12 Lessons on Transforming Primary Care
In July 2013, a working group of health system executives met at The Advisory Board Company’s office to talk about the future of the medical home. Many in the room had been working on medical home transformation for five or more years, and each were continuing to refine and expand the model.

This briefing covers 12 things we learned from that session.

DEFINING THE MEDICAL HOME

Our definition of the medical home focuses on four essential goals for primary care delivery supported by two components of the delivery model:

**Four Goals for Primary Care Delivery**
- Comprehensive care
- Patient engagement
- Coordinated care
- Enhanced access

**Two Components of the Delivery Model**
- Team-based approach
- Disease registry
The evolving role of the medical home

01 The medical home is not a one-size-fits-all care model. Rather, the medical home is best deployed to manage patients with complicated primary care needs.

02 Link the medical home to all ambulatory care settings to create a flexible primary care network.

03 There are limits to disease-specific approaches to medical home deployment. Focus instead on creating a unified care plan across multiple conditions.
The medical home is not a one-size-fits-all care model. Rather, the medical home is best deployed to manage patients with complicated primary care needs.

Medical home leaders are finding that the model aligns best with a targeted subset of the patient population—such as patients with two or more chronic conditions or patients with one chronic condition and a number of risk factors.
Targeting the Medical Home to the Level of Patient Risk

The highest risk patients—or the top 5% by cost—need more than the medical home.

Low-risk patients need easy access to primary care services but not the robust level of support offered by the medical home.

We have research on managing high-risk patients. [Just visit advisory.com/highriskcaremgmt]
Link the medical home to all ambulatory care settings to create a flexible primary care network.

When the medical home is developed within a larger health system, you gain the unique ability to serve different patient needs at different care sites while sharing information and resources.

Medical home strategies can—and should—fit in with broader ambulatory network alignment and population health goals.

For example, you can ensure easy access for patients by evaluating first-available appointments across PCP practices, retail clinics, or virtual care options.
Coordinating Primary Care Services Across the System

To learn how to build a consumer-oriented ambulatory network, visit advisory.com/hcab/ambulatorystrategy
There are limits to disease-specific approaches to medical home deployment. Focus instead on creating a **unified care plan** across multiple conditions.
While disease-specific interventions can be a good place to start the medical home transition, they can also unintentionally create silos. Advanced medical homes are instead merging appropriate care guidelines to create a unified care plan for patients with two or more chronic conditions.

Since one in four adults has a diagnosable behavioral health need, all medical homes should have a proactive strategy for uncovering and addressing these needs.

Start by merging existing chronic condition guidelines with guidelines around low-acuity behavioral health screening and management.

Get tips to help your behavioral health patients by visiting advisory.com/proactivebehavioralhealth
Staffing model evolving to support panel expansion

04 Every member of the care team should practice at the top of their license, not just the primary care physician.

05 As teams expand, you need clear role definition to avoid gaps, duplication, and team burnout.
Every member of the care team should **practice at the top of license**, not just the primary care physician.

When leaders start down the transition path, they focus on making sure primary care physicians perform only those tasks that require their clinical training and licensure. All other tasks are delegated to other members of the care team or practice.

But demand for primary care is only growing, and the focus of top-of-license care must also expand to each member of the care team. Medical home leaders should critically evaluate NP, PA, and RN tasks to ensure each member of the team is assigned tasks aligned with their clinical license.

Leaders should also evaluate tasks for other members of the team. For example, practice staff at the front desk interact with every patient walking through the door and can play an important role in educating the patient about the portal and other practice resources.

In addition, care teams should include family members or caregivers. Patient peers can also play a critical role as educators and coaches outside the primary care office.
Re-evaluating Role of the Entire Practice Team

<table>
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<tr>
<th>IN A TYPICAL PRIMARY CARE OFFICE</th>
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<tbody>
<tr>
<td>Physician</td>
</tr>
<tr>
<td>• Spends majority of visit addressing acute ailments</td>
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<tr>
<td>• Provides chronic care management in minutes after acute issues addressed, little standardization across patients</td>
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<tr>
<td>Clinic RN</td>
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<tr>
<td>• Like physician, spends majority of time on acute patient ailments</td>
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<tr>
<td>• Takes incoming patient calls concerning medication, lab results</td>
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<td></td>
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<tr>
<td>Medical Assistant</td>
</tr>
<tr>
<td>• Sets up patient in room, takes vital signs, assesses reason for visit</td>
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<tr>
<td>• Has downtime waiting for next patient</td>
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<td></td>
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<tr>
<td>Front Desk Staff</td>
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<tr>
<td>• Triages incoming patient calls</td>
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<tr>
<td>• Provides reminder calls to patients before scheduled appointments</td>
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<table>
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<tr>
<th>IN A MEDICAL HOME</th>
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<tbody>
<tr>
<td>• Patients are proactively scheduled for chronic care physician appointments</td>
</tr>
<tr>
<td>• Uses chronic care guidelines which provide framework for consistency across patients</td>
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<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td>• Prioritizes time for patient follow-up</td>
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<tr>
<td>• Proactively reaches out to patients to encourage self-management</td>
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<tr>
<td>• Physician or patient can schedule time with RN for one-on-one education</td>
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<tr>
<td>• Thoroughly assesses patient needs and reviews chart, labs, self-management goals in pre-visit chart review</td>
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<tr>
<td>• Performs basic pre-physician services like foot exam; records in chart for physician review</td>
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</tr>
<tr>
<td>• Liaises with clinic nurse before appointment to check for outstanding patient needs before reminder calls</td>
</tr>
<tr>
<td>• Discusses pre-visit testing with patient</td>
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As teams expand, you need **clear role definition** to avoid gaps, duplication, and team burnout.
When roles are not clearly defined, new care team members can quickly become responsible for every possible care quality metric. Given the breadth of medical home transformation, staff can burn out quickly.

Medical home leaders should prioritize a core set of goals or metrics for team members. With these in mind, teams can outline steps or tasks related to performance goals for each member of the care team.

Monthly or quarterly care management meetings can also help connect the care team by bringing together medical home staff from across practices to share information.

Lifebridge Health redefined care management positions and made better staffing decisions by conducting a comprehensive care management staff audit. See how at advisory.com/hcab/caremgmtaudit
Structure communication
plan and leadership team
to maintain momentum

06 Create forums to celebrate success
and share constructive feedback.

07 Support ongoing transition with an
administrator and physician leader.
Create forums to celebrate success and share constructive feedback.

Communication and education about primary care innovation and the population health transition path is a great way to keep the care team engaged, even for health systems years into medical home implementation.

Most importantly, you should encourage practices to share specific success stories, such as how the team accomplished quality goals, suggestions for implementing new practice patterns, or anecdotal stories of patient impact.
Elements of a Successful Communication Strategy

AVAILABLE AND ACCESSIBLE
- Delivered at regular, frequent intervals
- Requires minimal physician effort to participate in dialogue
- Employs range of communication modes

COMPREHENSIVE COVERAGE
- Reports on new initiatives, status of current projects, group quality, financial performance
- Explains rationale behind key decisions

PERSONALLY RELEVANT
- Constantly links group actions, initiatives back to shared strategy, vision
- Connects organizational change to individual physician benefits, concerns

Leaders should also encourage feedback about the transition process—and be quick to address or resolve any problems. After all, any challenges encountered by one practice are likely to be experienced by other practices along the way.

By establishing feedback loops and other forms of two-way communication, care teams have the opportunity to reach out for help and leaders can address problems early—and share any lessons with other practices.
Support ongoing transition with an administrator and physician leader.

The administrative leader can match medical home transformation needs to broader population health transformation and investment planning, while the physician champion can onboard physicians and maintain momentum with practices on the transition path. Physicians will be all the more likely to get on board with the new initiative when they’re hearing personal experience from a peer.
Key Characteristics and Skills of Medical Home Leaders

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<tr>
<th>CHARACTERISTICS</th>
<th>SKILLS</th>
<th>POTENTIAL TITLES IN ORGANIZATION</th>
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<tr>
<td>• Respected by physicians, both PCP and specialist, employed and independent</td>
<td>• Strong communication skills for engaging diverse stakeholders ranging from physicians to office staff to payers and employers</td>
<td>• Physician: Medical Director of Primary Care, Physician Group CEO or CMO, Chief Quality Officer</td>
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<tr>
<td>• Interest in improving primary care, quality, overall care continuum coordination</td>
<td>• Data expertise</td>
<td>• Administrator: Director of Quality, PHO Director, Large Practice Business Manager</td>
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<td>• Strong understanding of PCP practice economics, hospital/physician dynamics</td>
<td>• System-focused</td>
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<td>• Management experience a plus</td>
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No one has a perfect data set—the goal is to continually build and refine

08 Get started with the data you have and build in additional data sets along the way.
Get started with the data you have and build in additional data sets along the way.

Even advanced medical home leaders are still working to build a comprehensive data set. Most health systems—even those many years into care management deployment—are still integrating data sets from points across the continuum, including independent providers, payers, and other community groups.

Yet, most health systems made quality or cost improvements using the data they already had.

For example, one medical home started with a simple disease registry that tracked diabetes metrics. That registry has grown and expanded to fit the needs of the population health enterprise.

Learn how to identify which patients are at risk, why they are at risk, and who would benefit most from intervention.

Visit advisory.com/hcab/risksegmentation
Health systems should also integrate and refine data analytics systems to further help prioritize the teams’ time and attention.

Advanced medical home leaders are also thinking beyond practice and claims data to incorporate behavior, socioeconomic, and demographic data to better identify patients for management.

Data Provided by Different Electronic Sources

**Physician Practice Management Systems**
- PQRI measures
- Some HEDIS measures (e.g., well-visit scheduling)

**Ancillary Systems**
- Lab results
- Generic prescribing
- Prescriptions filled
- Radiology utilization

**State Databases**
- Immunizations
- Disease incidence
- Other state-specific measures tracked

**Hospital IT Systems**
- Core measures
- Length of stay
- Inpatient mortality
- Readmissions
- CPOE use
- Inpatient costs

**Ambulatory EMR**
- Prescriptions or other outpatient orders written
- Point-of-care actions (e.g., smoking counsel)
- Drug warning compliance

**Claims Data**
- Out-of-network visits
- Total cost of patient care

**DIFFICULTY OF OBTAINING DATA**

- Low
- High
Plan for changing downstream utilization patterns

09  Transforming primary care can reduce unnecessary downstream utilization.

10  Improve in-network utilization by connecting specialists to medical home.
Transforming primary care can reduce unnecessary downstream utilization.
Despite the seemingly mixed reviews in the academic literature, many advanced medical home leaders have seen an impact from the medical home transformation on downstream hospital volumes. Most often, these volumes represent preventable readmissions, preventable admissions, preventable ED utilization, and unnecessary utilization.

That’s why you should move from questions like, “How quickly are we comfortable reducing demand?” to “How do we position our organization to benefit from the upside of changing utilization patterns?”

We have a tool that identifies inpatient Medicare cases where a breakdown in outpatient care or patient activation led to a hospital admission. [Try it out at advisory.com/hcab/preventableadmissions](advisory.com/hcab/preventableadmissions)
Improve in-network utilization by connecting specialists to medical home.

While decreased unnecessary utilization is part of the planning for medical home deployment, systems also need to develop a collaborative specialist network. In some cases, medical home leaders have seen a tightening of referral relationships as primary care physicians align referrals to specialists with similar cost and quality goals.

Medical home leaders can foster the development of referral guidelines, cross-continuum pathways, and transparency around network cost or quality performance to tighten in-network connections. A coordinated network also increases ROI potential by maximizing retention of specialty volumes inside the system.
Working with Collaborative Specialists in the Market

STATUS QUO

Practices refer to variety of specialists primarily based on existing relationships, patient preference

MEDICAL HOME POTENTIAL IMPACT

Practices tighten referrals to specialists who support medical home practice coordination efforts, communication standards

MAKING REFERRALS “BY THE BOOK”

“The medical home physician in the project is doing it ‘by the book.’ In other words, he makes phone calls to specialists when referring patients and expects letters in return—which we need for pay-for-performance. If the letter doesn’t come, we call the specialist. And, if the specialist is not doing it, we don’t use that specialist any more.”

Chief Medical Officer
Medical Home Pilot in the Northeast
Align care delivery model and payment transformation

11 Care model and payment model innovation need to work in concert to fund future transformation.

12 Whenever possible, align performance metrics to allow care teams to focus on small set of key metrics.
Care model and payment model innovation need to work in concert to fund future transformation.

Changes to the primary care model must be coupled with changes to the payment model.

Two Transitions to the Value-Based Business Model

Leading with Care Transformation
- Invest quickly
- Prove concept
- Obtain value-based payment

Leading with Value-Based Contracts
- Meet payer demands for risk
- Secure share
- Adapt care model
Reimbursement models for the medical home continue to vary tremendously. Incentive models range from increases in pay-for-performance bonuses to per-member-per-month (PMPM) payments to shared savings. Even among medical home leaders, PMPM payments vary considerably.

The right model for you likely depends on local payer dynamics, particularly existing deployment of pay-for-performance bonuses and the willingness of the payer to innovate on the primary care reimbursement model.

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<tr>
<th>PAYMENT OPTION</th>
<th>DESCRIPTION</th>
<th>PROS</th>
<th>CONS</th>
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<tbody>
<tr>
<td>Pay-for-Performance/ Gainsharing</td>
<td>Rewards high-quality and/or low-cost practices with bonuses for achieving certain clinical or process metrics, goals</td>
<td>• Higher payer interest because less up-front risk&lt;br&gt;• Rewards achievements from new activities, goals</td>
<td>• Physicians must wait for bonus payment after care is delivered&lt;br&gt;• Metrics must continuously evolve, goals increase to maintain payment&lt;br&gt;• If metrics not standardized across payers, complications may arise</td>
</tr>
<tr>
<td>Increased Evaluation and Management Payment</td>
<td>Increase rate of standard primary care CPT codes</td>
<td>• Maintains standard procedures for documentation, billing</td>
<td>• Limited impact on “FFS treadmill”&lt;br&gt;• Not directly rewarding development of improved activities, team functions</td>
</tr>
<tr>
<td>Additional Fee-for-Service Visit Code</td>
<td>Payer adds new codes or provides payment for unpaid codes</td>
<td>• Specifically incents new activities</td>
<td>• Requires new documentation for codes&lt;br&gt;• Limited impact on “FFS treadmill”</td>
</tr>
<tr>
<td>Additional Per-Member, Per-Month Payment</td>
<td>Monthly payment to compensate practice for additional care provided for each patient covered under new model</td>
<td>• Steady, proactive payment to practice&lt;br&gt;• Specifically incents new activities</td>
<td>• Increases provider risk&lt;br&gt;• New payment mechanism for payer</td>
</tr>
<tr>
<td>Global Primary Care Payment</td>
<td>Global payment covering all patient primary care needs for set period of time</td>
<td>• Eliminates “FFS treadmill”</td>
<td>• Drastically increases provider risk&lt;br&gt;• Adoption influenced by history of capitation experience in each market</td>
</tr>
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Whenever possible, align performance metrics to allow care teams to focus on a small set of key metrics.

Leaders acknowledged one of the challenges in managing multiple contracts is the overwhelming number of performance metrics. If each payer has its own set of process or quality metrics, an individual practice could be tracking 50 or more data points.

Whenever possible, leaders should negotiate for the same metrics across contracts.

For example, some providers are using the Medicare Shared Savings Program quality metrics as the standard across all other contracts.

When a common set of metrics can’t be agreed upon, medical home leaders must internally prioritize a subset of the metric list.

For example, providers may select one or two diabetes metrics to focus care teams on what is likely to underpin diabetes management success across all contracts.
More Support on Primary Care Transformation

Care Transformation Center
This piece is based on a larger research initiative on care transformation. As part of the Health Care Advisory Board, we provide expert guidance to our members as they manage the transition to large, integrated systems responsible for managing patients’ health across the entire care continuum.
 advisory.com/caretransformationcenter

Population Health Advisor
Cohort-driven collaborative supporting the chief transformation officer combining in-person peer summits with ongoing, in-depth research and customized guidance.
advisory.com/populationhealthadvisor

Southwind
Helps hospitals and health systems achieve full medical staff integration through physician practice management and consulting services addressing physician employment, physician practice acquisition, clinical integration, and alternative models of physician alignment.
advisory.com/southwind

Crimson
Performance technology initiative that helps hospitals manage total cost and quality for defined populations—including self-insured employee plans—and inform risk-based contract negotiations with payers.
advisory.com/crimson
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