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Population management among the many advances

Four Years on, PCMH Rolls Ahead

By Todd Neff

Things have changed in the four years since University of Colorado Hospital's first national patient centered medical home (PCMH) designation. Starting with the AF Williams Family Medicine Clinic, eight UCH clinics, from Boulder to Park Meadows to Lone Tree, have earned official distinction for their efforts to give patients the right care when and where they need it, and in a way the patient understands.

The clinics have made huge strides in diverse areas. They've restructured teams and workflows to help ensure that patients see the same physician whenever possible. They've compiled registries of high-risk patients. They've expanded the roles of care team staff, having them engage patients between visits and remind them to take their meds. They've added behavioral health to the primary care mix.

So yes, UCH's PCMH efforts have come a long way since this publication covered AF Williams' receipt of the National Committee for Quality Assurance (NCQA)'s highest-level PCMH distinction 2011. Yet the headline of that story would be just as applicable today to the work AF Williams, its UCH-clinic cousins, and the 24 clinics across UCHealth are doing today: Each advance remains, as that headline put it, "one step in a long journey."

Long road. The journey, primary care providers across UCHealth will tell you, is epic, and the steps can seem painfully small, with impacts that are hard to measure. PCMH involves constant experimentation, and experiments do fail. But what's clear, four years into the trek, is that the goals of PCMH align with the vision of UCHealth (From health care to health) and with the inevitable transition of American health care from fee-for-service to outcomes-based payment systems.

"The current health care system, at a national level, promotes volume – more widgets, more health care transactions, equals more fee-for-service reimbursement," said DeeAnn Westfall, a UCHealth quality improvement coordinator. "But we're going to be held accountable not only for how many patients we see, but how well those people are doing. The outcomes need to be proven."

Often, the path from widgets to proven outcomes can seem indirect. One example is perhaps the most prominent of the current PCMH-related endeavors, called APEX, for Awesome Patient Experience. AF Williams and Snow Mesa Internal Medicine Clinic in Fort Collins are pilots in a UCHealth initiative aimed at sharply cutting the time patients spend waiting for care and making their visits with providers more productive. For patients, reducing what AF Williams Practice Manager Karl Sudfeld calls "non-value-added time" should improve satisfaction and with it their propensity to seek the care they need. At the same time, with appropriate staffing, the clinic could have the 40 minutes new providers spend on new-patient visits promises and open 250 new appointment slots a month, Sudfeld said.

Keeping tabs. A more straightforward example involves enhancements to clinics' tracking of high-risk patients. AF Williams and other clinics have been using patient registries for years, said Angel Perez, the UCHealth quality improvement coordinator who continues to shepherd UCH's primary care ambulatory clinics through NCQA PCMH recognition. These have been focused on diabetes, hypertension, and depression. Now, she said, the clinics are working on doing the same for a wider range of high-risk patients.

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"We hope to standardize the characteristics of what we call a complex high-risk patient across all practices, so Boulder uses the same criteria as Park Meadows and as AF Williams" Perez said.

Work by Kyle Knierim, MD, an AF Williams family medicine physician, was central to the work, Perez said. Knierim developed a risk-score assessment that takes into account utilization, comorbidities, severity of chronic conditions, mental health issues, and medications. For about two years now, the tracking system has run once a month, Perez said, pulling Epic electronic health record data from every UCH primary care patient and scoring based on relative risk.

Now, Perez said, clinics are working on translating those risk scores into workflow changes that help the clinics help the high-risk patients Knierim's system is identifying. While AF Williams is leading the way, the Epic-based risk-score assessment, as with other PCMH approaches, are there to share with the clinics of UCHealth North and South, with Westfall being the official conduit, Perez said.

Two-way street. In addition to supporting UCHealth North's APEX work, Westfall has since 2012 led a three-clinic PCMH initiative paid for by the Centers for Medicare & Medicaid Services' Comprehensive Primary Care Initiative (CPCI). Patient registries have been a central aspect of the CPCI work being done at Sterling Primary Care, Timberline Medical in Estes Park, and Prospect Internal Medicine in Fort Collins, Westfall said.

As with the initiative Knierim led, this is a population health effort involving stratifying patient risk. The CPCI work involves more than having a care team assistant occasionally calling a high-risk patient to remind them about an immunization. It's about establishing a two-way street from provider to patient, she said. True empaneled care, she said, is like a well-developed and consistently maintained Christmas-card list.

"Who out there in the world do you know, do you want to continue to know, and who would not be surprised to get a Christmas card from you?" Westfall said. "We want to be the health care team that a person or family would say, 'Yes, they know me and I know them.' So there's loyalty on both sides."

AF Williams, which has been ahead of the PCMH curve not only within UCHealth, but across Colorado (in 2014, the Colorado Academy of Family Physicians awarded the clinic its 2014 PCMH Practice of the Year) continues to experiment, too.

The change to the APEX model brought funding for two care managers – one paid for by UCH, the other by the University of Colorado School of Medicine's Department of Family Medicine – plus 50 percent of a social worker's time (the other half of whose time is being spent at Lowry).

UCH's AF Williams Family Medicine led the way with the NCQA's top PCMH designation in 2011; in 2013, UCH's other seven primary care practices joined AF Williams among the elite.

No kitchen sink. Care management has been a part of AF Williams' PCMH efforts for two years, said Aimee English, MD, a former chief resident and current practice transformation fellow at AF Williams. The practice now aims to refine it. Part of that involves a new initial assessment to filter and stratify patients' needs before throwing a kitchen sink of resources (i.e., long clinic visits with a physician, a social worker, behavioral health specialist, and other experts) at them. Among the criteria is patient engagement, because AF Williams found that some patients don't really want the care they need, which led to no-shows, wasted time, and resources.

"We group people into disease-out-of-control, multiple comorbid conditions, high utilizers, and people who have really complicated care-coordination needs," English said. "In some cases, that includes behavior health and social worker needs."

The goal, English said, is to figure out what works for patients in these different categories. Sometimes it takes some serious thought. She gave the example of a complicated patient, a homeless ED frequent-flier with out-of-control diabetes.

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"He met almost every category of risk," English said. "But despite meeting all those checkboxes, what he really needed was a house."

Even as PCMH efforts continue across UCHealth, Westfall and colleagues are thinking about the next step, which involves smoother interactions and transitions among the many players in patient care.

"We can't ignore that we live in a siloed community," Westfall said. "A big part of being a patient centered medical home is being part of a patient-centered medical neighborhood." That neighborhood must include the home itself, she added.

"Most of the time, our patients are not in hospitals and clinics," Westfall said. "They're off living their lives."