**TCPI:**
**Transforming Clinical Practice Initiative**

COMPASS
Practice Transformation Network

# *Preparing Clinicians for the Future*

**Tom Evans, MD**
**Compass PTN Learning Community**
**2016**

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## Objectives

- Consider the role of "requests and Offers" in catalyzing transformation
- Describe the Compass PTN resources and structure
- Explore the modified Breakthrough Series model, TCPI timeline, and the use of data to effect change in our clinical protocols

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# Growing Knowledge and Capability

## Resources

| **Resources** | Mine | Not Mine |
|---|---|---|
| Other's | | |
| Not Other's | | |

## Resources Available

| **Resources** | Mine | Not Mine |
|---|---|---|
| Other's | Public | Others |
| Not Other's | Private | Neither |

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## Growing Knowledge

***Requests***

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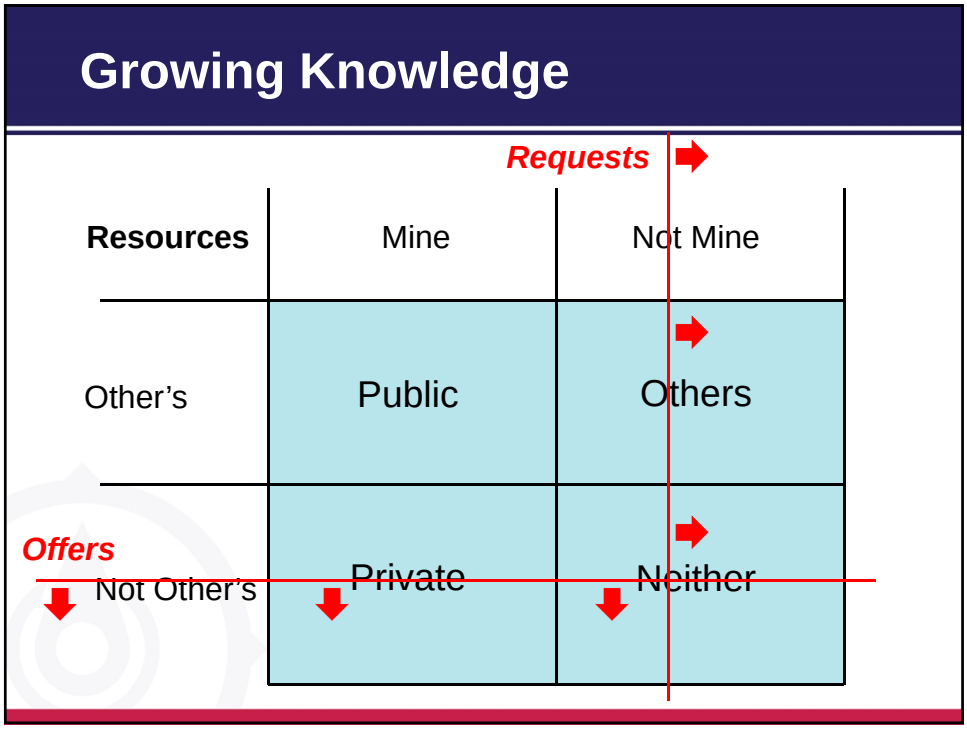
Growing Knowledge
Requests
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Mine
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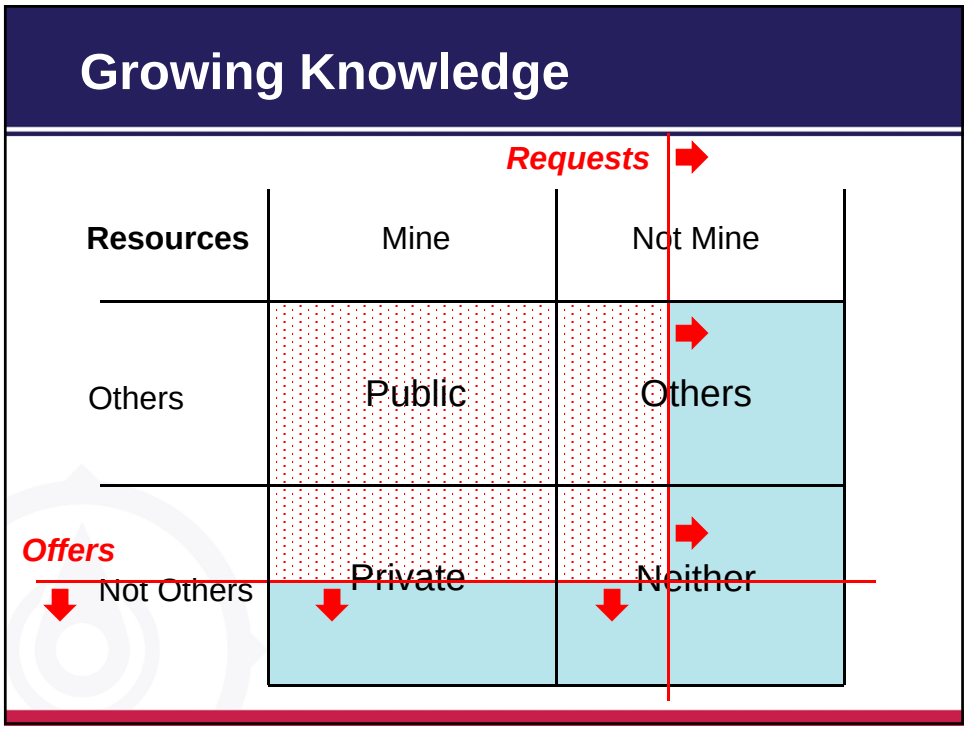
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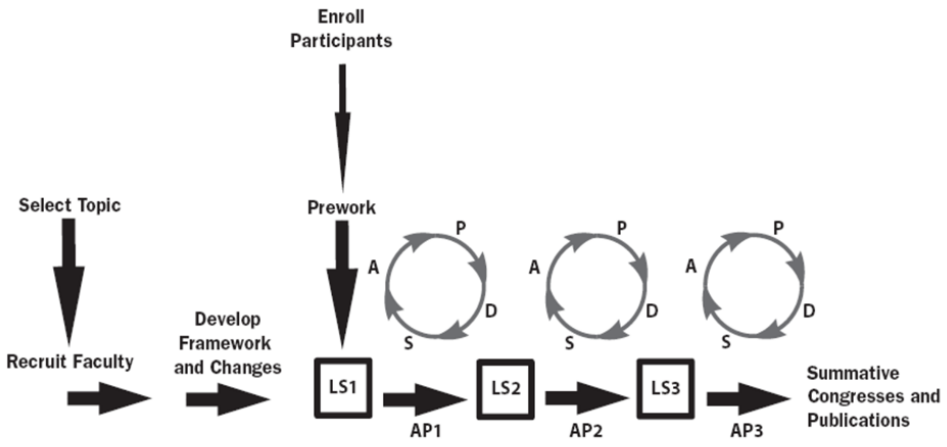
## Breakthrough Series Model

Figure 2. Breakthrough Series Model

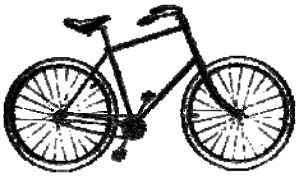



We don't know what we don't know.

"Knowledge comes in two flavors – "knowledge *that*" and "knowledge *how.*"

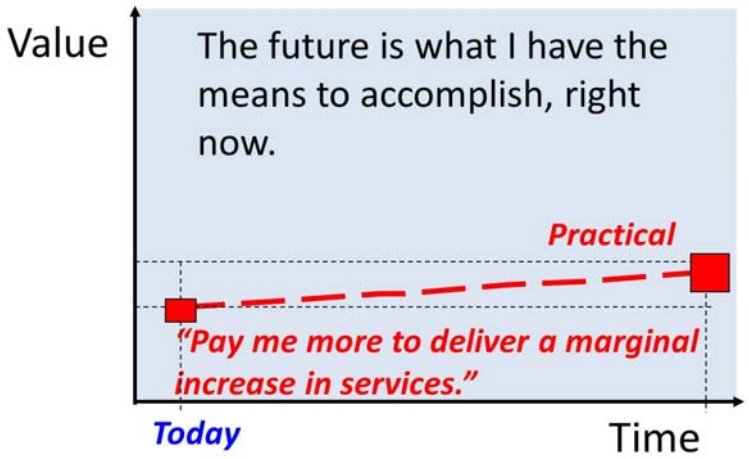
Knowing that a bicycle has two wheels, a seat, handlebars and a foot-pedal crank, for example, stands in sharp contrast to the practical knowledge of how to ride a bike.

*Brent James, MD*



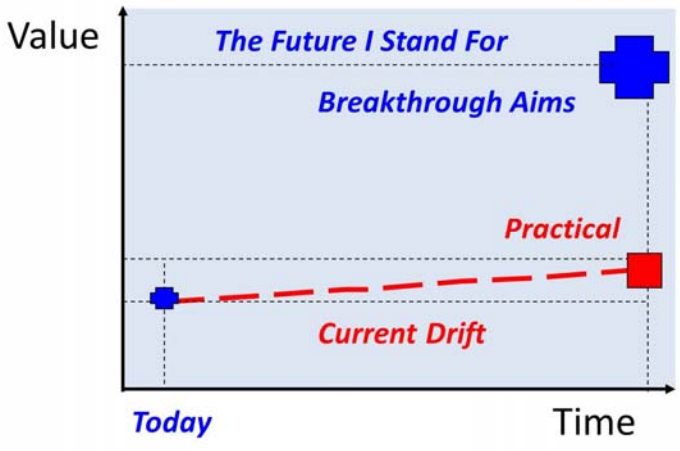
Systems create aims,
and measure results.

## A practical choice on Aims (ends)

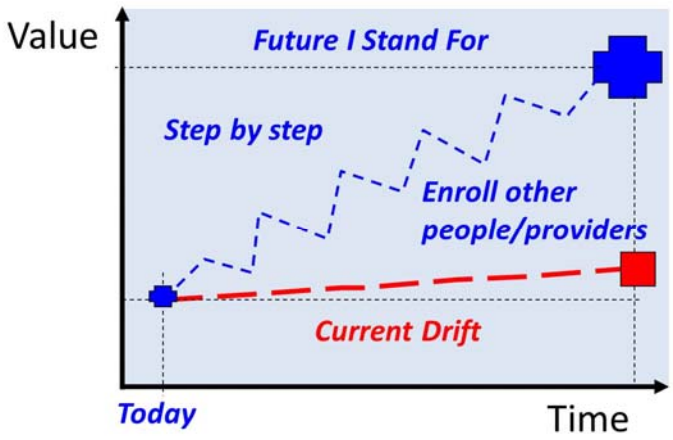


Systems don't create aims.
Aims create systems.

## How do I get from here to there?



## "Emergent" Strategy




Aims create systems.
Systems create results.

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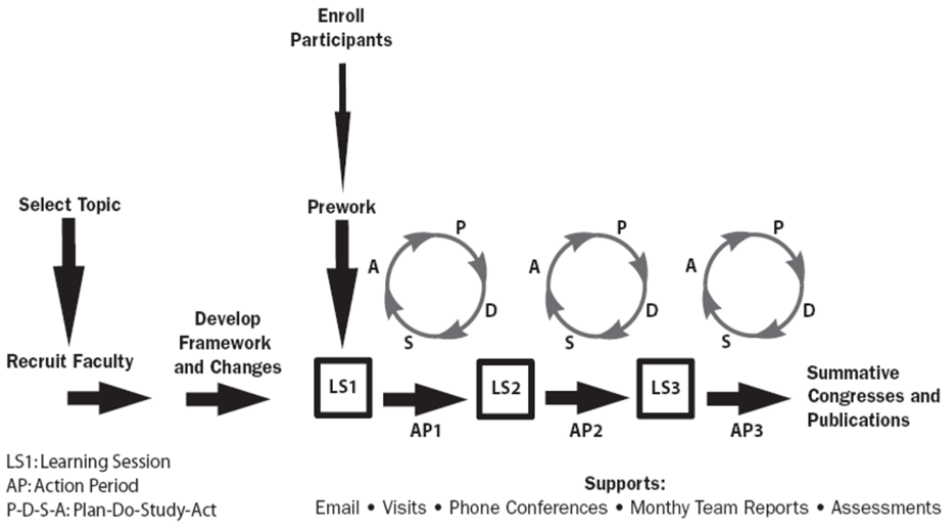

## Compass PTN Partners & Lead Organizations

COMPASS Practice Transformation Network

| | Georgia | Iowa | Kansas | Nebraska | Oklahoma | South Dakota |
|---|---|---|---|---|---|---|
| State | Georgia | Iowa | Kansas | Nebraska | Oklahoma | South Dakota |
| State Partner Lead(s) | Georgia Hospital Association Research and Education Foundation | Iowa Healthcare Collaborative | Kansas Healthcare Collaborative | ENHANCE Health Network | OU Physicians and Telligen | HealthPOINT at Dakota State University |

State QI Advisors → Designated Clinical & Operational Leads and Quality Improvement Advisors for every practice in each state

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## TCPI: 5 Phases of Transformation


Source: CMS TCPI PTN Information Webinar, November 20, 2014.

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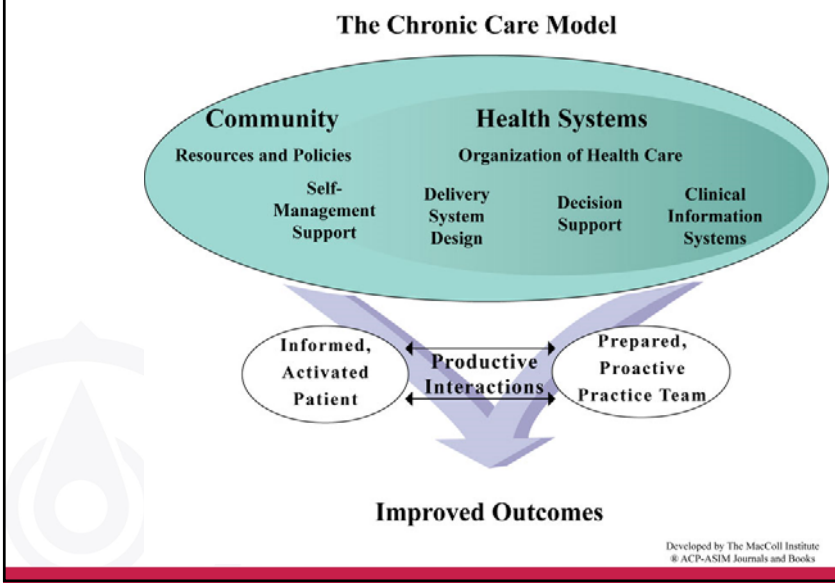
# *Patient-centered Medical Home Model*

IHC Iowa Healthcare Collaborative

## *What is Medical Home?*

- Originally introduced in 1967 by the American Academy of Pediatrics (AAP)
- Focused on the care of children with special needs
- Refers to a central location for storing a child's medical record for better coordination of care
- In 2002 the AAP expanded the definition of a Medical Home as a model of delivering primary care that is:
  - Accessible
  - Continuous
  - Comprehensive
  - Family-Centered
  - Coordinated
  - Compassionate
  - Culturally Effective

## Chronic Care Model




## Joint Principles

IHC Iowa Healthcare Collaborative

The Joint Principles of the PCMH are based on two conceptual frameworks:

Primary Care Model

- Accessible
- Continuous
- Coordinated
- Comprehensive

Chronic Care Model

- Patient Self Management Support
- Clinical Information Systems
- Delivery System Redesign
- Decision Support
- Health care Organization
- Community Resources

IHC Iowa Healthcare Collaborative

## *Joint Principles*

March 2007 the Joint Principles of the patient-centered medical home (PCMH) were established and endorsed by:

- American Academy of Pediatrics
- American Academy of Family Physicians
- American College of Physicians
- American Osteopathic Association

*Over 20 specialty healthcare organizations have also since endorsed the joint principles.*

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## *Joint Principles*

The Joint Principles define seven characteristics of the PCMH:

- Personal physician in ongoing relationship
- Physician directed medical practice team
- Whole person orientation
- Coordinated or integrated care across the system
- Quality and Safety are hallmark
- Enhanced Access
- Payment that recognizes value

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## *Patient-centered Medical Home*

**PCMH can facilitate**:

- *Successful transition from the hospital and reduction of preventable readmissions*
- *Patient engagement and self-management*
- *Coordination of community resources*

IHC Iowa Healthcare Collaborative

## *Terminology: Medical Home*

"***Medical Home*** is not a single place or location, but rather a concept of health care deliver structured around the patient's needs for care that is accessible, comprehensive, coordinated, and focused on quality and safety."

*AHRQ, AAFP, Patient-centered Primary Care Collaborative*

## *Terminology: Medical Neighborhood*

The ***medical neighborhood*** is a term coined by Fisher to describe "the constellation of services, providers, and organizations in a health system that contributes to the care of a population of patients."

- Functionally integrated, but not necessarily structurally integrated
- Does not assume risk

## *Terminology: Accountable Care Organization (ACO)*

An ***ACO*** is provider-led organization whose mission is to manage the full continuum of care and be accountable for overall cost and quality of care for a defined population

*Rittenhouse et al., 2009*

- Spectrum of organizational structures from vertically integrated HMOs to defined populations of enrolled patients under capitation.
- Both functionally and structurally integrated
- Can assume risk (shared savings or loss), such as APM

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## *Medical Home*

"At the center of integrated health care delivery is a high-performing primary care provider who can serve as a medical home for patients"

*Aetna Foundation, 2010*

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## *Effectiveness*

Colorado Multi-payer PCMH Pilot

- 15% decrease in ER visits
- 18% decrease in hospital admissions
- Improvements across all measures of diabetes care
- High levels of patient satisfaction

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## *Effectiveness*

Nebraska Medicaid Pilot

- Significant reduction in ER per 1000
- Significant decrease in rate of Rx written and spending
- Suggested increase in patient satisfaction
- Mixed provider/employee satisfaction
- Distinct improvement in outcomes

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## *Effectiveness*

Effectiveness increases over time/experience (PCPCC study released January 13, 2014)

- Significant impact on cost of care in 60% of practices (Unnecessary ER utilization and reduced hospital visits)
- Increasing provision of preventive care
- 30% report documented improving population health

*Why are we here?*

## TCPI: 5 Phases of Transformation


Source: CMS TCPI PTN Information Webinar, November 20, 2014. 42

## What is CMS asking us to do in TCPI?

- Move toward a PCMH model
- Measure quality on a monthly basis
- Assemble a learning community (enroll, engage, transform)
- Assess our progress and capture national lessons learned

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## TCPI Change Package

- National content for the TCPI program deployed across PTNs
- Aligns with the Practice Assessment Tool
- Organized into a goals, objectives and tactics model

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## TCPI Change Package Goals

1. Enhance Person & Family-centered Care Design
2. Provide continuous, data-driven quality improvement
3. Create sustainable business operations

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## CP1: Person and Family-centered Care

- Person and Family Engagement
- Team-based relationships
- Population management
- Practice as a community partner
- Coordinated care delivery
- Organized, evidence-based care
- Enhanced access

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## CP2: Continuous, Data-driven Quality Improvement

- Engaged and committed leadership
- Quality improvement strategy supporting a culture of quality and safety
- Transparent measurement and monitoring
- Optimal use of Health Information Technology (HIT)

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## CP3: Sustainable Business Operations

- Strategic use of practice revenue
- Workplace vitality and joy in the work
- Capability to analyze and document value
- Efficiency of operation

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## TCPI: 5 Phases of Transformation


Source: CMS TCPI PTN Information Webinar, November 20, 2014.

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## Practice Assessment Tool (PAT)

- Version 2.0 released in March based on PTN feedback
- Aligns with the Change Package
- Defines the improvement pathway and recognizes specialty specificity
- Initial measurement to launch work
- Used to track progress through the five phases in six month intervals

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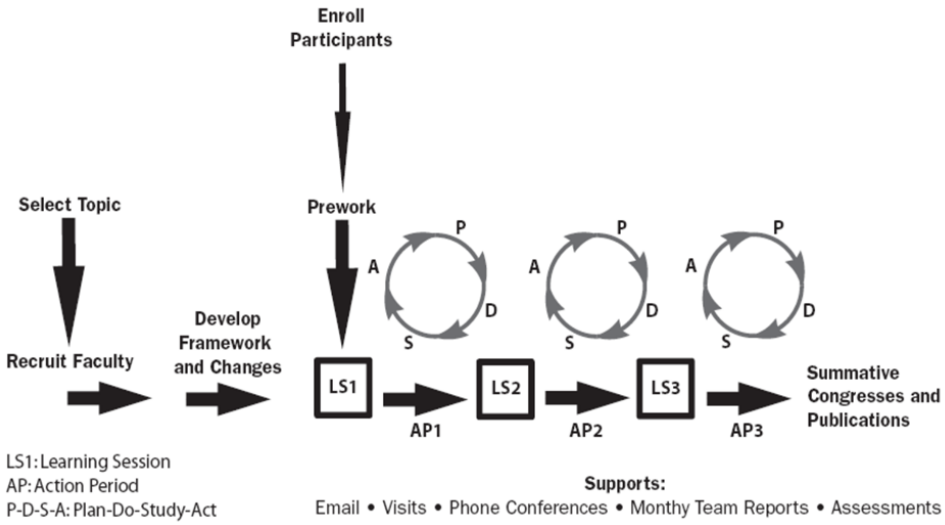


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