PITTSBURGH REGIONAL HEALTH INITIATIVE

Spreading Quality, Containing Costs.

EXECUTIVE SUMMARY

July 2014

Practice Transformation

A Case Study: Saint Vincent Medical Group

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PRHI's CENTER FOR PERFECTING PATIENT CARE℠ HAS BEEN APPROVED BY THE PENNSYLVANIA STATE NURSES ASSOCIATION AS A PROVIDER OF CONTINUING EDUCATION

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There is a lot of pressure on primary care organizations to provide a significant number of additional services that will minimize hospitalizations and emergency room visits, but they are not getting additional funding to do this. Many primary care organizations are attempting to redesign the way they provide care to offer more comprehensive services while trying to remain financially viable. It is a daunting challenge.

Under the accountable care organization (ACO) model, if ACOs deliver better outcomes, such as reducing their patients' admissions and readmissions, then the primary care providers could receive a portion of the money saved as a result to offset the costs of innovative services.

Saint Vincent Medical Group (SVMG), part of the Allegheny Health Network's Saint Vincent Health System (SVHS), has been tackling this challenge. The Erie, Pennsylvania multispecialty practice organization, which includes 17 primary care practices and one sports medicine practice, serving more than 65,000 patients, has embraced this opportunity to evaluate all aspects of its operations and the quality of the care it provides. The Pittsburgh Regional Health Initiative (PRHI) has partnered with SVMG over the past three years in their practice transformation efforts through our role in PA REACH, Pennsylvania's Regional Extension Center for Health Information Technology.

The concept of practice transformation is not new, but has gained traction over the past few years with the design and roll-out of the Patient Protection and Affordable Care Act. Google "primary care practice transformation" and you'll find a host of scholarly articles, websites, blogs, and consulting groups that provide practice transformation services. Yet, many questions remain about the concept. What is primary care practice transformation, exactly? What does it look like? Is there an evidence-based best practice guide to practice transformation and what is the preferred order for sequencing change efforts?

Who plays what roles in a transformed medical practice? How is positive change measured and sustained in a rapidly changing health policy and payment environment?

Since 2006, PRHI has worked with more than 330 primary care practices in western Pennsylvania through its involvement in a range of programs including PA REACH West, the Safety Net Medical Home Initiative, and two initiatives which focus on the integration of behavioral health into primary care: Partners in Integrated Care and COMPASS. Through these various initiatives, PRHI supports practices by providing training and coaching in PRHI's healthcare quality improvement methodology, Perfecting Patient Care[SM] (PPC); electronic health record (EHR) implementation and optimization; behavioral health and primary care integration; and Patient-Centered Medical Home (PCMH) implementation and recognition. SVMG has been a leader in practice transformation, having made the commitment to invest in the infrastructure needed to implement and sustain the type of changes necessary for improvements in quality, safety, efficiency, and cost containment.

SVMG faces many of the same time, financial, and personnel challenges that other practices face in building their capacity for continuous improvement. Moreover, like many practices, they serve a growing number of patients, many of whom have complex needs. Further exacerbating these constraints is the current reimbursement structure, which doesn't adequately support many of the services SVMG aims to provide (and that patients, payers, and the federal government expect practices to provide), such as care management, population outreach, behavioral health screening and intervention, and the use of health information technology (HIT) and data to drive quality. Attracting and retaining providers to primary care is an ongoing challenge. Notwithstanding these obstacles, SVMG has created a system that supports transformation.

SVMG's transformation recipe appears to be a combination of key ingredients: a clear vision, engaged leadership, a quality improvement strategy embedded throughout the organization, an understanding of the current and anticipated policy and payment environment, a willingness to challenge the status quo, and a commitment to placing the right people in the right positions with the right support.

Building the Foundation

Engaging Leadership

Every successful and sustainable large scale change effort requires leaders who can envision a future, clearly define and communicate that vision to their workforce and stakeholders, and allocate the resources necessary to empower frontline staff to be successful in implementing improvements aligned with strategic goals and the organization's vision. Engaged leaders do more than simply direct others in how to change. They model the behaviors they expect of others. They seek input from those within the organization who are most knowledgeable about the systems and work processes requiring improvement. They identify and break down barriers to change. They tackle the tough issues associated with getting people on board with the vision, challenging the status quo, and maintaining the momentum for change, even in the face of resistance.

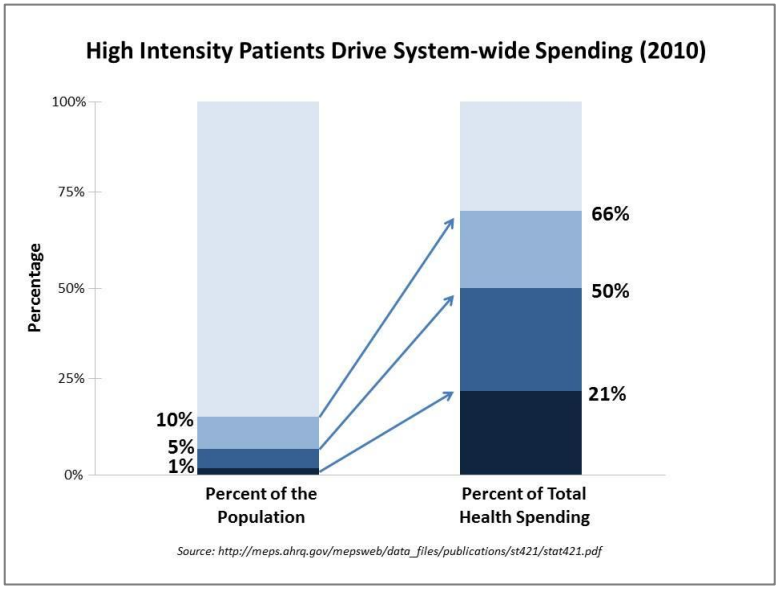
Dr. Sam Reynolds, SVMG's chief medical information officer (CMIO), has been with SVMG for ten years. He serves concurrently as a primary care physician at SVMG's Edinboro Medical Center and as the CMIO responsible for guiding the organization's HIT strategy. He possesses a comprehensive understanding of HIT and an

SVMG Chief Medical Information Officer Sam Reynolds, MD

understanding of the intersection between physician workflows and electronic health records. He knows what it's like to experience the conversion from paper to electronic records because he's lived it himself. He envisions a future where the promise of HIT in improving quality, safety, and efficiency is fully realized. He is realistic about the fact that EHRs aren't perfect, but knows that the existing functionality can be leveraged effectively to improve care.

When an organization is engaged in so many improvement efforts—optimizing IT, integrating behavioral health into primary care, implementing the PCMH model and applying for recognition, and working collaboratively with organizations across the healthcare continuum on accountable care—it can be easy to see them as separate, disjointed efforts, especially when the metrics and payment incentives attached to the initiatives are incongruent. Dr. Reynolds sees it as part of his job to help others to see how all the pieces of organizational transformation fit together.

"With payment reform in health care, we're seeing this shift from a fee-for-service mindset to one that is paying for value and paying for population health management," Dr. Reynolds says. "We have to adapt to this changing environment, and that requires using all available resources and tools to make that happen—eliminating waste, improving workflows, and coordinating care across traditional medical silos. We're trying to move practices into this new mindset of population health management."



"I think of the patient population as a pyramid," Dr. Reynolds continues. "At the top of the pyramid you have the five percent of the population with chronic disease that consumes about 50 percent of healthcare spending. We need to provide a higher level of support and care management for these high utilizers. Then, there's the next 10 percent of the pyramid: patients with a chronic disease that is currently under control, but who may decline as their disease progresses. Our goal is to take ownership of this population, to manage risk at the practice level. Finally, there's the bottom 85 percent of the pyramid with individuals who are relatively healthy. We need to support these patients in their efforts to stay well by providing good preventive screening, having quality population health outreach, and also coaching patients who have certain lifestyle issues that could put them at risk for developing a chronic disease. All of this requires training clinical staff in a model of team-based care, and assigning staff to new roles with new responsibilities—and giving them the new skill sets they need to succeed."

Dr. Reynolds also is well-attuned to the regulatory and policy environment and new demands for care redesign.

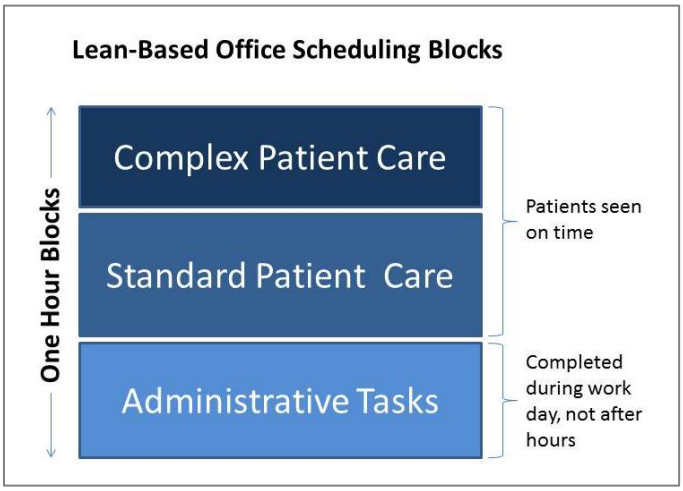
"Embedding a quality improvement strategy within an organization starts with an impassioned physician leader," says SVMG Executive Director Tom Murphy. "That's absolutely Sam Reynolds."

(L) Dr. Reynolds with SVMG Executive Director Tom Murphy

Murphy has also played an integral role in establishing the organization's quality-oriented strategy. Since joining SVMG in the spring of 2013, he has overseen all operations of the physician practices. Murphy is constantly looking for ways to improve efficiency. He achieves organizational buy-in for initiatives by launching pilot projects that give frontline staff a prominent voice and demonstrate improvements that generate buzz at other practices. For example, SVMG piloted a lean-based schedule template structure featuring repeating one-hour blocks of time, based on the feedback of providers.

In this system, patients are scheduled based on the complexity of their medical needs, with more complex patients seen at the top of the hour. The schedule includes a block of time at the end of each hour for staff to get caught up on administrative and clerical tasks typically done at the end of the day.

"We've created efficiencies," Murphy says. "Patients are happy because they are seen on time. Physicians and staff have a less stressful day because they don't fill out paperwork until seven or eight o'clock at night. We started with a couple of practices, and now we're rolling this out to nearly a dozen practices who want to participate after hearing positive things. These quality initiatives build momentum if you provide strong evidence and results, and then you share it with everybody. When you ask, 'Who's next?' you tend to get a lot of hands raised."



Embedding a Quality Improvement Strategy

In 2011, SVMG reached out to PRHI to explore bringing Perfecting Patient Care[SM] (PPC) training to management and frontline staff of Saint Vincent Health System to build skills for practice transformation. PPC, PRHI's lean healthcare quality improvement methodology, offers healthcare leaders and frontline staff the concepts and tools to redesign systems and work processes to help practices achieve perfect patient care. "Perfect care" means that every patient, every time, receives the care that he/she needs when it is needed, in the quantity needed, in ways that are safe, efficient, and without error. In a healthcare system laden with errors, inefficiencies, and waste, the goal of perfect patient care may seem unattainable. SVMG leaders, however,

aimed for nothing less and sought to equip their team with the necessary tools and skills to move the organization towards achieving the ideal.

Led by Dr. Reynolds, a team of SVMG leaders worked with PRHI trainers and coaches to define the objectives of the training, customize curriculum to the needs of the staff being trained, and outline a strategy for learners to apply their PPC skills after training. The result was a customized two-day PPC University offered twice at SVMG for a total of 86 participants.

SVMG staff takes a break during a Lean training event

At the time SVMG engaged with PRHI, lean wasn't new to Saint Vincent Health System. For example, SVHS already had hired a lean expert, Jean Tauber, to guide lean implementation throughout the health system. SVMG's engagement with PRHI for PPC training was part of its strategy to extend lean training beyond the walls of the hospital.

Visit SVMG practices today and you'll see PPC in action. Visual cues are used to enhance communication. A3 documents – which are lean tools used to capture problem solving cycles – are posted in staff lunch rooms. One-pagers about key lean concepts are posted where staff and providers may be easily reminded about the application of lean to daily work. Performance data reports are routinely made available to practice managers, providers, and staff to guide improvement efforts and monitor progress.

PPC training served as a catalyst to embedding a common quality improvement (QI) language, tools, and concepts throughout SVMG's 18 primary care practices. By weaving PPC into the fabric of the organization, SVMG built internal capacity for continuous improvement. SVMG continues to enhance that capacity today by leveraging internal lean experts to train and coach managers, staff, and providers on lean implementation.

Leveraging Health Information Technology

In 2009, the federal government set out to push health care into an era of EHR optimization and interoperability. The Health Information Technology for Economic and Clinical Health (HITECH) Act provided technical support and financial incentives to primary care physicians to select, implement, and optimize the use of EHRs.

This unprecedented investment in HIT signaled a major shift in the healthcare landscape. The Act acknowledged that functional, integrated health IT was fundamental to improving

> *"The widespread use of electronic health records in the United States is inevitable. EHRs will improve caregivers' decisions and patients' outcomes."*
>
> *David Blumenthal, M.D., M.P.P., (national coordinator for health information technology at the Department of Health and Human Services) and Marilyn Tavenner, R.N., M.H.A. (principal deputy administrator of the Centers for Medicare and Medicaid Services). New England Journal of Medicine, Aug 2010*

care delivery, care coordination across the healthcare continuum, and patient outcomes. The Act's Meaningful Use (MU) standards required EHR vendors to significantly upgrade the functionality of their systems: Many new work flows, data elements, user interface and reporting capabilities were added. Providers can now use this EHR functionality to manage patient care more efficiently and effectively. The HITECH Act offered significant financial incentives to primary care providers who could demonstrate a consistent ability to meet the MU standards.

Implementing an EHR is challenging on many fronts. Many primary care practices operate on very thin profit margins, making it difficult for them to afford the financial outlays needed to install an EHR system. In addition to this financial investment, providers and staff must have support as they adapt to new workflows and fundamental changes to practice operations. SVMG was well positioned to respond to the change in the healthcare environment brought about by the HITECH Act and to earn the financial incentives. SVMG was an early adopter of an EHR system, implementing the AllScripts Enterprise product several years before the passage of the HITECH Act.

SVMG leaders viewed the HITECH Act as an opportunity to optimize its EHR utilization. SVMG decided to take full advantage of the technical assistance provided through the Act. In 2010, SVMG partnered with PRHI, a subcontractor for Western Pennsylvania's Regional Extension Center (PA REACH West), to provide technical assistance to its primary care and other eligible providers. SVMG enrolled a total of 50 providers. With its own EHR implementation largely completed before the enactment of HITECH, SVMG worked with PRHI to focus on optimizing the use of the EHR to manage populations, enhance care coordination, and extract meaningful data to monitor outcomes and inform quality improvement efforts. SVMG viewed the EHR as much more than an electronic chart storage system. With proper implementation, staff training, and support, the system has become a powerful tool to enhance care delivery and coordination across the health system.

SVMG leveraged REACH funding and support to build capacity for data analytics and population health. As a result, the organization is now a leader in extracting data about its performance on a wide range of quality and care process indicators that are used to identify and manage patient populations: Sophisticated tools are routinely given to each practice and provider, allowing for the streamlined and consistent identification of and outreach to patients most in need of additional care management and self-management support. SVMG's diabetes segmentation report, for example, stratifies patients into risk categories based on a series of evidence-based guidelines. Diabetic report cards, a resource for patients and their care teams to monitor progress toward treatment goals, are automatically generated for every diabetic patient.


SVMG Business Intelligence Analyst Eric Munson

"The report cards give patients a one-page summary of all the things they need to watch to manage their diabetes," says SVMG Business Intelligence Analyst Eric Munson, who transforms raw data into actionable information. "It's an educational tool, and it also helps them develop questions for their doctor. I have had some providers tell me that patients receive that initial report card, and then come to subsequent visits with a three-ring binder containing their last couple of reports so they can keep track of their condition. It's a nice motivational piece of information for the patient to see how they have improved over time."

Registry lists of patients due for preventive services are generated regularly for practices, alerting them of the need to reach out and schedule patients for care. Pre-visit planning reports that include recent lab values, test results, health maintenance needs, and gaps in care help the care team to plan for visits in advance of the patients' arrival, minimizing the time spent during the visit hunting and searching for information and maximizing the face-to-face time between patients and their care teams.

SVMG's investment in HIT is paying off. All of their providers successfully attested to achieving Meaningful Use stage 1 and are well positioned to achieve stage 2 once vendor upgrades are completed. Providers have ready access to information to manage individual patient care and populations of patients. Practices are using the sophisticated data available to them to drive improvements in care delivery.

"We are pooling information from the clinical system to categorize the patient population and do risk stratification," Munson says. "We are looking at various risk factors that a patient may have—high blood pressure, high cholesterol, diabetes, depression—and seeing who needs immediate attention. We are also looking at moderate-risk patients who may be tipping into high-risk, so we can intervene and keep their health from deteriorating. It's looking at things in a more preventive way, as opposed to a volume-based model where you're getting patients through the turnstile."

SVMG has maximized its participation in REACH in other ways as well. Using REACH funding, Donna Smolko, a Certified Health Technical Specialist in Implementation Support (CHTS-IS), was hired and assigned her to work on-site with SVMG, supporting their efforts to leverage IT for population health management. Donna brought a wealth of experience in information technology and data analysis to her role as population health data/process analyst.

For more than two years, Donna provided training and support to providers and staff around patient-centered care, EHR optimization, and population health. "Her commitment and knowledge," says Dr. Reynolds, "have added value to design and implementation of SVMG's strategic vision, including recent initiatives such as the Accountable Care Organization (ACO) for the Erie community, in which SVMG is participating."

SVMG Clinical Redesign Facilitator Donna R. Smolko, CHTS-IS

Recognizing the value that Donna adds to the team and that funding to support her position was time limited, SVMG set about designing a sustainability plan for the health data/process analyst position after REACH financial support ended. In April 2014, Saint Vincent hired Donna as a full-time employee to facilitate practice transformation for Erie community practices participating in Saint Vincent's ACO.

From EHR Optimization to the Patient-Centered Medical Home

In 2007, four of the leading medical professional organizations – the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic

Association – released the Joint Principles of the Patient-Centered Medical Home. Though the PCMH model had been around in some form since the 1960s, it wasn't until the release of the Joint Principles that the PCMH model began to gain significant traction as a primary care delivery model.

The concept of the model is fairly simple – it asserts that primary care should be designed to deliver whole-person-oriented, well-coordinated care by a physician-led team focused on quality and safety. The PCMH model recognizes that patients are the primary managers of their health. It is the responsibility of the primary care practice to support patients' success in managing their own health by prescribing treatments and tools and coordinating care with other healthcare providers and community resources. The PCMH is aligned with health reform, aiming at improving outcomes; reducing costs; and enhancing patient, provider, and staff satisfaction.

SVMG anticipated that the PCMH would gain traction; the organization had begun redesigning care delivery in 2006, even before the release of the Joint Principles. At that time, in the absence of payment models to support the expansion of services including care management and population management that are necessary for successful implementation of the PCMH, they began to implement new workflows in their practices. In some respects, it was an uphill battle. Finding the personnel and financial resources to move the organization forward on its journey was not easy. Nor was gaining the buy-in of a large network of 100+ providers and their office staff who were not fully convinced that practice transformation was necessary or possible.

"The PCMH concept lit a fire in me," Dr. Reynolds says. "You can have a great electronic health record. But unless you have a team functioning together efficiently, you can't make the best use of that new tool."

Features of the PCMH

The Joint Principles of PCMH Include:

1. Ongoing patient relationship with a personal physician
2. Physician-led team of health care professionals
3. "Whole-person" care that includes prevention
4. Care is coordinated and integrated
5. Care is high quality and safe
6. Enhanced access to care via open communications and extended hours
7. Payment for value of care, not volume

Adapted from NCQA, http://www.ncqa.org/portals/0/PCMH%20brochure-web.pdf

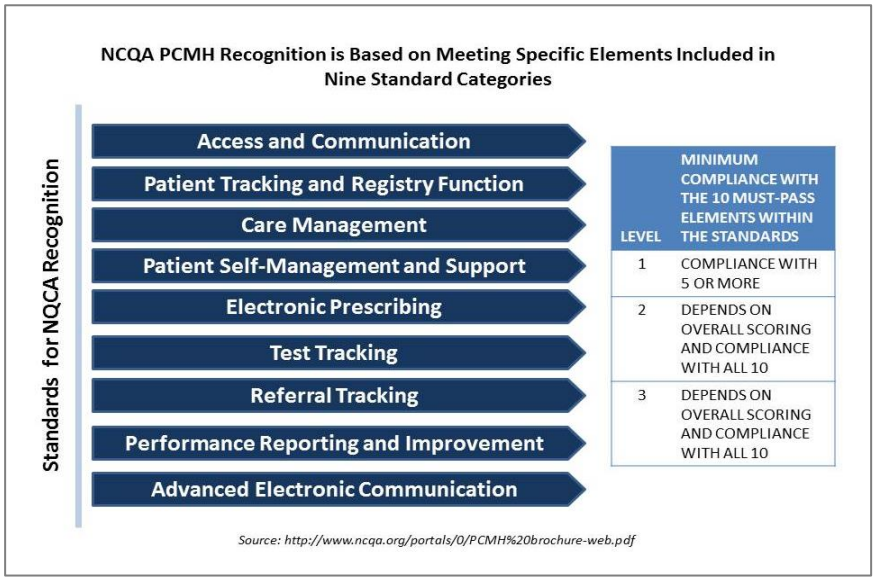
In the absence of sufficient payment models, SVMG sought opportunities to leverage support for its transformation journey. Beginning in 2010, SVMG participated in the PA Chronic Care Collaborative, an initiative of the then-Governor's Office of Health Care Reform. The multi-payer initiative studied the impact of payment reform, practice transformation support, and care management support on PCMH implementation and patient outcomes, with an initial focus on diabetes. Several SVMG practices participated, and as a result, implemented workflow redesign strategies to improve care and outcomes for diabetic patients. SVMG leveraged opportunities to participate in other initiatives as well. For example, the SVMG Family Medicine Residency Practice joined a residency PCMH learning collaborative. As a result, the practice achieved Level 3 PCMH recognition, the highest level of recognition awarded by the National Committee for Quality Assurance (NCQA). The residency practice was the first SVMG practice to achieve recognition, an accomplishment that reflects the efforts of the team to redesign care policies, processes, and procedures in accordance with PCMH standards.

Through its participation in these and other initiatives, SVMG gained a wealth of knowledge and experience to continue its journey of rolling out PCMH concepts across the practice network. They began in several practices by focusing on workflows such as open access scheduling – where patients can request a same-day office visit for routine or urgent needs – and pre-visit planning, a process by which the care team prepares for patient visits in advance to identify potential gaps in care to anticipate patient needs for services. They adopted a population management mindset, one that recognizes the importance of monitoring and managing the care of the entire patient population, not only the individual patients who come to the office for visits. They offered support and resources for patients living with chronic health conditions and recognized the value of reaching out to patients who are due or overdue for services.

SVMG developed a "transformation team," a multidisciplinary group of practice managers, providers, IT team members, and others across the practice organization charged with facilitating workflow redesign and transformation efforts in the practices. In September 2013, SVMG turned to PRHI for support. Having already completed a bulk of documentation needed for NCQA PCMH recognition – including corporate policies and procedures – the transformation team found that it was struggling with "where the rubber meets the road."

That is, while they had well-developed policies, procedures, and EHR workflows for PCMH processes such as referral tracking, population management, and chronic disease management, they found that fully implementing the policies in their practice network was a challenge. Changing workflows isn't easy; doing so requires changes in knowledge, attitudes, and behaviors of providers and staff. Improving policies, procedures, and EHRs was hard enough. Changing knowledge, attitudes, and behaviors proved to be an even more daunting challenge.

The transformation team seized the opportunity of applying for NCQA recognition to fundamentally change how care is delivered across the practice network.



"We had been on the PCMH journey for several years, but the process was not moving forward as fast as we would have liked," Dr. Reynolds says. "We were doing this piecemeal, one practice at a time. PRHI came on board and helped us develop a solid timeline and implementation strategy, and do it en masse."

PRHI began by meeting with the SVMG transformation team to understand their needs. The team had done a thorough gap analysis and identified the need to enhance knowledge and skills around the PCMH model and standards, as well as the need to secure additional support in facilitating the necessary workflow

redesign efforts at the practice level. In response, PRHI designed a customized curriculum for the transformation team that included information about the purpose of PCMH transformation, NCQA standards and documentation requirements, EHR workflows specific to the SVMG EHR, and workflow redesign. PRHI has a history of supporting primary care teams through initiatives such as Perfecting Patient Care℠ training and coaching, EHR implementation and optimization, workflow redesign, and PCMH implementation and recognition support.

Geographical distance posed a challenge to delivering training in PRHI's traditional face-to-face format, so PRHI experimented with web-based technology to provide remote training. Supplemented with occasional face-to-face sessions, PRHI's PCMH team delivered a series of nine web-based training sessions to the transformation team, on topics including access and continuity, population management, and self-management support, among others.

"PRHI had a wonderful rollout that allowed us to get all of our offices aligned," Dr. Reynolds says. "The training sessions were crafted around different elements of the NCQA recognition process. We actually worked through a lot of the documents and processes, and then standardized them across our primary care network."

Recognizing that training alone is insufficient to bring about the changes in knowledge, attitudes, and behaviors necessary for transformation, PRHI also provided on-site and remote coaching, as-needed, to transformation team members as they implemented the concepts and workflows explored in training. As of this publication, PRHI continues to provide consultation around the NCQA recognition process as SVMG applies for recognition for all of its practices. The workflow changes necessary for successful PCMH implementation across all SVMG practices were enacted over the past six months. Also, at the time of this publication, seven practices have achieved Level 3 Recognition, and the SVMG Family Medicine Residency Practice successfully achieved renewal of its Level 3 recognition.

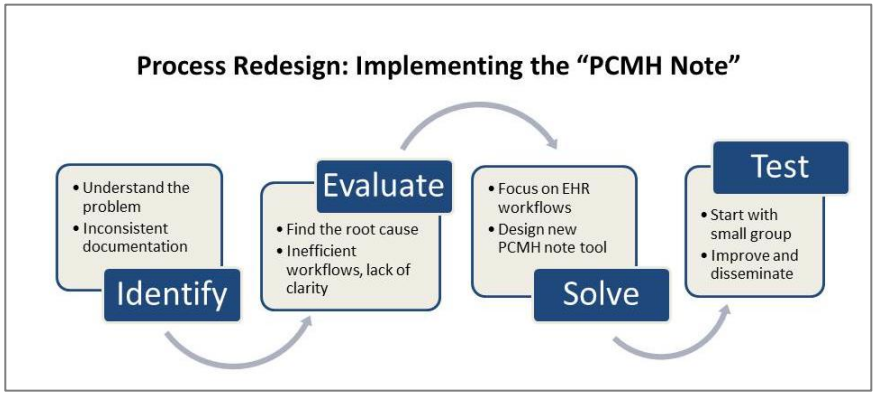
Rapid Continuous Improvement

One important contributor to SVMG's success is their practice of the lean concept of *kaizen*, or rapid continuous improvement. SVMG is able to rapidly implement new ideas and work flows, test them out on a small scale, adapt as needed, then roll them out across the organization.

An example of *kaizen* in action at SVMG is the PCMH note. When using lean as a quality improvement strategy, improvements are made in response to specific identified problems. The first step in problem solving, then, is to clearly define the problem and understand the current condition, including data about the extent of the problem and potential root causes. While exploring the PCMH standards of care planning and self-management support, a PRHI coach led the transformation team through a small scale chart review to allow the team to assess the degree to which care planning and self-management support activities were being documented in patient records.

For example, the team was looking to see whether or not patients with diabetes had a documented self-management goal (e.g. weight loss, exercise, or medication adherence), an assessment of potential barriers to self-management, and a referral to care management support for patients demonstrating a need. The team quickly ascertained that documentation of care planning and self-management support was inconsistent. The

next step was to evaluate the root causes of inconsistent documentation. The root causes identified included inefficient EHR workflows that made it difficult to capture care planning and self-management support concisely, lack of clarity about which members of the care team should be completing which aspects of care planning and self-management support, and inconsistent and incomplete workflows for incorporating these activities into office visits and other communication with patients.



The transformation group decided to focus its initial improvement effort on inconsistent and incomplete documentation caused by inefficient EHR workflows. Within one week, the team defined the requirements for a new note template that would capture all relevant care planning and self-management support activities and provided the requirements to the IT analyst. The IT analyst, within a week, had a new "PCMH note" designed and ready for use. Once it was available in the system, a few providers and care teams tested it out in practice to see how it worked and provided feedback for enhancements. Within two short weeks of identifying a problem, the team leveraged its IT resources, clinical expertise, knowledge of the PCMH standards, and the willingness of a handful of care team members to test out a new way of documenting. These team members tested the PCMH note and made changes in office workflows related to who on the care team completes which activities at which portion of the patient encounter.

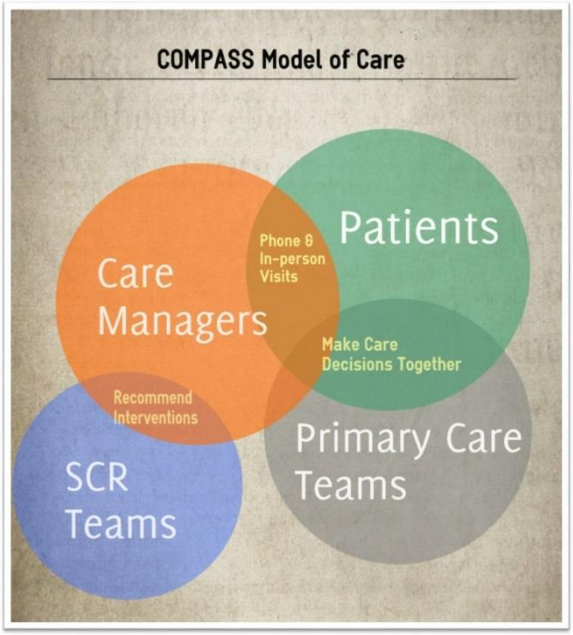
Fast forward three months. All providers and care team members are now trained in how to use the PCMH note, and tweaks made along the way have improved the note's utility. Comprehensive chart reviews for several of the SVMG practices have been completed, and, with the use of the PCMH note, all meet or exceed the documentation requirements for NCQA PCMH recognition. More importantly, care team members now have reliable access to information about patients' care plans and self-management goals to guide recommendations for treatment and resources.

"The PCMH note helps ensure that we don't miss self-management goals and that patients understand their health status," says Robyn Lombard, a manager who oversees four SVMG practices working with PRHI. "It prompts Medical Assistants (MAs) during the rooming process to get all of the information that the physician needs. That way, we can get patients more engaged in their health care from a preventive standpoint, rather than finding out there's something wrong later."

Anyone familiar with implementing quality improvement cycles, especially those that require IT workflow changes or enhancements, knows that implementing such changes can be complicated. Oftentimes, you must go through a change request process, garner support and approval from institutional leadership, and collect extensive data before deciding to move forward with changes. Rarely do improvements such as this example happen within two weeks. The fact that SVMG was able to identify a problem and implement an effective solution within such a short period of time demonstrates a firm commitment to continuous quality

improvement and a willingness to experiment with workflow redesign strategies on a small scale before rolling them out across the organization.

Integrating Behavioral Health and Primary Care: Caring for the Complex Patient



When PRHI took on the task of leading the western Pennsylvania region in a multistate Center for Medicare and Medicaid Innovation (CMMI) grant initiative called COMPASS[1] (Care of Mental, Physical, and Substance Use Syndromes), recruiting primary practices was a top priority. The COMPASS program is a three-year effort designed to help solidify the empirically-supported collaborative care management model as a solution for improved management of both mental and physical health problems. The intended outcome of the initiative is to develop a national model that improves patient health outcomes, the patient's experience of care, and the affordability of care. The targeted patient population includes individuals who have been dual-diagnosed with depression and either diabetes or heart disease.

To be successful, PRHI knew it needed to partner with practices that recognized the value of integrating behavioral healthcare screening and intervention services into the primary care practice. Partners needed to be willing to take a risk by experimenting with providing intensive care management support to the target population in the absence of a robust payment model to support this type of care. Additionally, the practices needed to be willing to open up their offices to PRHI's training and coaching team, which would provide implementation support. Given the solid track record that PRHI had with SVMG in past initiatives, SVMG was recruited to participate in COMPASS.

SVMG soon enrolled 15 of its primary care practices in COMPASS. In February 2013, SVMG identified staff members from within the SVHS organization to serve as COMPASS care managers. SVMG worked with providers and staff from each of the practices to design workflows for identifying patients with diabetes and/or heart disease and screening eligible patients for depression by using standardized assessment tools. The care managers, providers, and staff worked on ways of ensuring a "warm handoff," or a smooth transition of the patient, from the provider to the care manager. They identified a consulting psychiatrist and a medical

[1] The COMPASS project described was supported by Grant Number 1C1CMS331048-01-00 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

consultant to provide supervision to the care managers in the form of weekly case reviews and treatment recommendations to the primary care providers managing COMPASS patients' care.

SVMG COMPASS Care Manager Amy Albright

Amy Albright, an SVMG employee for more than 20 years, was hired as a COMPASS care manager in November of 2013. Albright previously served as a cardiac care nurse for 17 years and then became an in-hospital care coordinator, working with patients at high risk for hospital readmissions. She quickly applied her experiences to COMPASS' outpatient setting, collaborating with physicians whom she knew from her hospital days.

"My role as a care manager is to help patients with their comorbid conditions in closer collaboration with the doctor," Albright says. "That really puts patients at ease because they trust their doctor. I always refer to it as giving patients more love."

Albright establishes a line of trust and communication during her first conversation with a patient, exploring the confluence of factors that may cause a patient to feel depressed. To help facilitate these conversations, she often uses the motivational interviewing (MI) training that she received from PRHI.

"We use MI to try to figure out from the patient what their goals and priorities are – how important is their diabetes, their high blood pressure, fixing their depression," Albright says. "We use that to engage them. You're allowing the patient to communicate their thoughts and feelings, and you just kind of guide them."

The Saint Vincent Systematic Case Review Team Reviews a Caseload of Patients in COMPASS Care to Elicit Treatment Recommendations for the PCP During a Weekly Meeting. From Left to Right: Consulting Psychiatrist, Medical Consultant, and RN Care Managers

Less than a year and a half after joining the project, SVMG's systematic and comprehensive approach to rolling out COMPASS throughout the 15 practices (and subsequently to five additional practices in their Accountable Care Organization (ACO)) has paid off. Out of the 18 medical groups participating in COMPASS across the country, SVMG has consistently ranked among the top in terms of the number of patients enrolled in COMPASS collaborative care. As of June 13, 2014, Saint Vincent enrolled 365 patients in COMPASS care, and their preliminary data suggest promising results. With SVMG's HIT, SVMG is able to track the number of patients eligible for screening, the number who completed the screening, the number who screened positive, the number referred to the care managers, and the number of patients with whom the care managers engaged.

In addition to the COMPASS care team's skills, SVMG's population health management HIT systems and administrative and physician leadership are key facilitators of this success. For SVMG, participation in the COMPASS initiative has demonstrated the value of care management support for complex patients. It is now a strategic part of their ACO.

Developing the Workforce

SVMG recognized that for transformation to be possible and sustainable, it needed to prepare its workforce for new roles. From panel management, to population outreach, to health coaching, to optimizing the use of the EHR, primary care providers and staff are increasingly expected to take on new or enhanced responsibilities for which they may not have received formal training. Workforce development can be challenging for any organization; but, it's particularly challenging for organizations of SMVG's size and scope. Organizational leadership had to figure out various issues such as how to free up staff time for training, how to fund the training, how to design and deliver skills enhancement support, and how to recognize and compensate team members for advancing their skills and taking on new roles and responsibilities.

SVMG responded to the identified need to prepare staff for new roles and responsibilities through their Associate Advancement Program. SVMG first defined a vision of what advancement would look like. Then, they began to pilot the program on a small scale to test out the impact, assess what it would take to scale it, and work out any kinks before rolling it out across the organization.

Realizing the critical role that Medical Assistants (MAs) play in day-to-day practice operations, and the additional responsibilities they are well positioned to provide with regard to new primary care functions, SVMG began its workforce development efforts with MAs. The initial focus has been to prepare MAs interested in career advancement and taking on new roles to serve as partners with other primary care providers in health coaching and documentation of care activities. In this health coach pilot, MAs receive training to enable them to both help patients follow through with the care plan they mutually developed with their provider and to serve as scribe for the provider during face-to-face visits to enable enhanced communication between the provider and the patient.

"The health coach pilot embeds an additional MA into a primary care practice to focus on quality initiatives and help patients understand the importance of managing health between visits," Murphy says. "This reduces the administrative burden on physicians and allows them to see a few extra patients per day. Ultimately, the coaching provided by MAs and the additional face-to-face time that physicians have with patients improves health outcomes."

Health coach pilot participants practice talking through ambivalence as part of a PRHI Motivational Interviewing workshop

The initial small-scale pilot, referred to as the "Teamlet Model," was successful. In early 2014, SVMG was prepared to experiment with a larger pilot. Before doing so, they evaluated the business case. They explored the financial cost of staffing an office with an MA health coach, as well as the potential impact on provider productivity. The next steps involved

recruiting MAs and providers interested in participating in the pilot and defining metrics for evaluating the success of the program. Next, SVMG considered how to structure and deliver the skills enhancement training.

Faced with these issues, SVMG turned once again to PRHI for input. At the time, Dr. Bruce Block, PRHI's chief learning and informatics officer, had just developed a training program geared specifically toward MAs and Licensed Practical Nurses (LPNs) working in primary care. *Learning Solutions for MAs and LPNs* is a program designed around the work MAs and LPNs must accomplish in caring for patients with a chronic condition. Through the program, PRHI trainers and coaches work with participants to carefully map out each step in the process of care to find the best way to accomplish it. The program looks not only at the traditional work of clinical staff but also at the many new responsibilities created by the EHR, the patient-centered medical home, and pay-for-performance incentives. In short, the program is designed to help MAs and LPNs maximize their skills and add additional value to a practice and its patients.

The program helped SVMG prepare the MAs selected for the expanded health coach Teamlet pilot. In January 2014, Dr. Block began the five session training program with a small group of MAs and others interested in learning more about the training approach, which is specifically geared toward frontline workers. The group met for an afternoon every other week and explored what it takes to accomplish the traditional tasks of patient flow management and rooming for patients with chronic conditions. The group also explored how to provide self-management support, optimize use of the EHR, and apply quality improvement tools and techniques to office workflows. The program concluded in April 2014.

During the course of the program, participating MAs had the opportunity to share lessons learned about implementation strategies and best practices with each other. Additionally, MAs were able to discuss their concerns and anticipate the support they would need to be successful in their new role as health coaches.

The SVMG Associate Advancement program will extend beyond enhancing skills for MAs interested in becoming health coaches, however. SVMG has plans to advance current MAs and other team members into new roles. For example, panel managers will review the status of the practice's overall patient population and subpopulations of patients with specific conditions and then coordinate outreach to patients due for tests or services. SVMG also plans to expand the team of care managers initially funded by the COMPASS initiative. In fact, in April 2014, SVMG added a new care manager position, funded internally without grant support, to serve patients who are at high risk of poor outcomes or hospitalization due to their complex physical and behavioral health needs.

"As we move from more of a fee-for-service to a value-based payment model, associates will be able to walk this bridge with us and function even more exclusively as population health managers," Dr. Reynolds says. "Associates are increasing their knowledge and skills by learning how to develop a lean process, streamline communication, and record data; and immediately reinforcing learnings by applying them back to their own."

SVMG has several excellent examples of the positive impact of its workforce development efforts have on the advancement of the organization's team members. One such example is Kim Merritt Wiltse, a medical assistant who has been with SVMG since 2004, working with Dr. Reynolds in SVMG's Edinboro Family Practice.

“Kim,” says Dr. Reynolds, ”interacts well with patients, has a knack for using the EHR, is knowledgeable about how to provide self-management support to patients with chronic conditions, and recognizes the value that her work adds to patient care and the performance of the practice.”

In recognition of these talents, in the fall of 2013, Dr. Reynolds asked her to take on the challenge of coordinating the PCMH recognition efforts for all of SVMG’s primary care practices. Fulfilling the role of PCMH coordinator is not easy. It requires an intense focus on detail, an in-depth knowledge of NCQA PCMH standards and documentation requirements, an ability to facilitate colleagues from the various practices in completing practice-level documentation, and knowledge of quality improvement and workflow redesign strategies. Nevertheless, Dr. Reynolds had confidence in Wiltse’s ability to perform these duties admirably.

Wiltse immersed herself in learning about not only PCMH recognition, but also about what it takes to implement and sustain patient-centered workflows in practice. Wiltse continued to also serve as a medical assistant three days per week in addition to leading the practices through record reviews and documentation of policies, procedures, and workflows. As of this Executive Summary, Wiltse had submitted NCQA Recognition applications for 14 practices, and will shortly be submitting for the remaining three.

“Kim has really taken ownership of this initiative,” Dr. Reynolds says. “With PRHI training and support, she has built her knowledge and skills around the NCQA recognition process. She is also working with our affiliated practices in the ACO initiative to achieve the ‘triple aim’ of improving population health and the quality of care while reducing costs.

Her success,” says Dr. Reynolds, “recently led to another promotion within SVMG to full-time PCMH facilitator.”

“I’m there to examine the clinical aspects of practice transformation, provide feedback and answer questions for providers, and serve as a mentor for the MAs who have moved up into the health coach role,” Wiltse says. “I think the professional development opportunities allow the medical group to grow. Saint Vincent tries to use everyone to the highest capability of their role and their title. The training I received from PRHI set me up to succeed.”

Looking Ahead

SVMG envisions a future where primary care operates differently from traditional practices. No longer will all services be provided face-to-face, which is essentially the only type of service routinely covered by most current payment models. They envision a future in which physicians and other care team members are providing patients with services not only via face-to-face visits, but also by a secure electronic portal, telephone, and group visits. Comprehensive care will be provided by high functioning practice-based teams and enhanced by centralized support services, including a referral center, clinical quality nurses, and care managers. The primary care practices will be actively connected to the community and able to confidently transition patients to community-based, self-management support resources. Care teams will have ready access to actionable clinical quality data and health IT tools to support patient-centered care.

“When you’re in primary care, it’s kind of like being on a hamster wheel, with a constant flow of patient volume,” Dr. Reynolds says. “It’s hard to get off that wheel to focus on the entire patient population. Our goal is to not only educate, but support practices in making that transition.”

SVMG hypothesizes that this future will be better for patients, providers, and care team members. Ideally, for SVMG, all patients will have a personal primary care provider with whom to partner in managing their care. Patients will have ready access to the physician and the physician-led care team in face-to-face as well as virtual visits. They will have access to the information and tools they need via their personal health records to successfully manage their care. Care will be better coordinated, with seamless transitions when patients need to access care outside of the primary care office. Gaps in care will be prevented, and patients will get the care they need, when they need it, in the amount they need it, without waste or errors. Ultimately, patients will attain increased confidence in self-management, improved experience, and improved health outcomes.

“It’s really about developing clinical integration, where you have shared responsibility to track quality measures, provide additional care management services to high-risk patients, and prevent avoidable hospital readmissions because of poor transitions of care,” Dr. Reynolds says. “Now, health care is paying based on quality and cost reduction.”

Providers, too, will be more satisfied with their work lives. In a team-based care environment in which all care team members are operating at the top of their license and skill set, providers will feel confident in delegating tasks best performed by other care team members. For example, a physician able to successfully delegate will be better able to focus on those tasks that a physician is most equipped to perform.

SVMG is on its way to achieving its vision of a high value healthcare organization. It continues to actively seek opportunities to advance this vision, participating in a number of shared savings programs and other innovative payment models to enhance the financial viability and sustainability of the organization. SVMG wants to be a reliable, integral part of the Erie community for years to come. As they continue on the journey of patient-centered excellence, they serve as a model for the rest of region and the nation.