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## Changing Practice

### *Changing Practice: Facilitating Home-Based Care for High-Risk Patients*

When their health and functionality decline, many seniors reluctantly assume that nursing

home placement is their only option. Community-based care management and social services help older adults retain their independence, but typically do not include a sufficiently robust, integrated medical care component that would allow high-risk seniors to extend their time at home.

“The complex care needs of high-risk seniors can be successfully managed if we extend the reach of primary care into patient homes, thereby allowing older adults to continue to live in their communities for as long as possible,” says Sandee Ferguson, RN, Senior Vice President of Ohio’s Area Agency on Aging 10B, one of twelve such agencies in the state.

Ferguson’s project to expand community-based care management will use a screening tool to identify seniors at high risk of decline; further

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~ Sandee Ferguson

assessment will pinpoint the individual’s specific needs and prompt appropriate interventions. Interventions will be based on protocols that address risk factors known to lead to decline and eventual nursing home placement.

Project goals include increasing the length of stay in Ohio’s home and community-based Medicaid Waiver program; decreasing program disenrollments due to nursing home placement; decreasing hospital utilization; increasing member satisfaction; and, for in-patients who do enter a nursing home, ensuring a successful transition from the nursing home back to the community.

### *Changing Practice: Developing a Patient-Centered Medical Home for Seniors*

Optimal care for older adults requires a coordinated approach, given the complex health issues faced by this patient population – yet care fragmentation remains the norm. For patients,

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## Spotlight On: Building Collaborative Partnerships

Based on their experience in creating King County Care Partners – a collaborative that serves medically vulnerable SSI-eligible Medicaid patients clients via community-based nurse care management – Daniel Lessler, MD, MHA, Associate Medical Director of Harborview Medical Center and Rosemary Cunningham, Project Manager for King County Care Partners discussed how Practice Change Fellows can foster collaboration among different stakeholders in order to facilitate project implementation.

### *Suggestions For Building Collaborative Partnerships:*

- Talk individually with stakeholders prior to bringing the group together. This allows individuals to express their viewpoints and facilitates their willingness to consider new ideas.
- Provide data. Metrics that quantify improvement are extremely important in helping to build support for the project.
- Tell stories to prompt ongoing support. Many stakeholders, including funders, are moved by case studies of clients who have been positively impacted by the program.
- Focus on complementary interests. Emphasize that collaboration can accomplish goals that are not achievable by acting alone.
- Draw people in. Try to incrementally involve stakeholders who are resistant to change.
- Formalize the relationship. Contracts and documents, such as a memorandum of understanding, can help clarify relationships, roles, accountability, and commitments.



## Practice Meets Policy

The patient-centered medical home (PCMH), a model for providing comprehensive primary care based on ongoing relationships between patients and physicians, is a focus of many health reform efforts and has been adopted with varying degrees of success at practice sites across the country. Five panelists – David Gans, Vice President of Innovation and Research at the Medical Group Management Association; David Labby, MD, Medical Director of CareOregon; Molly Mettler, Senior Vice President of Mission at Healthwise; Phyllis Torda, Senior Executive for Strategic Initiatives at NCQA; and Robert Berenson, MD, Senior Fellow at the Urban Institute -- discussed the PCMH model and offered lessons that pertain to the Practice Change Fellows and the Advisory Board.

One key to PCMH success is to first ensure a practice's business and administrative efficiency. "Unless a practice is part of a paid PCMH demonstration project, it will be engaged in activities, such as purchasing new technologies and hiring new staff members, for which it will not be reimbursed," Gans noted. "Thus, maximizing operational efficiency, such as ensuring appropriate billing and coding practices, is required to protect the practice's financial sustainability."

PCMH practices must also be ready to implement new services, ultimately expanding their current definition of primary care. "The PCMH model can achieve a return on investment by more effectively treating complex patient populations, including senior populations," said Labby, noting that CareOregon began developing its PCMH in 2006. However, achieving this return requires a paradigm shift in how primary care is defined. "A PCMH raises the bar by enhancing primary care provision. For example, the PCMH might identify practices with a large number of Medicare recipients and embed a health plan nurse into each practice to ensure care appropriateness and continuity." Strong internal leadership is required to envision and design these changes, Labby added.

Molly Mettler noted that a truly successful PCMH will be patient-driven, since 80% of care is provided by the patient, friends, and family. "Therefore, regardless of model's struc-

tural elements, which will vary by site, the PCMH should provide support for self-care; assist older patients and their families with medical and end-of-life decisions; and solicit patient input so that care can meet the real needs and interests of the patient," she says.

The NCQA Patient-Centered Medical Home Recognition Program offers an objective assessment of a PCMH's success. As with other NCQA-sponsored Recognition Programs, PCMH Recognition provides external confirmation of quality and can lead to additional compensation from payers. The nine evaluation categories include access and communication; patient tracking and registry functions; care management; patient self-management support; electronic prescribing; test tracking; referral tracking; performance reporting and improvement; and advanced electronic communications. "The future of the PCMH model is contingent upon whether the model is financially sustainable and can lead to improvements such as reduced emergency department visits, reduced test duplication, increased e-processing, decreased hospital admissions and readmissions, and improved end-of-life care," said Torda. "Objective confirmation of the model's success can be critical to its sustainability at a given site."

Of course, sustainability will be based in large part on reimbursement. Not surprisingly, reimbursement for PCMH activities can be complicated, and varies across sites. "Little empirical data exists regarding optimal PCMH reimbursement mechanisms," said Berenson. He noted that the prevailing PCMH model combines fee-for-service payments for visits with a separate per-member-per-month payment for medical home activities. Reimbursement challenges include ensuring integrity in submitting claims for "intangible" activities and preventing a misalignment of incentives that arises when practices are protected from the consequences of assuming risk.

Despite these and other challenges of implementation, adopters are embracing the model based on its potential to improve care delivery. As Gans said, "People who are adopting a PCMH model believe it's the right thing to do."



*2009 Fellows Sandee Ferguson, Audrey Chun, and Alice Bonner present their projects at the new Fellows' first tri-annual meeting.*

## Changing Practice

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this means suboptimal care quality and service. For providers, the daily frustrations involved in patient care lead to exhaustion and burnout.

**“A geriatrics patient-centered medical home has to potential to provide optimal ongoing care for the seniors we serve.”**

~ Audrey Chun

Audrey Chun, MD intends to improve primary care delivery at the Mount Sinai Medical Center’s 2,500-patient outpatient geriatrics practice by developing a new model of care based on the patient-centered medical home concept, which is currently endorsed by numerous primary care organizations under the Primary Care Collaborative which includes the American College of Physicians and American Academy of Family Physicians .

Chun’s model will include multidisciplinary team care; disease management; patient self-management; and strategies to improve access, coordination, and continuity of care. “A geriatrics patient-centered medical home has to potential to provide optimal ongoing care for the seniors we serve,” says Chun, a Mount Sinai geriatrician. Process and outcome measures for the project include patient satisfaction; physician/staff satisfaction; quality indicators reflecting conditions common in older adults, such as falls, urinary incontinence, and memory loss; and decreased hospital utilization.

## Changing Practice: Implementing a State-wide Strategic Plan for Care Transitions

An effective transition from hospital to home or a skilled nursing facility is a major challenge for vulnerable patient populations, particularly older adults. Lack of coordination during transitions can lead to adverse events, poor clinical outcomes, and rehospitalization, notes Alice Bonner, PhD, RN. “Efforts to improve care transitions in Massachusetts are underway, but lack sufficient planning and integration,” Bonner says.

As part of her role as Director of the Bureau of Health Care Safety and Quality at the Massachusetts Department of Public Health, Bonner is working with a state-wide team to write a Care Transitions strategic plan, scheduled for completion in December 2009. The strategic plan will be used to align the goals and guide the integration and expansion of currently-funded care transitions projects across the state, including State Action on Avoidable Hospital Readmissions (STAAR) and Interventions to Reduce Acute Care Transfers (INTERACT II), both of which focus on preventing avoidable rehospitalizations in the senior population. Bonner’s Practice Change Fellows project will focus on facilitating effective implementation of the strategic plan throughout Massachusetts.

**“Efforts to improve care transitions in Massachusetts are underway, but lack sufficient planning and integration.”**

~ Alice Bonner

### Tri-Annual Meeting Highlights:

Fox Wettle, PhD, Associate Dean of Medicine at Brown University, facilitated a session in which program Advisory Board Members discussed how to increase the efficiency and effectiveness of the mentoring experience with the Fellows.

Nancy Whitelaw, PhD, Practice Change Fellows program co-director, provided highlights from the annual PCF program evaluation and discussed future directions for the program based upon survey findings.

## The Importance of Measurement in Health Care

Process and outcome improvement is a goal of all Practice Change Fellows projects. However, Fellows must understand how to measure these improvements so that they can determine whether their projects are making a meaningful difference in patient care. Dennis Ehrich, MD, FACC, Vice President for Medical Affairs at St. Joseph’s Hospital Health Center in Syracuse, New York described a quality measurement process that Fellows can use to evaluate their project.

The first step is to define and design the project. “The project should align with the mission, values, vision, and strategic plan of the organization, and should have support of senior leadership,” Ehrich says. To sustain a new program or service line, Fellows should select metrics that not only resonate with clinicians but also with administrative and financial leaders. “The data provided to stakeholders must be customized to fit their needs,” states Ehrich. Fellows should establish operational definitions that are accepted by all stakeholders. “Definitions should be clear and unambigu-

ous, and should specify the measurement method, procedures, and other criteria for data collection,” Ehrich says. To be compelling, operational definitions should be specific but should also reflect a broader goal, such as safety, effectiveness, or efficiency.

Then, Fellows can develop a data collection plan that specifies the process and outcomes data to be gathered and the collection method and frequency. After collecting the data, Fellows will analyze the data to determine if outcomes are improving as a result of the new process; if not, they should consider whether there is excessive variation in the process. Tools such as run charts and control charts can help Fellows identify trends. Defining targets and benchmarks to assess comparative performance is also important. Finally, Fellows should report their findings based on a data reporting plan that outlines who will receive the results and how often, the data format(s) used, and dissemination methods.

## The Practice Change Fellows Program

The Practice Change Fellows program is a two-year fellowship program designed to build leadership capacity among nurses, physicians, and social workers who have operations level responsibility for aging programs and geriatric service lines. The application period for the 2010 Class will run from January 2010 through April 2010. To learn more about the program please visit [www.practicechangefellows.org](http://www.practicechangefellows.org).

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