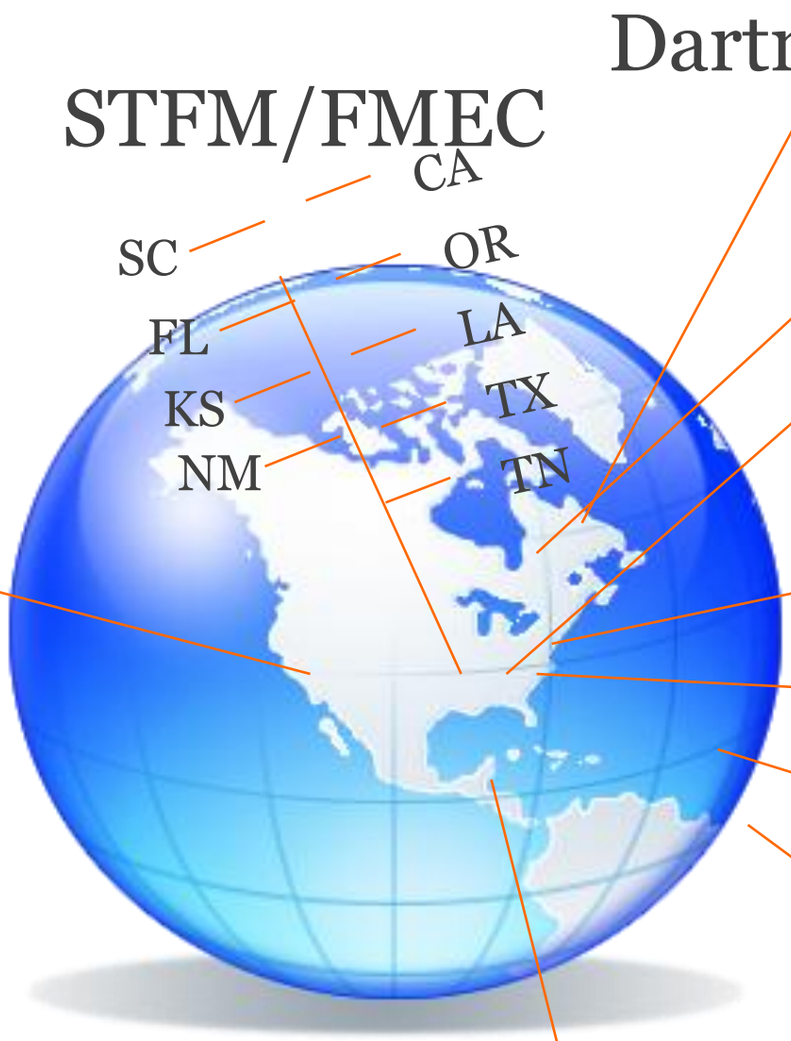
ONE ACADEMIC MEDICAL CENTER'S JOURNEY TOWARD A PATIENT CENTERED MEDICAL HOME

STFM
Conference on Medical Student Education
January 22, 2011
Catherine Florio Pipas, MD

Committed to Health:
The Health And Outcomes Of Our Patients, Employees And Population
The Health And Development Of Our Teams and Learners
The Health And Performance Of Our System

Pipas FM Pathway



Dartmouth, NH

JMC, Philadelphia

SWGFPR, Georgia

Palo Alto, CA

UNC, NC

MUSC Charleston, SC

Thailand

South Africa

Honduras

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Regional Primary Care Center

patient-centered, coordinated health care
Medical Home

IF WE BUILD IT, THEY WILL COME . . .

IF WE BUILD IT WITH THEM, THEY WILL BE HERE

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"According to an article in the upcoming issue of 'The New England Journal of Medicine,' all your fears are well founded."

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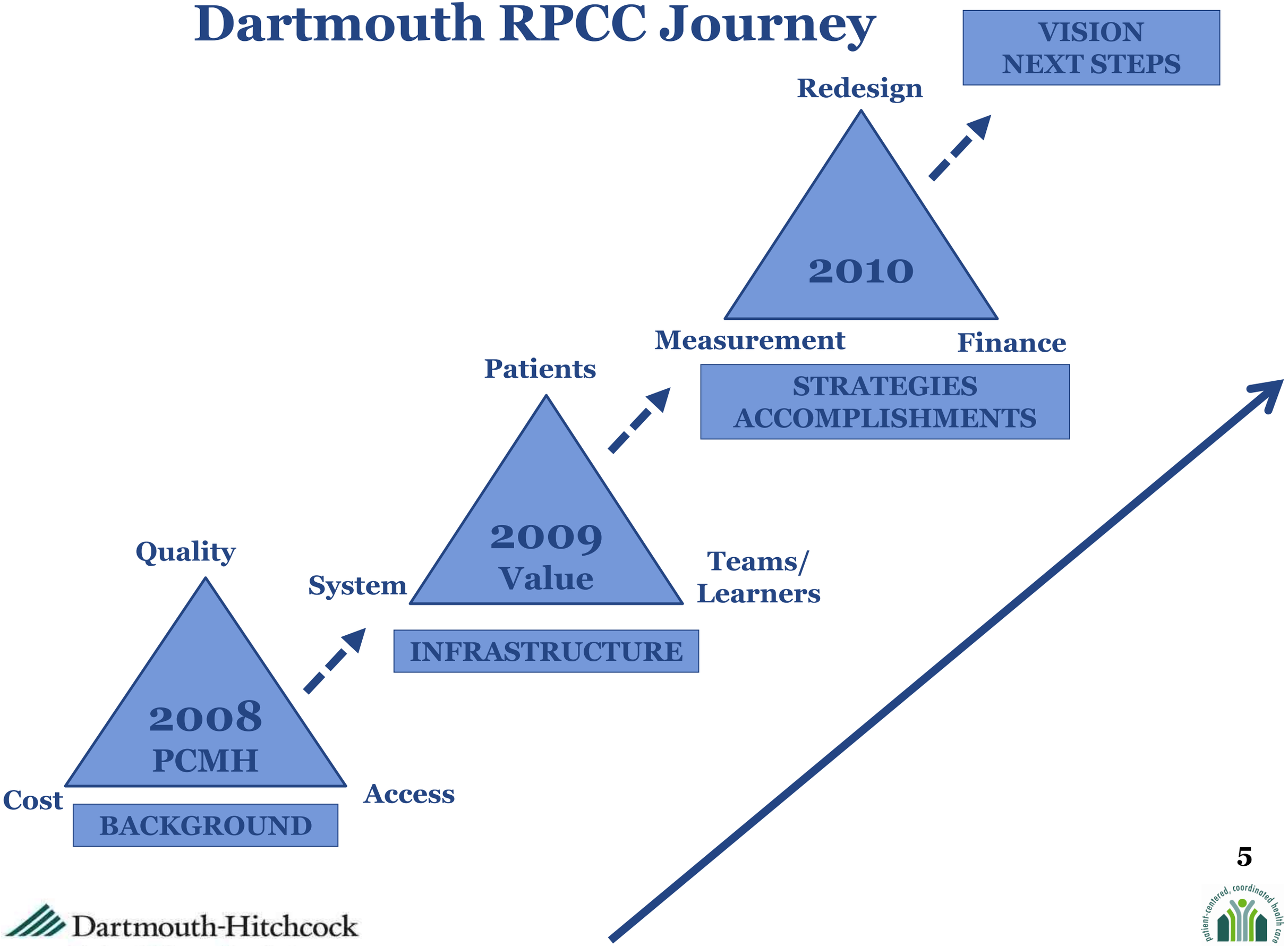
Dartmouth RPCC Journey



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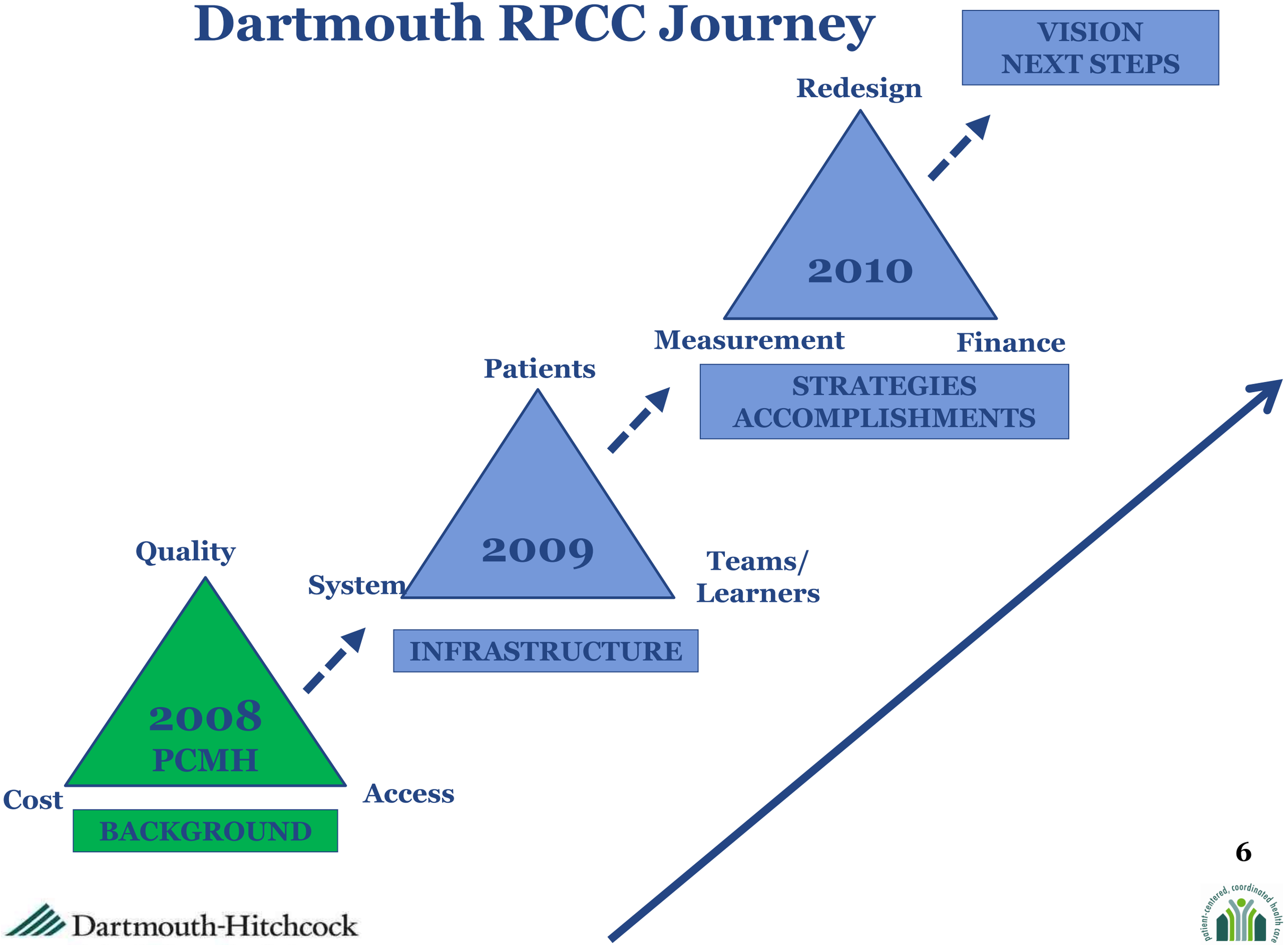
Dartmouth RPCC Journey



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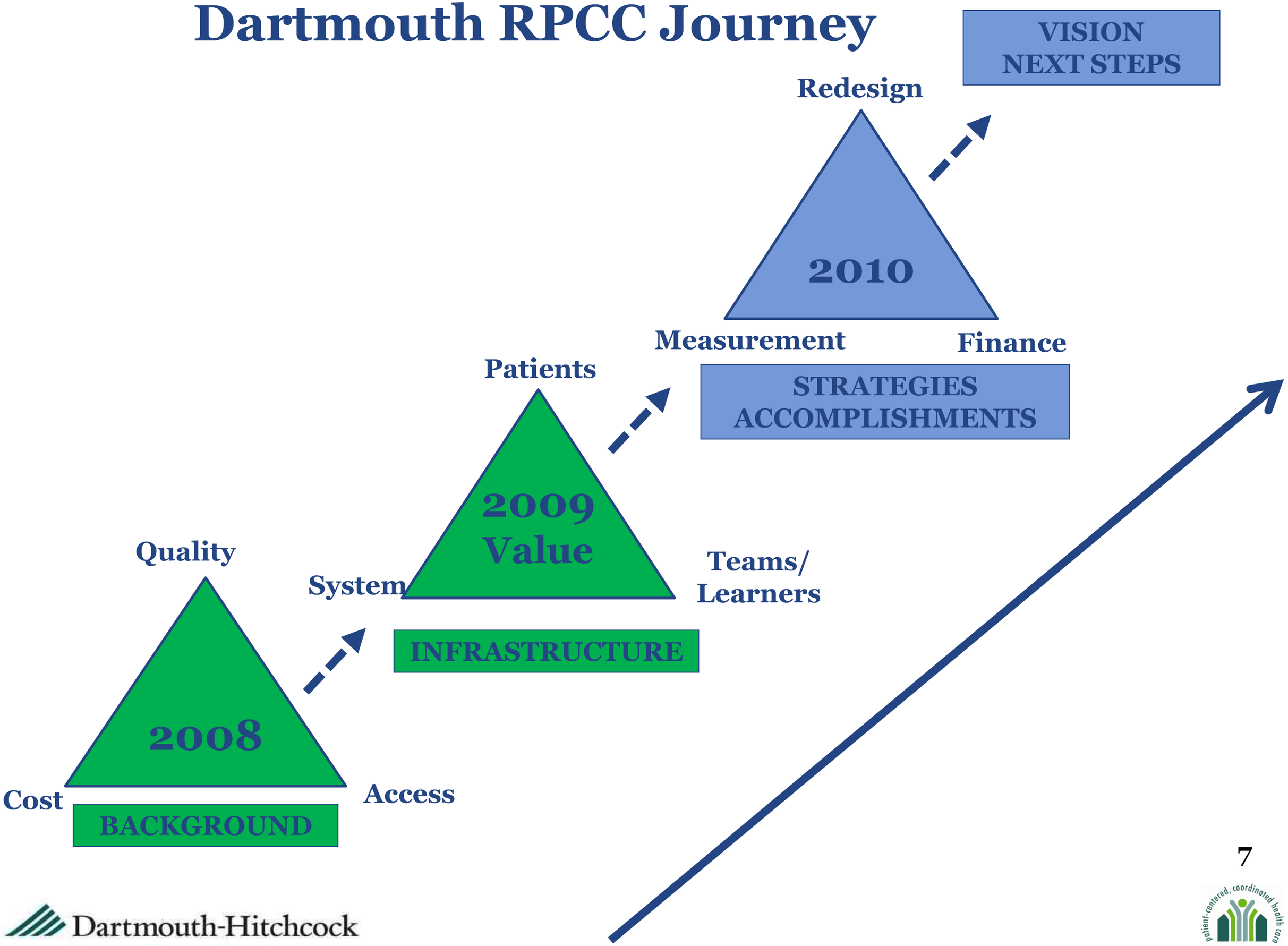

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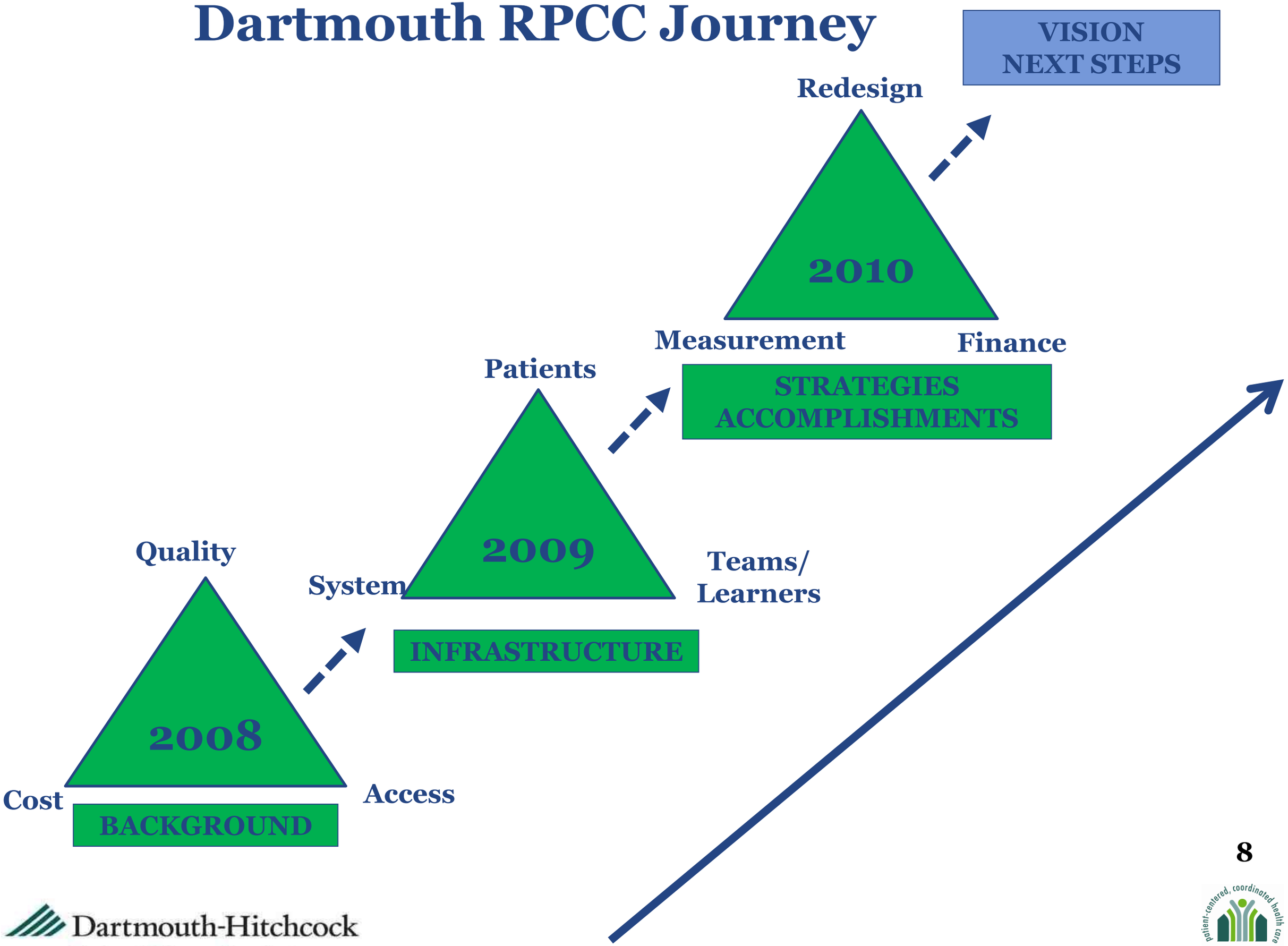

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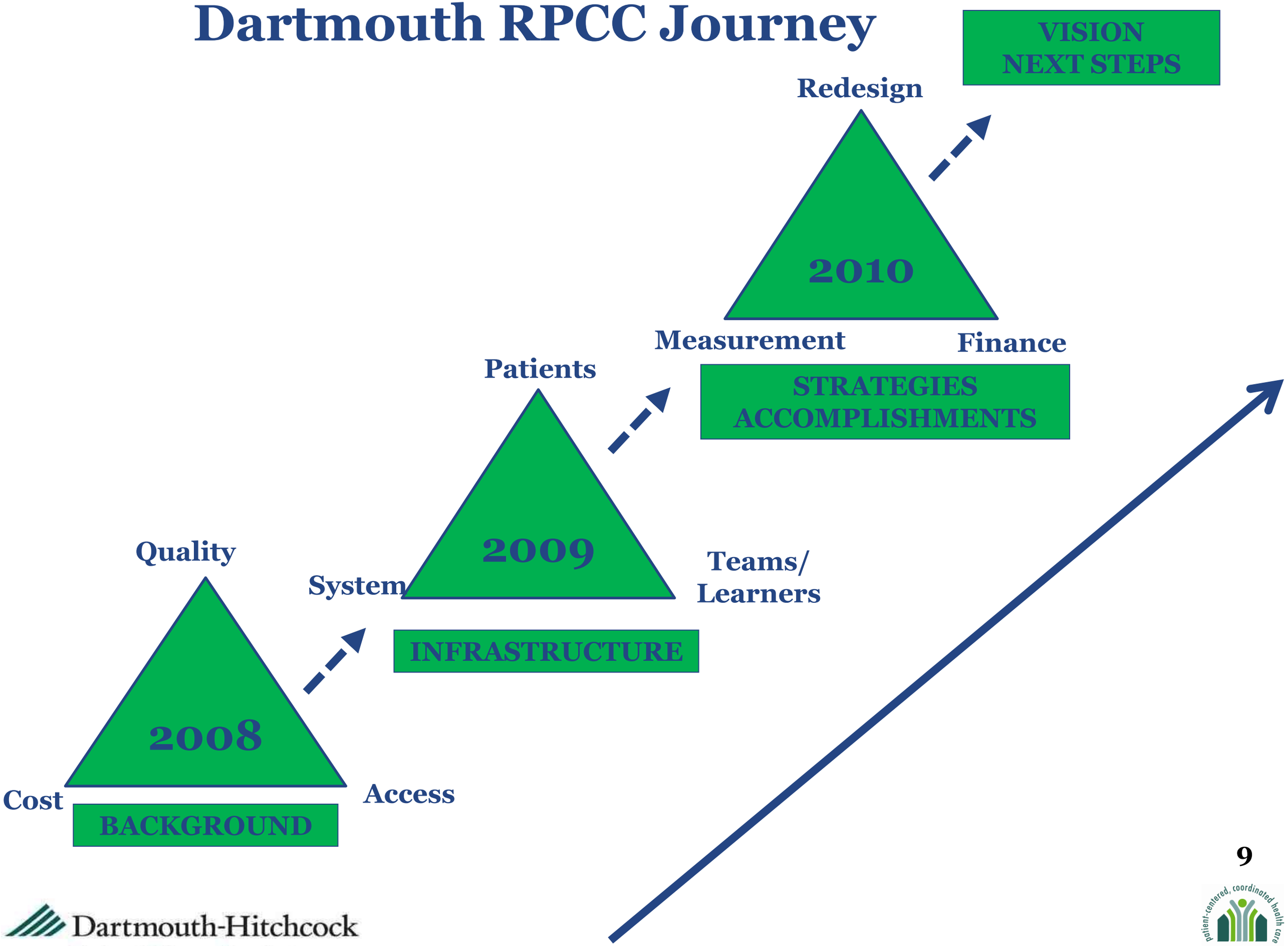

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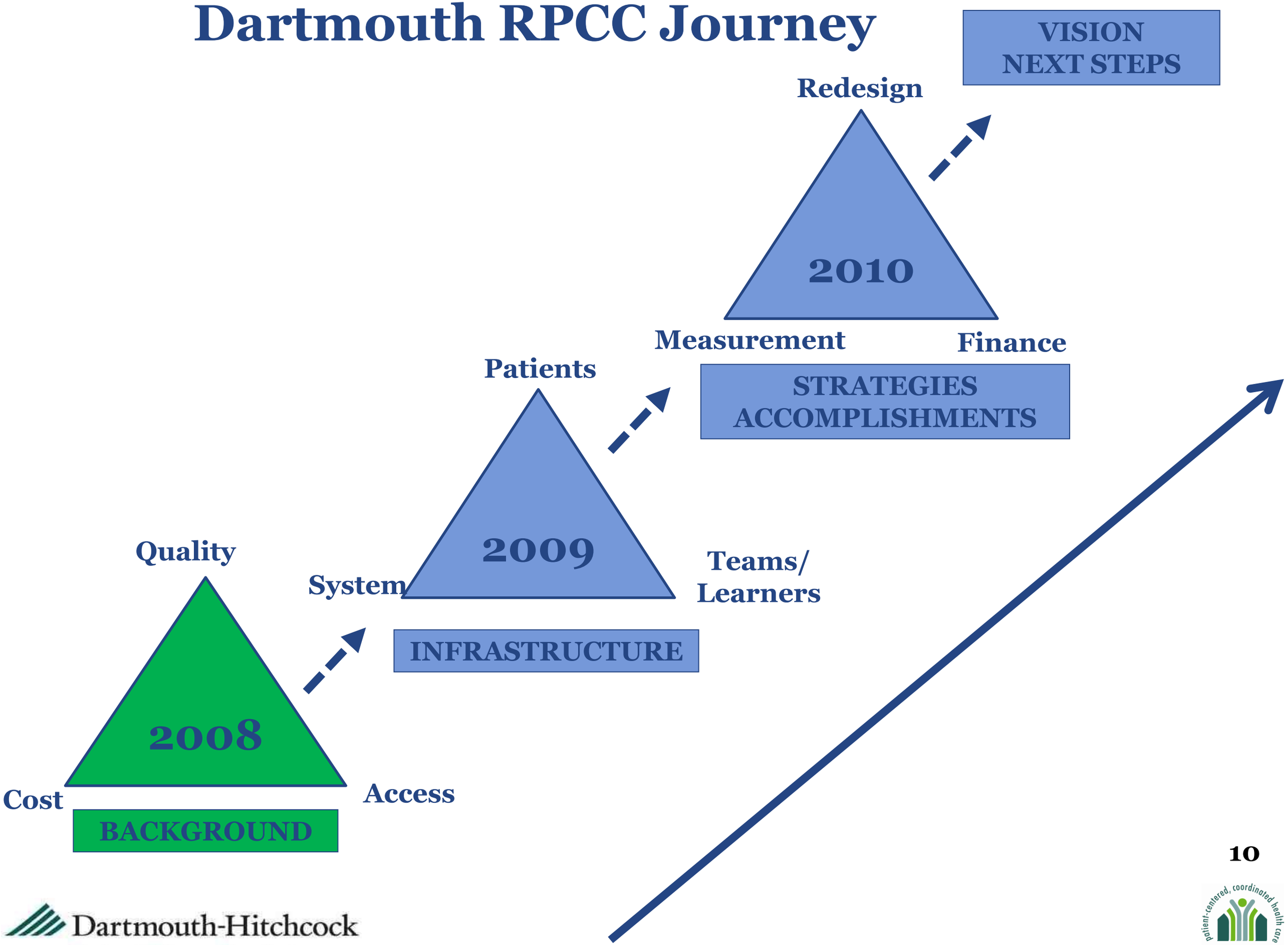

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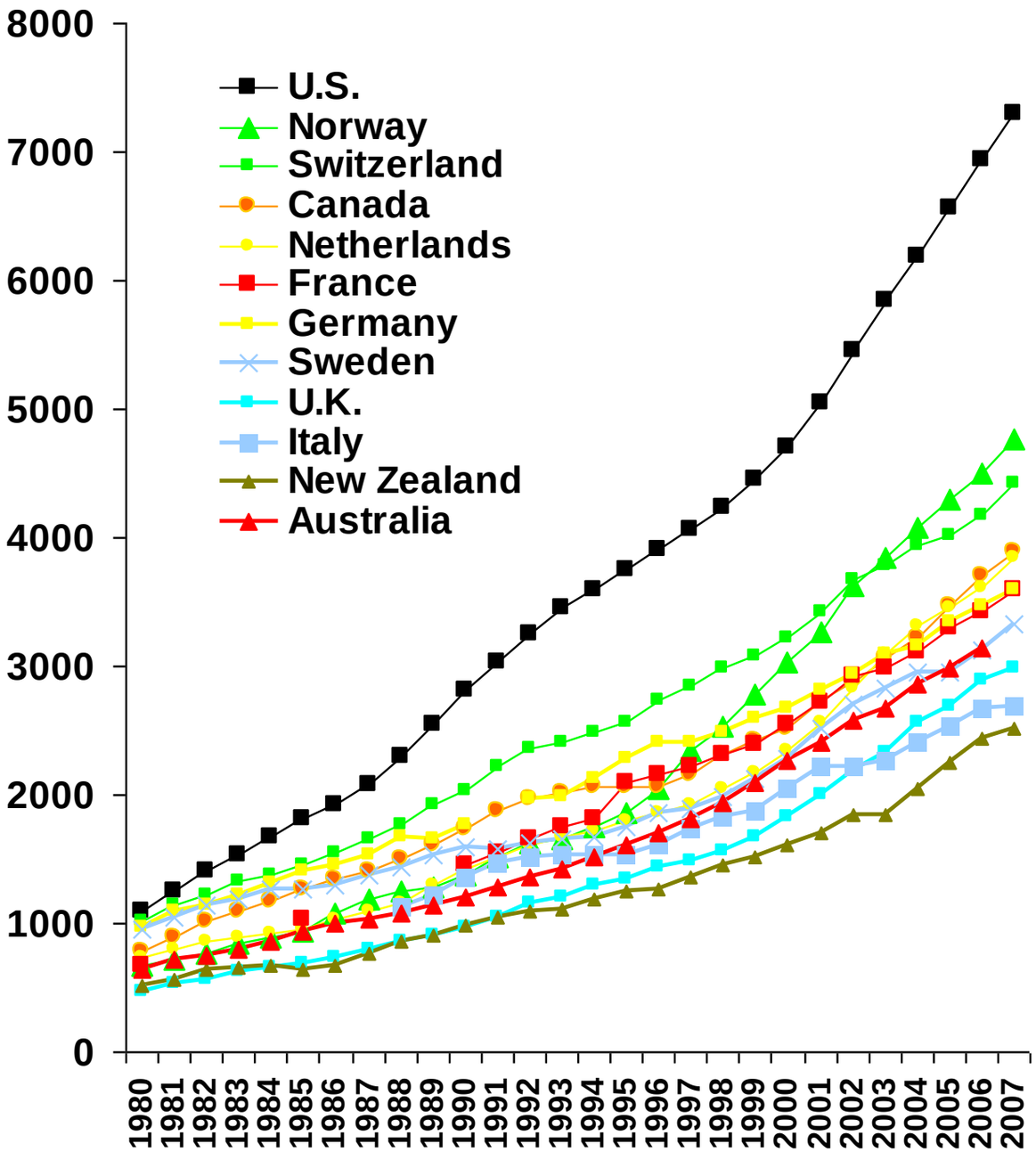
THE CHALLENGES WE FACE ARE GREAT

“The challenges we face are great, and we may not meet them in one term or with one president. But history tells us we have met greater challenges before. And the seriousness of the moment tells us we can't afford not to try. So as we set out on this journey, let us also forge a new path - a path that leads to unrivaled prosperity; to boundless opportunity; to the America we believe in and a dream that will always endure.”

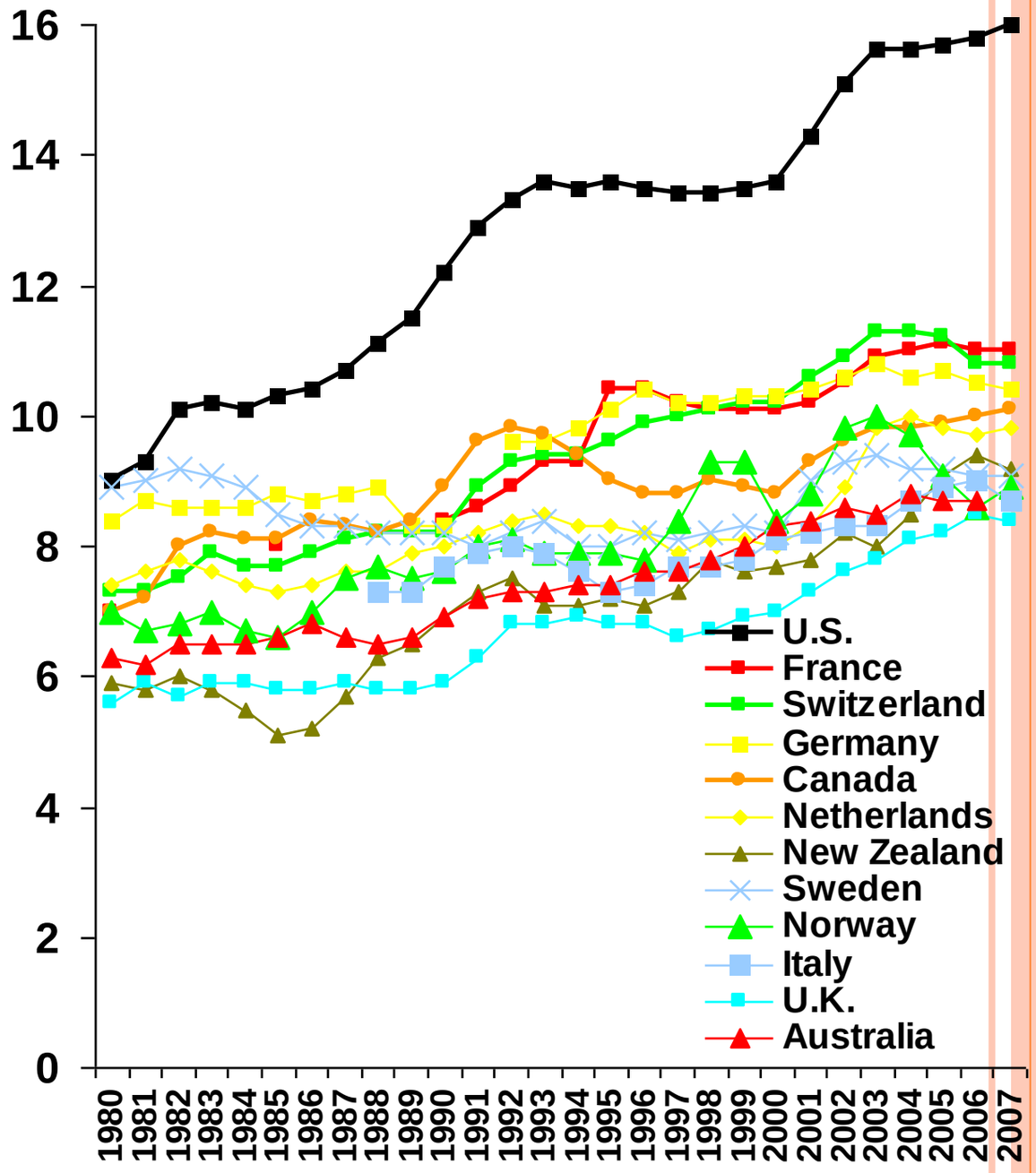
-Barack Obama
June 9, 2008, Raleigh, North Carolina

International Comparison of Spending on Health, 1980–2007[12]

Average spending on health per capita ($US PPP)



Total expenditures on health as percent of GDP



Source: OECD Health Data 2009 (June 2009).

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HEALTHCARE COST AND QUALITY VARY SUBSTANTIALLY AMONG GEOGRAPHIC REGIONS

"MORE SPENDING IS NOT BETTER" *IT GETS US MORE HOSPITALIZATIONS, MORE SPECIALTY VISITS AND MORE PROCEDURES, BUT NOT MORE QUALITY*– DR. JACK WENNBERG

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PIPAS @ The Dartmouth Institute "3 yrs in a nutshell"

1. ***"More spending is not better"*** Dr. Jack Wennberg
2. ***More supply is not better*** , *when supply goes up,* ***only Family Physicians go to areas of low access****"- Dr.* Dave Goodman
3. *"The* ***PCMH*** *is dependent on an Accountable Care organization (ACO) and an* ***ACO*** *is dependent on the PCMH"*— Dr. Elliott Fisher
4. "*We can't change healthcare systems* **without changes in the way we develop future health professionals"- Dr.** Paul Batalden

Translates to

OUTCOMES

- High Quality
- Appropriate Utilization
- Care for the whole Population

STRATEGIES

- Transform into PCMH
- Finance the PCMH
- Involve the Learners in the process
  - To learn/lead redesign
  - To grow PCP's

This Is NOT a Medical Home?

"We're running a little behind, so I'd like each of you to ask yourself, 'Am I really that sick, or would I just be wasting the doctor's valuable time?'"

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Medical Home Evolution

1967 — AAP NTRODUCTION

1998
- CNCC SET UP PHYSICIAN LED NETWORKS TO OFFER MEDICAL HOMES--$5.50 PER MONTH PER

2002 — AAP EXPANDED MEDICAL HOME DEFINITION IN 2002

2004
- FUTURE OF FAMILY MEDICINE SET OUT COMPONENTS OF "PERSONAL MEDICAL HOME"
- AAFP ESTABLISH PRINCIPLES OF "MEDICAL HOME"
- CNCC MEDICAL HOME PROJECTS SAVES MEDICAID $120MILLION
- NORTH CAROLINA STATE-WIDE ROLL OUT

2006
- TAX RELIEF AND HEALTHCARE ACT 2006 AAFP INVEST $8 MILLION IN TRANSFORMED TO SET UP DEMONSTRATION PROJECTS
- ACP ENDORSEMENT
- CMS BEGAN CREATING CPT CODES (PAEDIATRICS ONLY

2007
- AAFP; ACP; AAP; AOO SET OUT "JOINT PRINCIPLES" ESTABLISHED
- UNITED HEALTHCARE ANNOUNCE PLANS FOR MEDICAL HOME PROJECT IN FLORI
- CIGNA, WELLPOINT; AETNA EXPRESSED INTEREST IN DEVELOPING PILOT PROJE
- BLUE CROSS BLUE SHIELD DEVELOPED A MODEL DEMONSTRATION PROJECT
- IBM AND BOEING IMPLEMENTING A MEDICAL HOME INITIATIVE PILOT FOR REGIO WITH HIGH CONCENTRATION OF EMPLOYEES
- NCQA SET OUT MEASURES FOR CONSENSUS ON A MEDICAL HOME

2008
- BTE (BRIDGES TO EXCELLENCE) ENDORSEMENT
- 2008 NCQA ESTABLISHED AND ENDORSED THE QUALIFICATION AND ADMINISTRATION
- FEDERAL LEGISLATION TO IMPLEMENT MEDICAL HOME DEMONSTRATION PROJECTS BY 2010

2009
- TRANSFORMED REPORTS ON SUCCESS OF DEMONSTRATION PROJECTS
- TRANSFORMED CONVERTS TO COMMERCIAL COMPANY TO SUPP ESTABLISHING MEDICAL HOMES

CRISIS IN PRIMARY CARE MED- CONTINUING FALL NO. OF PCP POSITIONS FILLED--50% DROP SINCE 1998

FORECAST FOR GDP 3% SPEND ON CHRONIC HEALTHCARE CONDITIONS HITS NEW RECORDS

CHRONIC DISEASE ACCOUNTS FOR 75% OF 2005 $2 TRILLION HEALTHCARE SPEND

- FIRST BABY BOOMER TURNS 65 (DEMANDING AND REQUIRING A TOP TIER SYSTEM "MEDICAL CONCIERGE"
- IF SPENDING REMAINS THE SAME, IN 2030 HEALTHCARE COSTS FOR CHRONIC CONDITIONS WILL COMPRISE 7% OF GDP COMPARED TO CURRENT 3%

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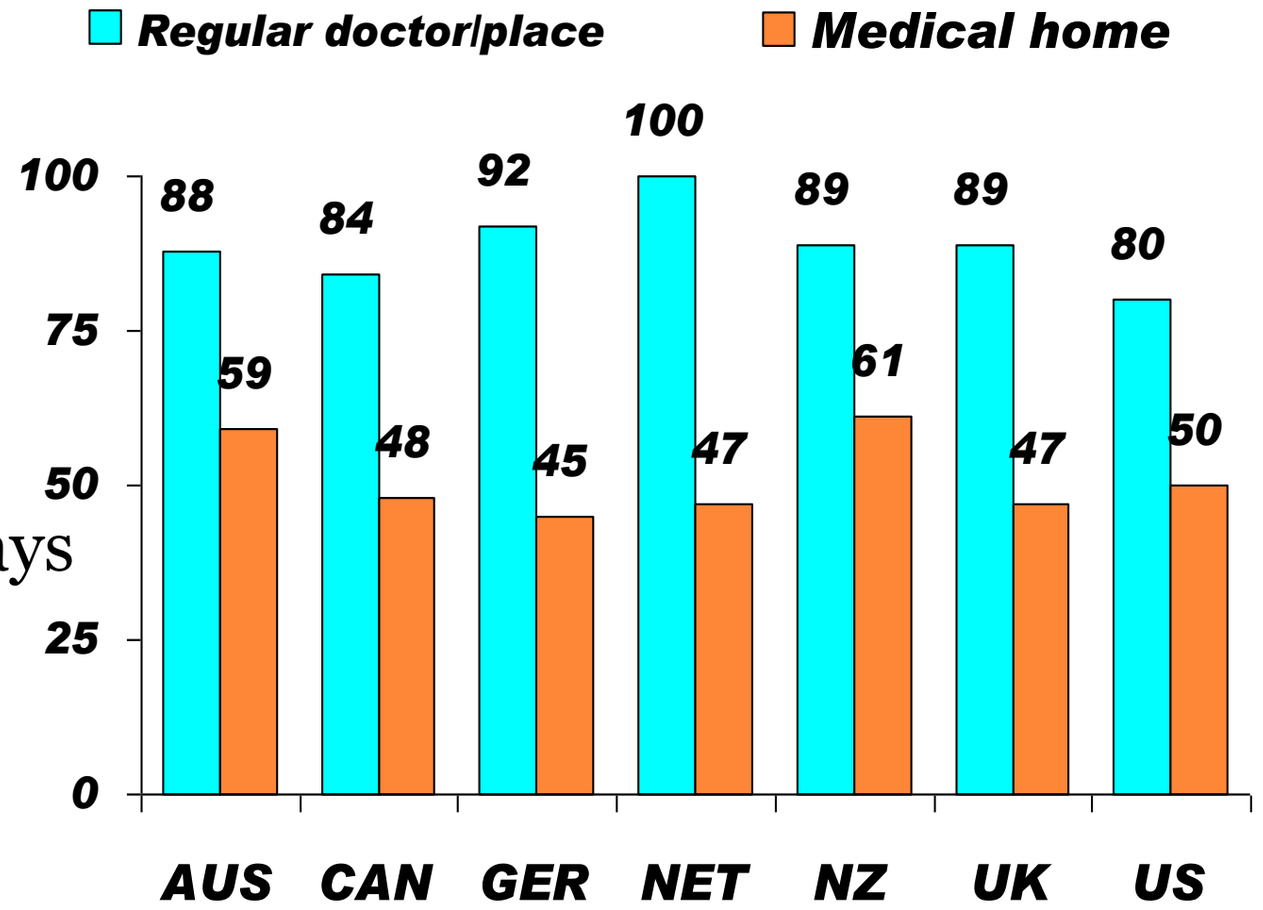
2007 Commonwealth Fund International Survey Results

- In each of 7 countries, having a "Medical Home"* improves patient experiences:
  - Access
  - Communication
  - Patient safety
  - Care coordination
  - Reduced duplication and delays
  - Preventive care
  - Chronic care management
  - Patient satisfaction



Available at: www.commonwealthfund.org

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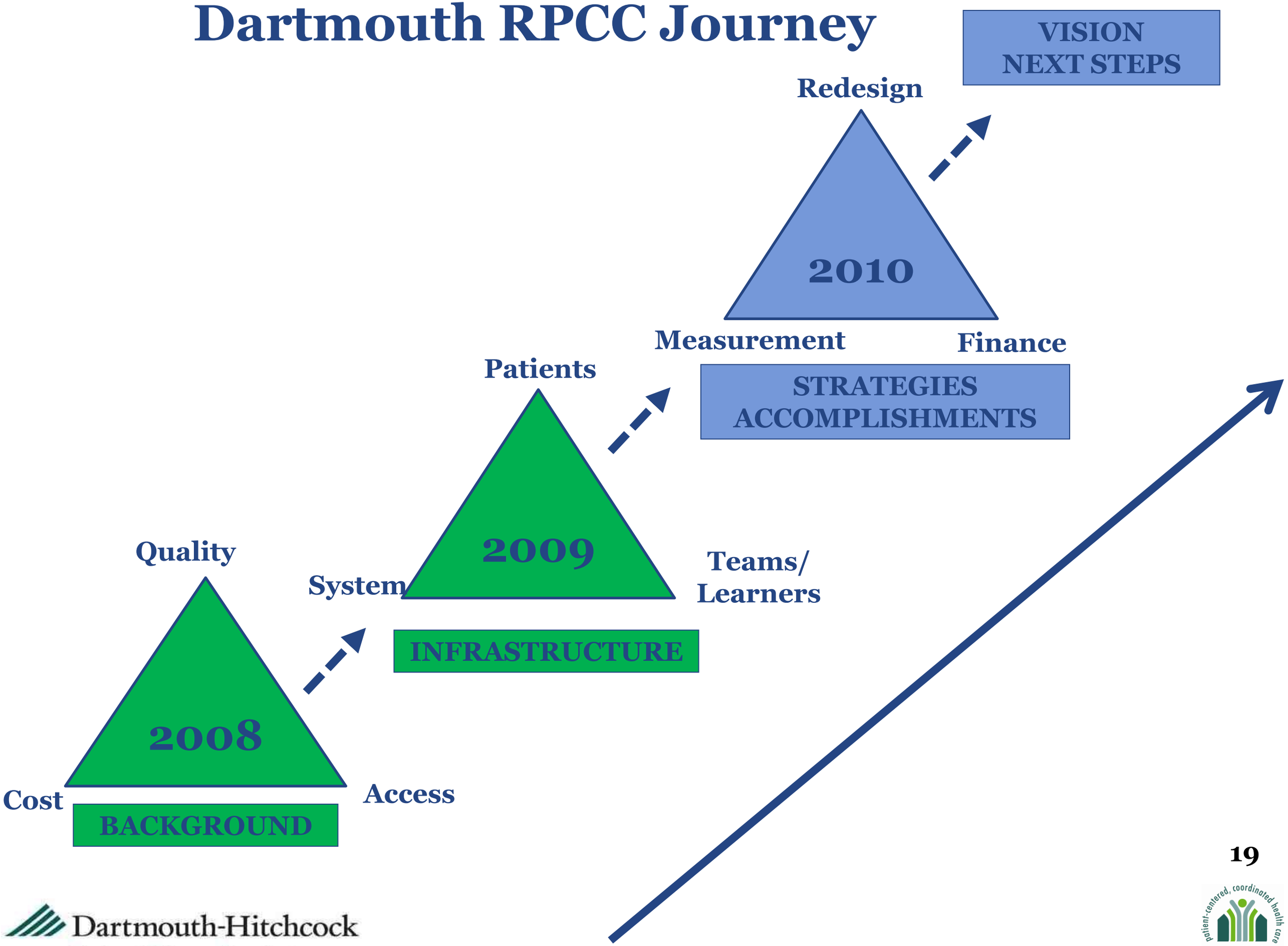

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Dartmouth Challenges

DH System
- Revenue
- Volume/Referrals
- Employee health
- Contract Delivery
- Research & Education

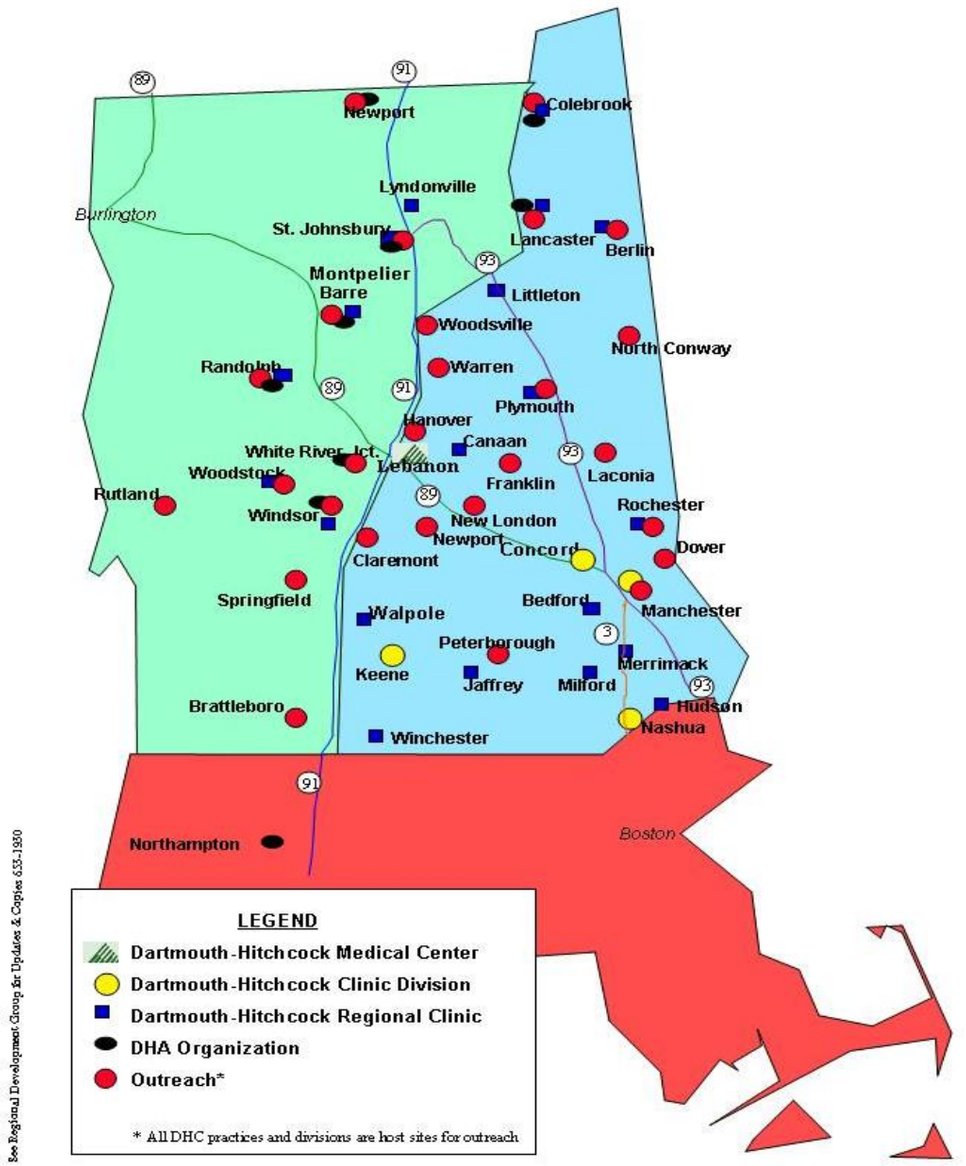
Patient Employee Population
- Access
- Continuity
- Quality & Safety
- Health Gaps

PC Team
- Satisfaction
- Efficiency
- Education
- Research
- Development
- Recruitment/ Retention

DH Vision 2007
"Healthiest Population Possible"

OVERVIEW

DH -Physicians **D-CBF**	1000+ *(29% PC)* *300+*
Employees **Payer mix**	D-H 7,073 DMS 1,106 47% govt
Residents **Med Students and Fellows**	>900 (*90 students per yr)
Outpatient Visits/yr	1.8 Million
Discharges	24,000
Full EMR **CMS PGP**	CIS to EPIC April 2011 >10M



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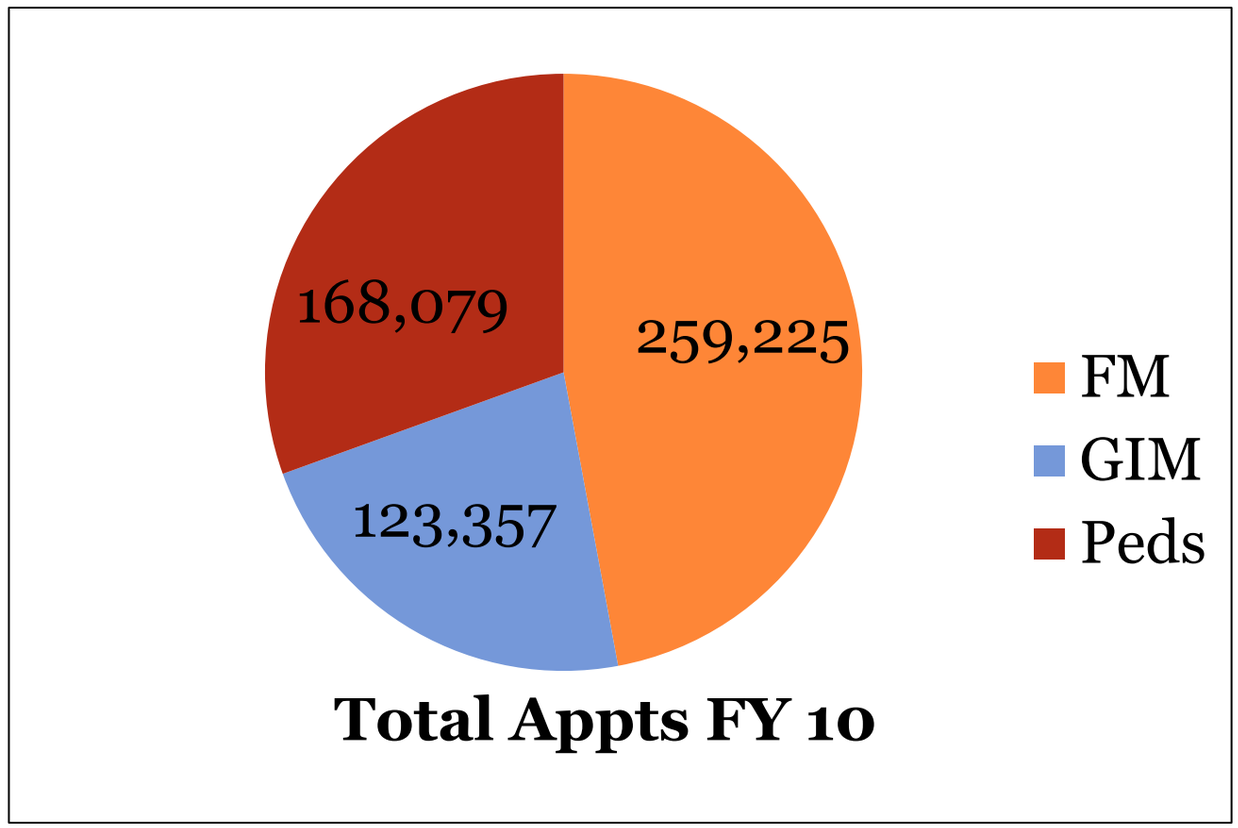
Dartmouth-Hitchcock Primary Care

D-H Keene

D-H Concord

D-H Lebanon

D-H Nashua



Total Appts FY 10

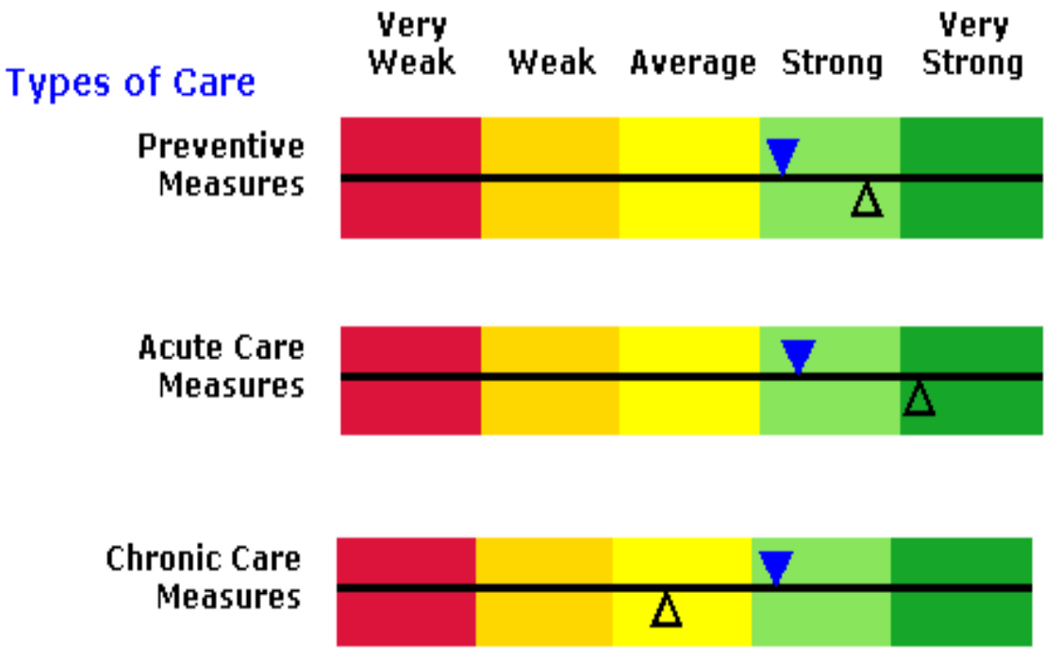
D-H Manchester

Primary care	5 divisions/23 practices/>70 teams
Physicians	225/160 full time clinical
Associate Providers	65
Support Staff	>700
Patient population	>300,000

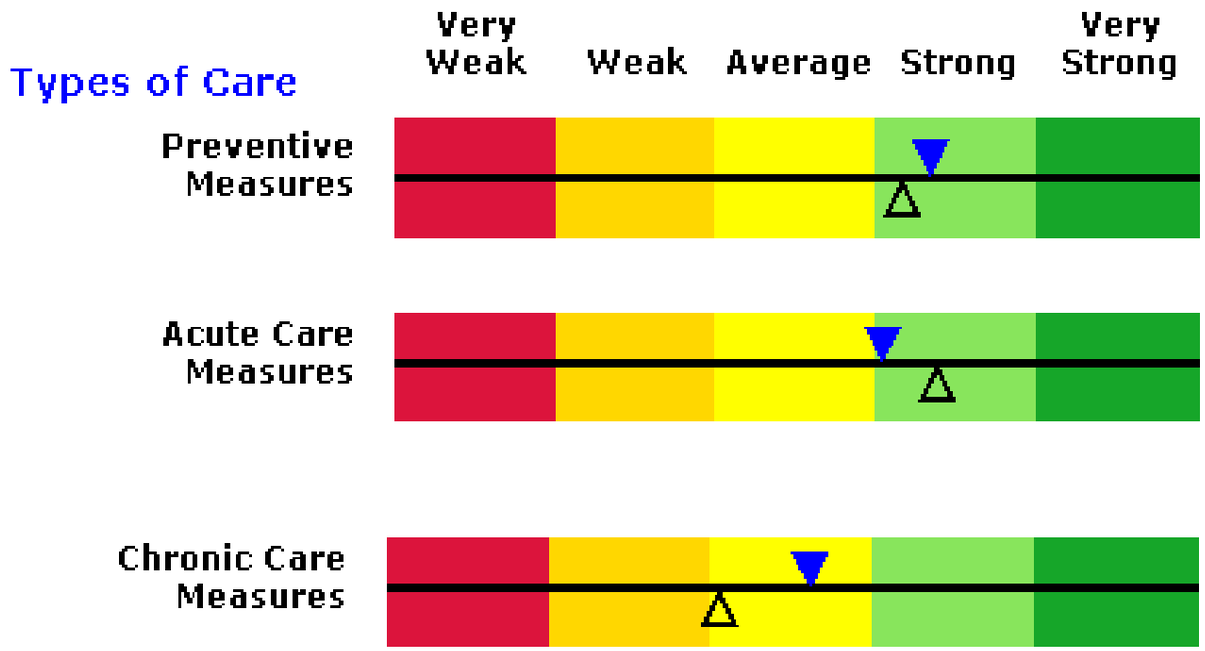
NH/VT Dashboard on Health Care Quality Compared to All States

Overall Health NH, NHQR 2008

New Hampshire



Vermont



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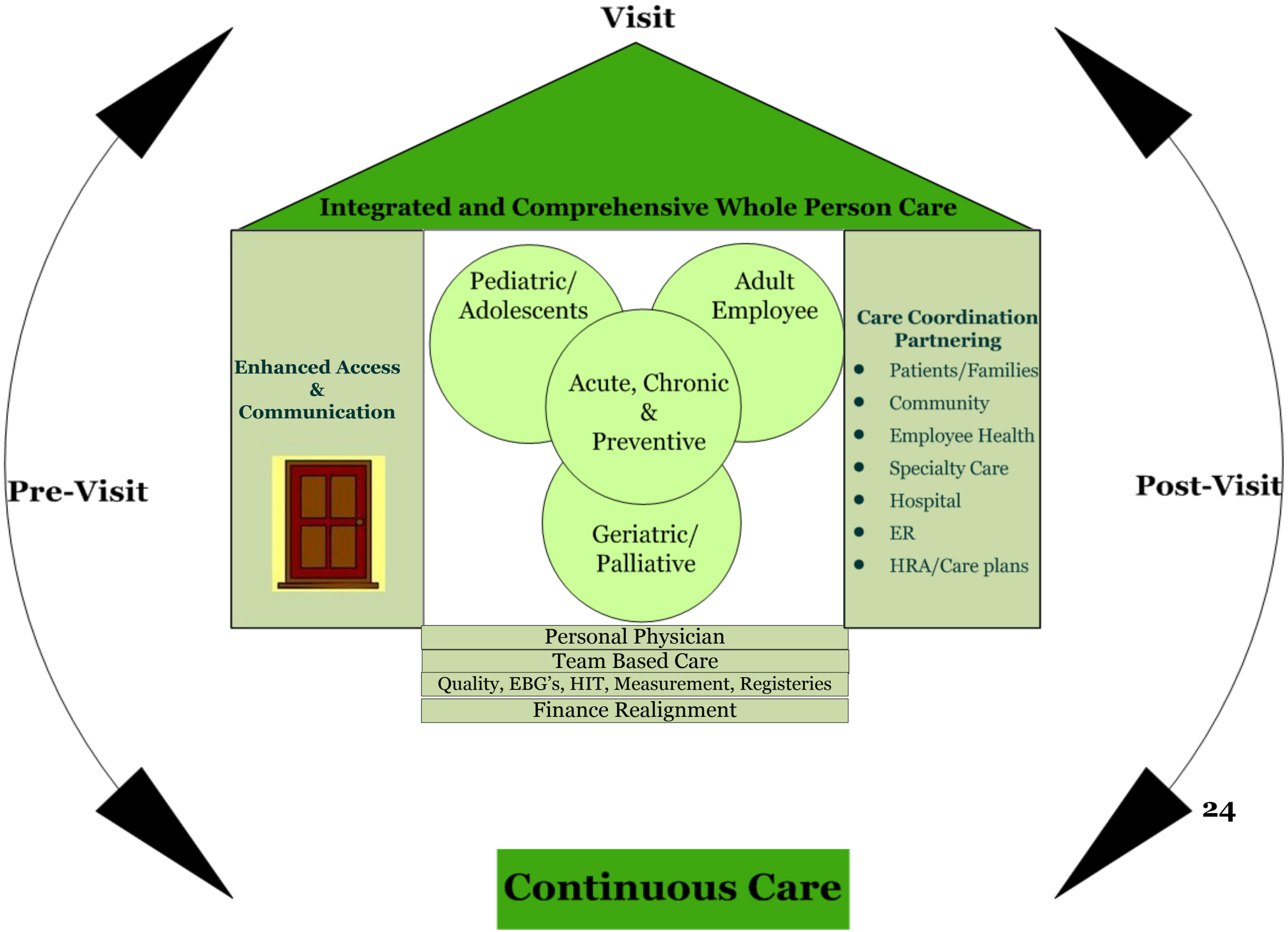
D-H Patient Centered Medical Home

"We know you and care for your continuously"



Top 10 Opportunities for Primary Care to add Value at Dartmouth
Top 10 reasons to invest in PC
VALUE = QUALITY/COST

10

1. Health Care in the US is broken
2. Patient centered and critical to improving quality outcomes and decreasing costs
3. Essential to executing on Vision of Healthiest Population Possible
4. Generating the referral base and specialty access in a multispecialty group practice
5. Regional Primary Care Leadership is primed system wide
6. The Medical Home is a nationally endorsed and recognized model
7. Health, wellness and savings for Employees
8. Capability to measurably improve performance
9. 23 frontline teaching and research laboratories for QI and Redesign
10. Future finance favors Primary Care with payment for the PCMH (proven success in quality, performance and shared savings in CMS)

D-Regional Primary Care Center (RPCC) endorsed April 2008

It Takes A Team, A Vision, and A Plan

Mission: To Advance Healthcare through Primary Care

Vision: To be a Center of Excellence for Patient & Family Centered Medical Homes

Governance
Design & Content
Implementation
Integration

DHH (Butterly, Colacchio, & Leblanc)

Executive Leadership (Caruso, Patchett, Patric, Pipas, Schon)

Leadership Steering Committee

Subcommittees, Councils & Task Forces

Measurement (Measurement Central) Chair: Patric Core Liaison: Patric

Practice Innovation (EBG & Tools) Chair: Council Core Liaison: Council

Value Added (End State Taskforce) Chair: Don Caruso Core Liaison: Caruso

Education & Training (Retreat Central) Chair: Patchett Core Liaison: Patchett

Evaluation & Research Chair: Reed Core Liaison: Johnson

Communication & Technology Chair: Cotter Core Liaison: Vashist

Councils
- **Care Coord** Chair: Johnson/Council Core Liaison: Johnson/Council
- **PFCC / PFA** Chair: Wilkinson Core Liaison: Pipas
- **Pop Mgt Tools** Chair: Maden Core Liaison: Andrews
- **QIPs** Chair: tbd Core Liaison: Patchett

Others
- Specialty MH Village
- Employee Model
- Behavioral Health
- Specialty Services
- Geriatric Partnership
- E-D
- SDM

Patient-Centered M H Practice Teams

Manchester /Bedford
Key Contacts:
Bedford FP/IMED & Pedi- Crenshaw
Manchester Peds- Etlinger
FM/IMED-Danis
Core Liaison: Patric

Nashua
Key Contact: Laliberte
Core Liaison: Johnson

Keene
Key Contact: Guyette
Core Liaison: Andrews

Concord
Key Contact: Atkinson
Core Liaison: Cotter

PATIENTS

Leb FM
Key Contact: May
Core Liaison: Vashist

Leb GIM
Key Contact: Brondel
Core Liaison: Council

Leb Peds & Plymouth Peds
Key Contacts: Payson, Smarse
Core Liaison: Patchett

Core Liaison ← Core Liaison →

Concord Atkinson Todd

Manchester Nordgren Aldrich

Keene Pitts Cotter

Nashua Burstein Fajans

Lebanon GIM Brooks/ Krasnoff Brondel

Lebanon FM Lazar Andrews

Leb Peds & Plymouth Chapman/ McClure Payson/Smarse

Other (PFA, Office of Care Mgmt)

Core Team
Andrews ,Caruso, Cotter, Council, Johnson, Patchett, Patric, Pipas, Vashist
Staff: King & Ward

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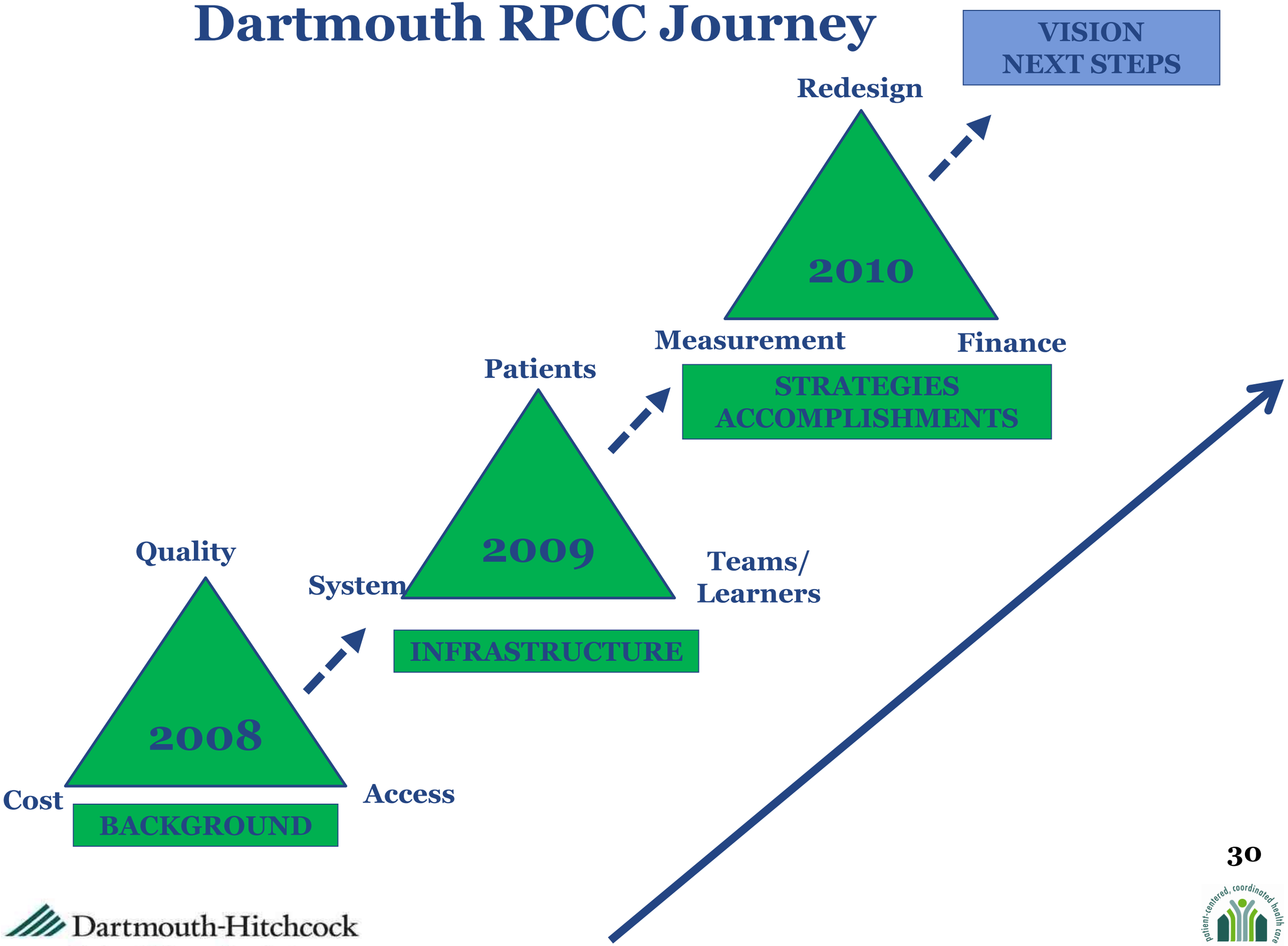
RPCC Budget and Frontline Investment

Job Title	FTE
Administrative Performance Director	1
Medical Director	0.5
Project Manager NCQA champion	1.0 1.0 (8 months)
Admin Assistant	1
PCMH-Care Coordinators (CC)	11
PCMH- Patient Data Coordinators (PDC)	4
Total Investment annually	1.5 M

Dartmouth RPCC Journey



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QUALITY LOOP to drive change

Measure

- Needs assessment
- Balanced Scorecard
- Performance Review processes

Prioritize

•Align with PCMH, DH, CMS, Cigna, NH Medicaid, Harvard Pilgrim, ...

Finance

(Reward and Recognition)

•Contract alignment

•Compensation alignment

Disseminate

(Implement- system wide)

•Best Practice Summits

•System wide training

•Web based Toolkit

•Communication

Redesign and Test

•Quality Improvement for all

•Support Pilots

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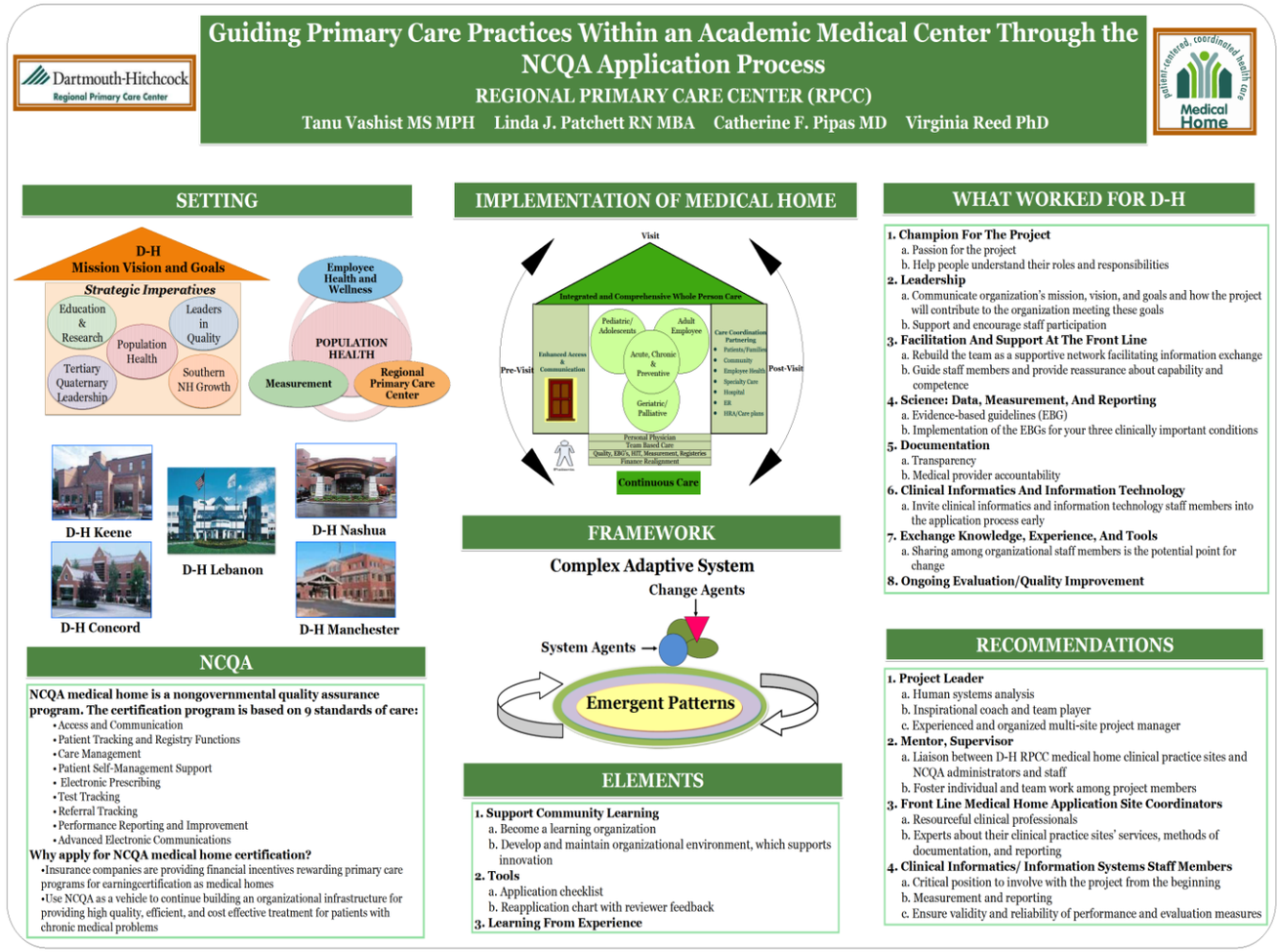
WHY AND HOW TO DO NCQA?

PEARLS FROM POSTER STFM DEC 2010

- TOOL for PCMH needs assessment (9 standards of care)
- Work plan for building a PCMH
- Basis for resource request
- Basis for compensation proposal
- CHAMPION- site specific
- CHAMPION -system wide



Guiding Primary Care Practices Within an Academic Medical Center Through the NCQA Application Process

REGIONAL PRIMARY CARE CENTER (RPCC)

Tanu Vashist MS MPH Linda J. Patchett RN MBA Catherine F. Pipas MD Virginia Reed PhD

Dartmouth-Hitchcock Regional Primary Care Center

Patient-centered, coordinated health care Medical Home

SETTING

D-H Mission Vision and Goals

Strategic Imperatives

Education & Research; Leaders in Quality; Population Health; Tertiary Quaternary Leadership; Southern NH Growth

Employee Health and Wellness

POPULATION HEALTH

Measurement; Regional Primary Care Center

D-H Keene; D-H Lebanon; D-H Nashua; D-H Concord; D-H Manchester

NCQA

NCQA medical home is a nongovernmental quality assurance program. The certification program is based on 9 standards of care:

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management Support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communications

Why apply for NCQA medical home certification?

- Insurance companies are providing financial incentives rewarding primary care programs for earningcertification as medical homes
- Use NCQA as a vehicle to continue building an organizational infrastructure for providing high quality, efficient, and cost effective treatment for patients with chronic medical problems

IMPLEMENTATION OF MEDICAL HOME

Visit; Integrated and Comprehensive Whole Person Care; Pediatric/ Adolescents; Adult Employee; Acute, Chronic & Preventive; Geriatric/ Palliative; Enhanced Access & Communication; Care Coordination Partnering; Pre-Visit; Post-Visit; Personal Physician Team Based Care; Quality, EBG's, HIT, Measurement, Registeries; Finance Realignment; Continuous Care

FRAMEWORK

Complex Adaptive System

Change Agents; System Agents; Emergent Patterns

ELEMENTS

1. **Support Community Learning**
   a. Become a learning organization
   b. Develop and maintain organizational environment, which supports innovation
2. **Tools**
   a. Application checklist
   b. Reapplication chart with reviewer feedback
3. **Learning From Experience**

WHAT WORKED FOR D-H

1. **Champion For The Project**
   a. Passion for the project
   b. Help people understand their roles and responsibilities
2. **Leadership**
   a. Communicate organization's mission, vision, and goals and how the project will contribute to the organization meeting these goals
   b. Support and encourage staff participation
3. **Facilitation And Support At The Front Line**
   a. Rebuild the team as a supportive network facilitating information exchange
   b. Guide staff members and provide reassurance about capability and competence
4. **Science: Data, Measurement, And Reporting**
   a. Evidence-based guidelines (EBG)
   b. Implementation of the EBGs for your three clinically important conditions
5. **Documentation**
   a. Transparency
   b. Medical provider accountability
6. **Clinical Informatics And Information Technology**
   a. Invite clinical informatics and information technology staff members into the application process early
7. **Exchange Knowledge, Experience, And Tools**
   a. Sharing among organizational staff members is the potential point for change
8. **Ongoing Evaluation/Quality Improvement**

RECOMMENDATIONS

1. **Project Leader**
   a. Human systems analysis
   b. Inspirational coach and team player
   c. Experienced and organized multi-site project manager
2. **Mentor, Supervisor**
   a. Liaison between D-H RPCC medical home clinical practice sites and NCQA administrators and staff
   b. Foster individual and team work among project members
3. **Front Line Medical Home Application Site Coordinators**
   a. Resourceful clinical professionals
   b. Experts about their clinical practice sites' services, methods of documentation, and reporting
4. **Clinical Informatics/ Information Systems Staff Members**
   a. Critical position to involve with the project from the beginning
   b. Measurement and reporting
   c. Ensure validity and reliability of performance and evaluation measures

Learners in the Medical Home-Pilot Survey Results

- 39/145 (9-DH) ambulatory teaching practices surveyed:
  - 67% multiple levels of learners
  - 56% EMRs (88% of these provide access to students)
  - 25% certified patient-centered medical homes (9-DH)
    - Of these 60% orient students to the PCMH
  - Students actively participated in :
    - Pt self mgmt 83%
    - Pt Education 50%
    - Group visits 12%
    - Huddles 29%
    - QI Projects 29 %
    - Performance reviews 12%
    - Registry data mgmt 4%
  - Barriers- alignment of time and continuity

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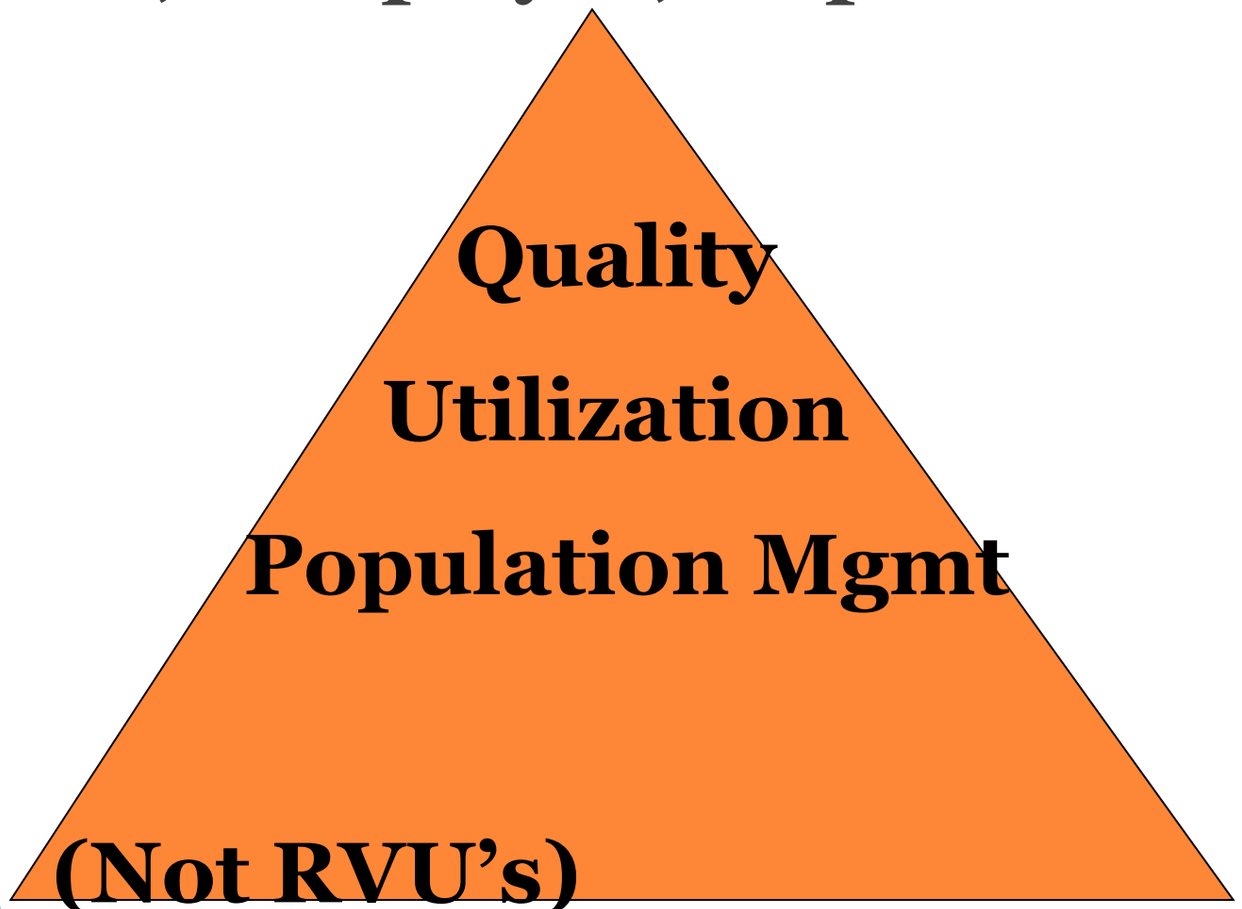
Prioritizing and Balancing Patient Outcome Metrics

Patient, Employee, Population



DH-ACO System **PC Team**

Divisional Comparative Benchmarking

Green Results = top 20% of scores
Red results = bottom 20% of scores

	Dartmouth-Hitchcock Clinic System Medical Home	Bedford Family Practice	Bedford Internal Medicine	Bedford Pediatrics	Concord Pediatrics	Concord Primary Care Dept	Keene Family Medicine	Keene Island St.	Keene Pediatrics	Keene Walpole	Keene Winchester	Lebanon Family Medicine	Lebanon GIM Lebanon	Lebanon GIM Lyme	Manchester Family Practice	Manchester IMED-Pedi	Manchester Internal Medicine	Manchester Pediatrics	Manchester Urgent Care	Nashua Family Practice	Nashua Hudson FP Team	Nashua Internal Medicine	Nashua Merrimack FP Team	Nashua Milford FP Team	Nashua West Center FP Team	Nashua Pediatrics	Nashua Urgent Care
Monthly Score Up To 9/1/09																											
Service (Provide Patient and Family Centered Care)																											
Outpatient satisfaction - visit overall-percent excellent	50	38	36	62	53	45	51	80	54	54	86	58	55	55	36	60	41	38	61	53	65	46	52	50	42	52	33
Outpatient satisfaction - sensitivity of staff to your needs-percent excellent	49	42	45	58	51	51	53	60	50	71	86	52	58	63	35	60	38	32	44	50	67	39	51	56	21	53	50
Outpatient satisfaction - scheduled appointment when wanted-percent excellent	43	52	32	42	45	38	41	75	43	55	83	46	51	48	37	63	35	25	60	42	43	45	44	29	22	36	40
Access for new patients - Primary Care	74	64	46	90	74	60	75	68	90	87	67	69	62	76	76	89	72	76	100	69	44	72	86	77	55	88	100
Quality (Close the Quality Gap)																											
Outpatient satisfaction - provider explained what was done-percent excellent	54	67	48	68	62	57	56	80	54	71	86	N/A	N/A	N/A	43	60	41	48	53	56	72	56	55	58	50	59	67
Outpatient satisfaction - thoroughness of the care received from the provider-percent excellent	65	61	55	66	71	60	64	80	58	71	86	70	75	65	55	80	60	56	58	63	69	66	63	63	68	67	83
Diabetes outcome composite	48	47	43	N/A	N/A	0	47	47	N/A	46	47	40	40	48	39	32	51	N/A	N/A	59	55	54	70	61	54	N/A	N/A
Diabetes process composite	25	19	18	N/A	N/A	36	19	23	N/A	9	23	23	19	17	21	9	24	N/A	N/A	40	37	36	40	44	40	N/A	N/A
Hypertension	68	65	63	N/A	N/A	77	68	66	N/A	64	73	61	61	68	64	62	70	N/A	N/A	74	72	70	81	77	69	N/A	N/A
People (Build an Empowering Culture) ***2009 Employee Survey***																											
Provider and staff satisfaction - top boxes*																				77	88	66	80	90	60	67	85
Provider satisfaction - top boxes*		75	75	75	100	86									45	85	85	86	75	86	75	85	100	75	86	86	
Staff satisfaction - top boxes*		62	62	62	68	56									57	77	77	75	100	77	75	83	77	94	55	87	85
Work well as a team - top boxes*																				76	100	82	61	94	70	73	86
Growth (Create Systems that Work)																											
New Primary Care patients as a percent of total Primary Care visits	4.1	1.8	3.8	2.8	4.4	4.0	3.6	4.2	5.0	4.1	2.6	8.5	5.2	6.6	4.3	4.7	2.1	4.5	2.5	3.6	6.0	5.2	3.2	3.6	4.2	3.6	3.2
Finance (Practice Careful Stewardship)																											
Expense variance to budget	0.7	12.6	-12.8	-2.4	0.0	0.0	0.8	-11.3	6.9	-5.3	10.9	-5.1	-2.6	-2.8	-6.8	-59.3	-7.0	0.0	27.0	0.0	-8.2	-10.2	1.7	8.5	18.2	7.8	###
RVU to budget	-12.3	-20.0	-3.4	-19.3	-25.4	-12.7	-13.7	-17.2	-24.6	-26.4	-14.0	49.5	24.4	41.4	-24.6	20.4	-31.0	0.0	-0.4	-18.0	0.4	-3.4	-17.0	5.5	-51.7	-18.6	14.6
RVU to MGMA Benchmark																											
Fiscal YTD Up To 9/1/09																											
Service (Provide Patient and Family Centered Care)																											
Outpatient satisfaction - visit overall-percent excellent	47	42	50	45	42	44	50	52	41	62	68	54	57	51	38	60	41	40	43	52	60	47	55	51	48	48	40
Outpatient satisfaction - sensitivity of staff to your needs-percent excellent	48	42	48	45	45	45	50	55	45	67	65	54	58	55	35	64	41	40	46	52	52	44	56	54	47	45	41
Outpatient satisfaction - scheduled appointment when wanted-percent excellent	44	41	43	43	39	38	43	41	39	61	62	56	50	49	38	44	38	34	53	49	52	38	48	46	40	39	48

Practice level- Score Cards

Report Date: 1/1/10

Scorecard Report

General | Scorecard | Chart | Trending Table | Notes | Annotation

Measure	Notes	Status	Trend	Result	YTD Result	YTD Target	Sample (n)	Score(%)
Service (Provide Patient and Family Centered Care)								**95.78**
Outpatient satisfaction - visit overall-percent excellent - 2 mo prior (Manchester Internal Medicine)				43	45	46	76	97.91
Outpatient satisfaction - sensitivity of staff to your needs-percent excellent - 2 mo prior(Manchester Internal Medicine)				49	45	46	74	98.8
Outpatient satisfaction - scheduled appointment when wanted-percent excellent - 2 mo prior(Manchester Internal Medicine)				45	39	42	64	92.07
Access for new patients - Primary Care(Manchester Internal Medicine)				74	75	80	--	94.31
Quality (Close the Quality Gap)								--
Outpatient satisfaction - provider explained what was done-percent excellent - 2 mo prior(Manchester Internal Medicine)				55	56	60	73	94.03
Diabetes outcome composite(Manchester Internal Medicine)				51	51	52	--	98.08
Diabetes process composite(Manchester Internal Medicine)				24	24	30	--	80
Hypertension(Manchester Internal Medicine)				70	70	75	--	93.33
Mammography adult preventative(Manchester Internal Medicine)				67	67	65	--	100
Pneumovax adult preventative(Manchester Internal Medicine)				--	--	--	--	--
Outpatient satisfaction - thoroughness of the care received from the provider-percent excellent - 2 mo prior(Manchester Internal Medicine)				62	64	64	77	100
People (Build an Empowering Culture)								**99.68**
Provider satisfaction - top boxes(Manchester Internal Medicine)				85	85	44	7	100
Providers - work well as a team - top boxes(Manchester Internal Medicine)				100	100	66	7	100
Staff satisfaction - top boxes(Manchester Internal Medicine)				77	77	78	26	98.72
Staff - work well as a team - top boxes(Manchester Internal Medicine)				58	58	57	26	100
Finance (Practice Careful Stewardship)								**0**
Expense variance to budget(Manchester Internal Medicine)				1.0	-6.7	0.0	--	0
RVU to budget(Manchester Internal Medicine)				-17.0	-7.9	0.0	--	0
Growth (Create Systems that Work)								**42.6**
New Primary Care patients as a percent of total Primary Care visits (Manchester Internal Medicine)				2.2	2.1	5.0	--	42.6

DIABETES DASHBOARD: All Patients

Results for adult patients assigned to a primary care panel and flagged with diabetes condition

Data current through

September 2009

Current Performance

Measure	Concord	Keene	Manch	Nashua	Leb PCP	Leb Non PCP	Leb FM	Leb GIM
DM Patients(N)	1592	4117	3210	2072	2626	7203	576	1769
BP	96%	89%	94%	96%	95%	63%	97%	95%
HgbA1c (year)	92%	80%	86%	91%	90%	45%	93%	89%
LDL	86%	74%	79%	86%	78%	28%	74%	78%
Microalbumin	79%	61%	71%	79%	62%	14%	71%	59%
Eye	62%	n/a	45%	62%	57%	11%	60%	58%
Foot	87%	n/a	76%	83%	64%	7%	69%	62%
Flu Vax	73%	39%	61%	71%	66%	26%	66%	67%
Pneumovax	89%	82%	76%	89%	79%	40%	79%	77%
BP <140/90	82%	74%	73%	78%	63%	68%	65%	61%
BP <130/80	54%	43%	39%	47%	36%	44%	37%	34%
A1C <=9.0	86%	91%	89%	91%	91%	84%	87%	92%
A1C <7.0	43%	58%	58%	60%	54%	39%	46%	56%
LDL <130	84%	92%	90%	90%	88%	89%	87%	89%
LDL <100	62%	72%	66%	68%	64%	71%	59%	65%

KEY:	
GREEN	>=.90
YELLOW	.70-.89
RED	<.70

LT GRAY= DPRP Measures

Resident Scorecard – New 2010

Resident Biannual Scorecard: [redacted]

Results as of January 2010

Measure	Resident Performance	Section Performance
Preventive Medicine:		
* Pneumovaccination- anyone 65+ with pnvx ever	89% (9)	74%
* Colon ca - colo 10yr, sig 5yr, FOB 1yr	48% (25)	64%
* LDL - men>35, women >45, q5yrs	76% (38)	87%
*Mammogram: Ages 42-70, in past 2 yrs - includes scanned	50% (10)	73%
Chronic disease: DIABETES		
*Percentage patients with diabetes with BP<130/80	66.7% (6)	33.5%
*Percentage patients with diabetes with A1c >9.0	33.3% (6)	9.6%
Chronic disease: HYPERTENSION		
* Percentage patients with dx of HTN with BP<140/90	66.7% (19)	58.1%
Process of Care:		
* Percentage Medication reconciliation (prior 6 m avg)	89.0%	87.9%
* Percentage Appts with Office note in CIS (prior 6 m avg)	100.0%	96.6%

What aspect of care would you like to improve?
Please list up to three steps you plan to take to improve your delivery of care for this measure.
1
2
3
6 MONTH FOLLOW UP (for review with preceptor at your next clinic evaluation)
Did you institute the changes you proposed?
What resources did you identify to help improve care?
What were the barriers to improvement?
What were the results of your intervention?

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REDESIGN
Initiatives and Accomplishments

2008----------2009----------2010

Culture of performance improvement

Team based care
(100%)
PCMH work plans
Performance reviews- all

Collaborative Training:

Quarterly MH training retreats (>300 attendees annually)

Role Definition, Optimization and Integration

Care coordinators- 100%
Pt data coordinators- 100%
Pt Family Advisors- 100%
Learners-100%
QI PROS (QIPS)-100%

Population mgmt tools

Registries
Pt summary reports
Evidence based Guidelines
Care Plans

Pilots

Disease focused-HTN,DM
Employee Health
*Shared Decision Making
*Geriatrics- FM /GIM
Behavioral Health
Health Coaching

Process Changes

Pre, Post and Continuous Care Processes

*HRSA funded learner focused initiatives

Improvement Starts with ME!

"An Unexamined Life is not worth living" Socrates.

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PERSONAL SWOT ANALYSIS WORKSHEET

Name:

☐ **I shared this document with my leader**

STRENGTHS: What do you do well? What unique resources can you draw on? What do others see as your strengths?	**WEAKNESSES:** What could you improve? Where do you have fewer resources than others? What are others likely to see as weaknesses?
OPPORTUNITIES: What good opportunities are open to you? What trends could you take advantage of? How can you turn your strengths into opportunities?	**THREATS:** What trends could harm you? What is your competition doing? What threats do your weaknesses expose you to?

INTERNAL FACTORS

EXTERNAL FACTORS

POSITIVE

NEGATIVE

50 Reasons Not To Change

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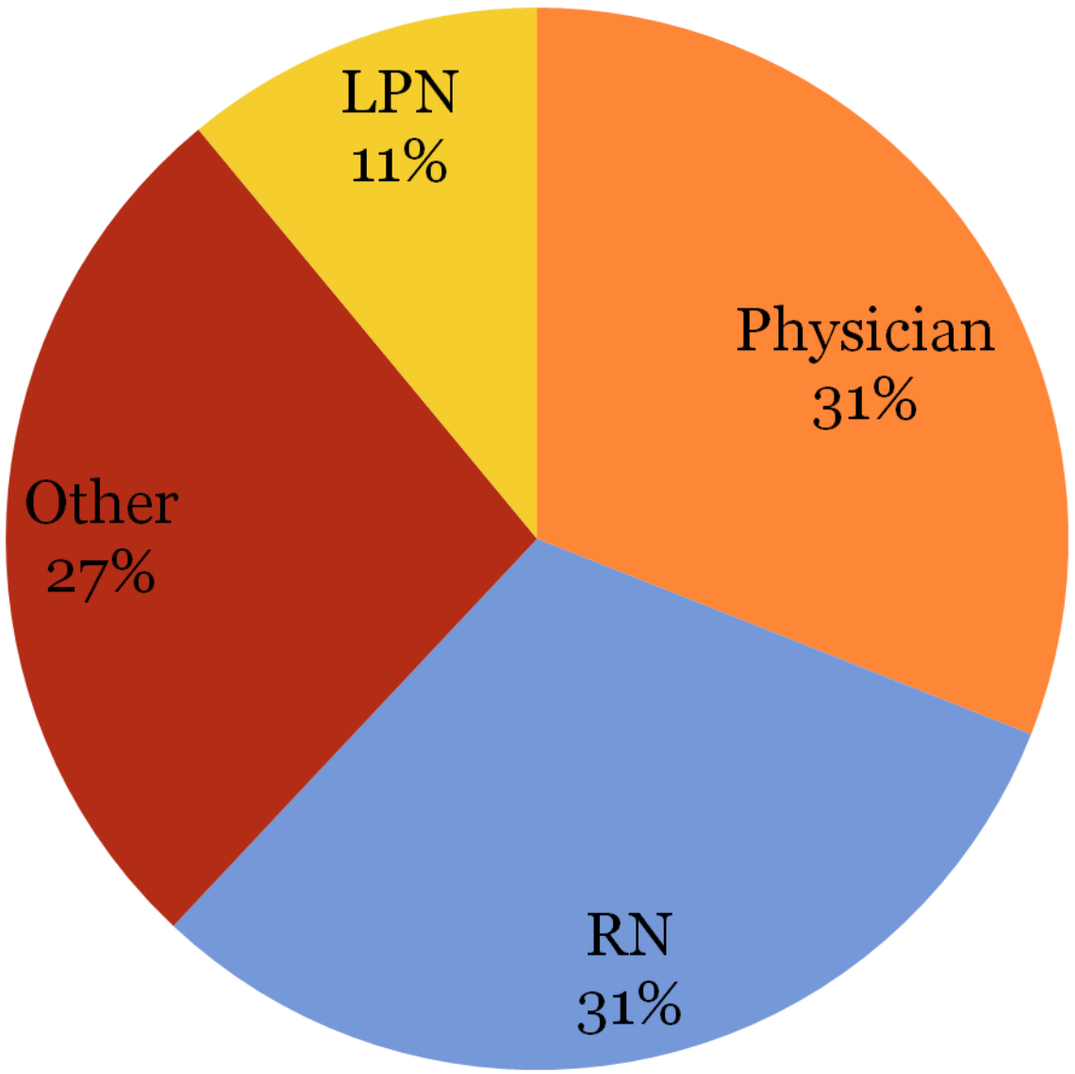
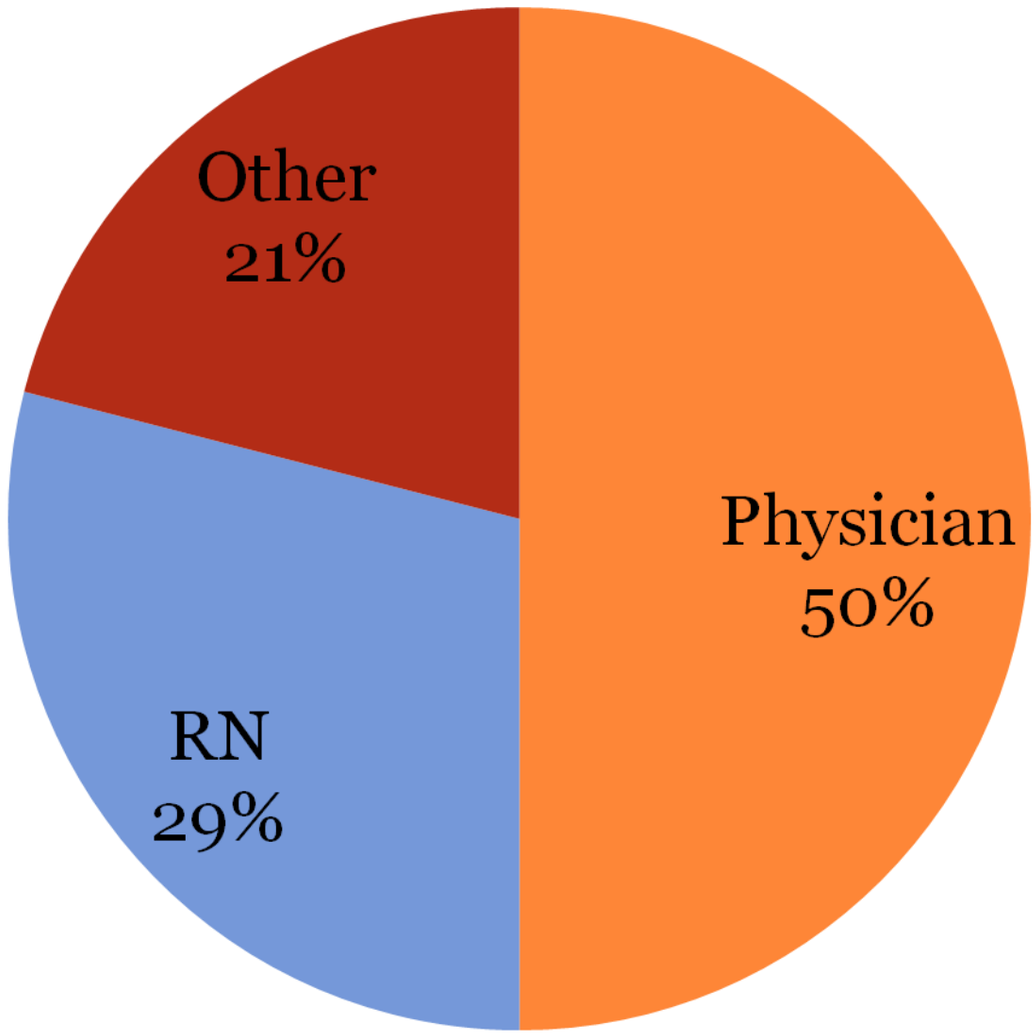
QIP Training

The people who do the work are the best qualified to improve it
Everyone has the capacity to learn improvement tools

Participants n=40



Faculty n=16



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QIP – QUALITY IMPROVEMENT PRO's

GOAL BUILD A QUALITY IMPROVEMENT CULTURE WITHIN THE MEDICAL HOME

Methods

- Collaborative learning
- 3- 1 day workshops (yr)
- Personal learning goals
- QI Application of projects at sites
- Evaluation
  - Self, site and pt outcomes

Curriulum

- Leadership / Meeting Skills
- PDSA
- Six Sigma
- Lean Thinking (Waste vs Value)
- 5 S (Sort, Set in order, shine, Standardize, Sustain
- Root Cause Analysis
- Change management

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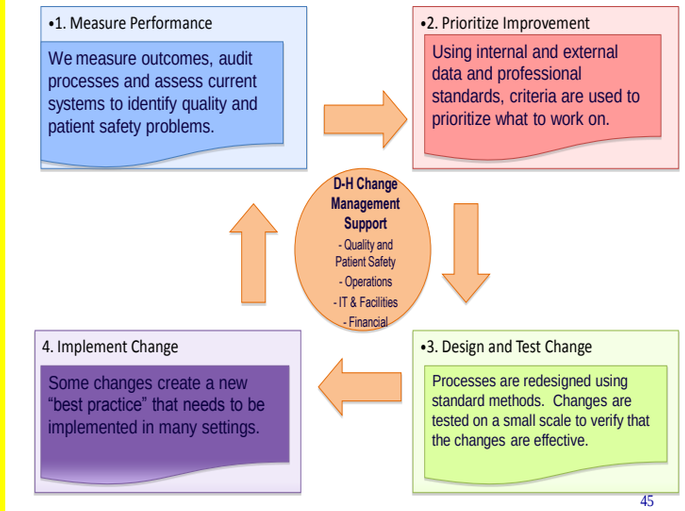
Measurement

Dartmouth Hitchcock Uses a Systems Approach That Forms a Quality Improvement Loop



Plan-Do-Study-Act

Measures

Change Ideas

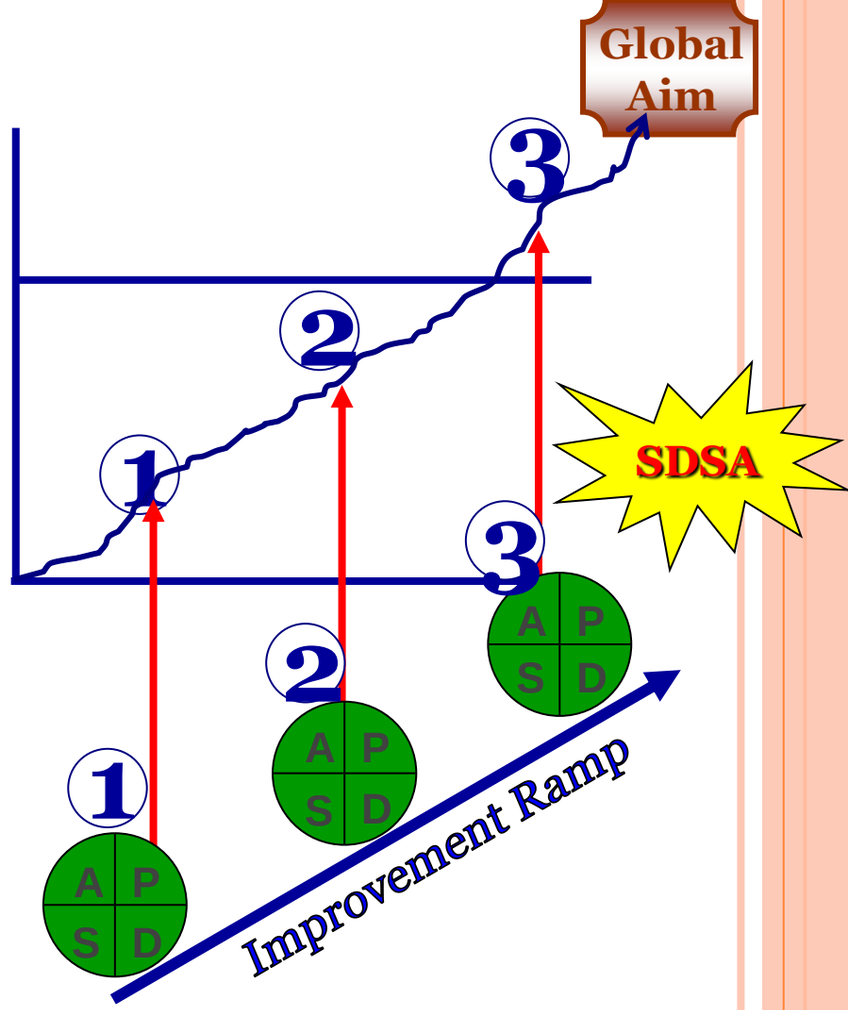
Specific Aim

Global Aim

Theme

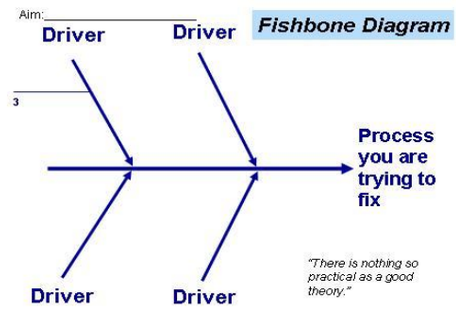
Assessment

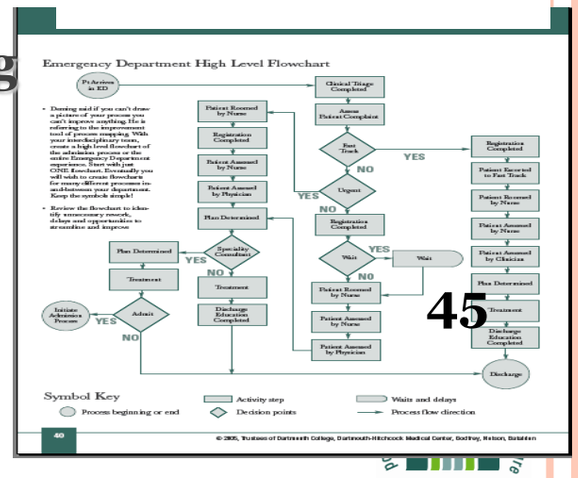
PDSA



Tools

Cause and Effect
Value Stream Mapping
Brainstorming
Flow Charting





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Proposed Future State Revised (10.16.10) – Office Visit — **Population Health DM Workgroup**

Prework

- Generate HDWS report (1 week prior)
- Open cohort report
- Enter MRN
- Update report w/ appropriate care elements
- File into appropriate folder for day of visit

Registration / Receptionist / Secretary

- Patient Arrives
- Demographics & insurance verified/updated
- Arrive patient in Epic
- Hand pt medication list
- Hand Visitor ID sheet to patient
- "What can I expect from my visit"
- CAM Survey Questionnaire Complete??
- Open inbox and review mail, family, social hx w/ patient
- Review mail, family, social hx w/ patient
- Patient leaves
- Check task list

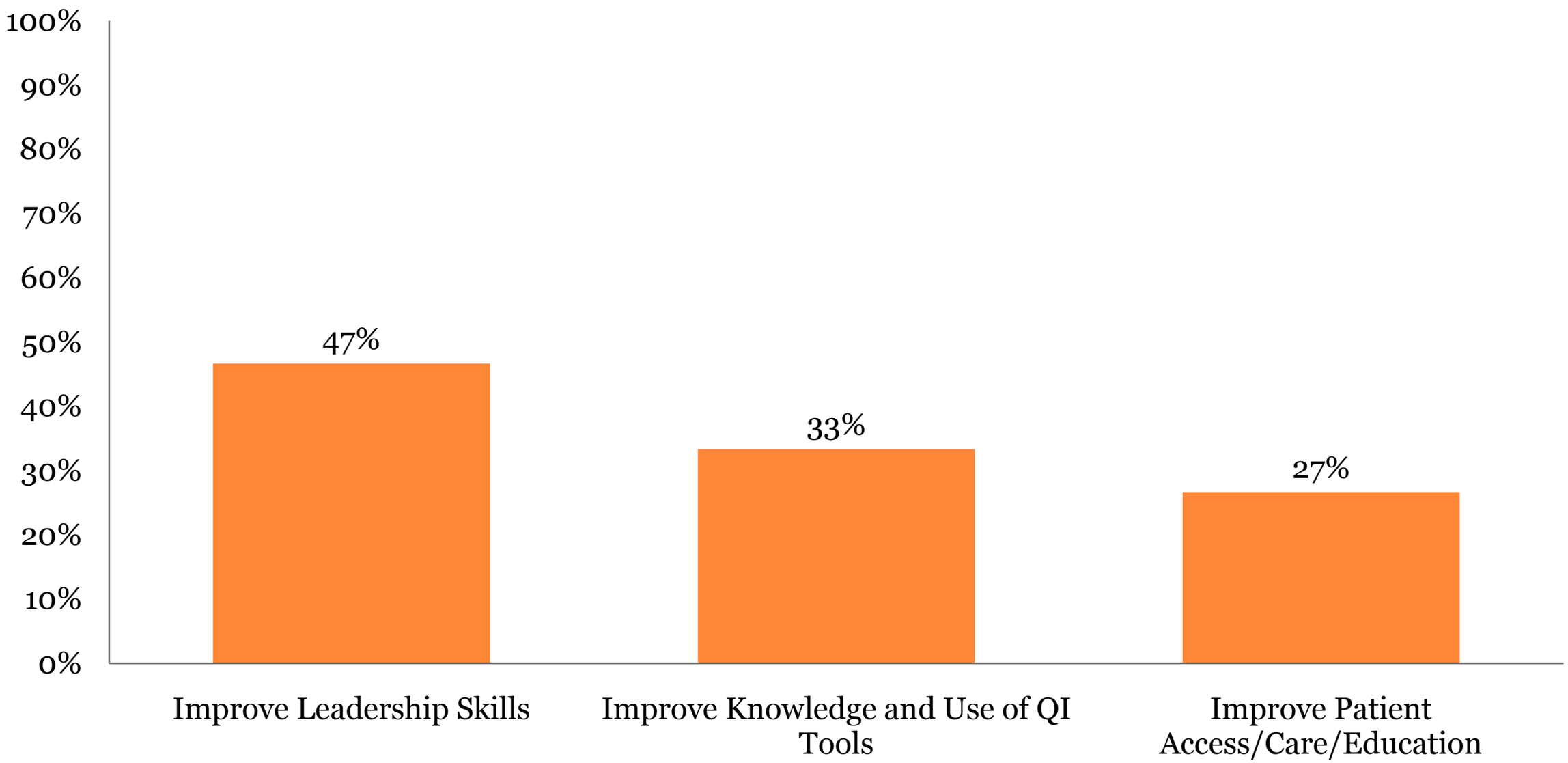
Flow Person

- Review Registry folder – Process visit for care element
- Monitor Epic schedule for patient arrival
- Electronic access to pt pre-work & billing sheet.
- Call patient from waiting area & room
- Open Rooming Tool (1 patient (2 clinicians))
- Enter Chief complaint
- Check pt weight & height – enter into Epic
- 4-Med reviews
- Confirm Medications & Allergies in Epic
- Review & update smoking status, AHRQ smoking hx, counseling & date readiness to change
- Enter patient + Systolic/Diastolic into Epic
- 8-Hypertension
- Complete Vitals Temp, Pulse, BP – Enter into Epic
- 13-Neuropathy/Foot examination
- Flow Person performs foot exam as per protocol. Enters results including monofil, pedal, visual, counseling Y/N & date
- 12-Chronic Kidney Disease
- Collect urine mic. per protocol for micro albumin (last exam >1 yr)
- 10-Immunization
- Pend LDL test Pend Hg A1c test As per protocol
- Immunization(s) given as per protocol and documented
- Does pt need prescription refills? (Pend order??)
- Does pt need screening appointments? (mammography) Pend order
- BPA: last dilated eye exam >1 yr?
- Pt had eye exam? Document and pt agreement obtained
- Leave encounter open – Sign off

Provider

- 15-CAD assessment (labs, BP)
- 14-Dyslipidemia
- Reviews last notes in Epic and documentation by flow person from today's visit. Enter exam room. Signs onto EOC
- Complete Med reconciliation
- 5-Psychosocial Assessment
- Complete Exam including psycho social and documents
- Smart Set
- 13-Neuropathy/Foot examination
- Discuss vital signs, lab results and self-monitored blood glucose values. Interpret foot exam.
- 4-Med reviews (ASA)
- 6-Physical activity
- Determine and discuss action plan and goals. Review with patient including medication change(s) as needed.
- Update Problem List
- Woman of childbearing age are able to conceive?
- Yes
- No
- Preconception counseling Document counseled Y/N, date.
- BPA: alert if LDL >100
- BPA: A1c >7%, consider CDE education
- BPA – If pt on Metformin and creatine = WM = 1.4, Men = 1.5
- BPA: Combined calculation of most rct lab value
- Pre BPA at close of encounter for missing labs, orders, etc.
- F/U appt needed?
- Yes
- No
- Sends task to front desk (appt secretary) to schedule labs and follow up visit
- 12-Chronic Kidney Disease
- 3-A1C Testing
- Add new orders signs Pended Orders Labs (A1c, lipids, micro albumin, creatine) Radiology Medications
- 7-MNT/ Nutritionist
- Referral Needed
- Assist documentation electronically during office visit
- Need to be able to document counseled need for referral, date recommended and readiness for change
- Result Notification Process: to be determined by result notification workgroup

Personal Learning Plan Selected by QIP's



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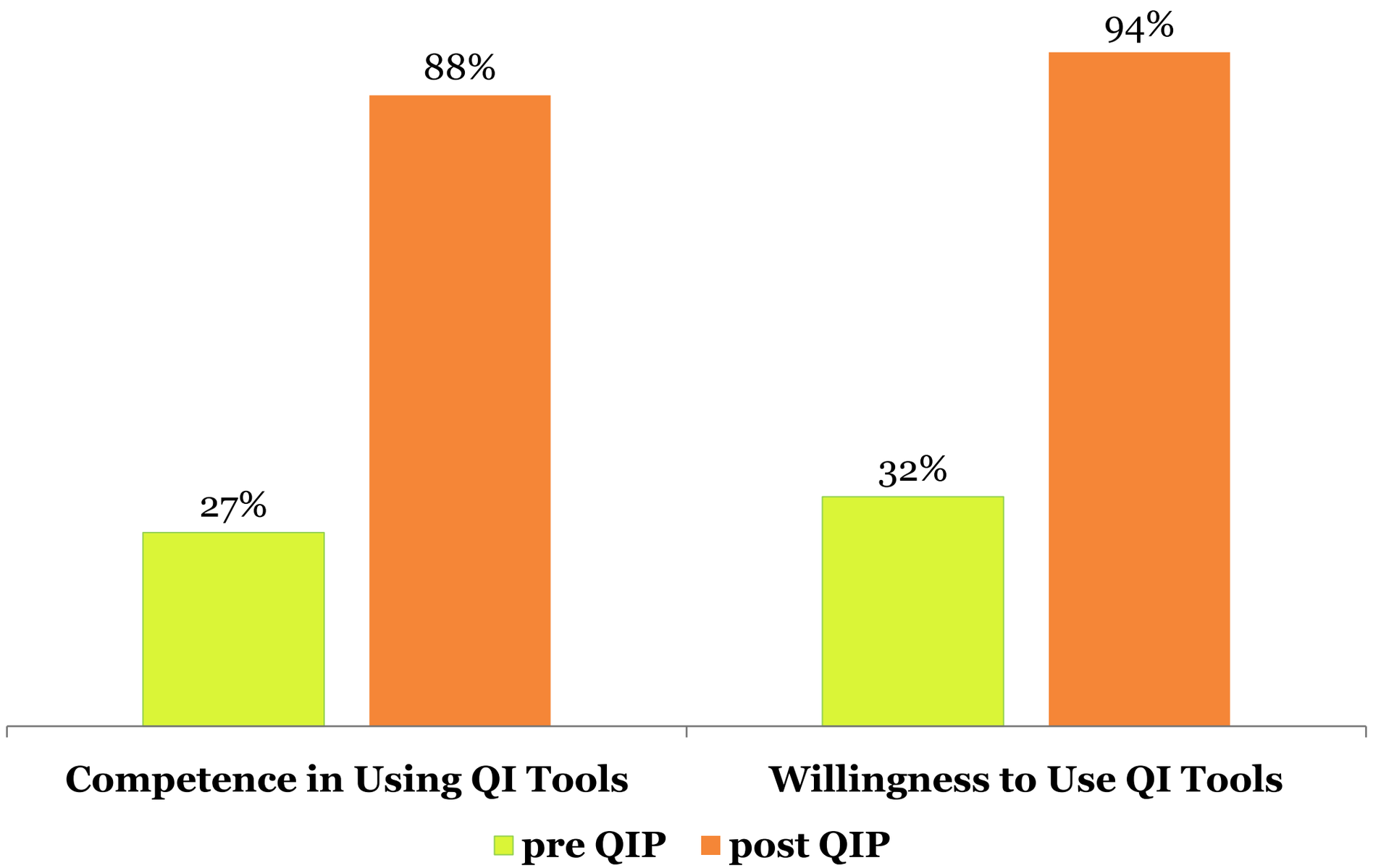
Self assessment



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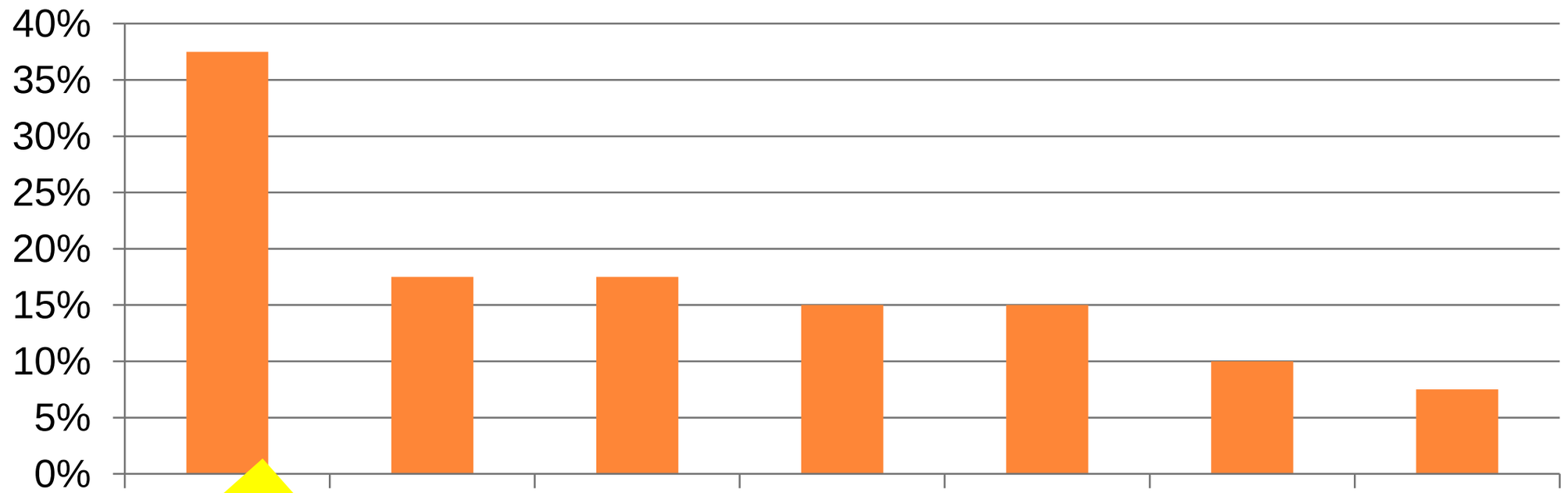
Why not use QI tools

N=40

Prioritize



Too difficult to use

Motivation/ownership

Getting Buy-in engaging..

Leadership/Empowerment

Staff (varied levels of QI..

Using it but don't realize it

Not enough time

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FY 09- FY 10 Average Scores and FY 11 Targets - RPCC Medical Home

	FY 09 Average – Medical Home	FY 10 Average – Medical Home (through	P-Value of less than 0.05 is	FY 10 Highest Scores in Medical Home (through July 2010)
SERVICE (Provide Patient and Family Centered Care)				
Outpatient Satisfaction - Visit Overall - % Excellent	47	49	0.15	66
Outpatient Satisfaction - Sensitivity of Staff to Your Needs - % Excellent	47	49	0.99	70
Outpatient Satisfaction - Scheduled Appointment when Wanted - % Excellent	43	44	0.23	61
Outpatient Satisfaction - Overall Rating of Provider - % Excellent	59	66	N/A	85
Access for New Patients (14 day)	71	74	(0.22)	100
QUALITY (Close the Quality Gap)				
Outpatient Satisfaction – Provider explained what was done - % Excellent	55	55	0.51	66
Diabetes Outcome Composite - % of patients with all outcome values within range	48	52	0.07	67
Diabetes Process Composite - % of patients with all measures done in last 12 mos	26	31	0.37	45
Hypertension - % of patients below 140/90	68	73	0.003	82
Mammography Adult Preventative - % of women 42-70 w/mammo done in last 2 yrs.	62	64	.009	82
Pneumovax Adult Preventative - % of pts. >65 that have been given or assessed		71		89
Outpatient Satisfaction – Thoroughness of the care received from the provider - % Excellent	64	66	0.88	82
Pediatric immunizations (30 months) - % of pts 30 months that have all required vaccinations	-	-		85
UTILIZATION / FINANCE (Practice Careful Stewardship) 2011 TBD				
Expense Variance to Budget (2009 & 2010)	-0.17	2.1	0.14	
RVU to Budget (2009 & 2010)	-2.3	-3.6	0.23	
POPULATION MANAGEMENT / GROWTH (Create Systems that Work)				
New Primary Care Patients as a Percent of Total Primary Care Visits - % new patients	4.6	3.9	.02	7%

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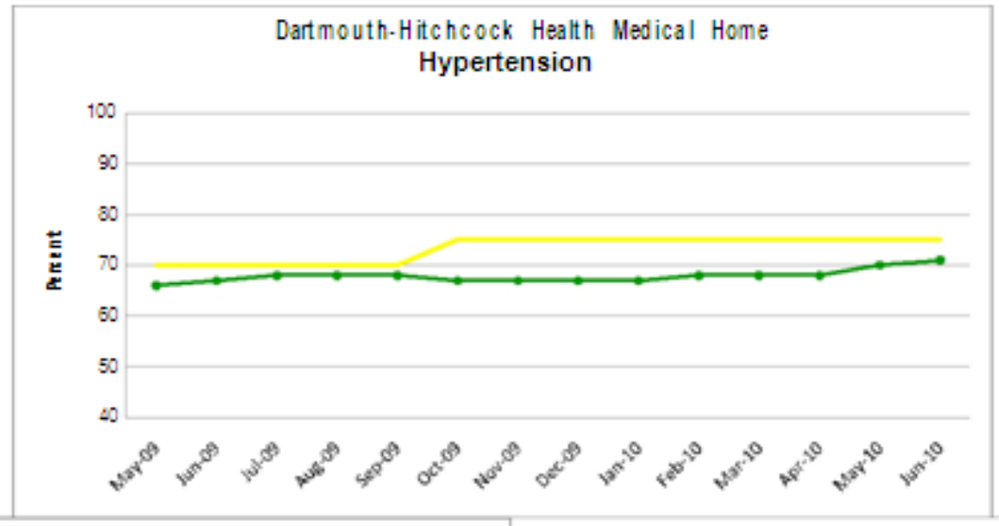
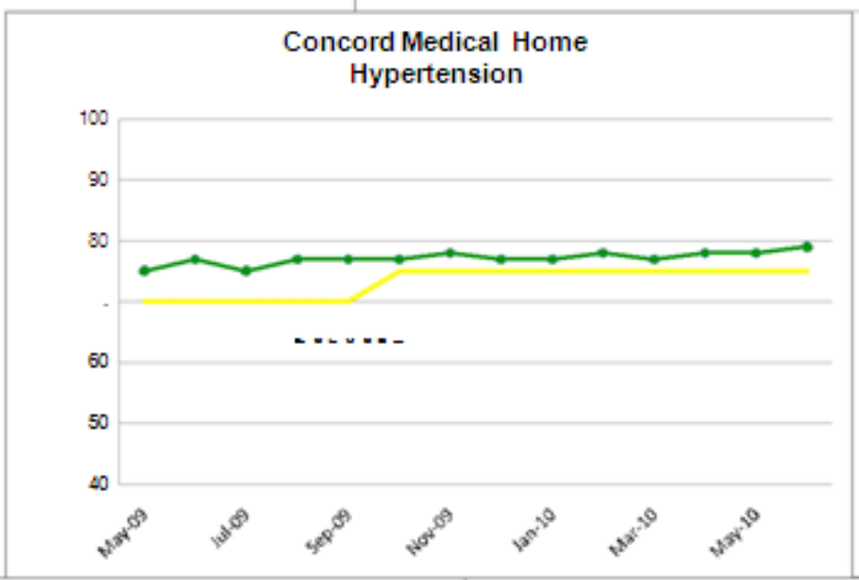
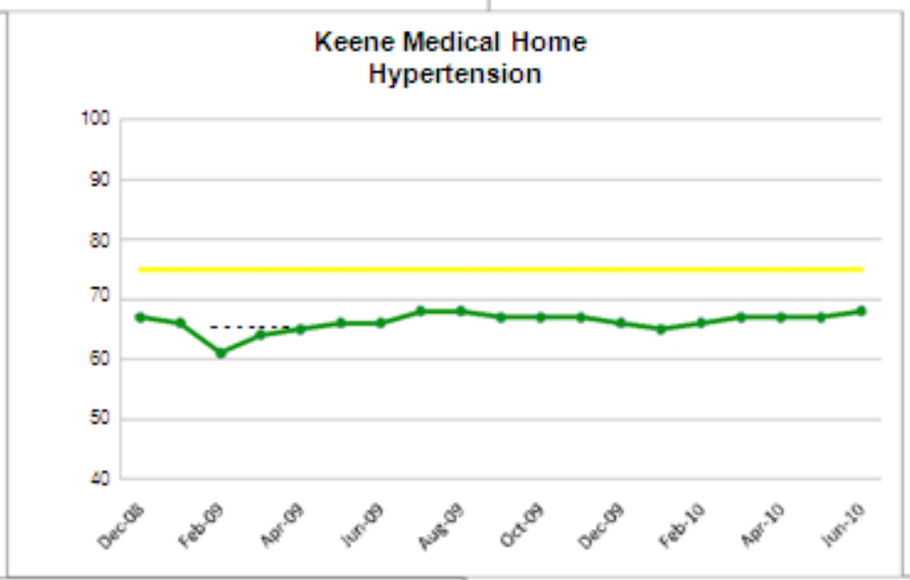
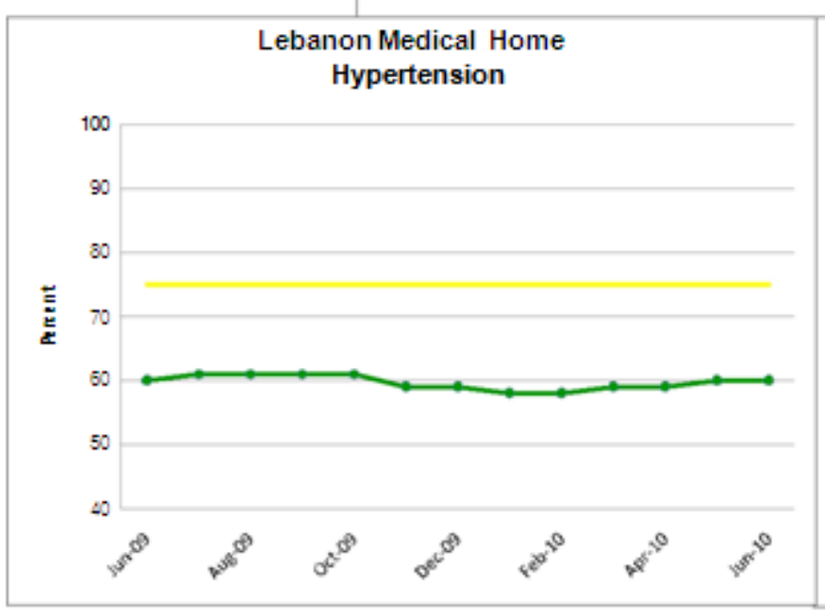
What % of my patients with a diagnosis of HTN have both systolic and diastolic BP values less than 140/90?

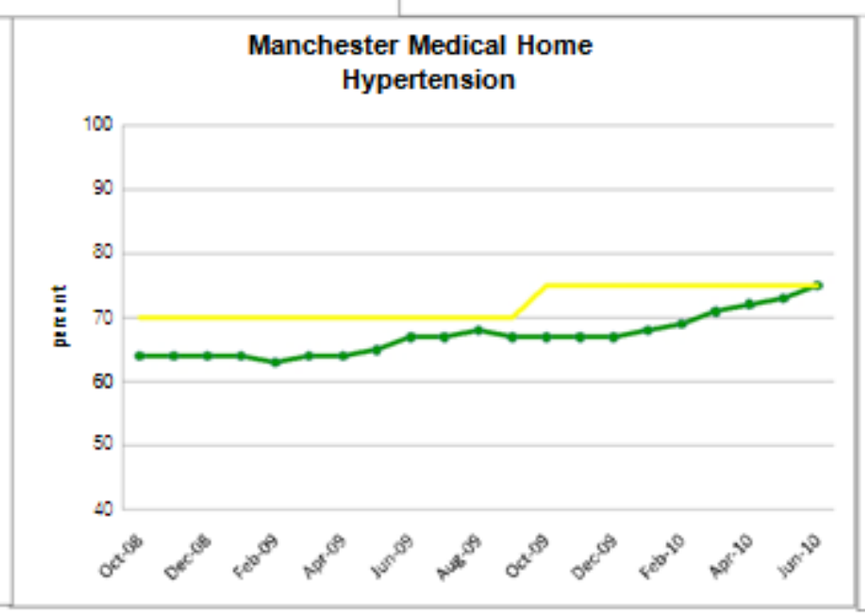


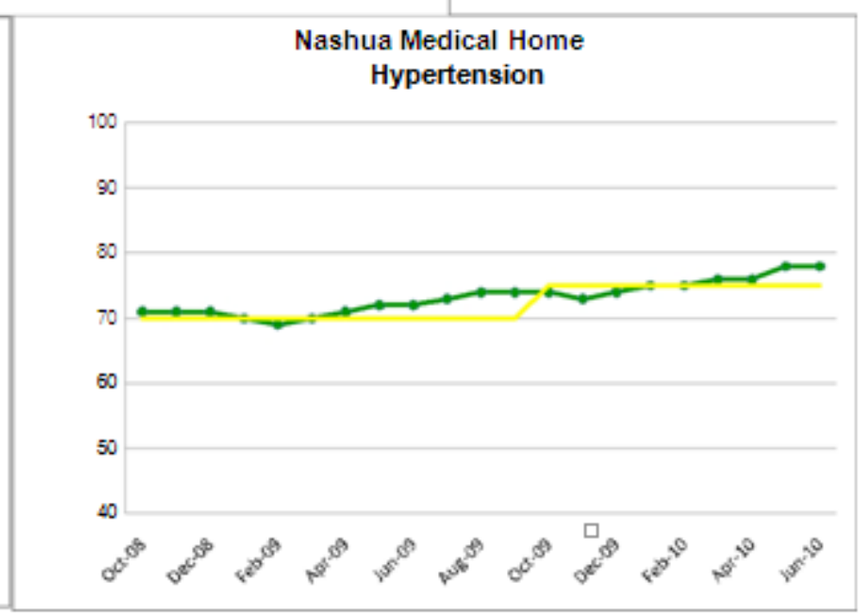
Scores across divisions





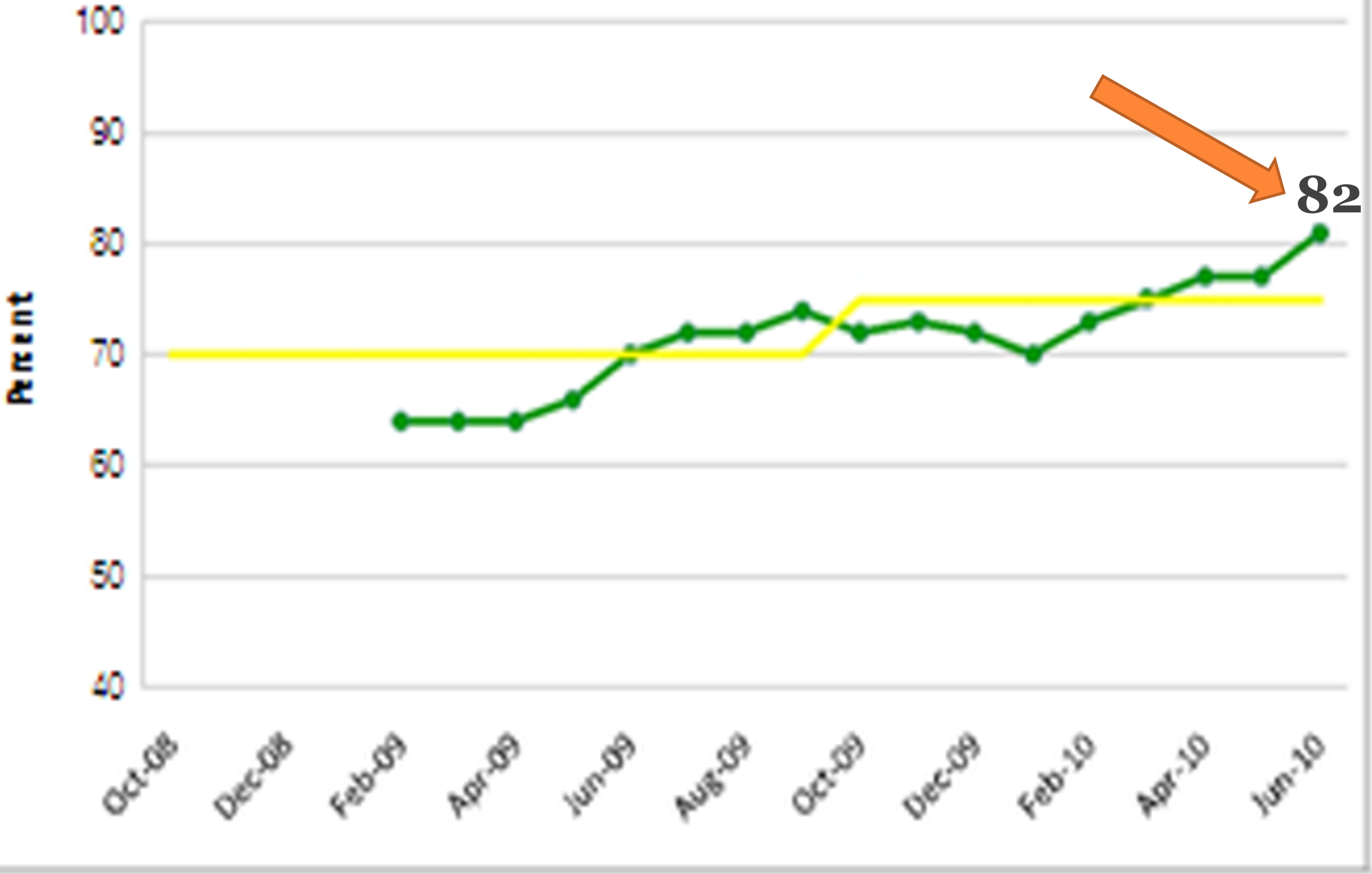






Green Line = Ytd results Yellow Line = Target

Manchester IMED Team C
Hypertension



Current Challenges

Measure
- Needs assessment
- Balanced Scorecard
- Performance Review processes

Prioritize
- Benchmarks
- Align with PCMH, DH, CMS, Cigna, NH Medicaid, Harvard Pilgrim, ...

Finance
(Reward and Recognition)
- **Contract alignment**
- **Compensation alignment**

Disseminate
(Implement- system wide)
- Best Practice Summits
- System wide training
- Web based Toolkit
- Communication

Redesign and Test
- Quality Improvement for all
- Support Pilots

How do we disseminate the "pockets of success" to assure system wide performance ?

How do we align DMS curriculum to maximize student role in the PCMH and assure they will be here?

How do we align old compensation and incentive models with new PCMH performance metrics *despite* Lagging Payment Reform ?

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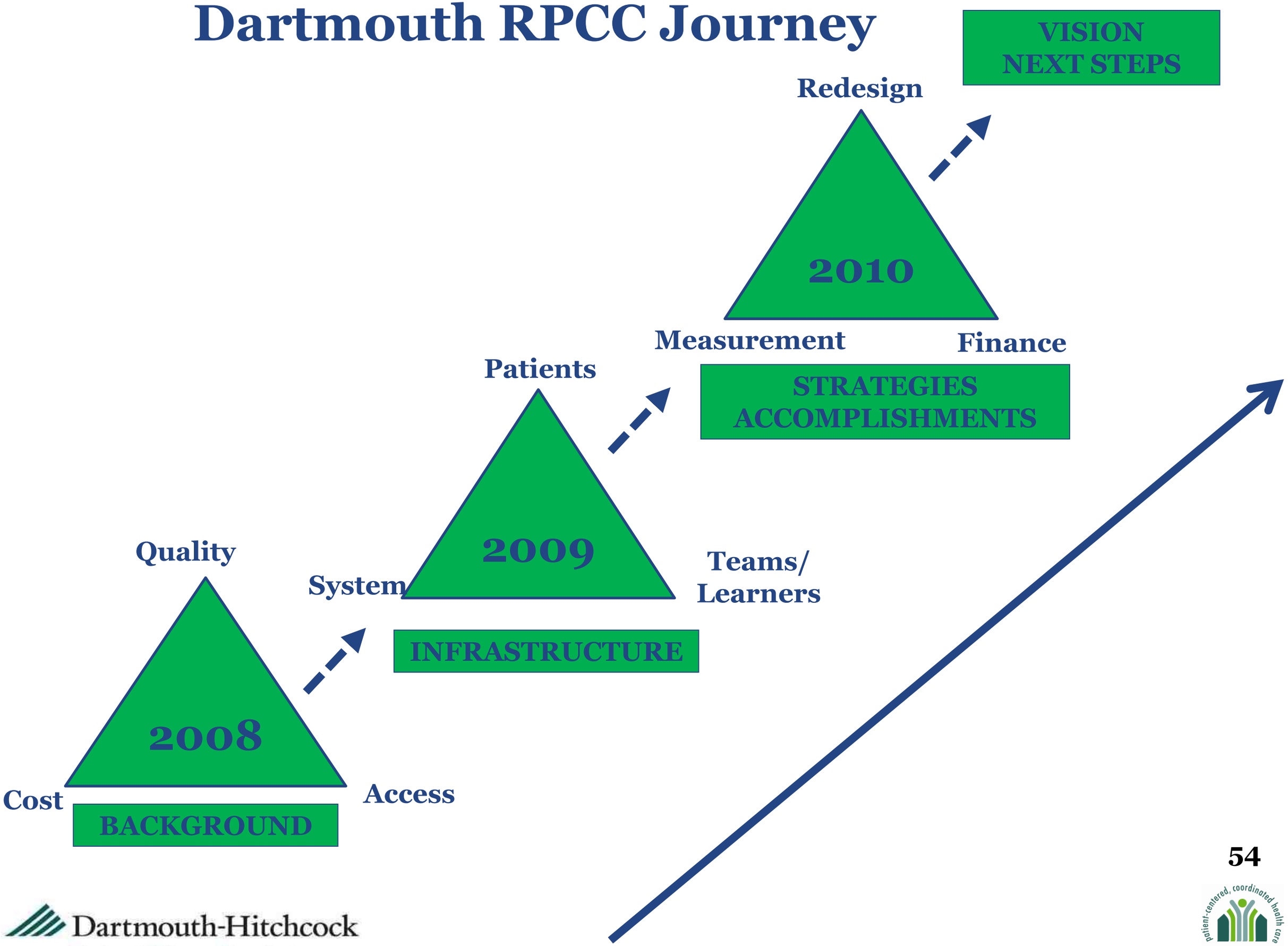
Dartmouth RPCC Journey



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VISION…What Does THE PCMH End State Look Like To u?

How will u know when u R done? What R the must haves?

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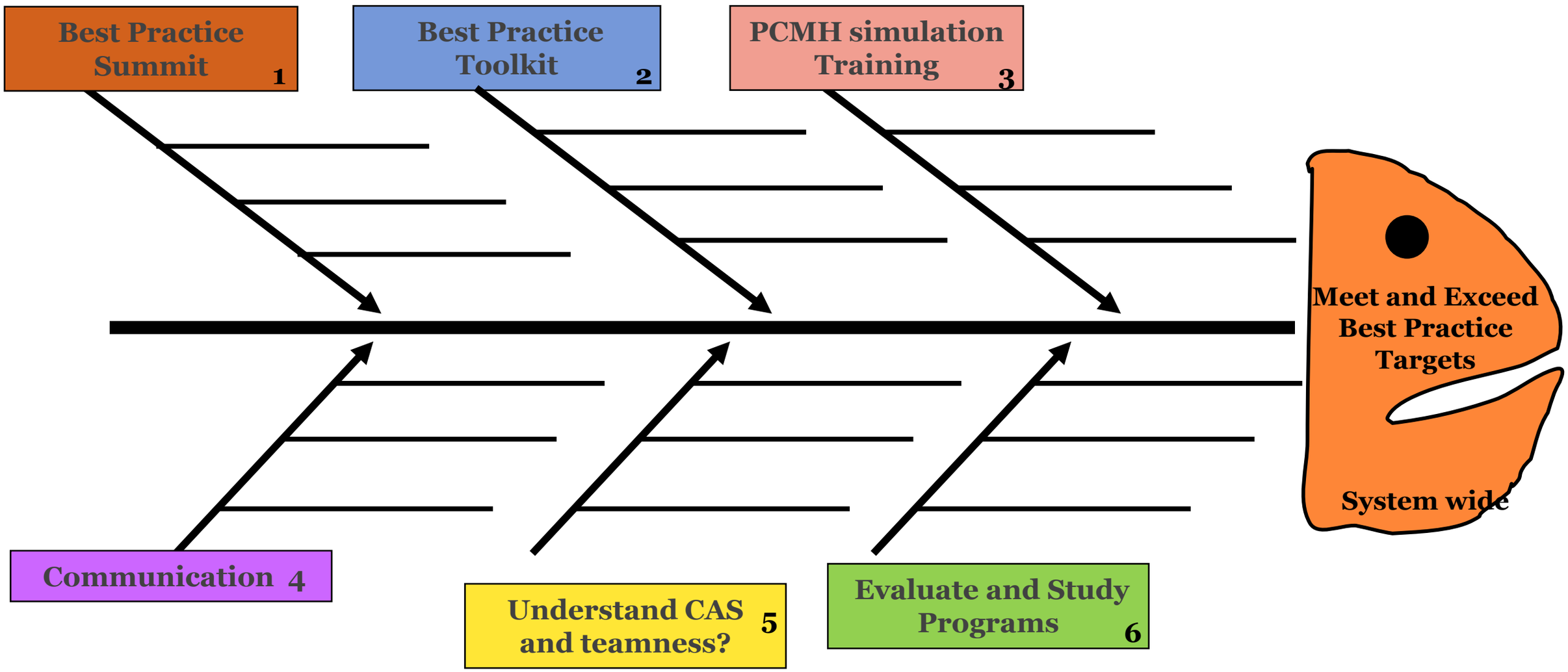
NEXT STEPS ARE TO OVERCOMING CHALLENGES

1. **Align** and disseminate Best Practice System wide
2. **Align** and match PCMH metrics to compensation and incentives (despite Lagging Payment Reform)
3. **Align** PCMH and medical education curriculum

Strategies To Align and disseminate Best Practice System wide



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DRAFT

RPCC Primary Care Compensation/Pilot Proposal 2011

Overall Aim: Fully ALIGN the PCMH metrics with finances and the development of our Accountable Care Organization (ACO)

Medical Home Base Salary + **Quality Bonus** + **Utilization Bonus** + **Population Raise** = •**Strong PCP infrastructure** •**Successful PCMH** •**Prepared ACO**

NCQA Level I/II/III	**P**ay for Performance Bonus	Shared savings for ER, Admissions, Readmission savings	**For growing panel of** Risk adjusted Patients
Source of Funding →→→→	Increased Medicare Reimbursement 2011 to PC NCQA level accreditation payments though external contracts and pilots , Ex. NH MH Keene Multi-payer pilot.	P4P quality care shared savings funded from contracts and demonstration pilot success including CMS, Cigna	ACO commitment to shared savings from proper utilization and decreased unwarranted spending of services	Recognized value for new patients into the practice and to the institution.

Skill

•Exposure

•Team experience

Knowledge

•training

DMS QIPS

Attitude

•mentoring

Aligning Medical Education "The three sciences" within the PCMH

Summary "PIPAS PEARLS"

1. **US Health care crisis = Opportunity for PC /PCMH**
2. **Leverage PC value to build Infrastructure**
3. **Have a vision, a plan , and the right people**
4. **Transformation starts with metrics**
5. **Know your baseline- "NCQA is our friend "**
6. **Redesign at the frontline - support pilots to find high performers**
7. **Improvement for all- takes time**
8. **System wide success is more than duplication**
9. **Finance must follow metrics**
10. **The PCMH can be the ideal place to align Health care redesign in medical education and grow a PC workforce**

Learning's in LEADing CHANGE

Catherine Florio Pipas 2010

Listen

Exercise (for example)

Ask (Always start with the right questions)

Don't forget "Please and Thank You"

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Useful Quality Improvement Web Sites

- http://www.improvementskills.org
  (Excellent tutorial site – free or $10 if you want CME)
- http://www.patientsafety.gov
  (Tools and links to improve patient safety)
- http://www.pqe.org
  (Partnership For Quality Education – Joint Sponsor By RWJ And Pew Trust)
- http://www.mceconnection.org/mce/
  (Managed Care Education Connection)
- http://www.ihi.org
  (Institute for Healthcare Improvement)
- http://www.ahrq.gov
  (Agency for Healthcare Research and Quality)
- http://www.hce.org
  (Health Care Excel)

PCMH REFERENCES

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