Affinity’s Medical Home Journey – Operational, Clinical and Financial Perspectives

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Affinity Health System

• Top 100 Integrated Healthcare Networks in the Nation

• Three (3) Hospitals
  – St. Elizabeth Hospital, Appleton
  – Mercy Medical Center, Oshkosh
  – Calumet Medical Center, Chilton

• Network Health Plan
  – 135,000 Members

• Affinity Medical Group
  – 264 provider multi-specialty group located in the Fox Valley area of Wisconsin
  – 878 non provider employees
  – 13 Level 3 NCQA Accredited sites, 9 submitted for Accreditation and 1 to submit prior to October 31

• Sponsored by Ministry Health Care & Wheaton Franciscan Healthcare
Agenda

• Establishment of Vision and Champion
• Hoshin process: Core/Coordination Team
• Team Roles
• Health plan partnership
• Physician Compensation Team
Establishment of Vision and Champion
The “Wonder” Years

• Vision: Medical Home is the way to improve quality and delivery of care in a PC shortage and for the future.

• Physician leader with the vision convinced senior leadership to be supportive of this vision.

• It was critical to have top Executive level support.

• Pilot at two primary care departments: Kaukauna FM and Koeller IM.
The “Wonder” Years

- Network Health Plan partnered from the start as this would improve access, costs and quality.
- The Medical Home strategy aligns the system brand promise of personalized care with the care delivery model.
- Medical Home differentiates Affinity Medical Group from other strong healthcare systems in our region by being first to market.
The Challenges

• Cultural paradigm shift
• Alignment of 100 PCP for support of this vision and a compensation structure that will continue to drive the outcomes.
• Geographic and Silo Issues: Implement 23 Medical Homes in a 50 mile radius.
• Affinity Medical Group Leadership transition left us without a champion
Hoshin Process
(must do, can’t fail)
Hoshin Process

- Hoshin Process within Affinity: aligns leadership support and resources from the system
- LEAN methodology – improve processes, eliminate waste
- Pilots demonstrated success. Then through Hoshin process developed several 3-month plans to guide our implementation across the system
  - No project manager utilized – ownership of process at each department, yet system standardization
- Core Team – development and directional
Structure and Function

• Leader Champion – President AMG

• Core Team:
  – President, COO, Director of Medical Operations (DMO), Marketing, Physicians, Network Health Plan (NHP), Director of Clinical Operations (DCO)

• Coordination Team:
  – DCO, President, LEAN Coach – team that makes the work happen

• Site based MH Teams:
  – Physician/Advanced Practice Provider (APP) Leadership, RN Specialists, Healthcare Associate (HCA), Patient Service Representative (PSR), Behavioral Health Coordinator, Mgmt

• LEAN methodology to address flows
Team Roles
Physician & APP

• Physician:
  – Provides overall leadership to the team
    • Retains PCP role—in collaboration with other team members
    • Overall accountability for performance of practice relative to attributes of Medical Home, related measures of success

• Advanced Practice Providers – APP (APNP/PA):
  – Leadership role in patient education
    • Retains PCP Role—in collaboration with other team members
    • Shares team accountability for Wellness/ Disease/ Population Mgt.
RN Specialists

• RN Specialist:
  – Leadership Role in Wellness & Disease Management, Population Management, Health Coaching
  • Chronic disease management
    – Coordinates implementation of disease management registries and other population management tools
  • Participates in direct patient care
    – Collaborative visits for Wellness & Disease Management
    – Acute care visits (protocol directed and/or collaborative)
    – Chronic disease follow-up (blood pressure checks, ADHD)
  • Phone follow-ups
Behavioral Health Coordinator

• Behavioral Health Care Coordinator:
  – Leadership role in psychosocial support of patients & team
    • Position(s) selected by team based on practice needs
    • Care Coordinator (LCSW)/Behavior Health Coordinator (MSW)/Behavioral Health Specialist (PhD)
    • Range of services:
      – Care management
      – Psycho-social assessments, counseling & group work
      – Patient advocacy, liaison to community resources
      – Provision of social support to team
Health Care Associate

- Health Care Associate (HCA): (LPN/MA)
  - Leadership role in workflow management
    - Rooms patients but role in initiating care is expanded via medication reconciliation, “paperwork control,” clinical protocols, and advanced intake tools
    - Key support role in access management
    - Team Nursing
Patient Service Representative

• Patient Service Representative (PSR):
  – Leadership role in Service Excellence & relationship management
    • Access management and coordination
    • Visit preparation
Network Health Plan Partnership
Insurance Plan

- Pilot support: $8PMPM
- Second year: Must implement and move to NCQA accredited
- Advantage of being able to get cost data on the care we provide to patients
AMH Outcomes: Cost

Overall Cost Comparison Review

NHP Overall | Medical Home Overall
---|---
PCP Care Only | Specialist Care Only | Overall Cost Review
18.66% | 8.51% | 9.74%
33.50% | -11.97% | 0.62%

Compares 12 month period ending 4/09 to 12 month period ending 4/10.
AMH Outcomes: Cost

Overall Cost Comparison Review
Compares 12 month period ending 4/09 to 12 month period ending 4/10

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<thead>
<tr>
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<th>NHP Overall</th>
<th>Medical Home Overall</th>
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<tbody>
<tr>
<td>Outpatient Cost</td>
<td>9.74%</td>
<td>0.62%</td>
</tr>
<tr>
<td>Inpatient Costs</td>
<td>-6.38%</td>
<td>-43.68%</td>
</tr>
<tr>
<td>Overall Cost Review</td>
<td>6.06%</td>
<td>-14.22%</td>
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Personalized Care
Full Implementation

- Health plan agreed to extend the $8PMPM to all practices.
- Move to a shared risk reimbursement model.
- Integration of health plan data (claims) into the ambulatory electronic record
Physician Compensation
Compensation

• Provider compensation – first year guarantee to facilitate meeting attendance and movement to team based care model.

• Physician involvement to develop compensation plan going forward
  – Implementation October 1, 2011
  – Rewards:
    • Quality, access, panel size, patient satisfaction, medical coordination, management of cost as well as production
Next Steps, Lessons Learned and Future Development
Lessons Learned

• Change management
  – Start from scratch?

• RN Specialists:
  – Thought they would be more case management
  – Weekly group meetings

• Provider engagement
  – Champion, Compensation, team development, interviewing, leadership training, collaborative across sites.

• Team Development
  – Behavioral based interviewing
  – Huddles
  – Role of Behavioral Health Coordinator
Future Development

• Medical Neighborhood
  – Integrative Medicine
  – Diabetic Education
  – Lipids
  – COPD
  – Vascular Screening
  – Physical Therapy

• Primary Care Innovation to continue redesign work

• Evaluate impact of compensation model
Next Steps

• Imbed Case Manager from Health Plan
• Implement on-going audits to assure maintenance of processes and NCQA standards
• Implement new compensation plan (Oct 1)
• Implement shared risk model of reimbursement (Jan 1)
Affinity Medical Home

• Questions?