Quality Grants Program 2011- Summary Report

<table>
<thead>
<tr>
<th>Name of Local Care Unit or Physician Group</th>
<th>Advantage Network PHO/Foundation Medical Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Medical Director</td>
<td>Rob Dorf, DO</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Wanda Kennerson</td>
</tr>
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<td>E-mail address</td>
<td><a href="mailto:Wanda.kennerson@snhmc.org">Wanda.kennerson@snhmc.org</a></td>
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<tr>
<td>Phone #</td>
<td>603-577-7536</td>
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<tr>
<td>Mailing address</td>
<td>Southern New Hampshire Medical Center, PO Box 2014, 8 Prospect Street, Nashua, NH 03061</td>
</tr>
</tbody>
</table>

Project Topic: Patient Centered Medical Home

Project Title: Patient Centered Medical Home Implementation

I. Overview: LCU overview (location, communities served, HPHC membership, total number and general specialty distribution of physicians and practices)

PHO primary care physicians manage care for more than 50,000 adult patients in the greater Nashua, N.H. service area, using billing data for a rough estimate.

1. Participating Providers:
   a. 95% of the primary care physicians will participate in the initial training.

<table>
<thead>
<tr>
<th>Specialty</th>
<th># of Physicians</th>
<th>% of PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>18</td>
<td>35%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>20</td>
<td>38%</td>
</tr>
<tr>
<td>IM/Ped</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>10</td>
<td>19%</td>
</tr>
<tr>
<td>Total PCPs</td>
<td>52</td>
<td>100%</td>
</tr>
</tbody>
</table>

b. This program will affect 100% of our patients.

II. Brief Project Description

Our program entails the implementation of a adaptive change model within Foundation Medical Partners primary care practices using the expertise of TransforMED with the goal of developing an effective and efficient primary care network through the creation of patient centered medical homes. Founded in 2005 by the AAFP, and working with over 500 primary care sites, we chose TransforMED because it is uniquely positioned to assist our organization in helping 1.) Improve clinical outcomes through the transition to NCQA recognized Medical Homes, 2.) Realization of both costs savings and efficiencies associated with developing a practice based team approach, including the integration of practice based care coordinators within this team and 3.) Implementation of
standardized chronic care management across participating practices beginning with CHF, diabetes and asthma. The Patient-Centered Medical Home (PCMH) model provides a blueprint for addressing these issues and sustainability.

The participating practices will come together for four one day learning collaborative to discuss topics at hand. Collaborative meetings use a variety of learning techniques including didactic and experienced teaching as well as active discussions, inquiry and exercises to informed reflection.

General guidelines include:
1. Develop clinical and implementation competence
2. Applying adult learning principles
3. Fostering sustainability by empowering learners
4. Modeling continuous improvement
5. Building effective teams
6. Integration of nurse care coordinators within the team
7. Promoting collaboration across teams
8. Engaging senior leaders
9. Encouraging self-care to sustain providers and best practices

III. Key Project Components

- The transformation process will involve powerful and implementable change ideas, and will be continuously updated based on the practice’s transformational efforts.
- The transformation plans reflect Foundation Medical Partners priorities for improvement and based on the change ideas developed during previous learning cohorts.
- The collaborative meetings present new topics in the change process and how practice improvement teams can implement these between meetings.
- The TransforMED facilitators and Foundation Medical Partner Coaches provide effective and ongoing support via site visits, conference calls and Delta Exchange in order for improvement teams to support practice redesign between learning sessions.
- The measurement, data, and communications infrastructure will enable improvement teams to report on and track progress and support continuous learning.
- The meetings and communication infrastructure will enable effective collaboration within and across pilots.
- Administrative support will enable the project to operate effectively and efficiently.

IV. Key Project Outcomes to Date

Project Planning and Development:

June – September 2011
- Project Plan – Multi-Site
- Assess operational compliance of NCQA PCMH Standards
- Form Core Team and Steering Committee
- Orchestrate the roll-out to Care Manager Program and patient portal to Foundation practices
- NCQA PCMH webinars

September – December 2011
- PCMH Kick-off Presentation
- Project Plan Defined
- Formed Core Team, Steering Committee and Sub-committees for planning and implementation.
- Workgroups work on NCQA Standards
- Organize Learning Collaborative for PCMH Training
Assessment Phase
January 2012

- Defined leadership teams within each practice
- Online Assessment Survey
- Change Readiness Survey
- Provider/Staff Satisfaction Survey
- Practice Metrics Data

Transformation Phase
February - March 2012

- Learning Collaborative I: Teamwork, Leadership, & Communication; Team Based Care; Change Management
- Coach Training
- Webinar: Change Management
- Develop PCMH Bulletin Board – all practices
- Gap Analysis
- Core Team – PCMH NCQA Standards Recognition Process
- Role out of Centricity Care Manager Program
- Role out of Patient Portal
- Launch on-line NCQA recognition application process
- Implement Huddles

V. Identify Any Goals Not Achieved

It is our plan to have written protocols or processes in place that satisfy the NCQA Standard requirements and align them with the training topics at the PCMH Learning Collaborative. This recognition process is very labor intensive and is require more time than anticipated.

VI. Plan for Extending and Sustaining Achievements beyond Grant Year

- Learning Collaborative
  1. Collaborative Two – May 16, 2012
     a. Access
     b. Practice Team Based Care
     c. Introduction to Care Coordination
     d. NCQA Session #1
  2. Collaborative Three – September 13, 2012
     a. Care Coordination
     b. Case Management
     c. Patient Engagement
     d. NCQA Session #2
  3. Collaborative Four – December 5, 2012
     a. Patient Engagement
     b. NCQA Session #3
     c. Sustainability

VII. Performance Measurement

1. All project proposals must have at least 3 performance measures. Please describe in the tables below. Please copy table format for additional measures.
<table>
<thead>
<tr>
<th>Performance Measure # 1</th>
<th>1. # of physicians and practice sites that have participated in initial training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source</strong></td>
<td>Project Coordinator’s records</td>
</tr>
<tr>
<td><strong>Current performance</strong></td>
<td>3 physicians/ 1 practice</td>
</tr>
<tr>
<td><strong>Target performance</strong></td>
<td>54 physicians / 25 practices (100% of PCP practices)</td>
</tr>
<tr>
<td><strong>Plan for interim reporting</strong></td>
<td>quarterly</td>
</tr>
<tr>
<td><strong>Project Outcome</strong></td>
<td>54 physicians / 25 practices (100% of PCP practices)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Measure # 2</th>
<th>2. # of practices that have identified nurse care coordinators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source</strong></td>
<td>Project Coordinator’s records</td>
</tr>
<tr>
<td><strong>Current performance</strong></td>
<td>1 practice</td>
</tr>
<tr>
<td><strong>Target performance</strong></td>
<td>17 practices</td>
</tr>
<tr>
<td><strong>Plan for interim reporting</strong></td>
<td>quarterly</td>
</tr>
<tr>
<td><strong>Project Outcome</strong></td>
<td>Currently 2 practices have a nurse care coordinator. A third the way into this project, we decided to halt recruitment and focus on implementing a training model that encompassed the entire practice into the transformation of Patient Centered Medical Home. A component of our PCMH implementation plan was to roll out the Care Manager Software Program to all primary care practices. This was completed by Feb. 2012. We have an RN working with each practice to formulate and implement a care management program that will include a care coordinator by December 2012.</td>
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<table>
<thead>
<tr>
<th>Performance Measure # 3</th>
<th>2. # of care coordinators who have completed training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source</strong></td>
<td>Project Coordinator’s records</td>
</tr>
<tr>
<td><strong>Current performance</strong></td>
<td>1 practice</td>
</tr>
<tr>
<td><strong>Target performance</strong></td>
<td>17 practices</td>
</tr>
<tr>
<td><strong>Plan for interim reporting</strong></td>
<td>quarterly</td>
</tr>
<tr>
<td><strong>Project Outcome</strong></td>
<td>As noted above, currently we have 2 care coordinators for the 2 practices. We also have 2 transitional care coordinators that manage discharge planning and follow up for our high risk population. Foundation Medical Partners Quality Director will be regulating, training and/or hiring nurse care coordinators during the PCMH transformation process for each primary care practice.</td>
</tr>
</tbody>
</table>
Performance Measure # 4  
3. # of physicians and practice sites that have implemented at least one disease management program as part of PCMH

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Foundation Medical Partners EMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current performance</td>
<td>0</td>
</tr>
<tr>
<td>Target performance</td>
<td>30 physicians/17 practices</td>
</tr>
<tr>
<td>Plan for interim reporting</td>
<td>quarterly</td>
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**Project Outcome**
As of February 2012, all providers (physician, APRN, PA) and nursing staff of primary care practices have been trained on our disease management program using Centricity Care Manager software for our diabetic population. Two practices have disease management processes in place. We are currently in the training phase for the remaining practices. We will then add congestive heart failure and asthma into the disease management program.

In addition, we have implemented an anti-coagulation program that six practices are currently using.

**Improvement Metrics**
Collaborative participants and leadership teams commit to quarterly metrics to gauge transformation. The participating practices regularly submit their metrics to quantify process improvements. Metrics will be used as a tool to facilitate skillful use of the intervention as well as to identify and address potential barriers to implementing and sustaining the practices as well as to assess the impact of the program. The continuous measurement of these metrics by the practice will create sustainability of the initiative long after TransforMED has ended its engagement.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Description</th>
<th>Population</th>
<th>Dates</th>
</tr>
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| Online Assessment | 1. The purpose of the Online Assessment is to allow us to assess your business operations, technical environment and practice management. | Each Practice Site | Jan. 2012 |
| Change Readiness Survey | The CRS is an online survey tool which allows the Leaders (physicians and practice managers) and Staff of your practice to provide feedback on the Change Readiness of the practice. This information can help you determine if the practice is ready for a successful change effort. The CRS can also assist you with identifying areas of focus for improving your practice’s change readiness. Aspects of the survey include Change Management, Communication, Leadership, Teamwork, and Work Satisfaction. | All staff at each practice site including providers. | Jan. 2012 |
| Site Visit | **Individual Interviews**  
1. One-on-one interviews (also called key stakeholder interviews) serve several purposes. These important meetings allow members of the practice to build personal relationships with the facilitator.  
**Team Meeting**  
2. Investing the effort to schedule and conduct an all-team meeting helps communicate to staff the importance of the project. The meeting gives an opportunity to engage staff at all levels and gives the facilitator a forum for establishing transparency, partnership, and availability.  
**Patient Paths**  
3. Following patient visits from check-in to check-out gives the facilitator insight into the culture of the practice and provides information related to workflow and practice processes  
**Process Observations**  
4. Observe different areas of the practice such as front office, clinical team, lab process, billing, etc. | Each Practice Site | Feb. 2012 |
| PCMH GAP Analysis & Progress Report | 1. Assess the Model Components and Factors  
a. Change Management  
b. Patient Centered Care  
c. Access to Care and Information  
d. Practice Based Services  
e. Care Management  
f. Care Coordination  
g. Practice-Based Team Care  
h. Quality and Safety  
i. Health Information Technology  
j. Practice Management | Each Practice Site | Baseline – Jan 2012; Quarterly |

- **PCMH NCQA Recognition**  
  *In parallel to the PCMH transformation process, the Core Team at Foundation Medical Partners will work on the NCQA recognition process with the anticipation of receiving Level III recognition.*

**VII. Lessons Learned/Words of Wisdom**

- Allow at least 3—6 months for the planning and development process.  
- Simplify how the transformation process will work in the primary care practices.  
- Promote PCMH within the practices using real provider experiences.  
- Provide/train on “easy wins” to reduce resistance to change.  
- Having a physician guest speaker at the learning collaborative was most effective.
- After first learning collaborative, practices began to make some system changes.
- Coaches supporting and meeting with practice leadership team has shown to be very helpful.