


TCPI:
Transforming Clinical Practice Initiative



COMPASS
Practice Transformation Network

*Preparing Clinicians
for the Future*

Tom Evans, MD
Compass PTN Learning Community
2016

1

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

2

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

Resources Available		
Resources	Mine	Not Mine
Other's	Public	Others
Not Other's	Private	Neither

Resources Available		
Resources	Mine	Not Mine
Other's	Public	Others
Not Other's	Private	Neither

Resources Available		
Resources	Mine	Not Mine
Other's	Public	Others
Not Other's	Private	Neither

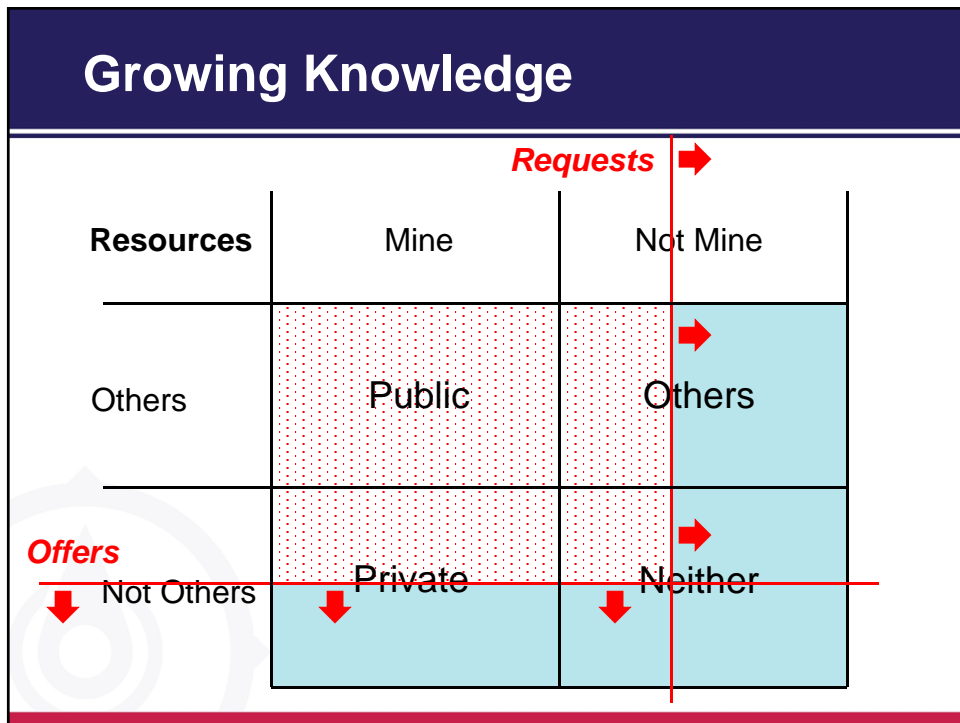
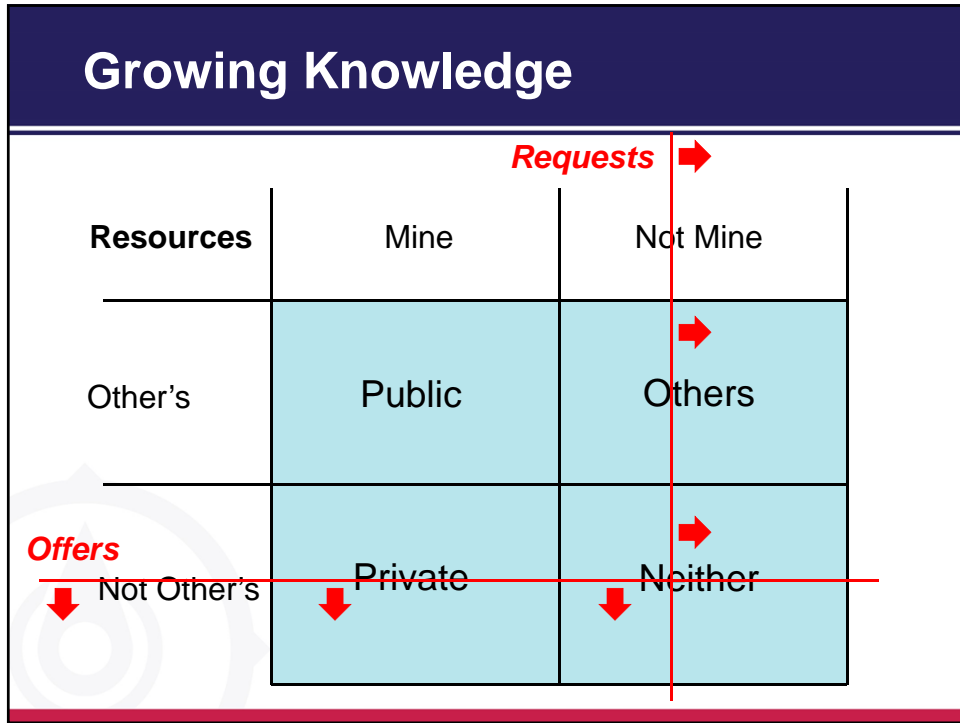
Resources Available

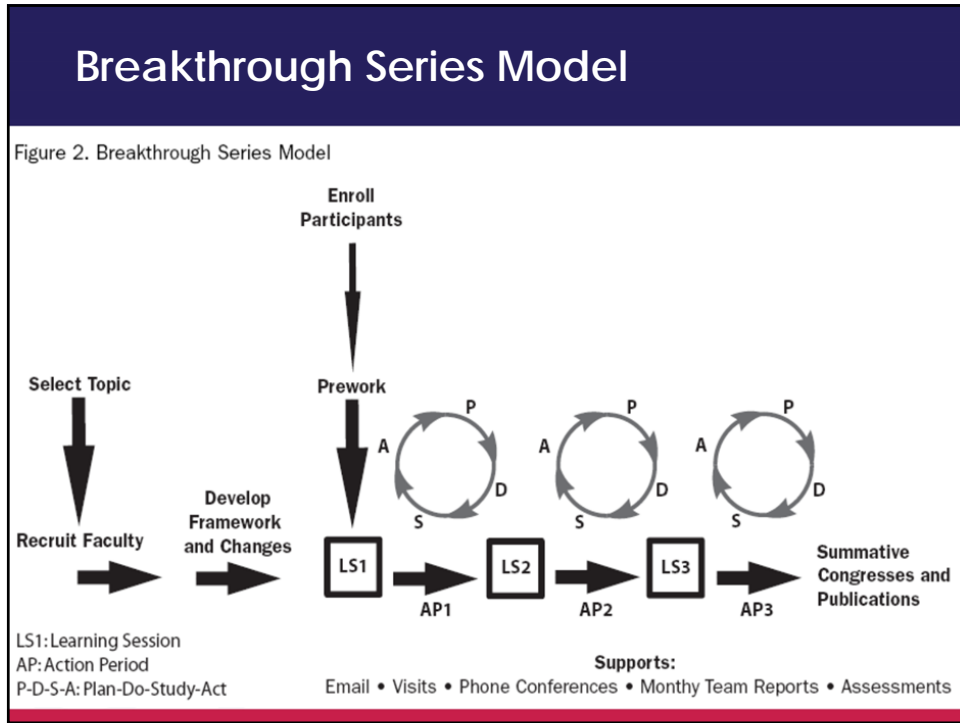
Resources	Mine	Not Mine
Other's	Public	Others
Not Other's	Private	Neither

Growing Knowledge

Resources	Mine	Not Mine
Other's	Public	Others
Not Other's	Private	Neither

Requests →





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

A faint logo in the bottom left corner of the slide, consisting of a gear with a flame-like shape inside it.

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

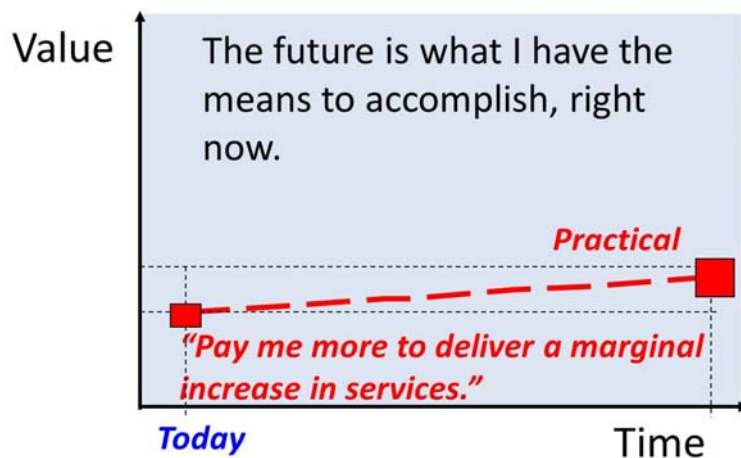
Knowing that a bicycle has two wheels, a seat, handlebars and a foot-pedal crank, for example, stands in sharp contrast to the practical knowledge of how to ride a bike.

Brent James, MD



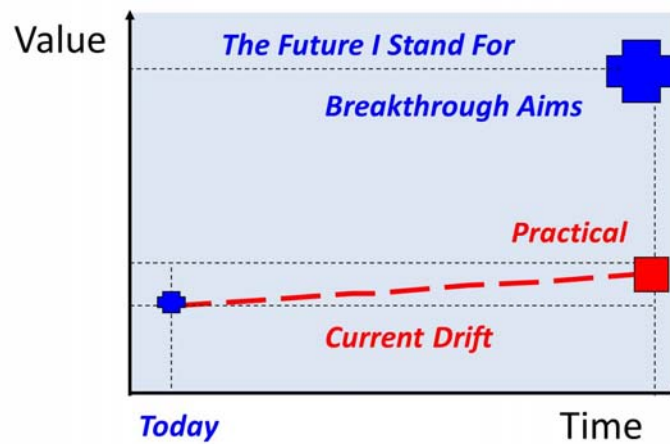
Systems create aims,
and measure results.

A practical choice on Aims (ends)

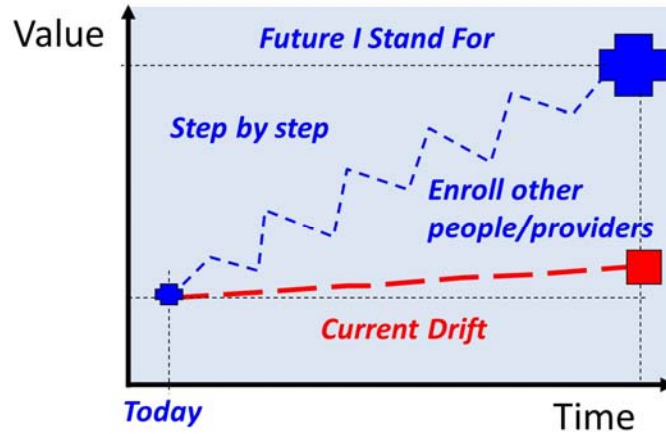


Systems don't create aims.
Aims create systems.

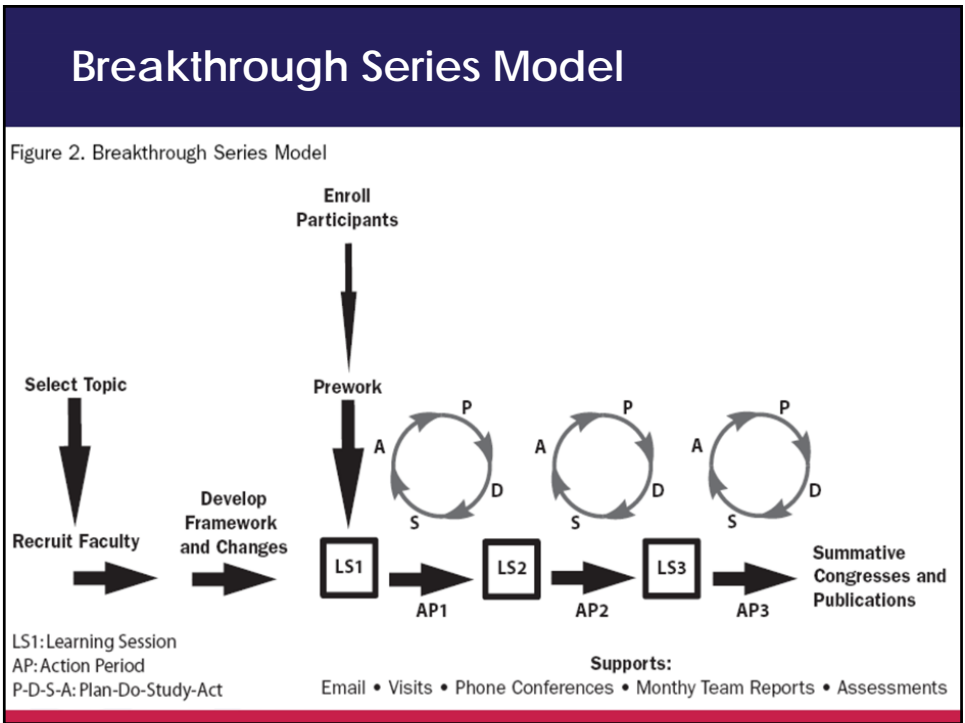

How do I get from here to there?

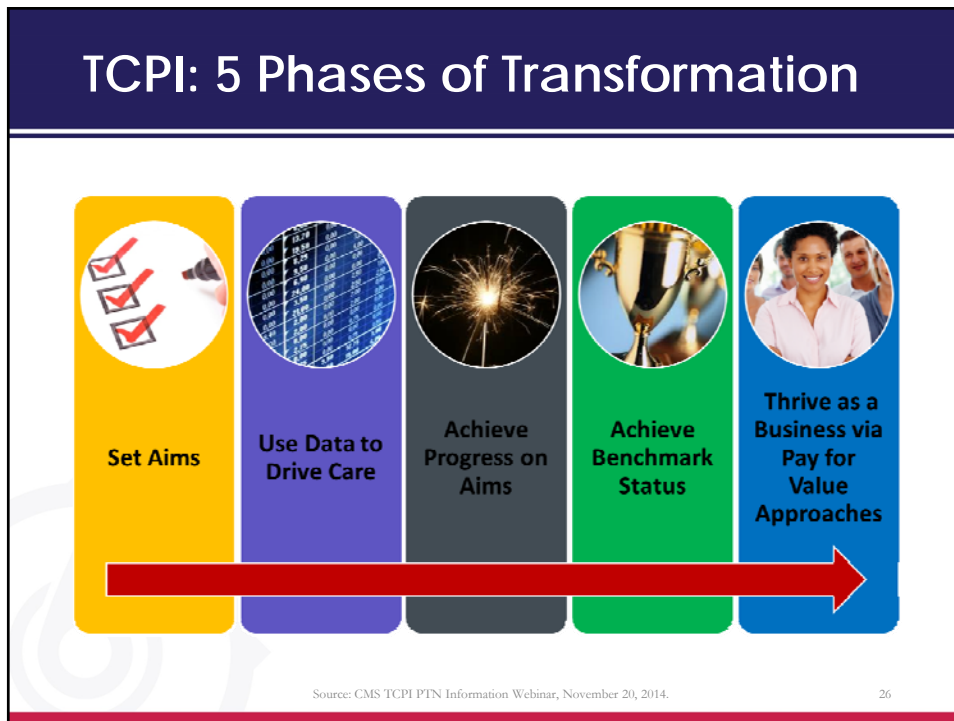
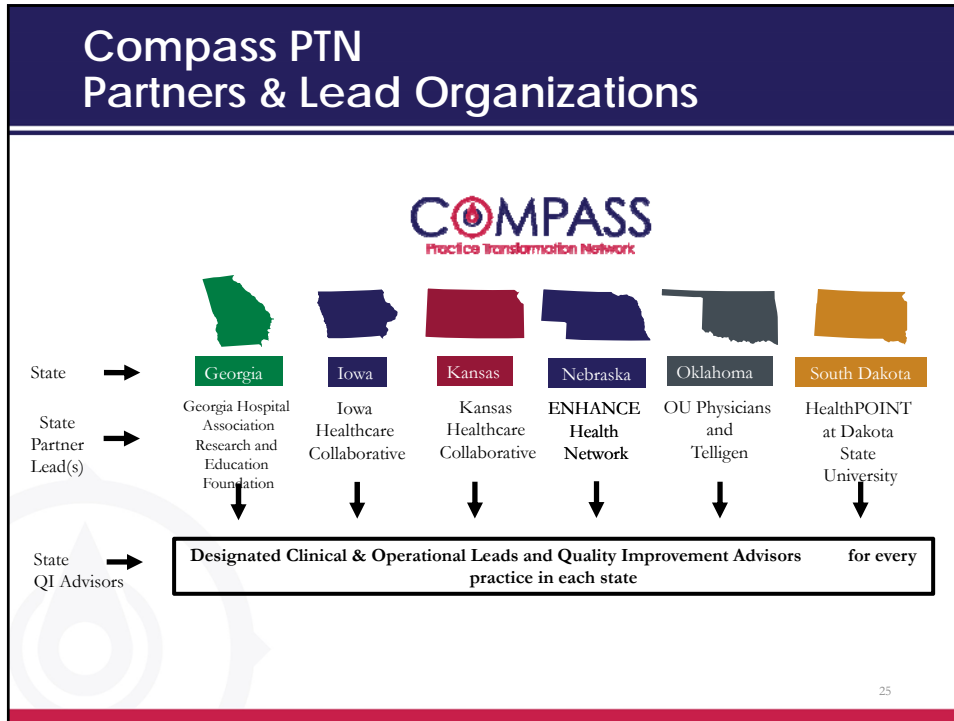


“Emergent” Strategy




Aims create systems. Systems create results.



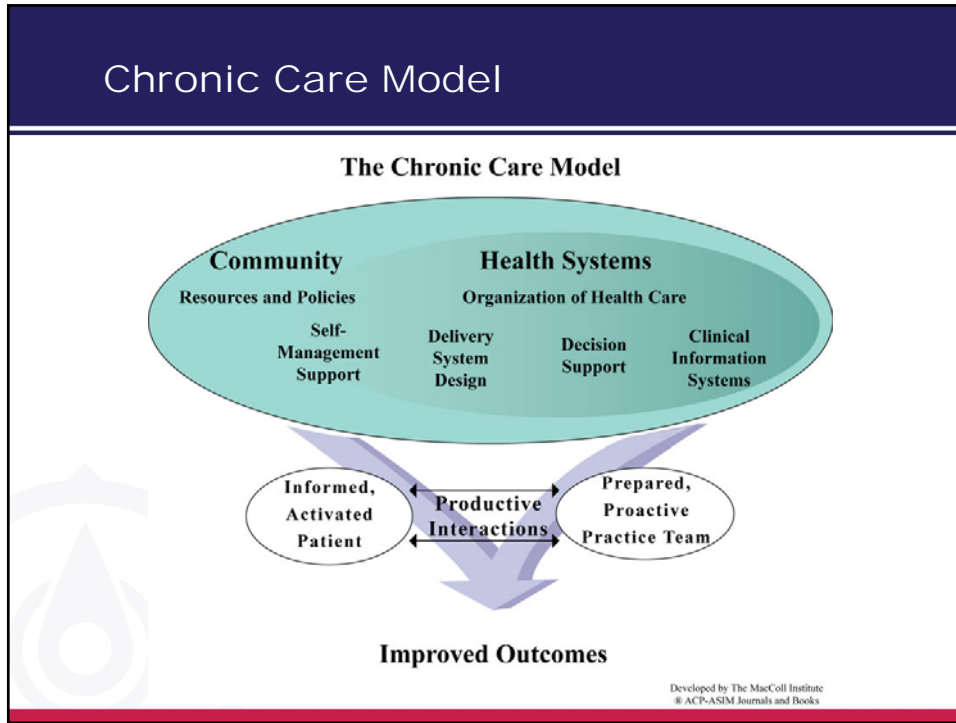


Patient-centered Medical Home Model



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
 - Coordinated
 - Continuous
 - Compassionate
 - Comprehensive
 - Culturally Effective
 - Family-Centered




IHC
Iowa Healthcare Collaborative

Joint Principles

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

Primary Care Model	Chronic Care Model
<ul style="list-style-type: none">• Accessible• Continuous• Coordinated• Comprehensive	<ul style="list-style-type: none">• Patient Self Management Support• Clinical Information Systems• Delivery System Redesign• Decision Support• Health care Organization• Community Resources




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.



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


 *IHC*
Iowa Healthcare Collaborative

*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



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




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






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



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

43

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

44

TCPI Change Package Goals

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

45



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

47

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)

48

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

49

TCPI: 5 Phases of Transformation



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

50

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

51

Breakthrough Series Model

Figure 2. Breakthrough Series Model

