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
Growing Knowledge and Capability

Resources

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### Growing Knowledge

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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)

The future is what I have the means to accomplish, right now.

"Pay me more to deliver a marginal increase in services."

Kansas Healthcare Collaborative
Systems don’t create aims. Aims create systems.

How do I get from here to there?

The Future I Stand For
Breakthrough Aims
Practical
Current Drift

Today

Time
“Emergent” Strategy
Aims create systems. Systems create results.

Breakthrough Series Model

Figure 2. Breakthrough Series Model

Supports:
- Email
- Visits
- Phone Conferences
- Monthly Team Reports
- Assessments

LS1: Learning Session
AP: Action Period
P-D-S-A: Plan-Do-Study-Act

Enroll Participants
Prework
A S D A S D A S
LS1 AP1 LS2 AP2 LS3 AP3
Summative Congresses and Publications
Compass PTN Partners & Lead Organizations

State Partner Lead(s)

Georgia
Iowa
Kansas
Nebraska
Oklahoma
South Dakota

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

TCPI: 5 Phases of Transformation

Set Aims
Use Data to Drive Care
Achieve Progress on Aims
Achieve Benchmark Status
Thrive as a Business via Pay for Value Approaches

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
  - Continuous
  - Comprehensive
  - Family-Centered
  - Coordinated
  - Compassionate
  - Culturally Effective
Chronic Care Model

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
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.

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
PCMH can facilitate:

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

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
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

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
“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
### 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

Set Aims
Use Data to Drive Care
Achieve Progress on Aims
Achieve Benchmark Status
Thrive as a Business via Pay for Value Approaches

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

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
TCPI Change Package Goals

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

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)
**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

**TCPI: 5 Phases of Transformation**

1. **Set Aims**
2. Use Data to Drive Care
3. Achieve Progress on Aims
4. Achieve Benchmark Status
5. Thrive as a Business via Pay for Value Approaches

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

Breakthrough Series Model

Figure 2. Breakthrough Series Model

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