

The Pennsylvania Chronic Care Initiative

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Cost Council

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PURCHASING

Chronic Care Commission Recommendations

- The Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission formed by Governor Rendell
- Commission delivered a strategic plan to the Governor and Legislature in February 2008 to:
 - Implement CCM through regional rollouts using
 - learning collaboratives,
 - practice coaches and
 - provider and consumer incentive alignment
 - First Rollout in Southeast PA in May 2008
 - The model is an integration of Chronic Care Model and the Patient-Centered Medical Home concepts
 - Initial focus is on diabetes and pediatric asthma

Implementation Priorities

- #1: Make **practice coaches** available to primary care practices to assistance with redesigning their practice.
- #2: Establish programs to **engage consumers in self-management** of their chronic conditions and meeting goals for healthier lives.
- #3: Provide all primary care clinicians use of a free, secure, web-based **patient registry**.
- #4: **Develop a statewide, pooled claims database** across insurers to provide transparency on how we are doing as a state in improving chronic care.

Implementation Priorities

- **#5: Adopt a certification process** administered by an independent third party to determine if practice qualifies for enhanced reimbursement. Decided on NCQA's PCP-PCMH Recognition program.
- **#6: Increase understanding about how to best support those persons who are most severely, chronically ill**, while maintaining an approach that addresses the needs of all people with chronic illness.
- **#7: Educate and inform consumers** about Pennsylvania's Chronic Care Model and how to access it.

Requirements: GOHCR

- Funding faculty and expenses for a year-long learning collaborative for participating primary care practices.
- Coordinating the flow of data and funds to practices.
- Providing ongoing project management support.
- Funding cost of registry.
- Funding data collection, evaluation and reporting activities through a contracted 3rd party.
- Budgeted \$2 million each year for 3 years.

Requirements: Primary Care Practices

- Participate in seven days of learning collaborative meetings.
- Work with an assigned practice coach
- Use a patient registry.
- Achieve Level 1 NCQA PPC-PCMH Recognition within 12 months.
- Report data.
- Reinvest funds into the practice site, including for case management.
- Three-year commitment.

Requirements: Primary Care Practices

- Most importantly, implement fundamental redesign of the practice for *all* patients, including, for example:
 - Using the registry to send patient reminders.
 - Conducting planned visits to address all aspects of the patients conditions.
 - Providing team-based care, using non-physician personnel to support the patient (education, care coordination, etc.).
 - Providing self-management support, involving the patient in goal setting, action planning, problem-solving and follow-up.
 - Providing enhanced access to the care team.
 - Performing population-based data analysis.

Requirement: Payers in SE Pennsylvania

- Three-year commitment.
- Financial support – design follows Commission framework, but *specific to the Southeast rollout*. Payments proportional to the revenues paid to each practice by each of the payers.
 - Payment to IPIP (Improving Performance in Practice) for Practice Coaches (1 for every 15 practices) @\$130K per coach per year.
 - Three-part provider payment model.

Provider Payment Model

- **Infrastructure development payments**
 - Licensing fee for registry, support for data entry to registry, cost of NCQA survey tool, NCQA application fee, and lost revenue for time to attend 7 days of learning collaborative meetings in the first year
- **Enhanced payments to FFS/capitation**
 - For initial three years, lump sum payments aligned with stepwise achievement of the three levels of NCQA PPC-PCMH recognition
- **Pay-for-performance**
 - Maintenance of existing program – common measures to be adopted across insurers by 2010
- **6 insurers in Southeast PA are contributing an estimated \$12 million over 3 years.**

Participants in SE Pennsylvania

- 32 practices
 - representing 149 clinician FTEs.
 - internal medicine, family practice, pediatrics and NP-led practices.
 - combination of independent practices and those affiliated with one of three academic systems.
- 6 payers
 - Aetna, AmeriChoice (Medicaid), CIGNA Healthcare, Health Partners (Medicaid), Independence Blue Cross, Keystone Mercy Health Plan (Medicaid).
 - Insurers including commercial (insured and self-insured), Medicaid and Medicare Advantage business.
 - no Medicare FFS.

Supporting Coalition

- The Primary Care Coalition
 - The PA Academy of Family Physicians, the PA Chapter of the AAP, and the PA Chapter of the ACP. Together they are the RWJF IPIP grantee in PA.
 - Improving Performance In Practice (IPIP)* practice coaches will assist with:
 - transforming the practice.
 - data collection and reporting.
 - linking practices to community resources.

- IPIP is a primary care-based quality improvement program featuring practice coaching, collaborative learning, patient registry support and monthly performance measurement and benchmarking funded by the Robert Wood Johnson Foundation. IPIP operates in 7 states.

Consumer Engagement: Progress to Date

- Each practice has designated staff member to be Self-management Advocate responsible for:
 - Training staff in self-management skills.
 - Working with care teams to identify each staff member's self-management training responsibility vis a vis each patient.
 - Monitor self-management activities in practice and retrain as needed.
- Half-day training for self-management advocates held on December 2:
 - Follow-up conference calls and breakout sessions during learning collaboratives are planned.
- Developing Social Marketing campaign.
- Developing process to increase availability of diabetes educators in community locations.
- IPIP starting to work on community level partnerships.

Anticipated Gains Based on Formal Evaluation

- Improved quality of care within 1 year.
- Reduced admissions and cost in 3 years.
- Improved access to care and member satisfaction.
- Support for the vulnerable and essential primary care professional community.
- A robust demonstration of the impact of a far-reaching, multi-payer strategy to transform care delivery.
- Lessons learned to hopefully apply to a broader system-wide model application.

Successes

- Strong stakeholder commitment in all regions.
- Successful in building support infrastructure to develop and implement initiative across regions.
- Largest collaborative initiative in the country.
- Made more progress on consumer engagement than any other collaborative.
- Near to having evaluation program in place.

Opportunities

- Need larger employer presence.
 - Insurers cannot make changes to self-insured coverage without employer buy-in.
 - Needed to enhance consumer engagement initiatives.
- Need consumer engagement champion on Commission and regional steering committees.
- Need to develop plan for spread and sustainability.
- Health plan participation and funding levels are voluntary, so program in jeopardy if key plan won't agree to Commission's framework.

Lessons Learned

- Changing health care systems requires a realignment of key stakeholder incentives (insurers, practices, patients).
- Governor's Office as convener has:
 - Brought all key stakeholders to the table and facilitated difficult discussions.
 - Served as decision-maker when stakeholders disagreed.
 - Used resources to fund key aspects of rollouts.
- Infrastructure to develop, rollout and support program is key:
 - Staffing Commission, subcommittees and regional rollouts.
 - Learning Collaboratives to train providers on practice redesign.
 - Practice Coaches for participating practices.
 - Patient registry with reporting function.
 - Assistance with NCQA PCC-PCMH application process.

Lessons Learned

- Practice model must include resources dedicated to care management and patient self-management.
 - Involvement of MacColl Institute has been key to design self-management program and train practice staff.
- Using a learning collaborative model to bring about change is a start, but practices need practice coaches to facilitate and reinforce changes.
- Sustaining the CCM initiative requires that:
 - Program leadership be protected from political winds.
 - If state is convener, it needs to budget funds to support project.
 - The program be formally evaluated and demonstrate savings after three years of operation.

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