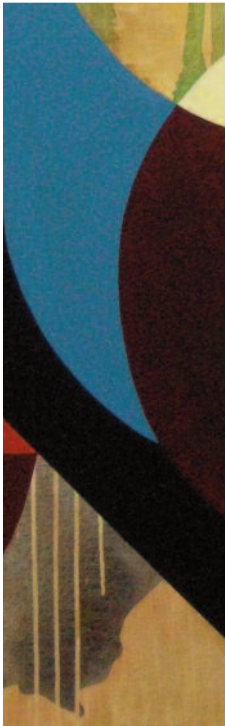
ABIM FOUNDATION FORUM

CHOOSING WISELY IN AN ERA OF LIMITED RESOURCES

INNOVATIVE ADVANCES IN WISE DECISION-MAKING



Innovative Advances in Wise Decision-Making

About the Format

After a brief introduction, Forum participants at each table should discuss which innovation session they would like to attend; ideally, each person at the table will attend a different session. Participants will then take several minutes to travel to their sessions (a list of sessions and their locations will be on your tables). Innovator presentations and discussions will last for 40 minutes; participants will then return to their tables.

Dear Forum Participants:

As part of days 1 and 2 of the 2012 ABIM Foundation Forum, we are pleased to welcome you to special sessions featuring the work of innovators in wise decision-making and stewardship of resources.

To identify these innovators, we drew on the expertise of the Forum Planning Committee, ABIM Foundation Trustees, American Board of Internal Medicine Directors and other experts. The presentations will feature cutting-edge work in organizations and training programs that steward resources with special emphasis on delivery systems and clinical practices that care for complex patients.

Some innovators may provide handouts at their sessions; these handouts will also be posted on the ABIM Foundation Forum's password-protected Slideshare account. You will receive Slideshare login information at the Forum.

If you would like to learn more about any of the featured innovations, you are also invited to attend informal breakfast conversations with the innovators on Monday at 7:00 am and Tuesday at 6:30 am in the Marineland Ballroom.

There is no need to sign up for these discussions; just look for the signs posted on the discussion tables.

Thank you very much. We look forward to your active engagement in these stimulating sessions.

Sincerely,

Daniel Wolfson
Executive Vice President and
Chief Operating Officer
ABIM Foundation
Session Moderator, Day 1

Richard Baron
Trustee
ABIM Foundation
Session Moderator, Day 2

Innovation Sessions

Innovation Sessions *(continued)*

Advancing High-Value Transitional Care: Translating Research into Practice

Presented by Mary Naylor

Background

Identifying innovative ways to assure person- and family-centered, safe, effective, efficient, equitable and timely care for older adults coping with multiple conditions and their family caregivers will be a major issue confronting our health care system for the foreseeable future.

Objective

To describe the efforts of a multidisciplinary team to improve care and outcomes for this vulnerable population through the design, testing and translation of the Transitional Care Model (TCM).

Methods

The TCM is a nurse-led, team-based care delivery system innovation designed to increase alignment of the care system with the preferences, needs and values of high-risk individuals and their family caregivers, and to achieve higher quality outcomes while reducing health care costs.

Results

Across multiple NIH-funded randomized clinical trials, the TCM has demonstrated improvements in health outcomes and the patients' experience with care and reductions in rehospitalizations and total health care costs for high-risk, older adults. The Coalition for Evidence-Based Policy has recognized the TCM as a "top-tiered" research-based care delivery model. With the support of many private foundations and partnerships with major health insurers and health care organizations, the TCM has been successfully translated into practice.

Conclusion

A rigorous body of evidence reinforces a tremendous opportunity to address the urgent need for higher value health care through widespread implementation of the TCM for chronically ill older adults.

Next Steps

Lessons learned through ongoing translational efforts will be discussed.

Can Geisinger's Approach to Delivery of High-Value Care Be Disseminated?

Presented by Earl Steinberg

Background

The Geisinger Health System is an integrated delivery system located in rural central Pennsylvania that employs 1,000 physicians and more than 500 advanced practitioners, owns and operates four hospitals and more than 40 outpatient practice sites, and owns a health plan that has 300,000 members in 43 Pennsylvania counties. Geisinger has earned accolades for its success delivering high quality care while controlling the cost of that care. Much of that success has been the result of innovations in care delivery and an infrastructure that enables Geisinger to deliver best practices in a reliable fashion.

Objective

Out of a sense of mission and pride, Geisinger has decided to try to export many of its innovations and approaches to delivery of high-value care to other care delivery systems. In the course of doing so, we hope to answer four questions:

1. Can particular approaches Geisinger has used to provide high-value care be replicated in other health care environments?
2. If so, which approaches can be replicated and under what circumstances?
3. Do those approaches produce the same improvements in quality of care and patient outcomes, the same reductions in cost of care, and the same improvements in patient and provider satisfaction in other settings as they have at Geisinger?
4. If so, under what circumstances?

Next Steps

This Innovation Session will focus on the innovations Geisinger plans to try to export, challenges associated with disseminating them outside of Geisinger, and the approaches we plan to use to incorporate Geisinger innovations, or adaptations of them, into other care delivery systems.

Caring for Dual Eligible Individuals

Presented by Adam Burrows

Background

Clinicians who work in interdisciplinary teams for managed care organizations may experience moral distress when caring for disabled individuals with complex health and social needs. Common sources of moral distress include balancing professional responsibilities with respect for patient autonomy and balancing commitments to patients with obligations to the organization. The Program of All-inclusive Care for the Elderly (PACE) is a successful model of fully integrated care for dual eligible, nursing home certifiable (NHC) seniors. The operational features of the PACE model include a large, staff-model interdisciplinary team and day centers that combine social programming with a full array of clinical interventions. There are currently 85 PACE organizations serving nearly 25,000 participants in 30 states, but there is increasing demand to provide integrated care to a broader population of dual eligible beneficiaries on a larger scale. Senior Care Options (SCO) is a flexible, Massachusetts-based model of integrated care for dual eligible seniors. In contrast to PACE, SCO serves the full spectrum of dual eligible seniors and utilizes a small care team that includes the patient's primary care physician.

Objective

To provide resources to clinicians that would increase awareness of the ethical dilemmas that create moral distress; enable interdisciplinary teams to identify, address and resolve ethical dilemmas on their own; and improve the delivery of person-centered care to vulnerable elders in fully integrated models of managed care.

Methods

Building on my career as a geriatrician, my leadership role as a PACE and SCO Medical Director, and my 15 years of experience with an ethics committee serving three Massachusetts PACE organizations, I developed three innovations: an ethics workshop for new PACE clinicians, an ethics committee serving seven rural PACE organizations, and an ethics committee for a Massachusetts senior care organization.

Results

Forums for understanding and resolving frequently encountered ethical dilemmas in community-based long-term care can improve clinician and organizational competency in delivering person-centered care to vulnerable elders. The most common ethical recommendations involve respect for autonomy, tolerance of risk, acceptance of outlier utilization, and resistance to the temptation of disenrollment.

Conclusions

As we promote the expansion of integrated care models for vulnerable and complex dual eligible beneficiaries, we must address challenges in growing capacity and supporting clinicians. Addressing ethical conflicts gets to the heart of what it means to deliver person-centered care to vulnerable elders with complex needs.

Next Steps

Disseminating the teaching from ethics case discussions and expanding the availability of ethics forums in emerging integrated care models.

Delivering High-Quality, Cost-Effective Care for Chronically Ill and Frail Medicare Patients: The CareMore Story

Presented by Ken Kim

Background

CareMore, since its inception in 1995, recognized that chronically ill and frail seniors received uncoordinated, often inadequate and unnecessary costly care from the existing "system."

Objective

Build and refine an alternative system designed to maintain health, improve outcomes and reduce cost for chronically ill and frail seniors.

Methods

Physician(s)-led initiatives to create programs [e.g., Extensivist program, congestive heart failure (CHF), diabetes mellitus, hypertension, Healthy Start, end-stage renal disease, etc.] occurred over the span of 17 years.

Results

Programs resulted in markedly improved clinical outcomes (readmission rate, CHF admission, stroke prevention, amputation rate, fall reduction, etc.) in comparison to community norms and Medicare fee-for-service.

Conclusions

A well-designed, comprehensive, coordinated system can result in markedly improved clinical outcomes, lower cost and improved quality of life for chronically ill and frail seniors.

Next Steps

CareMore is designing a care delivery model for dual Special Needs Plan demonstration projects for California, Virginia and Ohio.

Expanding a Regional Physician-Owned Independent Practice Association Network of Advanced Primary Care Model Practices Working Collaboratively with Specialists

Presented by Allan Crimm

Background

Advanced Comprehensive Care Organization (ACCO) is a physician-owned network founded by 10 independent, private Patient-Centered Medical Home practices distributed throughout the Southeastern Pennsylvania area. These practices have a solid track record of improving care for their patients over the last four years. Approximately 50% of all Southeastern Pennsylvania primary care physicians work in small practices with few resources or relationships to help them transform to a different model of care that can lower health care costs.

Objective

Using an Advanced Primary Care Model, ACCO seeks to become a larger regional organization that is of sufficient size and distribution to have a significant impact on overall health care costs and quality in the Southeastern Pennsylvania region. It will recruit and engage key specialists to join the effort to provide collaborative, value-driven care.

Results

- Obtained initial seed money through fees from founding primary care practices.
- Developed legal infrastructure.
- Developed relationship with two large commercial payers. Currently working on performance-based contracts with up-front payments to practices for development of practice capability, gain-sharing provisions and infrastructure support for ACCO.
- Developed relationships with union health and welfare fund for contracting and with a home health care company.
- Submitted proposal to Center for Medicare & Medicaid Innovation for a Healthcare Challenge grant.
- Hired and trained embedded care managers in each practice using common protocols to improve transitional care and engage prospectively identified patients at highest risk of hospitalization and ER use.

Conclusions

Obtaining the financial resources to expand and operate the network is far more difficult than finding practices willing and able to change.

MinuteClinic®

Presented by Troyen Brennan

Background

MinuteClinic is owned by CVS Caremark Corporation. MinuteClinics offer acute and chronic disease care for patients. Care is rendered by a nurse practitioner following guidelines built into the electronic medical record.

Objective

The innovation was to understand if this approach could provide high quality care, be well received by patients, and prove to be financially positive.

Methods

CVS Caremark hired new leadership to operate the company.

Results

Financial results improved, customer satisfaction was off the charts and quality was excellent.

Conclusions

Alternative providers in nontraditional settings can be an important part of health care delivery systems.

Next Steps

Our circumstances were fairly unique, but others in retail could emulate us—to accomplish this, though, they need to bring in a strong medical team to manage the enterprise, which is difficult for them.

Moving from Clinical Integration to Accountable Care

Presented by Mark Shields

Background

Advocate Physician Partners (APP) is a coordinated collaboration between physicians and APP's 12 hospitals. Beginning in 2004, as risk contracts declined and fee-for-service contracts grew, APP developed its Clinical Integration program to improve quality, safety and cost-effectiveness, which allowed its 3,000 independent physicians, along with 900 employed physicians, to jointly negotiate with insurance companies. This model has developed contracts with all commercial insurers in the northern Illinois market and received approval from the Federal Trade Commission. In 2011, APP became one of the nation's largest commercial Accountable Care Organizations.

Objective

The Clinical Integration program was designed to improve care across 3,900 physicians, most of whom were in small, single-specialty private practices.

Methods

To drive performance improvement, the program has used governance education programs, disease registries, online education, formal collaboratives, physician coaching, patient education and coaching, an incentive program, dedicated care managers and, recently, electronic medical records.

Results

Program results include a generic dispensing rate 2-5 percentage points higher than local insurers, cholesterol control in patients with diabetes that is 43% better than the national comparison rate, diabetes performance that exceeded national performance on all nine Healthcare Effectiveness Data and Information Set (HEDIS) measures, and a depression screening rate that is 85% better than the national rate.

Conclusions

A diverse network of physicians together with a hospital system can implement a program with physician leadership that improves quality, safety and cost-effectiveness and can form a basis for an Accountable Care Organization.

Next Steps

The model will expand to care for Medicare patients.

Nurse-Led Health Care Organizations: Innovations in Primary Care Delivery

Presented by Gail Partridge

Background

The Family Practice and Counseling Network (FPCN) was founded in 1992 with the non-profit corporation Resources for Human Development. FPCN began as a single nurse-led clinic and has since developed into three federally qualified nurse managed health centers, all located within Philadelphia. The majority of the patient population is considered to be vulnerable, living in trauma, poor and uninsured.

Objective

At the foundation of the FPCN culture is the belief that quality health care is a right, not a privilege. Who provides this primary care? Family Nurse Practitioners. Currently, FPCN employs 18 Family Nurse Practitioners who provide over 25,000 annual primary care visits. FPCN has expanded beyond primary care services alone. They offer dental and outpatient behavioral health services. Within primary care, services include: family planning, prenatal care, podiatry, ophthalmology and cardiology consultations, including echocardiograms—all within the same fee framework.

Methods

As FPCN has grown, so has its approach to delivery of primary care. It has expanded its services to include integrated behavioral health care embedded within primary care. This approach was to directly address the need for behavioral health care that was not being met with the limited outpatient services in Philadelphia. The Health Federation and Community Behavioral Health of Philadelphia brought this concept to the table and FPCN was pleased to join in this innovation. Licensed clinical social workers (LCSW) provide direct assessment and diagnosis of behavioral health issues within the primary care practice for all ages. In partnership with the patient, the "new" provider team of nurse practitioner and LCSW work together to provide comprehensive care. We are currently implementing the SBIRT (screening, brief intervention, referral and treatment) model for substance use and abuse, into our integrated approach as well.

Next steps

To continue to develop and expand our approach in the delivery of health care to address all the needs of our community.

Physician Engagement in the Journey Toward Accountable Care

Presented by Brent Asplin

Background

Fairview Medical Group (FMG) is a multispecialty group with over 500 providers, providing ambulatory services for the Fairview integrated delivery system, a nine-hospital system in Minnesota that includes the University of Minnesota Medical Center. In 2008, Fairview made a strategic decision to redesign its care delivery model to support population management. This decision led to a reorganization of its clinic system and an intensive care model innovation (CMI) effort within FMG.

Objective

Our approach to CMI was designed to engage frontline care teams in their work, with an innovation network design that leveraged neighboring clinics to test and spread care model changes. We used an adaptive leadership model to support clinical and administrative leaders in the change effort.

Results

The CMI process at FMG affected physician autonomy, clinical contact hours and compensation—each of which created cultural challenges for the organization. The adaptive leadership model has been an excellent tool for supporting clinic leaders and giving FMG a language for managing the complexities of our journey. We have identified many polarities in our work—interdependent and opposing principles or attributes that must be managed together over time (e.g., the need for both value and volume). The adaptive leadership model has been a useful framework for engaging physicians in the need to choose "both/and" rather than "either/or."

Conclusions

The challenges we face in health care cannot be overcome without fundamentally redesigning our approach to care delivery and payment. Given their unique role, an ongoing process for physician engagement is critical. The adaptive leadership model has been a helpful tool for maintaining a productive dialogue with physicians throughout the inevitable controversies that arise during care system reform.

Pioneer ACO and Underserved and Vulnerable Populations

Presented by Stephen Rosenthal

Background

Montefiore Medical Center established an infrastructure, 16 years ago, based on the principles of the Accountable Care Organization allowing providers to effectively and efficiently manage the care of patients under at-risk contracts. This infrastructure includes CMO, The Care Management Company of Montefiore, a wholly owned subsidiary of Montefiore that provides care coordination, chronic care management, provider and customer service and other administrative functions, and an independent practice association that includes Montefiore's delivery system and community-based and -employed providers. Montefiore also has electronic medical records with links to a regional health information exchange, a physician house calls program to provide care to homebound patients, a network of patient-centered medical homes, multiple telemonitoring programs for high risk patients, robust data analysis capabilities and workflow tools and processes to support providers. CMO is currently managing over 200,000 lives.

Objective

Proactive Care Management identifies through measurement the high priority individuals who would benefit from intervention and then selects interventions that can achieve the goals of improving the care of an individual, and the health of a population, while lowering cost.

Methods

Developed a model called Care Guidance, which identifies and creates individual care plans, and then care manages the patient.

Results

These resources are improving management of chronic disease, leading to fewer emergency department visits and readmissions and lower health care costs.

Conclusions

There are no magic bullets but rather a portfolio of effective interventions, customized to the patient and requiring continuous quality review.

Next Steps

Education modules could be developed and used by prospective care managers and other individuals in the role of coordinating and managing care.

PLUS: Innovation in Senior Care

Presented by Karen Van Wagner

Background

Meaningful advances in medicine for seniors may emerge not from pills or surgical procedures but from improvements in the way care is coordinated and information is managed. Many of these advances will be developed within Accountable Care Organizations (ACOs).

Methods

North Texas Specialty Physicians (NTSP), an independent physician association of more than 600 family and specialty doctors, and Texas Health Resources (THR), a multi-hospital health network, collaborated in January 2012 to launch PLUS, a Medicare Pioneer Accountable Care Organization in North Texas. PLUS addresses two of the primary cost drivers in health care delivery: poor patient education about cost-effective treatment options, and lack of access to patient histories and clinical decision tools.

Results

In forming PLUS, NTSP and THR recognized that completely new methods and roles for managing care needed to be developed. One example is the newly created role of Care Logistics Managers. These managers are integrated with the physician office team to assist with patient care transitions. Care managers have also been established in the acute care setting to provide similar patient support. These new methods and roles for managing care are supported by an enhanced health information exchange called Sandlot. Sandlot facilitates improvement in individual patient care through evidence-based automated prompts at the point of care and automated adherence reports that are used by providers and beneficiaries. As a result, quality of care and patient satisfaction are improved and costs are reduced.

Transforming the Care Delivery and Financing Models for Dual Eligible Beneficiaries: The Massachusetts Model

Presented by Julian Harris

Background

Massachusetts has played a leadership role in the development and implementation of integrated models of care delivery and financing for senior dual eligible members with our Senior Care Options (SCO) and Program for All-inclusive Care of the Elderly (PACE) programs. However, most of our dual eligible members under age 65 do not have access to an integrated model of care.

Objective

To develop an integrated model of care delivery and financing for dual eligible members under age 65 that leverages lessons learned from the medical home and the independent living movement to improve the quality of care for this complex population. By breaking down the silos that have existed between medical services, long-term services and supports through greater coordination and service mix optimization, these models can generate savings for the system.

Methods

Data analysis, literature review and extensive stakeholder engagement.

Results

Patient outcomes and financial results are to be determined, but stakeholder and CMS feedback about our process and our proposal has been very positive.

Conclusions

Given the opportunities to improve the lives of dual eligible members and to reduce costs through the development and implementation of integrated models of care delivery and financing, these initiatives need to be developed, scaled and evaluated through robust collaboration with members and other stakeholders.

Next Steps

Launch and evaluate the demonstration.

Veterans Affairs' Centers of Excellence in Primary Care Education

Presented by Stuart Gilman

Background

The Department of Veterans Affairs is transforming its primary care system using a patient-centered model to improve quality of care through Patient Aligned Care Teams (PACTs).

Objective

To explore how trainee curriculum in patient-centered care can advance health care quality and trainee capabilities in these domains: sustained relationships, shared decision-making, performance improvement and interprofessional collaboration.

Methods

The VA selected and funded five sites (San Francisco; Seattle; Boise, Idaho; Cleveland; West Haven, Connecticut) to develop workplace-based interprofessional models of primary care education for physician, nurse practitioner and other health profession trainees.

Results

All programs began training in academic year 2011-2012. Initial impressions suggest:

- trainees are forming positive impressions and desirable professional behaviors;
- achievement is highly dependent on the underlying systems of care; and
- rigid academic programs and traditions within and across professions impede progress. Accreditation requirement differences may be less important.

Conclusions

Such interprofessional education efforts emphasize the need for further development of:

- a shared education vocabulary to adequately describe workplace learning;
- educational research and program evaluation methodologies to better address complex real-world interventions; and
- educational activities that move beyond simply adding trainees from other professions to physician training constructs.

Co-development of new curricula by professions involved in clinical care as well as education of all professions' trainees is essential.

Next Steps

Implementation of subsequent years of the project is proceeding, with expansion of numbers of trainees and professions involved. Evaluation of patient, faculty, trainee and institutional factors will continue.

ABIM FOUNDATION
Mission Statement

To advance medical professionalism and physician leadership in quality assessment and improvement.

ABIM FOUNDATION

510 Walnut Street | Suite 1700
Philadelphia, PA 19106-3699
215.446.3530 | **1.800.441.2246 x 3530**
www.abimfoundation.org