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Advanced payment model

Case study part 2: Overcome operational challenges to succeed as a medical home

After you've taken the leap to become a patient-centered medical home (PCMH), keep an eye on ways to continually fine-tune your workflow — particularly around shared resources such as care management — to elicit long-term success.

Start the transition to a PCMH with the appropriate steps that include preparing for payer negotiations and deciding on your group's size (PBN 11/23/15). But don't sit back and think you're all done — you may find that the strategies you implement at launch will need to be tweaked and twisted, according to leaders at Adirondack Health Institute (AHI), a medical home initiative in New York with about 230 physicians and non-physician practitioners (NPPs).

The care management aspect of AHI's medical home program "has evolved quite a bit" since the program's inception in 2008, explains Bob Cawley, director of health system transformation with AHI in Glen Falls, N.Y. For instance, care management interventions originally focused on common, high-cost conditions, such as diabetes and hypertension. But as the medical home grew, so did the necessity for a new approach. "Instead of having a condition focus, we needed to have a patient focus," explains Cawley.

This shift in thinking ultimately meant big changes to the day-to-day workflow, including revised staff responsibility and the need for more advanced support systems, such as health IT infrastructure. Learn from AHI's hard-earned lessons with the following tips to get ahead of potential revisions before you embark on the transformation to a medical home.

• **Divide up your providers and build your organizational structure around smaller groups**, particularly if you're working with a large medical home program with many providers. Because its medical home program spans about 50 distinct practice sites across a large, rural region in New York, AHI decided to split up the sites into separate units, or what it calls "pods." This makes information- and resource-sharing far easier to manage, explains Cawley. "The pods are a community resource for quality improvement initiatives and care management resources," he explains. The drawn-back size of AHI's pods — they operate three pods, ranging from eight sites to about two dozen sites within each

pod — also creates more touchpoints between the practice sites and each pod's leadership team, the latter of which acts as a regional problem solver.

For instance, if a specific practice has a question about its electronic health record (EHR) or requires additional care management support, the local pod leaders can provide solutions, notes Karen Ashline, assistant vice president, Adirondacks ACO and a local pod coordinator. The close working relationship between the pod leaders and physicians in the community means fewer delays in troubleshooting problems, she says. Creating manageable practice groups also solves potential financial challenges, explains Cawley. A portion of the $8.4 million that payers provide AHI regional practices in annual per-member payments goes directly to the pods and pays for the salary of the care management staff as well as the quality-improvement support that Cawley mentioned, such as ICD-10 training.

• **Centralize care management and share your resources**. One of the most tangible benefits of AHI's pod system is the ability to manage care management operations, which are an essential part of a medical home program. At first, the care management aspect of the medical home program — which employs professional care managers to work alongside practices to focus on the health and mitigate cost burden of high-risk patients — was met with skepticism, notes Ashline.

"Building care management has been difficult because it was unknown," she says. Providers would say, "What's the care manager really going to do for me?" recalls Ashline.

Yet providers' uncertainty, while tangible at the outset, didn't last long. AHI leadership drove home to wary providers the larger shift defining their industry — the encroachment of value-based care, Ashline recalls. When providers wondered aloud how they could track patients and perform follow-up care in the current environment, the leadership team countered with the benefit of extra hands.

"It really felt to them that we were piling on burden after burden," recalls Ashline. "So we said, 'Let us build a team to help you.'"

What's more, the organizational structure abetted the physician buy-in. "The care managers exist at the pods, and they are assigned and embedded into practices," explains Cawley, who adds that larger practices may have "a single, dedicated care manager."

He provides an example of how this works in practice: The primary care provider identifies a high-risk patient and notifies the care manager. "Together, they work with the patient to develop a care plan. The care manager goes into more depth with the patient about achieving

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Resources

~ Adirondack Medical Home Initiative: *www.ahihealth.org/amhi/*

~ AHRQ, Patient-centered medical home resource center: *https://pcmh.ahrq.gov/*

~ MGMA, *A Comparison of the National Patient-Centered Medical Home Accreditation and Recognition Programs: http://online.mgma.org/PCMH-Report?source=blog*

specific goals," he says. For a diabetic patient, that might be losing weight; for a hypertensive patient, it's getting blood pressure under control.

Ultimately, the practice's ability to manage high-risk, high-cost patients is crucial to the quality metrics it's agreed to meet with payers (PBN 11/23/15). Over time, AHI's providers embraced this helpful hand, seeing the concrete benefits of their work; readmission rates, a telltale quality metric that speaks to high-quality transitions of care, have fallen to about 9% from a high of 16% since 2011 for AHI-affiliated patients, according to Ashline. "Now we have providers saying, 'Can I have my care manager more often?'" she says. "That's a real win for us."

• **Create a physician committee to get feedback, stay ahead of challenges.** One of the most important steps AHI made to get a true sense of on-the-ground challenges and opportunities was the creation of a local executive committee, comprised of physicians, to provide feedback.

In Ashline's pod, which consists of 24 practice sites, a physician executive committee provides oversight of important areas ranging from "operations and finance to quality and best practices," she says. The executive committee began as a volunteer organization, but in the program's third year the pod leaders sought — and received — nominations from the provider community. "This group — unless there are resignations or new interest — are reappointed each year," says Ashline.

The executive committee meets monthly and steers the use of intrapod resources. For example, the executive committee made the initial decision to split the per-member payments into two halves, with 50% going to the practices sites and the other half going to the pod to be "pooled to support care management operations," says Ashline. "Without this strong stance on resources, much of what we are able to do today would not be possible." — Richard Scott (rscott@decisionhealth.com)

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