastructure development Potential threat to payer's programs/staff

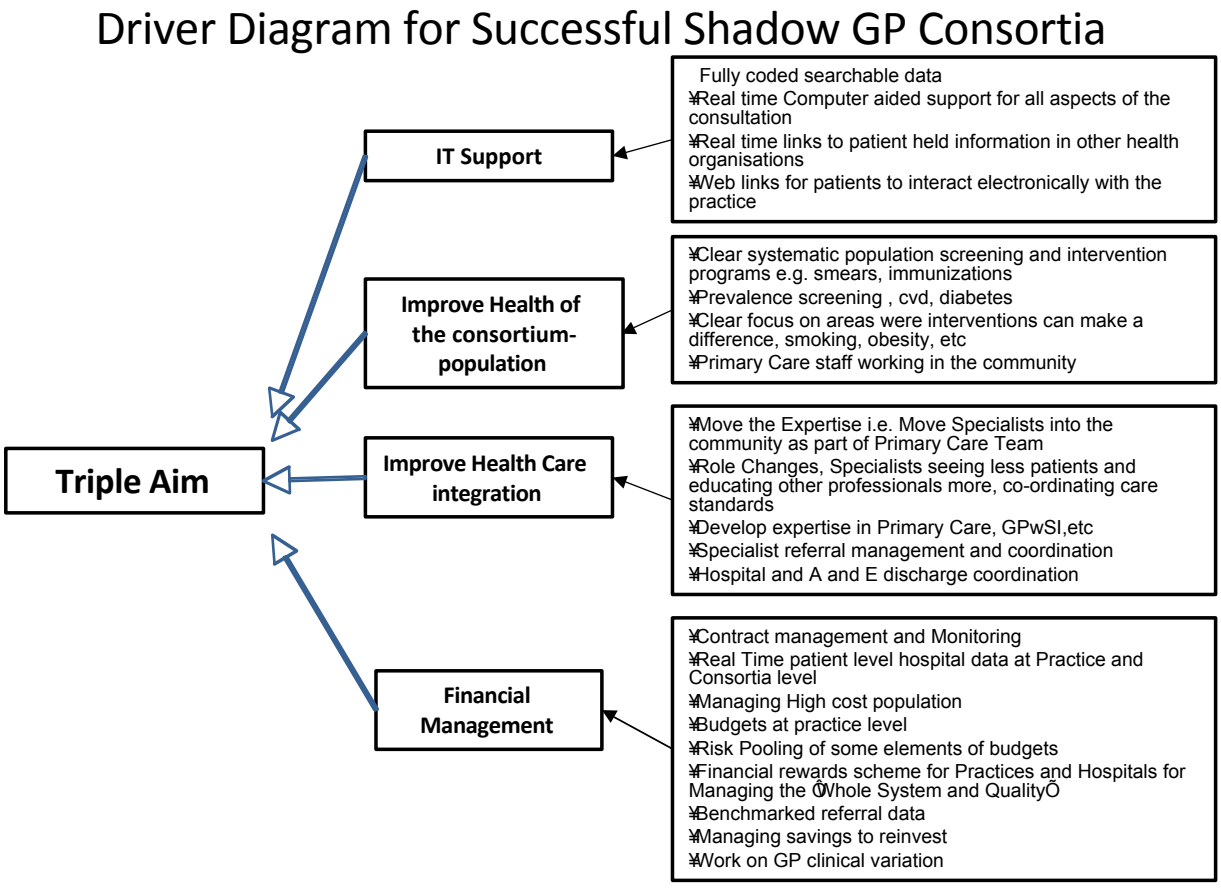
Since any one payment system has an inherent limitation, a blended model will likely be the most successful for 3.0 practices. For a more detailed description of this payment work see appendix G

Comments on the testing of PC 3.0 concepts

So far, the one major shortfall in this research project is the lack of testing. We tried an experiment to identify sites that were working on cutting edge aspects of primary care. We sent an email that briefly described Primary Care 3.0 and asked who might like to work with us on this. A number of people showed interest and telephone calls were scheduled. What we hoped to do was to identify projects that organizations were already working on, and provide some level of support to these projects, in order to learn from them and accelerate the work. The calls were held and the offers made, but at this time no specific linkage between primary care organizations and the R and D team were made. The assessment of this failure is that the offer was too vague and teams did not see the value in the support.

As we move forward, the following plan for testing will be tested.

1. We are going to test out the driver diagram that is in the GP consortia paper. This diagram needs work and we will test this by sharing with experts and seeking feedback.



2. Through the help of Triple Aim sites we have developed a number of ideas that are based upon the concept of PC. 3.0 that could be tested

Here is one example

1. Horizontal-connecting with the community

Efficient ways to improve broad population management and chronic care for those who are not currently that sick--care coordinators for the complex ill pt are probably attractive to payors, but the broader work doesn't interest them at present. Could community resources be part of the answer to this situation? Any community has a lot of uncoordinated resources. Can you develop a short list of resources and then contact any group to learn more about what they are doing? From

that interaction could you begin to work with that group to test out how you might work together? For example here is an idea to begin a test. Many communities have meals on wheels. The people they supportive have some level of vulnerability. Is there anything that the volunteers can do beyond meal delivery that would add to the health of that individual? Is there any way to connect primary care team to this resource? An actual example of how this might work comes from Eastern and Costal Kent PCT. Using housing specialists to ask questions about health as part of there interview in the home. The dental access question has worked and increased referrals, but the "do you want to quit smoking question" has not worked in the same way. We are looking at why

See appendix H for more details on potential tests for Primary Care 3.0

VII. Conclusions and Recommendations:

We recommend the following strategy for IHI:

1. Hold a seminar for GPs in 2011. See Appendix G for draft agenda

2. Ian Rutter has stated "The Triple Aim may appear too broad in focus for GP's in the early stages of development and therefore not helpful. This is a reply I have heard on several occasions. The Triple Aim has also been developing with the present set of sites over a number of years. It may be more appropriate to consider a specific program just for GP Consortia" Therefore, our specific recommendation is to create a virtual collaborative for the shadow GP consortia to start in 2011. We should use faculty from the UK and Europe primarily to run this work.

3. Develop specific courses that the GPs might want to participate in outside of the collaborative, such as quality improvement seminars, managing high risk populations, holding hospitals accountable for safety, etc.

4. As GP consortia gain more skill, encourage them to move over to the Triple Aim collaborative for a wider exposure to work around the world

5. No further work should be done on 3.0 unless tests are clearly described and testers are identified.

VI. Open Questions:

VIII: Appendices:

Appendix A- Visit to Southcentral Foundation in Anchorage Alaska. This is Alaska Native run health system

Here are some recent observations from a visit to Southcentral Foundation, which is an example of one of those organizations that are on the primary care 3.0 journey. This isn't meant to be comprehensive about Southcentral Foundation, and it assumes that you already know that they have some of the best primary care team structure in the world. However it is meant to give you a sense of what the journey needs to look like.

1. Constant and steady testing, redesign and improvement in all parts of the organization. I was impressed with all the "tweaks" I saw in processes that were doing well when I was there two years ago, but have been improved even more since that visit
2. Good long-term leadership.
3. Deep commitment to organizational development, from hiring to training, etc. This has continued to progress since my last trip.
4. Solid improvement capability. That is used on an ongoing basis throughout the organization
5. No wild swings from leadership. They don't jump from thing to thing, they just keep moving along in a steady but improving manner
6. Primary Care observations
   a. information technology that supports action, e.g., list management capabilities to manage population and communication
   b. continue to redesign the team. Integrated dietitians, put the scheduling person directly with the team
   c. A recognition that doctors can be part of the problem with complex patients, (e.g., their own schedules, etc.) Part of the behaviorist's job now is to help the clinicians function better with patients. This last item of how to help clinicians do a better job around the "soft skills" is a big deal.
7. They have work ongoing to maximizing health potential from conception to 5 year olds8. They are working on the complex patients. One is to develop a plan for each of the identified patients (customer-owner). The second is to help clinicians see how they might be part of the problem for this group
9. Their existence and approach is a method to close the disparity gap between Alaska Native Care and the rest of the population. Their total approach is really helping to overcome racial barriers. They build trust with customer-owners that I suspect is hard to measure but is so critical. Alaska Natives have endured much harm over the years, but their system is witness to how they are overcoming these barriers.
10. They helped me see that some of our new thinking about primary care 3.0 is right on track: working in the community, better integration with the rest of the health system, the concept of maximizing health and the GP as a 'fund holder" all good areas for us to keep working on.
11. They shared with me their Baldridge report. It had 20 pages of graphs, run charts etc. It was wonderful to see. My only recommendation is that they need a measure for the health of their population.

12. There was enough data in that report for me to make a crude approximation on per capita spending and see they have to be one of the highest value health systems in the US. Their rates look more like the UK than the US.

Appendix B – Visit to the University of New Mexico

The University of New Mexico has created a network of health extension agents that link with local community resources to improve the health of their state. The model is built off of the Agricultural Cooperative model. In addition, the U of NM organized part of their family practice primary care training such that one year of residence occurs at the University and 2 years occurs at community sites. They have incorporated public health training into their medical school curriculum. This work, lead by Arthur Kaufman, MD, HSC Office for Community Health, was described in an article in the Annals of Family Medicine.[4] The abstract of that article follows:

"The Agricultural Cooperative Extension Service model offers academic health centers methodologies for community engagement that can address the social determinants of disease. The University of New Mexico Health Sciences Center developed Health Extension Rural Offices (HEROs) as a vehicle for its model of health extension. Health extension agents are located in rural communities across the state and are supported by regional coordinators and the Office of the Vice President for Community Health at the Health Sciences Center. The role of agents is to work with different sectors of the community in identifying high-priority health needs and linking those needs with university resources in education, clinical service and research. Community needs, interventions, and outcomes are monitored by county health report cards. The Health Sciences Center is a large and varied resource, the breadth and accessibility of which are mostly unknown to communities. Community health needs vary, and agents are able to tap into an array of existing health center resources to address those needs. Agents serve a broader purpose beyond immediate, strictly medical needs by addressing underlying social determinants of disease, such as school retention, food insecurity, and local economic development. Developing local capacity to address local needs has become an overriding concern. Community-based health extension agents can effectively bridge those needs with academic health center resources and extend those resources to address the underlying social determinants of disease."

Appendix C – Hidalgo Medical Services

Hidalgo Medical Services' work is an example of how primary care can work on community issues. The organization began with a simple vision: "being able to bring a part time health

[4] Kaufman A et al. Health Extension in New Mexico: An Academic Health Center and the Social Determinants of Disease. *Annals of Family Medicine* 2010;8(1):73-81.

provider to a community with no healthcare resource," which grew to the present vision to "become the recognized leader in providing medical, dental, mental health and family support services for everyone in Hidalgo County and Southwestern New Mexico, as well as a national model for sustainable frontier health services and community development"[5]

The system began as a two-day per week clinic, and has grown to an organization that "operates at least 7 facilities in Grant and Hidalgo Counties. In Lordsburg and at Med Square Clinic in Silver City, HMS provides comprehensive primary care services, a moderate complexity lab and x-ray dental services, mental health services and family support." They are involved with medical and dental education. In fact they have grown so attractive as an organization that in a state with a shortage of 2000 dentist they are actually turning dental applicants away.

More importantly--at least from a Primary Care 3.0 perspective--they have developed a portfolio of work focused on improving the health of communities they serve. Through self-funded programs along with grant-funded programs, they are a national model of what a rural FQHC could do for its community. Their projects include work such as identifying diabetes, working with school age children, teen moms and young men. They have decreased teen pregnancy rates and improved the number of teen moms who graduate and even go on to college. Part of their novel approach includes a board that is made up 100% of members using their services. They have community health workers who are trained to deal with a wide range of services from assisting people with application for service to helping diabetics deal with health care issues to running the programs for youth and teens. Their novel approach is being supported by the CDC, and they are spreading to other parts of the U.S.

They are also using their knowledge to continue to build their infrastructure to become an Accountable Health Organization. Their visionary founder Charlie Alfero recognizes the destructiveness even in their own organization of a fee for service model and is pushing ahead to move to a new system.

More information is available on their website, http://www.hms-nm.org/

Appendix D – Components of Primary Care 2.0

The authors for this section are Cory Sevin, Tracy Jacobs, Cindy Hupke, and Zoë Kawaller

Care Team Development

In Primary Care 2.0, the care team blends multidisciplinary skills, focusing several people's insights – rather than a single physician's – on each patient. Primary Care Team development allows non-physician team members (nurses, medical assistants, case managers, etc.) to take on

[5] Hidalgo Medical Services. *History*. Accessed October 15 2010. Available at: http://www.hms-nm.org/about-hms/hms-history.html

clinical tasks that physicians have insufficient time, or skill, to perform. For instance, many practices have found that many primary care visits, especially for chronic disease, involve relatively simple matters that could be handled by nonphysician team members via protocols or standing orders.

Care team development will require that the team share defined goals, from an organizational mission statement down to specific, measurable operational objectives. The team must have both clinical and administrative systems in place, such as a process for refilling prescriptions and making patient appointments. Division of labor must be clearly defined, and each team member trained for his or her own role, and cross-trained to substitute for other roles. Communication among team members is key; effective team development will establish communication structures and processes.[6]

Population-Based Planned Care

Population-based planned care is designed to manage all members in a "population" who have a certain disease, regardless of the severity of individual cases. For example, every person with diabetes is assumed to be an active member and is managed as such, unless he or she requests otherwise. By contrast, disease management programs manage only those with the most severe forms of the disease, and only those who volunteer to participate. A "population" generally refers to the set of patients associated with the primary care practice, but it may also be defined geographically, or otherwise.

By managing an entire population with a given disease, population management programs can institute preventive measures for less severely afflicted members of the population, while continuing to manage the existing ailments of the more severely afflicted, higher-cost members. Population-based planned care emphasizes cross-continuum integration of care, from education and support for effective patient self-management, to coordination of multiple specialty physicians and delivery sites.

Working on Quality Access

The guiding principle for providers working on quality access is the statement: "People get what they need and want, when and how they need and want it." For practitioners of Primary Care 2.0, creating quality access requires balancing supply and demand for services on both a short- and long-term basis. Primary care practices must deeply understand the demand they face, and design patient-centered delivery systems to meet that demand, with no delays. Some strategies they may use to accomplish this include leveraging non-visit care, optimizing all staff and community resources, re-thinking the traditional visit format, and building in contingency plans for fluctuations in demand and supply.

---

[6] Bodenheimer T. Building Teams in Primary Care: Lessons Learned. California Healthcare Foundation 2007. Available at: http://www.chcf.org/publications/2007/07/building-teams-in-primary-care-lessons-from-15-case-studies

Efficiency and reliable design in the office

Efficiency in the office practice setting relates to eliminating waste, or non-value added steps, from all processes in the practice. Reliable design aims for the core processes in the office setting (especially those relating to patient safety) to be delivered correctly 100% of the time. Common concepts to design with efficiency and high reliability include:

- Standardization of processes, equipment, forms, roles and tasks
- Process mapping and subsequent process redesign to eliminate non-value added steps
- Clarity on roles, responsibilities and tasks
- Failure identification and mitigation
- Continual redesign

Information Technology Support

Information systems embedded within the clinical practice can provide accurate, timely, and comprehensive information about individual patients and whole populations. These systems may include electronic patient registries, medical records, prescribing, decision support and guidelines, patient portals, etc. Used meaningfully, health IT systems are an invaluable tool for increasing efficiency, reducing error, enhancing communication between and among providers and patients, promoting proactive planning for high risk groups, and supporting reliability through automatic prompts and reminders.

Leadership Engagement

Engaged leaders are involved in building the will for change, implementing systems to capture and spread knowledge within the organization, and designing and implementing an effective execution strategy that is connected to the strategies of the organization. Engaged leaders take responsibility and accountability for the performance and results of the system. To accomplish this goal, an engaged and effective leader must have a basic knowledge of its organization's many activities, the authority to muster resources and remove system barriers in the organization, and a direct connection to senior leadership.

Strong Learning System

A strong learning system enables all individuals and teams within an organization to obtain new knowledge, disseminate it throughout the organization, and build upon the shared learning continuously. Strong learning systems are capable of systematic problem solving, experimentation with new approaches, learning from experience and past history—both the organization's and its members'—and transferring knowledge quickly and efficiently throughout the organization (source: Jedlinsky M, Garrido T, Schilling L. Learning and Knowledge Management in Quality White Paper. Kaiser Permanente; July 2010)

Patient Engagement

In a broad sense, patient engagement is the extent to which an individual is involved in promoting and taking care of her own health and managing the conditions she may have. There are many ways individuals can support their own engagement with their health, one of which is a relationship with a provider and care team. From the perspective of an office practice, patient engagement is the extent to which a patient becomes involved in a relationship with a provider/ care team and their own care. Engaged patients are more likely to successfully manage their own complex healthcare needs (e.g. drug regimens, self-care behaviors) and experience better outcomes.

Accountable Outcomes

Primary Care 2.0 practices aim to be accountable for their patients' health outcomes, even in realms that may go beyond the traditional purview of a primary care practice. This broad accountability ensures that the practice has a continuous relationship with its patients, rather than one based on the isolated points in time when the patient visits the doctor's office. Currently, the boundary of accountability for primary care practices is shaped by the payment and environmental incentives in which they work. Spreading Primary Care 2.0 best-practices will require an understanding of which incentives must change, and what activities can be adapted within the current incentives structure.

Appendix E- GP Consortia Paper

Major changes are now unfolding in England. The government is moving from the present organizational model of Strategic Health Authorities (SHA) and Primary Care Trusts (PCT) to a new model in which GPs will be required to commission secondary care directly for their patients. Each GP will be required to join a "GP Consortium" which will replace PCTs. The reasoning for this restructuring is that GPs may be in the best position in the system to manage utilization, costs, and quality for their patient population. Indeed, approximately 90% of the health care activity occurs in connection with the primary health care system. However, 90% of the health care expenditures are associated with *hospital based care*. In the new system, GPs will be given direct responsibility for managing those expenditures. While these changes present new opportunities for improving quality, redesign of care pathways and reducing waste, they will require that GPs and the GP consortia to strengthen the set of skills, processes, and structures which have been used in Practice Based Commissioning. This paper presents an outline of the learning opportunities from the Triple Aim which, we believe, will be most critical.

Every GP Consortia and each of its constituent GP practice's must have a clear understanding of their goals and responsibilities in this new era. Crucially they must also have the skills and the tools available to achieve those goals for implementation of this policy to be successful. David Margolius and Thomas Bodenheimer have characterized the new goal as a paradigm shift in responsibility for Primary care from episodic, visit-based care to continuum, health-based care.

The new goal will be how do we make our patients as healthy as possible
We suggest that a useful goal for British GPs is the Triple Aim: -
Improve health for the population,
Improve experience of care for patients,
Maximize the use of finite resource
The Triple Aim is not a leap for GPs to make. Indeed it has been an implicit goal for many years. However, we believe that making this goal explicit fits well with the government's proposal and will provide consortia with a useful framework as they begin commissioning care.

Focus Areas within the Triple Aim

In this section we present an overview of the areas in which GPs and consortia will have the greatest leverage to pursue the Triple Aim. A table of suggested metrics is presented below. These are the areas that GP Consortia are and will focus on. The Triple aim enables them to join a World Wide learning set of similar Organisations aspiring to the same goals.

Despite its usefulness, the triple aim concept in England has at times been weakened by being "all things to all people." In particular, the "health" corner of the Triple Aim triangle has at times been interpreted too broadly to be effective in the primary care setting. Health has myriad known determinants, such as education, socioeconomic status, etc. While these determinants are certainly significant, we suggest that GPs interpret the health corner narrowly, at least at first. That is, the GP consortia should focus their energies on health issues with which they have the greatest leverage, such as prevention, immunizations and extra support for behavioral and chronic illnesses. These are their main responsibilities as primary care practitioners, and so they must do an excellent job in these areas before tackling wider health determinants. That said, GPs and consortia should continue to bear in mind that health is co-created with patients, and that multiple determinants will affect health outcomes. As the consortia gain greater skill, they may want to partner with organizations that impact these wider determinants. Still, in the first phase of consortia development, we encourage a focus on health care that can mostly directly and immediately impact population health.

To maximize limited resources, GP consortia should continue to focus on reducing utilization at higher levels of care—which is less efficient for care of chronic or complex conditions—and shifting resources into more accessible settings in their patients' communities. They should continue to improve their skills in ensuring that care is always delivered in the most appropriate and efficient setting. We have seen excellent work in such resource-shifting by Triple Aim teams in the UK. For instance, in Tayside Scotland the team has been able to dramatically decrease hospitalizations in several communities. They have been able to close beds and free up cash to put back into community care. Thus, shifting the balance of care has to be a key focus when GP consortia work on how to get the highest value for their per capita spend.

To continuously improve patients' experience of care, consortia may wish to familiarize themselves further with metrics of patient satisfaction (for instance, Patient Reported Outcomes Measurements) and other tools of continuous quality improvement. To some extent, the quality of care component of the Triple Aim is the component that GPs are best equipped to execute. At the same time, as GPs and consortia take on complex new responsibilities, they may be tempted to overlook this area or take it for granted. IHI's expertise in quality improvement will be a critical

and unique asset as we assist GP consortia in their early stages.

Listed below are the types of metrics in each of the domains presently used by Triple Aim sites. Metrics are crucial to the GP Consortia and to the Triple Aim. Existing sites use metrics which are fit for purpose in their own situations.

Dimension	***Measure***
Population Health	1. Health/Functional Status: single-question (e.g., from CDC HRQOL-4) or multi-domain (e.g. SF-12, EuroQol). 2. Risk Status: Composite health risk appraisal (HRA) score. 3. Disease Burden: summary of the prevalence of major chronic conditions; summary of predictive model scores. 4. Mortality: life expectancy; years of potential life lost; standardized mortality rates. *Note: Healthy Life Expectancy (HLE) combines life expectancy and health status into a single measure, reflecting remaining years of life in good health. See http://reves.site.ined.fr/en/DFLE/definition/.*
Patient Experience	1.Experience Questions from NHS World Class Commissioning or CareQuality Commission 2. Set of measures based on key dimensions (Safe, Effective, Timely, Efficient, Equitable and Patient-centered). 3. PROMS
Per Capita Cost	1) Total cost per member of the population, per month. 2) Total cost per member of risk stratified population per month per practice 3) Cost of certain diseases? May be interesting to measure how much diabetes patients are costing the practice at the same time as measuring quality, etc…

Practical Approaches to Accomplish the Goals

We believe that the GP practices and consortia can achieve the triple aim by developing a culture and environment that is driven by data and improvement. The GPs and their practices will need

to develop their skills in data presentation and analysis; facility with run charts will be particularly important. The practices will also need to improve their skills in waste reduction. Examples of waste might include unnecessary medication use, avoidable hospitalization, A and E use, and overuse of specialty services. IHI's waste tool and redesign work will be applicable here.

IHI will be able to train GPs not just in this technical skill, but also in the mindset of process improvement for the Triple Aim. That is, each GP will learn to think more consistently about the individual practice in the context of the whole consortia. Effective consortia will enable practices to collaborate on health strategies. For instance, the GPs in the Bolton PCT identified, as a community, a need to more aggressively to identify patients with primary cardiovascular risk factors. Working together, the PCT organized outreach and the GPs dramatically increased screening (Figure 1). The strategies together identified significantly more at-risk individuals (Figure 2), leading to more primary cardiovascular screening, intervention and ultimately a decrease in acute myocardial infarctions (Figure 3).

Figure 1: GPs in the Bolton PCT increased screening from 25% of the population to 80% between 2006 and 2009

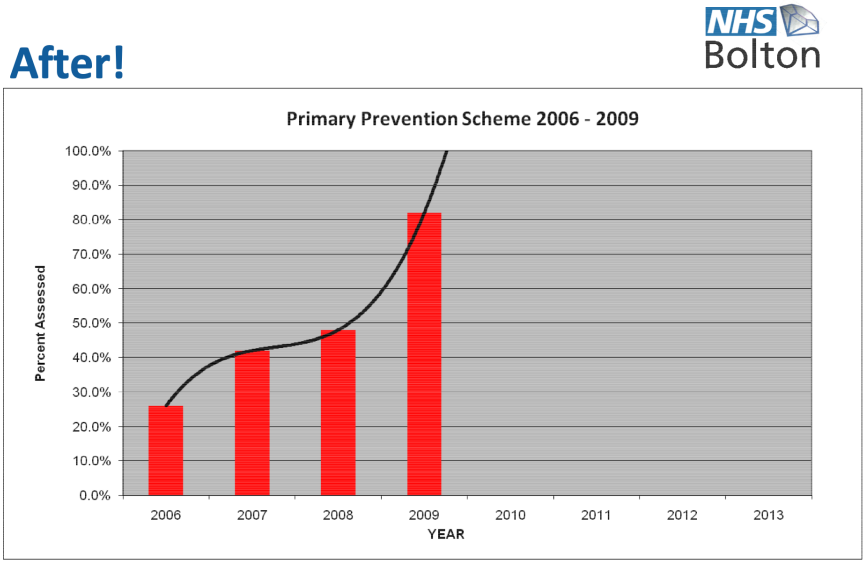


Figure 2: Between 2006/07 to 2009/10, the Bolton PCT dramatically increased the number of people in the community represented in disease registers.

Disease Registers

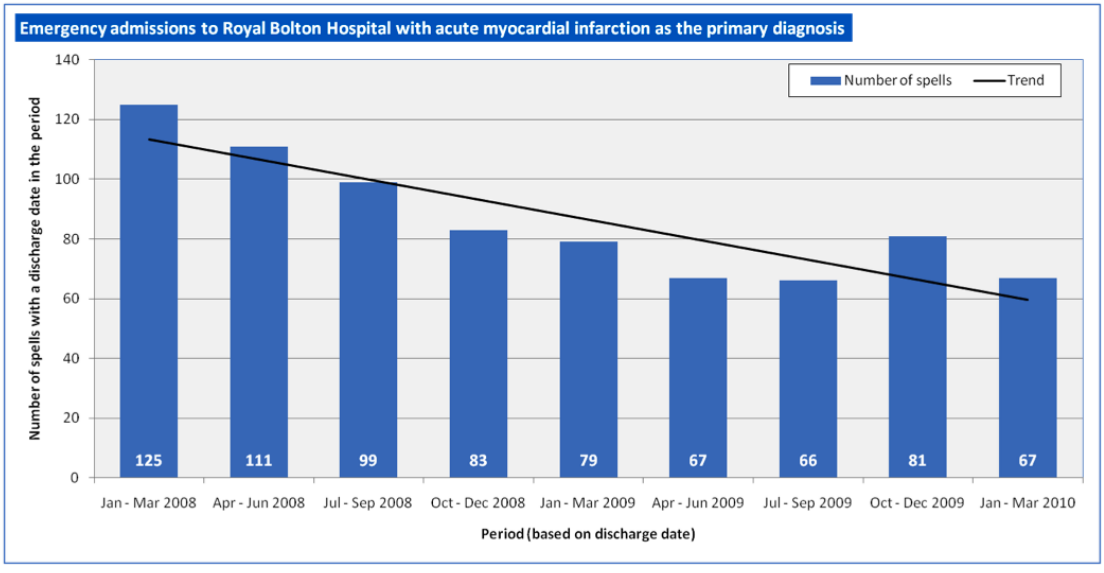
NHS Bolton

NHS Bolton: Disease Registers				
Clinical Area	2006/07	2007/08	2008/09	2009/10
Diabetes Mellitus	11,862	12,898	13,927	14,770
Hypertension	33,721	35,396	37,445	39,272
Chronic Kidney Disease	4,478	6,361	8,461	10,873
Primary Prevention Register		8,891	19,178	18,772 #
# Age reduced to 40 years				

Figure 3: Acute myocardial infarction emergency admissions fell by 50% over 2 years

MI Admissions

NHS Bolton



The GP Consortia will support its GP practices through its leadership, which will develop a culture and strategy for the member practices. We suggest that this culture and strategy should emphasize the consortia's capacity as a "learning system" of and for its practices. A learning system is one that iteratively tests and learns its way through issues, as opposed to designing and planning its way through. The best examples worldwide of sites that are most successful in delivering the Triple Aim have a learning based organizational structure. Developing a learning organization takes a commitment to: system level measures, explicit theory or rationale for system changes, segmentation of the population, learning by testing changes sequentially, using informative cases, continuous learning during scale-up and spread, and periodic review. A process for leadership identification and development are implicitly key for making and keeping these commitments.

Below we have listed the six key levers that the consortia have available to accomplish this work. These are, if you will, the tools to get the work done:

1. The Budget
a) Yielding savings for reinvestment
b) Incentive payments for managing the budget affectively

2. Learning System
a) Safety and Critical Incident reporting and learning across Organizational Boundaries
b) Joint Learning Collaboratives across Organizational Boundaries, focused on the removing all unnecessary steps in the patient journey
c) Multidisciplinary team meetings reviewing care of the dying, complex patients, safety, critical incidents, and referrals

3. Fully Integrated IT support
a) Fully coded searchable data
b) Real time computer-aided support for all aspects of the consultation
c) Real time links to patient-held information in other health organizations
d) Web links for patients to interact electronically with the practice
e) No Paper
f) Benchmarked data presented as run charts with cost and quality together

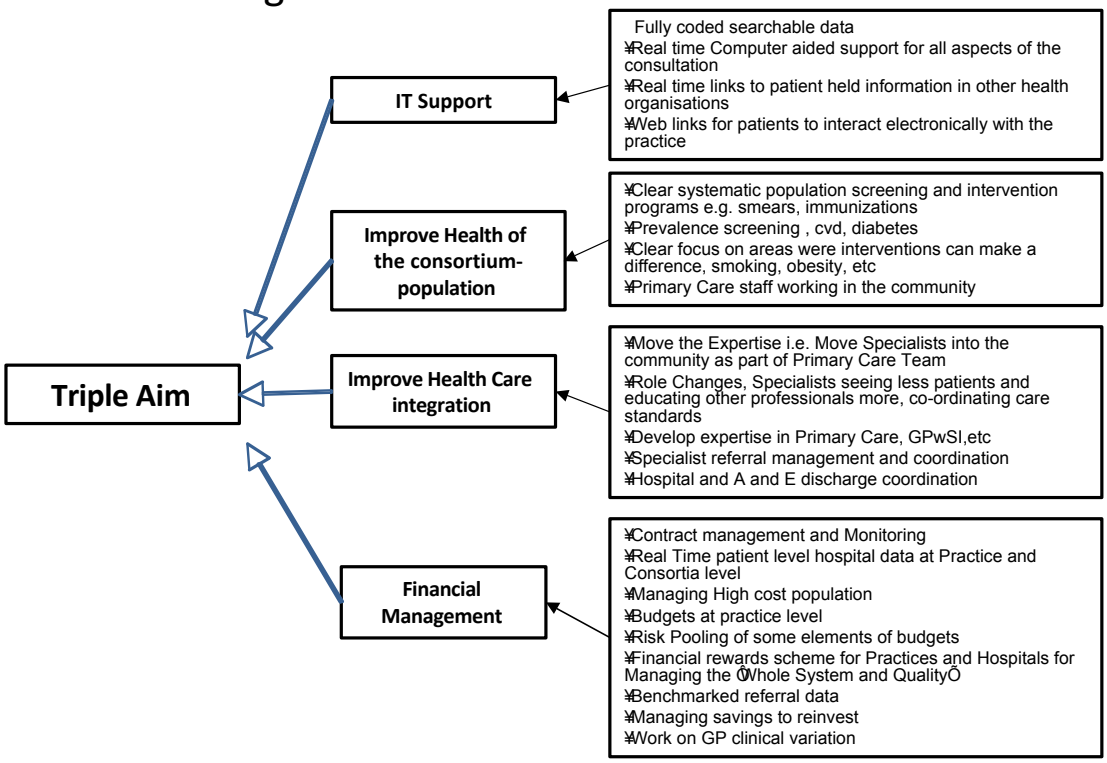
4. Shifting Care to Community Settings through Human Resource Development
a) "Move the expertise" - i.e. move specialists into the community as part of the primary care team
b) Role changes - specialists seeing fewer patients and educating other professionals more to coordinate care standards
c) Develop expertise in Primary Care, GPwSI, Advanced Nurse and Allied Health practitioners
e) Develop the expertise of Patients, expert patient programs

5. Shifting Care to Community Settings through Governance and Finance
a) Simple, quick approvals process
b) Governance proportional to the service being delivered
c) Run chart results reporting by providers of service
d) Item-of-service payments; payments less than equivalent hospital care
e) Monitoring and controls of service use

6. Primary Care management of the whole system
a) Contract management and monitoring
b) Real time patient-level hospital data at practice and consortia level
c) Sampled validation of data from financial systems to clinical systems and letters
d) Budgets at practice level
e) Risk Pooling of some elements of budgets
f) Financial rewards scheme for practices and hospitals for managing the whole system and its quality
g) Benchmarked referral data
h) Lead doctor and practice manager in each Practice
i) Management Allowance

The diagram below is a visual summary of this paper

Driver Diagram for Successful Shadow GP Consortia



Recommendations for IHI is the following strategy

1. Hold a seminar for GPs in 2011 See Appendix for draft agenda

2. Ian Rutter has stated “The Triple Aim may appear too broad in focus for GP’s in the early stages of development and therefore not helpful. This is a reply I have heard on several occasions. The Triple Aim has also been developing with the present set of sites over a number of years. It may be more appropriate to consider a specific program just for GP Consortia.” The specific recommendation is to create a virtual collaborative for the shadow GP consortia to start in 2011. Use faculty from the UK and Europe primarily to run this work. This collaborative or workgroup would still be part of the Triple Aim

3. Develop specific courses for GPs outside of the collaborative model, such as quality improvement seminars, managing high risk populations, holding hospitals accountable for safety, etc.

4. As GP consortia gain more skill, we can encourage them to move over to the Triple Aim collaborative for a wider exposure to work around the world

Appendix Draft Agenda

Day One – 2011

9:30 AM	**Registration- we will need some sort of "planning tool" that participants can use for the meeting**
10:00 – 11:00 AM	**Introduction to GP consortia framework and goal setting; During this session we will outline a framework to support a successful GP consortia and outline what the goals for the consortia might be**
11:00 – 1:00	Key Approaches to Managing the whole System
1:00 PM	**Lunch – Informal Networking**
2:00 – 4:00	Shift Care to Community Settings through Developing People -
4:00 – 4:15	Break
4:15 – 5:30	Shift Care to Community Settings through Governance and Finance
5:15 – 5:30	**Wrap-Up from Day One**

Day Two – 2011

8:30 AM	**Welcome Back**
8:45 – 10:00	*Developing a learning system*
10:00- 10:30	Tools for Quality Improvement - Data Analysis; Run Charts - The Model for Improvement -
10:30 – 10:45	**Break**

10:45 – 11:45	**The role of IT. It would be great to have a case example**
11:45 – 12.45	**Managing the budget**

Appendix G - Payment models

September 2010
Exploring Payment Methodologies for PCMH
Trissa Torres, Genesys Health System

Context:

In preparation of a Michigan application for the CMS Multi-payer Advanced Primary Care Practice Demonstration in summer, 2010, a coalition of Michigan payers and providers proceeded through an exploration process of payment models to support the Patient Centered Medical Home (PCMH). The goal was to identify a payment methodology that assured equity, commonality, and accountability across payers and providers throughout the state.

Assumptions:

- There is general recognition that achieving PCMH requires investment both in the transformational process and in sustainability of the new model of care. A clear example of this is the adoption of electronic data systems that require an upfront investment in the initial hardware and software as well as ongoing funding for system maintenance and improvement. Other elements of PCMH have similar initial and ongoing resource requirements.

- Another key principle is that PCMH transformation requires support at both the individual practice level and the practice group level. In Michigan, Physician Organization (POs) and Physician Hospital Organizations (PHOs) play a key role in supporting practice transformation. Thus payment methodologies must bring resources to the POs and PHOs, as well as the practices to optimize support at both levels.

-
- Though all domains of the PCMH are incorporated in Michigan's efforts, there was a deliberate choice to put special emphasis on four specific aspects of PCMH that were felt to be the least developed across our state and with most potential to result in budget neutrality: individual care management, care coordination, self management support and community linkages. In considering payment methodologies, payments to support these specific services were emphasized.
-
- There was also recognition that program delivery in the four key focus areas is still, for the most part, in early stages of development and evaluation, with only limited evidence on best practice. Thus, it is important to provide sufficient flexibility in payment to allow for learning, improvement and evolution of these services. For example: payment for a specific number of outreach interventions would be too limiting and could result in services designed to maximize payment rather than allowing exploration to determine how to maximize outcomes.
-
- Similarly, maximizing outcomes may require differing approaches across differing communities and populations around our state. Again, payment must be flexible enough to accommodate these variations.
-
- There is an assumption that PCMH when implemented effectively and efficiency can meet the requirement of budget neutrality. Payment amounts were designed around specific calculations to achieve budget neutrality.
-
- Although some purchasers, payers and provider groups are ready for and may be employing shared savings and shared risk payment models, there was general consensus that this approach was not ready for a statewide implementation, though may be a direction to head in the future.
-

Payment Methodologies Explored:

Enhanced Fee-For-Service (FFS)

BCBSM, the largest commercial provider in Michigan with largest existing PCMH demo in the country, including a significant portion of self insured products, currently employs this methodology as part of their payment system for PCMH. They provide a 10% increase in reimbursement on E&M services provided by the PCP designated as PCMH. One advantage of this methodology is that it brings money directly to the practice. It can reward early transformation efforts as well as ongoing support over time. Both an advantage and a disadvantage is that it allows the practice to direct these funds to their chosen areas of need. This can allow flexibility to tailor to individual practice needs, but requires accountability to assure dollars are invested in a manner that best supports improvement. Enhanced FFS is a fit for payers

with existing FFS reimbursement payment methodology. In capitated plans, increasing payment for each individual visit alone merely exhausts the primary care pool, and thus an equivalent increase the primary care pool would be required. Some worry that enhanced FFS rewards volume, driving unnecessary utilization. Others argue that over utilization of primary care is an oxymoron. There is also the potential that increased reimbursement rates can have the unintended consequence of driving up charges at the practice level. Higher charges may adversely impact self pay patients, restricting access for this subset of patients due to high out-of-pocket costs.

Incentive or Reward Payments

Most payers are already employing some form of reward or incentive payments based on performance against utilization and/or quality target measures. It would be relatively straight forward to focus these measures on key aspects of PCMH transformation. Early rewards could be for infrastructure development and later rewards could target improved outcomes. Incentive rewards can be directed toward individual providers, practices, and/or practice groups such as POs and PHOs based on individual or group performance. One of the biggest challenges is achieving alignment of these targets across various payers. Mal-alignment creates an undue burden on practices dispersing their focus to many different issues simultaneously. One of the risks of increasing incentive payments to primary care may be decreased availability in the short term, of reward funds for other providers such as specialists and hospitals. This contributes to mal-alignment. Presumably as cost reductions are realized, incentive pool dollars could be increased accordingly. Another disadvantage is that incentive dollars may only be paid once or twice a year limiting availability to support up-front investments such as hiring staff or purchasing equipment.

Per Member Per Month (PMPM)

Increasing a monthly capitated payment to practices (or centrally to POs or PHOs) for practices achieving PCMH designation, or steps toward PCMH, creates a flow of funds to support PCMH activities. This approach is attractive to providers, as they receive their funds up front in advance of costs. Like PMPM, FFS can fund early transformation efforts and sustain efforts over time. As with FFS uptick, PMPM allows flexibility for practices to invest in chosen focus areas, but without direct accountability for that investment. PMPM methodology is a fit for payers with existing PMPM payment approaches. For payers who historically have utilized a FFS approach, contracts with their purchasers may specifically prohibit a proactive payment methodology such as PMPM. In negotiating between payers, and in calculating and describing budget neutrality projections, it was helpful to discuss different payment options in PMPM equivalents, which became a type of currency for achieving commonality (for example, and x% FFS uptick is equivalent to ~ $z PMPM).

Expanded Service Codes

Some payers have authorized payment for expanded service codes billable for specific services such as care management or telephone follow-up by non-physician providers. One benefit of this approach is that it directly funds a set of care management and care coordination services that have

been identified as core to PCMH improvement efforts. One disadvantage from the perspective of the payers is that it can initially be difficult to estimate and budget for the quantity of services that may be billed. Additionally, because these codes are paid FFS, this mode rewards volume, creating a potential risk of overutilization. Some payers have defined the codes as being payable only to certain providers, such as nurses, which limits the ability to fund a broader team of providers. Some models indicate benefits to centralizing the expanded team to a PO, PHO, or community level to support several practices. Traditionally these entities do not bill directly for services and thus may not be able to take advantage of such codes. Lastly, patient co-pays and deductibles may still apply for these services, creating the situation where a patient may owe out-of-pocket expenses for a follow-up phone call to support care coordination. Some feel this creates disincentive to patient engagement and participation.

Delegation Agreements

Delegation agreements are when a payer redirects or "delegates" responsibility and funds for services that were previously provided by the insurer or contractor to a PO or PHO to provide like services more closely aligned with the practices. Historically, delegation agreements have been used for provider credentialing and utilization management. Now, in association with PCMH, they are being tested for services such as case management, care management, care coordination and self-management support. One advantage of this payment method is that it invests directly in the targeted focus areas for PCMH improvement that show promise for improving outcomes and reducing costs. Another advantage is that this type of investment builds infrastructure at the PO/PHO level crucial to support ongoing practice transformation. The biggest disadvantage is that in redirecting the funds to POs and PHOs, this can be a direct threat to existing programs and staff currently employed by the payer.

Conclusion:

Clearly there are advantages and disadvantages to each of these payment methodologies explored. A combination of payment methodologies may be required to achieve the desired balance of funds across the PO/PHO and practice levels. Regardless of payment approach, accountabilities must be built in, requiring robust tracking and reporting mechanisms for both costs and outcomes.

Appendix H Concepts that you could use some testing.

1. Vertical test ideas-(how can we make health care more integrated to improve care for the patient?)

Referral management (urgent and routine)

Transitions coordination

CHW/patient navigators/Care Partners managing referrals from inception to reception of reports

Electronic communication between hospitals, specialists, and PCP

Referral to public benefit programs to cover costs of specialty care

Reducing readmissions/ED

Focus on follow up of admissions

Notification to PCP of admission and discharge

Hospital discharge planners and care coordinators communicate early

CC phone call to discharged pt within 24 hrs; daily phone follow-up as needed

Office visit with 2-5 days

Reducing avoidable ED use by referring patients to medical homes when they do not have one.

2. Horizontal-connecting with the community

Efficient ways to improve broad population management and chronic care for those who are not currently that sick--care coordinators for the complex ill pt are probably attractive to payors, but the broader work doesn't interest them at present. Could community resources be part of the answer to this question? Any community has a lot of uncoordinated resources. Can you develop a short list of resources and then contact any group to learn more about what they are doing? From that interaction could you begin to work with that group to test out how you might work together? For example here is an idea to begin a test. Many communities have meals on wheels. The people they supportive have some level of vulnerability. Is there anything that the volunteers can do beyond meal delivery that would add to the health of that individual? Is there any way to connect primary care team to this resource? An actual example of how this might work comes from Eastern and Costal Kent PCT. Using housing specialists to ask questions about health as part of there interview in the home. The "dental access" question has worked and increased referrals, but the "do you want to quit smoking question" has not worked in the same way.

Explore if opportunities to advance 3.0 leveraging Public Health funding in national health care reform?