# Developing The Capacity To Improve Care

**MSSNY Contract Number: CO24582**
**Deliverable 11**

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# Overview

The New York Department of Health and the Medical Society of the State of New York (MSSNY) has undertaken a large scale project to transform the delivery of primary care services to the people living in the Adirondack Region of New York State.

The DOH OHITT/MSSNY Physician Practice Support Organization (PPSO) contract is a result of 2005 legislation directing the Department to "issue grant funding to one or more organizations broadly representative of physicians licensed in this state." Project funding was directed "to include, but not to be limited to":

- efforts to incentivize electronic health record adoption;
- interconnection of physicians through regional collaborations;
- efforts to promote personalized health care and consumer choice;
- efforts to enhance health care outcomes and health status generally through interoperable public health surveillance systems and streamlined quality monitoring."

The MSSNY PPSO contract was comprised of three components with eleven deliverables . An overview of each of the components is provided.

**Component 1: Statewide Working Group now to collaborate with NYeC**

The MSSNY statewide working group created the vision, oversees the effort, and formulates the final recommendation. Dr. John Rugge is the Chair of the working group and Dr. Salvatore Volpe is the Vice Chair. The group includes experts from across New York as well as representatives from the Adirondacks. Overall guidance of the project was developed.





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**Component 2: Implementation of 3 Sub regional Solutions in the Adirondacks**

The contract calls for implementation of the 3 sub regional solutions "to address the issues of access to care, care coordination, evidence based guidelines, quality of care, and performance reporting." This component includes discussions of the following:

- A baseline Pilot readiness assessment of the practices (Deliverable 2)
- A description of the PPSO's to be implemented (Deliverable 3)
- An initial description of the governance structures and overall scopes of service for the PPSOs (Deliverable 5)
- Interim progress report on PPSO development (Deliverables 7 & 9)
- Final report on PPSO development (Deliverable 10)

**Component 3: Technology Project**

The technology project within the contract is "for the costs of interfaces, software and other technical costs and support services to facilitate data access / exchange and connectivity with RHIO's and the SHIN-NY." Prior to HEAL 10, the technology project was planned to be the only health information technology for a large majority of the practices within the Adirondack Medical Home Multi-Payor Demonstration. Since the award of the HEAL 10 grant, DOH has directed the technology hardware and software funds to be directed to HIXNY, the local RHIO, for interconnectivity. This component includes information regarding:

- A technology design (Deliverable 4)
- A plan for performance reporting (Deliverable 6)
- A technology implementation plan (Deliverable 6)
- A technology operating plan (Deliverable 8)





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Finally the project concluded with the re-convening of the statewide working group to make recommendations regarding implications for statewide expansion as needed for connectivity for small and rural practices throughout New York State. The legislation also called for a final report from the Department that includes (among other requirements) "the appropriateness of a broader application of the health information technology program to increase the quality and efficiency of health care across the state." This document discusses the findings and processes believed to have State-wide applicability which would encourage the reproducible transformation of primary care throughout the State of New York.

# Care Delivery Process Improvements

## Access to care

Enhancements include appropriate triage, same day appointments, expanded hours, and innovative methods of allowing patients to communicate with their personal physician in a timely manner and in a language which is most comfortable for the patient. In the NCQA PCMH, there is one Standard and two Elements related to Access to Care, both of which are "Must Pass" criteria. Consistent and perpetual measurement and reporting is key to continued improvement.

## Care Coordination and Patient Management

Enhancements in care coordination and standardized delivery are the foundation of transforming primary care. This project identified Hudson Headwaters Health Network's "Blue Print for the Patient Centered Medical Home" as a "best in practice" that could be used in all areas. In addition, the standardized approach to patient management, including processes related to Stratification, Outreach, Encounter, Follow-Up, and Monitoring is easily implemented in any location.




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# Care Delivery Process Improvements

## Performance measurement

Standardization of care coordination and management, as well as the accompanying technology are key to developing and measuring performance. However, it is not enough to "think" care has been improved or cost reduced. Any successful replication must include the ability to objectively measure performance outcomes and compare performance across or between regions. The ability to extract standardized data elements and standardized performance data out of electronic systems is elemental to successful replication.

## Quality of care

The homogenous identification, selection, and application of evidence-based guidelines is critical to improving the quality of care in a financially beneficial manner. This project selected five conditions, two for the pediatric population and three for adults. The conditions selected for pediatrics were related to obesity and asthma management. The three conditions identified for the adult population were hypertension, diabetes, and chronic coronary artery disease. These five were chosen to provide the biggest impact in terms of improvements in health outcomes, as well as the potentially biggest reduction in cost. Once the conditions were identified, the optimal course of treatment will be derived from evidence-based research followed by the adoption of treatment "pathways" across the region. This deliberative process will be essential if other facilities or regions desire to transform the delivery of care.

# Critical Success Factors

## Communication of change management

A cornerstone to the success of this project was the dedication of participants at all levels to communicate frequently, transparently, and honestly about all aspects of the project. Failure to keep all participants engaged and informed of timeline adjustments could limit success in other areas.

## Technology

The significant investment made in developing and implementing electronic health records is a foundational requirement of expanding this project to other regions. Without electronic health records and disease registries feeding standardized data into RHIO/HIEs, providers will not be able to measure performance OR identify if the dual objectives of clinical care improvement and reduction of cost are met. Any region wishing to transform care must be aware of the critical role technology plays.

## Scale to create "Systemness"

One of the most challenging aspect of replicating these efforts to other areas is to recognize and actively work to change the overall culture of healthcare delivery. Ensuring all participants begin to view healthcare delivery as an interconnected system rather than autonomous revolving "parts" is imperative. Without conscious effort, participants will continue to only adjust autonomous spheres of influence. Failing to replicate a "systemness" world view will compromise the ability to improve care and ultimately reduce costs which result from interconnected relationships.





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# Critical Success Factors

## Continuous quality improvement

Initial training and focus will ensure participants practice patterns are changed. Participants must also be trained on a continuous improvement model to ensure they have the tools to aggressively continue to evolve to meet the future needs of patients. Without an emphasis on continuous process improvement, ensuring it becomes an integral part of how each practice operates it is easy to lose improvements. This project used the Plan, Do, Study, Act (PDSA) process. However, we believe any recognized, standardized process to address continuous process improvement could be used.

## Payment reform

Any consideration of State-wide replication must include fundamental changes from current reimbursement methodologies used by all third party payors. The traditional fee for service mechanisms reward the volume of patients seen or procedures performed. There is currently no, or very limited, financial value place on the "value added" activities required in a Patient Centered Medical Home (PCMH) organization. In PCMHs, care is to be managed and duplication eliminated. To accomplish these goals significant financial investments must be made to upgrade infrastructure and enable the technology needed to measure and monitor care. In addition, significant financial investments are needed to enable the operational and staffing changes required to coordinate care. The current expectation for these investments to be paid for in advance of payment reforms is unrealistic.

# Implementation Risks

## Operational infrastructure development

Significant time and energy has been spent in identifying organizations with the breadth and depth of resources to serve as Physician Practice Support Organizations (PPSOs). These organizations were willing to provide the funding and staff to begin this transformation before funding occurred. These organizations also committed significant time and energy to participating in routine meetings during all phases of the process. It would be imperative to find Article 28 organizations in other regions wishing to replicate the success of this project.

## Delivery system reform

As discussed, a critical success factor is comprehensive payment reforms. However, one of the major implementation risks is working to successfully embed a change in the healthcare culture. Healthcare delivery functions as autonomous silos with each participating provider receiving reimbursement for the number of patients seen; the number of tests run; or the number of procedures performed. One of the objectives of any replication will be to reduce the overall cost of healthcare delivery. Failure to work with participants to change their view of healthcare from a "solo sport" to a team-based endavor would be fatal. Any participants must be able to see the delivery of care along a continuum and as being delivered from interconnected systems rather than autonomous, revolving "parts."

# Implementation Risks

## Funding

As is the case with most efforts, the lack of adequate funding would be a limiting factor to replication. Significant funding is needed for technology development and application, staffing, performance reporting, and loss of productivity necessary to develop and deliver Patient Centered Medical Homes.

## Construction of measurement systems for continuous quality improvement

Bringing all participants to agreement on performance measurement is required. The diversity of organizations needed to successfully participate is a challenge in replicating this project. Agreeing on the conditions with the greatest return on investment in terms of both cost and healthcare outcomes is the first step. Perhaps more difficult is the need to obtain consensus from payors, hospitals, physicians, and governmental entities and develop the technology to support:

- What to measure
- How to measure
- How report
- Who is granted access to the information
- How it will be stored

# Risk Mitigation Strategies

## Communication

Communication across all participating stakeholders has been identified as the single biggest element to mitigate risks and ensure success. Strategic communication is imperative to ensure a common definition of success is defined; this can be accomplished through structured, regular meetings at the State level. These meetings should include all stakeholders representing legal, government, participating payors, participating practices, and contractor organizations. Tactical communication is needed to translate strategy into operationally achievable actions and should address governance, service offerings, and technology needs.

## Change management

Using a structured approach to manage the significant changes necessary for transformation is required for successful replication. This project used thoughtful planning and solicited input from all stakeholders. The implementation was sensitive to the concerns of all involved and recognized the need to develop a realistic timeline. Experts agree that for long term change to occur, goals must be realistic, achievable and measurable. One of the key risk mitigations strategies is to ensure all participants fully understand the strategic, operational, and financial imperatives driving the transformation of care throughout the State.

# Risk Mitigation Strategies

## Program management

Intense program management with constant milestone tracking to ensure compliance with the requirements and timelines should be undertaken during replication. An initial goal should be to develop realistic timelines with achievable milestones which are supported by all involved. Structured program management should then be used to communicate timelines and assign responsibilities, identify issues quickly, and rapidly work to their resolution in an effort to maintain compliance and reduce financial and personnel resource consumption.

## Data and information standardization

Creating a standard agreement as to what will be measured, how it will be documented, how it will be measured, how it will be reported is very important. It is also critical to discuss and agree to which organizations will provide information, which organizations can access the information, and how the information will be utilized by all organizations to improve care and reduce costs.

## Leadership dyads

To successfully replicate this project, it will be imperative to develop governance structures that provide a voice to pertinent stakeholders. It is also important to ensure those serving in leadership positions have sufficient breadth and depth of influence to ensure gridlock doesn't occur when organizations that are traditionally mistrustful of each other attempt to collaborate.





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# Outstanding Operational Issues

## Patient attribution

One of the fundamental issues that arose during the initial phases of development was how to determine functional patient attribution lists. These lists were key to determining which patients were included in the pilot and to which practitioner they should be assigned. In addition, the development of the $7 per patient per month was calculated on specific patient populations. Developing a common understanding of which patients are included and the rationale for patient exclusion is fundamental for participating practices to know the patient populations for which they are responsible. It also allows for financial planning, since patient attribution lists are important for determining the per member per month payments. It is important to ensure practices know how to utilize the capabilities of their electronic health records to manage specific patient populations. Developing the processes to enter the necessary data and then being able to identify patients by insurance plan and participation status may take significant training and effort. While the groups in the pilot project have defined common exclusion criteria, on-going communication and validation is required.

# Outstanding Operational Issues

## Lack of trust

Another significant issue encountered during the project was the fundamental lack of trust between and among stakeholders, which significantly slowed the change management efforts designed to smooth the transformation of care. Traditionally, participants have different goals and different relationships with the patient. Payors typically view patients as stratified risks groups; hospitals view patients as short term relationships, and physicians relationships with patients are personal and long term. Data inaccuracy can also contribute to a lack of trust among participants, even if innocent in nature.

Realizing these the differing relationships and priorities create fundament trust issues among the major stakeholders is important when replicating to other areas. Constant vigilance is necessary because trust is extremely hard to establish and easily lost. Each set back slows the change management process and slows the ultimate transformation toward Patient Centered Medical Homes.

## Change fatigue

The rapid rate of change necessitated by this project, as well as the comprehensive nature of change created significant mental and physical fatigue. Transformational changes in workflow, patient management, organizational relationships, and technology utilization were required. The pace of change was accelerated and contributed to the fatigue. Participants were forced to change their basic mindset about the delivery of healthcare and change their world view from one in which they were the “top dog” to one in which they are an important part of a team. For replication to succeed, the fatigue created must be account for and factored into the overall project plan.




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# Issue Resolution

## New York Department of Health (NYDOH) Leadership

NYDOH provided the leadership and guidance throughout this project. They set the tone for the project by including all participating stakeholders from the beginning. They developed impartial, collaborative relationships with all and provided mandatory, regularly scheduled meetings at which all stakeholders could voice concerns, discuss solutions, and reach consensus. They also leverage their governance oversight position to ensure resolution and forward progression on contentious issues, rather than allowing the project to languish due to competing interests. The NYDOH also facilitated constant communication among all stakeholders. The enforced a key requirement of regular meetings and transparent, timely communication on all issues. This prevented the formation of erroneous assumptions, and it fostered trust as everyone remained focused on the ultimate goal: health care delivery improvement for the region. Leadership also ensured program management skills were applied to this project. Program management differs from project management by strategy and scope. Program management ensures the correct projects are selected, coordinated, and completed to deliver long term improved performance. The NYDOH ensured the efforts of this project, the HEAL 10 grants, and HIXNY project all supported the transformation and improvement of healthcare delivery through the development of technology, performance improvement, and required reporting.

For any replication of this project to be successful, the continued vision, leadership, and guidance of the NYDOH will be critical.

# Issue Resolution

## Delayed deadlines

Transformation on this scale requires training and performance coaching to minimize the dissonance that occurs when expected patterns and processes are disrupted. The original program plan established aggressive performance timelines. The NYDOH worked closely to ensure the original project milestones were adjusted when necessary to ensure stakeholder success. This insight and flexibility was essential in mitigating the change fatigue and helped break down some of the inherent lack of trust. Several key deadlines were adjusted, including the submission requesting NCQA certification, to ensure participants were successful. As deadlines were adjusted, all stakeholders were notified and included in the decision. Constant communication is a theme of success and a key risk mitigation factor at all levels and stages of this pilot.

While it is imperative in any attempt to replicate this project to establish timelines and meet aggressive change goals, it is just as important to remain flexible during the execution of transformational activities. Strict adherence to initial milestones can result in resentment and lack of enthusiastic participation.





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# Lessons Learned

## Recognizing and managing significant learning curve

The transformation of the delivery of primary care services required by the Patient Centered Medical Home is a complete change in every facet of delivery. There is a significant learning curve for all involved stakeholder from the primary care provider, to the insurance company, to the governmental/legal rules. The effort and time needed to learn to embrace and work effectively in this new structure should not be underestimated. In PCMHs, care is delivered through effective, integrated care teams leveraging technology to focus on providing the best patient care regardless of site of service. A focus on standardized care through the use of evidence-based guidelines is also a change from traditional methods. In the new model required in the pilot program, providers must seek out evidence-based medicine and adhere to definitive care methodologies.

The payor community is also required to embrace significant changes in mindset. Historical reimbursement relationships have been based purely on volume. Working with providers and providing reimbursement for "value added" management and care coordination activities is a significant operating change and takes time for the payor community to modify payment, administrative, and financial models.

The current federal and state legal restrictions designed to prevent collusion and price fixing also make the full implementation of PCMH a complex undertaking. Significant education and discussion between multiple governmental and legal entities including the New York State Department of Health, the New York State Department of Insurance, the New York State Attorney General, the New York State Medical Society, as well as the other stakeholders is required for replication. Understanding the existing barriers to implementation take significant time, energy, and commitment.





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# Lessons Learned

## Recognizing and managing significant time investment

Overcoming the historic, legal, financial, operational, and practical barriers on any massive change takes significant time. The overall complexity of the pilot project should not be underestimated and it is important to acknowledge and design a plan to ensure the long term commitment and focus of all stakeholders. Additionally, overcoming the historically relationship between the necessary stakeholders will take significant time investment. As an example, most provider organizations and payor organizations are traditionally on opposite sides of the healthcare equation. Transforming this relationship into a collaborative one rather than the competitive one will require significant investments in time to develop and maintain trust.

## Understanding and developing necessary technology

It is important to understand the lack of nationally standardized technology infrastructure or data exchange elements create complexity that must be recognized for any effort at replication to succeed. Significant time and effort was spent to reach agreement on how to ensure standardization despite the various electronic systems utilized by participating organizations. The level of interoperability needed from complex, disparate systems for this project is groundbreaking. At the beginning of the project no one understood the effort and time involved in identifying common measurements, and then determining how these measurements could be extricated from each system to ensure comparability of data. Without leveraging information technology, it might be possible to meet the patient improvement goals of this project, but it would not be feasible to measure and report clinical or financial performance improvements. Additionally, a significant amount of time and effort was spent examining how to protect patient health information, obtain appropriate consents, and building the flow of the right level of information to the right participating organization.





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# Future Steps

## Fully leverage technology

Interactive technology is the bedrock for successfully managing health outcomes and accurately measuring the financial impact of improvements. It is imperative that practices, hospitals, and payors use the data derived from their systems to create useful information and ensure continuous improvements for the benefit of patients. Information should be used to improve health outcomes through the use of data tracking and trending, accurate stratification of patients, and coordination of care to ensure treatment in the most appropriate setting. Used continuously, these tools have the potential to significantly improve healthcare and significantly reduce costs associated with rendering care. Failure to fully leverage the time and financial investment in technology will reduce the impact of the pilot project and would be fatal to any attempt to replicate the process.

## Continued common vision

There are many organizations that must participate to transform healthcare delivery and reduce costs. Each of these organizations have diametrically opposing financial goals. Payors wish to keep costs low, physicians wish to treat patients as they see fit with limited interference, the State of New York wishes to ensure healthcare is locally available to all citizens, and patients just want to receive coordinated care from someone they trust while someone else pays for it! Aligning stakeholders is only possible through trust in a shared vision. A shared vision based on trust and common purposes can be created through facilitated meetings, as was done in this pilot project. These activities must be nurtured into the future through constant, open communication that is accurate and transparent. All stakeholders should be included without any groups "boxing out" or marginalizing any other group. This is another key to future replication.

# Future Steps

## Funding transition

A significant transformation during this pilot program is the commitment made by the major payors to provide a per member per month management fee to each participating provider obtaining NCQA PCMH recognition. This is the beginning step to help transition healthcare from one based on volume of services provided to one based on the value of services provided. Payors recognize the increased time needed by providers to engage their patients, ensure patient buy-in, and coordinate healthcare – all activities to which no incentive was linked in the old reimbursement model. Payors in this pilot project hope to be financially rewarded by healthier patients who prevent illness and obtain care in the most appropriate, cost effective setting. Providers are excited that foundational services are now financially valued.

To ensure continued progress in this project, payors and providers will need to continue to work together to monitor financial performance for participating patients against baseline data. While the pilot project will attempt to reduce Emergency room visits and avoidable hospitalizations, future considerations could include a shift to a shared savings model providing additional reimbursement for those that significantly improve health outcomes. Accurate, timely monitoring of patient level financial data in conjunction with clinical outcome data is key to ensuring stakeholders remain committed for the duration of the five year pilot and beyond.

Any replication effort must include training physicians to fully understand the new funding models and continued support by the payor community.


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